

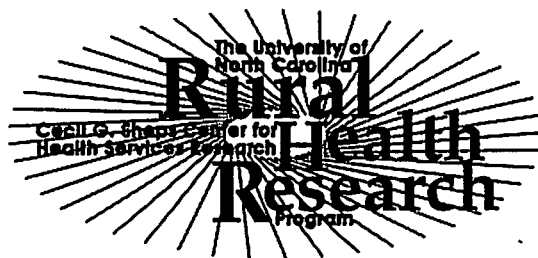
**USE OF FQHC REVENUE
FOR PHYSICIAN RECRUITMENT
AND RETENTION**

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DRAFT WORKING PAPER

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Abstract

The Federally Qualified Health Center (FQHC) program reimburses federally subsidized community and migrant health centers (C/MHCs) on a 100% reasonable cost basis for specified Medicaid and Medicare services. Survey data from a national sample of C/MHCs and secondary data sources were used to answer two questions: (1) how are C/MHCs using the financial gains realized through FQHC reimbursement; (2) do rural and urban C/MHCs differ in their priorities for use of the additional funds. Plans to use the additional funds for physician recruitment and retention purposes were given highest priorities by rural and urban C/MHCs.

Introduction

The Federally Qualified Health Center program was enacted under the Omnibus Budget Reconciliation Acts of 1989 (OBRA '89) and 1990 (OBRA '90) which called for the Health Care Financing Administration (HCFA) to reimburse "federally qualified health centers" (FQHCs) on a 100% reasonable cost basis for specified services provided to Medicaid and Medicare beneficiaries. Eligible entities include all of the approximately 560 Migrant and Community and Migrant Health Centers (C/MHCs) which receive federal funds under Sections 329 and 330 of the Public Health Services Act, the approximately 110 Health Care Centers for the Homeless which are funded under Section 340 of this Act, and Indian Health Service and tribal health care organizations. There are approximately 1,307 health centers which received FQHC designation. OBRA '89 also provided for other entities which are not federally funded but which meet the Public Health Service requirements for federal grant funding under Sections 329, 330 or 340 to obtain FQHC status as a "look-alike;" 65 health centers have received this look-alike designation.

The mission of the C/MHCs is to serve low-income persons. To fulfill this mission C/MHCs are required to participate in the Medicaid and Medicare programs and to have a sliding-fee scale for their services; this structure allows them no mechanism to shift unreimbursed costs to other (private) payers as hospitals and other providers do. In enacting the FQHC legislation, Congress sought to achieve three interrelated objectives: (1) eliminate the shift in costs from Medicaid and Medicare to federal grant funds; (2) free up federal grants to finance primary health care services for other low-income and uninsured individuals who comprise the C/MHCs target populations; and (3) expand C/MHC capacity to enhance scope of services and increase the number of individuals served within their respective communities (Lewis-Idema, Falik, Ricketts, Kolimaga, & Wright, 1992).

Although OBRA '89 and OBRA '90 stipulate 100% reasonable cost-based reimbursement for specified services, HCFA has the authority to set payment limits as a cost control measure. The most recent payment limits for each patient visit for FQHC Medicare reimbursement, effective through December 31, 1994, are \$69.65 for rural FQHCs and \$81.00 for urban FQHCs. These rates are adjusted annually by the Medical Economic Index. Individual State Medicaid agencies set different FQHC rates based on a variety of regulation and formulae.

The most obvious and compelling incentive for C/MHCs to seek the FQHC cost-based reimbursement is the prospect of increased revenue which would grow further as the centers expanded the number of publicly-insured patients they treated. An early implementation assessment of the FQHC program in 1992 showed that C/MHCs had not yet begun to increase their publicly-insured patient bases, largely because of lack of physical space to accommodate new patients, difficulties in recruiting additional providers, and need to upgrade record-keeping systems. Not surprisingly, these problems were identified as the initial targets for use of increased revenues generated by the FQHC reimbursement (Lewis-Idema, Falik, Ricketts, Kolimaga, & Wright, 1992). At the time the Lewis-Idema et al. study was conducted, C/MHCs in some states had not yet begun receiving Medicaid cost-based reimbursement, which was effective on April 1, 1990. Methodological and financing issues slowed the implementation process at the state level (FQHC Medicare reimbursement became effective on October 1, 1991).

Although OBRA '89 and '90 mandated FQHC cost-based reimbursement for Medicare and Medicaid, individual C/MHCs which do not expect to benefit financially may simply chose not to seek this reimbursement. Some C/MHCs are located in states which have higher-than-national average Medicaid reimbursement rates and, for them, cost-based reimbursement may actually decrease their revenues. Also, some C/MHCs had already been eligible to receive cost-based reimbursement from Medicaid and Medicare through programs such as the Rural Health Clinics Services Act (RHC) enacted in 1977 and the Federally Funded Health Centers (FFHC) which was created under the Johnson administration and substantially revised in the late 1970s (U.S. Congress, 1990). For most C/MHCs in North Carolina, for example, FQHC reimbursement has had virtually no impact because most of the C/MHCs in this state were receiving RHC and FFHC cost-based reimbursement prior to the implementation of the FQHC program. Other states, such as Illinois, had much lower levels of RHC participation, and FQHC enhancements made a large difference.

Our major purposes in conducting this study were to begin to document the impact of this important federal health policy initiative and to understand the needs and priorities of C/MHCs, particularly as they relate to physician recruitment and retention issues. We used primary data collection in the form of a survey instrument mailed to the executive directors of a nationally representative sample

of C/MHCs and secondary data analysis of the Bureau of Primary Health Care Common Reporting Requirements (BCRR) indicators to answer two primary research questions: (1) how are centers using the financial gains realized through FQHC reimbursement; (2) do rural and urban centers differ in their priorities for use of the additional funds.

Effective public policy is critical in fostering C/MHCs which provide needed access to care in medically underserved communities. As federal health reform proposals are being fine-tuned to arrive at the best alternative to provide access to care for medically underserved communities, this study provides policy makers with (a) an understanding of the effects of a federal policy initiative targeted to the financial stabilization of crucial health care providers in underserved communities; (b) an understanding of the financial decision-making, priority setting, and resource allocation processes of C/MHCs; and (c) an understanding of the need for physicians in rural and inner-city communities.

Data and Methods

Two sources of data were used for this analysis: a survey of community and migrant health centers conducted by the authors in Summer 1993 and BCRR 1990 data for all community and migrant health centers which had received federal grant subsidies under Sections 330 and 329 of the Public Health Service Act.

Survey Data. In May 1993 we mailed questionnaires to the executive directors of 290 C/MHCs which had responded to the authors' 1991 survey on health care provider recruitment and retention activities (Shi, Samuels, Konrad, Ricketts, Stoskopf & Richter, 1993). These health centers were chosen for this study because of their willingness to cooperate with the previous survey, their interest in provider recruitment and retention issues, and their representativeness of all community and migrant health centers. The centers were contacted by mail if they did not respond to the initial survey request; the final response rate of 62% was received over two months.

The major purposes of the survey were to assess: (1) the uses of revenues from FQHC cost-based reimbursement and, in particular, if increased revenues (i.e., for the C/MHCs whose overall revenues increased) are being used to recruit and retain health care professionals; and (2) how health care staffing in these C/MHCs

has changed since the 1991 survey. The questionnaire consisted of four major sections which covered current staffing, vacancies and staffing plans, revenue effects of Medicaid and Medicare FQHC cost-based reimbursement, and planned uses of the FQHC revenues. The responses to the questions relating to the first two topics on staffing and vacancies updates information from the 1991 survey and are being analyzed for another study. The responses to the questions relating to the FQHC reimbursement are reported below.

BCRR Data. BCRR indicators were used to supplement the survey data as a means to characterize and compare the responding and non-responding C/MHCs, to demonstrate the representativeness of respondents to the universe of C/MHCs, and to further characterize the respondents which are realizing financial gains from FQHC reimbursement.

The major variables obtained from the BCRR related to *health center size* (i.e., total medical users); *staffing* (i.e., number of primary care MDs, midlevels, and total medical services personnel including primary care MDs, other medical and surgical MDs, midlevel practitioners, medical nurses, and medical support staff); *medical salary compensation level* [i.e., average costs of medical salaries per FTE medical services personnel excluding National Health Service Corps (NHSC) salaries]; *revenue* (i.e., total revenue, percent of total revenue from Medicaid and Medicare); and *costs* (i.e., cost per medical encounter excluding laboratory, x-ray and pharmacy costs). Data from 1990 were chosen for two reasons: they represented the last full year of data prior to the receipt of FQHC reimbursement and thus serve as baseline data, and 1990 was the last year for which detailed Medicaid and Medicare expenditure and cost data were available on the BCRR system.

Analysis. The Student's t-test was used to detect statistically significant differences between groups and the differences are reported at the $p < .01$ and $p < .05$ significance levels. Comparisons included contrasts between total survey respondents and the universe of community and migrant health centers, urban respondents and urban non-respondents, rural respondents and rural non-respondents, and urban and rural respondents.

Results

Respondent Characteristics. Data in Table 1 show that the 180 survey respondents, representing an almost equal number of urban and rural health centers, are fairly representative of all C/MHCs for the nine variables studied with three exceptions. When compared to centers which did not respond to our survey, the survey respondents, when analyzed in aggregate, had, on average, fewer total medical users, fewer primary care physicians, and fewer medical services personnel. These differences are significant at $p < .05$. Comparisons of urban respondents with urban non-respondents and rural respondents with rural non-respondents indicate only one statistically significant difference within each group. The two urban groups differ significantly ($p < .05$) in average costs per encounter, with the non-responders having higher costs than respondents, and the rural respondent group having lower total revenues than the rural non-respondents.

As would be expected, there are statistically significant differences ($p < .01$) in the descriptive characteristics of urban and rural health centers in both the respondent and non-respondent comparison groups. Urban health centers tend to be larger than rural health centers in number of medical users and, correspondingly, the number of medical personnel employed, total revenues, and cost per encounter. Medicaid and Medicare revenues as percent of the health centers' total revenue fairly reflect the socio-economic and demographic characteristics of the communities in which these health centers are located and the Medicaid coverage policies of the states in which they are located. Rural areas tend to have a disproportionately higher number of residents who are age 65 and older and this demographic feature is reflected in the age mix of the rural health center clientele. Percent of revenue from Medicaid is higher than that of Medicare for both urban and rural health centers, but the urban centers receive nearly one-half of their revenue from this source as compared to a little more than one-fourth of revenues for the rural health centers. One explanation is that rural community and migrant health centers may be the only or one of a very few number of outpatient health care providers in an area and thus have a more diverse client base in terms of insurance status and ability to pay. Also, a previous study by the authors demonstrated a significantly high percentage of uninsured patients reported by physicians working in rural health centers, a variable which is not available on the BCRR data file (Kolimaga, Konrad, & Ricketts, in press). Community and migrant health centers in urban areas are more likely to have qualified for Section 330 funds

specifically because they serve poor, densely-populated neighborhoods with high concentrations of Medicaid patients.

There were no statistically significant differences in the average costs of medical salaries per FTE medical services personnel between respondents and non-respondents and between urban and rural centers. The variables on the BCRR data file do not permit calculation of average costs of medical salaries by specific type of provider so that, unfortunately, no conclusions can be drawn about urban-rural differentials in physician and midlevel salaries which may affect the centers' ability to recruit and retain these professionals.

Revenue effects of FQHC reimbursement. Data in Tables 2 and 3 show that an overwhelming majority of the survey respondents, 86%, are receiving FQHC cost-based reimbursement for Medicaid patients and that this reimbursement has either increased or is expected to increase overall revenues for over 88% of these centers. Similarly, the majority of respondents, 81%, are receiving FQHC cost-based reimbursement for Medicare patients and an overall 72% are receiving or expect to receive increased revenue from this source. These results confirm the attractiveness of this type of reimbursement. Although relatively more health centers report an actual or expected decrease in revenues with the Medicare FQHC reimbursement, this percentage, about 4.1%, is relatively small. Also, when compared to the effects of Medicaid FQHC reimbursement, more respondents expected Medicare FQHC reimbursement to have a minimal effect on revenue (17/145 vs. 1/154) or were uncertain of its effect (18/145 vs. 8/154). The latter finding probably reflects the fact that the respondents had less experience with this particular reimbursement because of its more recent implementation date [October 1, 1991 (Medicare) vs. April 1, 1990 (Medicaid)]. Survey data reveal that 74% of the responding C/MHCs were receiving Medicaid FQHC funds in 1991, compared to only 30% who were receiving Medicare FQHC funds in 1991. By the end of 1992, about 95% of the centers were receiving the Medicaid FQHC funds compared to 70% receiving Medicare FQHC funds.

An equal percentage (88%) of rural and urban health centers report an actual or expected increase in Medicaid FQHC revenues, while more rural health centers (77%) than urban health centers (66%) report an actual or expected increase in Medicare FQHC revenues. Urban health centers were more likely to have received

Medicaid FQHC funds sooner: 78% of the urban centers were receiving these funds by the end of 1991 compared to 69% of the rural centers. Approximately the same relationship holds true for receipt of Medicare FQHC funds: 75% of the urban centers were receiving these funds by the end of 1992 compared to 65% of the rural centers. The relative slowness of the rural centers to adopt FQHC is probably due to the fewer administrative and financial staff to manage the changes in accounting procedures required and the lower likelihood of the availability of sophisticated computer systems, which were findings of a previous study (Lewis-Idema, Falik, Ricketts, Kolimaga, & Wright, 1992).

When compared to all C/MHCs, those rural and urban C/MHCs which are gaining from FQHC reimbursement tend to have, on average: a higher number of total medical users, higher number of primary care MDs, higher number of total medical services personnel, lower average costs of medical salaries, slightly higher percentage of revenues from Medicare, but similar costs per encounter.

Planned use of FQHC funds. The priorities for the increased revenue of those C/MHCs which reported an actual or expected increase in overall revenue attributable to Medicaid and Medicare FQHC cost-based reimbursement are shown in Figure 1. Urban and rural health centers were identical in choices of their top three priorities for the use of the additional funds generated by FQHC reimbursement. The number-one priority for both rural and urban health center respondents was physician salary increases, followed by expansion of existing services and physician recruitment as the second and third priorities. The next highest priority reflect the C/MHCs' concerns about midlevels; midlevel recruitment and salary increases was the fourth highest priority for the urban and rural C/MHCs, respectively. The renovation or refurbishment of existing physical space placed fifth for both urban and rural respondents.

Figure 1 relates "yes" or "no" responses to each of the categories of revenue uses.¹ Our survey instrument also requested the respondents to assess the 100%, 75%, 50%, 25%, and 0% probability of actually using the funds for these purposes

¹The categories were largely drawn from a previous study in which the authors participated (Lewis-Idema, Falik, Ricketts, Kolimaga, & Wright, 1992) that assessed the early implementation of FQHC Medicaid reimbursement, and additional categories were added on the advice of expert reviewers of our draft survey instrument; therefore, the categories were known to reasonably reflect the needs of community health centers. Few health center executive directors volunteered another use of these funds.

within the following 12 months. When the data were analyzed to ascertain which of the planned uses of funds had a 75% or 100% probability of being used for the chosen purposes in the following year, the pattern of the top five responses remained basically the same. For rural centers, physician salary increases remained the top priority, but for urban centers it was replaced by the expansion of existing services. The next four highest priorities for the rural centers were expansion of existing services, physician recruitment, salary increases for midlevels, and midlevel recruitment. Physician recruitment and physician salary increases tied for the number two priority for the urban centers and were followed by midlevel recruitment, salary increases for midlevels, and renovation or refurbishment of existing physical space.

The dollar amount or percentage of revenue increases due to FQHC reimbursement was not asked in the survey because this would have entailed a much lengthier questionnaire and would have substantially decreased the survey response rate. The authors' previous involvement in studies involving C/MHC financial analyses, including the early implementation assessment of the FQHC program, confirm, however, that C/MHC executive directors and financial officers accurately estimate and relay the overall financial impact of individual program changes (Lewis-Idema, Falik, Ricketts, Kolimaga, & Wright, 1992; Sheps, et al., 1983; Ricketts, Konrad, & Wagner, 1983; Ricketts, Guild, Sheps, & Wagner, 1984; McLaughlin, Ricketts, Freund, & Sheps, 1985). Thus, we are confident in the accuracy of the response categories shown in Table 3 which include statements such as "expect an overall increase/decrease in revenue" and "can't predict." Further, before submitting the initial billing forms and cost reports, the C/MHCs were highly likely, with the help of the National Association of Community Health Centers, state and regional Primary Care Associations, and their accountants and financial consultants, to have estimated the revenue impact of the changes in reimbursement (NACHC, 1991a; Lewis-Idema, Falik, Ricketts, Kolimaga, & Wright, 1992).

Discussion

The National Association of Community Health Centers (NACHC) has reported that federally supported community and migrant health centers serve nearly 6 million people in all states, but they reach less than a quarter of those in the most dire need (NACHC, 1991b). C/MHCs are critical to assuring the needed access to care in many rural and inner-city communities that are too isolated or too poor to

attract and keep private physicians. In recent years, NACHC has reported that the financial health of C/MHCs has been worsening (NACHC, 1988a, 1988b, 1991b, 1991c). The contributing factors cited for this decline were increasing operating expenses, increasing sliding fee expenses (i.e., subsidies to patients), and increasing bad debts which were brought about largely by an increasing demand for services, an increasing number of sliding-fee scale users, inflation, and larger premiums for malpractice insurance. Within about the same time frame, however, the C/MHC program was successful in gaining annual appropriations increases, and the individual centers, in aggregate, experienced fairly impressive increases in Medicaid and fee-for-service revenues. C/MHCs increased their Medicaid revenues by 71% and fee-for-service revenues by 25% between 1987 and 1990; these increases were attributed mainly to on-site eligibility enrollment and more generous Medicaid eligibility requirements for pregnant women and children (Zuvekas, Chaurette, Bergheiser, & Sher, 1991). The passage of the FQHC program under OBRA '89 and '90 has helped to further stabilize the financial health of C/MHCs by allowing for Medicaid and Medicare reimbursement at a level that more accurately reflects the actual costs of providing services to the programs' patients. At the time this legislation was passed, about 40% of all C/MHC patients were covered by either Medicaid or Medicare (NACHC, 1991b).

Recent national health reform proposals acknowledge the need for additional funding of C/MHCs as well as their potential for playing an even greater role under national health reform. Several of these proposals target additional funds to these health centers, as examples: The American Health Security Act of 1993 (S. 491) will double grants to existing C/MHCs; The Managed Competition Act of 1993 (H.R. 3222) promises an unspecified amount of "new funding" will be made available to C/MHCs and RHCs; and the Action Now Health Care Reform Act of 1992 (H.R. 101) will increase the current authorization for C/MHCs by \$300 million per year for 5 years.

Two studies conducted immediately prior to or in the earliest stages of FQHC implementation were useful in documenting "wish lists" of C/MHCs for spending additional, relatively unrestricted funds. Implicit in almost all of the responses to the planned uses of additional funds from both of these studies is the need for additional providers. Zuvekas et al. (1991) report from their 1991 survey of C/MHCs the top three planned uses of increased revenues from FQHC reimbursement:

expand the number of people served, expand the scope of services provided, develop satellites in new service areas. Lewis-Idema et al. (1992)² conducted nine case studies of "best case examples" of FQHC implementation and concluded that there was an implicit hierarchy of uses of these funds: building construction and renovation, increasing physician and midlevel staffing and compensation levels, and identifying and filling service gaps. These two studies report the anticipated use and best case examples of centers likely to have revenue gains, but in this study we are able to establish the actual revenue impact of the FQHC program on a representative sample of C/MHCs and the use of enhanced revenue by C/MHCs which typically have been operating "at the margin," some for as long as 27 years.

More than 4 out of 5 respondents report that they are receiving FQHC reimbursement, which is indicative of the widespread implementation of the program. The program's impact on the centers' total revenue is also impressive: almost 90% of those receiving FQHC Medicaid reimbursement and more than 70% of those receiving the more recently established FQHC Medicare reimbursement have had overall revenue gains, indicating the program's positive financial impact on the centers. Generally, urban centers are slightly more likely to benefit from FQHC Medicaid reimbursement than rural centers; this can at least be partially explained by the tendency of urban centers to serve a higher proportion of Medicaid patients. Similarly, rural centers are more likely than urban centers to benefit from FQHC Medicare reimbursement.

Recruitment and retention of physicians was a high priority for all C/MHCs. Although BCRR data of survey respondents show that productivity of physicians and midlevels are within the C/MHC standards set by the Bureau of Primary Health Care (an average of 4,200-6,000 encounters per FTE physician and an average 2,100-3,000 encounters per FTE midlevel), the use of these funds for expanding existing services (second highest priority item) is consistent with the need for recruitment of physicians (third highest priority item). The reduction in funds to the National Health Service Corps throughout the 1980s had a profound negative effect on the availability of C/MHC providers, particularly physicians. Zuvekas et al. (1991) studied current and anticipated vacancies in C/MHCs in 1991 and found that there

²The 9 CHCs in this study were chosen because of their location in states in which FQHC implementation proceeded rapidly and because they had a substantial FQHC revenue gain and were able to quickly use the FQHC-generated revenues. Two of the authors of this study (Ricketts and Kolimaga) conducted and wrote the case reports on 5 of the 9 sites.

were an average 1.3 FTE physician and .40 FTE midlevel practitioner vacancies in rural centers and an average 1.9 FTE physician and .60 FTE midlevel practitioner vacancies in urban centers, attributing the rural-urban difference to the larger size of urban centers. The major reason for recruiting difficulties in urban centers was salary, while location was the greatest problem for rural and other smaller centers. FQHC revenue will overcome some of these difficulties, such as those related to salary and compensation levels and inadequate facilities, but it is not likely to be a quick-fix to the overall problem.

More emphasis was placed on the use of funds for the retention of physicians than for their recruitment, as indicated by the placement of physician salary increases as the number-one priority by both rural and urban health centers. Urban health centers, however, were more likely than rural health centers to be recruiting physicians, and the urban health centers were more likely to increase the salaries and benefits of their current physicians. There are no statistically significant differences ($p < .05$) between rural and urban centers in either their average medical salary costs or their average encounters per FTE physician.

The availability of FQHC indirect funds to support teaching activities is an important lever to increase physician retention in CHCs, particularly in rural communities where there is high physician turnover. Overall, 42% of the CHCs are involved in teaching activities, including 36% of rural CHCs and 48% of urban CHCs.

Conclusions

The FQHC program had three objectives: (1) eliminate the cost-shift from Medicare and Medicaid to federal grant funds; (2) free-up grant funds to finance services to more low-income and uninsured individuals; (3) enhance scope of services and increase the number of individuals served. The program has been successful in achieving the first objective. Assuming that the CHCs will carry through with their stated plans for the use of the FQHC funds, the other two program objectives will also be met. The ability of some of the centers to accomplish these last two objectives, however, will be limited by the availability of physicians and midlevels to provide the services. The isolation and other socio-demographic characteristics of rural areas and the general shortages of primary care physicians will continue to be serious impediments to provider recruitment and retention, particularly for rural C/MHCs. The Physician Payment Review Commission (PPRC)

found that the two major characteristics that affect rural primary care physician supply are poverty and population density, with poverty being more highly correlated with physician supply than density (PPRC, 1992). These are two factors which the FQHC program cannot ameliorate.

The national health reform debate has increased the awareness of federal, state and local policy makers and the general population to physician supply issues, especially the general need for more primary care physicians and the specific needs of rural and inner-city communities for these providers. The results of the many years of research and study by the PPRC (1992), the Council on Graduate Medical Education (1992), the Public Health Service's Bureau of Health Professions (U.S. Department of Health and Human Services, 1993) and others are now providing support to the need for legislative action in this area. The need and benefits of increasing the supply of primary care physicians is one area of comprehensive health reform which has widespread support and is not being contested by any of the major players in the national and state health reform arenas.

In summary, the FQHC program is an example of a federal initiative which is proving to be successful in meeting its objectives. We have shown that almost 90% of those C/MHCs receiving FQHC Medicaid reimbursement and more than 70% of those receiving FQHC Medicare reimbursement report actual or expected revenue gains. There are relatively small differences between urban and rural centers in their likelihood of having revenue gains, urban centers are slightly more likely to benefit from FQHC Medicaid reimbursement than rural centers and rural centers are more likely to benefit from FQHC Medicare reimbursement. Rural and urban health centers are identical in their top three priorities for the use of the additional funds: physician salary increases, expansion of existing services, and physician recruitment. FQHC reimbursement is enabling C/MHCs to provide better salary and compensation packages, to increase the number of persons served, to improve their facilities, and to expand their scope of services. FQHC reimbursement has played an important role in providing financial stability to C/MHCs. Hopefully, future federal health reform initiatives will lead to an increase in the number of physicians and other health professionals so that adequate staff are available to provide services.

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Table 1. Characteristics of Community and Migrant Health Centers

	Survey Respondents		All C/MHCs	
	Rural (n=91)	Urban (n=89)	Rural (n=224)	Urban (n=288)
Total medical users: a,b				
Mean	5,260	10,432	5,860	11,394
Median	4,064	8,016	4,659	8,108
Average number of medical services personnel employed:				
Primary Care MDs a,b	2.5	5.2	2.7	5.5
Midlevels ^b	1.1	2.0	1.2	2.2
Total medical services personnel ^{a,b}	9.0	21.4	9.8	22.1
Average costs of medical salaries per FTE medical services personnel (excludes NHSC)				
	\$39,989	\$43,539	\$40,162	\$42,029
Percent of revenues from Medicaid: ^b				
Mean	26.2%	46.2%	27.0%	45.5%
Median	24.6%	42.7%	24.5%	44.5%
Percent of revenues from Medicare: ^b				
Mean	16.0%	9.6%	15.7%	9.5%
Median	13.7%	6.9%	14.4%	6.4%
Total revenues: ^{d,b}				
Mean	\$434,523	\$1,097,324	\$516,960	\$1,320,076
Median	\$323,115	\$788,367	\$343,678	\$794,653
Cost per encounter: ^{b,c}				
Mean	\$34.43	\$39.15	\$34.38	\$41.61
Median	\$33.84	\$37.90	\$44.45	\$39.79

^a Statistically significant difference ($p < .05$) between total survey respondents and total survey non-respondents.

^b Statistically significant difference ($p < .01$) between all urban survey respondents and all rural survey respondents.

c Statistically significant difference ($p < .05$) between urban survey respondents and urban survey non-respondents.

d Statistically significant difference ($p < .05$) between rural survey respondents and rural survey non-respondents.

Data Source: 1990 Bureau of Primary Health Care Common Reporting Requirements

Table 2. C/MHCs Receiving FQHC Medicaid and Medicare Reimbursement

	Medicaid	Medicare
Rural	86.5%	84.1%
Urban	84.6%	78.0%
Total	85.6%	81.0%

Data Source: Survey of Federally Qualified Health Centers, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, May 1993

Table 3. Revenue Effects of FQHC Medicaid and Medicare Reimbursement

Revenue Effect	FQHC Medicaid		FQHC Medicare	
	% Rural C/MHCs (n = 77)	% Urban C/MHCs (n = 77)	% Rural C/MHCs (n = 74)	% Urban C/MHCs (n = 71)
Increased or Expected Increase	88.3%	88.3%	77.0%	66.2%
Decreased or Expected Decrease	0	1.3%	4.1%	4.2%
Little or No Effect	5.2%	6.5%	8.1%	15.5%
Can't Predict	6.5%	3.9%	10.8%	14.1%

Data Source: Survey of Federally Qualified Health Centers, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, May 1993

Insert Figure 1

Data Source: Survey of Federally Qualified Health Centers, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, May 1993

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