



The Clinic's Tale: Chasing FQHC Status Not for the Faint-Hearted

IN 1967, A YOUNG, CALIFORNIA-TRAINED physician from Jamaica threw himself into saving a struggling health clinic operating out of an old furniture store near the edge of Watts in Los Angeles. Dr. Bassett Brown's hard work and determination in the aftermath of the riots that swept the area — and through the intervening years — helped ensure basic health care services for generations of working poor and dispossessed in a 71-square-mile area of Los Angeles County.

The Central Neighborhood Health Foundation today remains an essential cord in the health care safety net of the county. And its future appears secure, despite the precarious nature of funding for the uninsured and the unrelenting needs of the clinic's target population. Yet the organization's survival until recently was very much in doubt.

Ironically, it was a federal program designed to ensure the financial health of community centers like Central Neighborhood that nearly triggered the clinic's demise. Known as the Federally Qualified Health Center program (FQHC), the initiative channels state and federal dollars to health care entities that provide a disproportionate share of services to Medicaid patients and the uninsured. In California, nearly three million individuals are treated annually at more than 1,000 locations by the state's 118 federally supported health centers.

The program has long been viewed as a panacea of sorts by inner-city clinics and represents a powerful bulwark for stemming the erosion of uninsured care funding. But as Central Neighborhood

quickly learned, achieving FQHC status can spawn unexpected administrative and financial problems and, in and of itself, provides no guarantee of financial stability.

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— BASSETT BROWN, MD
CENTRAL NEIGHBORHOOD HEALTH FOUNDATION

“The devil truly is in the details, especially after you've been approved as an FQHC,” said Steven Rousso, a senior principal and co-founder with HFS Consultants in Oakland, California. “There is no handbook for all the requirements and tasks, and no instructions. So if you don't have the expertise or don't get it from someone who does, you are almost certainly going to get in trouble.”

Financial Morass

Rousso last year helped extract Central Neighborhood from a financial morass that threatened to swallow the clinic after it was certified as a so-called FQHC Look-Alike in August 2010. Missed opportunities, faulty filings, and other administrative miscues resulted in total underpayments to the clinic of between \$500,000

and \$750,000 over a 16-month period and brought the clinic to the brink of closing.

Brown, Central Neighborhood's founder and current chief executive officer, now 75, acknowledges that administrative shortcomings contributed to the difficulties the organization faced as it transitioned to FQHC Look-Alike status. But he says the process of applying for FQHC designation and then operating under the program's guidelines would have been trying under the best of circumstances.

"If we had more resources, if we had more knowledge, if we had more time, I'm sure we could have done this in a more thoughtful, deliberate, and effective way," he said. "But it was, in fact, a very difficult process and a steep learning curve. So we were left scrambling to put out fires left and right just to keep the organization alive."

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— BOBBIE WUNSCH
PACIFIC HEALTH CONSULTING GROUP

Consultants like Rousso and others underscore that the FQHC program remains an essential tool for meeting the health care needs of the underserved in California and nationwide. But they also agree that the federal program's sometimes convoluted requirements, coupled with similarly elaborate — and often duplicative — state demands, can test even the most sophisticated organizations.

"FQHCs are an extremely complex corner of an already complex system," said Bobbie Wunsch, founder and partner of San Anselmo, California-based Pacific Health

Consulting Group, a firm that provides management consulting to public sector health care entities.

"Keeping up with the reporting requirements is a constant struggle, and I don't think there is anyone who would dispute that the system is far too complicated. But the reality is that everybody has their own rules. And everybody wants them followed."

A Model Community Clinic

The origins of the health center date back to the 1920s, when it was opened by a Baptist church group to provide care for Southerners coming to Los Angeles in pursuit of work. But the organization fell on hard times after the Watts riots of 1965. Brown, then a recent grad of Loma Linda University School of Medicine, was working as an emergency medicine intern at nearby Los Angeles County General Hospital in 1967 when he responded to a plea for help from the clinic.

Brown quickly found his calling providing care to the underserved and acquired what few assets the clinic owned in a non-cash transfer designed to keep the doors open. The physician was able to stabilize the clinic and, in short order, introduced new capabilities, including lab services and an x-ray machine. The construction of a modern, 9,000-square-foot medical arts building — half of which Brown financed himself — was completed in 1970. For many, the clinic's rebirth was seen as emblematic of the hoped-for recovery for Watts. The assistant U.S. surgeon general was among the dignitaries present for the grand opening ceremonies.

Through the years, Brown continued to strengthen and expand services for the largely Hispanic and Black populations in the area. The practice grew to 10 full-time primary care doctors, and specialist clinics were conducted on a regular basis. At its peak in the mid-1970s, Central Neighborhood employed over 100 and was seeing more than 300 patients a day. A visiting nurse program was developed to provide follow-up care in the home.

A Changing Financial Landscape

The road the clinic traveled from a funding standpoint, at least in the early years, was relatively smooth. The newly created Medi-Cal program provided strong support, and a separate, prepaid contract from the state for indigent care — one of the first in California — lent further sustenance. But by the early 1990s, changes in the Medi-Cal program that essentially inserted subcontracting IPAs and managed care companies between the state and community providers had the effect of spawning new competition and diluting funds available for care. In an attempt to adapt, the clinic entered into an arrangement with Blue Cross to provide Medi-Cal managed care services. But the partnership was ill-suited.

The net result was that Central Neighborhood lost many of its patients to other providers, and the clinic's capitation rate — which had been \$25 per member per month — tumbled to \$15. Because the clinic operated as a for-profit entity, grant funding was unavailable.

“Our patient load was dropping, so we had to let doctors and personnel go, one by one,” Brown said. “Everything was dying on the vine, and we realized that ultimately the only way we were going to survive was to convert from a for-profit to a nonprofit and become an FQHC. But we knew it would take time.”

330s and Look-Alikes

The forerunner of today's FQHC program, the federal community health initiative was established in the 1960s to provide federal grants to clinics located in medically underserved areas and treating patients regardless of their ability to pay. Two other qualifications for community health centers were codified under Section 330 of the Public Health Service Act: The clinic also was required to provide a detailed scope of primary health care and supporting services, and it had to be governed by a majority of community members who represented the population served.

Federal community health centers originally were complementary to — and independent of — the state-federal Medicaid program. But that separation ended in 1989 when Medicaid revenues were harnessed to bolster the federal grants. Medicaid dollars thus became the primary source of funding for community health centers.

The Omnibus Budget Reconciliation Act of 1989 also drew a distinction between Federally Qualified Health Centers (known as 330s after the defining section of the Public Health Service Act) and FQHC Look-Alikes. The key differences were that, unlike 330s, Look-Alikes were not eligible for federal grants, nor could they take advantage of free malpractice coverage or gain special safe harbor protection under federal anti-kickback provisions.

Otherwise, both 330s and Look-Alikes were entitled to cost-based reimbursement calculated from allowable health center costs in lieu of standard Medicaid and Medicare fee-for-service rates. The cost-based rates allowed FQHCs to pay for fixed and variable overhead and infrastructure costs, in addition to primary care services, and proved a major financial boon for many clinics. But by 1999, cost-based reimbursement was deemed inflationary and was replaced by a prospective payment system (PPS). This approach nonetheless continued to take into account clinic overhead expense, and Look-Alikes and 330s consequently were able to maintain significantly higher per-visit rates than the Medicaid fee-for-service reimbursements paid to non-FQHC providers.

Chasing FQHC Status

It was that prospect of a major bump in cash flow — from \$18 per basic Medi-Cal visit to a projected \$155 — that drew Central Neighborhood Health Foundation to the FQHC program. The clinic had struggled financially through much of the 1990s, and Brown worked to sustain it with ever-increasing personal financial contributions and loans. But the situation continued to worsen, and pursuit of FQHC designation consequently

began in earnest in 2004. At the suggestion of a colleague, Brown was able to recruit a group of graduate students from the University of California, Los Angeles School of Public Health to assess the clinic's readiness for meeting the requirements of the FQHC program.

The grad students' 215-page report was finished in late 2004 and largely confirmed that, assuming the clinic's successful conversion to nonprofit status, Central Neighborhood was well-positioned to take advantage of the FQHC program. However, the authors warned that the clinic's documentation of clinical policies and processes needed to be strengthened to meet FQHC requirements. Administrative and financial management capabilities also were deemed deficient. Numerous policies and procedures, the report said, "were found to lack the detail required to sufficiently and successfully maintain the accounting system, including billing, credit, and collection processes." The center further lacked "adequate internal controls that should ensure fiscal integrity of financial transactions and reports."

Brown said the clinic attempted to make the necessary management and financial reporting changes recommended in the report. "We understood that we needed to beef those areas up," Brown said. "But cash flow was tight and it was difficult to take all the steps we needed to."

Complicating the run-up to submission of the FQHC application was the need to simultaneously convert the clinic's organizational structure from for-profit to nonprofit. The transfer of assets and contracts, including a critically important county contract for indigent care awarded in 2005, effectively required the simultaneous operation of two parallel businesses for an extended period of time.

Central Neighborhood also had to secure licensure and certification as a primary care clinic from the California Department of Public Health (CDPH) before becoming an FQHC. Like the federal application, the state process took time and effort to complete.

As part of the FQHC application process, Central Neighborhood was required to obtain letters of support from other FQHCs operating in the same area. But of the five L.A.-area clinics that Brown approached, only one agreed to provide a letter to federal regulators on Central Neighborhood's behalf.

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"They were fearful of competition, but it was an insane fear," Brown said. "I've been in the community for more than 40 years, longer than any of them. It came down to the fact that they perceived us to be a competitive threat. But the truth is, all of us together can barely put a dent in the overall need here. So that was very disappointing."

Central Neighborhood ultimately submitted its inch-and-a-half-thick FQHC application, in triplicate, in March of 2009. "It was extremely elaborate," Brown said. "We had to show that we met all the requirements and that we understood the whole concept of managing care so as to achieve good outcomes."

Missing Paperwork

Approval of Central Neighborhood's FQHC Look-Alike status came in August 2010 from the federal Health Resources and Services Administration (HRSA), the administrators of the FQHC program. An application submitted two months later to win the full 330 designation (and attendant annual grants of up to \$650,000) was put on hold by HRSA, due to shortcomings identified by the agency.

Those problems included the absence of letters of support from other FQHCs; failure to identify gaps in health services or other private practices accepting public insurance; along with the need for further development of policies, procedures, strategic goals, objectives, outcomes, evaluation measures, and plans for recruiting and retaining additional staff, according to a comment letter from HRSA.

With Look-Alike status nonetheless secured and the clinic's prospective payment system (PPS) rate established by HRSA at \$155 per patient visit, the clinic next approached the Medi-Cal program about setting a so-called Code 18, or "wrap-around rate." Under federal law, the state is required to make a supplemental, or wrap-around, payment to cover 80 percent of the difference between what managed care organizations reimburse the clinic and the clinic's full PPS rate. The remaining 20 percent of the PPS can be recovered through a reconciliation process at year-end.

The wrap-around rate represents an increasingly key component of the overall FQHC reimbursement structure as more Medi-Cal beneficiaries are shifted into managed care plans. In Los Angeles, the Medi-Cal rate for non-FQHCs is around \$18 per visit. The clinic's wrap-around, therefore, should have been, at minimum, in the neighborhood of \$110.

In reality, however, the state pegged the rate at a mere \$30. Brown questioned the judgment, but the state was "adamant" in justifying the calculation, he said. Central Neighborhood consequently accepted the decision, and cash flow collapsed from projected levels.

With the financial situation spiraling out of control, Brown turned to community health center experts at the California HealthCare Foundation for advice. The Foundation, in turn, recommended that Central Neighborhood work with Rousso, a consultant specializing in community health centers and FQHCs. Rousso conducted a detailed review of the clinic's documentation and quickly discovered the primary problem.

"Basically, the clinic hadn't submitted the proper paperwork to the state to show what their Medi-Cal managed care plan reimbursements were, so the rate was set at a very low level," Rousso said. "It was a lack of knowledge about the requirements on the part of the clinic, poor communication on the part of the state, and also the absence of anyone advocating on the clinic's behalf."

The consultant's review uncovered other omissions. Two other state programs that offered enhanced reimbursement for FQHCs — Healthy Families Code 19 and Medi-Medi Code 02 (for enrollees who are both Medicare and Medi-Cal eligible) — had not been accessed by the clinic. The result was additional foregone revenue.

Finally, the clinic had not been properly enrolled as a Medicare FQHC provider. Like Medicaid, Medicare also pays an enhanced reimbursement rate to 330s and Look-Alikes. But because Central Neighborhood was unaware of this fact, the clinic was continuing to receive standard fee-for-service rates and thus leaving dollars on the table with each Medicare patient treated.

'A Lot of Land Mines'

Central Neighborhood's unfamiliarity with myriad FQHC rules collectively cost the clinic between \$500,000 and \$750,000, Rousso estimated, the bulk of which resulted from Medi-Cal underpayments. Yet the consultant said he didn't fault the clinic's management for the problems. Unfortunately, he said, it's a scenario he's encountered many times before.

"I've seen these kinds of mistakes over and over again, particularly with new centers," he said. "They get FQHC status, but no one tells them what to do after that, like how to enroll in Medicare and Medicaid, how to get the various rates, how to bill, the different codes to bill, provider numbers, how to get registered with the right agencies. And then there are ongoing reimbursement issues after start-up. So there are just a lot of land mines out there."

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— STEVEN ROUSSO
HFS CONSULTANTS

One of the biggest problems facing new FQHCs, Rousso said, is the fragmented nature of agency oversight and compliance.

"You're dealing with HRSA, you're dealing with one state agency on licensing issues, another on provider enrollment, another for audits and investigation for rates; with CMS for approvals on the Medicare side, and you're

dealing with the Medicare fiscal intermediary. So right there, you're interacting with five or six organizations, and there is no real communication between them. That, in itself, is troubling."

"Dr. Brown is a physician and his main focus is medicine," Rousso added. "He's dedicated his life to providing care to the underserved. How could he be expected to know this stuff? It's like me trying to do a colonoscopy."

Ongoing Demands

Wunsch, founder and partner at Pacific Health Consulting, agreed that the application and enrollment processes associated with start-up FQHCs can seem overwhelming. But the challenges don't stop there. Once a clinic is operational, it must comply with a host of ongoing reporting requirements. These include detailed annual reports to both HRSA and Medi-Cal, as well as to the Office of Statewide Health Planning and Development (OSHPD) and county agencies. Each report typically has different parameters, questions, and terminologies, although there is frequent overlap between them.

Moreover, because many FQHCs receive funding from private foundations, those entities likewise require reports designed to account for, and justify, the grants. Finally, case, morbidity, outcomes, and quality information must be collected and shared on a regular basis with multiple agencies to accommodate the larger quality objectives of the FQHC care model.

"A clinic literally could have up to 50 different funding sources, and 50 different reports that must be turned in at different times of the year," Wunsch said. "I think it's every community health director's dream that the process be simplified."

She added that although the vast majority of FQHCs ultimately get a handle on the reporting and compliance

demands, sustaining the appropriate level of oversight is an increasingly difficult task.

“In the last five years, a lot of FQHCs have brought in compliance officers,” she said. “I think that illustrates perfectly the fact that the system has become so complex that you basically need a whole department to make sure you’re following the rules.”

Back from the Brink

Today, Central Neighborhood is steadily climbing back on solid financial ground. Rousso said corrected and missing documentation is being resubmitted to Medicare, Medi-Cal, and other state agencies, and the odds are good that a significant portion of the lost revenues from 2010 and 2011 can be recovered. The consultant has helped Central Neighborhood clarify its Medi-Cal managed care utilization and reimbursements, and a new wrap-around rate has been set by the state at \$132 per patient visit.

Central Neighborhood is currently seeing about 200 patients per day and employs five physicians, six physician extenders, and 12 medical assistants. Last summer, the health center was awarded a Healthy Way L.A. contract to provide a medical home for low-income patients as part of the Bridge to Health Care Reform established by the Obama administration. Healthy Way provides free health care coverage to low-income, uninsured adult citizens and legal residents via a medical home delivery model. The clinic likewise has secured a parallel Disability Assessment Contract with the county’s Department of Public Social Services. The contract will provide an opportunity for hundreds of indigent and homeless patients to access and establish a medical home through Central Neighborhood.

Separately, Central Neighborhood is exploring the possibility of working with area hospitals to decompress crowded emergency departments by establishing satellite clinics at the hospitals. The clinics could absorb uninsured patients through the Healthy Way L.A. program. “It’s

something that could save these hospitals a lot of money,” Brown said.

Meeting the clinic’s ongoing reporting requirements — particularly in the area of quality and outcomes data — should get easier as Central Neighborhood’s automation capabilities are strengthened. According to Brown, the clinic was certified as a “meaningful user” of electronic medical records in 2011. As such, Central Neighborhood will be eligible under the 2009 HITECH Act for financial assistance over the next five years to help bolster its information infrastructure.

Brown said he is enthusiastic about the medical home case management and disease tracking components of the FQHC program. “I think that once all the electronic medical records are in place, it’s going to be a huge step forward toward improving the health status of the community,” he said.

And while the future of the Patient Protection and Affordable Care Act remains very much up in the air, the prospect that many of the currently uninsured ultimately could receive care through an expanded Medicaid program raises the prospect of potentially significant additional reimbursement for Central Neighborhood.

Building for the Future

As for the overall lessons gleaned from the clinic’s recent experience, Brown recommended that community health centers considering a conversion to an FQHC hire a qualified consultant or attorney at the outset — both to work with the organization through the application process and to stay involved once operational status is achieved. One possibility, he said, was that multiple clinics could band together to spread the cost of a top-notch consultant. He added that retaining a financial officer who was experienced in managing the reimbursement complexities of FQHCs likewise was essential.

Although Central Neighborhood's FQHC odyssey has been daunting, Brown said he feels positive about how the situation is playing out.

"I can see light at the end of the tunnel now," he said. "This work has been my life, and the job that needs to be done is enormous. I think I've always had good insight into the problem of treating the underserved and what the potential solutions were. And that's why I pursued FQHC for the clinic. More than anything, I want to establish a solid foundation for the clinic's future, so that it will continue when I'm gone, and not die with me."

ABOUT THE FOUNDATION

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