Are FQHCs the Solution to Care Access for Underserved Children?

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In this issue of *Pediatrics*, Nath and colleagues[1] present an ecological analysis of federally qualified health centers (FQHCs) in California, looking at how Medicaid and uninsured children use emergency departments (EDs). The article is timely because the Affordable Care Act and many state policymakers have bet on FQHCs as the solution to improving health care access for low-income populations while also reducing costs. The central issue, however, is how we ensure that poor children receive the same standard of care as others.

FQHCs are health care delivery sites funded by states through federal block grants to provide primary care and related services, such as behavioral health, dental care, and transportation, to low-income and medically underserved communities. From just a few centers, there are now 1202 licensed FQHCs with >10 000 sites serving >20 million persons across the United States.[2] This growth is likely to continue for several reasons. First, many pediatricians and other primary care providers (PCPs) either refuse to accept or severely limit Medicaid patients in their panels because of low reimbursement rates.[3] Although the Affordable Care Act raised reimbursement rates in many states, those federal supplements are ending, and pediatric reimbursement will likely remain low.[4] Second, states see FQHCs as a cheaper way to provide primary care for low-income patients than traditional settings.[5] Finally, the Affordable Care Act provides regulatory and financial incentives to expand the use of FQHCs.[6]

As Nath and colleagues[1] note, the literature has said little about how children use FQHC services. Thus, they examined how emergency department use by uninsured and Medicaid-enrolled children in California from 2009 to 2013 changed as new FQHCs were brought online. They found that increases in the geographic density of FQHC sites were associated with modest reductions in ED visits. Other measures of FQHC access were not associated with changes in ED use. The authors take precautions to address possible biases in conducting an ecological analysis by examining trends over time, assessing different outcome measures and controlling for several supply-side factors.

What do their findings say about access to primary care for low-income children going forward? It is unclear why improved primary care access provided at FQHCs did not produce a greater decrease in pediatric ED use. The growth of stand-alone EDs across the country increased pediatric use of emergency facilities independent of primary care access over the past few years.[7] The data in this study also predate the largest parts of the Affordable Care Act implementation. Therefore, the greatest growth of FQHCs, the increases in coverage, and the expansions of accountable care all took place after this study. It is possible that reduced ED use would be observed in the wake of these larger changes. Finally, there is evidence that poor families may simply prefer ED care to primary care, perceiving it to be less expensive, more accessible, and of higher quality than ambulatory care.[8]

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Separately from the findings of the study, the authors' findings point out the rapid growth of FQHCs and their involvement with children. FQHCs arose when low-income communities could not find PCPs to take uninsured and Medicaid-eligible patients. FQHCs provided an alternative primary care system because private PCPs were not serving impoverished neighborhoods and populations. This growth forces us to ask whether a separate health care system, like the FQHCs, is the best way to deliver care to the poor.

In an ideal world, Medicaid reimbursement, social services, and the availability of ancillary services would improve enough in community primary care practices that we would not need a separate system for Medicaid or uninsured children. All settings providing pediatric primary care should provide full service to children in poverty or be coordinated in a way to be a complete medical neighborhood. Unfortunately, in the real world, private primary care offices will likely continue to be reluctant to serve publicly insured children. However, we should not blindly accept a parallel publicly funded primary care system for children in poverty without stopping to reflect on the experiences of "separate-but-equal" systems in transportation, justice, and education that have rarely been equal. The authors raise an early warning about the rapid changes that have occurred in primary care and give us a chance to decide which solutions or combinations of primary care settings we will adopt.

It is critical that we have more studies examining services in FQHCs, to ensure that children served there receive the same quality of care as other children. We should also consider how best to integrate settings serving impoverished children with other pediatric settings so that all children receive coordinated care. Finally, there should be an open discussion among pediatricians, policymakers, and community members about why care for poor children is reimbursed at a lower level, thus creating the need for a separate health care system.

ABBREVIATIONS

ED: emergency department
FQHC: federally qualified health center
PCP: primary care provider

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