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**QUALITY INCENTIVES FOR FEDERALLY QUALIFIED HEALTH CENTERS,  
RURAL HEALTH CLINICS AND FREE CLINICS:  
A REPORT TO CONGRESS**

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## EXECUTIVE SUMMARY

This report to Congress is submitted pursuant to Section 13113(b) of the American Recovery and Reinvestment Act of 2009 (hereafter, the Recovery Act), under Title XIII, also known as the Health Information Technology for Economic and Clinical Health Act or the “HITECH Act.” The Section requires the Secretary of Health and Human Services to provide “a study that examines methods to create efficient reimbursement incentives for improving health care quality in federally qualified health centers, rural health clinics, and free clinics.”

The report discusses current initiatives and incentives that apply to these categories of primary care clinics and the current knowledge regarding quality of care and the use of health information technology in this sector. Insofar as the report was authorized under the HITECH Act, it particularly addresses issues related to the use of health information technology by these clinics.

Federally qualified health centers (FQHCs), rural health clinics (RHCs), and free clinics serve as critical sources of primary health care for over 25 million patients at more than 10,000 sites across the country, from remote rural areas to congested central cities. They deliver preventive and primary health care services to patients who would otherwise have difficulty securing access to quality care either because they live in medically underserved or health professional shortage areas, have low incomes, are uninsured or on Medicaid, live in rural areas, and/or have other characteristics that make it difficult to access care. The Institute of Medicine defines the health care safety net as “the providers who organize and deliver a significant level of health care and other related services to uninsured, Medicaid and other vulnerable patients.”<sup>1</sup> By this criterion, FQHCs, RHCs, and free clinics are critical components of the nation’s health care safety net.

FQHCs and RHCs are specific types of facilities; federal statutes define their qualifying criteria and responsibilities but also grant them certain benefits in recognition of the challenges they face and populations they serve. FQHCs are non-profit organizations or public entities that provide comprehensive primary care to patients in medically underserved areas or populations without regard to the patients’ ability to pay. As defined in Section 1861(aa)(4) of the Social Security Act, there are four types of FQHC entities: (1) organizations funded under Section 330 of the Public Health Service Act (Section 330); (2) organizations that HRSA determines meet the requirements for funding under Section 330 but do not receive such funding (the so-called look-alikes); (3) a handful of grandfathered facilities; and (4) certain Indian health service and tribal providers including urban Indian programs. The vast majority of FQHCs fall into the first category of Section 330 grantees, and this report focuses on the availability of incentives to this category of FQHC. FQHCs are eligible to receive cost-based Medicaid, Medicare, and Children’s Health Insurance Program (CHIP) reimbursements, subject to payment caps and other rules. These payments are typically higher than Medicare or Medicaid rates paid to regular physicians’ practices and reflect the broader range of services they are required to provide and the needs of the populations they serve. As of 2010, there were 1,124 health center grantees providing services in more than 8,100 service sites, serving 19.5 million patients. About two-

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<sup>1</sup>Lewin M, Altman S, eds. America’s Health Care Safety Net: Intact but Endangered. Washington, DC: Institute of Medicine (National Academy Press); 2000.

fifths of FQHC patients were uninsured and two-fifths were on Medicaid or CHIP. In this report, the discussion of FQHCs generally focuses on Section 330-funded health center grantees, which constitute the great majority of all FQHC entities.

RHCs are clinics that provide primary care services, located in medically underserved or health professional shortage areas in non-urbanized locations. They must be staffed by a physician and have a nurse practitioner, physician assistant or certified nurse midwife available at least 50 percent of the time the clinic operates. About half are provider-owned, typically by a hospital, and about half are independent and may be owned by a physician, another clinician, or other entity. They may be for-profit, non-profit, publicly-owned, or unincorporated. RHCs are certified by the Centers for Medicare & Medicaid Services (CMS) and receive cost-related Medicare, Medicaid, and CHIP reimbursements, subject to payment caps and other rules; these are also typically higher than other physicians' rates. While FQHCs are located in both urban and rural areas, by definition, RHCs are required to locate in a non-urbanized area (although some are in areas that have since become more urbanized). As of 2010, there were close to 3,800 RHCs. In 2008, RHCs served about 1.6 million Medicare and 2 million Medicaid patients. Although the total number of patients served by RHCs is not known, a reasonable estimate is 5 to 8 million patients in 2008. RHCs are not required to serve Medicaid or uninsured patients, but they often do. A recent survey of independent RHCs indicated that over a quarter of their patients were on Medicaid and an eighth of billings were for free, discounted, or only partially paid care, suggesting that many patients are uninsured.

While there is no commonly accepted definition of a free clinic, Congress has enacted legislation that defines the term for purposes of extending medical malpractice liability protection under the Federal Tort Claims Act (FTCA) for certain individuals sponsored by qualified free clinics. Under this definition (found in the Public Health Service Act at 42 U.S.C. 233(o)), free clinics are health care facilities operated by nonprofit private entities that: (1) do not accept reimbursement from third-party payers; (2) do not impose charges upon patients (either on the basis of services provided or ability to pay); and (3) are licensed or certified in accordance with applicable law regarding the provision of health services. Using a broader definition similar to that used by the National Association of Free Clinics, free clinics are non-profit clinics that serve uninsured patients either for free or for a nominal charge. They are often staffed by volunteer clinicians and vary widely in size and scope of operations; only one-quarter offer full-time services. Some offer relatively limited services, while others are broader. Free clinics generally do not take insurance payments and rarely receive government funding; much of their operating support comes from charitable donations. A national survey estimated that in 2006 there were about 1,000 free clinics (using the broader definition) in the U.S., serving about 1.8 million patients. At an average clinic, 92 percent of patients were uninsured. About one-eighth of those free clinics receive benefits as sponsoring organizations for their eligible personnel under the FTCA.

## **QUALITY AND HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVES**

Through a number of initiatives, the federal government seeks to improve the quality of health care by offering financial incentives to health care providers who meet specified performance criteria. For example, the 2009 Recovery Act creates substantial multi-year



financial incentives in Medicare and Medicaid for eligible professionals and hospitals to adopt and “meaningfully” use certified electronic health record (EHR) technology. The goal of the incentive program is to encourage providers to collect, monitor, and share health information to improve the quality of care. Even earlier, Medicare had initiated a variety of incentive programs for physicians to report quality-related information, to use electronic prescription systems, and to pilot other performance-based payment approaches. Many States’ Medicaid programs and private insurers have developed “patient-centered medical home” initiatives that offer bonuses to primary care practices that demonstrate enhanced capabilities to provide care for and monitor patients with chronic diseases; in addition, the Patient Protection and Affordable Care Act of 2010, as amended, (hereafter, the Affordable Care Act) authorizes State Medicaid agencies to develop health homes to deliver such care to individuals with multiple chronic conditions. Many States have other quality and performance-based payment programs, often implemented under Medicaid managed care.

While clinicians at FQHCs, RHCs, and free clinics provide similar types of primary care services as other office-based physicians, they are often ineligible for the quality and health information technology incentives that those other providers are eligible to receive. Free clinics are effectively excluded from incentive payments because they typically do not collect third-party insurance payments and, therefore, cannot earn incentives linked to insurance payments. For FQHCs and RHCs, the exclusion from incentives typically applies in Medicare. For example, in the Recovery Act which authorizes Medicare EHR incentives, these incentives are specified for “covered professional services furnished by an eligible professional” and are related to the Medicare physician fee schedule, but these criteria do not apply to FQHCs and RHCs, so they are not eligible for these incentives.

In contrast, the federal Medicaid EHR incentives authorized under the Recovery Act apply to eligible professionals who work at FQHCs and RHCs; these professionals may assign to their incentive payments to the FQHCs and RHCs that employ them, thus effectively providing the incentives to the clinics. It is expected that the majority of eligible professionals will assign the incentives to the clinics, although this will depend on the terms of their employment and requires that the contract between the clinic and the eligible professional address this issue. To be eligible for the Medicaid EHR incentives, the professionals must practice predominantly in an FQHC or RHC and have a patient volume of at least 30 percent “needy individuals.” The “needy individual” population is defined for FQHCs and RHCs as individuals eligible for free and sliding fee scale patient care, along with Medicaid and CHIP insured individuals. In contrast, regular office-based physicians must meet the standard of 30 percent Medicaid volume, except for pediatricians who have a 20 percent Medicaid standard. Analyses indicate that almost all FQHC clinicians could be eligible for Medicaid EHR incentives based on these criteria. Many RHC clinicians have sufficient Medicaid and uncompensated care volume to qualify, but not all. Since providers can only take either the Medicare *or* the Medicaid incentives and the Medicaid incentives are the more generous of the two, the exclusions of FQHCs from Medicare incentives is a negligible issue in practice. However, RHCs with insufficient Medicaid and uncompensated care, will be ineligible for both Medicare and Medicaid incentives.

Other Medicaid incentives are designed by State Medicaid agencies (or sometimes by the managed care plans that operate under Medicaid) and appear to vary widely. A 2009 survey of State primary care associations (State associations that represent FQHCs and other safety net

providers) indicated that some States offer medical home, quality, or HIT incentives to FQHCs, while other States offer such incentives to office-based physicians but exclude FQHCs. We are not aware of comparable surveys about RHCs' eligibility for Medicaid quality incentives, but it is plausible that they are treated similarly to FQHCs since the underlying payment approaches used for FQHCs and RHCs are similar in Medicaid.

While FQHCs and RHCs are often excluded from incentive payments, their base Medicare and Medicaid payments are calculated based on costs and are often higher than base payments for regular physician practices. These payments are designed to help support FQHCs and RHCs which could otherwise have difficulty operating in underserved areas, and reflect the broader range of services they provide because of the needs of the populations they serve. The Medicare payment rates are subject to statutorily-mandated caps and could fall below the actual costs of care. If the purpose of incentive payments is to encourage providers to take additional steps to improve quality or to adopt health information technology which incur additional costs, then the fact that FQHCs and RHCs are often ineligible for these incentives may make it less likely that they will adopt the desired changes.

The Affordable Care Act gives State Medicaid programs the option to develop "health home" projects for enrollees with chronic diseases. This provides a new opportunity to promote enhanced integration and coordination of primary, acute, behavioral and other services. CMS issued basic guidance on November 16, 2010. States have substantial flexibility in how to structure these programs and may modify their provider payment methodologies to offer an incentive for the adoption of health home improvements. A number of States have expressed interest in health homes and it is reasonable to expect that many will build upon the experiences they already have with prior medical home projects. It is likely that many FQHCs and RHCs will be able to participate in health home projects, but their participation will be subject to State decisions and it is too early to assess how these projects will be ultimately implemented.

Other, non-reimbursement-based incentives related to quality improvement also exist, including in-kind benefits, grants, and technical assistance. Individuals practicing at FQHCs receiving Section 330 funds and individuals at participating free clinics (including volunteer clinicians, board members, and certain staff) are eligible for FTCA medical malpractice liability protection, because they are "deemed" federal employees under the Public Health Service Act. This coverage is only available to centers that have sought FTCA coverage and provided required quality assurance and performance improvement plans. RHCs do not qualify for this coverage but do periodically report performance as part of the Quality Assessment and Performance Improvement Program.. Some RHCs or FQHCs are eligible for Rural Health Broadband grants from the Federal Communications Commission, designed to improve HIT services for non-profit or public organizations, but for-profit RHCs are ineligible. HRSA and the Office of the National Coordinator for Health Information Technology (ONC) provide and fund a variety of technical assistance services which help certain FQHCs, RHCs, free clinics, and other health care providers adopt new technologies and improve the quality of care.

## THE QUALITY ENVIRONMENT OF FQHCs, RHCs, AND FREE CLINICS

Regardless of incentives, issues of quality of care and use of HIT are important to all safety net clinics. FQHCs are required to maintain an ongoing Quality Improvement/Quality Assurance (QI/QA) program that addresses clinical services and management, and maintains the confidentiality of patient records; they are also required to report annually on key quality indicators. RHCs must provide program evaluations. (Quality assessment and performance improvement plans for RHCs were addressed under a 2008 proposed rule, but final rules have not been issued.) Free clinics whose eligible individuals are covered by the FTCA also must submit periodic assessments and improvement plans.

The Bureau of Primary Health Care (BPHC), which administers the health center program at HRSA, has long stressed quality measurement and improvement by FQHCs. Since the 1970s, BPHC has required that FQHCs file annual administrative reports that include some clinical quality measurements. In the 1990s, BPHC began work with the Institute for Healthcare Improvement on implementation of the Health Disparities Collaboratives expanded care model to monitor and improve primary care for those with chronic health conditions and although this program has ended, many of the practices it instigated remain today. Program requirements mandate that FQHCs maintain an ongoing QI/QA program that addresses clinical services and management. A large number of research studies have examined the quality and cost-effectiveness of care at FQHCs and have generally concluded that they provide good quality primary care that helps patients stay healthy and reduces the use of more expensive specialty or hospital care, including emergency department care and inpatient admissions. The Office of Management and Budget has rated the health center program as effective, its highest rating.

There is relatively little research or national data about the quality of care provided by RHCs or free clinics. Unlike FQHCs, there is no regular administrative reporting system that provides quality-related data about these categories of providers. There have been studies of a small number of clinics, but it is unlikely that they represent RHCs or free clinics nationally.

Another important issue which could affect the quality of care at safety net clinics is the adequacy and robustness of the primary care workforce, particularly in the future. Although the demand for primary care practitioners is rising, fewer American medical students and residents have been selecting primary care fields. Many areas, such as rural communities and inner cities, often have an insufficient supply of primary care clinicians. Since FQHCs and RHCs are located in medically underserved and health professional shortage areas or serve medically underserved populations, their communities already face challenges recruiting and retaining primary care staff, and these challenges may intensify in the future. Since free clinics often rely on volunteer clinicians, they are also likely to be affected by primary care clinician shortfalls. If FQHCs, RHCs, and/or free clinics are unable to secure sufficient primary care clinicians, including physicians, nurse practitioners, or physician assistants, they could have greater difficulties providing quality care for their patients.

## THE HIT ENVIRONMENT OF FQHCs, RHCs, AND FREE CLINICS

An important national goal is to promote the adoption and meaningful use of certified EHR technology, in order to foster quality improvement and monitoring for health care. Some information is available about the use of EHR systems at the safety net clinics, but the data can be difficult to interpret. First, the types of EHR systems used vary widely; many use rudimentary or basic systems, while a much smaller share have more comprehensive systems and are used in a fashion that meets the “meaningful use” criteria envisioned under the Recovery Act. Second, general trends show that the rate of adoption and use of EHRs is climbing quickly and is expected to accelerate even more rapidly beginning in 2011 when the Medicare and Medicaid EHR incentives become available. Therefore data from even two to three years ago may not reflect current use.

A 2008 survey by the National Association of Community Health Centers (NACHC) indicates that about half of Sec. 330 funded health centers had some type of EHR system and more were planning to acquire them. Since that time, there has been a major effort to upgrade HIT capacity at FQHCs; the 2009 Recovery Act provided \$1.5 billion in funding for capital improvements at FQHCs, including improving HIT systems; and the Affordable Care Act, as enacted, appropriated additional capital funding to FQHCs. Researchers at George Washington University and NACHC recently completed a new survey of FQHCs and found that 69 percent use EHRs, substantially more than in 2008. A survey by the University of Central Florida found that about one-quarter of RHCs had an EHR system, but that survey had a very low response rate (11 percent) and its generalizability is uncertain. Other data, not specifically about RHCs, indicates that rural physicians are less likely to have EHRs than their urban counterparts, in part because rural practices tend to be smaller. The University of Southern Maine is fielding a new survey of RHCs and better data should be available later. Preliminary data from a new 2010 survey by the National Association of Free Clinics, presented for the first time in this report, indicate that about one-quarter of free clinics had EHR technology and one-sixth planned to adopt one, but respondents to the survey tended to be larger than average (and thus had greater human and financial resources), so these findings are likely an upper-bound estimate of EHR use by the overall population of free clinics.

Together these data suggest that at least half of FQHCs and perhaps a quarter of RHCs and free clinics have at least some EHR capacity, although the percentage that “meaningfully use” the technology as set forth in new federal regulations, is certainly much smaller. Preliminary data from the National Center for Health Statistics indicate that 50 percent of all office-based physicians had some EHR technology in 2010, but only 10 percent had “fully functional systems,” a definition that still falls short of measuring meaningful use. This suggests that FQHCs are roughly on par with the overall physician community in EHR use (and perhaps slightly ahead given the NACHC survey data are from 2008), but that RHCs and free clinics lag behind, perhaps because of a combination of their limited resources, small size, and other factors, such as rural location. (A more accurate comparison might be between these clinics and EHR use by physicians in group practices, but 2010 data showing the use of EHRs in group practices are not yet available). Even so, only a fraction of the clinics with EHRs may be able to meet the “meaningful use” criteria that have been developed by the federal government suggesting that further improvements will be needed even among clinics that already have EHR technology.

For safety net clinics, like many other providers, a barrier to the adoption of EHR technology has been the costs of acquiring and implementing the systems. Some clinics have difficulty raising the capital for such systems, particularly if they are non-profit or have limited resources. In addition, some clinics may encounter problems that are broader than their individual capacity to acquire EHR systems. For example, the Federal Communications Commission's report on its National Broadband Plan noted that an estimated 9 percent of FQHCs and 26 percent of RHCs are in locations that lack broadband access, which would deter their effective use of EHRs and ability to share data with others.

## CONCLUSIONS

This report has three primary conclusions:

- FQHCs, RHCs, and free clinics are essential components of the nation's primary care health safety net. They help provide care to those who would otherwise have difficulty accessing regular primary care services on an affordable basis, because they are in a medically underserved or health professional shortage area, are uninsured or on Medicaid, and/or have low-incomes or other vulnerabilities. Collectively, these safety net clinics provide vital preventive and primary care services at over 10,000 sites and serve more than 25 million patients.
- FQHCs, RHCs, and free clinics are often excluded from eligibility for federal and some State financial incentives that are designed to encourage and support improvements in the quality of care or the use of health information technology. For example, the statutory authorization for Medicare EHR incentives specifies they are for "covered professional services furnished by an eligible professional" and are related to the Medicare physician fee schedule, but these criteria do not apply to clinicians at FQHCs and RHCs, so they are not eligible for the Medicare incentives. (This exclusion does not apply to Medicaid EHR incentives, which permit payment to eligible professionals at FQHCs and RHCs, however.) Free clinics are excluded because they generally do not collect health insurance payments and therefore cannot receive bonuses that are tied to insurance reimbursements.
- Existing data indicate that FQHCs generally provide good quality care and are using electronic health record (EHR) systems at levels somewhat higher than other office-based physicians. Data about quality at RHCs and free clinics are scant, although systems of quality assessment and performance improvement plans are often in place. Recent surveys suggest that RHCs and free clinics lag behind other office-based physicians in their use of EHR systems.

While this report indicates that some clinics do not qualify for incentives designed to improve care, it is still critical that safety net clinics keep pace with technological and practical advances in the American health care sector. The HHS Action Plan to Reduce Racial and Ethnic Health Disparities (April 2011) notes the importance of safety net clinics, including FQHCs, in providing access to quality health care for vulnerable populations in the U.S. and the significance

of reducing barriers to effective access to quality care as an approach to reduce health disparities. These include efforts to measure and provide incentives to improve the quality of patient care, the meaningful use of health information technology and the dissemination of patient-centered medical homes. It is important that safety net clinics are able to keep pace with broader changes in the American health system to strengthen patient care for needy populations.



## CHAPTER 1: INTRODUCTION

### PURPOSE OF THIS REPORT

While the American health care system has the capacity to provide sophisticated cutting-edge care for complex medical conditions, millions of Americans continue to have problems accessing quality care for basic primary and preventive health services. Americans may face barriers to care because they lack health insurance coverage, have low incomes, and/or live in areas without enough primary care practitioners. Across the nation, from the most isolated rural areas to crowded inner cities, there are thousands of safety net providers serving these vulnerable populations, including:

- **Federally qualified health centers (FQHCs)** that serve patients in medically underserved areas or populations without regard to their patients' ability to pay;
- **Rural health clinics (RHCs)** that care for patients in rural areas that are medically underserved or have shortages of health professionals; and
- **Free clinics** that provide care to uninsured patients either for free or with nominal charges.

Together, these safety net clinics are responsible for the basic preventive and primary health care of well over 25 million low-income patients, across the life cycle, from prenatal development to the oldest old. Their patients include the working poor, the unemployed, farm families, homeless people, migrant workers, those living in public housing, and many more. These facilities provide fundamental health care for many of the nation's most vulnerable patients, who would otherwise have difficulty accessing care in the mainstream health care system.

Despite our system's ability to deliver cutting-edge health care, the quality of care received is often suboptimal for many Americans. International surveys suggest that the United States often lags behind other developed nations in the quality of health care delivered.<sup>2</sup> Over the past decade, including initiatives under the 2010 Patient Protection and Affordable Care Act, as amended, (hereafter the Affordable Care Act), there have been efforts to improve the quality of care. One mechanism (but by no means the only) is to offer health care providers financial incentives to promote better quality health care. However, in many cases, these incentives have excluded some or all providers at safety net primary care facilities, such as FQHCs, RHCs, and free clinics. This is particularly problematic since these safety net clinics serve millions of uninsured and/or Medicaid patients and sometimes lack the financial capacity to invest in quality improvements (including but not limited to health information technology).

The 2009 American Recovery and Reinvestment Act (hereafter the Recovery Act) requested a report to Congressional committees that addressed the issue of quality incentives for these safety net primary care providers:

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<sup>2</sup>For example, see Schoen C, Osborn R, Doty MM, Bishop M, Peugh J. Toward higher-performance health systems: adults' health care experiences in seven countries. *Health Affairs*. 2007;26(6): w711-34 or Anderson G, Marcovich S. *Multinational comparisons of health systems data 2007*. New York (NY): Commonwealth Fund; 2010 Apr.

Section 13113(b) REIMBURSEMENT INCENTIVE STUDY AND REPORT.—

- (1) STUDY.—The Secretary of Health and Human Services shall carry out, or contract with a private entity to carry out, a study that examines methods to create efficient reimbursement incentives for improving health care quality in Federally qualified health centers, rural health clinics, and free clinics.
- (2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of jurisdiction of the House of Representatives and the Senate a report on the study carried out under paragraph (1).

This report examines the current state of knowledge about quality in federally qualified health centers, rural health clinics, and free clinics and these clinics' ability to participate in existing quality incentive programs. The Recovery Act included investments to spur the development and dissemination of health information technology, which is intended to improve the efficiency, quality, and coordination of care, thus this report focuses on incentives for the use of health information technology among safety net primary care providers, in addition to other quality incentives. It also focuses on existing approaches and their applicability to FQHCs, RHCs, and free clinics.

This report is organized as follows. Following the executive summary, the introduction provides basic background about FQHCs, RHCs, and free clinics; including basic cross-cutting themes. The introduction is followed by three chapters about: (1) federally qualified health centers, (2) rural health clinics, and (3) free clinics. Each chapter provides more details about the type of provider, current quality initiatives and HIT use, and eligibility for and uptake of current incentives. These three chapters are followed by a brief concluding chapter.

## **A COMPARISON OF THE THREE TYPES OF SAFETY NET PRIMARY CARE PROVIDERS**

While the overarching purpose of FQHCs, RHCs, and free clinics is similar – to address the primary care needs of people who would otherwise have difficulty accessing care – each type of facility has a different policy history, organizational profile, and set of needs. What these three types of organizations have in common is that unlike Medicaid and Medicare which provide health care coverage, these organizations actually deliver health care to patients, employing tens of thousands of physicians, nurses, and other health professionals who care for millions of patients, including many who are uninsured. The federal government has established policies and subsidies to support FQHCs and RHCs, while there is little federal support or policy for free clinics.

Both FQHCs and RHCs are defined by federal legislation (Sections 1861(aa) and 1905(l) of the Social Security Act). There are other “health centers” that offer many of the same functions but are not designated as FQHCs. Many other health care providers, such as physicians' offices and outpatient clinics located in hospitals, also exist in rural areas, but are not designated as RHCs and do not receive cost-based RHC payments.

Both FQHCs and RHCs are eligible to be reimbursed by Medicaid, the Children's Health Insurance Program (CHIP) and Medicare using cost-based methodologies subject to caps (in the case of Medicare) and other rules. (See below for more information on reimbursement to



FQHCs and RHCs). Free clinics generally do not receive reimbursement from Medicaid, CHIP, or Medicare.

Table 1 summarizes many of the key organizational differences between FQHCs, RHCs, and free clinics. Key differences include:

**Federally qualified health centers** are, broadly speaking, the largest and most comprehensive of these types of health care facilities. Building on the Community and Migrant Health Centers programs started in the 1960s and 1970s, the term ‘federally qualified health center’ was established under the Omnibus Budget Reconciliation Act of 1989 to define the types of entities eligible for cost-related reimbursement under Medicare; Medicaid FQHC provisions were enacted in 1990. The term “FQHC” as defined in Section 1861(aa)(4) refers to four types of clinics: (1) health center grantees that receive funding under Section 330 of the Public Health Service Act for community, migrant, homeless and public housing health centers; (2) entities that have been identified by HRSA and designated by CMS as meeting all Section 330 requirements and being eligible for Section 330 grants but do not directly receive them (but could be subgrantees; these are the so-called “look-alikes”); (3) a handful of grandfathered facilities; and (4) outpatient clinics and programs operated by tribal organizations and funded through funding under certain titles of the Indian Health Care Improvement Act.<sup>3</sup> These non-profit or public facilities provide primary care and preventive services to medically underserved patients, including the uninsured and Medicaid patients, as well as Medicare and commercially-insured patients, without regard to patients’ ability to pay. Health center grantees and FQHC look-alikes also must have community-based boards, in which patients form a majority. They must serve areas that are considered medically underserved or serve medically underserved populations.<sup>4</sup> FQHCs offer care on a sliding fee scale to patients at or below 200 percent of the federal poverty level. The Health Resources and Services Administration (HRSA), through its Bureau of Primary Health Care (BPHC), administers the Section 330 grant program and provides oversight of and policy guidance to health center grantees and FQHC look-alikes. HRSA also provides other support, such as administering the program that provides liability coverage (essentially medical malpractice insurance) to health center grantees under the Federal Tort Claims Act pursuant to the Federally Supported Health Centers Assistance Acts; and facilitating access to discounted prescription drugs under the Section 340B program of the Public Health Service Act (Section 340B program). FQHCs are also eligible for cost-related reimbursement, subject to caps and other rules, from Medicaid, CHIP, and Medicare, based on policies from the Centers for Medicare & Medicaid Services (CMS).

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<sup>3</sup>These tribally-based organizations include outpatient health facilities operating under the Indian Self-Determination Act or as urban Indian organizations receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991. For a more comprehensive definition of an FQHC and other key rules, see Centers for Medicare & Medicaid Services. Fact sheet: federally qualified health center. 2009 Apr. Available from: <http://www.cms.gov/MLNProducts/downloads/fqhcfactsheet.pdf>. It should also be noted that some urban Indian programs that fall into this category also receive Section 330 funds.

<sup>4</sup>Medically underserved areas, medically underserved populations, and health professional shortage areas are designated by HRSA, based on regulatory criteria. The agency is currently undertaking a negotiated rulemaking process to consider revisions to these regulatory criteria.

**Table 1: Basic Comparison of the Three Types of Safety Net Primary Care Facilities**

In 2010, there were 1,124 health center grantees which included more than 8,100 sites

	<b>Federally Qualified Health Centers (FQHCs)</b>	<b>Rural Health Clinics (RHCs)</b>	<b>Free Clinics</b>
<b>Basic Description &amp; Federal Definition</b>	Non-profit or public centers that offer comprehensive primary and preventive care without regard to patients' ability to pay. Most FQHCs are Section 330 grantees. Often also offer restorative dental and mental health services. Frequently use team-based care, including advanced practice clinicians and others. Required to treat all patients regardless of ability to pay.	Rural primary care clinics with at least one physician and a nurse practitioner or physician assistant at least 50 percent. May be for-profit, non-profit, or public. Must be able to provide primary care and certain other services. About half are independent and half are owned by hospitals or other providers.	Non-profit clinics that provide care to disadvantaged, predominantly uninsured patients. They either charge no fees or nominal fees, although they may ask for donations. Provide care regardless of a patient's ability to pay.
<b>Location and Shortage Area Requirements</b>	Health center grantees and look-alikes must serve a medically underserved area or medically underserved population.	Must locate in non-urbanized area and in medically underserved or health professional shortage area.	None.
<b>Key Statistics</b>	2010: 1,124 grantees, operating in more than 8,100 sites. 19.5 million total patients served by grantees.	2010: about 3,800 RHCs. 2008: 1.6 million Medicare and 2 million Medicaid patients. Perhaps 5 to 8 million patients.	2006: about 1,000 free clinics. 1.8 million total patients.
<b>Major Federal Revenue Sources</b>	Section 330 health center grants. Medicaid, CHIP and Medicare payments.	Medicaid, CHIP and Medicare payments.	Generally no federal insurance reimbursement or grants.
<b>Medicaid/Medicare Payment Methods*</b>	In Medicare, an all-inclusive cost-based payment per encounter subject to caps. In Medicaid and CHIP, a prospective payment system or alternative is used.	Similar to FQHCs.	Generally none.
<b>Billing Practices</b>	May bill Medicaid, CHIP, Medicare or commercial insurance. For patients below 200% of poverty, must offer services on a sliding fee scale.	May bill Medicaid, Medicare, or commercial insurance. Not required to offer sliding scale fees or free care, but many do.	Very few receive insurance payments. Either provide care for free or at a nominal price.
<b>Other Federal Benefits</b>	Grantees eligible for FTCA liability coverage; look-alikes do not. Both receive access to discount prescription drugs through Section 340B program, technical assistance, etc.	May be eligible for some other benefits, e.g., FCC Rural Broadband funds for public or non-profit RHCs, technical assistance.	Some receive liability coverage under FTCA.
<b>Primary Federal Agencies</b>	Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA) for Section 330 grants and overall policy. Centers for Medicare & Medicaid Services (CMS) for Medicaid, CHIP, and Medicare payment policy.	CMS for certification as an RHC and for Medicaid and Medicare payment policy. Office of Rural Health Policy (ORHP) in HRSA provides some general rural health assistance, including telemedicine.	None, except that BPHC provides policy related to FTCA liability coverage.
<b>National Associations</b>	National Association of Community Health Centers	National Association of Rural Health Clinics	National Association of Free Clinics

\* Under federal policy, States may not pay providers for services furnished without charge to the community, but may pay if the provider bills other liable third parties. Thus, in some cases, Medicaid may pay clinics for such services.

and cared for 19.5 million patients, according to the Uniform Data System (UDS) reports for grantees, as tabulated by HRSA. FQHCs are required to provide comprehensive primary and preventive health services, as well as services that assist patients in accessing medical services, such as translation/ interpretation, transportation, and assistance with enrolling in Medicaid or CHIP. Many provide a broader range of oral and mental health services, although these are not required by statute. In addition, while FQHCs are focused on primary and preventive care, some provide specialty medical services as well. These services may be provided through referral arrangements, via contracts, or directly on-site. In 2010, health center grantees were staffed by 9,592 physicians, 6,362 mid-level practitioners and 30,589 medical support staff in addition to 9,452 dental professionals, 4,241 behavioral health workers, 12,128 enabling services staff, and 1,978 information technology personnel (all expressed as full-time equivalents).

- **Rural health clinics**, as defined in Section 1861(aa)(2) of the Social Security Act, are primary care clinics located in non-urbanized areas designated as medically underserved or health professional shortage areas (although some are located in areas that have become more urbanized over time). They must have at least one physician and at least one nurse-practitioner or physician assistant who must be available at least half the time the clinic is open. They can be public, non-profit, for-profit, or unincorporated. CMS certifies RHCs, which thereby receive cost-based Medicaid, CHIP, and Medicare payments.<sup>5</sup> RHCs are not required to serve uninsured or Medicaid patients, although many do.<sup>6</sup> While they do not receive any core grants, HRSA's Office of Rural Health Policy provides some technical assistance to RHCs since they play a key role in ensuring access to care in rural areas. About half of RHCs are "independent" clinics which are freestanding clinics or office-based practices (often physician-owned) and about half are "provider-based" clinics that are subunits of a larger organization (usually a hospital). CMS data indicate there were about 3,800 RHCs in 2010. Current estimates of the number of patients served are not available, but according to CMS data, RHCs served 1.6 million Medicare patients and 2 million Medicaid patients in 2008. Estimates from an earlier survey indicate that about 31 percent of RHC visits were for Medicare and 25 percent were for Medicaid; this suggests that a reasonable estimate of the total number of patients seen in 2008 is between 5 and 8 million.<sup>7</sup>
- **Free clinics** have no universally accepted definition.<sup>8</sup> They can be broadly viewed as non-profit primary care clinics that provide care to the uninsured for free or with nominal charges. They may range from a part-time clinic staffed by a volunteer physician in a church basement to a large multi-practitioner facility with a substantial budget. Most dispense medications. Few free clinics receive federal funding. Only 6 percent of free clinics receive third-party insurance payments and 92 percent of free clinic patients are

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<sup>5</sup> Centers for Medicare & Medicaid Services. Fact sheet: rural health clinic. ICN006398. 2007 Jun [cited 2011, Jan 13]. Available from: <http://www.hsagroup.net/images/rhcfactsheet.pdf>.

<sup>6</sup> Hartley D, Gale J, Leighton A, Bratesman S. Are rural health clinics part of the rural safety net? Maine Rural Health Research Center, Univ. of Southern Maine, 2010 Sept.

<sup>7</sup> Gale J, Coburn A. The characteristics and roles of rural health clinics in the United States: a chartbook. Portland (ME): University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center, 2003.

<sup>8</sup> See Chapter 4 for the definition used by the National Association of Free Clinics and the definition used with respect to the Federal Tort Claims Act.

uninsured, according to a 2006 survey.<sup>9</sup> That study estimated there were about 1,000 free clinics, serving about 1.8 million patients. Some of them are eligible for liability coverage under the Federal Tort Claims Act (FTCA) for their providers and other specified individuals.<sup>10</sup> The federal criteria for FTCA coverage of certain free clinics prohibit them from accepting third party insurance payments, although other free clinics are not bound by this prohibition. An important implication of this policy is that quality incentives based on these Medicare or Medicaid reimbursement mechanisms are not applicable to free clinics. Although the language of Section 13113(b) of the Recovery Act discusses “reimbursement incentives,” it may be necessary and appropriate to consider other forms of incentives than reimbursement-based incentives in order to make them potentially applicable to free clinics.

## **KEY DIFFERENCES BETWEEN FQHCs AND RHCs**

While FQHCs and RHCs share some similar attributes, such as serving an underserved area or population, they differ in several key areas that may affect their status, resources, and capacity for addressing quality of care issues:

- While Section 330 health center grantees and FQHC look-a-likes must serve a federally-designated medically underserved area (MUA) or population, RHCs must locate in a non-urbanized MUA, health professional shortage area (HPSA), or Governor designated shortage area (although some are located in areas that have since become more urbanized).
- Section 330 grantees and FQHC look-alikes require a patient majority board, while RHCs do not have any board requirements.
- While both FQHCs and RHCs are required to provide primary care services, FQHCs are required to provide a broader range of services, including case management, health education, and enabling services that assist patients in accessing the medical services provided by the center.
- Health center grantees receive Section 330 grants, but RHCs and FQHC look-alikes do not receive core federal grants.
- While FQHCs serve all patients regardless of ability to pay, including the uninsured, there is no comparable requirement for RHCs, although many provide care under a sliding fee scale and/or provide free care.
- Health center grantees are required to submit annual reports on their patient mix, staffing, utilization and financial performance; there is no comparable reporting requirement for RHCs or FQHC look-alikes.

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<sup>9</sup> Darnell J. Free clinics in the United States: a nationwide survey. *Archives of Internal Medicine*. 2010;170(11):946.

<sup>10</sup> This protection applies to qualified volunteer clinicians at these free clinics and to certain staff and board members, but not to the clinics themselves.

- RHCs are required to have nurse practitioners or physician assistants on staff; FQHCs do not have this requirement but generally employ advanced primary care clinicians as well.

There are major differences in the levels of federal policy development and research knowledge for these three types of organizations. For health center grantees and FQHC look-alikes, HRSA has established a substantial body of federal policy and reporting requirements. CMS has established policies relating to Medicare, Medicaid, and CHIP payment for all FQHCs (for Medicare, CMS pays FQHCs directly, for Medicaid and CHIP, States pay providers, while the federal government reimburses States for the federal share of program expenditures). There is a relatively large research literature about FQHCs, as well. While Section 330 creates a substantial administrative responsibility in HRSA for health center oversight, there is no similar authority vested in HRSA for RHCs. Rather, the RHC statute is largely limited to issues involving Medicare, Medicaid, and CHIP reimbursement. Similar to FQHCs, CMS is responsible for certifying RHCs under Medicare, Medicaid, and CHIP. CMS is also responsible for paying RHCs' Medicare claims, and for reimbursing States for the federal share of RHCs' Medicaid and CHIP claims. The Office of Rural Health Policy (ORHP) in HRSA focuses on RHCs because of the key role they play in terms of access to care. The Office is charged in Section 711 of the Social Security Act with advising the Secretary on rural health issues. However, RHCs are just one of the many types of rural providers that fall under the office's aegis, along with rural hospitals and all other rural health providers. While there is a relatively large body of research about rural health care, little of it focuses specifically on RHCs, as opposed to rural physicians or hospitals in general. Free clinics are perhaps the most elusive of all. For free clinics, there is no HRSA authority (other than regarding FTCA coverage) and no statute addressing Medicare, Medicaid, or CHIP reimbursement. Very little federal policy regarding free clinics exists, except that specified individuals serving at certain free clinics are eligible for liability coverage under the FTCA; that component is administered by the Bureau of Primary Health Care, HRSA, mentioned above. There is relatively little research literature about free clinics, but we are fortunate to be able to present new survey information collected by the National Association of Free Clinics in this report.

## **OVERVIEW OF MEDICARE, MEDICAID, AND CHIP PAYMENTS TO FQHCs AND RHCs**

An important difference between FQHCs and RHCs and other ambulatory care providers is that FQHCs and RHCs are generally reimbursed by Medicaid, the Children's Health Insurance Program (CHIP), and Medicare using a cost-related system, subject to caps (in the case of Medicare) and other rules, as established in statute. These payments are often higher than those paid under regular physician fee schedule systems used by these programs, and reflect several factors, including:

- FQHCs and RHCs often have a lower volume of patient revenue generated from commercial insurance;
- FQHC and RHC patients often have more significant health care needs than the general population;
- FQHCs and RHCs are located in areas where there are healthcare shortages;



- FQHCs are required to provide a broader range of services than a standard physician's office, including case management, transportation, and supportive services.

Some key aspects of Medicare, Medicaid and CHIP payment systems for FQHCs and RHCs are summarized in Figure 1. Under Medicaid and CHIP, FQHCs and RHCs are reimbursed using a

**Figure 1: Comparison of Medicare Payment Methods for Physicians, Federally Qualified Health Centers, and Rural Health Centers**

Although physicians (or sometimes other clinicians like nurse practitioners or physician assistants) can provide ambulatory care services in regular physicians' offices, FQHCs, or RHCs, payments differ depending on where the service is provided. The standard method of paying physicians is the Medicare physician fee schedule. Physicians submit claims forms (CMS-1500 forms) to Medicare Part B contractors that describe the procedures provided to the patient, and the level of reimbursement paid by Medicare is based on the specific services rendered, as determined under the physician fee schedule system.

However, clinicians furnishing services in FQHCs and RHCs to Medicare beneficiaries do not submit claims forms or receive payment directly from Medicare. Both FQHCs and RHCs are paid as institutional facilities, and submit a UB-04/CMS-1450 form for payment to a Part A contractor. This form includes different types of information than the CMS-1500. FQHCs and RHCs are reimbursed using an all-inclusive rate per visit (or encounter) based on the historical allowable costs of care at that facility, up to nationally determined caps. In order to set these rates, FQHCs and RHCs must file annual cost reports with CMS. These rates pertain to allowable costs for these facilities, established under federal rules, and reflect statutorily determined Upper Payment Limits.<sup>11</sup> There are exceptions for certain services that may be billed separately, such as flu and pneumonia vaccinations. (Under 1834(o) of the Social Security Act, as amended by Section 10501 of the Affordable Care Act, the Medicare payment methodology for FQHCs is to be changed to a prospective payment system that takes into account the type, duration and intensity of services, which must be effective by FY 2015. As required under the Affordable Care Act, FQHCs began reporting HCPCS codes starting in January 2011, and this data will be used to develop the PPS. This new payment methodology and reporting requirement does not apply to RHCs.)

Rules for Medicaid and CHIP differ. Although federal law establishes a minimum payment methodology for FQHCs and RHCs, the specific claims forms used, policies, and levels of payment are established by States and vary from State to State. However, all State Medicaid programs reimburse FQHCs and RHCs directly (as opposed to sending payment to individual professionals) and use a per-visit payment rate determined under a prospective payment rate system or alternative payment methodology. As in Medicare, FQHC and RHC professionals are not reimbursed under physician payment systems for Medicaid or CHIP, and as a result are not eligible for incentive programs that are linked directly to physician payments.

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<sup>11</sup> Provider-based RHCs in hospitals with fewer than 50 beds are not subject to the Upper Payment Limit.

prospective payment system.<sup>12</sup> Each FQHC has a specific per-visit rate, which is based on its reasonable costs in 1999 and 2000 and updated annually for medical inflation, as measured by the Medicare Economic Index, and which may be revised periodically to reflect changes in the scope and intensity of services provided. Since they are based on historical costs, they are “cost-related,” but since the rate updates are based on changes using the Medicare Economic Index, not actual costs, this is considered a “prospective” payment system. A 2005 Government Accountability Office report noted that the Medicare Economic Index is not necessarily the most appropriate indicator of changes in Medicaid costs for FQHCs or RHCs.<sup>13</sup>

Under Medicare, each FQHC and RHC receives an “all-inclusive rate” per qualifying visit; this rate is based on its reported costs and is subject to upper payment limits.<sup>14</sup> Because of the combination of payment caps or differences between actual cost changes and those reflected in the Medicare Economic Index, the actual payments received by FQHCs and RHCs could fall below the entities’ current costs in some circumstances. Under the Affordable Care Act, Medicare will implement a new prospective payment methodology for FQHCs (but not RHCs) in FY 2015.

An important difference between the payment-per-visit systems used to pay FQHCs and RHCs and the fee-for-service system for regular physician payments typically used under Medicare, Medicaid or CHIP involves visits where multiple services are provided. If a physician’s office provides more than one service during a single visit, it can often bill separately for each service. However, since FQHC and RHC payment rates cover all services provided during the visit, FQHCs and RHCs are not able to bill separately for separate services provided during the same visit. It should be noted, however, that in some managed care systems, physicians may be paid capitated or bundled payments.

## **TYPES OF QUALITY CRITERIA AND INCENTIVES**

To provide quality incentives implies that there are ways to assess health care quality. This report considers different types of quality criteria (e.g., clinical performance criteria and structurally-based criteria) and different incentive methods (e.g., reimbursement bonuses or reductions, grants, in-kind benefits, preferences, workforce support, and technical assistance).

Some quality criteria are clinically-based, such as “60 percent of diabetic patients should attain hemoglobin A1c levels (a measure of blood sugar levels) below 8 percent” or “80 percent of diabetic patients should have their hemoglobin A1c levels tested at least twice a year.” The first criterion is outcome-based and measures an actual health status outcome, while the second is process-based and assesses whether a recommended medical procedure was conducted. These

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<sup>12</sup> State Medicaid and CHIP programs also have the option of reimbursing FQHCs and RHCs using alternative payment methodology approved by CMS, provided that the rate is at least equal to the prospective payment rate and is agreed to by the provider.

<sup>13</sup> Government Accountability Office. Health centers and rural clinics: state and federal implementation issues for Medicaid’s new payment system, (GA)-05-452, 2005 Jun.

<sup>14</sup> Freestanding RHCs and those attached to larger hospitals have an all-inclusive rate (currently capped at \$78.07) and Medicare reimburses 80 percent of that rate. However, the coinsurance for Medicare beneficiaries is 20 percent of the reasonable and customary charges, not the all-inclusive rate. Provider-based RHCs in hospitals with fewer than 50 beds are not subject to the Upper Payment Limit.

clinically-based criteria are sometimes called “performance-based payment criteria and intend to incentivize performance changes based on clinical outcomes.

Other criteria are operationally-based and rely on measures of a provider’s ability to achieve certain objectives that are believed to improve the quality or efficiency of care. For example, current criteria for Medicare or Medicaid electronic health record (EHR) incentives are based on the expectation that effective use of certified EHR technology will improve the quality of care by making it easier to share data between providers and to monitor care provided (or care outcomes) through analyses of electronic data. The federal government has established criteria for “meaningful use” of this technology by eligible professionals, eligible hospitals, and critical access hospitals and offers Medicare and Medicaid payment incentives to the eligible professionals and hospitals that adopt EHRs and meaningfully use their certified EHR technology.

Another example of an operationally-based criterion which is particularly relevant to primary care facilities is the designation of being a “medical home” or a “primary care provider.” For decades, many managed care arrangements have designated physicians or other clinicians (e.g., nurse practitioners or physician assistants) as primary care providers who are assigned patients (or members). These providers are responsible for providing certain preventive and primary care services and coordinating care for those patients; they also have the authority to make referrals for more advanced testing or treatment. Typically, designated primary care providers receive a monthly payment for this ongoing care service. More recently, several physician associations advanced the concept of a “patient-centered medical home” (PCMH) which connects a patient to a single physician and utilizes more advanced capabilities to monitor and coordinate care for that patient. Those who meet the more advanced PCMH standards could qualify for additional payments, in recognition that these heightened capabilities improve the quality of care and reduce the costs of specialty or hospital care.

We note, in advance, that the incentives discussed in this report focus primarily on incentives for medical care, and not on incentives for dental, vision, behavioral, substance abuse, and long-term care, or other social or supportive services, such as language assistance. There is no question that these other services are important, particularly for many of the vulnerable populations served by FQHCs, RHCs, and free clinics, and improving access to these services is part of a more comprehensive vision of health care that is supported by HHS. HRSA has encouraged FQHCs to expand the scope of dental and behavioral health services and provided funding for these service expansions. Many RHCs and free clinics also provide some of these services. Nonetheless, most discussions and policy initiatives regarding quality incentives or health information technology today focus on medical care and not these other areas of health care. Similarly, the measures of quality for these other services are less developed than quality measures for medical care services and current EHR systems are often not designed to address the multiple needs of these other services. To a great extent, a fundamental issue at this point in time is improving access to these other services.

**Payment Incentives.** Some of the most widely utilized types of incentives are financial incentives linked to insurance payments. The most common approach is to add a percentage or dollar bonus to payments to providers who meet the given quality criterion. A variant is to



impose a penalty to those who do not meet the criterion. For example, the Medicare eligible professional (physician) EHR incentives are initially paid as a bonus to Medicare physician payments (for up to five years and up to a capped amount per year) to those who meaningfully use the technology. In 2015 and after, Medicare payments are reduced for enrolled eligible professionals who do not demonstrate that they meet the criteria for meaningful use. The shift from financial reward to penalty allows providers time to adopt and meaningfully use certified EHRs before seeing reductions in Medicare payments.

FQHCs and RHCs, however, are not eligible for Medicare EHR incentive payments or similar incentives such as the e-Prescribing or Physician Quality Reporting System.<sup>15 16</sup> In addition, in the Recovery Act, which authorizes Medicare EHR incentives, the incentives are specified for “covered professional services furnished by an eligible professional,” but clinicians practicing at FQHCs and RHCs are not enumerated among the eligible professionals. All of these incentives are linked to the Medicare physician fee schedule, which does not apply to FQHCs and RHCs. Free clinics are generally ineligible since they do not collect Medicare payments. The differences in Medicare and Medicaid payment methodologies for FQHCs and RHCs are summarized in Figure 1.

These safety net providers are ineligible to receive some additional funds available to other providers participating in quality-enhancing projects. The risk is that disparities in program eligibility will result in safety net providers being unable to make the care delivery changes targeted in these programs. Because they are often non-profit and/or have limited financial resources, safety net clinics such as FQHCs, RHCs, and free clinics are predisposed to having difficulty raising the capital necessary for investments in HIT systems and other upgrades that improve the quality of care. In the long run, if these safety net providers are unable to adopt initiatives underway throughout the health care sector, there is potential for compromised care at safety net locations relative to other health care settings. These safety net providers may not receive additional funds for participating in quality-enhancing projects that other physicians can receive. In turn, this might mean that they are less able to make the care delivery changes targeted by these policies. In the long run, if these safety net providers are unable to adopt initiatives underway throughout the health care sector, this could compromise the quality of care received by their patients.

While FQHCs and RHCs are ineligible for Medicare EHR incentives, eligible professionals at these clinics will often be eligible under Medicaid criteria instead (and eligible professionals may only receive EHR incentives from *either* Medicare or Medicaid). The Medicaid incentives are defined by the HITECH statute and can amount to up to \$63,750 per eligible provider over six years. The pool of eligible professionals is somewhat broader than for Medicare and includes nurse practitioners, certified nurse midwives, dentists, and physician assistants who practice at FQHCs or RHCs that are so led by a physician assistant, in addition to

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<sup>15</sup> The Medicare Electronic Prescribing Incentive Program (eRx) provides incentive payments and payment adjustments to eligible professionals who are successful electronic reporters. The incentive payment for 2011 and 2012 is equal to 1 percent of total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period.

<sup>16</sup> Currently, the Medicare Physician Quality Reporting System provides incentive payments to eligible professionals who satisfactorily report data on quality measures for qualified professional services furnished to Medicare beneficiaries. For 2011, this incentive payment is equal to 2 percent of total estimated Medicare Part B Physician Fee Schedule allowed charges for covered professional services furnished during the reporting period.

physicians. For practices other than those at FQHCs and RHCs, eligible professionals may qualify for Medicaid incentives if they have at least 30 percent volume of Medicaid patients (or 20 percent for pediatricians). For eligible professionals who practice predominantly at FQHCs and RHCs, however, the criterion is adjusted to include 30 percent from Medicaid, CHIP, or “needy individuals” which include those who receive free care or use a sliding fee scale. These eligible professionals may assign their Medicaid incentive payments to the FQHCs and RHCs that employ them, but this may depend on the terms of their employment with the clinics. If eligible professionals do assign their incentive payments to their employers, FQHCs and many RHCs would receive Medicaid EHR incentives. As discussed in Chapter 2, virtually all FQHCs meet the “needy individual” care volume requirements for Medicaid EHR incentives. As discussed in Chapter 3, many RHCs -- but not all -- will also meet these requirements. Federal law only allows eligible professionals to take advantage of either Medicaid or Medicare incentives, so eligible professionals at FQHCs will generally be eligible for EHR incentives, but those at some RHCs will not meet the eligibility standard for either Medicare or Medicaid. Unlike under the Medicare incentives, eligible professionals who fail to meet meaningful use criteria in the future are not subject to Medicaid penalties under the federal rules. Since free clinics rarely take insurance, they are largely omitted from these incentives..

Other Medicaid incentives are more difficult to specify than those under Medicare, because they are determined by States or, in some cases, by managed care plans that operate under State Medicaid programs. There is no centralized listing of all State Medicaid quality incentive programs. It is reasonable to believe that free clinics are almost always excluded, but the participation of FQHCs and RHCs appears to vary. GW researchers surveyed State primary care associations (which represent FQHCs) in 2009 and found that many State Medicaid programs or Medicaid managed care plans offer certain payment or incentive arrangements, particularly related to primary care provider or medical home status, HIT adoption and utilization, or health care quality.<sup>17</sup> The National Academy for State Health Policy has conducted surveys of State Medicaid or CHIP medical home projects.<sup>18</sup> (These data are discussed more in Chapter 2). In some cases, FQHCs are excluded from incentive programs for which physicians are eligible, but in many cases FQHCs are also eligible. While we do not have comparable data at this time for RHCs, it is reasonable to believe that State policies for FQHCs often apply to RHCs as well since State Medicaid programs tend to pay FQHCs and RHCs similarly.

Section 2703 of the Affordable Care Act gives State Medicaid programs the option to develop “health home” projects for enrollees with chronic conditions. CMS issued preliminary guidance to States on November 16, 2010.<sup>19</sup> The overall goal is to “build a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for State Medicaid programs.” CMS expected States to build upon their experiences with medical home projects to expand and to “build linkages to other community and social supports,

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<sup>17</sup>Ku L, Shin P, Jones E, Bruen B. Financing health centers as patient- and community-centered medical homes: analyses and recommendations. New York (NY): Commonwealth Fund; 2010 June (draft).

<sup>18</sup>Kaye N, Takach M. Building medical homes in state Medicaid and CHIP programs. National Academy for State Health Policy; 2009.

<sup>19</sup>Mann C. State Medicaid Director and State Health Official Letter: Health Homes for Enrollees with Chronic Conditions, Nov. 16, 2010.

and to enhance coordination of medical and behavioral health care, in keeping with the needs of persons with multiple chronic illnesses.” The legislation provides substantial flexibility to State Medicaid agencies in how to develop and structure their programs, although they must apply to CMS through the State Plan Amendment process and obtain approval. CMS has already awarded planning grants to 13 States related to these projects. As of early September, three States had filed State plan amendments to initiate health home plans and other States are expected to initiate such projects in the future. Approved projects will be eligible for 90 percent federal matching in the first two years. States may modify provider payment policies to offer incentives to providers. While the legislation does not explicitly mention payment incentives for such projects, it notes that States may make payments to providers of health home services and that the State may elect alternative payment methodologies. The legislation specifically mentions a variety of types of designated providers, including “community health centers,” “rural clinics,” as well as physicians or group practices, but specifies that the State must determine eligibility criteria and that the providers must be able to perform certain functions. It is reasonable to believe that FQHCs and RHCs will often be able to participate in many of the State Medicaid health home projects, but it is still too early to assess the level of participation or impact at this early stage of the initiative. To the extent that future Medicaid health home projects resemble the large number of medical home projects that have already been implemented or tested in Medicaid, it seems reasonable to believe that these programs will often include payment incentives for primary care providers to meet health home criteria.<sup>20</sup>

Table 2 summarizes the major quality incentives available in the health care sector that are implemented through reimbursement policies; it also indicates their applicability to health centers, RHCs, and free clinics. This column does not describe eligibility criteria; instead it describes whether FQHCs, RHCs, and free clinics would be eligible for the incentive even if they adopted the quality-enhancing initiative. Aside from reimbursement incentives, alternative forms of incentives exist which could also encourage quality improvements. These include:

**Grants.** Quality improvements can be induced with grants to safety-net health care providers or to associations representing these providers (e.g., State primary care associations) that help finance certain activities. For example, the Bureau of Primary Health Care (BPHC) provides financial assistance to support the accreditation of FQHCs and their recognition as patient-centered medical homes. At one point, HRSA supported Community Access Program grants to help FQHCs, hospitals, and other community organizations fund efforts to coordinate care at community levels, but authorization for this support expired. Certain foundations sometimes pay for grants to help certain types of clinics purchase HIT systems. A limitation of the grant approach is that grants are typically one-time or need to be periodically re-issued, so there is not an assured or steady stream of funding. Certain types of grants are open only to public or non-profit organizations, such as the FCC Rural Broadband grants, which exclude for-profit RHCs from eligibility.

**Additional Benefits.** Congress has enacted legislation to extend eligibility for protection under the Federal Tort Claims Act (FTCA) for the performance of medical, surgical, dental, or related functions to FQHCs that receive federal grant funding under Section 330 of the Public

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<sup>20</sup> Takach M. Reinventing Medicaid: State innovations to qualify for and pay for patient-centered medical homes show promising results. *Health Affairs*. 2011; 30(7): 1325-34.

Health Service Act (including certain listed individuals acting on behalf of those FQHCs) and to certain listed individuals acting on behalf of free clinics (but not to the free clinic as an entity). This federal liability protection reduces or eliminates the need for these covered entities and individuals to purchase private medical malpractice coverage. Health center grantees and FQHC look-alikes also receive access to discounted prescription drugs under the Section 340B program. Both activities reduce FQHCs' and free clinics' costs and enable them to focus resources on improving the quality or range of services offered. To be eligible for FTCA coverage, FQHCs that receive Section 330 grant funding and eligible free clinics must satisfy specific quality assurance requirements.

**Table 2: Summary of Major Reimbursement Incentives and their Application to Safety Net Clinics**

Name	Description of Incentive	Applicability to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Free Clinics*
Medicare Electronic Health Record Incentive	Offers payments up to \$44,000 for eligible professionals serving Medicare patients who adopt and meaningfully use EHRs. Beginning in 2015, payments reduced if not meaningful users.	<b>Generally not applicable.</b> To be eligible, professionals must bill under the physician fee schedule, which FQHCs and RHCs do not. Free clinics generally do not accept Medicare payments. Since payment adjustments are tied to the Physician Fee Schedule, FQHCs, RHCs, and free clinics, would not be subject to the Medicare penalties that begin in 2015.
Medicaid Electronic Health Record Incentive	Offers payments up to \$63,750 for eligible professionals who serve a minimum volume of Medicaid (and in some cases, “needy”) patients to adopt and meaningfully use EHRs	<b>Most professionals at FQHCs and some at RHCs eligible.</b> Professionals that practice predominantly at an FQHC or RHC that have at least a 30 percent patient volume of “needy individuals” are eligible. Almost all FQHC-based providers have sufficient volume to qualify, but not all RHC providers do. Free clinics generally do not accept Medicaid payments.
Medicare Physician Quality Reporting System	Currently provides incentive payments to eligible professional who satisfactorily report data on quality measures. Beginning in 2015, payment adjustments apply to eligible professionals who are not satisfactory reporters.	<b>Generally not applicable.</b> To be eligible, professionals must bill under the physician fee schedule, which FQHCs and RHCs do not. Free clinics generally do not accept Medicare payments.
Medicare e-Prescribing Incentive	Eligible professionals earn incentive payments or are subject to payment adjustments based on whether or not the eligible professional is a successful electronic prescriber.	<b>Generally not applicable.</b> To be eligible, professionals must bill under the physician fee schedule, which FQHCs and RHCs do not. Free clinics generally do not accept Medicare payments.
Medicaid Health Home Projects	Will be determined by States	<b>Will be determined by States.</b> Legislation mentions “community health centers” and “rural clinics” as being among the types of providers that a State may include.
Other Medicaid Incentive Payments	Some Medicaid States or managed care programs offer incentives for quality, health information technology or medical home/health home.	<b>Varies by State.</b> Sometimes States include FQHCs or RHCs in incentive programs that are also used for physicians, but in other cases FQHCs or RHCs are excluded. Free clinics generally do not accept Medicaid payments.
Medicare and Medicaid FQHC and RHC Payments	Provides cost-based payment methodology for FQHCs and RHCs. They are paid for certain services based on reasonable costs per visit, up to a certain limit.**	<b>Applicable to FQHCs and RHCs.</b> Generally increases Medicare and Medicaid reimbursements for RHCs and FQHCs. Not directly linked to quality or HIT criteria, but cost-based rates are designed to support primary care providers in underserved areas in order to improve access to care, which is a necessary precursor to quality of care. Free clinics are not eligible.
<p>* Payment of these incentives typically require that providers meet some criterion before they are paid, such as demonstrating that they meaningfully use EHRs or otherwise meet the criteria specified by CMS or the State.  ** Provider-based RHCs in hospitals with fewer than 50 beds are not subject to the Upper Payment Limit.</p>		

**Preferences.** Under the Affordable Care Act, health plans offered in the new health insurance exchanges will be required to include “essential community providers,” like FQHCs, in their contracting arrangements, although the extent to which they must be included is not specified. This helps facilitate the entry of safety net providers, particularly FQHCs which are enumerated among the types of essential community providers, into these business arrangements. Many states already require including essential community provider in the networks of Medicaid managed care organizations.

**Workforce Support.** HRSA supports the National Health Service Corps which arranges for physicians and other clinicians to practice in underserved areas in exchange for loan repayments or scholarships. These clinicians can meet their requirements by working for FQHCs or certain RHCs. While this program does not have the explicit purpose of improving quality, quality may be compromised when there are not enough clinicians.

At the national level, there is evidence of a growing problem of an insufficient primary care workforce, in part because a dwindling number of medical students and young physicians are selecting primary care specialties.<sup>21</sup> Maintaining an adequate supply of primary care practitioners will be an ongoing issue of importance for these safety net primary care clinics. The Affordable Care Act provided additional funding for the National Health Service Corps and other health workforce support, including the creation of a National Health Workforce Commission. The health insurance expansions planned under health reform will further stimulate the demand for primary care practitioners.<sup>22</sup> If FQHCs, RHCs and free clinics are unable to have a sufficient supply of primary care practitioners and other health professionals, they will have great difficulty providing quality health care.

**Technical Assistance.** HRSA provides technical assistance for FQHCs and RHCs. Some of this assistance is provided by federal staff and some is provided by HRSA-funded contractors or affiliated professional organizations, such as State primary care associations (non-profit State-level representatives of health centers) and State primary care or rural health offices (State agencies that help provide policy guidance and technical assistance to primary care and rural providers.) The Office of the National Coordinator for Health Information Technology (ONC) also funds a variety of types of technical assistance to help local health care providers adopt health information technology, such as Regional Extension Centers, Beacon Communities or State Health Information Exchange grants and cooperative agreements. The Regional Extension Centers, for example, provide outreach, education and support in implementing EHRs for a broad array of practices, including FQHCs, small medical practices, critical access and rural hospitals and other settings that serve needy patients. The State Health Information Exchange grantees were encouraged to work with rural and safety net providers. Medicaid State agencies also provide technical assistance to providers at FQHCs and RHCs who are not part of the ONC-funded Regional Extension Centers’ primary target population, such as dentists.

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<sup>21</sup> Bodenheimer T, Pham H. Primary care: current problems and proposed solutions. *Health Affairs*. 2010; 29(5): 799-805.

<sup>22</sup> Ku L, Jones K, Shin P, Bruen B, Hayes K. The states’ next challenge: securing primary care for expanded Medicaid populations. *New England Journal of Medicine*. 2011; 364(6):493-95.



Some forms of technical assistance and guidance are offered to clinics through other programs. For example, many FQHCs, RHCs, and free clinics are Ryan White HIV/AIDS Program grantees. Those grantees receive assistance to improve the delivery of HIV/AIDS services, including the development of core clinical performance measures to assess the quality of HIV/AIDS services for the populations served. In addition, BPHC has issued guidance to health center grantees that enumerate standards for HIV testing based on recommendations from the Centers for Disease Control and Prevention.<sup>23</sup>

A particularly useful form of technical assistance may be support that enables these facilities to band together to better coordinate their activities. For example, HRSA's Bureau of Primary Health Care currently provides funding through cooperative agreements to provider organizations like the National Association of Community Health Centers and State Primary Care Associations to provide technical assistance to FQHCs. The Office of Rural Health Policy also helps support the National Association of Rural Health Clinics to provide technical assistance to RHCs. These associations, in turn, provide training and technical assistance to health centers (as defined by the various membership organizations) on a variety of topics. This may include assistance in upgrading quality and attaining meaningful use, sometimes working in cooperation with Regional Extension Centers and State Medicaid or health agencies. BPHC also supports health center controlled networks comprised of member FQHCs that collaborate, share, and integrate numerous functions at the network level including HIT for quality improvement purposes. This network model provides organizational support to member centers, essentially enabling them to receive a benefit that would be difficult for an individual health center to obtain or afford on its own (e.g. a shared information network or information coordinator). Although core members of the networks are health center grantees, the networks may extend to other clinics and can include RHCs or free clinics.

Current federal and State policies and programs include a spectrum of initiatives to foster quality improvements among health care providers and to spur better use of health information technology. The following chapters focus in on how these apply specifically for FQHCs, RHCs, and free clinics, which have varying needs and opportunities.

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<sup>23</sup> BPHC. Program Assistance Letter 2010-13. HIV testing in health care settings. 2010 Sept 29.

## CHAPTER 2: FEDERALLY QUALIFIED HEALTH CENTERS

### BACKGROUND

#### DEFINITION AND FEDERAL REQUIREMENTS

Section 1861(aa)(4) and Section 1905(1)(2)(B) of the Social Security Act identifies three types of entities that are eligible to be Federal Qualified Health Centers (FQHCs):

- The largest group consists of health center “grantees” that receive grant funding under Section 330 of the Public Health Service Act as community, migrant, homeless, and/or public housing health centers.<sup>24</sup> (These were initially individual grant programs that were consolidated in 1996 to provide comprehensive health care to “medically underserved populations”).<sup>25</sup> The Bureau of Primary Health Care (BPHC) within HRSA determines which health centers receive grants and manages the grant program;
- Facilities that were treated as comprehensive Federally funded health centers as of January 1, 1990 (the grandfathered health centers);
- FQHC look-alikes, which are designated by CMS (at the recommendation of HRSA) as meeting all of the qualifications necessary to be a Section 330 grantee, but do not actually receive Section 330 funds directly; and
- Outpatient health facilities operating under the Indian Self-Determination Act (P.L. 96-638) or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991 (P.L. 94-437).<sup>26</sup>

While free clinics might use the term “health center” in their clinic name and similarly share in the mission to serve high need populations and can receive FTCA coverage, they are not considered part of HRSA’s health center program. Health care organizations must apply to BPHC for grant funding or to become an FQHC look-alike; all health centers grantees and look-alikes are qualified to enroll in Medicare as FQHCs. A primary benefit of being an FQHC is that these providers receive cost-based reimbursements for Medicare, Medicaid, and CHIP, subject to payment limits and other rules, as described in more detail later in this chapter. *For the rest of this report, we primarily focus on FQHCs that receive Section 330 grants (commonly referred to as “health center grantees”), which constitute the great majority of FQHCs.*

From its origins as a demonstration pilot program launched by the Office of Economic Opportunity in 1965, the health center program has grown into the largest single primary care practice system in the nation. In 2010, 1,124 health center grantees provided comprehensive primary health care services at more than 8,100 service delivery sites to nearly 19.5 million patients in every State and territory. (Also in 2009, an additional 100 FQHC look-alike health centers provided services to similar populations).

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<sup>24</sup> 42 USCS §254b

<sup>25</sup> Health Centers Consolidated Act of 1996 (P.L. 104-299) and the Safety Net Amendments of 2002 (P.L. 104-299).

<sup>26</sup> For a more comprehensive definition of an FQHC and other key rules, see Centers for Medicare & Medicaid Services. Fact sheet: federally qualified health center. 2009 Apr. Available from: <http://www.cms.gov/MLNProducts/downloads/fqhcfactsheet.pdf>.



Health center grantees and look-alikes are subject to a set of statutorily-mandated requirements.<sup>27</sup> Four of the most fundamental are: (a) service to a community or population designated as medically underserved; (b) provision of a comprehensive range of primary and preventive health care services; (c) governance by a community board, the majority of whose members are patients of the health center; and (d) charging patients with incomes at or below 200 percent of the federal poverty line based on a sliding scale. Figure 2 shows the required primary health care services that all FQHCs must provide by law, either through staff and supporting resources, or through contracts and cooperative agreements with other entities.<sup>28</sup> Federally qualified health centers provide preventive services to vulnerable populations that would otherwise have limited access to certain services, such as immunizations, health education, mammograms, Pap smears, and other screenings. All health center services are subject to federal confidentiality requirements and information related to patients may not be divulged without consent, in accordance with applicable law.<sup>29</sup>

**Figure 2: Required Primary Health Care Services for Health Center Grantees<sup>30</sup>**

Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology, that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives
Diagnostic, laboratory, and radiologic services
Preventive health services including: prenatal and perinatal care; appropriate cancer screening; well-child services; immunizations for vaccine-preventable diseases; screenings for elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; voluntary family planning services; and preventive dental services
Emergency medical services
Pharmaceutical services as may be appropriate for particular centers
Referrals to providers of medical services (including specialty referral when medically indicated) and other health related services (including substance abuse and mental health services)
Patient case management services (including counseling, referral and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State and local programs that provide or financially support the provision of needed medical, education, social, housing, or related services
Services that enable individuals to use the services of the health center (including outreach and transportation services, and if a substantial number of the individuals in the population served by the health center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals
Education of patients and the general population served by the health center regarding the availability and proper use of health services

<sup>27</sup> For a complete list of all program requirements, see <http://bphc.hrsa.gov/about/requirements/index.htm>

<sup>28</sup> 42 U.S.C. §254b(b)(1).

<sup>29</sup> 42 C.F.R. §51c.110.

Previously subject to periodic reauthorization, the FQHC program is authorized permanently under Section 330 of the Public Health Service Act as a result of the Affordable Care Act (ACA).<sup>31</sup> As of February 2011, the combined effects of the Recovery Act and the ACA was expected to result in FQHCs doubling in size in the coming years, serving a potential population estimated to range from 36 million to 40 million people.<sup>32 33</sup> These provisions included: \$11 billion in federal funds for health center expansions, a Medicaid expansion projected to cover an additional 16 million individuals, and the establishment of health insurance exchanges to offer private health insurance to the individual and small group markets and provide subsidies to low-income individuals.<sup>34</sup> The uninsured are disproportionately concentrated in urban and rural communities classified as medically underserved, and service to such communities is a basic health center program requirement.<sup>35</sup> Given the primary care needs of those who will be newly insured under the Affordable Care Act and FQHCs' experience in serving the types of individuals who are likely to gain insurance, the FQHC expansion is integral to assuring health care access for both the newly insured and the estimated 23 million people who will remain uninsured following full implementation of reform. Section 330 funding was reduced by \$600 million in FY 2011 and it seems likely that additional cuts will be made in future years, under the Budget Control Act of 2011.

## HEALTH CENTER PATIENTS<sup>36</sup>

In 2010, health center grantees served 19.5 million people nationally, many of whom are among the nation's most vulnerable populations and who face challenges accessing health care due to a combination of geographic, economic, cultural, and linguistic barriers. Nearly all patients are low income, with almost 93 percent of health center patients having family incomes at or below 200 percent of the federal poverty line (for patients where income is known) (Figure 3). As shown in Figure 4, racial and ethnic minority groups comprise larger shares of FQHC-patient populations than they do the U.S. as a whole (for patients where race and ethnicity are known). At the same time, 38 percent of health center patients are uninsured and another 39 percent depend on Medicaid and the Children's Health Insurance Program (CHIP, Figure 5).

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<sup>31</sup>Rosenbaum S, Jones E, Shin P, Tolbert J. Community health centers: opportunities and challenges of health reform. Menlo Park (CA): 2010 Aug [cited 2011 Jan 5]. Available from: <http://www.kff.org/uninsured/upload/8098.pdf>.

<sup>32</sup> Ku L, Richard P, Dor A, Tan E, Shin P, Rosenbaum S. Strengthening primary care to bend the cost curve: the expansion of community health centers through health reform; Brief No. 19. Geiger Gibson/RCHN Community Health Foundation Research Collaborative; 2010 Jun.

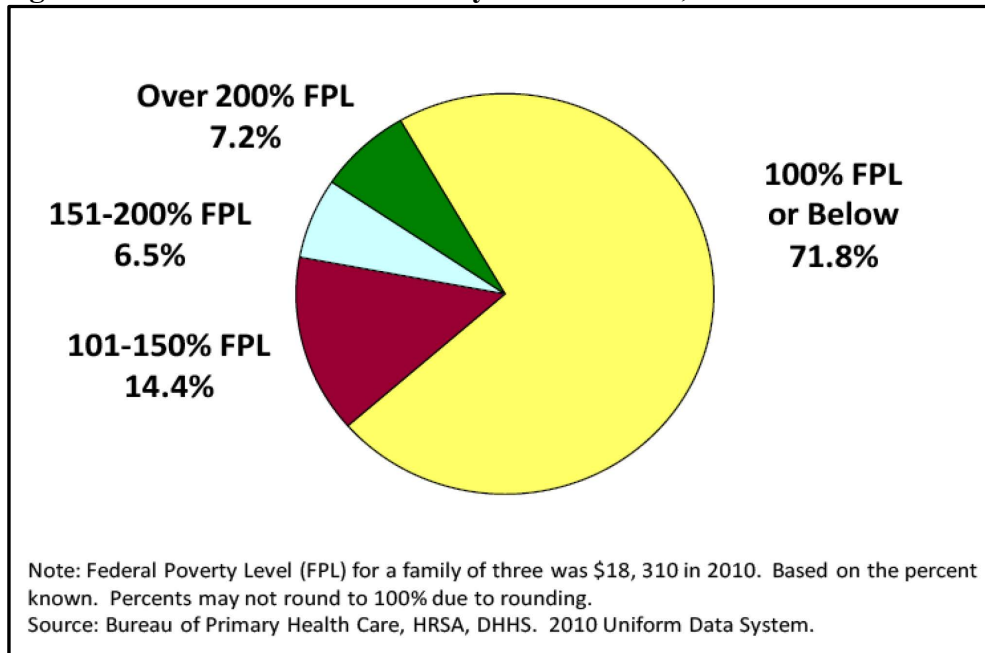
<sup>33</sup> National Association of Community Health Centers. Expanding health centers under health care reform: doubling patient capacity and bringing down costs. 2010 Jun.

<sup>34</sup> As of February 2011, Section 2303 of the Affordable Care Act appropriate \$11 billion over 5 years for the health center program through the "Community Health Center Fund."

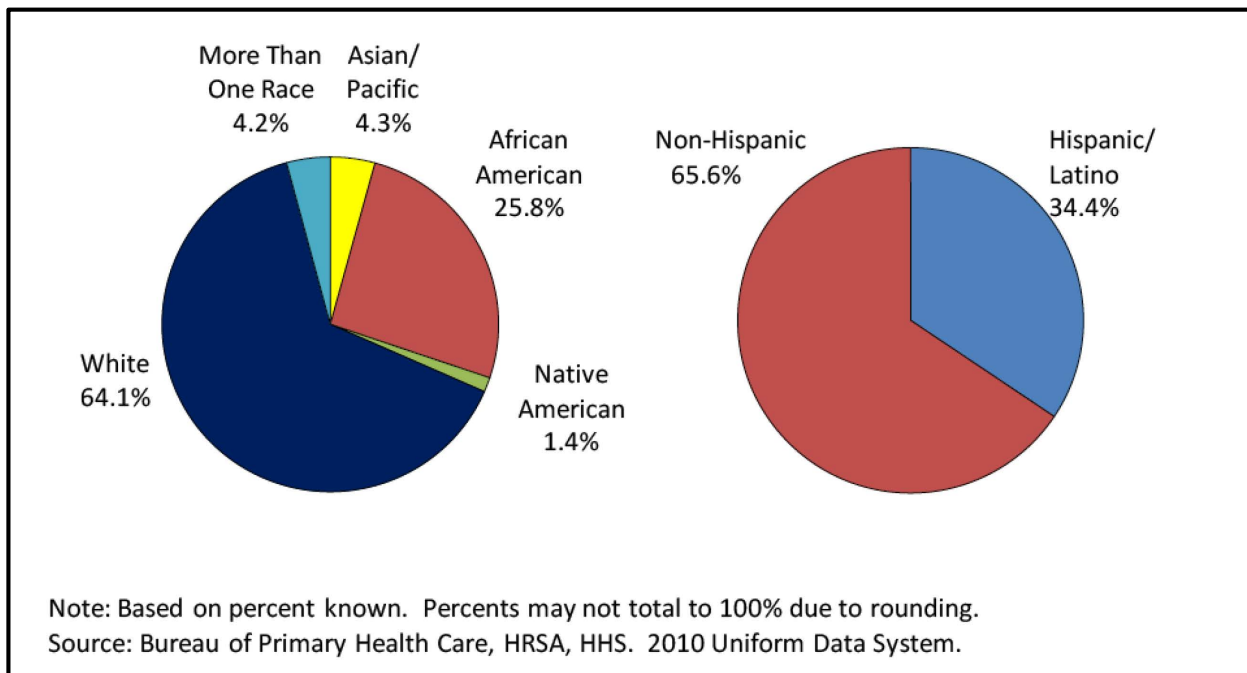
<sup>35</sup>Rosenbaum S, Jones E, Shin P. National health reform: how will medically underserved communities fare? Brief No. 10. Geiger Gibson/RCHN Community Health Foundation Research Collaborative; 2009 Jul.

<sup>36</sup> Data for this section were compiled from the 2009 Uniform Data System maintained by the Health Resources and Services Administration.

**Figure 3: Health Center Patients by Income Level, 2010<sup>37</sup>**



**Figure 4: Health Center Patients by Race/Ethnicity 2010<sup>38 39</sup>**

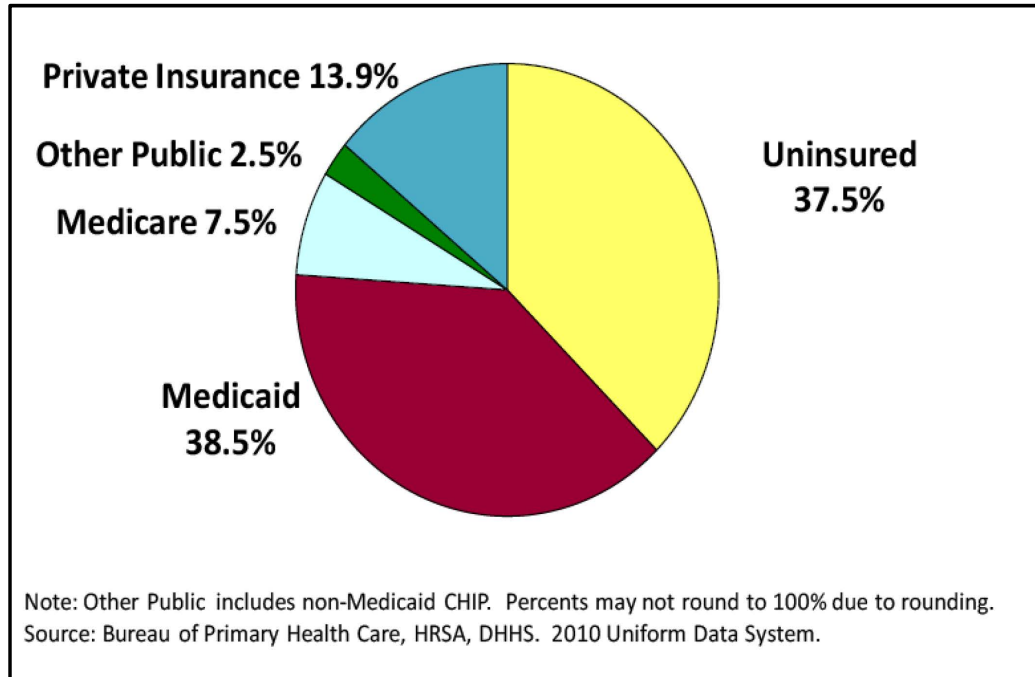


<sup>37</sup> In the UDS, income is not reported for about 23 percent of patients (data not shown).

<sup>38</sup> In 2010, 79.6 percent of the U.S. population was white and only 15.8 percent of the U.S. population was Hispanic (U.S. Decennial Census).

<sup>39</sup> In the UDS, race/ethnicity is not reported for about 20 percent of patients (data not shown).

**Figure 5: Health Center Patients by Insurance Status, 2010**



### IMPACT OF FQHCs ON COST AND QUALITY

A body of research, conducted by many different researchers using different methods and data bases, indicates that by providing high quality primary care and preventive services to vulnerable populations, FQHCs reduce the use of other unnecessary care, such as emergency room or inpatient care, and result in lower health care costs.<sup>40</sup> FQHC expansion lowers utilization of emergency room visits where health centers are present.<sup>41</sup> It has been estimated that the expansion of FQHCs under the Affordable Care Act (if fully implemented) will save as much as \$180 billion in total health care costs between 2010 and 2019, including more than \$50 billion in federal Medicaid savings and more than \$30 billion in State savings.<sup>42</sup> Overall, the Office of Management and Budget, operating under the Government Performance and Reporting Act, has rated the health center program as “effective,” its highest rating.<sup>43</sup>

In addition to providing care to people who would otherwise experience unmet health needs, evidence suggests that FQHCs provide a high quality of care. The Institute of Medicine and the Government Accountability Office have recognized FQHCs as models for screening,

<sup>40</sup>Streeter S, Braithwaite S, Ipakchi N, Johnsrud M. The effect of community health centers on healthcare spending & utilization. Washington, DC: Avalere Health. 2009 Sep.

<sup>41</sup>Rust G, Baltrus R, Ye J, Daniels E, Quarshie A, Boumbulian P, Strothers H. Presence of a community health center and uninsured emergency department visit rates in rural counties. *Journal of Rural Health* 2009;25(1):8-16 and Cunningham P. What accounts for differences in the use of hospital emergency departments across U.S. communities? *Health Affairs* 2006; 25: W324-W336.

<sup>42</sup>Ku L, Richard P, Dor A, Tan E, Shin P, Rosenbaum S, *op cit*.

<sup>43</sup> ExpectMore.gov in the Office of Management and Budget. Program assessment: health centers. 2007 [cited 2011, Jan 13]. Available from: <http://www.whitehouse.gov/omb/expectmore/detail/10000274.2007.html>.

diagnosing, and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer, and HIV.<sup>44</sup> It appears that for patients with chronic illnesses, FQHCs have been able to simultaneously achieve improved outcomes and lower costs.<sup>45</sup> In the area of maternal health, data show that low-income women served by FQHCs experience lower rates of low birth weight compared to all mothers. For both maternal measures and other quality indicators, racial and ethnic disparities within States decline as the share of the States' low-income population served by FQHCs rises.<sup>46</sup>

## **REIMBURSEMENT POLICIES FOR FQHCs**

For Medicare, Medicaid, and CHIP, FQHCs are paid on an institutional basis, using methods that differ from regular physician practices. In Medicare, for covered services, they are paid an all-inclusive payment per encounter, which is based on cost reporting, up to a statutorily-determined cap. Under Section 10501 of the Affordable Care Act, the Medicare payment methodology for FQHCs will be changed effective October 1, 2014 to a prospective payment system.

In Medicaid and CHIP, FQHCs are also paid by State agencies on an all-inclusive per encounter basis using one of two methodologies. They may be paid based on a prospective payment basis, based on the reasonable costs of services in 1999 and 2000, adjusted upwards on an annual basis using the Medicare Economic Index. They may also be paid under an alternative payment methodology, approved by the individual FQHC, under which payments are at least equal to the prospective payments that would otherwise be made. In many cases, these payment methods may lead to payments that are higher than those calculated under the Medicare or Medicaid physician payment methodology.

## **QUALITY INITIATIVES IN FQHCs**

### **ORIGINS OF TODAY'S QUALITY INITIATIVES**

The key programs described in this section delineate the evolution of the quality focus and commitment of the health center program dating from its earliest years. Because it was experimental at the time of its 1965 inception, an early feature of the Neighborhood Health Center demonstration pilot program (now the health center program) launched by the Office of Economic Opportunity (OEO) was attention to quality assurance using a systematic method of medical care audit and review, as practiced at the time.<sup>47</sup><sup>48</sup> Routine periodic reviews of quality

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<sup>44</sup>Institute of Medicine. Unequal treatment: confronting racial and ethnic disparities in healthcare. Washington, D.C.: National Academy of Sciences Press; 2003 and U.S. Government Accountability Office. Health care: approaches to address racial and ethnic disparities. Washington, D.C.; 2003; GAO-03-862R.

<sup>45</sup>Chin M. Quality improvement implementation and disparities: the case of the health disparities collaboratives. *Medical Care*. 2010; 48(80):668-675.

<sup>46</sup>Shi L, Stevens G, Wulu J, Politzer R, Xu J. America's health centers: reducing racial and ethnic disparities in prenatal and birth outcomes. *Health Services Research* 2004;39(6), Part I, 1881-1901.

<sup>47</sup>Created to administer the War on Poverty programs, the OEO was dismantled by Nixon in 1974. The program has since been relocated to the Bureau of Primary Health Care in the Health Resources and Services Administration.

and cost became a signature component of the health center program as it evolved over the decades and these early quality initiatives have formed the basis for many of the endeavors in place today. Several early initiatives related to quality of care are mentioned briefly in this section. Because of their early exposure to quality assurance and medical care audit practices, FQHCs have an advantage over RHCs and free clinics in meeting the requirements of today's quality initiatives.

### **Bureau Common Reporting Requirement**

The initial annual reporting requirement for health center grantees, dating from the late 1970s, was the Bureau Common Reporting Requirement (BCRR) which included tables of demographic, administrative, financial, and clinical data used for monitoring health center performance. Clinical Table 5 (under the BCRR) included several measures such as percent of children age 18 – 26 months fully immunized and percent of women receiving Pap smears.<sup>49</sup> The performance measures reported were periodically audited as part of Primary Care Effectiveness Reviews in which site teams reviewed health center grantees' board of governance, administrative, clinical, dental (where applicable), and financial management. The comprehensive set of program measures subsequently evolved into the Uniform Data System (UDS), and remains a central feature in today's national health center program.

### **Clinical Outcome Measures by Life Cycle (1980s, pre-HEDIS)**

The number and range of required clinical performance measures expanded in the 1980s to include clinical outcome measures for each stage of the life cycle, namely childhood, adolescence, women's and prenatal health, adults, and geriatrics. As part of the annual grant application, FQHCs were required to submit specific objectives with annual performance targets for each clinical measure. Many of these measures were close or identical to the HEDIS (Health Plan Employer Data Information Set) measures which were developed later by the National Committee for Quality Assurance (NCQA) for use on the assessment of commercial and public managed care plans. This portion of the annual grant application evolved into what is now known as the Health Care Plan component of current health center grant applications.

### **Health Disparities Collaboratives (HDC) (1998-2008)**

One of the best-known and well-documented quality initiatives for health center grantees was the Health Disparities Collaboratives (HDCs) created and led by HRSA/BPHC, which initially aimed to improve the quality of care for chronic conditions.<sup>50</sup> After demonstrating success with chronic conditions, the model was expanded to address preventive care, cancer screening, and perinatal care. This national effort to eliminate disparities and transform health

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<sup>48</sup>Personal communication with Mildred Morehead, MD MPH, Dept Community Health Albert Einstein College of Medicine, Medical Care Review pioneer, OEO consultant; and Gerald Sparer, Director, OEO Office of Health Affairs, Evaluation Unit (1971).

<sup>49</sup>Personal communication with Dr. Carol Garvey, former Medical Officer, Bureau of Community Health Services (1980).

<sup>50</sup>Chin M, Cook S, Drum M, Jin L, Guillen M, Humikowski C, Koppert J, Harrison J, Lippold S, Schaefer C. Improving diabetes care in midwest community health centers with the health disparities collaborative. *Diabetes Care*. 2004;27(1): 2-8.



centers was launched in 1998 in partnership with the Institute for Healthcare Improvement (IHI). The HDC strategy was to introduce the Expanded Care Model and the Model for Improvement to all FQHCs, to support the implementation of these models, and to improve the systematic tracking and reporting of population-based and individual-level care for a specific set of conditions and subject matters. The collaboratives included peer-to-peer learning networks which helped FQHCs learn from each other through experience and research.

Between 1998 and 2008, up to 800 FQHCs participated in one or more HDC which covered a range of conditions and topics starting with diabetes in 1998, then proceeding through asthma, cardiovascular disease, depression, cancer, preventative care, prenatal care, and redesign through 2007. The overall learning experience provided participants and centers with a robust quality improvement toolkit containing many useful components, such as patient registries, improved reporting systems, and improved methods of organizing community coalitions to leverage available resources.<sup>51</sup>

Although the program is no longer actively maintained by HRSA, most participating FQHCs have retained selected HDC components such as the patient registries, coordination of care for specific chronic conditions, and tracking and reporting quality of care measures. State primary care associations continue to provide substantial technical assistance to FQHCs to help them meet these quality standards.

The fundamental conceptual framework for the HDCs was the Chronic Care Model, developed by Dr. Ed Wagner of the MacColl Institute for Healthcare Innovation and the Expanded Chronic Care Model.<sup>52 53</sup> Most components of the care model have been incorporated into health center practices as a result of their HDC participation. This is of particular note since many of the standards related to the National Committee for Quality Assurance's PCMH recognition program are based on components of the Chronic Care Model, thus facilitating the natural progression to PCMH recognition for FQHCs.

## **CURRENT HRSA/BPHC INITIATIVES REGARDING QUALITY ACTIVITIES**

HRSA continues to build on the activities described above by supporting quality initiatives among FQHCs through a range of technical assistance mechanisms and other approaches. For example, BPHC provides policy and technical assistance directly to health center grantees, look-alikes, and potential applicants; it also provides technical assistance through contracts and cooperative agreements with related organizations, including but not limited to the National Association of Community Health Centers, the National Center for Farmworker Health, the National Health Care for the Homeless Council, the National Center for Health in Public Housing, State/regional primary care associations, and health center controlled networks. The Quality Assessment and Performance Improvement Program under development

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<sup>51</sup>Health Resources and Services Administration. Health disparities collaboratives, executive summary. Rockville (MD): 2006 Sep [cited 2011 Jan 5]. Available from: <http://www.healthcarecommunities.org/ImprovingQHcare.aspx>.

<sup>52</sup>Wagner E. Chronic disease management: what will it take to improve care for chronic illness? *Effective Clinical Practice*. 1998;1(1): 2-4.

<sup>53</sup>Barr V, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, Saliveras S. The expanded chronic care model: an integration of concepts and strategies from population health promotion and the chronic care model. *Hospital Quarterly*. 2003;7(1): 73-82.

at CMS will also expand quality activities at FQHCs (see chapter on RHCs for a fuller discussion of this proposed initiative).

Through its program management activities, HRSA continues to reinforce and clarify program expectations, grant requirements, and initiatives that promote quality improvement, quality assurance, risk management, and performance improvement. The requirements and initiatives described in the following subsections generally apply to all health center grantees and look-alikes. These organizations include Community Health Center Programs (CHCs, funded under Section 330(e)), Migrant Health Center Programs (MHC, funded under Section 330(g)), Health Care for the Homeless Programs (HCH, funded under Section 330(h)), Public Housing Primary Care Programs (PHCP, funded under Section 330(i)), and FQHC look-alikes. The familiarity that health center grantees and look-alikes have with these quality-related expectations renders them well-positioned to adopt other quality incentives offered by the federal government to all health care providers.

### **Requirement for On-going Quality Improvement/ Quality Assurance Program**

One of the basic requirements for being a health center grantee or look-alike is to have an on-going quality improvement/assurance program.<sup>54</sup> This program must:

- Include a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;
- Include periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall:
  - be conducted by physicians or by other licensed health professionals under the supervision of physicians;
  - be based on the systematic collection and evaluation of patient records;
  - identify and document the necessity for change in the provision of services by the health center and result in the institution of such change where indicated; and
  - maintain the confidentiality of patient records.

### **Annual Uniform Data System (UDS) Reporting with Clinical Measures**

As noted above, the original Bureau Common Reporting Requirement (BCRR) reporting requirement has evolved and expanded over the years into the Uniform Data System (UDS) which currently requires reporting on a standard set of information and measures about the administrative, clinical, and financial performance of FQHCs. Today, the UDS provides a wealth of information, including key clinical-quality-related performance measures starting in 2008. These indicators include prenatal care and birth outcomes data, as well as common indicators of community health such as hypertension, diabetes, childhood immunization, pap

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<sup>54</sup> See Health Resources and Services Administration. Summary of key health center program requirements. [cited 2011 Mar 1]. Available from: <http://bphc.hrsa.gov/about/requirements/index.htm> for a complete list of program requirements.



tests, overweight and obesity, and substance-related disorders.<sup>55</sup> The systematic and regular reporting of measures such as these allows government officials and the public to assess the operations and performance of health center grantees.

Clinical performance measures are periodically adjusted and modified by HRSA to be consistent with other nationally reported measures, such as those developed by HEDIS. The most recent example of such periodic adjustment is the realignment of the UDS clinical measures with the clinical quality measures that were part of Stage 1 of the Meaningful Use criteria.<sup>56</sup> This internal self-monitoring, using nationally standardized measures, facilitates FQHCs' participation in incentive programs when the same performance measures are adopted by performance-based payment incentive programs offered by State Medicaid managed care plans and commercial health plans.

### **Performance Measures in Grant Applications**

Grantees must also report on clinical measures as part of the application for service area competition or annual budget period renewal grants. Required health care performance measures for 2010 grants include the six clinical measures from the 2009 UDS as well as one behavioral health and one oral health performance measure of the grantee's choice.

### **Federal Tort Claims Act (FTCA) Deeming**

Another incentive to promote and maintain a culture of improvement and safety is the Federally Supported Health Centers Assistance Acts and the deeming requirements for maintaining coverage. Health center grantees (but not look-alikes) have been eligible for this no-cost form of medical malpractice coverage since 1994. Under Federally Supported Health Centers Assistance Acts, FQHCs that receive Section 330 funds may, upon application, be deemed as employees of the federal government for purposes of medical malpractice liability insurance under the Federal Tort Claims Act (FTCA). For deemed FQHCs, medical malpractice claims filed against all eligible health center providers and arising from activities within the scope of their deemed federal employment are handled by the U.S. Department of Justice (and claims are paid by the federal government).<sup>57</sup> This FTCA coverage represents enormous financial savings for health center grantees, especially as the cost of commercial malpractice insurance continues to escalate. HRSA requires the eligible organization, in its application for deeming, to demonstrate that the following two quality-related requirements are met:<sup>58</sup>

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<sup>55</sup> Bureau of Primary Health Care. UDS Reporting Instructions for Section 330 Grantees for use to submit Calendar Year 2009 UDS Data. Rockville (MD): Health Resources and Services Administration in U.S. Department of Health and Human Resources; 2009 Oct.

<sup>56</sup> Health Resources and Services Administration. Proposed uniform data system changes to clinical measures for calendar year 2011, Program Assistance Letter 2010-12. 2010 Aug 30. Available from: [bphc.hrsa.gov/policiesregulations/policies/pdfs/pal201012.pdf](http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pal201012.pdf)

<sup>57</sup> United States Government Accountability Office. Federal tort claims act: information related to implications of extending coverage to volunteers at HRSA-funded health centers. Washington, D.C.; 2009;GAO-09-693R.

<sup>58</sup> Health Resources and Services Administration. Requirements for federal tort claims act (FTCA) medical malpractice coverage. Rockville (MD): Program Assistance Letter 2010-06; 2011 May 28. Available from: [bphc.hrsa.gov/policiesregulations/policies/pal201006.html](http://bphc.hrsa.gov/policiesregulations/policies/pal201006.html)

- 1) The applicant has implemented appropriate policies and procedures to reduce the risk of malpractice and the risk of lawsuits arising out of any health or health related functions performed by the covered entity,<sup>59</sup> e.g., a Quality Improvement/Quality Assurance (QI/QA) Plan must be submitted, with clear documentation that the governing Board reviewed and approved the plan; and<sup>60 61</sup>
- 2) The applicant has implemented a system whereby professional credentials, references, claims history, fitness, professional review organization findings, and licensure status of its physicians and other licensed or certified health care practitioners are reviewed and, where necessary, has obtained the permission from these individuals to gain access to this information.<sup>62</sup>

## Accreditation Initiative

As previously discussed, it has been a longstanding HRSA policy that health center grantees should demonstrate the highest quality standards. To advance this goal, HRSA established the Accreditation Initiative in 1996 to better support FQHCs pursuing accreditation from an independent accrediting body that requires meeting quality and patient safety standards, and health center program expectations.<sup>63</sup> As of January 2011, 256 FQHCs were accredited either by Accreditation Association of Ambulatory Health Care (AAAHC) or by The Joint Commission (TJC), formerly known as the Joint Commission on Accreditation of Healthcare Organizations; only the AAAHC and TJC are contracted under HRSA to provide survey services under the Accreditation Initiative.<sup>64</sup> FQHC look-alikes are also encouraged to seek accreditation but are not eligible to participate in the Accreditation Initiative; only grantees can qualify to have accreditation fees (for ambulatory care services, behavioral health services, and laboratory services, and for purposes of expanding clinical services) paid for by BPHC.

Securing and maintaining accreditation requires successful periodic completion of a rigorous and comprehensive multi-day onsite survey through which the FQHC must demonstrate compliance with nationally recognized standards of health care quality. For both initial surveys and periodic resurveys, HRSA provides supplemental resources to health center grantees such as access to survey-related education, training, and technical assistance.<sup>65</sup>

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<sup>59</sup>42 U.S.C. §224(h) of the Public Health Service Act, codified at 42 U.S.C. §233(g)-(n).

<sup>60</sup>Health Resources and Services Administration Program Assistance Letter 2010-06, *op cit*. It should be noted that a revised Program Assistance Letter will be issued in the first quarter of calendar year 2011, providing additional guidance as to deeming requirements for calendar year 2012.

<sup>61</sup>Health Resources and Services Administration. Summary of key health center program requirements. [cited 2011 Jan 7]. Available from: <http://bphc.hrsa.gov/about/requirements/index.html>

<sup>62</sup>American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient centered medical home [Internet]. Philadelphia (PA): ACP; 2007 Mar. Available from: <http://www.medicalhomeinfo.org/downloads/pdfs/jointstatement.pdf>

<sup>63</sup>Bureau of Primary Health Care. The health center program: accreditation. [cited 2011, Jan 13]. Available from: <http://bphc.hrsa.gov/policiesregulations/accreditation.html>.

<sup>64</sup>Bureau of Primary Health Care. National Quality Recognition Measure, July 2010.

<sup>65</sup>Health Resources and Services Administration. Accreditation Initiative Update. Rockville (MD): Program Assistance Letter 2009-12; 2009 [cited 2011 Jan 5]. Available from: <http://bphc.hrsa.gov/policy/pal0912/>.

## MEDICAL HOME INITIATIVES

Even before formal establishment of medical home initiatives, FQHCs functioned as “medical homes” where patients get routine and ongoing preventive and primary care services, as well as referrals for more specialized services. Medical homes help coordinate a patient’s overall medical care and for decades this is a role HRSA has encouraged FQHCs to play. Much of the recent interest in a strengthened medical home model arose after four associations representing primary care physicians jointly defined the Patient-Centered Medical Home (PCMH) as a model of care where each patient has an ongoing relationship with a personal physician who leads a team that coordinates patient care.<sup>66</sup> The objectives of the PCMH model are to improve access to care, quality and efficiency of care, patient satisfaction, and coordination with other components of the health system. The PCMH model essentially updates the general “medical home” model and adds additional expectations for services that are particularly important for ongoing management of chronic diseases, including self-management by patients and their families, monitoring of care, and coordination with other health providers.

The most widely used criteria for PCMH recognition are from the National Committee for Quality Assurance (NCQA) which developed a set of standards known as the Physician Practice Connections® – Patient-Centered Medical Home™ (PPC-PCMH).<sup>67</sup> These recommendations became the basis of one of several NCQA recognition programs.<sup>68</sup> Through a rigorous application process, organizations may apply for this recognition for each practice site at one of three levels (Level 1, Level 2 and Level 3) depending on how many of the standards are currently being met at the individual site.<sup>69</sup> NCQA recently revised the standards and broadened its focus on physicians to now include “clinicians,” which include nurse practitioners and physician assistants. This change<sup>70</sup> should help many FQHCs where advanced practice clinicians serve as primary care clinicians.

Several FQHCs have been involved with NCQA over the past few years as this program has evolved, and many FQHCs have received NCQA recognition as PPC-PCMHs. BPHC and NCQA are working together to monitor the extent to which FQHCs have attained PPC-PCMH recognition. BPHC recently launched an initiative to help provide resources for FQHCs to support their efforts to achieve NCQA PPC-PCMH recognition.<sup>71</sup>

In May 2008, the Commonwealth Fund, Qualis Health, and the MacColl Institute for Healthcare Innovation initiated a demonstration project to help safety net primary care clinics

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<sup>66</sup>American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association, *op cit*.

<sup>67</sup>The AAAHC currently offers on-site accreditation surveys for organizations seeking Medical Home accreditation and the TJC is in the process of developing medical home designation for ambulatory health care organizations.

<sup>68</sup>National Committee of Quality Assurance. Patient-centered medical home recognition program. Washington, D.C.; 2011 [cited 2011 Jan 5]. Available from: <http://www.ncqa.org/tabid/631/Default.aspx>.

<sup>69</sup>The NCQA criteria establish scores for meeting criteria in nine performance areas, such as care management or performance reporting and improvement. Higher scores lead to recognition at higher levels within the PPC-PCMH system.

<sup>70</sup>National Committee for Quality Assurance. PCMH 2011 Standards and Guidelines. Washington, D.C.; 2011 Jan 31.

<sup>71</sup>Bureau of Primary Health Care. HRSA Patient-Centered Medical/Health Home Initiative. Rockville (MD): Program Assistance Letter 2011-01; 2010 [cited 2011 Jan 5]. Available from: <http://bphc.hrsa.gov/policy/pal1101/>.

become high-performing PCMHs and achieve benchmark levels of quality, efficiency, and patient experience. The overall goal of this “Safety Net Medical Home Initiative” which continues through 2013 is to develop and demonstrate a replicable and sustainable implementation model for medical home transformation. Five Regional Coordinating Centers (Colorado, Idaho, Massachusetts, Oregon and Pennsylvania) partner with 12-15 safety net clinics and with community stakeholders in their respective States. While the initial goal is practice transformation, all partners expect to participate in future Medicaid and other quality incentive programs related to health reform in their States.<sup>72</sup>

A related but separate set of medical home initiatives are occurring in at least 18 States, coordinated by the National Academy for State Health Policy (NASHP); most of these initiatives include FQHCs. The Commonwealth Fund provides the primary support for NASHP’s work with State Medicaid and CHIP programs to implement policies that advance the medical home. Between 2007 and 2009, NASHP worked with leading States (Colorado, Idaho, Louisiana, Minnesota, New Hampshire, Oklahoma, Oregon and Washington) to identify, develop, and disseminate policy options for high performing medical homes. In 2009-2010, eight new States (Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas and Virginia) received technical assistance to develop medical home initiatives. As with the Safety Net initiative discussed above, the initial focus is on practice transformation, with the future potential to participate in State incentive programs as they evolve.<sup>73</sup>

HRSA has been careful to point out that NCQA PCMH recognition is distinct from ambulatory care accreditation, as discussed above, and that FQHCs are encouraged to seek both ambulatory care accreditation and PCMH recognition.

## **HEALTH INFORMATION TECHNOLOGY (HIT)**

### **Adoption of Electronic Health Records (EHR)**

Although a small number of FQHCs have had electronic health records (EHRs) for several years, it is only recently that the number of centers using EHRs has started to increase significantly. Of the 362 FQHCs that responded to a 2008 HIT survey by the National Association of Community Health Centers, 49 percent reported that they were using an EHR and were either “all electronic” or were “part paper and part electronic”.<sup>74</sup> (A recent Commonwealth Fund study also collected data about EHR use among FQHCs in 2009, but that report does not provide an overall estimate of the extent to which FQHCs are using any type of EHR technology).<sup>75</sup>

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<sup>72</sup> Qualis Health. Safety net medical home initiative. [cited 2011 Feb 2] Available from: <http://www.qhmedicalhome.org/safety-net/about.cfm>.

<sup>73</sup> National Academy for State Health Policy. Medical home and patient-centered care. 2010 [cited 2011 Feb 2] Available from: <http://www.nashp.org/medical-home-patient-centered-care>.

<sup>74</sup> Lardiere M. A national survey of health information technology (HIT) adoption in federally qualified health centers. Bethesda (MD): National Association of Community Health Centers; 2009 May.

<sup>75</sup> Doty M, Abrams M, Hernandez S, Stremikis K, Beal A. “Enhancing the Capacity of Community Health Centers to Achieve High Performance: Findings from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers.” New York: Commonwealth Fund. 2010.

Since the 2008 survey, HRSA has continued to encourage FQHCs to expand their use of EHRs. The 2009 Recovery Act provided \$1.5 billion in funding for health center grantees to make capital improvements, including acquisition or upgrades of EHRs, and as of February 2011 the ACA provides another \$1.5 billion for additional capital improvements, including HIT investments.

The George Washington University Department of Health Policy, working in conjunction with NACHC, recently completed a new “Readiness Survey” of EHR use by FQHCs as of December 2010 to February 2011.<sup>76</sup> Surveys were sent electronically to 1,124 health centers, of which 714 responded, for a 63.5 percent response rate. The survey found that 69 percent of health centers responding use EHRs, with 45 percent all electronic and 24 percent partially electronic. In comparison, a recent national survey of office-based physicians found that, as of 2010, about 50 percent had some type of EHR.<sup>77</sup> Thus, it appears that FQHCs are perhaps somewhat ahead of the general ambulatory physician community in their use of EHRs. Nonetheless, it is important to recognize that simply having an EHR does not mean that it is being used at the level of “meaningful use.” The GW survey for FQHCs found that 26 percent to 82 percent were in compliance with individual core functional measures of meaningful use. Almost all FQHCs (91 percent) planned to apply for Medicaid EHR incentives in the next two years. In view of the long history with quality initiatives discussed previously, it seems likely that eligible professionals practicing at FQHCs will continue to be leaders in improving the quality and efficiency of patient care, and the use of HIT will help to achieve this objective.

### **Health Center Controlled Networks (HCCNs)**

Health Center Controlled Networks (HCCNs) are networks of providers that are controlled by health center grantees. Specifically, HRSA defines them as: “a group of safety net providers (a minimum of three collaborators/members) collaborating horizontally or vertically to improve access to care, enhance quality of care, and achieve cost efficiencies through the redesign of practices to integrate services, optimize patient outcomes, or negotiate managed care contracts on behalf of the participating members.” HCCNs aim:

“to improve operational effectiveness and clinical quality in Health Centers through the provision of management, financial, technological and clinical support services. HCCN initiatives are typically focused in functional areas requiring high-cost and/or highly

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<sup>76</sup> Cunningham M, Lara A, Shin P. Results from the 2010-11 Readiness for Meaningful Use of HIT and Patient-Centered Medical Home Survey. Policy Research Brief #27. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington Univ., Revised Dec. 12, 2011.

<sup>77</sup> Hsiao CJ, Hing ES, Scoey T, Cai B. Electronic medical record/electronic health record systems of office-based physicians: United States, 2009 and preliminary 2010. National Center for Health Statistics. 2010 Dec. Regrettably, the most recent NCHS data do not present statistics for group practices, which might be a more appropriate comparison for FQHCs.



specialized trained personnel, procurement of large infrastructure systems, or in functional areas where operational mass drives economies of scale.”<sup>78</sup>

As of early 2011, there were 61 HCCNs receiving Section 330 funding from HRSA to support this broad range of activities.<sup>79</sup> In addition, a national HCCN Steering Committee supported by NACHC provides informal networking among HCCNs and facilitates sharing of experiences from different States.

HCCNs are particularly relevant to this discussion of EHR adoption as this has tended to be the initial priority and focus of most HCCNs working with their affiliated FQHCs throughout the U.S. Although there is a range of organizational types of HCCN grantees, currently funded HCCNs support their members with a shared group approach to EHR selection, adoption, technical support, and the technical assistance needed to facilitate the required practice transformation related to the switch to electronic records.

### **Patient Registries & Clinical Data Warehouses**

Patient registries and clinical data warehouses are both key functional components of quality management and improvement systems that allow practices to deal with improving care from a population health perspective. A “patient registry” provides the ability to record and track groups of individual patients with similar diagnoses and conditions within a single practice or group of practices within a health center network. A “clinical data warehouse” supports the aggregation of such clinical information from many practices and levels of care (such as ERs and hospitals) to allow comparisons among practices and regions and to help identify high performing sites where best practices might be identified and shared as part of a regional learning community.

Health center grantees that were involved with one or more Health Disparities Collaboratives (HDCs) often continue to use the patient registry specific to that HDC condition or subject matter. While most of today’s popular EHR products claim to have a built in patient registry, these are typically quite limited and usually offer little capacity for the more complicated analyses provided by the patient registries that HRSA supplied under the Health Disparities Collaboratives.

There has been a growing awareness and recognition by FQHCs of the need for a third party regional clinical data warehouse to store and manipulate patient specific information coming from multiple sources. This data system should have the capacity to compare patient registry and outcome data across practices and FQHCs. GW researchers have studied an example of a regional clinical data warehouse maintained by the Michigan Primary Care Association that includes patient level health outcomes for patients with diabetes, cardiovascular disease, asthma, and depression from over 100 FQHCs in 24 States. All centers had participated

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<sup>78</sup>Health Resources and Services Administration. What is a health center controlled network? Rockville (MD): [cited 2011, Jan 5]. Available from:

<http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/OpportunitiesCollaboration/abouthccns.html>.

<sup>79</sup>HCCNs can be found at the HRSA’s website Find a health center controlled network. Rockville (MD): [cited 2011, Jan 13]. Available from: [http://findanetwork.hrsa.gov/Help/About\\_Search\\_Settings.htm](http://findanetwork.hrsa.gov/Help/About_Search_Settings.htm).

in at least one HDC, and this regional initiative emerged in response to the end of the HDC program. This data warehouse has the technical capability to aggregate and analyze clinical information across providers, FQHCs, and States. Such data could additionally be used to compare performance measures for both intra- and inter-center reporting and assessments, and to help identify best practice sites.<sup>80</sup>

It is believed that the use of patient registries is widespread among FQHCs, as this was one of the most fundamental components of the -HDCs discussed previously. In addition, many FQHCs in other regions are involved with clinical data warehouse initiatives similar to that of the Michigan Primary Care Association.

## **QUALITY INCENTIVE PROGRAMS**

### **QUALITY INCENTIVES IN MEDICAID & COMMERCIAL MANAGED CARE PLANS**

One popular quality initiative in the health care sector is performance-based payment; which CMS defines as the: “use of payment methods and other incentives to encourage quality improvement and patient-focused high value care.”<sup>81</sup> Many health care purchasers see performance-based payment as a means to align health care spending with the quality, efficiency, and effectiveness of services as opposed to only their quantity. In a climate of rapidly escalating health care costs and public fiscal crises, this is seen as an attractive means for using limited financial resources more effectively.

A 2007 Commonwealth Fund survey of all State Medicaid directors and programs found that 28 States had a performance-based payment system in place (about half of which had been in place for more than five years), and an additional 15 States had plans to adopt one by 2012.<sup>82</sup> Likewise, a 2006 study found that over half of commercial health maintenance organizations offered quality incentives, suggesting that performance-based payment type initiatives are prevalent in both the public and private sectors.<sup>83</sup> However, FQHCs are often unable to participate in these initiatives based on their unique payment mechanisms and patient mixes. As noted in Chapter 1, FQHCs are typically ineligible for Medicare incentives because they do not meet the definitions of eligible professionals and are not paid under the physician fee schedule. In some cases, Medicaid incentives are also tied to physician payment methods, which may exclude FQHCs. In the case of commercial insurance, only a small percentage of FQHC patients have commercial managed care plans; so privately provided incentives are only relevant to a small share of total FQHC patient volume.

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<sup>80</sup>Shin P, Jones E, Jacobs F, Tuckson R. Building a national data repository to measure and improve health center quality. *Journal of Ambulatory Care Management*. 2010 Oct; 33. Hayashi A, Jones E, Stevens D, Shin P, Finnegan B, Rosenbaum S. Health center data warehouses: opportunities and challenges for quality improvement; Brief No. 13, Geiger Gibson / RCHN Community Health Foundation Research Collaborative; 2009 Aug.

<sup>81</sup>Centers for Medicare & Medicaid Services. Quality-based payment strategies. State Medicaid Director Letter #06-003; 2006 Apr 6 [cited 2011 Jan 7]. Available from: <http://www.allhealth.org/briefingmaterials/LetterfromCMS-qualitybasedpaymentstrategies-499.pdf>.

<sup>82</sup>Kuhmerker K, Hartman T. Pay for performance in state Medicaid programs. New York (NY): Commonwealth Fund; 2007 Apr.

<sup>83</sup>Rosenthal M, Landon B, Normand SL, Frank R, Epstein A. Pay-for-performance in commercial HMOs. *New England Journal of Medicine*. 2006;355(18):1895–1902.

In the case of public incentives, a 2009 GW survey of primary care associations found that only about half of State Medicaid programs offered a performance-based payment program in which FQHCs could participate.<sup>84</sup> These quality incentives are typically related to Medicaid managed care plans. The managed care plan may distribute these incentives to individual contracted FQHCs, based on outcome measures reported for health center patients. In some States, health plans are allowed to favor higher performing providers and FQHCs through more favorable auto-enrollment of unassigned Medicaid patients.

### **Medicare Physician Quality Reporting System (PQRS)**

In recent years, Medicare has provided “pay for reporting” incentives under the Medicare Physician Quality Reporting System (PQRS) to physicians and other eligible professionals that satisfactorily submit data on quality measures for covered professional services furnished to Medicare beneficiaries. Because these PQRS incentives are calculated based on services that are furnished by eligible professionals and paid under or based on the Medicare physician fee schedule, most providers at FQHCs (who are paid under a different payment system) are ineligible for these Medicare pay for reporting incentives

### **“Health Home” Demonstration Projects: Medicare, Medicaid, Multi-Payer**

In several States, regional coalitions of health payers (including managed care organizations, commercial health insurers, public health insurers, and self-insured employers) have created demonstration programs to assess the benefits of integrated approaches to care coordination, especially for high expense patients with chronic illnesses. These demonstrations, often referred to as “health home” projects, involve shared health information technology (HIT), performance measurement, and/or quality-based reimbursement. FQHCs have been active players in some of these projects and could be able to benefit from incentives offered.<sup>85</sup> <sup>86</sup> However, the extent of participation, amount of incentive revenues, and potential barriers or challenges specific to FQHCs are unknown at this time.

A 2009 review by the National Academy for State Health Policy found that more than 30 Medicaid and CHIP programs had or were planning medical home initiatives.<sup>87</sup> In a separate project, GW surveyed State primary care associations and interviewed selected health center, State agency, and managed care staff about medical home and quality initiatives in their States. In many States, FQHCs already receive capitated payments to serve as primary care providers in Medicaid primary care case management (PCCM) (25 States) or capitated managed care programs (25 States), essentially acting as medical homes.<sup>88</sup> Under capitated managed care,

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<sup>84</sup>Ku L, Shin P, Jones E, Bruen B, *op cit*.

<sup>85</sup>Kuhmerker K, Hartman T, *op cit*. Table A-5, pp 58-59.

<sup>86</sup>Center for Health Care Strategies (CHCS), Multi-payer quality improvement. 2011 [cited 2011 Jan 7]. Available from: [http://www.chcs.org/info-url\\_nocat5108/info-url\\_nocat\\_list.htm?attrib\\_id=16303](http://www.chcs.org/info-url_nocat5108/info-url_nocat_list.htm?attrib_id=16303).

<sup>87</sup>Kaye N, Takach M. Building medical homes in state Medicaid and CHIP programs. National Academy for State Health Policy; 2009.

<sup>88</sup> In PCCM programs, most services are provided under fee-for-service arrangements, but Medicaid enrollees select or are assigned primary care providers who receive a monthly fee (usually about \$3) to provide overall case management services and coordinate referrals for other services. In capitated managed care, the plan is paid a



FQHCs centers earn additional payments for medical home incentives in 6 States, while 15 States offer quality or health information technology (HIT) incentives for which FQHCs are eligible. In 9 States, FQHCs in PCCM receive other quality or HIT incentives. Fee-for-service Medicaid payments are received by centers in 42 States, but only 4 offer medical home, quality, or HIT incentives under the fee-for-service system. Interviews with officials in those States indicated there was great diversity in the nature of medical home programs, medical home criteria, and progress of program development.

States have used different criteria to define medical homes for their projects. Several States use the NCQA PCMH criteria. Some States augment these criteria, while others select a subset of the NCQA standards and others develop their own standards.<sup>89</sup>

In some States, private physicians are eligible for medical home incentives, but providers serving in FQHCs are not.<sup>90</sup> This situation generally arises in those States that use the physician fee schedule to provide the incentive, since Medicaid reimburses FQHC providers on an institution-based all-inclusive cost per encounter basis instead. In some cases, it appeared that this was because States erroneously interpreted federal rules for paying FQHCs as constituting a cap on payments, so they could not pay more.

The GW FQHC “Readiness Survey” previously mentioned provided insights into the current state of health centers’ preparation for medical home initiatives.<sup>91</sup> While only 6 percent of FQHCs surveyed already had NCQA PCMH recognition as of late 2010/early 2011, another 12 percent had applied for recognition and about half (51 percent) planned to apply for PCMH recognition in the next 18 months. In addition, about 12 percent had or were seeking medical home recognition under another program (e.g., a State program).

In November 2010, CMS announced that it would provide demonstration project funding and Medicare participation to multi-payer advanced primary care practice demonstration projects in eight States, which will include Medicare, Medicaid, and some commercial plans. The medical home criteria used in these initiatives will be established by the States and will likely vary from State to State.<sup>92</sup>

CMS also plans to implement a three-year advanced primary care (medical home) demonstration project for FQHCs that serve more than 200 Medicare beneficiaries.<sup>93</sup> FQHCs that enroll will seek to attain Level 3 NCQA-PCMH recognition and will receive \$6 per member

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monthly capitation fee to arrange for medical care services and members usually choose or are assigned a primary care provider to coordinate medical services. In this case, the primary care provider may be paid on a capitated monthly basis to provide certain primary care services, but may be paid fee-for-service for additional services beyond those basic requirements.

<sup>89</sup> National Academy for State Health Policy. Medical home states. Washington, D.C.: 2011 Jan [cited 2011 Jan 24]. Available from: <http://www.nashp.org/med-home-map>.

<sup>90</sup> Ku L, Shin P, Jones E, Bruen B, *op cit*.

<sup>91</sup> Cunningham M, Lara A, Shin P., *op cit*.

<sup>92</sup> Centers for Medicare & Medicaid Services. CMS introduces new center for Medicare and Medicaid innovation, initiatives to better coordinate health care. Press Release; 2010 Nov 16.

<sup>93</sup> Centers for Medicare & Medicaid Services. Fact Sheet: Federally qualified health center advanced primary care practice (FQHC APCP) demonstration. Aug. 2011. Available at: [https://www.cms.gov/DemoProjectsEvalRpts/downloads/FQHC\\_Fact\\_Sheet.pdf](https://www.cms.gov/DemoProjectsEvalRpts/downloads/FQHC_Fact_Sheet.pdf)

per month for their Medicare patients. Given that Medicare provides (on average) six percent of FQHC revenue, this demonstration project is likely to impact only a small share of national health center revenue and patients at the present time. However, FQHCs are beginning to see the graying of their patient populations, with many senior patients eligible for Medicare or dually eligible for Medicaid and Medicare. Indeed, there are growing number of FQHCs that have embraced senior populations in their service areas, and have developed innovative programs with social services, home care, and “aging in place” initiatives. Although it may not be imminent for the majority of centers, this will be a clear future direction for all FQHCs and an important immediate direction for FQHCs with larger shares of older patients.

As authorized by the Affordable Care Act, CMS recently announced a Medicaid State plan option to provide “health homes” for individuals with chronic conditions. CMS will make planning funds available and will provide a 90 percent federal matching rate for the first two years of program operation.<sup>94</sup> Although the CMS guidance does not create specific criteria for health home projects that can be developed, it specifies that these projects should include at least the following services:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.
- Coordination with the Substance Abuse and Mental Health Services Administration to ensure that plans deal with behavioral and substance use services.

The National Academy for State Health Policy is working with a group of State Medicaid directors in developing State-specific standards for medical homes and incentive programs for those practices that meet the medical home criteria. Because FQHCs already provide many of the required services, they are likely to be well positioned to play a leading role in these health home projects.

## **MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY**

Under the 2009 American Recovery and Reinvestment Act, CMS is providing substantial financial incentives for eligible providers who adopt and “meaningfully use” certified electronic health record (EHR) technology. According to CMS:

“The criteria for meaningful use will be staged in three steps over the course of the next five years. Stage 1 (2011 and 2012) sets the baseline for electronic data capture and information sharing. Stage 2 (expected to be implemented in 2014) and Stage 3

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<sup>94</sup>Mann C. Health homes for enrollees with chronic conditions. State Medicaid Director Letter 10-24. Centers for Medicare & Medicaid Services; 2010 Nov 16.

will continue to expand on this baseline and be developed through future rule making.”<sup>95</sup>

Beginning in 2011, Medicare incentives are available to eligible professionals who meaningfully use certified EHRs and Medicaid incentives are available to eligible professionals who adopt, implement, or upgrade certified EHR technology. For Medicare, the potential incentive is up to \$44,000 per eligible professional, which will be paid out over five years, beginning in 2011. For Medicaid, the maximum incentive is \$63,750 per eligible professional, which will be paid out over six years. The Medicaid incentives are paid to the eligible professionals, but they have the option to reassign their payments to their employers. While FQHCs are not eligible for either incentive, since health center professionals are generally salaried, it is expected that they will often assign their payments to the FQHCs, though providers and FQHCs may need to stipulate this assignment in their employment contracts. Eligible professionals at FQHCs are not eligible for the Medicare incentives but virtually all are expected to be eligible for the Medicaid incentives. In addition, Medicaid incentives are larger and do not require the eligible professional to meaningfully use the technology in the first year.

To be eligible under Medicaid, eligible professionals who have over 50 percent of their encounters at FQHCs must demonstrate that at least 30 percent of their encounters are to “needy individuals” defined as individuals covered by Medicaid or CHIP, individuals receiving uncompensated care, or individuals billed under a sliding fee scale based on their income. Patient volume may be calculated at the group practice level as a proxy. A recent GW analysis indicates virtually all FQHCs will meet this patient volume at the group level.<sup>96</sup> However, it should be noted that only specified professionals (physicians, dentists, certified nurse mid-wives, nurse practitioners, and those physician assistants practicing at physician assistant-led FQHCs or RHCs) are eligible for these benefits. Any incentive payment reassigned to an entity other than the eligible professional earning the incentive is conditional upon a contract between the eligible professional and their employer or another entity with which the professional has a relationship. Such a contract must be consistent with all federal laws and each eligible professional may assign their payment to only one employer or entity. In addition to meeting the patient volume requirement, incentive payments are contingent upon eligible professionals adopting, implementing, upgrading, or meaningfully using certified EHR technology in their first participation year (for Medicaid only) and in subsequent years upon meaningfully using certified EHR technology.<sup>97</sup>

FQHC look-alikes are not eligible for infrastructure funds but eligible professionals practicing at them are eligible to receive Medicaid payments for the adoption and use of certified EHR technology. As is the case with practitioners at FQHCs, any payments to the organization are conditional upon eligible professionals assigning their payment to the health center. Given the lack of funding for infrastructure, it is possible that in future years, FQHCs will have an advantage relative to FQHC look-alikes in obtaining, implementing, and using certified EHRs.

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<sup>95</sup>Centers for Medicare & Medicaid Services. EHR incentive programs: meaningful use. 2010 [cited 2011 Jan 7]. Available from: [https://www.cms.gov/EHRIncentivePrograms/30\\_Meaningful\\_Use.asp](https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp).

<sup>96</sup>Finnegan B, Ku L, Shin P, Rosenbaum S. Boosting health information technology in Medicaid: the potential effect of the American Recovery and Reinvestment Act. Washington, D.C.: George Washington University; 2009 Jul 7.

<sup>97</sup>CMS. EHR incentive programs: meaningful use, *op cit*.

## ONGOING DATA COLLECTION ON MEANINGFUL USE AND PCMH RECOGNITION

The 2010 UDS added a set of questions asking respondents about their EHR capabilities. All FQHCs were asked to report whether they have an EHR system installed and in use and to specify which system is in place. FQHCs with EHRs in place were asked to indicate whether their system had the capacity to meet each of the capabilities listed in the CMS meaningful use criteria, and whether it was being used in such a capacity.<sup>98</sup> Finally, FQHCs were required to indicate the extent to which they used their EHRs in compiling data required for their UDS report.<sup>99</sup> With the availability of this type of data for all FQHCs, researchers in future years will have access to much more information in assessing the extent of EHR use among FQHCs.<sup>100</sup>

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<sup>98</sup> These capabilities include: (1) patient history and demographic information, (2) clinical notes, (3) computerized provider order entry, (4) electronic prescription entry, (5) reminders for guide-line based interventions or screening tests, (6) capability to exchange key clinical information among providers of care and patient-authorized entities electronically, (7) notifiable diseases sent electronically, (8) reporting to immunization registries, (9) capability to provide patients with electronic health records; and (10) protection of electronic health information.

<sup>99</sup> Bureau of Primary Health Care. UDS Reporting Instructions for Section 330 Grantees for use to submit Calendar Year 2010 UDS Data. Rockville (MD): Health Resources and Services Administration in U.S. Department of Health and Human Resources; 2011 Jan.

<sup>100</sup> As of the date of this report, HRSA staff are still reviewing the 2010 UDS data about EHR use of community health centers. This is the first time these data have been reported and staff are carefully examining them.

## CHAPTER 3: RURAL HEALTH CLINICS

### BACKGROUND

As defined in Section 1861(aa)(2), rural health clinics are facilities primarily engaged in furnishing outpatient services and located in non-urbanized areas experiencing health care practitioner shortages or medical underservice.<sup>101</sup> The Rural Health Clinics (RHCs) program was established by Congress in 1977 as one of several programs created to improve the delivery of health care services in rural areas. The main goal of the RHC program is to increase access to primary care services for Medicare and Medicaid patients in underserved rural areas. RHCs receive cost-based Medicare and Medicaid reimbursement to support ongoing practice operations in recognition of the extra costs required to serve low volume areas and vulnerable populations. Cost-based reimbursement makes it more attractive for clinics to start or continue practicing in rural areas that may otherwise have difficulty attracting qualified primary care clinicians.

Early participation in the RHC program was lower than expected, with only 581 RHCs operating in October 1990. However, during the 1990s, growth took off and by October 1999, there were 3,477 RHCs.<sup>102</sup> As of 2010, there were about 3,800 RHCs serving residents of rural underserved areas in 45 States, representing a vast expansion of federally designated providers that deliver primary, preventative, and acute care services in underserved rural areas.<sup>103</sup> Clinics located in a non-urbanized area as defined by the U.S. Census Bureau and in an area designated as a shortage area for healthcare professionals or medically underserved area can apply for RHC certification from the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).<sup>104</sup>

RHCs exhibit various organizational types and arrangements. Clinics may be public or private, and for-profit or not for-profit. RHCs are classified in two main categories: *provider-based* and *independent*. Provider-based clinics are owned and operated as an “integral part” of a hospital, nursing home, or home health agency participating in the Medicare program. As an integral and subordinate component of a larger healthcare organization, provider-based RHCs operate under the licensure, governance, and professional supervision of that organization. Most provider-based RHCs are hospital-owned. Independent clinics are free standing clinics or office-based practices not owned and/or operated by a larger healthcare system. More than half of independent clinics are owned by clinicians.

Over the past two decades, there has been a substantial focus on improving the quality of care, access to services, and efficiency of the health care system in the United States.<sup>105</sup> Reflecting these goals, Section 4205(b) of the Balanced Budget Act of 1997 revised the

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<sup>101</sup> CMS does not require RHCs to reapply for RHC status on the basis of location. Therefore, some RHCs which were located in “non-urbanized” areas may now be located in urbanized areas due to population growth.

<sup>102</sup> Gale J, Coburn A, Finerfrock W. Results from a survey of rural health clinics. Portland (ME): Maine Rural Health Research Center, Edmund S. Muskie School of Public Service, University of Southern Maine; 2002.

<sup>103</sup> GW analyses of the Name and Address Listing for Rural Health Clinics issued by CMS; 2010 Jan 11.

<sup>104</sup> National Association of Rural Health Clinics. Starting a rural health clinic - a how-to manual. Rockville (MD): Health Resources and Services Administration, Office of Rural Health Policy; 2004.

<sup>105</sup> Institute of Medicine. Crossing the quality chasm: a new health system for the 21<sup>st</sup> century. Washington, D.C.: National Academy Press; 2001.

requirement for RHCs to include mandatory participation in quality improvement activities focused on care outcomes. The Office of Rural Health Policy in the Health Resources and Services Administration (HRSA) also provides a small number of grants for quality improvements and access to rural health care services. Numerous programs administered by CMS and State agencies provide additional financial incentives for health care organizations to adopt new technologies and measure and report performance, some of which apply to RHCs. While all clinics and physician practices face challenges in improving the quality of care and adopting new innovative technology solutions, RHCs have unique challenges and issues to overcome that result from the patient populations they serve and their rural locations. Further, RHCs are ineligible for many of the incentives offered by the federal government to health care practitioners because they are not paid using Medicare's physician fee schedule, but use instead an institutional, cost-based reimbursement method.

### THE RURAL HEALTH CLINIC SERVICES ACT

In 1977, Congress passed the Rural Health Clinic Services Act (PL 95-210) to improve access to primary health care in rural, underserved communities and to promote a collaborative model of health care delivery using physicians, nurse practitioners, and physician assistants. In subsequent legislation, Congress added mental health care provided by psychologists and clinical social workers to the core set of services and certified nurse midwives to the core set of primary care professionals.<sup>106</sup>

The Rural Health Clinic Services Act authorizes cost-based Medicare and Medicaid payment mechanisms for RHCs and uses these payment mechanisms as the principal incentive for becoming Medicare-certified. Medicare visits are reimbursed on an allowable cost basis (the All Inclusive Reimbursement Rate) and Medicaid visits are reimbursed under a prospective payment system (PPS) rate which is based on average per encounter costs of clinic patients. States may also develop an alternative payment method, as long as the payment is agreed to by the clinic and the amount is at least equal to the amount the clinic would have received under the PPS method.

### RHC ELIGIBILITY CRITERIA

**Staffing.** The Rural Health Clinic program was the first federal initiative to encourage the use of a team approach to health care delivery, through the requirement to include physicians, physician assistants (PAs), and nurse practitioners (NPs). Each Medicare-certified RHC must have: one or more physicians and one or more PA or NP. The PA or NP must be on-site and available to see patients at least 50 percent of the time the clinic is open for patient care. Rural Health Clinics are not required to have certified nurse midwives (CNMs), but those that do may use the CNMs to meet the 50 percent staffing requirement (but would still have to employ a PA or NP).

**Location.** According to the Rural Health Clinics Act, RHCs must be located in communities that are both "rural" and "underserved." Eligibility criteria specify that RHCs must locate in a non-urbanized area, which is defined in terms of census block population density by

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<sup>106</sup>National Association of Rural Health Clinics, *op cit*.



the U.S. Census Bureau; although some are now located in areas that have become more urbanized.<sup>107</sup> RHCs must also be located in a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA). These areas are designated based on the availability of health care professionals relative to the population as defined by HRSA.<sup>108</sup> RHCs may also locate in areas designated as shortage areas by State governors and certified by the Secretary of the Department of Health and Human Services (DHHS). CMS does not require RHCs to reapply for RHC status on the basis of location. Therefore, some RHCs which were located in “non-urbanized” areas may now be located in urbanized areas due to population growth.

**Facilities.** RHCs may be either permanent locations in standalone buildings, designated spaces within larger facilities, or mobile units that move from one community to another according to a set schedule.<sup>109</sup>

**Reimbursement Policies.** RHCs are paid on an institutional basis, not as physician practices unless they have received an exception to the established payment limit. In Medicare, for covered services, they are paid an interim all-inclusive payment per visit, which is based on cost reporting, up to a cap on reasonable payments. Freestanding RHCs and those attached to larger hospitals have an all-inclusive rate (currently capped at \$78.07) and Medicare reimburses 80 percent of that rate. However, the coinsurance for Medicare beneficiaries is 20 percent of the reasonable and customary charges, not the all-inclusive rate. Provider-based RHCs in hospitals with fewer than 50 beds are not subject to the upper payment limit.

In Medicaid, they are also paid by State agencies on an all-inclusive per visit basis using one of two methodologies. They may be paid based on a prospective payment basis, based on the reasonable costs of services in 1999 and 2000, adjusted upwards based on the Medicare Economic Index or may be paid under an alternative payment methodology, that at least equals the prospective payment that would otherwise be used. In many (but not all) cases, these payment methods may lead to payments that are higher than those that would be made if they paid using the Medicare or Medicaid physician payment methodology. While visit-specific payments may be higher or lower under the all-inclusive payment, CMS’s end of the year reconciliation typically finds that RHC payments are higher as the result of the all-inclusive payment system. In the aggregate, we believe payments are higher than those that would be made under the traditional Medicare fee-for-service program.

**Policies and Procedures.** RHCs are required to maintain accurate and up-to-date record keeping systems that include clinical records for all patients and ensure patient confidentiality. Clinic staff must be involved in the development of these systems and descriptions of the system must be included in each clinic’s policy and procedures manual. RHCs are also required to have written policies, developed with the advice of a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern the provision of health care services. Written patient care policies must describe: services provided

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<sup>107</sup>For more information, see U.S. Census Bureau Geography Division. Census 2000 urban and rural classification. 2009 Dec [cited 2010 Dec 15]. Available from: [http://www.census.gov/geo/www/ua/ua\\_2k.html](http://www.census.gov/geo/www/ua/ua_2k.html).

<sup>108</sup>For more information, see Health Resources and Services Administration. Shortage designation: HPSAs, MUAs, and MUPs. 2010, May [cited 2010, Dec 15]. Available from: <http://bhpr.hrsa.gov/shortage/>.

<sup>109</sup>All areas served by mobile units must be designated shortage areas.

directly by the clinic's staff or through arrangement, guidelines for medical management of health problems, and the process for annual review of clinic policies.

## PROFILE OF RHCs

Regrettably, there is little current information about the characteristics of RHCs. About half (52 percent) of RHCs are independent clinics while the remainder (48 percent) are provider-based. Unfortunately, little comprehensive information about these clinics is publicly available, with most published data coming from a survey conducted by the Maine Rural Health Research Center at the University of Southern Maine in 2000.<sup>110</sup> This survey was mailed to 1,600 RHCs randomly selected from the Online Survey, Certification, and Reporting database maintained by CMS. Of the 1,600 mailed surveys, 611 surveys were returned; an additional 151 surveys were undeliverable as a result of clinic closures and incorrect addresses. According to this survey, independent clinics are most commonly owned by physicians, NPs, or PAs (55 percent) and provider-based clinics are most commonly owned by hospitals (90 percent). On average, RHCs had 1.7 physicians and 1.3 advanced practice clinicians (PAs, NPs or CNMs). But RHCs often had staff vacancies as well, perhaps because of their rural locations. The survey found that about 30 percent of RHC patients were Medicare patients, 24 percent were Medicaid patients, 15 percent were uninsured patients, 30 percent were commercially insured patients, and 4 percent had other coverage. RHCs tended to be isolated: in 81 percent of the zip codes where RHCs were located, there was only one RHC, although there could be other health care providers.

A 2010 survey by the Maine Rural Health Research Center at the University of Southern Maine focused on independent RHCs and found that they often provide safety net functions, based on a survey of 392 randomly selected RHCs, with a response rate of 93 percent.<sup>111</sup> More than five out of six (86 percent) of the independent RHCs offer free or discounted medical care and on average 27 percent of their patients were on Medicaid. About one-eighth (13 percent) of their billings were counted as free, discounted, or bad debt, which suggests that a large share of these patients were uninsured or underinsured. Almost all were still accepting new Medicaid or CHIP patients. More than half (58 percent) offered language interpretation for patients with limited English proficiency. When independent RHCs were located in counties without an FQHC, they tended to have larger shares of patients covered by Medicaid or CHIP.<sup>112</sup>

According to 2008 Medicare and Medicaid claims data, RHCs conducted approximately 7.4 million Medicare patient visits and approximately 6 million Medicaid patient visits. Research conducted by the Maine Rural Health Research Center at the University of Southern Maine showed that 31 percent of RHC visits were for Medicare and 25 percent were for Medicaid.<sup>113</sup> This research also revealed that the total number of Medicare and Medicaid patients

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<sup>110</sup>Gale J, Coburn A. The characteristics and roles of rural health clinics in the United States: a chartbook. Portland (ME): University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center, 2003.

<sup>111</sup>Hartley D, Gale J, Leighton A, Bratesman S. Safety net activities of independent rural health clinics. Working Paper #44. Portland (ME): University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center; 2010 Sep.

<sup>112</sup>This survey only included independent RHCs. We do not know the extent to which profiles of provider-based RHC patients differ from those of independent RHCs.

<sup>113</sup>*Ibid.*



seen in RHCs in 2008 was 3.6 million. Based on this information it can be estimated that the total number of patients seen in RHCs per year is between 5 and 8 million.

### **Prior Research on Quality at RHCs**

There are relatively few studies examining the quality of care provided at RHCs that go beyond assessments at a single or small number of clinics, which may not be more broadly generalizable. A study by Janice Probst and her colleagues examined the effect of the presence of RHCs or FQHCs on county-level hospitalization rates for ambulatory-care sensitive conditions in eight States.<sup>114</sup> Ambulatory care sensitive conditions include diabetes, asthma, and other conditions that can be effectively treated with good quality primary care. For example, lower hospitalization rates for older adults were observed in counties with FQHCs or RHCs compared to counties with neither facility. A study by Edwards and Tudiver examined women's health screenings at RHCs and found that, although RHCs do not receive insurance payments for treatment of uninsured women, mammogram and pap smear rates for uninsured and insured women were comparable to those for other health providers.<sup>115</sup>

### **QUALITY INITIATIVES IN RHCs**

#### **HEALTH, SAFETY, AND QUALITY**

Based on existing research, there is little evidence to suggest widespread adoption among RHCs of quality and performance enhancing technologies and initiatives. CMS is trying to promote such endeavors through proposed changes in the RHC regulations. On June 27, 2008 CMS issued a proposed rule which would require RHCs to establish a quality assessment and performance improvement (QAPI) program as a condition of participation in the RHC program.<sup>116</sup> It should be noted, however, that until final, the proposed rule imposes no new requirements on the public; and that CMS is giving meaningful consideration to public comments received in response to the proposed rule.

The proposed rule would specify changes in participation requirements and payment provisions for both RHCs and FQHCs. This proposed rule would also amend the Medicare certification requirements for RHCs as required by Section 4205 of the Balanced Budget Act of 1997. In addition to changes to location requirements and payment methodology, the rule:

- Would require RHCs and FQHCs to maintain and document their infection control process;

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<sup>114</sup> Probst J, Laditka J, Laditka S. Association between community health center and rural health clinic presence and county-level hospitalization rates for ambulatory care sensitive conditions: an analysis across eight US states. *BMC Health Services Research*. 2009; 9:134

<sup>115</sup> Edwards J, Tudiver F. Women's preventive screening in rural health clinics. *Women's Health Issues*. 2008; 18: 155-166.

<sup>116</sup>Centers for Medicare & Medicaid Services. Medicare program; changes in conditions of participation requirements and payment provisions for rural health clinics and federally qualified health centers; Proposed Rule. *Federal Register*. June 27, 2008;73(125). Legislation requires that final rules be issued within three years of the proposed rule issuance.

- Would require RHCs and FQHCs to post their hours of operation;
- Would update the emergency services standard and patient health records condition for certification to reflect advancements in technology and treatment; and
- Would require RHCs to establish a Quality Assessment and Performance Improvement Program (QAPI) program. The QAPI program will replace the longstanding annual program evaluation requirement.

While this rule is waiting to be finalized, CMS announced that RHCs could voluntarily adopt the QAPI initiative in lieu of the annual program evaluation each RHC is required to perform. Although many RHCs have voluntarily adopted the QAPI initiative, widespread adoption will likely not occur until the initiative is mandatory.

## **QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM**

### **Quality Improvement Requirement**

If the QAPI program becomes mandatory RHCs will be required to design, implement, maintain, and evaluate a performance improvement program. Performance improvement programs should reflect the complexity of the RHCs' organization and services, clinical needs, and resources; and must use data to improve the quality of care furnished to their patients.<sup>117</sup> The proposed rule dictates that RHCs should target services for improvement, such as: high-volume, high-risk services, the care of acute and chronic conditions, patient safety, coordination of care, convenience and timeliness of available services, or grievances and complaints.

Based on the proposed rule, RHCs must adopt or develop performance measures that fit their improvement goals, are agreed upon by their professional staff, and are aligned with nationally approved standards and practices. The clinic should be able to prove with objective data that sustained improvements have taken place in actual care outcomes, patient satisfaction levels, and/or access to care. Although there is not a mandated QAPI structure, experts from the field provide recommendations for quality improvement methodology and structure. Sample quality improvement methodologies that could be utilized by RHCs include Plan Do Check Act (PDCA) cycles, Lean, and Six Sigma.<sup>118</sup>

### **QAPI Implementation**

While QAPI is still not mandatory, when it was outlined in the 1997 BBA, its intended implementation date was January 1, 1998. During the interim period, CMS has encouraged RHCs to begin developing QAPI plans in order to assess and improve performance in accordance with legislative intent, and toward this end, HRSA, the National Association of Rural Health Clinics (NARHC), and the National Organization of State Offices of Rural Health (NOSORH) are providing technical assistance. Only very limited research exists assessing the

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<sup>117</sup>42 C.F.R. § 491.11.

<sup>118</sup>Grice D, Dunn M. Quality Assessment and Performance Improvement. Rural Health Center Association Conference. Reno(NV) 2010 .

effectiveness of these efforts. In a 2002 working paper for HRSA, Knott and Travers assessed RHC compliance with the QAPI proposed rule and the capacity of State agencies to provide RHCs with technical assistance in QAPI implementation.<sup>119</sup> Since then, a substantial amount of technical assistance has been provided to help RHCs improve their quality assessment and performance.

## **ADOPTION OF CARE COORDINATION AND CASE MANAGEMENT PRACTICES**

Currently, there is very little research assessing the uptake of care coordination and case management practices among RHCs.<sup>120 121</sup> The University of Central Florida conducted a survey of RHCs in late 2009, but only attained a 10.7 percent response rate, which suggests that the data might not be generalizable.<sup>122</sup> This survey asked questions about the adoption of case management and integrated care practices in RHCs. The majority of rural health clinics (73.6 percent) reported that they did not have a disease management program coordinated by case managers, although 13.4 percent reported partially implementing such programs. This survey suggests that personnel shortages may be a significant impediment to coordinated care programs in RHCs, with 62.0 percent reporting insufficient personnel to form primary care interdisciplinary teams but 59.2 percent reporting that they frequently coordinated services with other providers in the community.

## **USE OF HEALTH INFORMATION TECHNOLOGY (HIT)**

Currently, a centerpiece of the national health care agenda is adoption of HIT among health care providers of all types, and federal and State policies exist to help support eligible professionals, eligible hospitals, and critical access hospitals in adopting and “meaningfully using” certified electronic health record (EHR) technology and to develop an information infrastructure to help link the EHR systems together. However, evidence suggests that adoption and implementation of HIT systems is occurring only slowly, with rural providers lagging behind their urban counterparts.<sup>123</sup> For example, data from the 2007 National Ambulatory Medical Care

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<sup>119</sup>Knott A, Travers, K. Implementing quality assessment and performance improvement systems in rural health clinics: clinic and state agency responses. Working Paper #42 Rockville (MD): Health Resources and Services Administration, Office of Rural Health Policy; 2002.

<sup>120</sup> One definition of care coordination is: “the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.” McDonald K, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C, Brustrom J, Malcom E. Care coordination measure atlas. Agency for Healthcare Research and Quality. AHRQ Publication No. 11-0023-EF, 2011, Jan. [Accessed 2011, May 5]. Available from: <http://www.ahrq.gov/qual/careatlas/index.html>.

<sup>121</sup> One definition of case management is: “all the activities which a physician or other health care professional normally performs to insure the coordination of the medical services required by a patient. It also, when used in connection with managed care, covers all the activities of evaluating the patient, planning treatment, referral, and follow-up so that care is continuous and comprehensive and payment for the care is obtained.” Slee D. *Slee’s Health Care Terms*. Rev. 2007,

<sup>122</sup>Ortiz J, Meemon N, Tang C, Wan T, Paek S. Rural health clinic efficiency and effectiveness: insight from a nationwide survey. *Journal of Medical Systems*. 2008 Dec.

<sup>123</sup>Bahensky J, Jaana M, Ward M. Health care information technology in rural America: electronic medical record adoption status in meeting the national agenda. *The Journal of Rural Health*. 2008;24(2): 101-105.

Survey found that physicians in non-metropolitan (i.e., rural) areas were less likely to have minimally functional electronic medical record systems than those in metropolitan areas (13.2 percent in rural areas vs. 18.0 percent in non-rural areas).<sup>124</sup> Lower levels of health information technology by rural health care providers occurred for all types of health facilities: physicians' offices, hospital outpatient departments, hospital emergency departments, and ambulatory surgery centers, compared to providers in non-rural areas.<sup>125</sup> A recent survey of family physicians found that use of HIT in support of medical home projects was low among all respondents, but adoption was significantly lower among nonmetropolitan practices.<sup>126</sup>

In addition to asking about care coordination practices, the 2009 University of Central Florida survey contained questions about HIT system acquisition, though given the low response rate, results should be interpreted with some caution. About one-quarter of the respondents (27 percent) had an EHR system, but half of that group had their systems in place for less than one year. Further, the low rates of HIT adoption have created impediments to adoption of quality initiatives. For example, about one fourth of survey respondents were unable to retrieve or did not report historical data on patient volume, with many stating that they lacked a system that could generate such information.<sup>127</sup> The Maine Rural Health Research Center at the University of Southern Maine is fielding a survey of use of electronic health records by RHCs and the results should be available later.

It is not completely clear if the lower use of HIT by rural providers is due to their rural location or other practice characteristics, such as their smaller sizes. Solo or small physician practices are also less likely to have HIT systems. A recent analysis of national data on electronic health records found that, after controlling for practice size, type, specialty and other characteristics, the differences in electronic health record use for rural physicians was no longer statistically significant.<sup>128</sup> Even so, some factors, such as a broader problem of access to broadband internet services in rural areas may provide additional barriers for rural health care providers. As discussed later in this chapter, the Federal Communications Commission has been making efforts to expand broadband services for rural health care providers.

Independent RHCs may have greater barriers to HIT use than provider-based RHCs. Outpatient departments and emergency departments at rural hospitals are more likely to have electronic health record systems than office-based rural physicians. It seems plausible that RHCs owned by hospitals can share the same systems and networks as other parts of the hospitals, while independent RHCs may face greater difficulties if they have to install and operationalize systems on their own. However, it may be possible for independent RHCs to enter into

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<sup>124</sup>Hing E, Hsiao CJ. Electronic medical record use by office-based physicians and their practices: United States, 2007., and National health statistics reports 23. Hyattsville, MD: National Center for Health Statistics; 2010 Mar.

<sup>125</sup>Hing E, Hall M, Ashman J. Use of electronic medical records by ambulatory care providers: United States, 2006., and National health statistics reports 22. Hyattsville, MD: National Center for Health Statistics; 2010 Apr.

<sup>126</sup>Mueller K, Ullrich F, MacKinney C. Use of health information technology in support of patient-centered medical homes is low among non-metropolitan family medicine practices. RUPRI Center for Rural Health Policy Analysis Rural Policy Brief No. 2011-2; 2011 Apr.

<sup>127</sup>Ortiz J, Meemon N, Tang C, Wan T, Paek S, *op cit*.

<sup>128</sup>Bruen B, Ku L, Burke M, Buntin M. More Than Four in Five Office-Based Physicians Could Qualify for Federal Electronic Health Incentives. *Health Affairs*. 30(3):472-80. 2011 Mar.

agreements with other local health care providers, such as hospitals or FQHCs to join electronic networks formed by these other providers to facilitate adoption of HIT systems.

## QUALITY INCENTIVE PROGRAMS

There are numerous incentive programs at the federal and State levels for improving quality and efficiency in the health care system and the following sections describe existing federal incentive programs. Although there is no comprehensive list of State incentive programs, these sections describe several exemplary programs as examples of State initiatives. One of the themes of these sections is that RHCs frequently do not qualify for quality and efficiency incentive programs, which may be one reason for their limited adoption of performance reporting and health information technology practices.

**Physician Quality Reporting System.** The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system,<sup>129</sup> which currently provides an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries. The Program was further modified by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (Pub. L. 110-275), Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275), and the Affordable Care Act of 2010 (Pub. L. 111-148).<sup>130</sup> Eligible professionals under the Physician Quality Reporting System include: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, occupational and physical therapists, and as of 2009, qualified audiologists. Beginning in 2010, group practices may also qualify for incentive payments under the program. For the 2009 and 2010 Physician Quality Reporting System, the incentive to both individuals and groups is equal to two percent of Medicare Part B allowed charges for covered professional services furnished during the reporting period. Because Physician Quality Reporting System incentives apply to eligible professionals, and are calculated based on services that are furnished by eligible professionals and paid under, or based on, the Medicare physician fee schedule, RHCs are unable to participate in the Program; and forgo a potentially valuable incentive to promote the collection and reporting of quality data by RHCs.<sup>131</sup>

**Medicare Electronic Prescribing (eRx) Incentive Program.** Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)<sup>132</sup> authorizes an incentive program for eligible professionals (EPs) who are successful electronic prescribers beginning January 1, 2009.<sup>133</sup> Although the Medicare eRx Incentive Program is independent of the Physician Quality Reporting System, the applicable quality incentive percent used to calculate bonus payments is the same for 2010. In 2010, eRx incentives are available for EPs who demonstrate that they are successful electronic prescribers based on reporting the eRx

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<sup>129</sup> CMS initially referred to this program as the “Physician Quality Reporting Initiative” or PQRI, but has recently decided to rename it the “Physician Quality Reporting System.”

<sup>130</sup>Centers for Medicare & Medicaid Services. Physician quality reporting system. [cited 2011 Jan 3] Available from: <https://www.cms.gov/pqri/>.

<sup>131</sup>Goldberg D. Discussion group at National Association of Rural Health Clinics Fall Institute. Reno, NV 2010.

<sup>133</sup>H.R. 6331 The Medicare Improvements for Patients and Providers Act, Section 132; 2008.



quality measure for at least 25 unique electronic prescribing events during 2010. A group practice may also, based on a different set of criteria for reporting, qualify in 2010 for an eRx incentive payment equal to two percent total estimated Medicare Part B allowed charges for covered professional services furnished by the group practice during the reporting period. Similar to the Physician Quality Reporting System, eRx incentive payments apply to eligible professionals and are calculated based on services furnished by eligible professionals and paid under, or based on, the Medicare physician fee schedule, and therefore, RHCs are ineligible for this incentive program.

**Medicare and Medicaid EHR Incentive Program.** Provisions of the Recovery Act provide Medicare and Medicaid incentive payments to eligible professionals, eligible hospitals, and critical access hospitals that adopt and successfully demonstrate meaningful use of certified electronic health record (EHR) technology.<sup>134</sup> In general, RHCs (and providers practicing at RHCs) are not eligible for Medicare incentive payments because they do not meet the statutory definition for eligible professionals and their covered professional services are not billed or paid under the physician fee schedule as is required by the Recovery Act.

Although RHCs are not directly eligible for Medicare EHR payments, hospital-owned RHCs could be indirect beneficiaries of Medicare hospital EHR incentives. Hospitals may be eligible for the Medicare EHR incentives and some hospitals own RHCs. However, outpatient volume is not a factor in determining the amount of EHR incentives that a hospital receives. If a hospital sets up an EHR system and receives Medicare incentives for meaningful use, it may share the system with outpatient clinics, so hospital-owned RHCs could be indirect beneficiaries of the EHR incentives, although they are not directly eligible.

Eligible professionals practicing predominantly at RHCs are eligible for Medicaid EHR incentives if at least 30 percent of their patient volume consists of “needy individuals” (including individuals eligible for Medicaid or CHIP, uncompensated care patients, and those subject to a sliding fee scale).<sup>135</sup> Some eligible professionals practicing at RHCs meet the 30 percent “needy” patient threshold, but others do not.<sup>136</sup> Given the expected growth of Medicaid caseloads after the implementation of Medicaid expansions under the ACA in 2014, it is likely that more RHCs would meet the 30 percent threshold after 2014. It should be noted, however, that the incentive payments are to the eligible professionals practicing at RHCs, and RHC receipt of incentive payments is conditional upon establishment of an agreement between the RHC and the eligible professional.

In addition to eligibility challenges, small and independent RHCs are expected to have difficulty adopting EHRs due to a lack of financial resources (capital) and technical knowledge. Rates of health IT use are low among non-metropolitan primary care practices, many of which

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<sup>134</sup>Centers for Medicare & Medicaid Services. Medicare and Medicaid programs; electronic health record incentive program. Federal Register; July 28, 2010;75(144).

<sup>135</sup> The predominant practice criterion requires that over 50 percent of the professional’s patient encounters, from the six-month period from the most recent calendar year, occurred at the RHC.

are small and independent.<sup>137</sup> Other research has also found lower utilization of health IT in small and independent practices,<sup>138,139</sup> indicating that this is an issue for many RHCs. Another hurdle RHCs face is that many EHR systems (including practice management systems) do not readily conform to the payment mechanisms and reporting requirements of RHCs. Since RHCs represent a small segment of the EHR market, vendors have little incentive to develop systems meeting the RHC needs.<sup>140</sup>

**Federal Efforts to Help Promote Rural HIT and EHRs.** As part of their ongoing efforts to foster the use of HIT and EHRs, federal agencies are taking various steps to help rural providers, such as RHCs to adopt EHRs. The Regional Extension Centers (RECs), sponsored by ONC, provide assistance to primary care providers, including small practices such as those often found in rural areas to learn about and adopt EHRs and attain meaningful use. In addition to these general efforts, HHS has provided supplemental funding to RECs to target assistance to critical access and rural hospitals, many of which have RHCs. In addition, ONC established the Beacon Communities projects to further promote EHRs and health information exchange in 17 communities, some of which include rural areas, such as the Mississippi Delta or the island of Hawaii. CMS has worked with ONC to promote State health information exchange, some of which will include rural providers. Other types of efforts are described below.

**Rural Health Information Technology Network Development Program (RHITNDP).** Authorized under Section 330A(f) of the Public Health Service Act, the Rural Health Information Technology Network Development Program (RHITNDP) provides \$12 million annually (up to \$300,000 per grant for up to three years), for networks of rural providers to adopt and meaningfully use EHRs through one-time grant funding that can be used for activities such as: workforce analysis, EHR strategic plan development, EHR training, purchase of HIT equipment, the identification and location of certified HIT equipment vendors, and installation of broadband. Applicants must be networks with a history of collaboration and a memorandum of understanding. The goals of the RHITNDP are to improve the financial viability of rural networks by achieving cost efficiencies and economies of scale; to enhance professional development and workforce recruitment and retention; to facilitate the sharing of staff and expertise across network members; to strengthen the continuum of care; and to promote care quality improvements.<sup>141</sup> The RHITNDP is likely to help those RHCs that partner with other organizations with the up-front costs associated with investing in certified EHR technology. Moreover, the encouragement for even loosely affiliated networks to invest in HIT as a group is likely to create incentives for vendors to develop systems meeting the RHC needs; as well as

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<sup>137</sup> Keith J. Mueller, PhD; Fred Ullrich; A. Clinton MacKinney, MD, MS. Use of Health Information Technology in Support of Patient-Centered Medical Homes Is Low among Non-metropolitan Family Medicine Practices. RUPRI Center for Rural Health Policy Analysis, Rural Policy Brief. Brief No. 2011-2. 2011. 1-4.

<sup>138</sup> Goldberg D.G. and Kuzel A.J. (2009). Elements of the patient-centered medical home in family practices in Virginia, *Annals of Family Medicine*, 7, 4, 301-308.

<sup>139</sup> Rittenhouse DR, Casalino LP, Gillies RR, Shortell SM, Lau B. Measuring the medical home infrastructure in large medical groups. *Health Aff(Millwood)*. 2008;27(5):1246-1258.

<sup>140</sup> Goldberg, D.G. (2010). Discussion group. National Association of Rural Health Clinics (NARHC) Fall Institute. Reno, NV.

<sup>141</sup> Health Resources and Services Administration. Electronic handbook for applicants/grantee: rural health information technology network development program. Health and Human Services Administration, 2011.



increase the financial and human resources of the potential purchasers to the point where EHRs become a real possibility.

**Telehealth.** Telehealth is the use of technology to provide clinical services when a healthcare provider and patient are separated by geographic distance, which makes telehealth a particularly useful tool for rural healthcare providers.<sup>142</sup> For Medicare purposes, telehealth services are delivered through a telecommunications system that includes audio and video equipment permitting two-way, real-time interactive communications between a patient located at a rural site, with or without the presence of a healthcare practitioner, and a physician or other healthcare practitioner located in a distant site.<sup>143</sup> Medicare also covers services delivered via a telecommunications system where the service is one that inherently does not require direct contact between the patient and physician, including teleradiology (the professional interpretation of an x-ray).

HRSA has a long history of supporting telehealth programs, providing pioneering support for many of the rural telehealth programs in this nation. On October 1, 2001, Medicare coverage for healthcare services delivered via telemedicine was expanded to include consultations, office visits, office psychiatry services, and other additional services. RHCs may also receive reimbursement from some private insurance companies for telehealth services.

Telehealth represents an option for RHCs to deliver health care services to residents of remote, underserved areas. Telehealth services that could be delivered by RHCs include certain primary and acute care services, dermatology, radiology, nursing, and psychiatric care. RHCs face several major challenges in delivering telehealth services. The biggest issue is the cost of telehealth equipment, which many clinics have determined to be unfeasible based on the total reimbursement received for telehealth services. Another major concern is access to computer technology and the internet, both of which are required for interacting with a RHC provider for telehealth services.<sup>144</sup>

**FCC/Rural Health Broadband.** The Federal Communication Commission (FCC) implemented the Rural Health Care Pilot Program Selection Order in 2007.<sup>145</sup> For eligible rural health care providers, the pilot program funded 85 percent of construction costs associated with State and regional broadband networks and advanced telecommunication and information services provided in the network. In 2010, the Rural Health Care Support Mechanism Notice of Proposed Rulemaking (NPRM) recommended the expansion of broadband use by public and non-profit providers. Based on lessons learned in the pilot, the Commission recommended that the program subsidize 50 percent of monthly operating costs in addition to the 85 percent subsidy of initial capital costs.

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<sup>142</sup>Center for Telehealth & E-Health Law. Frequently asked questions. 2009 [cited 2011 Jan 3]. Available from: <http://www.telehealthlawcenter.org/content/?page=18>.

<sup>143</sup>Rural sites are defined as those not within a Metropolitan Statistical Area.

<sup>144</sup>Goldberg D, *op cit*.

<sup>145</sup>Federal Communication Commission. Rural health care pilot program selection order. Washington, D.C.; 2010 [cited 2011 Jan 3]. Available from: <http://www.fcc.gov/cgb/rural/rhcp.html>.

Eligible health care providers include public and non-profit providers under Section 254(h)(7)(B) of the Communications Act and the FCC's rules for the existing Rural Health Care Program. The provider eligibility requirements include public and non-profit RHCs, but exclude for-profit RHCs.

In 2010, the FCC announced that, based on the pilot program, it planned to expand the rural health broadband program on a national basis, using funds from the Universal Service Fund, based on a fee assessed on telecommunications firms.<sup>146</sup>

**Patient Centered Medical Home Practice Certification.** Several associations representing primary care clinicians jointly defined the Patient-Centered Medical Home (PCMH) as a model of care where each patient has an ongoing relationship with a personal physician responsible for leading a team that coordinates care.<sup>147</sup> The PCMH model is thought to increase access, quality, and efficiency of care; improve patient satisfaction; and facilitate coordination with other components of the health system. The model is now a central theme in both federal and State policies. CMS is sponsoring a Multi-payer Advanced Primary Care Demonstration Project in several States and planning a similar Medicare project for FQHCs.<sup>148 149</sup> The National Committee of Quality Assurance (NCQA) has developed a Physician Practice Connections-Patient Centered Medical Home (PCC-PCMH) recognition program, which is widely used.<sup>150</sup> No federal support program currently exists to assist RHCs to gain recognition as a medical home.

Another potential obstacle to PCMH designation for safety net clinics has been that many RHCs and some FQHCs rely heavily on PAs and NPs as principal providers of primary care. The law mandates that a PA or NP be on-site and available to see patients at least 50 percent of the time but does not set a minimum time for physician on-site availability. Every RHC has a physician who serves as the Medicare Director of the clinic, but the level of direct patient care involvement of that physician can be limited. However, the new 2011 NCQA PCMH standards have revised the criteria to recognize "clinicians," a broader term that recognizes the role of non-physician clinicians like nurse practitioners.<sup>151</sup> The change to NCQA guidelines will likely minimize this obstacle for RHCs or FQHCs relying on NCQA PCMH criteria.

**State Initiatives Promoting Medical Homes.** An example of a medical home project at the State level is the New York State Department of Health (NYSDOH) incentive for the development of medical homes. The NYSDOH anticipates that these homes will improve health

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<sup>146</sup>iHealthBeat. FCC approves plan to expand broadband for health facilities. 2010, Dec [cited 2011 Jan 3]. Available from: <http://www.ihealthbeat.org/articles/2010/7/15/fcc-seeks-to-distribute-400m-to-boost-rural-health-care-networks.aspx>.

<sup>147</sup>American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient centered medical home [Internet]. Philadelphia (PA): ACP; 2007 Mar. Available from: <http://www.medicalhomeinfo.org/downloads/pdfs/jointstatement.pdf>.

<sup>148</sup> See [https://www.cms.gov/DemoProjectsEvalRpts/downloads/mapcpdemo\\_QA.pdf](https://www.cms.gov/DemoProjectsEvalRpts/downloads/mapcpdemo_QA.pdf)

<sup>149</sup> See <http://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=CMS1230557>

<sup>150</sup>National Committee of Quality Assurance. Patient-centered medical home recognition program. Washington, D.C. [cited 2011 Jan 3]. Available from: <http://www.ncqa.org/tabid/631/Default.aspx>.

<sup>151</sup> National Committee for Quality Assurance. PCMH 2011 Standards and Guidelines. Washington, D.C.; 2011; Jan 31.

outcomes through better coordination and integration of patient care for persons enrolled in New York Medicaid.<sup>152</sup> Upon federal approval, office-based practitioners and Article 28 clinics recognized by NCQA's PPC-PCMH will receive additional payment for primary care services to Medicaid beneficiaries. In this incentive program, there will be three levels of incentive payments for fee-for-service providers, consistent with NCQA's recognition levels. The NCQA recognition program is heavily focused on the use of information technology to support optimal patient care and performance measurement. While FQHCs and other clinics are included in the program, RHCs are not mentioned. New York has eight federally-designated RHCs, and it is unclear whether or not they are able to apply.<sup>153</sup>

Another example is the Blue Cross Blue Shield of Michigan (BCBSM) PCMH program in which 1,800 physicians in about 500 practices were designated as patient centered medical home providers.<sup>154</sup> Approximately 5,000 more physicians are working toward PCMH designation. Preliminary data suggests designated practices are better at managing patient care to improve quality and reduce costs. Medical home practices have a 2 percent lower rate of adult radiology usage than other practices, and a 2.6 percent lower rate of adult inpatient admissions. There are 156 RHCs in Michigan that could potentially benefit from this program.<sup>155</sup>

While Michigan and New York provide two examples of State medical homes projects, there is no national catalogue of State Medicaid medical home projects; nor is there information about the extent of RHC participation in State initiatives. However, in the 1999 survey of RHCs, 56 percent of respondents reported that Medicaid managed care plans were available to patients in their markets, 47 percent participated in at least one Medicaid managed care plan, and 25 percent of respondents reported receiving wrap-around payments to supplement Medicaid managed care payments.<sup>156</sup> It is also likely that RHCs are eligible for many of the Medicaid initiatives offered to FQHCs (and described in the corresponding chapter of this report), but to-date, we know of no survey that has assessed the extent of RHC participation in such programs.

**State Initiatives Promoting Performance-Based Payment.** As of July 1, 2006, more than half of all State Medicaid programs were operating one or more performance-based payment programs, similar to those offered by other payers, employers, consumers, and regional groups. One report noted that 70 percent of existing Medicaid performance-based payment programs operate in managed care or primary care case management (PCCM) environments, focusing on health care for children, adolescents, and women.<sup>157</sup> For example, the Oregon Health Care Quality Corporation, involving State government, health plans, medical groups, insurers, purchasers, providers, and consumers, is working to incorporate standardized performance

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<sup>152</sup>New York Department of Health. Announcing New York Medicaid's statewide patient-centered medical home incentive program. New York State Medicaid Update 2009; 25(16).

<sup>153</sup>statehealthfacts.org. New York: rural health clinics. Menlo Park (CA): Kaiser Family Foundation; 2010 [cited 2011, Jan 3]. Available from: <http://www.statehealthfacts.org/profileind.jsp?cat=8&sub=98&rgn=34>.

<sup>154</sup>Health Data Management. Michigan blues builds on medical home. 2010 Jun [cited 2011, Jan 3]. Available from: <http://www.healthdatamanagement.com/news/medical-home-michigan-bcbs-40543-1.html>.

<sup>155</sup>statehealthfacts.org. Number of Medicare certified rural health clinics. Menlo Park (CA): Kaiser Family Foundation; 2010 [cited 2011 Jan 3]. Available from:

<http://www.statehealthfacts.org/comparemaptable.jsp?ind=423&cat=8&sort=a>.

<sup>156</sup>Gale J, Coburn A, Finerfrock W, *op cit*.

<sup>157</sup>Kuhmerker K. Pay-for-performance in state Medicaid programs. New York (NY): Commonwealth Fund; 2007.

measures into their performance-based payment activities. However, it is unclear to what extent RHCs are eligible for the programs offered in various States.

**State Initiatives Promoting HIT Adoption.** Several Medicaid programs are “paying for participation,” rather than “performance,” in an effort to encourage providers to adopt EHRs, electronic prescribing, and other technologies, though it is unclear how commonplace this is across the States. For example, Alabama is offering reimbursement increases tied to provider participation in a program that uses technology to improve monitoring of patients with chronic diseases.<sup>158</sup> Another example of a State based program to encourage EHR adoption is the Electronic Health Record Loan Program offered by the Minnesota Department of Health. In this program the Office of Rural Health and Primary Care will grant six-year no interest loans with funds available in early 2011 to assist in financing the installation or support of interoperable EHR systems. Loan funds are primarily intended for EHR software, hardware, and vendor support expenses.<sup>159</sup> Because these programs are not clearly targeted towards RHCs, it is unclear how many RHCs participate in these programs.

## RHC CHALLENGES IN HIT AND QUALITY OF CARE INITIATIVE ADOPTION

While all providers face challenges in adopting new technologies and performance enhancing practices, RHCs are often particularly challenged as the result of both human and financial resource constraints. The national survey of RHCs in 1999 asked clinics about their financial and human resources. Across the nation, all rural providers are likely to have difficulty finding health care professionals: while 20 percent of the nation’s population lives in rural areas, less than 11 percent of the nation’s physicians practice in such areas. Of survey respondents, 18 percent reported a physician vacancy in the previous year, 77 percent of which had trouble recruiting and filling the position with average physician vacancies open for 10 months prior to being filled. Similar challenges were reported with respect to NP, PA, Certified Nurse Midwife (CNM), and mental health positions.<sup>160</sup> While more recent data about the staffing of RHCs are not available, more recent data reveal that workforce shortages continue to be a common problem for rural health care providers.<sup>161</sup> In addition to human resource constraints, many survey respondents in the 1999 study reported financial constraints, although it was not clear why they had these constraints. It is nonetheless noteworthy that the number of RHCs has increased since 1999, indicating that they still find RHC status attractive; and highlighting that the data from this study, while the best available, are not current. Financial and human resource constraints faced by many RHCs can pose significant impediments to the adoption of any performance enhancing practice that requires an upfront outlay of money and time on the part of providers.

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<sup>158</sup> *Ibid.*

<sup>159</sup> Minnesota Department of Health Office of Rural Health and Primary Care. Electronic health record loan program. [cited 2011, Jan 3]. Available from: <http://www.health.state.mn.us/divs/orhpc/funding/>.

<sup>160</sup> Gale J, Coburn A, Finerfrock W. *op cit.*

<sup>161</sup> Center for Health Reform and Modernization, United Health. *Modernizing Rural Health Care: Coverage, Quality and Access*. Working Paper 6. July 2011.

## HEALTH CARE REFORM LEGISLATION

The Affordable Care Act, as amended, enacted major reforms to the U.S. health care system and many of their provisions will influence the ability of RHCs to provide care.<sup>162</sup> It is important to note that many initiatives authorized in the Affordable Care Act do not have funds appropriated for implementation and require the issuance of regulations. The ultimate impact of the Affordable Care Act will depend on both the structure of these regulations, and how States implement many of the policies. However, the Affordable Care Act's expansion of insurance coverage appears likely to increase the extent to which patients in underserved rural areas have health coverage, which would likely result in increasing the proportion of RHC patients with some sort of coverage, either through Medicaid or private insurance. This could ultimately result in improved RHC finances, and may help RHCs finance service upgrades and prompt them to invest in their facilities for future growth. On the other hand, the Affordable Care Act may also introduce structural changes to the broader health system and to providers' incentive and reimbursement systems that could leave those providers – including those located in rural areas – at a disadvantage if they are unable to adapt their business models.

The following is a brief summary of certain health reform provisions that are directly relevant to rural health care providers, especially RHCs.

**Payment.** The Medicare Payment Advisory Commission is required to conduct a study on the adequacy of payments under the Medicare program for items and services furnished by providers in rural areas. The study will analyze and provide recommendations on various aspects of care in rural areas including: 1) adjustments in payments; 2) access of Medicare beneficiaries to items and services; 3) adequacy of payments to providers; and 4) the quality of care furnished. (Section 3127. Medicare Payment Advisory Commission Study of Medicare Payments for Health Care Providers Serving in Rural Areas)

**Telehealth Services.** Telehealth has already been demonstrated to be a useful tool for RHCs. Section 10306(2)(B) of the Affordable Care Act promotes the use of telehealth for providers located in medically underserved areas to treat behavioral health issues and stroke under CMS's new Innovation Center. The statute suggests that telehealth can improve the capacity of providers to care for patients with chronic and complex conditions. Although Medicare already reimburses RHCs for telehealth services, adoption has been relatively low as the result of high up-front costs. These up-front costs can be particularly problematic for rural providers who often are unable to implement HIT due to limited access to capital and workforce challenges.<sup>163</sup> Benefits provided under health care reform legislation may thus have exponential impacts if they include both up-front funding and technical assistance that allows RHCs to capitalize on existing Medicare incentives in addition to the newly created ones. Further, recent White House rule rollbacks included a proposal to make it easier for providers to use telehealth

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<sup>162</sup>George Washington University Department of Health Policy. Summaries of national health reform proposals. Washington, D.C. [cited 2011, Jan 3]. Available from: <http://gwumc.gwu.edu/sphhs/departments/healthpolicy/healthReform/proposalSummaries.cfm>.

<sup>163</sup>White House Press Release. President Announces New Jobs Initiatives for Rural America. 2011. Aug [cited 2011 Sep. 13]. Available from: <http://m.whitehouse.gov/the-press-office/2011/08/16/president-announces-new-jobs-initiatives-rural-america>.



technology when treating Medicare and Medicaid beneficiaries living in rural areas. With potential savings of up to \$13.6 million, the new rule would allow physicians to provide video consultations to rural hospitals without being credentialed at each site.<sup>164</sup>

**Comprehensive, Coordinated, and Community-Based Care.** The legislation specifies a number of initiatives aimed at improving the coordination of care. Some of these initiatives include:

- A demonstration project intended to allow States to test new ways to better coordinate hospital, nursing home, home health, and other critical health care services to Medicare beneficiaries in rural areas. (Section 3126. Improvements to the Demonstration Project on Community Health Integration Models in Certain Rural Communities);
- A community-based collaborative care network, which is a consortium of health care providers with a joint governance structure that provides comprehensive, coordinated, and integrated health care services for low-income populations. These networks include disproportionate share hospitals and all rural health clinics. (Section 3027. Title X, Subtitle C, Section. 10333 Community-Based Collaborative Care Networks);
- A community-based care transitions program to fund eligible entities to help them furnish improved transition services to high-risk Medicare beneficiaries. Eligible entities are hospitals having high readmission rates and community-based organizations that provide care transition services through arrangements with such hospitals. Selection of participating entities will place priority to those entities that: a) participate in a programs to provide concurrent care transitions interventions with multiple hospitals and practitioners; or b) serve medically underserved populations, small communities, and rural areas. (Title III, Subtitle A, Section. 3026(c)(3));
- A State option to provide health homes for Medicaid patients with chronic conditions. Health Home Services are comprehensive and timely quality services provided by a designated provider, or team of health care professionals. Qualified providers may be free standing, virtual, or based in a larger provider organization (such as a hospital, FQHC, community mental health center, or rural clinic). Health Home services include: 1) comprehensive care management; 2) care coordination and health promotion; 3) comprehensive transitional care; 4) patient and family support; 5) referral to community and social support services; and 6) use of health information technology to link services. (Title II, Subtitle I, Section 2703(a) State Option to Provide Health Homes for Enrollees with Chronic Conditions).

Given the wide array of services currently offered at RHCs and the emphasis on team-based care, they are well-positioned to play a leading role in some of these initiatives. However, to do so, they will need to expend both time and money at the onset, both of which tend to be in

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<sup>164</sup> iHealthBeat. White House Effort to Roll Back Rules Aims to Facilitate Telehealth. 2011, Aug [cited 2011 Sep. 13]. Available from: <http://www.ihealthbeat.org/articles/2011/8/25/white-house-effort-to-roll-back-rules-aims-to-facilitate-telehealth.aspx#ixzz1WQoAI7A6>.

short supply among rural providers. The extent to which technical assistance and other support is offered up-front, may be a primary determinant of the extent of RHC participation in initiatives such as these.

## **SUMMARY/CONCLUSIONS**

RHCs are an important part of the rural health care infrastructure as they provide a wide range of primary care services to rural, underserved populations. Many of the current incentive programs for quality improvement and HIT do not include RHCs as eligible participants. For example, RHCs are unable to capitalize on available Medicare incentives such as the PQRS and eRx incentive payments due to their exclusion from the list of eligible providers and the fact that they are not paid using Medicare's physician fee schedule. RHCs are also sometimes excluded from grant programs, as is this case for for-profit RHCs in the FCC's rural health broadband initiative.

In addition to being ineligible for some programs, in other cases RHCs may not benefit from incentive programs because they lack the financial and human resources to make the initial investments in technology and/or training. This is particularly likely to be a challenge for the almost half of RHCs that are small clinical practices which cannot benefit from the resources available to larger provider-based RHCs.

Many of the challenges RHCs face in adopting new technology and improving quality are not unique to these clinics, but these providers do have an additional set of challenges that accompany their practice in rural locations. In particular, lack of information about available incentive programs, lack of knowledge of specific quality improvement techniques, inexperience with performance measurement and reporting, and unfamiliarity with electronic medical records and other new technologies serve as impediments to RHC innovation and reform. These challenges highlight the importance of both financial and non-financial incentives to encourage improvements in RHC quality and efficiency of care. While financial incentives (that are available to RHCs) are clearly necessary, they may not be sufficient unless accompanied by corresponding technical assistance; education and training; and guidance and tools.



## CHAPTER 4: FREE CLINICS

### BACKGROUND

Congress, in enacting legislation that extended eligibility for medical malpractice liability protection under the Federal Tort Claims Act (FTCA) to volunteer health professionals of sponsoring free clinics, provided a statutory definition of the term –free clinic. However, there is a lack of consensus among federal and State agencies and the free clinic sector about what constitutes a free clinic. The lack of any common standard is likely a result of several factors including: limited scope of government oversight and financing, absence (until 2001) of a formal national body representing free clinics, and the purposeful orientation of free clinics to shape themselves according to the particular needs of the communities in which they reside.

From a review of the free clinic literature, examination of practices of existing free clinics, and consideration of various definitions of free clinics adopted by the National Association of Free Clinics and State and regional free clinic associations, there emerges a common set of qualities that characterize free clinics:<sup>165</sup>

Free clinics are private, non-profit, community-based organizations that provide a range of medical, dental, pharmacy, and/or behavioral healthcare services mostly to uninsured individuals. They are staffed principally by volunteer healthcare professionals but also utilize paid staff. They are located in permanent stand-alone facilities, mobile units, or housed in borrowed or rented spaces, such as in church basements or homeless shelters. They may be free-standing entities or part of/affiliated with another non-profit organization (e.g., church, hospital, or social service agency). They are usually privately funded. They charge no fees or nominal fees for services, or they may request donations, neither of which is typically a condition of service.

It is worth noting that the characterization above is silent on the issue of acceptance of third-party billing. The free clinic sector itself does not always consider engagement in third party billing as a bar to participation in national, regional, or State free clinic associations, but some existing legal definitions of free clinics prohibit clinics from receiving any third-party reimbursement. In particular, the federal definition of a free clinic adopted for the purposes of extending medical malpractice coverage to free clinic health professionals under the FTCA excludes from the population of free clinics those clinics that receive reimbursement from any third party.<sup>166</sup> The definition used in California, which licenses free clinics, also excludes clinics that bill third-party payers.<sup>167</sup>

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<sup>165</sup> The National Association of Free Clinics defines them as: –volunteer-based, safety-net health care organizations that provide a range of medical, dental, pharmacy, and/or behavioral health services to economically disadvantaged individuals who are predominately uninsured. Free clinics are 501(c)(3) tax-exempt organizations, or operate as a program component or affiliate of a 501(c)(3) organization. Entities that otherwise meet the above definition, but charge a nominal fee to patients, may still be considered free clinics provided essential services are delivered regardless of the patient’s ability to pay. National Association of Free Clinics. What is a free clinic. 2008 [cited 2011 Feb 2]. Available from: <http://www.freeclinics.us/about-us/what-free-clinic>

<sup>166</sup>42 U.S.C. 233(o).

<sup>167</sup>Section 1204 of the California Health & Safety Code.

## HISTORY

Free clinics have evolved from an “outlaw force in medicine” to a preferred model that private physicians adopt to provide care for the growing numbers of uninsured and underserved individuals.<sup>168</sup> The American Medical Association (AMA) shunned the free clinic movement of the 1960s, an era when the number of free clinics increased rapidly. During this period, free clinics often emerged to treat “outsiders” such as drug addicts and runaway youths, but clinics today mostly serve other segments of the population such as low-income and underinsured individuals. In this respect, the history of free clinics reveals free clinics as gap-fillers. “Gap-filler” does not reflect on what a free clinic can do but rather what a community requires of it. Some communities have large gaps and others have narrower and more specialized gaps. Perhaps because they have been unencumbered by a strict definition, free clinics have been able to adapt to changing community needs. Since 1994 official AMA policy has supported free clinics. In the mid-1990s, the Robert Wood Johnson Foundation funded 40 projects through a \$12 million initiative to encourage private physicians to improve access to care for the uninsured and underinsured. Under this grant program, physicians in nearly one of every three projects chose a free clinic model as a method to improve access to health care.<sup>169</sup>

## PROFILE OF THE FREE CLINIC SECTOR

The literature on free clinics is limited. A national survey of a sample of free clinics was published in 2005, but was hampered by methodological weaknesses.<sup>170</sup> The most comprehensive account of the free clinic sector is based on a 2006 survey of all known free clinics.<sup>171</sup> The description of free clinics that follows is drawn from this national survey (more detail on methodology is provided in the referenced reports). The 12-page mail survey obtained information about free clinics’ organizational characteristics, patients, services, staff and volunteers, and future plans. It achieved a 76 percent response rate and was based on a census of all known free clinics (n=1,007 free clinics) operating in the U.S. from October 2005 to December 2006. Multivariate analysis of non-respondents based on clinic year of founding, geographic region, and population size for the surrounding community revealed no statistically significant differences between respondents and non-respondents.

There are approximately 1,000 known free clinics in the United States. Free clinics are known to exist in every State (including the District of Columbia) except Alaska, although their numbers vary considerably State to State. The largest share of free clinics is in the South (45

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<sup>168</sup>Smith DE, Seymour R. Addiction medicine and the free clinic movement. *Journal of Psychoactive Drugs*. 1997;29(2): 155-160.

<sup>169</sup>Scott HD, Bell J, Geller S, Thomas M. Physicians helping the underserved: the reach out program. *JAMA* 2000;283(1): 99-104.

<sup>170</sup>Nadkarni M, Philbrick J. Free clinics: a national survey. *American Journal of the Medical Sciences*. 2005;330(1): 25-31.

<sup>171</sup>Darnell J. Free clinics in the United States: a nationwide survey. *Archives of Internal Medicine*. 2010;170(11): 946. Darnell J. Free clinics: what are they, and why does the number vary geographically? Chicago, IL: The University of Chicago, 2008. The following paragraphs are based on information derived from Darnell’s 2006 survey.

percent), followed by the Midwest (29 percent); nearly 75 percent of all known free clinics are found in these two regions.

## **HETEROGENEITY IN THE FREE CLINIC SECTOR**

The free clinic sector is highly varied. To illustrate this, we divide free clinics into groups based on hours open per week. The first group includes clinics that typically are open one day or less per week and 5 or fewer hours. They account for the largest share of all clinics (29 percent). The second group (22 percent) comprises clinics that mostly are open 2 or 3 days per week. The third group (24 percent) is open roughly half the time (i.e., 12–29 hours per week). The fourth group (25 percent) consists of clinics that operate full-time (30 or more hours per week).

Not surprisingly, the clinics that are open more hours per week have much greater capacity than those that are open fewer hours. Clinics open five or fewer hours per week offer the most limited services: physical exams, urgent/acute care, chronic disease management, medications, and health education, usually in a donated space, on a walk-in basis, and completely free of charge. With a reported mean annual operating budget of only about \$50,000, most operate without any paid staff or funding from government sources. The proportion of clinics formally affiliated with another organization is highest among the smallest clinics (52 percent), but financial and non-financial supports from parent organizations or affiliates are not widespread.

Clinics open 6–11 hours per week (which includes the median clinic that is open 11 hours/week) operate 2 days per week, on average, during the evening and daytime. Most are structured as independent organizations, offering the same set of services as the smallest free clinics. Half reportedly offer medical services at no charge, but most screen patients' income and insurance status before serving them. Most clinics in this group employ some paid staff, usually on a part-time basis. To a much greater extent than the smallest free clinics, clinics open 6–11 hours per week appear to cultivate a pool of volunteer physicians, which is reflected both in the doubling in the mean reported number of referrals and the percentage of clinics that report referrals to specialists.

Clinics open 12–29 hours per week tend to offer on-site laboratory services, gynecological care, and case management, in addition to the services available at the smaller free clinics. These services complement the basic services. They also may better meet the needs of patients, who are mostly women and, to a greater extent than that reported by smaller clinics, immigrants. Having on-site laboratory services likely facilitates their greater level of independence, as these larger free clinics need not refer patients to another provider for lab tests. Nearly all reportedly are open during the day, but many also have evening hours; the mean number of days open per week is 4. Most clinics reportedly schedule appointments, but many also see walk-ins. Nearly all clinics open 12–29 hours per week have some paid staff, some of whom are in full-time positions.

On the final end of the spectrum are full-time clinics, which are open 30 or more hours per week. They offer the broadest scope of services and serve the largest number of patients. In addition to the services available at the smaller free clinics, most full-time clinics reportedly

provide on-site vision screening and tuberculosis care. Just under half also provide dental services. Nearly all full-time clinics reportedly have full-time paid staff. Full-time free clinics are more likely to report targeting some of the neediest classes of patients – the homeless, immigrants, persons with substance abuse disorders, and persons with HIV/AIDS. However, with the exception of the homeless, less than half of full-time free clinics report targeting one of these populations.

There is some evidence that as the number of hours a clinic is open increases, there is a greater tendency toward bureaucratization, demonstrated by the increased screening of patients based on income and residence. Full-time clinics have sometimes shed free clinics' historical misgivings about government involvement, as most reportedly accept some funding from government sources and a small percentage (15 percent) bill third-party insurers. The acceptance of government funding (and with it, government rules) represents a significant departure from the model of free care embraced by the smallest free clinics, which reportedly eschew funding that comes with strings attached and apparently operate with few rules. As they grow, free clinics face potential trade-offs between scope and independence.

## **ORGANIZATIONAL CHARACTERISTICS AND OPERATIONS**

The following paragraphs summarize some of the organizational characteristics of free clinics. These organizational characteristics reveal the range of organization structures used by free clinics, as well as some differences between free clinics and other safety net providers.

More than half of free clinics are independent entities (57 percent). Among clinics that reported an affiliation, 30 percent declared being *part of* another organization, and 13 percent asserted being *an affiliate of* another institution. Of the affiliations free clinics reported, a hospital is the most common type (32 percent), with churches the second most common (26 percent).

Many clinics have small budgets and relatively few have large budgets. The mean operating budget for all clinics was \$278,383 in 2006. Free clinics draw from a diverse portfolio of sources for financial support. Individual donations are the most frequently cited source of funding (91 percent). Most free clinics also cited civic groups (67 percent), foundations (65 percent), churches (66 percent), and corporations (55 percent) as donors. Conspicuously absent from the list of top funding sources are government funding and third-party reimbursement. Nearly 60 percent of free clinics report receiving no funding from government sources and only 6 percent of free clinics receive third-party insurance reimbursements.

Most free clinics enlist clinicians as volunteers rather than paid employees.<sup>172</sup> The provider type cited most frequently cited is physician (79 percent). Free clinics also use other volunteer health professionals, including nurses (73 percent) and nurse practitioners/physician assistants (55 percent). Social workers and psychologists are less well-represented in volunteer

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<sup>172</sup>Many free clinics utilize medical students and residents as volunteers and often free clinics provide clinical training opportunities for them. Evidence suggests that exposure to underserved communities during medical school is associated with greater intention to serve underserved areas; thus medical student volunteer participation appears to benefit both the clinic and the student, as well as the larger health care system.

positions; only 26 percent of clinics reported utilizing volunteer social workers, and 12 percent reported using volunteer psychologists. While free clinics rely heavily on volunteer licensed healthcare professionals to deliver services, more than three-quarters of free clinics utilize paid staff (78), either full-time (55 percent) or part-time (61 percent). The mean number of paid staff is 2.7.

### **PROFILE OF FREE CLINIC PATIENTS<sup>173</sup>**

Free clinics disproportionately serve women, minorities, immigrants, the homeless, the poor, the near-poor who have income between 100-200 percent of poverty, and other vulnerable populations. A defining characteristic of free clinics is that they deliberately seek to serve the uninsured. At an average free clinic, nearly all (92 percent) free clinic patients are uninsured.

At an average clinic, 58 percent of patients are female. Because un-insurance is higher among those without access to public insurance programs, free clinics serve mostly non-elderly adults (80 percent of free clinic patients are adults 18–64 years old, 12 percent are children 0–18, and 8 percent are elderly).

At an average free clinic, half of the patients are white. While African Americans accounted for 12 percent of the 2000 U.S. population, they reportedly represented, on average, 21 percent of free clinic patients in 2006.<sup>174</sup> Similarly, Hispanics or Latinos constituted about 13 percent of the U.S. population but comprised 25 percent of free clinic patients. The disproportionate rate of minority patients in free clinics reflects higher rates of un-insurance among these populations.

At an average clinic, 56 percent of patients are described as poor, with incomes at or below 100 percent of the federal poverty line, another 41 percent of patients are considered “working poor,” with incomes between 100 percent and 200 percent of poverty, and only 3 percent of patients reportedly have family incomes above 200 percent of poverty.

To varying degrees, free clinics say they target their services to one or more “special populations.” Approximately 2 in 5 free clinics reported serving homeless patients (42 percent) and/or immigrants (39 percent). Nearly 1 in 5 free clinics reported serving patients with substance abuse disorders (19 percent), and 1 in 10 free clinics reported serving patients with HIV/AIDS.

Many free clinics appear to serve as a regular source of health care for their patients. Three-quarters of free clinics characterized the care they provide to their patients as ongoing, 20 percent described the care as intermittent, and about 5 percent portrayed the care as episodic, but rarely saw patients more than once.

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<sup>173</sup>Individual patient-level data are not available. In the 2006 national free clinic survey, clinics were asked to provide summary data about their patients’ attributes: gender, income, race/ethnicity, and age. The percentages reported are clinic-level means. For example, at an average clinic, 52 percent of patients are reportedly poor. This is not equivalent to saying that across all free clinics, 52 percent of all patients are reportedly poor.

<sup>174</sup>Grieco E, Cassidy R. Overview of race and hispanic origin: census 2000 brief. U.S. Census Bureau, U.S. Department of Commerce. 2001. [cited 2011, Jan 3]. Available from: <http://www.census.gov/prod/2001pubs/cenbr01-1.pdf>.

Patient volume provides information about the relative contribution that free clinics make in the ambulatory healthcare safety net. Free clinics reported, on average, serving 748 new patients per clinic per year and 1,792 total unduplicated (new plus returning/established) patients per clinic per year. Together, the 1,007 known free clinics are estimated to serve 1.8 million mostly uninsured patients annually.

## SCOPE OF SERVICES AND COST

Free clinics are estimated to provide approximately 3.5 million on-site medical and dental visits annually. Like all primary care clinics, free clinics provide some services on-site but also refer patients for services outside the clinic. Overall, free clinics reportedly provide a fairly limited range of services on-site, such as urgent care and physical exams, but provide access to a broader range of care using their referral networks. The mean number of reported referrals to providers is 368.

Most free clinics reported offering physical exams (81 percent) and urgent/acute care on-site (62 percent). Likely reflecting the high chronic disease burden experienced among poor, minority, and uninsured persons, most free clinics reported offering chronic disease management services (73 percent) on-site. About one-third of free clinics reported providing immunizations and vision screening on-site. While less than half of free clinics overall provide gynecological care, among clinics open 30 or more hours per week, the majority offer gynecological services. More than one-third of clinics reported offering dental services on site, while nearly half make referrals for dental services. About 44 percent of clinics offered on-site laboratory services and 9 percent of clinics offered on-site x-rays. Specialty care is available mostly by referral. Case management services on site are offered by 42 percent of clinics. Most free clinics reported providing on-site health education (77 percent). Among all clinics, 87 percent reported offering medications on-site. The ability to fill prescriptions (for free or for a nominal cost) at free clinics is arguably one of the services most desired by uninsured patients, as prescriptions may not be available for free from other safety net providers.

A key distinguishing feature of free clinics from other ambulatory safety net providers is their provision of “free” care. Contrary to the conventional view, free clinics are not always zero-price but may charge a nominal amount or request a donation for services.<sup>175</sup> Among clinics that charge a fee and specify the amount of the fee or donation, the mean reported fee/donation is \$9.30. About half of free clinics reported charging no fees or requesting no donations for medical care, dental care, or medications.<sup>176</sup>

## IMPACT

It is difficult to judge free clinics’ impact because very few studies have measured patient outcomes. We know that free clinics as a whole serve millions of uninsured persons who may not receive (any or better) care elsewhere. For instance, a study of patients at three free clinics

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<sup>175</sup>Zon C. Free clinic movement is alive and well. *Voluntary Action Leadership*. 1979;11.

<sup>176</sup>Darnell *op cit*.



reported patients' reasons for using free clinics (Keit et al.). The top four reasons were: no health insurance (82 percent), told by friends/family (59 percent), prescriptions (38 percent), and do not know where else to go (34 percent). Keis and colleagues also reported that 74 percent of free clinic patients did not identify a usual source of care other than the free clinic or the emergency room.<sup>177</sup> Thus, free clinics serve as important gap-fillers, offering services not available (or accessible) elsewhere.

With respect to reduced-price service availability, free clinics compare favorably to physician practices. A 2003 study by Fairbrother and colleagues found that fewer than 25 percent of internist physicians reported that they were able to secure medications at a reduced cost "most of the time" for their uninsured patients (who presumably face difficulties affording care). They also found that only 5 percent of physicians were able to get diagnostic services and only 9 percent of physicians were able to get laboratory tests at a reduced cost "most of the time" for their uninsured patients.<sup>178</sup>

Free clinics also may do better than FQHCs in arranging certain diagnostic procedures for their uninsured patients. Gusmano, Fairbrother, and Park reported that 60 percent of health centers provide x-ray on-site, 30 percent refer out and uninsured patients pay, and 10 percent refer out and the health center pays.<sup>179</sup> By comparison, 44 percent of free medical clinics reportedly directly provide laboratory services on-site and 81 percent make arrangements for patients to receive laboratory services at no cost, and an additional 17 percent at reduced cost.

On the other hand, there is considerable heterogeneity among clinics in the free clinic sector. Nearly 30 percent of free clinics are open five or fewer hours per week and this subgroup of free clinics provide only basic health services on site. These limitations raise prudent questions about the adequacy of these part-time free clinics to meet the needs of uninsured patients. Moreover, the model itself, which relies mostly on volunteer health professionals to deliver services and private donations for its operating budget, has inherent limitations to expansion. These findings highlight that in a provider group as diverse as the free clinic sector, there is a wide range of services offered – with some locations offering comprehensive primary and preventative care and other locations offering a more limited set of services.

## **QUALITY INITIATIVES IN FREE CLINICS**

### **WHAT DO WE KNOW ABOUT QUALITY OF CARE IN FREE CLINICS?**

Very little is known about the quality of care in free clinics. The published literature documenting patient outcomes is limited in both quality and quantity. Of the small number of

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<sup>177</sup>Keis R, DeGeus G, Cashman S, Savageau J. Characteristics of patients at three free clinics. *Journal of Health Care for the Poor and Underserved*. 2004;15(4): 603-617.

<sup>178</sup>Fairbrother G, Gusmano M, Park H, Scheinmann R. Market watch: care for the uninsured in general internists' private offices. *Health Affairs*. 2003;22(6): 217-224.

<sup>179</sup>*Ibid.*

studies that exist, some only assess the quality of care in a single clinic and other studies lack the appropriate statistical methods.<sup>180 181</sup>

While it was usual in the early years of this free clinic era (before 1995) to find free clinics espousing the delivery of quality services in their mission statements, it was far less usual to find clinics with formal policies and procedures to measurably assure the realization of this vision. In the mid-1990's, when private funding began to focus more on qualitative results in measuring grant performance, free clinics began to develop measures to reflect improvements on quality in order to assure on-going support from traditional funding partners.

The 2006 national free clinic survey collected information about board certification, one rough indicator of the quality of the physicians who deliver care. Free clinics reported that, on average, 95 percent of physicians who work/volunteer in free clinics are board-certified. It is important to note that these percentages are self-reported by free clinic staff and may not reflect actual levels of board certification of physicians. The national free clinic survey also asked free clinics whether they had a regular process for tracking medical errors. Only 43 percent of the respondents affirmed having one.<sup>182</sup>

## **QUALITY INCENTIVE PROGRAMS**

Many current programs aimed at improving the quality of health care operate by offering providers payment incentives through the public and private insurance reimbursement rates. Because free clinics accept neither form of payment, they are categorically excluded from all such programs. Therefore, the programs most likely to provide incentives for improving the quality of care at free clinics are FTCA coverage, various accreditation programs, and performance metrics attached to grant funding. In all three of these cases, participation in the program or receipt of funding may be tied to quality of care (and other) standards. We highlight FTCA coverage because it is the only federal program targeting free clinics.

## **FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM**

**Overview of the federal program.** In 1996, Congress enacted Federal Tort Claims Act (FTCA) legislation that extended eligibility for FTCA medical malpractice protection for volunteer free clinic health care professionals through Section 194 of HIPAA (Public Law 104-191) which amended Section 224 of the Public Health Service (PHS) Act. The Affordable Care Act added FTCA protection for free clinic board members, officers, employees, and contractors. FTCA coverage for free clinics does not extend to entities (as is the case for FQHCs). As of February 1, 2011, approximately 5,500 individuals at 139 locations had been approved for FTCA coverage.<sup>183</sup> While there is some protection offered through the Federal Volunteer Protection Act and many State Good Samaritan Acts, the presence of State immunity protections is sporadic

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<sup>180</sup>Stroebel RJ, Gloor B, Freytag S, Riegart-Johnson D, Smith S, Huschka T, Naessens J, Kottke T. Adapting the chronic care model to treat chronic illness at a free medical clinic. *Journal of Health Care for the Poor & Underserved* 2005;16(2): 286-296.

<sup>181</sup>García A. Clinical and life quality differences between Mexican American diabetic patients at a free clinic and a hospital-affiliated clinic in Texas. *Public Health Nursing* 2008;25(2): 149-158.

<sup>182</sup>Darnell J, *op cit*.

<sup>183</sup>Based on administrative data from the Bureau of Primary Health Care.

and inconsistent. These laws typically have not been tested in court, making individuals who might rely on such protection wary of their usefulness. The FTCA is Federal protection that provides medical liability protection for board officers, staff, and independent contractors in addition to volunteer health professionals (and thus, goes well beyond the Volunteer Protection Act). The FTCA is broader, deeper, well-tested, and designed as a free clinic benefit, and is therefore much preferred and more valuable to free clinics nationally.

Under FTCA malpractice protection, eligible parties (including volunteer health care professionals) can be deemed PHS employees for the purposes of malpractice coverage. Medical malpractice liability claims filed against the provider are first handled by the U.S. Department of Health and Human Services administratively and then defended by the U.S. Department of Justice should the claim be subsequently filed in Federal court. To participate in the program, free clinics must submit an annual FTCA deeming application on behalf of their eligible individuals to the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA, BPHC) that administers the Program.

Coverage under the FTCA program is conditional upon the sponsoring clinic demonstrating implementation of policies and procedures to reduce the risk of medical malpractice, including implementation of quality improvement/quality assurance and risk management policies as well as formal policies for credentialing and privileging. When the FTCA program first became available to free clinics in 2004, it outlined a number of specific practices to assure that certain standards of patient care and program operation are maintained such as protocols for triage, referrals, assurance of confidential medical records for each patient, etc.<sup>184</sup>

In the absence of FTCA coverage, some otherwise willing free clinic volunteers may be unwilling to volunteer their time. This is particularly true of individuals such as retired physicians or other independently licensed practitioners whom have maintained licensure but not malpractice insurance. The FTCA incentives both help free clinics obtain needed volunteers and encourage clinics to adopt quality improvement initiatives. FTCA coverage represents an in-kind benefit offered by the federal government; the National Association of Free Clinics (NAFC) estimated that the 2010 eligibility expansion had a value of about \$10 million in insurance protection.

While FTCA coverage represents a valuable benefit to free clinics, it is currently only available to clinic personnel and not for the institutions themselves (unlike FQHCs, in which the entire institution is eligible). It is noteworthy that free clinics appear to be relatively low risk; in the five years since FTCA coverage was granted to free clinic covered individuals, there has been only one filed claim made against any covered volunteer. This case is still pending.<sup>185</sup>

**Barriers/Challenges.** A critical feature of the FTCA program relates to the definition of free clinic provided in the guidance, which as written confines FTCA eligibility to a small set of potential participants. The Congressionally established definition of a free clinic is fairly

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<sup>184</sup> Although authorizing legislation passed in 1996, funds were not appropriated until 2004.

<sup>185</sup> United States Government Accountability Office. Federal Tort Claims Act: information related to implications of extending coverage to volunteers at HRSA-funded health centers. Washington, D.C.; 2009;GAO-09-693R.

straight-forward in that services must be provided free of charge, the clinic may accept no third party payments along with several other criteria. The issue of “free” significantly limits those who might apply. Charitable clinics, which by definition have a first party nominal or sliding fee schedule, are unable to receive FTCA coverage for any visit in which a fee is imposed. Hybrid clinics that accept Medicaid or Medicare that may provide free care in some cases and bill insurers in other cases are ineligible as are clinics in administrative hubs that refer patients to volunteer physicians within their practices.<sup>186</sup> In short, the definition of free clinic is sufficiently narrow so as to preclude widespread free clinic participation in the program.

Another eligibility limitation results from the restriction on allowable funding from private donors and “grants,” which by definition precludes clinics that receive any government funding for the delivery of health services from participating. There are many clinics that must choose between FTCA coverage and funding that is provided on a per patient (or “unit cost”) basis even if the latter source of funding demands no specific patient information. If a grant or funding stream can be construed as reimbursement, FTCA coverage is jeopardized.

In addition to regulatory barriers to free clinic participation, there are other barriers. Because of their independent and small nature, many free clinics are unaware of FTCA coverage or do not know how to apply.

## **ACCREDITATION**

Accreditation is a set of standards, adopted and approved by a membership organization that establish levels of performance and organizational structure to reflect best practices in the delivery of service and other clinical and administrative areas. Currently only two State associations have approved free clinic accreditation programs: North Carolina and Virginia. The accreditation program in North Carolina started in 2003, followed by Virginia in 2008. Both States, under strong board and executive leadership, felt that their credibility would be strengthened if State associations established standards of care and organizational development for their member clinics. Rather than have their unique care delivery models meet externally defined standards, each State association developed a set of standards uniquely designed to fit the free clinic model. North Carolina established three levels of excellence and Virginia developed a similar system. Accreditation can create a culture of goal attainment and attention to quality. As the attainment of higher levels of accreditation assume higher recognition, the achievement or promotion to a higher level can serve as a non-financial incentive.

Right now, attainment of accreditation has little tangible value. Without the State or other funding partners acknowledging accreditation as an element to be formally considered in funding requests, there is minimal incentive to pursue or maintain accreditation. Self-motivation or sector recognition has value, but may take a secondary position when the clinic finds itself in difficult economic times.

The National Committee for Quality Assurance (NCQA) is a not-for-profit organization dedicated to improving quality in the health sector. All nine free clinics in West Virginia have

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<sup>186</sup>This includes clinics that serve Medicaid patients whom seek care in the clinic due to a shortage of providers accepting Medicaid coverage.

engaged in the process of seeking NCQA recognition. The group view is the achievement of this recognition will strengthen their evolution in the changing health care environment as a result of health reform. While the NCQA standards are not presently structured to fit a “free clinic” health care delivery system, the structured engagement toward a widely-recognized level of quality is seen as a critical factor in assuring the continuing viability of the free clinic model in the future.

NCQA has also developed standards for a variety of primary care physician practices and FQHCs to be recognized as Patient-Centered Medical Homes. These standards are gaining widespread acceptance as a universal set of quality indicators that all in primary practice should strive to achieve. Currently NCQA does not have a set of standards that reflect the unique needs of the free clinic model. Free clinics seeking recognition from NCQA are held to standards developed for other models of care. While there certainly are common grounds, the lack of standards designed to specifically apply to the unique nature of free clinics is a challenge.

NCQA recognition is not currently tied to any particular revenue benefit. If the recognition is acknowledged by a private funding partner, it can strengthen a grant request, but achievement of the recognition does not specifically cause approval of any particular revenue.

## **GRANT-MAKING**

**North Carolina Example.** The North Carolina Association of Free Clinics and their funding partner, Blue Cross and Blue Shield of North Carolina Foundation (BCBSNC Foundation) have developed a new approach to grant making designed to enhance the quality of care provided in the safety net. BCBSNC Foundation has a history of supporting North Carolina’s free clinics, through their support of the State association and of new clinics in underserved areas. In 2009, BCBSNC Foundation agreed to renew their five-year \$10 million commitment only if the agreement incorporated the attainment of quality measures. Teams led by executive directors of State free clinics developed outcome measures to be used by potential grantees. These outcomes tracked improvement in patients’ health status regarding conditions most commonly seen at free clinics. Between 2009 and 2014, grant funds will gradually shift from basic operating support to support driven by achievement of quality measures and improvements in same. Free clinics will have the opportunity to increase their grant allocations when they demonstrate success in their treatment interventions. While there will continue to be funds available for new starts where necessary and the formula will include some basic grant support, a significant and increasing percentage, ultimately reaching 75 percent–80 percent of the total annual grant of an individual free clinic’s allocation will be determined by the attainment of these goals defined by quality measures.

Free clinic programs have an opportunity to implement treatment models tied to positive patient outcomes and be proportionately rewarded for their success. Incentives have shifted to rewarding quantifiable improvements in patient health and free clinics are encouraged to develop quality-enhancing innovations. Free clinics have historically been incubators of innovation in cost-effective, quality care; quality-based grant-making reinforces this role.

Quality-based grant-making also provides clear outcome measures to funders; allowing them to justify their resource commitments and demonstrate to the philanthropic community that their financial contributions “made a difference.” Successful attainment of agreed upon performance goals demonstrates a return on investment, generates measurable improvements in community health, and may serve to stimulate renewed funding based upon past success.

Further, this type of funding model encourages the adoption of health information technology (HIT) by free clinics to track patient outcomes and generate reports for funders. Electronic health records are an important input into this process; as grants become increasingly conditional upon the achievement of performance targets, free clinics will gravitate towards the technology that will enable them to secure continuous funding streams.

### **CURRENT STATUS OF QUALITY IMPROVEMENT ACTIVITIES AMONG FREE CLINICS**

Recognizing the wide variation in free clinic operation and practice, particularly with respect to the adoption of quality improvement incentives, researchers recently surveyed U.S. free clinics about their quality-related activities.

**NAFC Survey.** In late 2010, the NAFC administered an on-line survey of its members to gauge the extent of their involvement in quality initiatives and their use of HIT. The 30-item survey was divided into four parts covering clinic characteristics, use of computers, participation in quality improvement activities, and incentives to increase participation in quality improvement activities.<sup>187</sup> Of the 433 NAFC members invited to participate, 170 responded (39.3 percent response rate). Informal channels yielded an additional 45 responses for a total of 215 total responses. The 45 responding free clinics that are not members of NAFC are likely to be members of a State free clinic association (and subject to State association requirements) because State free clinics executives extended the invitation to participate in the survey to their members.

Clinics responding to the NAFC survey tended to differ from the total population of free clinics in several ways. Table 3 provides a summary of these differences. Free clinics responding to the NAFC survey tended to be larger, with more professional staff, longer operating hours, and larger budgets than the national population of clinics enumerated in 2006. Because it is expected that quality improvement activities will be easier for larger clinics that have more financial and human resources, data from the NAFC survey can be interpreted as providing an upper bound estimate of the prevalence of quality improvement activities among free clinics.

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<sup>187</sup> Survey administration commenced on September 7, 2010 and concluded eight weeks later on November 9, 2010. During this time 433 members of the NAFC that provided medical care were contacted via email. Informal invitations also were announced during a session attended by 78 participants (most of whom are NAFC members) about quality and HIT at the NAFC Annual Summit held in Cleveland, Ohio in October 2010. In addition, executives representing state free clinic associations encouraged their members to participate. No incentives were provided for participating. During this time 433 members of the NAFC that provided medical care were contacted via email. Informal invitations also were announced during a session attended by 78 participants (most of whom are NAFC members) about quality and HIT at the NAFC Annual Summit held in Cleveland, Ohio in October 2010. In addition, executives representing state free clinic associations encouraged their members to participate.



**Table 3: Comparison of NAFC Respondents to National Survey Respondents**

	<b>NAFC Survey Respondents, 2010</b>	<b>National Survey Respondents, 2006</b>
Freestanding entities	77.4%	56.6%
Mean Full-time staff	9.3	2.7
Mean Hours open per week	28	18
Mean Annual Operating Budget	\$816,885	\$278,383
Mean Annual Patients	3,993	1,796
Mean Annual Patient Visits	8,102	1,792

**Participation in quality improvement activities.** The survey gauged free clinics' participation in quality improvement activities through a series of questions designed to capture information about the quality improvement activities' existence, scope, relevance to free clinic operations, and level of involvement of stakeholders. While nearly two-thirds of free clinics reported participating in formal quality improvement activities, fewer than half (46 percent) have a written, current board-approved quality assurance plan.

Two-thirds of clinics reportedly have regular meetings to review and assess quality improvement activities. Similar numbers of clinics reported using quality improvement findings to modify policies to improve patient care. Most clinics (81 percent) reported that the clinic periodically reviews patients' medical records to determine quality, completeness and legibility. One-third of clinics reported that their policy requires regular reports to a governing body on a quarterly basis or more frequently (i.e., monthly). But 44 percent of clinics reported having no policy requiring regular reporting. Further, the survey did not ask respondents about the required content for these reports, so it is likely that many of them primarily include financial and service-load data.

The majority of clinics (two-thirds) reported that the purposes of quality improvement activities were to (a) set goals based on actual performance levels; and (b) to improve the performance of the clinic as a whole. Performance data were reportedly collected on patients' satisfaction and experiences with care (67 percent), clinical outcomes (63 percent), and physician/provider productivity (31 percent). The lower level of attention on provider productivity likely reflects the fact that most providers in free clinics are volunteers.

The type of individuals actively engaged in quality improvement activities include: volunteer health professional staff (67 percent), paid administrative staff (65 percent), and paid health professional staff (48 percent). The Executive Director (64 percent) and Medical Director (61 percent) were cited most often as the individual responsible for quality improvement activities, although over 40 percent of clinics also report having a responsible committee.

The survey asked respondents about the financial and human capital requirements for quality improvement activities. Respondents typically reported that they "did not have" or "needed more" dedicated staff to lead efforts, information systems, financial support, staff training, and staff recognition. More than one-third (39 percent) of clinics reported not having dedicated staff to lead quality improvements efforts and just over half indicated that they needed additional dedicated staff. For each of the following inputs, at least half of respondents reported

not having this component of quality improvement activities: information systems, financial support, staff training, and staff recognition.

**Incentives to increase participation in quality improvement activities.** The survey asked respondents to choose one of the following four options as an external incentive likely to encourage quality improvements: “cash payments”, “in-kind goods and services”, “technical assistance”, and “none”. Because only one answer option was permitted, responses should be interpreted as clinics’ preferred option. Technical assistance was the most frequently cited response (40 percent), followed by cash payment (27 percent), none (17 percent), and lastly, in-kind goods and services (17 percent).

Clinics also were asked to select the type of organization that should administer incentives to increase quality improvement activities. The choices (in a check all that apply format) included: a national/State/regional free clinic association, federal agency, State agency, or private entity such as a foundation or other objective third party. Free clinics strongly preferred having their own associations (national/regional/State) administer an incentive program (68 percent) followed by a private entity (53 percent). Government agencies, either federal (23 percent) or State (24 percent), were far less favored.

#### **FTCA DEEMED CLINICS QUERY**

In late 2010, an electronic mail query was independently undertaken by Julie Darnell and Martin Hiller (who authored this chapter). A message was sent to all 132 free clinics that were actively approved for FTCA coverage as of August 1, 2010. It was felt that this subset of free clinics, which had some quality assurance activities in place in order to qualify for the added federal malpractice protection, made a worthwhile study. The query also provided an opportunity to gain some additional knowledge regarding health information technology initiatives that were in place at free clinics.

The nine-item electronic mail query was sent to 132 free clinics on November 10, 2010 and interim results are available. As of December 17, 2010, 60 responses were received, a 45 percent response rate. Of the approved free clinic responses, 58 clinics (97 percent) indicated that securing FTCA coverage stimulated the creation of their Quality Assurance (QA) policies. Of the 60 respondents, 8 (13 percent) indicated they had at least minimally implemented the policies, 17 (28 percent) had moderately implemented the policies and 35 (59 percent) had fully implemented the submitted approved QA policies. Finally, 28 (47 percent) of the respondents saw money as the key incentive needed to increase QA at the clinic, 23 (38 percent) preferred an FTCA-like benefit as key for their involvement in improving QA measures, and 4 respondents (7 percent) mentioned accreditation as the key incentive for their improving QA activities.

#### **HEALTH INFORMATION TECHNOLOGY (HIT) IN FREE CLINICS**

We are unaware of any published studies that describe HIT implementation in free clinics. Due to the dearth of existing studies, we rely on unpublished work—i.e., the NAFC survey and the FTCA email query—to describe the current status of HIT in free clinics.

The NAFC survey, described above, included a set of questions about free clinics' use of HIT. As is the case with quality incentives, because the NAFC respondents tend to be larger organizations with greater financial and human resources, we expect these results to represent an upper bound estimate of the rates of HIT usage in the free clinic sector. Respondents reported using computers for one or more purposes in all but 2 instances. Free clinics report using computers for a variety of tasks, including: administrative purposes (94 percent), tracking patient visits (86 percent), tracking medications dispensed (65 percent), tracking volunteers' hours (64 percent), and capturing, managing and providing data on patients with specific conditions using a patient registry (63 percent). Just over one-quarter of free clinics (26 percent) report having electronic health records.

Overall, a minority of clinics are reportedly using technology to track their patients' encounters or utilization of specific services. For example, nearly half reported having electronic access to patients' laboratory test results and having an electronic list of all medications, though the list was usually limited to medications prescribed by their own doctors. About 36 percent of clinics reported having electronic alerts or prompts about potential problems with drug dosages or interactions. Only about one in five clinics reported electronic prescribing of medicine. Slightly less than one-third of free clinics reported using HIT either occasionally or routinely for electronic entry of clinical notes.

The survey assessed clinics' ability to monitor patient information using medical record systems. Clinics were asked to report the ease with which they can generate information about their patients. Just over half reported that it would be "easy" (i.e., < 24 hours) to generate a list of patients by diagnosis. Generating other lists besides diagnosis, however, is more difficult if not impossible, for many clinics, though the range in ability is considerable. For example, one-fourth of clinics reported that generating a list of patients by health risk would be easy, while another fourth reported that it would be impossible. Similarly, while about 20 percent of clinics can easily generate a list of patients overdue for tests or preventative care, about 45 percent of clinics are unable to generate such lists. Only 18 percent of clinics reported that they could easily generate a list of patients by lab results.

The survey assessed free clinics' current use of electronic health records (EHR) or future plans for adoption of an EHR. About one-quarter of free clinics reported currently having an EHR with an additional 17 percent having concrete adoption plans in place, and an additional 33 percent considering adoption. Among the quarter of clinics who reported neither currently having an EHR nor having any future plans for its adoption, free clinics cited the following resource constraints as barriers: high start-up costs (75 percent), lack of time, staff, and technical expertise necessary to select an appropriate EHR (73 percent), and high ongoing costs for licensing and updates (71 percent). Other clinics cited "don't see a need" (13 percent) and/or "don't believe that clinics would see a return on investments" (27 percent) as reasons for not adopting EHRs. Clinics without EHRs in place specified the following incentives as potential inducements to the adoption of an EHR: cash payments (61 percent), technical assistance (56 percent), and in-kind goods and services (42 percent).

The email query of FTCA sponsoring clinics afforded an opening to learn about implementation of HIT. Only 10 (17 percent) of the respondents had implemented an electronic medical record system and just 13 (22 percent) of percent those who did not have EHR systems had an active plan to build such capacity. Of those who had EHRs, 6 (60 percent) had a system that informed their QA activities. Among those with an EHR, 7 (70 percent) indicated that the EHR was externally funded.

## CONCLUSION

The free clinic sector is very diverse, and is comprised of a range of clinics, from those offering basic healthcare services one night a week to full-time providers offering a broad range of primary care services on site as well as access to free or reduced-cost specialty care arranged through a network of providers.

Several different types of initiatives have emerged in recent years to improve the quality of care at free clinics. They include: FTCA coverage, accreditation programs, and grants tying funding to outcomes. With the exception of the FTCA program, which currently reaches about one-eighth of all free clinics, the existing quality assurance programs have originated from inside the free clinic sector. A recent survey suggests that two-thirds of free clinics participate in formal quality assurance activities.

EHRs are believed to offer a tool for improving quality, and in this regard recent data suggest that one-quarter of free clinics have implemented an EHR system, and more clinics are planning or considering implementation. Free clinics identify costs and effort as barriers to EHR adoption.

Because few free clinics receive third-party insurance payments, quality and HIT incentives that operate through reimbursement system are unlikely to induce adoption of new practices or technologies. In particular, the federal incentives created by the Recovery Act and the Affordable Care Act are funded through Medicaid and Medicare, and acceptance of either form of payment precludes free clinics from other federal benefits such as FTCA coverage. For this reason, policymakers interested in promoting quality of care improvements and/or HIT investment among free clinics will need to find alternative strategies. Given the great variation in institutional capacity among free clinics, technical assistance is likely to be a critical component in both inducing participation and in achieving success.

## **CHAPTER 5: CONCLUSIONS**

### **THE SCOPE AND DIVERSITY OF THE PRIMARY CARE CLINICS**

Collectively, federally qualified health centers (FQHCs), rural health clinics (RHCs), and free clinics constitute an essential core of the health care safety net in the United States and deliver preventive and primary care services to well over 25 million patients who would otherwise find it difficult to access quality primary care on an affordable basis. The federal government provides partial support to FQHCs and RHCs through a variety of approaches, including Medicaid, CHIP, and Medicare payments that are cost-related, subject to payment caps (in the case of Medicare) and other rules. Free clinics, on the other hand, receive little federal support. Because these clinics serve so many low-income, uninsured, and minority patients, they play an especially important role in addressing and mitigating disparities in health care access that can afflict vulnerable populations throughout the United States.

As described in the preceding chapters, these primary care clinics vary widely. FQHCs are the largest, serving an annual average of 1,7322 patients per grantee in 2009, according to data from the Uniform Data System. The national survey of free clinics found an average annual caseload of about 1,800 patients per clinic. Data about average caseloads of RHCs are not available, but they are likely to be closer to those for free clinics. In each category, however, there is tremendous diversity: there are very small clinics operating on shoestring budgets and very large centers with numerous clinicians serving tens of thousands of patients.

### **INCENTIVES FOR QUALITY AND HIT**

For a number of years, the federal government has sought to encourage physicians and other ambulatory care providers to improve the quality of patient care and to employ health information technology using a variety of approaches, often on the basis of reimbursement incentives linked to Medicare reimbursements. Despite the importance of FQHCs, RHCs, and free clinics in meeting the primary care needs of millions of vulnerable patients, they have often been excluded from receiving Medicare incentive payments, as is the case of electronic health record (EHR) incentives established under the 2009 Recovery Act. This exclusion generally occurs because, by statute, Medicare incentives are for eligible professionals furnishing covered services and paid under the standard physician fee schedule system, which does not apply to clinicians practicing at FQHCs, RHCs, and free clinics. Instead, FQHCs and RHCs are paid under a different system, while free clinics generally do not receive any third-party compensation. Thus, although physicians (and in many cases, nurse practitioners, physician assistants, and/or certified nurse midwives) deliver primary care services to Medicare patients similar to those provided by “regular” office-based physicians, they are ineligible for the same Medicare incentives. Since FQHCs are generally eligible for more generous Medicaid EHR incentives, their ineligibility for Medicare EHR incentives is a moot issue, but the lack of eligibility for Medicare EHR incentives does pose a problem for many RHCs. Moreover, FQHCs remain ineligible for other Medicare incentives for which there is no Medicaid counterpart.

In contrast, FQHCs and RHCs sometimes receive incentive payments for services rendered to Medicaid patients. The federal Medicaid EHR payment incentives explicitly permit physicians and other eligible professionals at FQHCs and RHCs to receive the incentives if they serve a sufficient volume of Medicaid and/or other needy patients, including those receiving uncompensated or sliding scale fee care. Other Medicaid incentives are developed by individual States and vary widely in terms of incentive availability for different types of providers. In some cases FQHCs and RHCs are eligible for State Medicaid incentives paid to other office-based physicians, but in other cases they are not. In other situations, the incentives are not directly paid by the State Medicaid programs, but by Medicaid managed care plans, which also have diverse policies. In general, FQHCs care for more Medicaid patients than Medicare patients, so the Medicaid incentives are more important to them. The situation for RHCs is more mixed; they serve a more diversified caseload and some RHCs have larger Medicaid patient volumes while others have larger Medicare volumes. Free clinics, once again, are excluded from Medicaid incentives since they do not collect insurance payments.

In addition to explicit differences in the extent to which these safety net clinics are eligible for incentives, there may be additional barriers that affect the ease with which primary care clinics may be able to access these incentives. Although we recognize that the obstacles we describe here are likely to affect other providers (particularly small practices and solo physicians), they are likely to impact all safety net providers regardless of practice size or structure. Because of their safety net nature, many of these clinics lack appreciable capital or resources. In addition, all FQHCs, all free clinics, and many RHCs are non-profit organizations, and as such, face obstacles raising capital. Thus, they may be unable to make the initial investments necessary to trigger certain incentives. For example, in order to collect a first year Medicaid EHR incentive payment of \$21,250 per eligible professional, a clinic (or eligible professional) might incur costs that exceed the incentive payment. Not only does the clinic have to bear the additional costs, it may have to incur the costs up front prior to receiving payments.<sup>188</sup> While this is true of all providers, many safety net providers have less access to capital and fewer financial resources available to make up front expenditures. Further, many of these clinics, particularly RHCs and free clinics, are very small practices with fewer administrative resources and/or less access to consultants or specialists who can help them acquire and operationalize these systems. As described in Chapter 3, research shows that smaller physician practices are less likely to have electronic health records systems. Many clinics are part of a broader system or network that can facilitate the adoption of electronic systems (such as FQHCs that are part of health center controlled networks or provider-owned RHCs that are part of a hospital system, such as one supported by HRSA's Flex Critical Access Hospital Health Information Technology Network grants).<sup>189</sup> Still, many are independent organizations without access to broader networks that may help ease implementation burdens.

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<sup>188</sup> Under the original legislation, the professionals were required to demonstrate a legal or financial commitment to purchase certified an EHR system before any payment is made. This requirement was repealed by the Medicare Extenders Act of 2010 (Pub. L. 111-309).

<sup>189</sup> Health Resources and Services Administration. Evaluation of the Flexibility Critical Access Hospital Health Information Technology Network Implementation Program: Final Report. Washington, DC: Dept. of Health and Human Services, Dec. 2010.



Clinicians at these safety net clinics are less likely to financially benefit from quality and HIT-related incentives than other office-based physicians who treat Medicare and/or Medicaid patients, but there is no clear evidence that gaps in incentive availability have adversely impacted these clinics' quality of care or use of HIT services, relative to other types of providers.<sup>190</sup> Rigorous studies of the level of quality of care for office-based physicians compared to FQHCs, RHCs, or free clinics that account for receipt of quality-related incentives have not yet been conducted. Among other things, the largest and broadest of these incentives, the Medicare and Medicaid EHR incentives have only begun to go into effect in 2011, so it is too early to assess their impact.

## **CURRENT KNOWLEDGE ABOUT QUALITY AND HIT PERFORMANCE IN THESE CLINICS**

As described in Chapters 2, 3, and 4 of this report, the federal government has policies to promote quality assessment and improvement in FQHCs and RHCs and, to a lesser extent, in free clinics. The Health Resources and Services Administration (HRSA) has emphasized FQHC quality monitoring and improvement for decades. Because there is an annual reporting system – the Uniform Data System – for all FQHCs that receive grant funding from HRSA, there is a relatively strong body of information about many aspects of service and care at these facilities. In recent years, HRSA has begun to require the submission of quality data by every health center grantee in the UDS reports and these data are still being refined. There is also a substantial body of research which suggests that, on balance, FQHCs provide high-quality primary care that helps reduce the need for other more expensive specialty or hospital care, thus reducing overall health care costs. The Centers for Medicare & Medicaid Services (CMS) establishes FQHC Medicare payment policies and works with States to establish FQHC Medicaid payment policies. CMS is currently planning a Medicare patient-centered medical home demonstration project to improve quality at FQHCs.

Less is known about the quality of care or other aspects of operations at RHCs and free clinics. In part this is because, unlike the Bureau of Primary Health Care's oversight of FQHC operations and policy, federal oversight of RHCs and free clinics is less developed, with no routine data collection efforts and less research conducted. CMS is primarily responsible for designation and payment of RHCs, while HRSA's Office of Rural Health Policy provides some technical assistance for RHCs and other rural health care providers. The federal government has relatively virtually no oversight over free clinics, except as it relates to the eligibility of free clinics' personnel for liability coverage under the Federal Tort Claims Act (and associated quality improvement requirements), which is overseen by the Bureau of Primary Health Care.

Somewhat more is known about the use of HIT and EHRs among safety net primary care clinics, although significant knowledge gaps exist. A recent survey indicates that more than two-thirds (69 percent) of FQHCs had at least some use of EHRs as of late 2010/early 2011, some of which was likely spurred by federal initiatives to boost the use of health information technology and 91 percent plan to apply for Medicaid EHR incentives.<sup>191</sup> More recent surveys, although

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<sup>190</sup> While clinicians at FQHCs are less likely to benefit from many incentives, almost all should be able to meet the Medicaid EHR incentive criteria. RHCs and (especially) free clinics, however, are generally less likely to be eligible for the incentives described in this report.

<sup>191</sup> Cunningham M, Lara A, Shin P. *op cit*.

imperfect, suggest that as many as one-quarter of RHCs and free clinics have EHRs. National data about the use of EHRs found that half of all office-based physicians had EHR systems, although only 10 percent had “fully functional” systems. This suggests that FQHCs are somewhat ahead of the overall office-based physician community in terms of EHR uptake, but RHCs and free clinics lag behind, perhaps because of their small size, limited resources, and/or rural nature. It is also clear that the great majority of these providers have not yet attained the level of use required to meet the “meaningful use” criteria defined for Medicare or Medicaid EHR incentive payment programs.. Not only is it important to encourage more clinics to adopt EHR systems, but it is also important to encourage those who have such systems to upgrade their capabilities to meet the meaningful use criteria.

There is growing interest in this area. As of late 2010, a survey of free clinics (discussed in Chapter 4) has just been completed and national surveys of FQHCs and RHCs are currently in progress; results should be available later in 2011. The strong national efforts to expand HIT, in part triggered by the Recovery Act (and the HITECH Act within that law), has spurred considerable interest in assessing progress towards these goals. Widespread use of improved HIT is an important ingredient of efforts to improve the quality and efficiency of care, ranging from helping primary care providers function as patient-centered medical homes to helping report quality performance measures.

## **HEALTH REFORM AND THE SAFETY NET CLINICS**

Other important forces, including but not limited to health reform under the Affordable Care Act, will shape these facilities in the future. The planned health insurance expansions – in the form of both Medicaid and private health insurance expansions – will have major effects on these primary care providers. Both FQHCs and RHCs will likely see increases in the percentages of their patients who have health insurance, whether covered by Medicaid or the health insurance exchanges. After the State of Massachusetts implemented its State health reform effort and sharply reduced the uninsured population, the demand for care, particularly ambulatory care, at safety net providers like FQHCs and safety net hospitals rose.<sup>192</sup>

The impact of health reform on free clinics is still uncertain. If the number of uninsured people falls as expected and there is further funding for FQHCs, some free clinics may consider trying to become FQHCs, while others may want to continue as free clinics focusing on care for the remaining uninsured.

The health reform legislation also helps some of these clinics by requiring that health plans offered under the new health insurance exchanges include “essential community providers,” where available that serve low-income, medically underserved individuals. This definition includes FQHCs as well as clinics that provide certain services, such as family planning services or Ryan White HIV/AIDS services. The health reform law also improves access to discounted prescription drugs for certain safety net facilities.<sup>193</sup> This may also encourage health plans to include RHCs as providers. To the extent that these clinics are located

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<sup>192</sup> Ku L, Jones E, Shin P, Byrne F, Long S. The role of the safety net after health reform: Lessons from Massachusetts. Forthcoming, Archives of Internal Medicine, 2011.

<sup>193</sup> See Section 340B(a)(4) of the Public Health Service Act.

in medically underserved or health professional shortage areas, health plans may also want to include them to broaden their primary care service capacity. Again, free clinics are likely to be excluded since they do not generally participate in insurance programs.

A broad issue facing FQHCs, RHCs, and free clinics is the potential shortage of primary care physicians. Although the demand for primary care practitioners is rising, fewer American medical students and residents have been selecting primary care fields. While there is some disagreement about the adequacy of the total number of primary care practitioners, there is no question that there are problems of maldistribution of primary care resources and that certain areas, such as rural communities and inner cities, often have an insufficient supply of clinicians. Since FQHCs and RHCs are located in medically underserved and health professional shortage areas, their communities are already facing primary care capacity problems and these problems could intensify in the future. Similarly, since free clinics rely on volunteer clinicians, they are likely to be affected by primary care clinician shortfalls. The insurance expansions under the Affordable Care Act, including the Medicaid eligibility expansions, are likely to increase the demand for care from primary care clinicians, including those at FQHCs and RHCs.<sup>194</sup> If FQHCs, RHCs, and/or free clinics are unable to secure sufficient primary care clinicians, including physicians, nurse practitioners or physician assistants, they could have greater difficulties providing quality care for their patients.

The health reform law includes many policies aimed at addressing primary care practitioner shortages, including (but not limited to): (1) increased Medicaid and Medicare reimbursement levels for primary care services, (2) Medicare bonuses for primary care physicians practicing in health professional shortage areas, (3) increased funding for the National Health Service Corps, and (4) creation of a National Health Care Workforce Commission. However, some of these provisions, such as the increased Medicaid and Medicare reimbursements, may not apply to practitioners at FQHCs, RHCs, and free clinics since they are not paid under physician fee schedules. On the other hand, safety net clinics may have an advantage in coping with physician shortfalls in that they already emphasize the use of team-based care. This care model, in which other clinicians including nurse practitioners, physician assistants, registered nurses, and other allied health staff play a greater role in providing care, frees up physicians to focus on care that requires their advanced skills and training. To the extent that HIT helps clinicians deliver care more efficiently, it may also reduce future workforce problems.

The health reform law also fosters efforts to increase coordination and better use of primary care to reduce complications associated with chronic health conditions and to lower the need for hospital care, including both emergency and inpatient care. Two principal approaches include development of new “medical home” or “health home” initiatives and “accountable care organizations.” The law encourages State Medicaid programs to develop “health home” programs for those with chronic conditions and offers a 90 percent federal match for health home services during the first two years of operation. The medical/health home initiatives encourage primary care providers to develop enhanced capacities to monitor, coordinate, and care for

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<sup>194</sup> Ku L, Jones K, Shin P, Bruen B, Hayes K. The states' next challenge: securing primary care for expanded Medicaid populations. *New England Journal of Medicine*. 2011; 364(6):493-95.

patients with chronic health conditions like diabetes, cardiovascular problems, or asthma, thus reducing the need for more expensive emergency or inpatient hospital care.

In April 2011, CMS published proposed regulations regarding the establishment of the Medicare Shared Savings Program, under which accountable care organizations (ACOs) will coordinate care for assigned Medicare fee-for-service beneficiaries.<sup>195</sup> ACOs are networks of physicians and other health care providers who will be encouraged to coordinate services to deliver more efficient care that also meets quality benchmarks. As an incentive ACOs that meet quality performance standards will be eligible to receive a share of Medicare savings back from the government. The development of ACOs may spur new efforts to improve quality and efficiency, particularly in the care of those with chronic conditions. The role of ACOs in Medicaid, which provides a larger share of revenue for FQHCs and for some RHCs than Medicare, is less clear.

Most analysts agree that for either patient-centered medical homes or ACOs to be successful, primary care providers must at least have functional EHR systems that can be used to monitor patients' conditions and to share information across providers.<sup>196</sup> Medical home, health home and ACO approaches use a blend of financial incentives and changes in the internal organization of health care providers to achieve improved quality and increased efficiencies. Many health care providers, including FQHCs and RHCs, are interested in these initiatives, although it will take time to learn how many actually attain "medical/health home" status or join ACOs. Free clinics, on the other hand, are precluded from receiving any such incentives because they generally do not accept third party payments. Further, some free clinics, including those that offer very specialized services or are open very few hours per week or sporadically, may be ill-prepared to function as medical homes, although other, larger and better organized free clinics might be able to do so.

## CONCLUSIONS

FQHCs, RHCs, and free clinics are all critical parts of the nation's primary care health safety net. Collectively, these safety net clinics provide preventive and primary care services at over 10,000 sites across the nation and serve well above 25 million patients. Without these clinics, their patients would experience difficulties getting routine primary care services on an affordable basis, because they live in medically underserved or health professional shortage areas, are uninsured or on Medicaid, and/or have low-incomes or other vulnerabilities.

However, these clinics are often excluded from eligibility for federal or State financial incentives that are designed to encourage and support improvements in the quality of care or the use of health information technology. Free clinics are excluded because they generally do not collect health insurance payments and therefore cannot receive bonuses that are tied to insurance reimbursements. While FQHCs and RHCs receive cost-related reimbursements from Medicare, Medicaid and CHIP subject to payment limits and other caps, they are generally ineligible for

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<sup>195</sup> Centers for Medicare & Medicaid Services. Medicare program; Medicare shared savings program: accountable care organizations: Proposed rule. Federal Register April 7, 2011: 76(67):19528-54.

<sup>196</sup> See, for example, Deloitte Center for Health Solutions. Medical home 2.0: the present and the future. Washington, D.C.: Deloitte; 2010 Dec.

incentive payments from Medicare because the statutory criteria do not include FQHCs or RHCs among the professionals or institutions eligible for incentives and because clinicians working at these clinics are not paid under the standard Medicare physician fee schedules. Thus, they are generally ineligible for Medicare incentive payments and are sometimes excluded from Medicaid incentives as well. Almost all eligible professionals working at FQHCs should be eligible for Medicaid EHR incentives and many of them working at RHCs should also be eligible. These clinicians could make these incentive payments payable to the clinics where they work. Both the federal government and other payers, including State governments, provide other types of incentives, including grants, technical assistance or other policies, to help upgrade quality or HIT use among these clinics and other health care providers.

Research indicates that FQHCs are a source of good quality health care.<sup>197</sup> Recent evidence shows FQHCs are using EHR systems at levels slightly higher than other office-based physicians. Because FQHCs usually employ multiple clinicians, sometimes organize networks of centers, and have received other support to build their HIT infrastructure, they may be better positioned than many other clinics or physician practices to meaningfully use certified EHR technology. Data about quality at RHCs and free clinics are scant, although systems of quality assessment and performance improvement plans are often in place. Recent surveys suggest that RHCs and free clinics use EHR systems less than the overall average for physician practices. Small size, limited resources and rural location may create barriers to the transition to EHRs for some of these providers.

This report finds that in some cases, FQHCs, RHCs or free clinics, are not able to participate in some incentives to upgrade health information technology or quality of care, which might impede their efforts to make such changes, compared to other types of health care providers that are eligible for the incentives. In April 2011, the HHS Plan to Reduce Racial and Ethnic Health Disparities was released.<sup>198</sup> The plan notes the importance of safety net clinics, like FQHCs, in helping to meet the health care needs of vulnerable Americans, including racial and ethnic minority populations and those with low incomes. It also discusses the importance of reducing barriers to quality care, including efforts to measure and provide incentives for better health care for minorities, to extend the meaningful use of electronic health records by safety net clinics and to establish patient-centered medical homes, as part of a national strategy to reduce health disparities. It is important that safety net clinics, including FQHCs, RHCs and free clinics, keep pace with broader changes occurring in the American health system in order to address the health needs of their patients and communities.

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<sup>197</sup> See the studies cited in footnotes 41 to 47.

<sup>198</sup> U.S. Department of Health and Human Services. HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care. April 2011. Available at <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285>.