

Frequently Asked Questions about Federally Qualified Health Centers and their Oral Health Programs

What is a Federally Qualified Health Center (FQHC)?

Health centers are community-based and patient-directed organizations that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing.¹

A FQHC is defined by the Medicare and Medicaid statutes.² FQHCs include all organizations receiving grants under [section 330 of the Public Health Service Act](#),

What are the benefits of being an FQHC?

- Section 330 grant funds to offset the costs of uncompensated care and enabling services (i.e. education, translation and transportation, etc)
- Access to medical malpractice coverage under [Federal Tort Claims Act](#) (FTCA)
- Enhanced Medicare and Medicaid Reimbursement
 - Prospective Payment System reimbursement for services to Medicaid patientsⁱ
 - Cost-based reimbursement for services to Medicare patients
- Drug Pricing Discounts for pharmaceutical products under the [340B Program](#)
- Access to on-site eligibility workers to provide Medicaid and CHIP enrollment services
- Access to [Vaccines for Children Program](#) for uninsured children
- Access to [National Health Service Corps](#) (NHSC) medical, dental, and mental health providers
- National Association of Community Health Centers committed to improving the mission of health centers ([NACHC](#))³

What are the fundamental elements of a health center?

- Located in or serve a high need community (designated Medically Underserved Area or Population) or specific high-risk target population. [Find MUAs and MUPs](#)
- Governed by a community board composed of a majority (51% or more) of health center patients who represent the population served. [More about health center governance](#)
- Provide comprehensive primary health care services as well as supportive/enabling services that promote access to health care.
- Provide services available to all with the availability of a [sliding fee scale](#) adjusted based on ability to pay (family size and income) for those individuals living at 200% or below of the [federal poverty level](#). Patients over 200% poverty pay full fee, which are set by the health center to align with the area's average fees.
- Meet other performance and accountability requirements regarding administrative, clinical, and financial operations.

¹ For purposes of this document, the term *Federally Qualified Health Center* will be used to designate only federally funded facilities participating in the Consolidated Health Centers program run by the Federal government's [Bureau of Primary Health Care](#) (BPHC), within the [Health Resources and Services Administration](#) (HRSA) of the [Department of Health and Human Services](#) (DHHS). Other facilities that do not receive section 330 funds – such as FQHC Look-alikes and centers that receive only local and state funds – are not included under this definition. FQHCs are commonly known and recognized in federal legislation as *Health Centers*.

² These statutes are within sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.

³ NACHC has published a guide, *So You Want to Start a Health Center: A Practical Guide for Starting a Federally Qualified Health Center*, which is available online at http://www.nachc.com/client/documents/publications-resources/05_start_chc.pdf

Who do health centers serve?

- **People of all ages.** Approximately 33 percent of patients in 2009 were children (age 18 and younger); about 7 percent were 65 or older.⁴
- **People without and with health insurance.** The proportion of uninsured patients of all ages was approximately 38% in 2009; the number of uninsured patients increased from 4 million in 2001 to over 7.2 million in 2009.
- **People of all races and ethnicities.** In 2009, 27 percent of health center patients were African-American and 35 percent were Hispanic/Latino--more than twice the proportion of African-Americans and over two times the proportion of Hispanics/Latinos reported in the overall U.S. population.
- **Special populations.** In 2009, health centers served nearly 865,000 migrant and seasonal farm workers and their families; more than 1 million individuals experiencing homelessness; and more than 165,000 residents of public housing.

Health Center Population vs. U.S. Population (2009)

	Health Center Program	U.S. Population*
Percent by income level		
At or below the Federal Poverty Guidelines	71.4%	14.3%
At or below 200% of the Federal Poverty Guidelines	92.5%	33.0%
Percent by Insurance Status		
Uninsured	38.2%	16.7%
Medicaid	37.1%	15.7%
Medicare	7.3%	14.3%
Percent Known Ethnicity		
Hispanic/Latino	34.9%	16.0%
Not Hispanic/Latino	65.1%	84.0%
Percent Known Race		
White	62.0%	80.0%
Black/African American	26.8%	13.0%
Asian	3.3%	5.0%
Native Hawaiian/Pacific Islander	1.2%	0.0%
American Indian/Alaska Native	1.5%	1.0%
More than one race	5.3%	2.0%

<http://www.hrsa.gov/data-statistics/health-center-data/NationalData/2009/2009datasnapshot.html>

⁴ The number of seniors served by health centers is growing. Due to Medicare eligibility, this group does have more “options” for care, but having an interdisciplinary “one stop shop” for their health care needs is very attractive.

What are the different types of health centers?

- **Grant-Supported Federally Qualified Health Centers** are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs and receive funds under the Health Center Program (Section 330 of the Public Health Service Act).
 - **Community Health Centers** serve a variety of underserved populations and areas.
 - **Migrant Health Centers** serve migrant and seasonal agricultural workers
 - **Healthcare for the Homeless Programs** reach out to homeless individuals and families and provide primary care and substance abuse services.
 - **Public Housing Primary Care Programs** serve residents of public housing and are located in or adjacent to the communities they serve.
- **Federally Qualified Health Center Look-Alikes** are health centers that have been identified by HRSA and certified by the Centers for Medicare and Medicaid Services as meeting the definition of “health center” under Section 330 of the PHS Act, although they do not receive grant funding under Section 330.
- **Outpatient health programs/facilities operated by tribal organizations** (under the Indian Self-Determination Act, P.L. 96-638) or urban Indian organizations (under the Indian Health Care Improvement Act, P.L. 94-437).

How long have FQHCs been around?

The Community Health Center program was established in 1975 and authorized under section 330 of the Public Health Service Act.

How many FQHCs are there and how many provide dental services?

In 2009, there were 1,131 health centers and about 75% of those centers provided on site dental services. These health centers served 18,753,858 individuals for medical, dental and behavioral health services. In 2009, 3,438,340 patients received dental care during 8,401,705 visits. These services were delivered by 2,577 dentists and 1,018 dental hygienists.

For additional information on the Uniform Data System summary compiled annually by HRSA, see <http://www.hrsa.gov/data-statistics/health-center-data/NationalData/2009/2009nattotsumdata.html>.

What portion of oral health professionals work within FQHCs?

Approximately 2% of the current dental workforce provides care within FQHCs with 69% of health center dentists participating in organized dentistry.

Can FQHCs contract with private dental practitioners to provide dental services?

Yes. In 2009, the U.S. Congress determined that federally supported health centers (FQHCs and “Look Alikes”) may contract with private dentists to provide dental services to health center patients in the dentists’ private offices. This determination resolved controversy over the allowability of this practice, thereby encouraging adoption of contracting as an important approach to increasing dental care for underserved populations.

For additional information, see http://www.cdhp.org/resource/FQHC_Handbook

Must a FQHC be located in a federally designated health professional shortage area (dental HPSA) in order to offer dental services to their patients?

No. Health centers strive to offer an interdisciplinary approach to patient care and a [health professional shortage area designation](#) is not a pre-requisite for providing medical, dental and/or behavioral health

services. A dental HPSA is a separate designation that reflects the number of dentists in a specified area to the number of patients. In some circumstances, it can also reflect the number of *full time equivalent* dentists who provide dental services to a specific population, such as Medicaid eligible individuals.

If a health center dental program is fully staffed, in conjunction with the private practice dentists in an underserved area, the ratio of dentists to eligible population may be met and the dental shortage area would not be designated. HPSAs are usually re-evaluated every three or four years, unless circumstances warrant a more immediate evaluation. These designation requests are usually compiled by [state health department primary care offices](#) with assistance from [state primary care associations](#) and sometimes [state dental associations](#).

Dental HPSAs are especially relevant to health centers as they are an essential determinant in determining whether loan repayment incentives can be utilized in recruitment and retention of dental providers. For more information on HPSAs, see <http://bhpr.hrsa.gov/shortage/>. For information on federal and state loan repayment incentives, see <http://nhsc.hrsa.gov/loanrepayment/> and <http://nhsc.hrsa.gov/loanrepayment/state.htm>.

What is the scope of dental services provided in federally funded health centers?

The federal statute governing health centers requires these facilities to provide dental screenings to determine the need for dental care and the delivery of preventive dental services. The last federal oral health guidance for health centers was issued in March 1987. However, the HRSA guidance governing the section 330 grant process uses the statutory authority given the DHHS Secretary to expand the definition of primary oral health care to include not only prevention, education, and emergency care, but also basic restorative and basic rehabilitative services that replace missing teeth. This is commonly referred to as providing comprehensive primary oral health services.

Health centers encourage the use of quadrant dentistry in order to complete treatment plans in a timely manner. Health centers are likewise encouraged to maintain efficiency, effectiveness and productivity through adequate numbers of operatories per dentist (3:1) and numbers of dental assistants per dentist (roughly one assistant per operatory).

Health centers understand the importance of oral health as an essential component of primary health care and strive to integrate oral health into general health. This interdisciplinary approach to patient care allows health center providers to better handle the more complex/chronic problems that underserved populations present with.

Does this lack of current HRSA oral health guidance affect health center dental programs?

The last official HRSA oral health guidance to health centers was issued in March 1987. In the absence of such guidance and the lack of technical assistance that formally had been provided by regional dental consultants, it has become painfully clear that FQHC executive directors and fiscal officers are often the principal guides and mentors for the increasing number of new dental graduates who are desperately trying to provide leadership within their health centers. As well meaning as these administrators are, they cannot provide the expertise needed to ensure that these dental programs are sustainable and efficient.

The lack of direction is evident as a growing number of dental programs face sustainability issues. While not the norm, some health centers allocate federal grant dollars solely to medical programs, while dental programs are expected to be self-sustaining. Others advocate *churning* (doing one procedure per encounter) as a means to maintain financial viability, while not acknowledging the inherent ethical concerns and hardship to the patient.

What are the revenue sources for FQHCs?

The revenue or sources of funds for the health centers are split among federal 330 grant funding, Medicaid and Medicare reimbursements, state and foundational grants, and self-pay/insurance.

Are individual health centers able to access unlimited federal 330 grant funds?

No. Individual health centers compete for 330 grant funds generally every five years. These grant funds are finite and usually comprise about 15 to 25% of the overall health center funding.

Can health centers accept self-pay or private insurance patients?

Yes. This funding source generally accounts for 5-7% of overall health center funding. Patients have a choice in where they seek health care. In many of these private insurance cases, it is often a matter of continuity of care. For example: an individual loses their job with dental insurance at a local meat packing plant and brings the family to the health center for health care (medical, dental and behavioral health). After three years, the plant reopens and dental insurance is reinstated. Continuity of care is prized by all health professionals. As the family was satisfied with the quality interdisciplinary care delivered by the health center, they opt to remain patients of the organization. These private insurance dollars actually supplement the finite 330 grant dollars available for supporting sliding fee scale patients, so the health center is actually able to see more underserved patients by virtue of this diverse funding stream.

Allowing for such a payer mix is critical in assuring that the dentists who work in FQHCs can provide a broad array of services and remain competent in all areas of dentistry. It affords these dentists opportunities to continue to utilize all of the skills they were trained to perform.

What is the ADA doing to promote greater collaboration between dentists working in health centers and those working in private practice?

The ADA is working to increase the familiarity of dentists working in private practice with those working within FQHCs. There are more similarities than differences between these two practice models. To promote this growing familiarity, the ADA recommends:

- There should be a dentist on every health center board of directors to provide guidance and insight.
- Experienced private practitioners could regularly mentor inexperienced dental directors.
- New graduates looking to build their own private practices could work part-time within health centers, securing loan repayment while gaining experience within an interdisciplinary approach to patient care.

To this end, *The ABCs of FQHCs* is a free continuing education course offered by the Council on Access, Prevention and Interprofessional Relations at the 2009, 2010 and 2011 ADA Annual Sessions to encourage greater appreciation of health center dental programs. Similar education modules are being developed for use within state and local dental societies. State dental associations have been encouraged to collaborate with state primary care associations, which advocates on behalf of health centers. Acting together within the parameters of a state oral health coalition, state dental associations and state primary care associations can be more effective advocates for their constituents and the patients they serve.

Health centers are not *islands unto themselves*. They are a vital part of the dental public health safety net. There is a role for increased collaboration among dentists working in health centers and those working within private practice. Working together, these dentists can strengthen the dental public health infrastructure to better meet the oral health needs of the underserved within their communities.

In summary, how does a FQHC compare to a private dental practice?

Similarities

- All dental facilities, like all businesses, must remain financially viable. According to the previous HRSA Administrator, Dr. Elizabeth Duke, about 4% of health centers experience financial difficulties at any point in time. Although a similar figure is not available for private practices, it would be safe to assume that financial difficulties are universally a problem for all businesses.
- Both have payrolls to meet, while ensuring that quality care is delivered. Both are concerned about enough patients coming through the door.
- All dental facilities have to deal with the usual assortment of regulators, such as the Occupational Safety and Health Administration, the Environmental Protection Agency and others.
- Providing a broad complement of services to patients assures that the skills and competencies of the dentist are maintained.

Differences

- Dental clinics within federally funded health centers are subject to audits by federal reviewers to review the types of patients seen, the treatment delivered and the appropriateness of care. Noncompliance with program requirements (such as the types of services the health center is required to provide and health performance measures) must be remedied pursuant to an action plan with timetables for completion developed by the reviewers.
- In addition to seeing all patients living at or below the federal poverty level (FPL) regardless of ability to pay, federally funded health centers are expected to provide case management, translation services, and transportation assistance.
- The center's fee schedule should be consistent with the private sector rates in the geographic area in which the health center resides.
- The health center must provide a sliding fee scale for individuals living at or below 200% of the FPL, which is based on family size and income.
- About one in three health centers is accredited by The Joint Commission pursuant to which they receive additional on-site monitoring.

Observations

- Federally funded health centers receive 15 – 25% of their resources from their federal 330 grant, which is designed to offset the cost of providing care to the poor uninsured, which clearly private practices do not receive. Such health centers also can possibly offer new dentists NHSC loan repayments and they all have access to the Federal Tort Claims Act program for malpractice coverage, and have access to the program for discount drugs.
- Health centers have the Prospective Payment System (PPS) compensation rate, which is different from the Medicaid payments system established for private practitioners. PPS reimburses on a rate based per encounter and the national average PPS rate for health centers is about \$110. However, some centers opt for an alternative method of payment that is negotiated with the state. It is difficult to compare the average Medicaid rates received by private practice dentists under Medicaid and the average PPS rate.

ⁱ The Consolidated Appropriations Act, P. L. 106-554, incorporates the text of Medicare, Medicaid and Children's Health Insurance Program (CHIP) Benefits Improvement Act of 2000 (BIPA, H.R. 5661) that includes section 702: New PPS for FQHCs and rural health clinics (RHCs). This section repeals the Balanced Budget Act (BBA) of 1997 that would have phased-out the reasonable cost based reimbursement system found in section 1902(a)(13)(C) of the Social Security Act. In its place, the new law establishes a prospective payment methodology to guarantee health centers a minimum per visit payment for services provided to Medicaid beneficiaries.

For Medicaid services provided between January 1, 2001, and September 30, 2001, States are required to reimburse FQHCs and RHCs at 100 percent of the average costs of providing FQHC and RHC services to Medicaid beneficiaries for the 2 previous FYs (1999 and 2000) with adjustments made for changes in the scope of services

provided by the FQHC and RHC. Payment amounts are calculated on a per visit basis. For FY 2002 and years thereafter, FQHCs and RHCs will be reimbursed based on the previous year's payments, increased by that year's Medicare Economic Index for primary care and adjusted for changes in a FQHC's and RHC's scope of services.

Those FQHCs and RHCs that are established on or after January 1, 2001, in their first year will be reimbursed in an amount equal to 100 percent of costs for providing Medicaid services. Costs are determined based on rates established by the prospective payment methodology for other FQHCs and RHCs located in the same or adjacent area with a similar caseload. In the absence of such a center or clinic, a newly established FQHC or RHC clinic will be reimbursed in accordance with the prospective payment methodology or on other tests of reasonableness as the Secretary of Health and Human Services may specify.

For those FQHCs and RHCs working within managed care arrangements, BIPA maintains the "wrap-around" payments established by the BBA. The FQHCs and RHCs will receive supplemental payments from the State for the difference between the amount they would have received under the prospective payment methodology and the amount received under contract with the managed care organization. Supplemental payments must be made pursuant to a payment schedule agreed to by the State and the FQHC or RHC and in no case may occur less frequently than every 4 months.

A State may use an alternative payment methodology to reimburse FQHCs and RHCs for services rendered to Medicaid beneficiaries as long as such an alternative methodology reimburses FQHCs and RHCs no less than the amount that they would be reimbursed using the prospective payment methodology and (2) the health center agrees to that methodology.

The law requires the Comptroller General to initiate a study on how to rebase or refine cost reimbursement methodologies for services to FQHCs and RHCs within the fourth year after enactment.

For additional information on Prospective Payment System, see <http://bphc.hrsa.gov/policy/pal0109.htm#newpps>

Revised: March 2011 (Spangler/Geiermann)