Northwestern Journal of Law & Social Policy

Volume 9
Issue 1 *Fall 2013*

Article 5

Fall 2013

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Recommended Citation

James Hennessy, *FQHCs and Health Reform: Up to the Task?*, 9 Nw. J. L. & Soc. Pol'y. 122 (2013).
http://scholarlycommons.law.northwestern.edu/njlsp/vol9/iss1/5

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Northwestern Journal of Law and Social Policy
Volume 9 (Summer 2013)

FQHCs and Health Reform: Up to the Task?

James Hennessy[1]

ABSTRACT

This Article addresses the future of Federally Qualified Health Centers (FQHCs) in an entirely reformed primary care landscape under the Affordable Care Act (ACA). Given health centers' ability to fill crucial access gaps that will remain after health reform, FQHCs stand to undertake an increased role and are thus vital to the implementation of the ACA. Yet questions remain as to whether current FQHCs are capable of taking on an increased demand for services resulting from ACA expansion. Health centers are already busy, and more patients are coming as many burdens of health reform will inevitably fall on their shoulders. FQHCs have grown in capacity and number over time, but such development has varied considerably. Because increased funding will not be sufficient to bolster the current primary care network, FQHC qualification requirements must adapt to a new health care environment.

This Article specifically targets Medically Underserved Area (MUA) and Medically Underserved Population (MUP) designations as improper threshold requirements for FQHC status. MUA/MUP designations—prerequisites to FQHC qualification—are increasingly imprecise, outdated, and overly-complex. The MUA/MUP status requirements have barred many deserving areas from creating FQHCs, and they must be changed in order for centers to meet their critical obligations in light of an unprecedented growth in demand for health services.

INTRODUCTION

Federally Qualified Health Centers (FQHCs)[2] are non-profit, community directed health care providers responsible for improving primary care access to millions of Americans, regardless of their ability to pay. Congress passed FQHC-enabling legislation as part of the Social Security Act in 1989,[3] and the application process and requirements for federal qualifications are governed under the Public Health Service Act.[4] Currently, 1,200 health centers deliver care through over 8,000 service delivery sites across the United States.[5] These centers are required by statute to be located in deeply impoverished

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[1] J.D. Candidate, UCLA School of Law, 2013; B.A. Gonzaga University, 2009; I would like to thank Courtney Powers and Michelle Kezirian for their guidance and suggestions.

[2] FQHCs will also be referred to as "health centers" throughout this paper.

[3] Social Security Act, 42 U.S.C. §1396d (2012) (amended by § 4161 of the Omnibus Budget Reconciliation Act of 1990); *see also* HEALTH AND RESOURCES AND SERVICES ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVICES, COMPARISON OF THE RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER PROGRAMS 3 (2006), *available at* http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf.

[4] *See* 42 U.S.C. § 254b (2012).

[5] *See America's Health Centers*, NAT'L ASS'N OF COMMUNITY HEALTH CENTERS FACT SHEET (Nat'l Association of Community Health Centers, Bethesda, MD), July 2012, *available at* http://www.nachc.com/client/documents/America%27sHealthCenters.pdf [hereinafter *America's Health Centers*].

communities or medically underserved populations.[6] A medically underserved population (MUP) signifies a population or area designated by the Department of Health and Human Services (HHS) Secretary as "an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services."[7] FQHC patient populations thus predominantly consist of low-income patients who are uninsured or covered by Medicaid and other public programs.[8] Additionally, with active community involvement in care delivery, FQHCs offer more than medical care;[9] they offer services that remove common barriers to health care, including transportation, translation, insurance enrollment, case management, health education, and home visitation.[10]

Achieving FQHC status is a difficult but often essential task for providers and otherwise financially fragile health centers. Gaining federal qualification—which provides enhanced Medicaid reimbursement, grants to support capital and operational costs, discounted pharmaceuticals, access to National Health Service Corps clinicians, and medical malpractice liability protection—has allowed many health centers to remain operational.[11] The federal government provides grants of up to $650,000 toward each new FQHC, and this funding often remains the health centers' primary financial resource.[12] Federal grants help defray the exorbitant capital and operational costs endemic to the delivery of health care.[13] Because FQHCs must serve patients regardless of their ability to pay, these organizations depend on governmental support.[14]

The primary goal of FQHCs is to provide high-quality primary and preventive health care services to people in rural and urban medically underserved areas.[15] The Public Services Health Act requires that FQHCs provide "all required primary, preventive, enabling health services."[16] In addition to providing comprehensive primary medical care, FQHCs provide services not traditionally found in private medical care

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[6] *See* 42 U.S.C. § 254b; *see also, e.g.,* MID-ATLANTIC ASS'N OF COMMUNITY HEALTH CENTERS, A DISCUSSION ON MARYLAND FEDERALLY QUALIFIED HEALTH CENTERS: A ROAD MAP FOR SUPPORT 5 (2003), *available at* http://www.machc.com/sites/default/files/documents/Road%20Map%20to%20Support.pdf [hereinafter A ROAD MAP FOR SUPPORT].

[7] *See* 42 U.S.C. §254b.

[8] Aaron Katz, Laurie E. Felland, Ian Hill, & Lucy B. Stark, *A Long and Winding Road: Federally Qualified Health Centers, Community Variation and Prospects Under Reform*, HSC RESEARCH BRIEF NO. 21 (2011), *available at* http://www.hschange.com/CONTENT/1257/?PRINT=1.

[9] *Community Health Centers: A Unique Approach to Primary Care*. NAT'L ASS'N OF COMMUNITY HEALTH CENTERS FACT SHEET (Nat'l Association of Community Health Centers, Bethesda, MD), Aug. 2012, *available at* http://www.nachc.com/client/documents/UniqueModel.pdf [hereinafter *Community Health Centers*].

[10] *Id.* at 1.

[11] Katz et al., *supra* note 8.

[12] *See Benefits of Being an FQHC*, MID-ATLANTIC ASS'N OF COMMUNITY HEALTH CENTERS, http://www.machc.com/content/benefits-being-fqhc (last visited Sept. 24, 2013).

[13] *See National Health Care Expenditures Data,* CENTERS FOR MEDICARE AND MEDICAID SERVICES, OFF. OF THE ACTUARY, NAT'L HEALTH STAT. GROUP, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html (last visited Sept. 24, 2014). *See also* Sarah Goodell & Paul Ginsberg, *High and Rising Healthcare Costs: Demystifying U.S. Health Care Spending*, ROBERT WOOD JOHNSON FOUNDATION POLICY BRIEF 16 (Oct. 2008), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2008/rwjf32704.

[14] *See* 42 U.S.C. § 254 (2012); 42 U.S.C. § 330(k)(3)(G)(iii)(I) (2012).

[15] *See* A ROAD MAP FOR SUPPORT, *supra* note 6; Katz, et al. *supra* note 8.

[16] *See* 42 U.S.C. § 254(a)-(b).

practices, such as family and community outreach, transportation, health and nutrition education, parenting classes, and referral to other social services,[17] FQHCs tailor their services to fit the special needs and priorities of their diverse communities, and in doing so, they have served as efficient safety net providers for many years.[18] As a result, FQHCs are considered to be not only providers of medical care to individuals, but also mainstays with regard to the overall improvement of community health.[19]

Generally, FQHCs have enjoyed success providing primary and preventive health care services in the communities they serve. Uninsured individuals living within close proximity to an FQHC are less likely than other uninsured individuals to possess an unmet medical need, less likely to visit the emergency room or have a hospital stay, and more likely to have had a general medical visit.[20] Overall, the FQHC model has enhanced community health outcomes, created system-wide savings through reduced hospital and emergency room visits, and stimulated economies in numerous low-income communities.[21]

In addition to overall community health, FQHCs have reduced and eliminated disparities in health care outcomes. One study indicates that disparities in health status do not exist among health center patients, even after controlling for sociodemographic factors.[22] FQHCs have also been shown to lower the utilization of specialty care, emergency departments, and hospitals.[23] Furthermore, studies have found significantly reduced rates of specialty referrals, hospital admission rates, and lengths of stay for those using FQHCs, compared with those who use other providers.[24] Moreover, if avoidable visits to emergency rooms were redirected to health centers, anywhere between an additional $1.6 and $8 billion in national health care costs could be saved annually.[25] Four states in particular have demonstrated that Medicaid beneficiaries relying on FQHCs for usual care are 19% less likely to use the emergency department for unnecessary visits.[26] Unsurprisingly, the success of FQHCs in improving health care outcomes has led to significant growth among health center networks nationwide.[27]

As a policy matter, lower utilization with regard to specialty care and emergency departments has led to significant cost savings for the health care system as a whole.[28]

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[17] A ROAD MAP FOR SUPPORT, *supra* note 6.
[18] *America's Health Centers, supra* note 5, at 1-2.
[19] Katz, et al. *supra* note 8.
[20] *America's Health Centers, supra* note 5, at 2.
[21] *Community Health Centers: A Turnkey Solution for Access to Care*, NAT'L ASS'N OF COMMUNITY HEALTH CENTERS ISSUE BRIEF (Nat'l Ass'n of Community Health Centers, Bethesda, MD), August 2012, *available at* http://www.nachc.com/client/documents/AccessSolution.pdf [hereinafter *A Turnkey Solution*].
[22] *America's Health Centers, supra* note 5, at 2.
[23] *Id.*
[24] *See, e.g.,* NAT'L ASS'N OF COMMUNITY HEALTH CENTERS, A NATION'S HEALTH AT RISK II: A FRONT ROW SEAT IN A CHANGING HEALTH CARE SYSTEM 1 (2004), *available at* http://www.nachc.com/client/NationsHealthIISTIB7.pdf.
[25] *Id.*
[26] *Cost Effectiveness of Care Provided at Health Centers*, NAT'L ASS'N OF COMMUNITY HEALTH CENTERS FACT SHEET (Nat'l Ass'n of Community Health Centers, Bethesda, MD), December 2011, *available at* http://www.nachc.com/client/documents/CostEffectivenessFS.pdf [hereinafter *Cost Effectiveness of Care*].
[27] *See America's Health Centers, supra* note 5, at 1-2 (stating that health centers served as the medical and health care home for over 20 million people nationally, and that the number is quickly growing).
[28] For a detailed discussion of this matter, *see* LINA CHOUDHRY ET AL., THE IMPACT OF COMMUNITY HEALTH CENTERS & COMMUNITY AFFILIATED PLANS ON EMERGENCY DEPARTMENT USE (2007), *available*

Despite providing a broader array of services and serving more at-risk patients, one study has found that the average cost at FQHCs runs a dollar less per patient per day compared to all physician settings.[29] Many studies conducted over the past 30 years underscore the effectiveness of FQHCs in furnishing services of good quality in a cost-effective fashion.[30] Furthermore, because FQHCs have generated over $24 billion in health care savings annually, the White House Office of Management and Budget recently rated these health centers one of the most effective federal programs.[31] The expansion of FQHCs under the Affordable Care Act (ACA) has a projected additional savings of up to $11 billion by 2015.[32] Serving uninsured populations in a cost-effective manner has truly become the hallmark of FQHCs.

Although FQHCs have primarily acted as safety net providers for uninsured communities, their role has increased and shifted over time. Originally created as part of the war on poverty in the 1960s, the FQHC program grew rapidly alongside increased demand for free or low-cost health care in the 1980s following a series of pivotal Medicaid expansions, as FQHCs shifted from being fringe providers to anchors of many local health care systems. Fortunately, widespread political support[33] encouraged the number of FQHC organizations to increase nationally—from about 700 to 1,200 in recent years.[34] Remarkably, the number of uninsured patients at FQHCs has nearly doubled from 3.9 million in 1998 to 7.4 million today.[35] Over time, these health centers have demonstrated an ability to expand. As this Article will demonstrate, if qualification requirements are adjusted to allow for the additional proliferation of new FQHCs, health centers will be poised to serve even more patients in the near future.

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at http://www.nachc.com/client/ACAPReport.pdf. *See Also* Michael McCue, *FQHCs Need More Funding: Centers Save Billions Each Year*, MANAGED HEALTHCARE EXECUTIVE (Mar. 1, 2009), http://managedhealthcareexecutive.modernmedicine.com/mhe/Emergencydepartments/FQHCs-need-more-funding/ArticleStandard/Article/detail/584940.

[29] *Cost Effectiveness of Care*, *supra* note 26, at 1.

[30] Sara Rosenbaum & Timothy M. Westmoreland, *The Supreme Court's Surprising Decision On The Medicaid Expansion: How Will The Federal Government And States Proceed?* 31 HEALTH AFF. 1663, 1672 (2012).

[31] *A Turnkey Solution, supra* note 21.

[32] *Community Health Centers: The Return on Investment*, NAT'L ASS'N OF COMMUNITY HEALTH CENTERS FACT SHEET (Nat'l Ass'n of Community Health Centers, Bethesda, MD), November 2010, *available at* http://www.nachc.com/client/documents/CHCs%20ROI%20final%2011%2015%20v.pdf [hereinafter *Community Health Centers: The Return on Investment*].

[33] *See* Press Release, The White House, Office of the Press Secretary, President Obama Announces Recovery Act Awards to Build, Renovate Community Health Centers in More Than 30 States (Dec. 9, 2009), *available at* http://www.whitehouse.gov/the-press-office/president-obama-announces-recovery-act-awards-build-renovate-community-health-cente (stating that President Obama furthered President Bush's efforts in his health care centers initiative in 2002 by announcing nearly $600 million in ARRA to support major construction and renovation projects).

[34] Katz et al., *supra* note 8.

[35] *America's Health Centers, supra* note 5, at 3.

I. FQHCS AND THE AFFORDABLE CARE ACT

A. Critical Safety Net Provider

In *NFIB v. Sebelius*, the Supreme Court upheld the constitutionality of the ACA.[36] When Congress passed the ACA, the authors of the bill understood the need for enhanced access to primary care.[37] To that end, the legislation's central goal was to provide affordable coverage and primary care to more Americans.[38] The ACA addresses this objective through various provisions, including: 1) the expansion of Medicaid to 133% of the Federal Poverty Level (FPL),[39] 2) the elimination of categorical exclusions to Medicaid coverage, 3) a temporary Medicare-Medicaid reimbursement match,[40] 4) the elimination of pre-existing condition requirements for health insurance,[41] and 5) the requirement that individuals carry health insurance (the individual mandate).[42] Some public health experts even view the extension of Medicaid to all non-elderly low-income people who were previously ineligible for coverage as the ACA's central achievement.[43] Until the ACA, federal law did not provide general eligibility for low-income people who did not fit into one of the named categories—specifically, low-income adults without dependent children.[44] Congress sought to ensure that benefits would be extended to virtually all low-income non-elderly people who meet citizenship requirements and whose household income falls below a federal financial threshold.[45] This provision alone is expected to provide coverage to 16 million more Americans.[46] Furthermore, a "90-10 match" by the federal government ensures that states will pay only 10% of present Medicaid expansions though 2020.[47] The federal government has indeed demonstrated a strong emphasis on health care access through the Affordable Care Act.

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[36] Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).
[37] *See* Michael Ollove, *Medicaid Expansion Puts Spotlight on Access to Primary Care*, KAISER HEALTH NEWS (February 14, 2013), *available at* http://www.kaiserhealthnews.org/stories/2013/february/14/medicaid -primary-care-doctor-payment.aspx.
[38] Katz et al., supra note 8.
[39] *Community Health Centers and Health Reform*, NAT'L ASS'N OF COMMUNITY HEALTH CENTERS, http://www.nachc.com/client/Summary%20of%20Final%20Health%20Reform%20Package.pdf (last visited September 24, 2013).
[40] Olloye, *supra* note 37.
[41] *See* Patient Protection and Affordable Care Act, Pub. L. 111-148.
[42] For an excellent graphic detailing the ACAs individual mandate, *see* Kaiser Family Foundation, *The Requirement to Buy Coverage Under the Affordable Care Act*, http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/ (last visited Oct. 27, 2013).
[43] Rosenbaum & Westmoreland, *supra* note 30, at 1672.
[44] *Medicaid and HIV/AIDS,* KAISER FAMILY FOUNDATION (Mar 5, 2013), http://kff.org/hivaids/fact-sheet/medicaid-and-hivaids/ (stating that under current law, to qualify for Medicaid, a person must meet financial criteria and also belong to one of Medicaid's categorically eligible groups).
[45] Rosenbaum & Westmoreland, *supra* note 30, at 1673.
[46] THE HENRY J. KAISER FAMILY FOUNDATION, THE HEALTH REFORM LAW'S MEDICAID EXPANSION: A GUIDE TO THE SUPREME COURT ARGUMENTS 2 (2012), *available at* http://www.kff.org/healthreform/upload/8288.pdf.
[47] *Id.*

Yet whether the ACA will solve the access problem is debatable, as many have questioned whether such an expansion will in fact be realized.[48] Ultimately, an expansion in coverage means little without accompanying services. After all, a lack of insurance is just one of many factors affecting access to health care today.[49] Additional barriers to access, irrespective of insurance, include primary care workforce shortages, poor benefits coverage or underinsurance, and the denial of specialty care. Indeed, accessing primary care can be quite challenging, even for the insured. Fortunately, because FQHCs are capable of filling many of these critical access gaps, they will likely prove to be a key player in effectuating the success of the ACA.[50]

The distinction between coverage and access is most evident in provider workforce shortages that may immediately result upon the implementation of the ACA. This will largely come as a result of provider reluctance to accept new patients because of low reimbursement rates.[51] Although rates vary because they are set by each state, Medicaid often pays health care providers less than the cost of the care, placing providers in a difficult position with regard to accepting new patients. Indeed, with more and more states finding themselves on unstable financial ground, many providers may be reluctant to provide any Medicaid services *at all*. Nationally, only 69.4% of physicians are currently accepting new patients with Medicaid, markedly lower than the percentage accepting new self-pay, privately insured, or Medicare patients.[52] Furthermore, some states with tighter budgets have exhibited even more striking provider shortages. In California, the rate of acceptance has recently been reported at 57.1%, the second lowest in the nation.[53] In the current economy and health care environment, states and providers have struggled to balance the necessity of medical care while also being fiscally responsible.

FQHCs may placate these workforce shortages by offering enhanced Medicaid reimbursement, which allows FQHCs to receive rates that are often higher than cost for Medicaid patients.[54] Prior evidence suggests that providers' acceptance of Medicaid

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[48] *See, e.g.,* Rosenbaum & Westmoreland, *supra* note 30, at 1672 (questioning the holding of the US Supreme Court regarding Medicaid expansion and how it will affect the 16 million who were expected to receive coverage as a result of such expansion under the ACA).

[49] *See, e.g., Addressing Racial and Ethnic Disparities in Health care,* AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, http://www.ahrq.gov/research/findings/factsheets/minority/disparit/ (last visited September 23, 2013) (explaining that insurance coverage accounted for only one-fifth of the change in access to a usual source of care).

[50] *See Federally Qualified Health Centers: Threat or Collaborative Opportunity?*, QUORUM HEALTH RES. (Sept. 2010), http://www.qhr.com/content/white_papers/Federally_Qualified_Health_Centers_-_White_Paper_-_Sept_2010.pdf (indicating a requirement for FQHCs to provide support for Medicaid enrollment); *see also* 42 U.S.C. § 254b(k)(3)(G) (2012) (including a requirement to have a system in place to determine eligibility for patient discounts on the basis of patients' ability to pay; and a requirement to care for the undocumented; and a requirement to provide transportation services for those who cannot get to the health center on their own).

[51] *See* Sandra L. Decker, *In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help*, 31 HEALTH AFF. 1673, 1673 (2012).

[52] *Id.* at 1675.

[53] *Id.*

[54] For a brief explanation of the FQHC Prospective Payment System, see *FQHC Prospective Payment System: Essential to the Health Center Model*, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, *available at* http://www.nachc.org/client//Health%20Center%20PPS%20Fact%20Sheet_final.pdf.

patients will increase as payment rates increase.[55] A recent study indicates that higher state Medicaid-to-Medicare fee ratios correlate with greater acceptance of new Medicaid patients.[56] Although the ACA increases Medicaid rates to Medicare-like levels, these increases are temporary and no provision for an extension beyond 2014 presently exists. Conversely, FQHCs offer a more permanently enhanced reimbursement structure that will alleviate this particular access issue, as higher reimbursement mitigates the tough financial decisions a provider must make.

FQHCs are equipped with even more tools to address provider shortages. First, FQHCs are eligible to team up with the National Health Service Corps (NHSC), which offers loan payments and scholarships to primary care physicians who commit to work at FQHCs.[57] The ACA has allocated $1.5 billion to the NHSC over five years, enough to place an estimated 15,000 primary care providers in provider-short communities.[58] FQHCs can also address the provider shortage through strict staffing requirements. Federal law requires FQHCs to maintain a core staff to carry out all required primary, preventive and enabling health services and additional health services as appropriate and necessary.[59] Complimentary malpractice coverage under the Federal Tort Claims Act adds yet another incentive for providers to provide care at FQHCs.[60] Further requirements, including accessible hours of operation and locations, are detailed under section 330 of the Public Health Services Act.[61]

Another major question surrounding health care reform relates to the state reduction of Medicaid benefits. When adjusting to the Medicaid expansion, rather than tightening eligibility, many states have reduced optional benefits and specialty care. Even after health care reform, Medicaid only requires dental coverage for children, and numerous states have reduced or eliminated Medicaid dental coverage for adults accordingly.[62] Illinois, whose Medicaid program was once considered among the most generous, recently cut $1.6 billion out of its $15 billion Medicaid budget, thereby reducing adult dental coverage to emergency tooth extractions.[63] Illinois also cut vision benefits and eliminated both chiropractic and podiatry coverage.[64] In about half the states, Medicaid covers dental care only for pain relief and emergencies, while other states only provide for certain procedures.[65] Yet even in states where Medicaid enrollees receive regular dental care, finding dentists who accept Medicaid can be next to impossible

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[55] *Id.*
[56] *Id.* at 1673.
[57] *National Health Service Corps and FQHCs Primary Care Initiative*, AM. PSYCHOLOGICAL ASS'N (Sept. 2009), http://www.apa.org/about/gr/education/advocacy/2009/nhsc-fqhc.aspx.
[58] *National Health Service Corps*, AM. COLL. OF PHYSICIANS, http://www.acponline.org/advocacy/where_we_stand/assets/iii3-national-health-service-corps.pdf.
[59] 42 U.S.C. § 254b(a) (2012).
[60] *See Frequently Asked Questions about Federally Qualified Health Centers and their Oral Health Programs*, AMERICAN DENTAL ASSOCIATION, *available at* http://www.ada.org/sections/advocacy/pdfs/faq_fedqual_healthctrs.pdf.
[61] 42 U.S.C. § 254b.
[62] Abby Goodnough, *Hard to Grin While Bearing Cuts in Medicaid Dental Coverage*, N.Y. TIMES, Aug. 29, 2012, at A16.
[63] *Id.*
[64] *Id.*
[65] *Id.*

because of inadequate reimbursement rates.[66] To make matters worse, the importance of oral health cannot be overstated. Dental problems were the primary diagnosis in 830,590 emergency room visits in 2009, up 16% from a similar survey done only three years before.[67] This is one particular area where a large amount of money is spent on health care for less than adequate results, all of which will not be solved by expanded Medicaid coverage alone.

Fortunately, FQHCs may resolve dental issues given that FQHC status is conditioned upon the provision of dental and other health services. FQHCs deliver more than primary care. All are required by section 330 to provide primary health services,[68] which are defined as including "preventive dental services."[69] FQHCs are further required to provide additional health services to the community as appropriate and necessary.[70] Health centers thus provide services not typically furnished in other primary care settings, including behavioral health and pharmaceutical services in addition to dental care.[71]

Of course, the possibility that various individual states may refuse to participate in Medicaid expansion looms in the background of the ACA.[72] Medicaid is a voluntary shared state and federal health insurance program, meaning that no state is required to participate. As states adjust to the ACA, much will turn on political and budget considerations.[73] Medicaid already accounts for more than 20% of the average state budget,[74] and although the upfront "90-10 match" will help, the federal government's share will decrease over time.[75] Of the total $430 billion in program spending in fiscal year 2011, 60% came from the federal government.[76] Importantly, because most states are already suffering financially and the *NFIB v. Sebelius* decision gives them the option to determine how to pursue Medicaid expansion under the ACA,[77] FQHCs may shoulder substantial additional burdens when states cut back services or enrollment.

Alternatively, FQHCs may play a major role in incentivizing states to keep and expand Medicaid by ensuring cost savings for each state's program. Cost-effective means of using Medicaid will allow states to avoid difficult choices regarding public health

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[66] *See* Jeffrey A. Roberts, *Medicaid Patients Struggle to Access Dental Care*, HEALTH POLICY SOLUTIONS (February 6, 2013), *available at* http://www.healthpolicysolutions.org/2013/02/06/medicaid-patients-struggle-to-access-dental-care/.

[67] THE PEW CENTER ON THE STATES, A COSTLY DENTAL DESTINATION: HOSPITAL CARE MEANS STATES PAY DEARLY 7 (2012), *available at* http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State_policy/Pew_Report_A_Costly_Dental_Destination.pdf.

[68] 42 U.S.C. § 254b(a)(1) (2012).

[69] 42 U.S.C. § 254b(a)(1)(A)(i)(III)(hh).

[70] *See* 42 U.S.C. § 254a(1)(B) (2012).

[71] *Cost Effectiveness of Care*, *supra* note 26, at 1.

[72] For an illustration of where states stand with Medicaid expansion, updated daily, *see Where the States Stand on Medicaid,* THE ADVISORY BOARD COMPANY, http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap (last visited Sept. 17, 2013).

[73] Shannon McMahon, *Medicaid Expansion: A Closer Look at Vulnerable Populations and State Coverage Opportunities*, HEALTH AFF. BLOG (Sept. 10, 2012), http://healthaffairs.org/blog/2012/09/10/medicaid-expansion-a-closer-look-at-vulnerable-populations-and-state-coverage-opportunities.

[74] Rosenbaum & Westmoreland, *supra* note 30, at 1664.

[75] *See America's Health Centers*, *supra* note 5.

[76] Rosenbaum & Westmoreland, *supra* note 30, at 1664.

[77] *See* McMahon, *supra* note 73 (citing the Supreme Court's decision to allow states the option to expand Medicaid coverage).

coverage. Although states do not directly realize savings by relying on FQHCs *per se*, stemming the costs of their most expensive budget item, Medicaid, will provide assistance in the long term. One study showed that after controlling for socioeconomic factors as well as health conditions and behaviors, "total annual healthcare spending for North Carolina FQHC patients averaged 62% less than patients served by other primary care providers in the state."[78] Similar research in Indiana found annual savings of 48% per patient.[79] In Washington, Medicaid recipients treated at FQHCs required 31% fewer hospital emergency room visits, 44% fewer prescriptions, and 71% fewer hospital outpatient visits than those treated at other facilities.[80] In California, Medicaid recipients treated at FQHCs had 14% lower hospital costs than those who were not treated at the centers.[81] In New York, Medicaid recipients treated at FQHCs had 24% lower hospital costs than those who were not treated at FQHCs.[82] Although states do not directly realize these savings, the reductions in hospitalizations, prescriptions, and outpatient visits can have a profound impact on state budgets.

B. Growing Demand

FQHCs are busy, and more patients are coming. Despite lack of insurance, under-insurance, and growing primary care shortages, FQHCs *already* serve over 20 million patients.[83] This is an astounding figure, especially given that only 1200 FQHCs exist nationwide. The broad insurance expansions contained within the ACA will cause a swell in demand for services.[84] Moreover, because private delivery will not absorb demand increases for the medically needy, this burden will fall heavily on the shoulders of FQHCs. [85] Most FQHCs should expect a surge of new patients in almost every community similar to that in Massachusetts, where a recent study found a significant increase in the number of patients receiving care from health centers as a result of state health care reform.[86] Massachusetts FQHCs saw tremendous growth in the number of both insured and uninsured patients they serve.[87] An increase in demand will result in an even greater need for FQHC services.

Although FQHCs have historically adapted well to health care delivery changes, it is unlikely they will be able to continue to absorb the impact of future changes to the

[78] *Cost Effectiveness of Care*, *supra* note 26, at 1.
[79] *Id.*
[80] See NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, A NATION'S HEALTH AT RISK II: A FRONT ROW SEAT IN A CHANGING HEALTH CARE SYSTEM 19 (2004), *available at* http://www.nachc.com/client/NationsHealthIISTIB7.pdf.
[81] *Id.*
[82] *Id.*
[83] *Community Health Centers*, supra note 9.
[84] *See* Kaiser Family Foundation*, Health Coverage Under the Affordable Care Act,* 308 JAMA 2556 (2012).
[85]Michael McCue, *FQHCs Need More Funding*, MANAGED HEALTHCARE EXECUTIVE (Mar. 1 2009), http://managedhealthcareexecutive.modernmedicine.com/mhe/Emergency departments/FQHCs-need-more-funding/ArticleStandard/Article/detail/584940.
[86] *See* Paul Bailey & Brian Osberg, *Healthcare Reform: Opportunities and Challenges Facing FQHCs*, *Northwest Regional Primary Care Association*, NORTHWEST REGIONAL PRIMARY CARE ASS'N, http://www.nwrpca.org/health-center-news/203-health-care-reform-opportunities-and-challenges-facing-fqhcs.html (last visited Sept. 23, 2013).
[87] *Community Health Centers: The Return on Investment*, *supra* note 32, at 2.

health care system. Some experts opine that existing FQHC service capacity in certain areas is insufficient to absorb a dramatic increase in the number of uninsured served by FQHCs.[88] In order to survive, FQHCs will thus require additional support to meet the demand from the newly insured and to care for those who still lack insurance.[89] As was the case in Massachusetts after the Commonwealth reformed its health care system, FQHCs will require transitional and ongoing support to respond to the increase in demand for services and to continue caring for those who remain uninsured.[90] In Massachusetts, a number of health centers struggled to respond to increased demand after reform, as many lacked the requisite capacity.[91] Because the ACA will also result in a significant patient population increase nationwide, FQHCs may face similar struggles in absorbing increased demand.

C. Satisfying Demand: Expand or Create From Scratch?

The first step to meeting increased demand is determining whether the government should simply expand existing FQHCs or establish more FQHCs. Both strategies have merit and thus should be entertained to some degree. Expanding the service capacity of existing FQHCs will be necessary to maintain an ongoing network in established underserved areas, and funding such sites will be an efficient use of resources.

The more contentious issue is whether *more* FQHCs are needed in addition to expanding current sites. Although the ACA supports the expansion of FQHCs, its language does not distinguish whether new funds are allocated for the expansion of existing FQHCs or the creation of entirely new ones. Under the ACA, Congress has allocated $11 billion to FQHCs to be spent over a period of five years.[92] $1.5 billion is earmarked for existing FQHCs to meet their extraordinary capital needs.[93] The ACA is silent as to the purpose of the remainder of the money. Under the ACA, $9.5 billion of the $11 billion will be allocated generally, both to new FQHCs and to expand the capacity of existing health centers.[94] More explicit support is needed to show that the creation of new FQHCs is necessary.

Current data on nationwide FQHC distribution might indeed lend such support. While the number and capacity of FQHCs has grown over time, health center development has varied considerably across communities.[95] Some communities have relatively extensive FQHC capacity for their Medicaid and uninsured populations, while others have lagged substantially in such growth by comparison.[96] These populations can

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[88] Maryland, for example, has historically struggled in meeting even smaller increases in demand prior to the ACA. *See* A ROAD MAP FOR SUPPORT, *supra* note 6, at 2.
[89] *A Turnkey Solution*, *supra* note 21, at 3.
[90] *Community Health Centers: The Return on Investment*, *supra* note 32, at 2.
[91] *Id.*
[92] *See* H.R. 3590—886 § 10503 (2010); *see also* Press Release, Dep't of Health and Human Services, Health Care Law Increases Payments to Doctors for Primary Care (May 9, 2012), *available at* http://www.hhs.gov/news/press/2012pres/05/20120509b.html.
[93] *Id.*
[94] *See The Obama Administration and Community Health Centers*, WHITEHOUSE.GOV, *available at* http://www.whitehouse.gov/sites/default/files/05-01-12_community_health_center_report.pdf.
[95] Katz et al., *supra* note 8.
[96] *Id.*

often be found in areas that may seem counterintuitive. For example, Somerset County in New Jersey does not have access to FQHCs because the county as a whole has been classified as an affluent area.[97] Yet there are populations within that county that ostensibly need FQHCs.[98] Research has also identified certain communities where physicians are less willing to provide charity care or treat Medicaid patients, yet no FQHCs exist.[99] The number of FQHC facilities ranges from more than 100 sites in Boston and Miami to just a handful of sites in Little Rock, despite Little Rock having a high poverty rate and low supply of primary care physicians.[100] As will be explained later, much of the FQHC disparity issue arises because of challenges in demonstrating need based on local health system characteristics.[101]

Health center disparities cannot be mitigated by simply enhancing capacity at existing sites, or by encouraging FQHCs to draw patients from neighboring communities. The government's ability to expand capacity at current health centers is limited because FQHCs cannot compromise their "community based" requirement. The "community based" requirement mandates that the health care governance board of an FQHC must be composed of individuals who make up the community and are consumers at the health center.[102] Accordingly, any site or patient population must be within a reasonable distance from the existing board and organization. This limitation hinders the ability to create new sites for existing FQHCs, making the creation of entirely new FQHCs a more appropriate option.

II. REVISITING QUALIFICATION STANDARDS

A. Qualification under the MUA/MUP Designation

Even if the federal government were to earmark a specific amount of money for the creation of new FQHCs, increased funding is not sufficient to bolster the current network. New FQHCs must undergo a strict federal qualification process to ensure they are able to adequately serve previously underserved populations. If sufficient FQHCs are to be established in appropriate areas once the ACA is fully implemented, certain qualification requirements must adapt to a new health care landscape.

This Article specifically targets Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) as improper threshold requirements to FQHC status.[103] Developed over 30 years ago,[104] the MUA/MUP designation is a prerequisite, or first step, to obtaining FQHC status, which is identified as a result of a

[97] *See Id.*
[98] *Id.*
[99] Laurie E. Felland, et al., *Suburban Poverty and the Health Care Safety Net,* CTR. FOR STUDYING HEALTH SYSTEM CHANGE, July 2009, *available at* http://www.hschange.com/CONTENT/1074/.
[100] Katz et al., *supra* note 8.
[101] *Id.*
[102] 42 U.S.C. § 254b(k)(3)(H) (2012) (This board is "composed of a majority of individuals who are being served by the center and, who, as a group, represent the individuals being served by the center" in terms of demographic factors such as race, ethnicity, and sex.).
[103] *See* 42 U.S.C. § 254b(3).
[104] *See* Eileen Salinsky, *Health Care Shortage Designations: HPSA, MUA, and TBD*, NAT'L HEALTH POLICY FORUM 7 (June 4, 2010), *available at* http://www.nhpf.org/library/background-papers/BP75_HPSA-MUA_06-04-2010.pdf.

state and federal process. To generate these designations, the government looks at four variables: 1) the percentage of a population with incomes below the federal poverty level, 2) infant mortality rates, 3) the percentage of a population age 65 or over, and 4) the number of primary care physicians per 1000 people.[105] In turn, an assessment is made by the Health Resources and Services Administration (HRSA), which determines the geographic areas which can apply for FQHC funding.[106] In some funding cycles, only specified areas can even apply.

B. Problems with the MUA/MUP Requirement

The MUA and MUP designations are not as compelling as they once were. Although the designations may have historically sufficed to identify areas of medical need, at least one critic has questioned their present validity, utility, and scope.[107] These designations might indeed be viewed as outdated, cumbersome, and scientifically unsound as well as inadequate in distinguishing levels of shortage or under-service.[108] This dissatisfaction with the designations is not surprising, given the complexity of the task at hand. Estimating unmet service needs is a difficult endeavor, and the importance of such measures in allocating capacity development resources renders the task all the more crucial.[109]

Although the MUA/MUP methodology is highly technical, it is also imprecise. As mentioned previously, HRSA focuses on four variables: poverty, infant mortality, provider to population ratios, and elderly to population ratios.[110] These are important variables, but they may also disadvantage communities that exhibit other types of health needs, such as high rates of chronic disease, which are targeted by the ACA.[111] Areas with few specialty providers (such as dentists or mental health providers) are also disadvantaged. Under the MUA/MUP methodology, each area is scored on a 100 point scale, based upon the four HRSA variables, and scores of 62 or less are designated as eligible. An area score of 61 would therefore render an area FQHC-eligible, whereas a score of 63 would disqualify. Given the complexity of the access issue, these designations seem imperfect as proxies for the numerous interrelated factors that shape access to care.

Proponents of the MUA/MUP designation might argue that, even if imprecise, the process exists as a gatekeeper to ensure that HRSA prioritizes areas where FQHCs are needed most. Yet in many cases, low-income neighborhoods are obscured within an overall higher-income area, making it more difficult to target priority areas.[112] Underserved pockets may exist in a given area, but be deprived of an FQHC because of

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[105] *Id.*
[106] *See Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations*, http://www.hrsa.gov/shortage/ (last visited Oct. 17, 2013).
[107] *See Id.*
[108] *Id.*
[109] *Id.*
[110] Salinsky, *supra* note 104, at 7.
[111] News Release, US Department of Health & Human Services, Approximately $40 Million in Affordable Care Act Funds for Statewide Chronic Disease Prevention Programs (June 7, 2011), *available at* http://www.hhs.gov/news/press/2011pres/06/20110607a.html.
[112] Katz et al., *supra* note 8, at 5.

their locations in wealthy counties as whole—like Somerset, New Jersey.[113] So long as Somerset is not classified as an MUA, for example, no FQHCs can be placed there. In Little Rock, Arkansas, the presence of four large tertiary care hospitals give the appearance of sufficient provider capacity, even though the community reportedly lacks outpatient providers to serve its large low-income population.[114] Similarly, in Florida, although roughly one million individuals lived (as of 2006) in areas designated as an MUA or MUP, many others in the state did not live in a federally designated area but had the same degree of difficulty in accessing healthcare services.[115] Such individuals generally live in affluent areas—with many physicians and healthcare resources—but cannot access services because they are poor or uninsured.[116]

Because the MUA/MUP requirement was adopted to determine grantee eligibility for FQHCs in 1975, one critic claims it fails to provide an up-to-date perspective on current health needs.[117] Although much has changed since the 1970s, updates for the MUA/MUP designations are not required and apparently do not frequently occur.[118] Indeed, HRSA has estimated that approximately 50% of MUA/MUP designated areas would lose their designations if more current data were used to assess compliance with the existing designation criteria.[119] Orange County, California, for example, used census data to determine and document demographic shifts among clinic neighborhoods throughout the county but still struggled in some cases to meet formal MUA definitions.[120] High-need communities are difficult to identify, and given the low provider acceptance rates of Medicaid patients that are not addressed by the ACA, this challenge will continue even in a reformed healthcare landscape.

On top of the questions relating to their validity, MUA/MUP designations add unnecessary complexity to an already burdensome process. Relevant data requirements are substantial, and communities are required to pursue these MUA/MUP designations on their own.[121] In addition to strenuous research,[122] the process includes the submission of a designation proposal to the federal government and awaiting its response.[123] This phase alone may take a long time to complete, often resulting in a two year delay in the application process.[124]

C. The Impact of Reform on MUA/MUP Designations

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[113] *Id.*
[114] *Id.*
[115] ERIN SOLOGAISTOA, COMMUNITY HEALTH CENTERS IN FLORIDA 18 (2006), *available at* http://www.fachc.org/pdf/cd_FACHC%20Guide%20to%20Florida%20CHCs%20Final.pdf.
[116] *Id.*
[117] *See* Salinsky, *supra* note 104, at 7.
[118] *Id.*
[119] *Id.*
[120] Katz et al., *supra* note 8, at 5.
[121] STATE OF MARYLAND, DEP'T OF HEALTH AND MENTAL HYGIENE, JOINT CHAIRMEN'S REPORT ON THE FEASIBILITY OF FEDERALLY QUALIFIED HEALTH CENTERS IN EVERY MEDICALLY UNDERSERVED AREA IN MARYLAND (2009) *available at* http://www.msa.md.gov/megafile/msa/speccol/sc5300/sc5339/000113/012000/012731/unrestricted/20100608e.pdf [hereinafter *Joint Chairman's Report*].
[122] *See* Thomas C. Ricketts, III, *et al.*, *Designating Places and Populations as Medically Underserved: A Proposal for a New Approach*, 18 J. OF HEALTH CARE FOR THE POOR AND UNDERSERVED 568 (2007).
[123] *Id.*
[124] *Id.*

Given the complexity of the access issues relevant to the ACA already addressed in this paper, MUA/MUP designations only stand to lose additional relevance in the future. Obtaining affordable access to health care is no longer a problem confined to the most impoverished classes; the middle class also struggles to access health care. Indeed, the 16 million additional citizens expected to be eligible for health insurance under Medicaid in January 2014 are primarily those with low incomes but above the FPL.[125] An increasing number of patients with incomes over 200% of the FPL are flocking to health centers.[126] Thus, the "100 percent of FPL" figure will continue to lose relevance in the calculation of MUA/MUP designation.

Furthermore, the existence of providers in a given area does not necessarily indicate that the area is adequately served. MUA/MUP designations rely heavily on measures of physician supply relative to the size of a local population to assess geographically available care.[127] Yet although providers may be located in any given area, a significant amount of providers are no longer accepting any new Medicaid patients, meaning that practically every county has had or will have a high need. FQHCs are needed in these areas but would likely fail to meet HRSA's current designations.

Rather than having the federal government screen out deserving areas, HRSA should allow individual FQHCs to make a case for need in their respective areas. To clarify, this proposal is not intended to subvert prior emphasis on serving high-need communities, nor should it effectuate such a result. The seemingly imprecise and burdensome MUA/MUP process has lost function and credibility in this new era of health reform, and it will only continue to decline given the increasingly complex access issue our country now faces. Hindering access points with archaic methodologies, as these designations do, counteract the efforts set forth by the ACA.

D. Alternative Gatekeepers

Proponents of HRSA designations may argue that if the requirements were shed, FQHCs would crop up in prosperous areas where little need exists. However, numerous alternative gatekeepers already effectively augment the FQHC qualification process. First, each FQHC must perform a needs assessment when seeking qualification. To apply for FQHC status, each health center must demonstrate and document the needs of its target population and update its service area when appropriate.[128] Applicants must document: the need for primary care services in their area, their plan for addressing these needs, the history and clinical capacity of their organizations, the environment of the communities they serve, and provide detailed budget and staffing information.[129] Here, health centers may still make a case for poverty levels, disparity factors, physician shortages, unemployment, and/or lack of health insurance, just as they would under the MUA/MUP designations. The only difference is that receiving a score of 63 on the MUA/MUP analysis because of an anomalous community feature—like tertiary care

[125] McMahon, *supra* note 73.
[126] *A Turnkey Solution*, *supra* note 21, at 3.
[127] Salinsky, *supra* note 104, at 4.
[128] 42 U.S.C. § 254b(k)(2)–(k)(3)(J) (2012).
[129] *How to Apply: Health Center Program Grant Funding*, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, http://bphc.hrsa.gov/about/howtoapply/index.html.

hospitals, for example—would not necessarily prevent a health center from acquiring FQHC status.

Second, the process is incredibly competitive. Numerous applications are received annually, but only so much funding is available in a given cycle.[130] Between 2004 and 2008, only 17% of applications for FQHC status were granted.[131] In 2011, 900 proposed centers applied for funding, and only 70 were approved.[132] Competition based on information from each individual application, rather than HRSAs screening process, will allow the Federal government to consider more communities in counties, like Somerset, based on how a particular health center compares with others applying in that same cycle. The process would be more competitive, and only funding would limit FQHC status approval, rather than broken qualification designations. Federal funding has increased with healthcare reform, while MUA/MUP designations have not.

Importantly, many other aspects of the application process may adequately replace the MUA/MUP designations as gatekeepers. Given that chasing FQHC status is regarded as not being for the "faint-hearted,"[133] the burdensome process alone would deter health centers that deem themselves less worthy of FQHC qualification after self-assessment. Indeed, few would spend the requisite time and resources on the application process if they felt they possessed a lukewarm case for qualification. FQHC applicants are also required to produce a statement of interest from the local community to establish an FQHC, including letters of support from the nearest FQHC and from the state Primary Care Association. Because it is difficult to gather uninformed or feigned community support from these entities, little doubt exists that they could serve as adequate gatekeepers. Thus, the FQHC process will not be hindered by the absence of the MUA/MUP designation requirements. Revising the application process in this manner will make way for more qualified FQHCs, designed to meet the triple aims of reform to serve communities in need.

CONCLUSION

The future of healthcare delivery in the United States is uncertain. Successful healthcare reform is tied to lowering barriers, enhancing primary care, and maintaining a strong network of safety net providers. Money is and always will be tight, but if the government is serious about addressing the access problem, dollars are well spent on cost-efficient FQHCs. FQHCs are not quite ready to shoulder increased burdens, and money alone will not solve the problem. In achieving the ACA's goal of increasing access to healthcare, the potential of health centers to ameliorate the disconnect between

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[130] *See* AM. DENTAL ASS'N, FREQUENTLY ASKED QUESTIONS ABOUT FEDERALLY QUALIFIED HEALTH CENTERS AND THEIR ORAL HEALTH PROGRAMS *(2011), available at* http://www.ada.org/sections/advocacy/pdfs/faq_fedqual_healthctrs.pdf (stating that individual health centers compete for 330 grant funds generally every five years, and that these grant funds are finite and usually comprise about 15-25% of the overall health center funding).

[131] *Joint Chairman's Report*, *supra* note 121, at 5.

[132] Beth Fitzgerald, *The Race to Build More Federally Funded Health Centers in New Jersey*, NJ SPOTLIGHT, Jan. 13, 2012, http://www.njspotlight.com/stories/12/0112/2340.

[133] CALIFORNIA HEALTHCARE FOUNDATION, THE CLINIC'S TALE: CHASING FQHC STATUS NOT FOR THE FAINT-HEARTED (2012), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20ClinicsTaleChasingFQHCStatus.pdf.

coverage and access renders FQHCs essential players in healthcare reform. Given their importance, the process of qualification needs to change to expand the safety net and accommodate new methods of healthcare delivery.