History of FQHC

Federally qualified health centers (FQHCs) are safety-net providers that offer outpatient services. FQHCs include community health centers, migrant health centers, health care for the homeless centers, public housing primary care centers, and health center service “lookalikes.”

<https://www.youtube.com/watch?v=aV9jJpX0PZI>

**America’s Health Centers** owe their existence to a remarkable turn of events in U.S. history, and to a number of determined community health and civil rights activists who fought more than 50 years ago to improve the lives of Americans living in deep poverty and in desperate need of health care.

Among those determined to change these conditions was [H. Jack Geiger](http://en.wikipedia.org/wiki/H._Jack_Geiger), then a young doctor and civil rights activist who, while studying in South Africa, witnessed how a unique community-based health care model had brought about astonishing health improvements for the poorest citizens of that country.

Moving on the opportunity presented by President Lyndon B. Johnson’s major [War on Poverty](http://en.wikipedia.org/wiki/War_on_Poverty) initiatives in the early 1960s, Dr. Geiger and other health care pioneers submitted proposals to the federal Office of Economic Opportunity to establish health centers in medically underserved inner-city and rural areas of the country based on the same health care model Geiger had studied in South Africa. Funding for the first two “Neighborhood Health Centers” (as they were then called) – one in Boston, Massachusetts, and the other in Mound Bayou, Mississippi – was approved in 1965, and the Community Health Centers Program was launched.

The health center model that emerged targeted the roots of poverty by combining the resources of local communities with federal funds to establish neighborhood clinics in both rural and urban areas around America. It was a formula that not only empowered communities to establish and direct health services at the local level via consumer-majority governing boards, but also generated compelling proof that affordable and accessible health care produced compounding benefits.

Today Community Health Centers serve as the primary medical home for [**over 30 million people in more than 13,000 rural and urban communities across America**](https://www.nachc.org/research-and-data/research-fact-sheets-and-infographics/americas-health-centers-2020-snapshot/).  These community-based “family doctors” enjoy longstanding bipartisan support by Administrations and policymakers at all levels, as well as in both the private and public sectors.

Important Federal Organizations

SAMHSA

 https://www.samhsa.gov/

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (HHS) that leads public health efforts to advance the behavioral health of the nation and to improve the lives of individuals living with mental and substance use disorders, and their families.

**Vision**

To provide leadership and resources – programs, policies, information and data, funding, and personnel – advance mental and substance use disorder prevention, treatment, and recovery services in order to improve individual, community, and public health.

**Mission**

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

* 1. HRSA https://www.hrsa.gov/

The Health Resources and Services Administration is an agency of the U.S. Department of Health and Human Services located in North Bethesda, Maryland. It is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable. It is the primary funder for FQHCs.

* 1. UDS

The Uniform Data System (UDS) is **an annual reporting system** that provides standardized information about the performance and operation of health centers delivering health care services to underserved communities and vulnerable populations.

* 1. CMS https://www.cms.gov/

"The [Centers for Medicare & Medicaid Services](https://www.cms.gov/About-CMS/About-CMS) (CMS), is part of the Department of Health and Human Services (HHS)." The "CMS develops [Conditions of Participation (CoPs) and Conditions for Coverage (CfCs)](https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries."

FAQs

What is a PPS Rate?

A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).  CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, skilled nursing facilities, and Federally Qualified Health centers.

There is one national, unadjusted “base” prospective payment system (PPS) rate for the FQHC-approved qualifying visit codes for all FQHCs.

What is FTCA?

The Federal Tort Claims Act (FTCA) affords **Federally Qualified Health Centers** (FQHC) a significant benefit, substantially eliminating medical malpractice insurance expenses to cover their providers. FTCA coverage, in turn, improves health centers' ability to attract and retain medical providers.

What is Credentialing and Privileging?

Credentialing is "the process of assessing and confirming the license or certification, education, training, and other qualifications or a licensed or certified healthcare practitioner."

Privileging is "the process of authorizing a health care practitioner’s specific scope and content of patient care services."

The "CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the [CoPs/CfCs](https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs)." Health Care Organizations seeking CMS approval may choose to be surveyed either by an accrediting body, such as The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP) and DNV-GL; or by state surveyors on behalf of [CMS](https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs). Types of Health Care Organizations to which the [CMS standards apply](https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs) and also at which Privileging is typically applicable are Hospitals (including acute care, critical access and psychiatric), Surgery Centers, Mental or Behavioral Health Centers, and Federally Qualified Health Centers (FQHCs). This is not to say however, that there are not other Health Care Organization types that perform privileging, these are just the most common, and also the ones that typically have other Accreditation Standards (TJC, HFAP, DNV-GL, AAAHC, HRSA) related to Privileging that they must meet as well, in addition the CMS’s CoPs related to Privileging.

Administrative Policies you need to have/know:

* 1. Patient Documentation Requirements
	2. Performance Evaluation and Improvement Plans
	3. Administrative Structure of your clinic
	4. Administrative Supervision requirements of various staff
	5. Clinical Supervision requirements of various staff
	6. Policy and Procedures for Crisis Management
	7. Peer reviews vs record reviews