

REPORT 9 OF THE COUNCIL ON MEDICAL SERVICES (A-23)  
Federally Qualified Health Centers and Rural Health Care  
(Reference Committee G)

EXECUTIVE SUMMARY

This report, initiated by the Council, provides information and background on Federally Qualified Health Centers (FQHCs) and similar clinics serving areas of medical need. Additionally, the report discusses the importance of these centers to providing essential health care and the physician experience for those who work in these settings. The report also details relevant American Medical Association (AMA) policy and provides recommendations to ensure that these clinics are maintained and that physicians are able to practice without undue burden.

The Council understands that FQHCs and similar clinics serving areas of medical need are a key aspect of the AMA's existing advocacy to reduce health care disparities in rural communities through increasing access to health care services. The AMA has a robust body of policy and advocacy efforts supporting general efforts to improve health care in rural communities. To fully support the health care services provided in these clinic settings, the Council discusses the importance of maintaining funding streams, reducing physician administrative burden, and ensuring that all care provided is overseen by a physician. In order to maintain the feasibility of FQHCs and similar health centers, it is important that a continued investment be made by the federal government as FQHCs receive a majority of funding through grants from the federal government. These grants allow these health services to be delivered to communities that would otherwise face significant barriers to access. In addition to ongoing funding, it is important that the regulating bodies of these health centers ensure that the certification and operating regulations do not place undue burdens on the physicians practicing in these settings. Physicians nationwide are faced with significant administrative work and those practicing in settings like FQHCs may face even more daunting administrative tasks. Finally, to ensure that these underserved communities receive high quality health care, it is important that all care be overseen by physicians. Oversight regarding physician supervision must be maintained to guarantee that all communities served by FQHCs, and similar health centers receive high-quality health care.

The Council recommends adoption of two new policies, one advocating for clear certification requirements and other policies that reduce the administrative burden on physicians practicing in FQHCs, and a second supporting federal funding to maintain costs associated with operating these health centers. In addition to these two new policies, the Council recommends reaffirming existing AMA policy that supports the implementation of programs to improve rural communities' health, H-465.994, advocates for the authorization of Chronic Care Management reimbursement for physicians, D-390.923, and limits the scope of practice for nonphysician providers without supervision of a physician, H-160.947 and H-35.965.

# REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-A-23

Subject: Federally Qualified Health Centers and Rural Health Care

Presented by: Lynn Jeffers, MD, MBA Chair

Referred to: Reference Committee G

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1 Adequately addressing the issues that contribute to poor health outcomes and significant disparities  
2 for those who live in rural communities continues to be challenging. Approximately 14 percent of  
3 Americans live in a rural area, representing approximately 46 million people.<sup>1</sup> The health  
4 disparities for rural Americans are quite stark, as these communities tend to be poorer, older,  
5 sicker, and die at a 50 percent higher rate from unintentional injury.<sup>2</sup> One contributing factor to  
6 these disparities is the lack of accessible health care facilities and physicians. Approximately 66  
7 percent of all Primary Care Health Professional Shortage Areas are in rural communities,  
8 indicating a disproportionately high lack of access to care<sup>3</sup>. Additionally, those in rural areas are  
9 geographically further from hospitals and physicians, increasing barriers to access care<sup>3</sup>. Although  
10 the American Medical Association (AMA) has robust existing policy regarding improving the  
11 health of rural America, there is limited policy directly related to the centers that serve these  
12 populations.

13  
14 This report, initiated by the Council, provides information and background on Federally Qualified  
15 Health Centers (FQHCs) and similar clinics serving areas of medical need. Additionally, the report  
16 discusses the importance of these centers to providing essential health care and the physician  
17 experience for those who work in these settings. The report also details relevant AMA policy and  
18 provides recommendations to ensure that these clinics are funded adequately and that physicians  
19 are able to practice without undue burden.

## 20 21 BACKGROUND

22  
23 Although rural communities are often woefully underserved, FQHCs and Rural Health Clinics  
24 (RHCs) are two types of practices working to bring additional care to these communities. While  
25 FQHCs do not exclusively serve rural communities, many do serve these areas. FQHCs are health  
26 centers that serve communities, regardless of population density, that are designated health care  
27 shortage areas. These clinics are unique in that they not only provide medical care services, but  
28 also wraparound and social services. RHCs are clinics that serve designated health care shortage  
29 areas that are also considered rural. These clinics provide health care services to their communities,  
30 and may, but are not required to, provide social support services. FQHCs and RHCs are similar in  
31 many ways but do have distinct differences with RHCs only serving rural communities and FQHCs  
32 providing services beyond the traditional health care paradigm. Each of these centers work to  
33 provide health care to communities that are in desperate need and, in turn, help to mitigate health  
34 care disparities.

## Federally Qualified Health Centers

As previously noted, FQHCs are health care centers that provide health care services to rural or urban shortage areas. FQHCs are often the last line of care for individuals who otherwise may go without health care services. These practices are a central location for patients to receive coordinated preventive care and disease management. FQHCs provide medical services and are often able to support patients in accessing dental, social, and mental health services. These centers are vital for the communities they serve by providing care to approximately 30 million people in over 1,400 locations across the country.<sup>3</sup> Not only are the communities served by FQHCs often underserved, but they are also often underinsured. Approximately 59 percent of patients at FQHCs are insured publicly and 20 percent are uninsured.<sup>3,4</sup> These centers are vital in rural communities, with nearly half (45 percent) of all centers serving rural communities where they are, if not the only, one of very few sources of health care services.<sup>4</sup>

These health centers were originally created in 1965 by President Lyndon B. Johnson as an element of his administration's "War on Poverty." These centers were initially called community health centers and operated in a semi-permanent capacity for about a decade. In 1975, these health centers were officially authorized as a permanent program with their incorporation in section 330 of the Public Health Services (PHS) Act. After gaining permanency, the program continued to receive bipartisan support and was continually funded by Congress. In the late 1980s and early 1990s, FQHCs were established as a part of Medicare and Medicaid and were given a \$150 million increase in funding. The following decade brought additional funding increases and reauthorization for FQHCs via efforts by Congress and the Administration. In 2009, \$2 billion was invested in FQHCs through the reauthorization of Children's Health Insurance Program and the American Recovery and Reinvestment Act. An additional funding increase was earmarked in 2011 with the passage of the Affordable Care Act (ACA). However, in the same year a significant budget deficit tempered the initially indicated \$11 billion investment and slowed the expansion of FQHCs. Over the next decade, FQHCs continued to receive funding through reauthorizations and, both directly and indirectly, the implementation of the ACA in 2014. More recently, FQHCs faced significant challenges, as did all of health care, in battling the COVID-19 pandemic. In 2021, the American Rescue Plan was enacted and FQHCs received approximately \$7.6 billion through a variety of different programs.<sup>5</sup> Notably, FQHCs provided care to 30 million Americans in 2021, indicating their vital place in the landscape of American health care.

In practice, FQHCs are diverse in the services they provide to their patients, with some providing expanded services like mental and behavioral health, but at the core they all meet the basic definition of providing at least primary care services to rural or urban shortage areas. Within these types of practices, clinics fall under one of three categories, a health center program grantee, a "look-alike" program, or an Outpatient Tribal facility. Health center program grantees are what are traditionally referred to as an FQHC. Along with meeting a host of eligibility requirements, in order to receive this designation, the center must receive a grant under section 330 of the PHS Act. FQHC "look-alike" clinics are those that meet many of the same eligibility requirements as the aforementioned health center program grantees, but do not receive grants or funding from section 330 of the PHS Act. Finally, Outpatient Tribal facilities are similar, in that they meet many of the same requirements as a PHS Act granted FQHC; however, they are operated by a tribe, tribal organization, or urban Indian organization. These clinics are funded through either the Indian Self-Determination Act or Title V of the Indian Health Improvement Act. In specific circumstances these clinics are able to be grandfathered in and may not meet each of the eligibility requirements of FQHCs or "look-alikes".<sup>6</sup> In the remainder of this report the use of the term FQHC will be inclusive of each of these three types of clinics, unless specifically distinguished. Clinics that are classified as FQHCs serve a wide variety of patients and can be seen across the country referred to

1 as organizations like, Community Health Centers, Migrant Health Centers, Health Care for the  
 2 Homeless Health Centers, and Public Housing Primary Care Centers.<sup>6</sup>

3  
 4 In order to be designated a FQHC, a center must meet a multitude of practice requirements.  
 5 Specifically, care must be provided by a physician, nurse practitioner (NP), physician assistant  
 6 (PA), certified nurse midwife (CNM), clinical psychologist, clinical social worker, or a certified  
 7 diabetes self-management training/medical nutrition therapy provider. FQHCs must be under the  
 8 medical direction of a physician, but each of the previously mentioned nonphysician practitioners  
 9 are able to independently see patients. When seeing a patient, the visit must be deemed either  
 10 medically necessary or a qualified preventive health visit. Visits generally occur at the health center  
 11 but may take place in the patient’s residence if the patient is home-bound.<sup>6</sup> Traditionally, these  
 12 visits were required to occur in person and face-to-face, however during the COVID-19 Public  
 13 Health Emergency, exceptions were made for increased telehealth visits. These exceptions have  
 14 been extended beyond the end of the health emergency and will allow for practitioners to continue  
 15 to see some patients virtually.

16  
 17 While FQHCs provide a diverse range of services that vary from clinic to clinic, there are a core set  
 18 of services that must be offered in order to receive a FQHC certification. Required services include  
 19 primary health services like family medicine, internal medicine, pediatric, and obstetrics and  
 20 gynecology care. FQHCs are required to provide diagnostic lab services, preventive health  
 21 services, emergency medical services, and referrals. FQHCs are also required to provide dental  
 22 screenings to determine if further dental care is needed and while some may have an on-site dentist,  
 23 full dental care is not a requirement. Additionally, FQHCs are required to provide supplemental  
 24 services to enable access to care, like transportation, and community education. While not required,  
 25 FQHCs may also provide care including pharmaceutical services (e.g., pharmacies and/or drug  
 26 monitoring), behavioral and mental health services, environmental health services, screening and  
 27 control of infectious diseases, and/or injury prevention programs.<sup>6</sup> In short, the medical services  
 28 provided by an FQHC are designed to allow for a “one stop shop” mentality where patients are able  
 29 to receive care for a variety of needs.

30  
 31 In addition to the medically centered requirements of an FQHC, there are also more administrative  
 32 requirements that must be met. These clinics must demonstrate effective procedures for tracking,  
 33 compiling, and reporting operating costs and patterns of service use as well as the availability,  
 34 accessibility, and acceptability of services offered. These records should be provided to the  
 35 governing body upon request. Additionally, the FQHC must complete and file an annual  
 36 independent financial audit with the Secretary of the Department of Health and Human Services.  
 37 Regarding payment, FQHCs must have a contracted agreement with the state for those who are  
 38 eligible for state insurance plans and encourage patients to participate in any insurance plan for  
 39 which they are eligible. These centers are also responsible for collecting appropriate payment from  
 40 patients through an established sliding scale fee/payment plan. Finally, they must ensure that no  
 41 patient is turned away from receiving services due to the lack of ability to pay.<sup>6</sup>

42  
 43 FQHC governance boards must be comprised of a majority (51 percent+) of individuals who  
 44 receive care at the clinic, and must meet at least once a month. Additional ongoing quality  
 45 improvement processes must be continuous and include both clinical services and management  
 46 operations. Additionally, FQHCs must have established continuing referral relationships with at  
 47 least one hospital and must demonstrate continued efforts to establish and maintain relationships  
 48 with other health care providers in the area.<sup>6</sup>

49  
 50 Any patient can be served at an FQHC, regardless of insurance status or ability to pay. While some  
 51 FQHCs have a more specified focus, for example a migrant population, there is no restriction on

1 who they are able to provide care for. To ensure that the services offered are geographically  
 2 accessible, clinics must regularly review the size of their catchment area and adjust if needed.  
 3 Whenever possible, these boundaries should conform with existing local boundaries and work to  
 4 eliminate any geographical barriers. FQHCs must operate in an area that has been designated as a  
 5 Medically Underserved Area (MUA) or with a population that has been designated a medically  
 6 underserved population. Should the clinic operate in an area in which a “substantial portion” of the  
 7 community are limited-English speakers, there are specific cultural and language requirements that  
 8 must be met. Clinics in these areas must ensure that services are provided in the language and  
 9 cultural context that is appropriate for the community. Additionally, the clinic must employ at least  
 10 one staff member who is fluent in the language dominant in the community and English in order to  
 11 provide assistance in bridging cultural or linguistic differences.<sup>6</sup>

12  
 13 The COVID-19 pandemic and subsequent vaccination campaign highlighted the importance of  
 14 FQHCs in delivering care to those who are underserved, underrepresented, and underinsured. The  
 15 Office of the Assistant Secretary for Planning and Evaluation’s Office of Health Policy’s research  
 16 report investigating the barriers and facilitators in COVID-19 vaccine outreach indicated the  
 17 widespread success of FQHCs in delivering high rates of vaccination in the communities they  
 18 serve. Specifically, 62 percent of FQHCs held vaccination events or mobile clinics in their  
 19 communities, distributing 14+ million doses of the vaccine to communities. Importantly, these  
 20 FQHCs were not only successful in vaccinating their communities, but 66 percent of vaccinations  
 21 were given to people of color, supporting work to decrease health disparities.<sup>7</sup> In a more specific  
 22 example, an FQHC, Proteus, serving primarily H2-A visa workers in Iowa, Nebraska, and Indiana,  
 23 set up an innovative program to mitigate the spread of COVID-19. In a non-COVID year the  
 24 FQHC provides these farm workers with preventive health care and training on topics like heat  
 25 stress and pesticide safety. When the pandemic arose, this model was modified to include infection  
 26 mitigation training for the workers and farm owners, COVID testing, providing personal protective  
 27 equipment, housing, virtual town halls, and contact tracing. As most of the H2-A visa workers were  
 28 Spanish-speaking, this work was all done in a bilingual and culturally responsive fashion. This  
 29 program was able to mitigate the spread of COVID while the workers were in the United States,  
 30 when they went to their home country, and when they returned to the United States for the  
 31 subsequent agricultural season.<sup>8</sup>

32  
 33 However, the success of FQHCs providing care to underserved communities is not limited to  
 34 COVID. FQHCs across the country provide care to individuals who are in underserved  
 35 communities, with 62 percent of patients reporting being a person of color. One specific example is  
 36 a FQHC, Dartmouth Geisel Migrant Health Center, that serves primarily Latino patients in the  
 37 Northeast United States. It was found that the work done by this FQHC, especially around care  
 38 coordination and interpreter services, improved the access to care for the community they served.<sup>9</sup>  
 39 These examples demonstrate the power of FQHCs to support communities in not only times of  
 40 crisis, like a pandemic, but in everyday health care needs. These centers are vital to providing  
 41 health care services to the communities they serve.

42  
 43 Rural Health Clinics

44  
 45 While RHCs are similar to FQHCs in many ways, there are some key differences. Most  
 46 significantly, RHCs only serve rural areas and populations. Similar to FQHCs, RHCs can vary in  
 47 type, from independent, hospital-based, or provider-based centers. These clinics are designed to  
 48 increase the accessibility of primary care in areas that are underserved due to their rural status.<sup>10,11</sup>

49  
 50 As a point of clarification, although RHCs and rural hospitals may sound similar in name, they are  
 51 two separate types of practice. They face distinct differences in financial support, eligibility, and

1 operating requirements. To avoid confusion, rural hospitals will not be included in the current  
2 report. A recent report from the Council (Council on Medical Service Report 9-J-21) addressed  
3 rural hospitals.

4  
5 RHC services are provided by a physician, NP, PA, or CNM and must be under the medical  
6 direction of a physician. RHCs are required to have a NP, PA, or CNM providing care services at  
7 least half of the time the center is open. These centers are required to provide primary care and  
8 routine diagnostic and lab services and, while not required, may provide other types of services  
9 such as Transitional Care Management, General Behavioral Health Integration, Chronic Care  
10 Management, Principal Care Management, and Psychiatric Collaborative Care Management.  
11 Although these clinics are able to provide behavioral and mental health services, they cannot be  
12 designated as a rehabilitation agency or a primarily mental disease treatment facility. Patient visits  
13 follow very similar requirements as an FQHC in that they must be medically necessary or a  
14 qualified preventive health visit and can take place at the center, the patient's home, a skilled  
15 nursing facility, or hospice. Visits are not able to take place in an inpatient or outpatient hospital  
16 department. Similar to FQHCs, visits were historically required to be in person, but the COVID-19  
17 pandemic allowed for telehealth exceptions that have now been extended beyond the Public Health  
18 Emergency.<sup>7,8</sup>

19  
20 In order to meet the administrative requirements of RHC certification, centers must file annual cost  
21 reports that include payment rates, reconcile interim payments, graduate medical education  
22 adjustments, bad debt, and administrative payments. Payment is primarily made through a bundled  
23 All-Inclusive Rate (AIR) that is determined for all qualified primary and preventive care services.  
24 Dependent upon the patient's insurance status, a co-pay may be applied to the services. For  
25 example, patients with Part B Medicare coverage would pay for 20 percent of the AIR once their  
26 deductible is met. These centers must also maintain a contractual agreement with at least one  
27 hospital to provide services that are not available at the RHC.<sup>7,8</sup>

28  
29 Unlike FQHCs there are no specific requirements related to the governance, quality improvement,  
30 nor culture or language of patients. RHCs do have specific requirements related to their service  
31 areas. These centers must serve a community that has been designated as a Primary Care  
32 Geographic Health Professional Shortage Area, Primary Care Population-Group Health  
33 Professional Shortage Area, MUA, or a governor-designated and secretary-certified shortage area.  
34 Additionally, these communities must be designated as non-urbanized. Each year RHCs serve  
35 approximately 7 million people throughout 47 states.<sup>8</sup>

36  
37 While FQHCs and RHCs are mutually exclusive, they are similar in their basic mission which is to  
38 provide health care to individuals who are underserved. There are also similarities in the types of  
39 health care providers and types of services permitted. One of the defining differences between the  
40 two is the source of funding. FQHCs must receive funding via Section 330 of the PHS Act, while  
41 RHC funding comes from alternative federal avenues, such as appropriations from the Centers for  
42 Medicare & Medicaid Services. A full comparison outlining the certification requirements for  
43 FQHCs and RHCs has been appended to this report.

#### 44 45 PHYSICIAN EXPERIENCE IN FQHCs

46  
47 Physicians who work in FQHC settings may experience unique benefits and challenges. While the  
48 benefits of working in an FQHC are somewhat difficult to quantify, many physicians report that  
49 their work is more gratifying than other settings and that they believe they are helping communities  
50 that otherwise would not have adequate access to health care. There are also more tangible benefits

1 to working in an FQHC, such as student loan repayment programs and visas for foreign-born  
 2 physicians.

3  
 4 Although these specific benefits and the ability to serve communities that are desperate for quality  
 5 health care can provide physicians with a sense of fulfillment, there are significant challenges that  
 6 these physicians face working in FQHCs<sup>12</sup>. For example, working in an FQHC does not relieve the  
 7 physician burden of administrative paperwork. Serving a patient base that has higher rates of public  
 8 insurance means that physicians are spending more time dealing with the rules, protocols, and  
 9 paperwork associated with payment. The voluminous amount of paperwork that patients are  
 10 required to complete to register as an FQHC patient can frequently lead to disruptions in  
 11 scheduling and physicians spending significant amounts of time reviewing and signing the  
 12 paperwork. In addition to the increased administrative and regulatory burdens, since physicians at  
 13 FQHCs are operating in underserved areas it is often difficult to find reasonable timely referrals  
 14 and coordinate care for patients who may need advanced or specialty care. Some physicians who  
 15 work in FQHCs report feeling that they are practicing medicine without the support of a medical  
 16 team or other physicians. For physicians in these settings, providing care to their patients, who are  
 17 often facing complex medical conditions, can be a significant undertaking. Physicians practicing in  
 18 FQHCs are frequently part of a limited network of providers in the area they serve, leading to  
 19 increased stress and working hours in order to attempt to provide quality care on a reasonable  
 20 timeline to the patients they serve.<sup>9,10</sup>

21  
 22 Finally, physicians working in FQHCs often have additional duties related to the supervision of  
 23 nonphysician providers, which adds another set of tasks to already full schedules. FQHC  
 24 physicians report spending considerable time on weekends and evenings reviewing cases that are  
 25 handled by the non-physician practitioners in order to remain in compliance with federal  
 26 regulations and provide quality care. Notably, physicians working in FQHCs report 11 percent  
 27 higher burnout than their colleagues working in other practice settings.<sup>13</sup>

28  
 29 RELEVANT AMA POLICY

30  
 31 The AMA has a number of existing policies related to rural health and FQHCs. Many of the current  
 32 AMA policies related to rural health are centered around rural hospitals. Policies H-465.979 and  
 33 H-465.990 focus on the economic viability of rural hospitals. Each encourages efforts and  
 34 legislation to support these hospitals' efforts to stay open and serve their communities. Policy  
 35 D-465.998, established with Council on Medical Service Report 9-J-21, and Policies H-240.971,  
 36 H-465.978, and H-240.970, all deal with the payment challenges that are faced by many rural  
 37 physicians and hospitals. The policies both recognize and offer potential solutions for remedying  
 38 the payment differentials between rural and urban medical care. Finally, Policies H-465.984,  
 39 H-465.996, and H-465.999 focus on the certification and regulations of rural health care centers  
 40 and hospitals.

41  
 42 The Council believes that, in conjunction with FQHCs and RHCs, rural hospitals are another vital  
 43 strategy to deliver care to rural communities. Notably, the Council's recent 2021 report,  
 44 "Addressing Payment and Delivery in Rural Hospitals" (Council on Medical Service Report  
 45 9-J-21) included policy recommendations that remain informative and relevant as to the current  
 46 state of rural hospitals in America. As previously noted, in order to avoid confusion, this current  
 47 report has remained focused on health care in non-hospital settings, like FQHCs and RHCs.

48  
 49 The AMA also has policies related to rural health care that are not centered solely around hospital  
 50 centered care. Policies H-465.994 and H-465.982 are concentrated around improving the health of  
 51 rural communities through promoting access to medical care. Policy H-465.978 works to recognize

1 and advocate for fixing the payment bias that is seen between rural and non-rural providers. The  
2 policy advocates specifically for payment equity in telehealth legislation. Finally, Policy  
3 H-465.980 supports the development and improvement of rural health networks to be centered  
4 around the needs of the communities they serve.

5  
6 With respect to FQHCs, Policy D-390.923 acknowledges the need for Chronic Care Management  
7 payment for physicians who practice in FQHCs. Additionally, the AMA has existing policy  
8 surrounding issues of scope of practice for non-physician providers. Specifically, Policies D-  
9 35.989, H-160.947, and H-35.965 ensure the regulation of and appropriate scope (including  
10 physician supervision) of midwives/CNMs, PAs, NPs, and “related medical personnel.”

## 11 12 DISCUSSION

13  
14 FQHCs are, by definition, located in areas where health care is hard to access. As previously  
15 discussed, FQHCs were key in meeting the needs of communities that arose during the peak of the  
16 COVID-19 pandemic. FQHCs also have a long history of working to reduce health care disparities  
17 and providing preventive and primary care to the underserved.<sup>8,9</sup> Although the AMA has  
18 established policy on improving the health of rural Americans, the Council believes that  
19 strengthening our support of FQHCs is warranted.

20  
21 One specific method to ensure the viability of FQHCs and RHCs is by reducing physician burnout,  
22 one of the core tenets of the AMA’s Recovery Plan for America’s Physicians. Burnout is reported  
23 at higher levels in physicians who practice in FQHCs,<sup>10</sup> with significant time and resource burdens  
24 related to the administrative aspects of maintaining patient care.<sup>9,10</sup> The Council believes that this is  
25 a potential point of intervention via the addition of AMA policy to ensure that administrative  
26 burdens placed on physicians practicing in these settings are not undue and do not influence levels  
27 of burnout.

28  
29 In addition to ensuring that physicians are able to continue practicing in FQHCs the Council  
30 believes that it is also essential that the AMA advocate for continued federal support for these  
31 practices. Existing funding for FQHCs should be maintained and increased when feasible to  
32 support the expansion of existing clinics and founding of new clinics in underserved communities.  
33 The Council understands the importance of FQHCs in providing health care services for  
34 communities that have limited access and believes that it is essential to support these clinics and  
35 the physicians who practice in them.

36  
37 Finally, in order to ensure that patients cared for in FQHCs are receiving high-quality medical care  
38 services, it is important to ensure that care is always performed under the supervision of a  
39 physician. While regulations for both FQHCs and RHCs allow for practitioners like PAs, NPs, and  
40 CNMs to provide care, they do require the supervision of a physician. The AMA does have  
41 existing policies that ensure support for state and local medical societies in identifying and  
42 advocating for the existing requirement of physician oversight. Each of these additions and  
43 reaffirmations of policy will ensure that the AMA works to support essential access points of care  
44 for rural communities and the physicians who provide this care.

## 45 46 RECOMMENDATIONS

47  
48 The Council on Medical Service recommends that the following be adopted and that the remainder  
49 of the report be filed:



- 1       1. That our American Medical Association (AMA) support certification requirements and  
2       other policies that reduce the administrative burden for physicians practicing in Federally  
3       Qualified Health Centers (FQHCs). (New HOD Policy)  
4
- 5       2. That our AMA support sufficient federal funding to maintain the operation and costs  
6       associated with establishing and operating a FQHC, FQHC “Look-Alike”, or Outpatient  
7       Tribal Facility. (New HOD Policy)  
8
- 9       3. That our AMA advocate for regular updates to the Medicaid FQHC Prospective Payment  
10      System that at least keep pace without inflation. (New HOD Policy)  
11
- 12     4. That our AMA reaffirm Policy H-465.994, which supports efforts to develop and  
13      implement proposals and programs to improve the health of rural communities. (Reaffirm  
14      HOD Policy)  
15
- 16     5. That our AMA reaffirm Policy D-390.923, which advocates for the authorization of  
17      Chronic Care Management reimbursement for all physicians, including those practicing in  
18      FQHCs or Rural Health Clinics. (Reaffirm HOD Policy)  
19
- 20     6. That our AMA reaffirm Policies H-160.947 and H-35.965, which both advocate for the  
21      support of state and local medical societies in identifying and working to prevent laws that  
22      may allow for non-physicians (e.g., nurse practitioners, physician assistants) to operate  
23      without the supervision of a physician. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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**APPENDIX A: FQHC & RHC REQUIREMENTS**

	FEDERALLY QUALIFIED HEALTH CENTERS	RURAL HEALTH CLINIC
SUMMARY	<i>Provide at least primary care services to rural and urban shortage areas.</i>	<i>Provide primary care services for patients who live in rural shortage areas.</i>
SUBTYPES	<ul style="list-style-type: none"> <li>• <b>FQHC (Health Center Program Grantees):</b> Organizations receiving grants under section 330 of the PHS Act.</li> <li>• <b>“Look-Alikes”:</b> Organizations that meet the eligibility requirements of an FQHC, but do not receive funding under section 330 of the PHS Act.</li> <li>• <b>Outpatient Tribal Facilities:</b> Organizations operated by a tribe, tribal organization, or urban Indian Organization.</li> <li>• <b>Examples:</b> Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Independent RHC:</b> Clinics that meet the designation for an RHC and are standalone.</li> <li>• <b>Hospital-Based RHC:</b> Clinics that meet the designation for an RHC and are housed at a hospital.</li> <li>• <b>Provider-Based RHC:</b> Clinics that meet the designation for an RHC and are owned and operated by a nursing home or home health agency participating in Medicare.</li> </ul>
PRACTITIONERS	Services must be provided by a physician, NP, PA, CNM, CP, CSW, or furnished by the care of an aforementioned provider.	Must have a physician providing medical direction. A NP, PA, or CNM must provide care services at least 50 percent of the time.
FUNDING	Dependent on the subtype of FQHC. For official FQHCs they must receiving funding from grants under section 330 of the PHS Act. FQHC “look-alikes” may receive grants and funding from a variety of sources but <i>cannot</i> receive grants under section 330 of the PHS Act. Outpatient Tribal facilities are funded through the Indian Self-Determination Act or Title V of the Indian Health Care Improvement Act.	Funding is via Medicare reimbursement and patient co-pays.
RECORDS & REPORTING	Must demonstrate an effective procedure for compiling and reporting operations costs, patterns of service use, availability, accessibility, and acceptability of services offered. Must establish and maintain records and provide the authorities with access to examine, copy, and reproduce.	Clinics must file an annual cost report that includes payment rate, reconcile interim payments, graduate medical education adjustments, bad debt shots, and administrative payments.
AUDITING	Must provide an independent annual financial audit and file with the HHS secretary.	Must cooperate with audits done by oversight bodies.
REQUIRED SERVICES	Primary health services including family medicine, internal medicine, pediatrics, OBGYN care, diagnostic lab services, preventative health services, emergency medical services, referrals, case management services, services that enable access to the FQHC, and community education.	Must provide routine diagnostic and lab services, including chemical urine exams, hemoglobin or hematocrit tests, blood sugar tests, and occult blood stool specimen’s exam, pregnancy tests, and primary culturing onsite.
ADDITIONAL SERVICES	Pharmaceutical services, behavioral & mental health services, environmental health services, screening & control of infectious diseases, and injury prevention programs.	May provide care management services like Transitional Care Management (TCM), Chronic Care Management (CCM), General Behavioral Health Integration (BHI), Principal Care Management (PCM), and Psychiatric Collaborative Care Management.
POPULATIONS SERVED	Must serve a MUA or a MUP.	Must serve a non-urbanized community that is designated as a medical shortage area.

QUALITY IMPROVEMENT	Ongoing process that includes clinical services and management.	No specific quality improvement requirements.
PAYMENT & REIMBURSEMENT	Contracted agreement with the State for those eligible for medical assistance through a state plan. Collect appropriate reimbursement from patients who are insured and establish a prepared schedule of fees/payments from patients on a sliding scale, while ensuring no patient is turned away due to a lack of ability to pay. Must encourage patients to participate in insurance programs and plans for which they are eligible.	Reimbursement is paid via a bundled All-Inclusive Rate (AIR) per visit for all qualified primary and preventative care services. Dependent upon services and insurance status, patients may have a copay. For example, those with Part B coverage would pay 20 percent once their deductible is met and the AIR would pay 80 percent.
GOVERNANCE	Governed by a board comprised of a majority (51+ percent) of individuals who receive care at the center. The board must meet at least monthly.	No specific governance requirements.
SERVICE AREA	Must regularly review to ensure that the size of the catchment area is appropriate to ensure that services are available and accessible. Service boundaries should conform with local boundaries to the extent practical and should eliminate barriers to access due to geography.	Must serve a community designated as one of the following: a Primary Care Geographic Health Professional Shortage Area, Primary Care Population-Group Health Professional Shortage Area, MUA, Governor-designated and Secretary-certified shortage area.
COLLABORATIVE AGREEMENTS	Continued efforts to establish and maintain relationships with other health care providers. Must have an ongoing referral relationship with at least one hospital.	Must have arrangements with at least one hospital to provide services that are not available at the clinic.
CULTURAL & LANGUAGE CONSIDERATIONS	If a center serves a community with a “substantial portion” of limited-English speakers, services must be provided in the language and cultural context that is most appropriate. A staff member who is fluent in that language and English must be identified to bridge cultural and linguistic differences.	No specific cultural or language consideration requirements.
VISITS	Each visit must be medically necessary or a qualified preventative health visit. These visits traditionally needed to be face-to-face, but extensions have been made to allow for continued telehealth visits. Should multiple visits be required in the same day, they are considered one cumulative visit. Visits may also take place in the patient’s place of residence should they be home-bound.	Each visit must be medically necessary, a qualified preventive health visit. These visits can take place at the RHC, the patient’s residence, Medicare-covered Part A skilled nursing facility, scene of an accident, or hospice. Visits cannot take place at an inpatient or outpatient hospital department or in a facility specifically excludes RHC visits. Should multiple visits be required in the same day, they are considered one cumulative visit.
EXCLUSIONARY CRITERIA	FQHCs cannot be designated as an RHC.	Cannot be designated as a FQHC, rehabilitation agency, or be a primarily mental disease treatment facility.

**Appendix B**  
**AMA Policies Recommended for Reaffirmation**

**Policy H-465.994, “Improving Rural Health”**

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA’s policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
  - Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
  - Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
  - Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
  - Advocate for adequate and sustained funding for public health staffing and programs. (Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19; Modified: CSAPH Rep. 2, A-22)

**Policy D-390.923, “Chronic Care Management Payment for Patients Also on Home Health”**

Our AMA will advocate for the authorization of Chronic Care Management (CCM) reimbursement for all physicians, including those practicing in Rural Health Clinics and Federally Qualified Health Centers, for patients in a home health episode. (Res. 801, I-17)

**Policy H-160.947, “Physician Assistants and Nurse Practitioners”**

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

- (1) The physician is responsible for managing the health care of patients in all settings.
- (2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner’s authorized practice, as defined by state law.
- (3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- (4) The physician is responsible for the supervision of the physician assistant in all settings.
- (5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician’s delegatory style.
- (6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
- (7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care. (BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13; Reaffirmed: Res. 206, I-22)

**Policy H-35.965 “Regulation of Physician Assistants”**

Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by organizations to board certify physician assistants in a manner that misleads the public to believe such board certification is equivalent to medical specialty board certification. (Res. 233, A-17; Modified: Res. 215, I-19)