Federally Qualified Health Centers

Impact of the ACA and Health System

Change on the Iowa Safety Net

University of Iowa

Public Policy Center

*DRAFT*

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# Federally Qualified Health Centers

## Introduction

Federally Qualified Health Centers (FQHCs) are health care providers that receive grant funding under Section 330 of the Public Health Service (PHS) Act, which is intended to provide funding opportunities for organizations to administer care to underserved populations. Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs are eligible to receive Section 330 grants. An organization that receives Section 330 funding is automatically certified as an FQHC.

Benefits of being an FQHC include:

* Grant funding (up to $650,000 can be requested for start-up)
* Prospective Payment System reimbursement for services to Medicaid patients
* Cost-based reimbursement for services to Medicare patients
* Medical malpractice coverage through the Federal Tort Claims Act
* Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program
* National Health Service Corps access
* Eligibility for the Vaccine for Children program
* Qualification for additional federal grants and programs.[[1]](#endnote-1)

The FQHC Look-Alike Program is for entities that operate and provide services consistent with all statutory, regulatory, and policy requirements that apply to section 330-funded health centers, but do not receive funding under section 330. [[2]](#endnote-2)FQHC Look-Alikes, like FQHCs, additionally receive automatic designation as a Health Professional Shortage Area (HPSA) which makes them eligible to apply for National Health Service Corps (NHSC) personnel as well as eligible to receive J-1 visa physicians.[[3]](#endnote-3) However, FQHC Look-Alikes meet similar eligibility requirements of an FQHC but do not receive Section 330 grant funding.[[4]](#endnote-4) These FQHC look-alikes receive some benefits like the FQHCs including the following: Prospective Payment System reimbursement for services to Medicaid patients and eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program.

The HRSA expectations of the FQHCs include 19 key requirements under the domains of need for FQHC, services provided, governance, management and finance.[[5]](#endnote-5)

FQHCs must be either a public entity or a private nonprofit. Both FQHCs and FQHC Look-Alikes must have a board of directors comprised of a majority of active, registered clients of the health center who are representative of those served by the center. Preventive medical, dental, mental health and substance abuse services must be provided directly by the FQHC or by arrangement with another provider. FQHCs must also provide services that enable individuals to use the services of the health center, such as outreach, transportation, and language interpretation. . FQHCs must use a sliding fee scale for uninsured patients with annual incomes between 100-200% of the Federal Poverty Level (FPL), and must provide a full discount to individuals and families with annual incomes at or below 100% FPL, although FQHCs may charge a nominal fee for those patients. Health center services must be available to all, regardless of ability to pay.[[6]](#endnote-6)

## FQHC Funding

According to 2009 data from Kaiser State Health Facts, the largest source of revenue for Iowa’s FQHCs comes from Medicaid (35.7%) (Table 1).[[7]](#endnote-7) Federal grants provide over a quarter (27.4%) of the total revenue, while private insurance provides 11.7% and patient self-pay provides 9% of the total FQHC revenue.[[8]](#endnote-8) Each revenue source as a percent of total revenue is shown in the table to the right. This data is representative of the 13 FQHCs in Iowa.

|  |  |
| --- | --- |
| Table1.  Distribution of Revenue by Source for FQHCs in Iowa, 2009 | |
| Medicaid | 35.7% |
| Federal Grants | 27.4% |
| Private Insurance | 11.7% |
| Patient Self-Pay | 9.0% |
| Medicare | 6.6% |
| Foundation/Private Grants/Contracts | 3.9% |
| State & Local Grants | 3.6% |
| Other Revenue | 1.3% |
| Other Public Insurance | 0.8% |

Further information on revenue streams for the 13 FQHC grantees in Iowa is reported annually in the Uniform Data System Report from the Bureau of Primary Health Care - Health Resources and Services Administration (HRSA).[[9]](#endnote-9) According to the 2010 Iowa Report, total patient related revenue and other revenue received by FQHCs in Iowa in 2010 is equal to $124,805,188 (Table 2). Total patient related revenue is $91,063,313 including $33,025,599 from Medicaid, $9,015,723 from Medicare, $1,675,637 from other public, and $16,228,388 in private charges. Total other (non-patient related) revenue is $33,741,875.[[10]](#endnote-10)

Since 2007, total patient related revenue for FQHCs has increased by $28,869,959 or 46%. Between 2007 and 2010, the dollar amount of Medicaid and Medicaid as a percent of total revenue has increased. Additionally during the time, Medicare, self-pay and other public revenue for FQHCs have increased annually while the percent of total patient related revenue in each of the categories varies year to year. The dollar amount and percent of private revenue varies from 2007-2010.[[11]](#endnote-11)

Since 2007 the total amount of other (non-patient related) revenue for FQHCs has increased by 29% despite a decrease in 2008. The total dollar amount of Bureau of Primary Health Care (BPHC) grants increased by 14% from 2007-2010. The total dollar amount of other federal grants decreased by 54% from 2007-2008, but increased by 240% from 2008-2009 and by another 93% from 2009-2010. This increase is largely a result of the availability of American Recovery and Reinvestment Act grants as a revenue source in 2009- 2010. The amount of non-federal grants and contracts varies from 2007-2010.[[12]](#endnote-12)

Table 2. FQHC Revenue 2010

|  |  |  |
| --- | --- | --- |
| Patient Related Revenue | Amount | Percent |
| Medicaid Non-Managed Care | $27,710,517 | 30.4% |
| Medicaid Managed Care (capitated) | $0 | 0.0% |
| Medicaid Managed Care (fee-for-service) | $5,315,082 | 5.6% |
| Total Medicaid | **$33,025,599** | **36.3%** |
|  |  |  |
| Medicare Non-Managed Care | $8,983,363 | 9.9% |
| Medicare Managed Care (capitated) | $0 | 0.0% |
| Medicare Managed Care (fee-for-service) | $32,360 | 0.0% |
| Total Medicare | **$9,015,723** | **9.9%** |
|  |  |  |
| Other Public including Non-Medicaid Chip (Non-Managed Care) | $1,675,637 | 1.8% |
| Other Public including Non-Medicaid Chip (Managed Care Capitated) | $0 | 0.0% |
| Other Public including Non-Medicaid Chip (Managed Care Fee-for-service) | $0 | 0.0% |
| Total Other Public | **$1,675,637** | **1.8%** |
|  |  |  |
| Private Non-Managed Care | $16,178,866 | 17.8% |
| Private Managed Care (capitated) | $49,522 | 0.1% |
| Private Managed Care (fee-for-service) | $0 | 0.0% |
| Total Private | **$16,228,388** | **17.8%** |
|  |  |  |
| Self-Pay | $31,117,966 | 34.2% |
|  |  |  |
| TOTAL CHARGES for Patient Related Revenue | **$91,063,313** | **100.0%** |

Source: http://bphc.hrsa.gov/uds/doc/2010/Iowa.pdf

|  |  |  |
| --- | --- | --- |
| Other Revenue | Amount | Percent |
| Migrant Health Center | $416,600 | 2.3% |
| Community Health Center | $16,531,226 | 90.8% |
| Health Care for the Homeless | $1,109,313 | 6.1% |
| Public Housing Primary Care | $0 | 0.0% |
| Total Health Center Cluster | $18,057,139 | 99.2% |
| Capital Improvement Program Grants | $144,074 | 0.8% |
| Total BPHC Grants | **$18,201,213** | **100.0%** |
|  |  |  |
| Ryan White Title III HIV Early Intervention | $988,429 | 10.1% |
| Other Federal Grants | $992,656 | 10.2% |
| ARRA New Access Point & Increased Demand for Services | $2,982,337 | 30.6% |
| ARRA Capital Improvement Project & Facility Improvement Project | $4,779,223 | 49.1% |
| Total Other Federal Grants | **$9,742,645** | **100.0%** |
|  |  |  |
| State Government Grants and Contracts | $1,630,488 | 32.1% |
| State/Local Indigent Care Programs | $404,572 | 8.0% |
| Local Government Grants and Contracts | $794,493 | 15.7% |
| Foundation/Private Grants and Contracts | $2,244,645 | 44.2% |
| Total Non-Federal Grants and Contracts | **$5,074,198** | **100.0%** |
|  |  |  |
| Other Revenue (non-patient related revenue not reported elsewhere) | $723,819 | 100.0% |
| TOTAL OTHER REVENUE | **$33,741,875** |  |

Source: <http://bphc.hrsa.gov/uds/doc/2010/Iowa.pdf>

|  |  |  |
| --- | --- | --- |
| Total Patient Related Revenue | $91,063,313 | 73.0% |
| Total Other Revenue | $33,741,875 | 27.0% |
| COMBINED TOTAL REVENUE | **$124,805,188** | **100.0%** |

Source: http://bphc.hrsa.gov/uds/doc/2010/Iowa.pdf

Financial costs by service area, as reported in the 2010 UDS for all FQHCs in Iowa, are shown in Table 3: xvii

Table 3. FQHC Financial Costs by Service Area, 2010

## FQHC Providers in Iowa

There are currently 13 FQHCs in the state of Iowa, making up just over 1% of the total 1124 FQHCs in the United States (Table 4).[[13]](#endnote-13) These FQHCs include 12 Community Health Centers and one Migrant Health Center. Iowa has one additional Community Health Center classified as an FQHC look-alike.[[14]](#endnote-14) The name and location of all 14 Centers are listed in the table below. Each of the 14 centers is an Iowa Safety Net member.

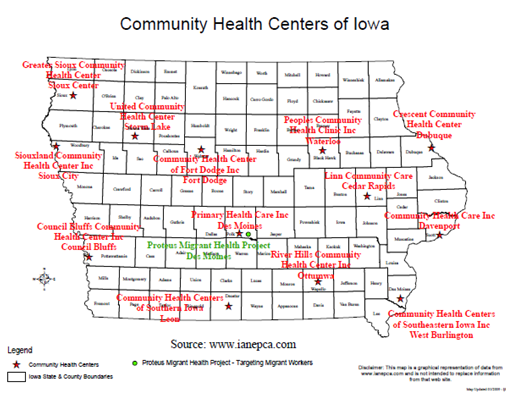
Table 4. Iowa’s Federally Qualified Health Centers

|  |  |
| --- | --- |
| Name | Location |
| Primary Health Care, Inc. | Des Moines/Marshalltown |
| Siouxland Community Health Center | Sioux City |
| Community Health Center, Inc. | Davenport |
| Community Health Centers of Southern Iowa, Inc. | Leon/Lamoni |
| Peoples Community Health Clinic, Inc. | Waterloo/Clarksville |
| United Community Health Center | Storm Lake |
| Community Health Center of Fort Dodge | Fort Dodge |
| Linn Community Care | Cedar Rapids |
| Crescent Community Health Center | Dubuque |
| Council Bluffs Community Health Centers, Inc. | Council Bluffs |
| River Hills Community Health Center | Ottumwa/Centerville/Richland |
| Community Health Centers of Southeastern Iowa, Inc. | West Burlington/Keokuk/  Columbus City |
| Proteus, Inc. (Migrant Health Center) | Des Moines-based |
| Greater Sioux Community Health Center (FQHC Look-Alike) | Sioux Center |

Source: <http://bphc.hrsa.gov/uds/doc/2010/Iowa.pdf>

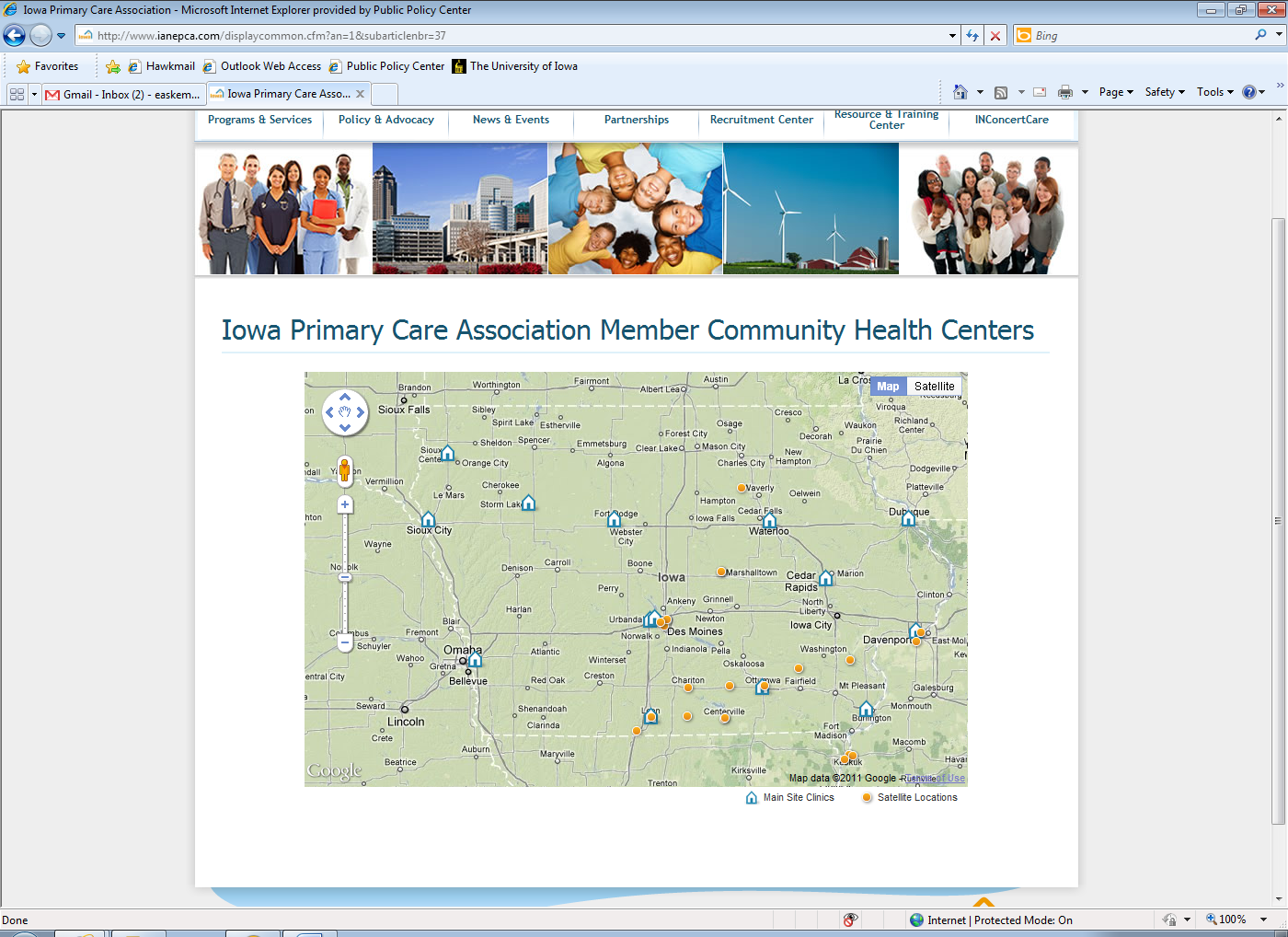
Iowa’s FQHC locations and FQHC affiliated satellite clinics are shown in the following maps (Figures 1 and 2). Figure 1 depicts the locations of Iowa’s Migrant Health Project (an FQHC) and 13 Community Health Centers (12 FQHCs and one FQHC Look-Alike). Figure 2 shows the locations of 19 Community Health Center satellite clinics affiliated with the 14 total main site clinics.

Figure 1. Names and Locations of Iowa’s FQHCs/CHCs.



Source: <http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/community_health_ctrs.pdf>

Figure 2. Iowa Primary Care Association Community Health Centers Clinics and Satellite Locations[[15]](#endnote-15)



Source: <http://www.ianepca.com/displaycommon.cfm?an=1&subarticlenbr=37>

## Provider Full Time Equivalents (FTEs)

According to the Iowa Collaborative Safety Net Provider Network Calendar Year 2010 Data Report, 14 Community Health Centers[[16]](#endnote-16) in Iowa employed 66 FTE physicians (M.D. or D.O.) and 63 FTE mid-level providers (includes physician assistants and nurse practitioners).[[17]](#endnote-17)

UDS data from 2010 shows that all FQHCs in Iowa were staffed by 124 FTE dental providers, which included 30 FTE dentists, 19 FTE dental hygienists and 75 FTE dental assistants, aides and techs. xvii

Other providers included 19 FTE Mental health providers and 29 FTE pharmacy personnel. xvii

## Numbers Served

In recent years, Iowa’s FQHCs have reported an increasing number of patients and encounters. In 2009, 108 delivery sites for the 13 FQHCs saw 154,020 patients and had 556,862 encounters.[[18]](#endnote-18) In 2010, the number of patients increased by 10.5% to 172,312 and the number of encounters increased by 8.1% to 602,001.[[19]](#endnote-19)

Table 5. Clients served by FQHCs 2007-2010

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | # Community Health Centers | Total Patients | % Change from previous year | Total Encounters | % Change from previous year |
| 2007 | 13 | 124,759 | - | 423,141 | - |
| 2008 | 13 | 137,830 | 10.5% | 488,598 | 15.5% |
| 2009 | 14 | 154,020 | 11.7% | 556,862 | 14.0% |
| 2010 | 14 | 172,312 | 11.9% | 602,001 | 8.1% |

## Patient Demographics

Insurance Status/Income Level

According to 2009 data from the National Association of Community Health Centers (NACHC), compared to the general population, patients who use FQHCs in Iowa are more commonly uninsured, below 100-200% of the Federal Poverty Level (FPL), and living in rural areas (Figure 3). Patients who use Iowa FQHCs are also more likely to be enrolled in Medicaid, but less likely to be enrolled in Medicare than the than general population.[[20]](#endnote-20)

Figure 3. FQHC Demographic Characteristics 2009

Source: <http://www.nachc.org/client/documents/IA10.pdf>; <http://www.nachc.org/client/state_X_key_facts_2009.pdf>

FQHC patient insurance data from the Iowa Safety Net 2010 Data Report illustrates that a large portion of patients who utilize FQHCs are uninsured or self-pay for services (Table 6). About one third of patients receive Medicaid coverage. Additionally, less than one quarter of FQHC patients had private insurance as their principal insurance.[[21]](#endnote-21)

Table 6. FQHC Client Insurance Coverage 2010

|  |  |  |
| --- | --- | --- |
| Insurance Status (Unduplicated Patients) | # Patients | % Patients |
| Uninsured/Self Pay/Private Pay | 67,070 | 38.9% |
| Medicaid | 56,200 | 32.6% |
| Medicare | 12,138 | 7.0% |
| Other Public Insurance | 746 | 0.4% |
| Private/Commercial Insurance | 36,158 | 21.0% |
| Total | 172,312 | 100.0% |

Source: Iowa Collaborative Safety Net Provider Network CY 2010 Data Report p32

### Race

A significant portion of patients (unduplicated) seen at Community Health Centers in Iowa are White/Caucasian (69%), while 16% of patients’ race is unknown (Figure 4). Blacks/African Americans make up 12% of patients at CHCs.

Figure 4. FQHC Client Race 2010\*

\*Data Source: CY10 Safety Net Data Report

### Ethnicity

Two-thirds of patients (unduplicated) seen at Iowa’s CHCs are not Hispanic or Latino, while 18% are Hispanic or Latino (Figure 5).

Figure 5. FQHC Clients by Race 2010\*

\*Data Source: CY10 Safety Net Data Report

### Age

The 6-17 year old age group represents the largest portion of patients (unduplicated) seen at CHCs in Iowa with 19% of the total patients. Age groups 0-5 years and 25-34 years represent the second largest portion of patients with 15% of the total number of patients each. Patients 65 and older represent 6% of the total number of patients, which is the smallest of all age groups.

Figure 6. FQHC Clients by Age 2010\*

\*Data Source: CY10 Safety Net Data Report

### Sex

Of the 172,312 patients served by Iowa FQHCs in 2010, 56% were female and 44% were male. The ratio of male and female patients has been consistent in recent years.[[22]](#endnote-22)

### Primary language

Only about 11% of all the patients were best served in a language other than English.xvii

### Health Status

The most common primary diagnosis from all FQHC visits for 2010, according to the UDS data, were the chronic health conditions listed in Table 7 below: xvii

Table 7. FQHC Clients by Diagnosis 2010\*

|  |  |  |
| --- | --- | --- |
| Diagnosis | No. of visits | No. of patients |
| Diabetes Mellitus | 27,639 | 10,031 |
| Hypertension | 25,189 | 13,452 |
| Depression/Mood disorders | 13,609 | 5,936 |
| Otitis Media/Eustachian tube disorders | 10,181 | 6,984 |
| Heart disease | 6,075 | 2,292 |

Select preventive services provided at FQHCs in year 2010 are shown below (Table 8). Immunizations, including flu vaccines, were the most common preventive services provided at FQHCs. xvii

Table 8. Preventive Service Received by FQHC Clients 2010\*

|  |  |  |
| --- | --- | --- |
| Preventive Services | No. of visits | No. of patients |
| Immunizations | 39,395 | 32,555 |
| Health supervision of infant or child (ages 0 through 11) | 29,067 | 17,906 |
| Seasonal Flu Vaccine | 18,886 | 17,851 |
| Pap test | 12,782 | 12,059 |
| Contraceptive Management | 8,656 | 4,596 |

Selected dental services provided at the FQHCs in Iowa in year 2010 are shown in Table 9. Preventive dental services, including check-ups, cleanings and fluoride treatments, were the most common dental procedures provided. xvii

Table 9. Dental Service Received by FQHC Clients 2010\*

|  |  |  |
| --- | --- | --- |
| Dental Services | No. of visits | No. of patients |
| Oral Exams | 56,284 | 41,596 |
| Prophylaxis | 35,972 | 26,863 |
| Fluoride treatment | 34,826 | 25,539 |
| Restorative Services | 30,612 | 15,794 |
| Oral surgery | 11,882 | 9,485 |
| Rehabilitative services  (Root canals, Gum treatment, Crowns, Bridges, Braces) | 4,401 | 2,933 |
| Sealants | 3,873 | 3,259 |
| Emergency Services | 2,975 | 2,527 |

## Legal Review of the Impact of the ACA on FQHCs

The Patient Protection and Affordable Care Act (“ACA”) utilizes the definition for FQHCs that is already in use, which depends on the clinic receiving money through the Public Health Service Act.[[23]](#endnote-23) The ACA expands the Medicaid and CHIP Payment and Access Commission’s (“MACPAC”) duties including reviewing and assessing payments to FQHCs.[[24]](#endnote-24)

In an attempt to address the primary care worker shortage at FQHCs, Congress established a family nurse practitioner training program in the ACA.[[25]](#endnote-25) The training program provides one year of training at an eligible center for any nurse practitioner who is either licensed or eligible for licensure and demonstrates a commitment to a career as an FQHC primary care provider.[[26]](#endnote-26) The ACA does not define, nor provide the Secretary authority to explain, how a nurse practitioner demonstrates commitment.

Regarding financing, the ACA substantially alters payments to FQHCs by establishing a prospective payment system for FQHCs.[[27]](#endnote-27) Currently, FQHCs are reimbursed based on reasonable costs.[[28]](#endnote-28) The Secretary is authorized by the ACA to develop the prospective program’s details accounting for the type, intensity, and duration of services.[[29]](#endnote-29) During the first year of the prospective payment system, aggregated payments will equal 100 percent of the estimated reasonable costs assuming the PPS was not implemented.[[30]](#endnote-30)

PPS payment during subsequent years will be based on the prior year’s payment rates increased by either the percentage increase based on the Medicare economic increase (for only the first year after PPS implementation) or by the percentage increase in a market basket of FQHC goods and services (identified by regulations and applied in years after the first post-implementation year).[[31]](#endnote-31)

Similar to the nurse practitioner training, the ACA authorizes payment to area health education centers.[[32]](#endnote-32) Included in the required activities is the provision that area health education centers must utilize field placements of health care providers in order to prepare the providers for serving in underserved areas or areas of health disparities; one possible field placement is with FQHCs.[[33]](#endnote-33)

An additional training program focused on primary care that potentially impacting FQHCs is authorized by Section 5301 of the ACA.[[34]](#endnote-34) This ACA section enhances grants to eligible institutions for primary care training, and grant applicants having formal agreements (or joint applications) with FQHCs located in underserved areas will be given priority when awarding grants.[[35]](#endnote-35) The potential impact of this section would be to bring more health care students into FQHCs.

The Affordable Care Act also directly impacts FQHC financing; the ACA authorizes specific amounts for each year from 2010 to 2015 beginning at $3 billion and ending at $8.3 billion, respectively.[[36]](#endnote-36) The ACA also authorizes appropriations to FQHCs 2016 and beyond.[[37]](#endnote-37) Compared to the years prior to 2016, authorized amounts in 2016 and after are determined by a formula based on the increase in costs for patients served by FQHCs multiplied by the increase in the number of patients served by FQHCs.[[38]](#endnote-38)

The ACA encourages health institutions to network with other health institutions. The ACA also encourages FQHCs to network with other health institutions by establishing grants for community-based collaborative care networks.[[39]](#endnote-39) The community-based networks must include a hospital in addition to an FQHC.[[40]](#endnote-40) The ACA does not explicitly provide for grant amounts. Priority is given to community-based networks that provide a broad range of services to high volumes of low-income people.[[41]](#endnote-41)

Similar to the primary care training but focusing on oral health, the ACA establishes grants for institutions and individuals training for careers in general, pediatric, or public health dentistry.[[42]](#endnote-42) Grant applicants having formal agreements with FQHCs located in underserved areas will be given priority when awarding grants under this ACA section.[[43]](#endnote-43)

In another training program established by the ACA, graduate nurse demonstration project funding is authorized for 5 hospitals having written agreements with a school of nursing and a non-hospital community-based care setting, which includes FQHCs.[[44]](#endnote-44) Participating FQHCs are reimbursed according to the ACA for reasonable costs associated with providing training to the graduate nurses.[[45]](#endnote-45)

Finally, the ACA establishes a grant for developing teaching health centers in order to prepare primary care residents.[[46]](#endnote-46) An FQHC is explicitly defined by the ACA as a teaching health center.[[47]](#endnote-47) Grants under this section are limited to three years and a total award of $500,000.[[48]](#endnote-48) Funds from the grant can be used for:

* Establishing, or expanding, a primary care residency training program;
* Curriculum development;
* Recruitment, training, and retention of residents and faculty;
* Accreditation
* Faculty salaries; and
* Technical assistance.

Further, a teaching health center listed as a sponsoring institution can be reimbursed for direct and indirect expenses for either the expansion or establishment of a medical resident training program.[[49]](#endnote-49) Direct costs are calculated according to: payments per resident multiplied by the number of residents in the center’s residency program.[[50]](#endnote-50) Additionally, indirect medical education expenses are also reimbursed to a teaching health center.[[51]](#endnote-51)

Further, the ACA authorizes grants to a maximum of 15 eligible entities in order improve access to dental health services in rural and underserved areas.[[52]](#endnote-52) The demonstration program provides grants to the eligible entities for not less than $4 million (total) and a maximum of 5 years.[[53]](#endnote-53) The grants fund training programs for alternative dental health care providers who include: community dental health coordinators, advance practice dental hygienists, primary care physicians, dental therapists, and dental health aides.[[54]](#endnote-54) FQHCs are explicitly included in the ACA as eligible entities.[[55]](#endnote-55) Further, eligible entities must be within either a program accredited by the Commission on Dental Accreditation or a dental education program in an accredited institution.[[56]](#endnote-56)

The ACA requires health insurers offering qualified plans to cover specific health service categories within the essential health benefits package.[[57]](#endnote-57) If an enrollee to a qualified health plan receives services from an FQHC, the health insurer offering the qualified health plan must pay, at a minimum, the amount the health insurer would have received from either Medicare or Medicaid to the FQHC.[[58]](#endnote-58)

**For the actual amended statutory language based on the ACA, please consult the complete legal review of the ACA on FQHCs.**

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    FQHC FAQ from the Rural Assistance Center updated 08/3/10. Accessed from <http://www.raconline.org/info_guides/clinics/fqhcfaq.php#whatis> on 7/21/11;

    Greater Sioux Community Health Center Incorporated. Accessed from <http://www.greatersiouxchc.org/index_files/Page385.htm> on 9/8/11. [↑](#endnote-ref-14)
15. Two of the satellite clinics shown on Figure 2 are located in Rock Island and Moline, Illinois but are affiliated with Community Health Center Inc. of Davenport, Iowa. [↑](#endnote-ref-15)
16. The Iowa Collaborative Safety Net Provider Network defines Community Health Centers (CHCS or Federally Qualified Health Centers) as health care delivery sites that are community-based, patient-directed, and serve populations with limited access to health care. Data for the 14 Community Health Centers in Iowa include 13 FQHCs and 1 FQHC Look-Alike. [↑](#endnote-ref-16)
17. Iowa Collaborative Safety Net Provider Network CY 2010 Data Report [↑](#endnote-ref-17)
18. Iowa: Federally Qualified Health Centers from Henry J. Kaiser Family Foundations. Accessed from <http://www.statehealthfacts.org/profileind.jsp?cat=8&sub=99&rgn=17> on 7/21/11. [↑](#endnote-ref-18)
19. Bureau of Primary Care – Health Resources and Services Administration 2010 Iowa Report. Accessed from <http://bphc.hrsa.gov/uds/doc/2010/Iowa.pdf> on 9/19/11. [↑](#endnote-ref-19)
20. National Association of Community Health Centers Iowa Health Center Fact Sheet. Accessed from <http://www.nachc.org/client/documents/IA10.pdf> on 7/11/11.

    National Association of Community Health Centers Key Health Center Data by State, 2009. Accessed from <http://www.nachc.org/client/state_X_key_facts_2009.pdf> on 7/11/11. [↑](#endnote-ref-20)
21. Iowa Collaborative Safety Net Provider Network CY 2009 Data Report p29 [↑](#endnote-ref-21)
22. Iowa Collaborative Safety Net Provider Network CY 2010 Data Report

    xvii 2010 UDS Aggregated [↑](#endnote-ref-22)
23. ACA Section 5002(b)(1)(17) [↑](#endnote-ref-23)
24. ACA Section 2801(a)(1)(B)(i)(I)(bb) [↑](#endnote-ref-24)
25. ACA Section 10501(e) [↑](#endnote-ref-25)
26. ACA Section 10501(e)(a); ACA Sections 10501(e)(f)(1)(A) and (B). [↑](#endnote-ref-26)
27. ACA Sections 10501(i)(3)(A)-(C) [↑](#endnote-ref-27)
28. CCH’s Law, Explanation, and Analysis of the Patient Protection and Affordable Care Act, Including Reconciliation Impact, Volume 1. Wolter Kluwers: Chicago, IL. [↑](#endnote-ref-28)
29. ACA Section 10501(i)(3)(A). [↑](#endnote-ref-29)
30. ACA Section 10501(i)(3)(A). [↑](#endnote-ref-30)
31. ACA Section 10501(i)(3)(A). [↑](#endnote-ref-31)
32. ACA Section 5403(a). [↑](#endnote-ref-32)
33. ACA Section 5403(a). [↑](#endnote-ref-33)
34. ACA Section 5301. [↑](#endnote-ref-34)
35. ACA Section 5301. [↑](#endnote-ref-35)
36. ACA Section 5601(a). [↑](#endnote-ref-36)
37. ACA Section 5601(a). [↑](#endnote-ref-37)
38. ACA Section 5601(a). [↑](#endnote-ref-38)
39. ACA Section 10333. [↑](#endnote-ref-39)
40. ACA Section 10333. [↑](#endnote-ref-40)
41. ACA Section 10333. [↑](#endnote-ref-41)
42. ACA Section 5303(2). [↑](#endnote-ref-42)
43. ACA Section 5303(2). [↑](#endnote-ref-43)
44. ACA Sections 5509(a)(1)(A), (e)(5). [↑](#endnote-ref-44)
45. ACA Section 5509(a)(2)(A). [↑](#endnote-ref-45)
46. ACA Section 5508(a). [↑](#endnote-ref-46)
47. ACA Section 5508(a). [↑](#endnote-ref-47)
48. ACA Section 5508(a). [↑](#endnote-ref-48)
49. ACA Section 5508(c). [↑](#endnote-ref-49)
50. ACA Section 5508(c). [↑](#endnote-ref-50)
51. ACA Section 5508(c). [↑](#endnote-ref-51)
52. ACA Section 5304. [↑](#endnote-ref-52)
53. ACA Section 5304. [↑](#endnote-ref-53)
54. ACA Section 5304. [↑](#endnote-ref-54)
55. ACA Section 5304. [↑](#endnote-ref-55)
56. ACA Section 5304 amending Subpart X of part D of title III of the Public Health Service Act (42 U.S.C. Sections 256f et seq.) [↑](#endnote-ref-56)
57. ACA Sections 1302(a),(b). [↑](#endnote-ref-57)
58. ACA Section 1302(g). [↑](#endnote-ref-58)