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Compliance considerations in the organization and operation of Federally Qualified Health Centers

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The designation "FQHC" is assigned by the federal Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) and the Centers for Medicare & Medicaid Services (CMS) to private nonprofit or public healthcare organizations that serve predominantly uninsured or medically underserved populations, in accordance with the Health Center Program authorized by Section 330 of the Public Health Service (PHS) Act.[1] Once designated as an FQHC, certain Medicare and Medicaid payment methodologies are applied to the center's reimbursement, and other benefits (e.g., 340B Drug Program eligibility) can be pursued.

FQHCs must comply with Section 330 program requirements and all applicable state and federal regulations. FQHCs are required to be located in or serve a federally designated Medically Underserved Area or Population (MUA or MUP). All FQHCs must be governed by a consumer board of directors and provide comprehensive primary health services to persons in all stages of life. FQHCs must offer their services to all persons regardless of ability to pay and charge for services on a board-approved, sliding fee scale based on patients' family income and size.

Section 330 program requirements

Section 330 refers to a section of the Public Health Service Act that defines federal grant funding opportunities for organizations to provide care to underserved populations. FQHCs must meet all applicable Section 330 requirements, including the following.

Governance requirements

In order to obtain/maintain FQHC status, an organization seeking FQHC status must maintain a governance structure that complies with each of the Section 330 governance requirements.[2] Section 330 requires all FQHC boards to have a majority of consumer members who are served by the FQHC and who reasonably represent the individuals served by the FQHC in terms of demographic factions (e.g., ethnicity, race, sex). To be considered "served" by the FQHC, the board member must be a current registered patient of the FQHC and have accessed the FQHC in the past 24 months to receive at least one in-scope service that generated the visit.[3] Non-consumer members are selected from professional fields present in the community, such as legal, financial, healthcare, and social services. No more than half of the non-consumer members can earn more than 10% of their income from the healthcare field.[4]

The FQHC governing board must have between nine and 25 members. Employees and their relatives (e.g., spouses, children, parents, siblings) are ineligible to serve on the board. FQHC bylaws must prescribe specific methods for selecting new board members. FQHC boards have legal and fiduciary responsibilities for clinic operations and grants, must perform periodic strategic planning, and evaluate progress toward organizational goals. Specifically, the board must meet at least once a month, select services to be provided by the FQHC,

schedule the hours during which services will be provided, and approve the selection of a director for the FQHC.[5]

Mission and strategy requirements

The mission of all FQHCs must include the improvement of the health status of underserved populations in their targeted service area. FQHCs must assess the needs of the community and populations that they serve and document such an assessment. After setting up the services, FQHCs must measure the effectiveness and quality of services provided. They must collaborate with other healthcare providers, such as specialty providers, hospitals, and other social service agencies.[6]

Health services requirements

FQHCs must provide the following services, either directly or through a written contractual arrangement: primary care; dental; mental health; substance abuse; diagnostic lab and X-ray; prenatal and perinatal; cancer and other disease screening; blood level screenings (e.g., lead levels, communicable diseases, and cholesterol); well child services; child and adult immunizations; child eye and ear screening; family planning; emergency medical; pharmaceutical; case management; outreach and education; eligibility and enrollment services; transportation and interpretation; and referrals to specialty providers and hospital services.

FQHCs must provide all patients with a "continuum of care." This means that patients have access to all required services, access to specialty and hospital services, and after-hours coverage. Hours of operation must encourage access to care by having some early morning, evening, or weekend hours. FQHC healthcare providers must ensure the appropriate mix of services for the target population. Also, FQHCs must consider the mix of services already available to patients through other providers to minimize the duplication of services and maximize the efficient use of their financial resources. If FQHCs do not directly provide required services, they must have written agreements with other providers for those services.

All FQHCs must have a medical director who supervises all clinical activities, and medical doctors who are licensed and residency-trained. Other clinicians must have appropriate licensure. Also, all FQHCs must establish policies and procedures for hours of operation, patient referral and tracking, use of clinical protocols, risk management, procedures, patient satisfaction assessment, a consumer bill of rights, and a patient grievances process.[7]