

Should our Family Medicine Practice be a Federally Qualified Health Center (FQHC)?

The pros, cons, and how-to



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- RPS Consultant—focus on rural, new programs
- FQHC experience:
 - CMO, Appalachian Community Health Centers (AMCHC);
 - Medical Director of Blue Ridge Community Health Services
- GME experience
 - Recovering FM program director; Teaching health center x 2
 - Chief Innovation Officer, MAHEC Asheville, NC
 - Clinical professor, UNC-Chapel Hill
- No Conflicts to report

Educational Objectives

- Why consider this model?
- What are the advantages to being an FQHC?
- What are the pitfalls and drawbacks?
- What are the keys to building a successful collaboration?

Why is this important?

- Financial pressures
- Opportunities for growth and expansion

Financial Pressures

- Decreasing hospital revenue in non-expansion states
- Shift to HSAs and effect on primary care
- Issues around possible ACA repeal
- BBA 2015—section 603 limiting OPPS reimbursement for outpatient services.

Opportunities for growth and expansion

- FQHCs in Medicaid expansion states doing very well
- Opportunities for residency expansion
 - New programs in smaller/rural areas with “unfavorable payer mix”
 - New clinic or clinic expansion
 - Restriction on provider-based reimbursement

What is an FQHC?

- History of the FQHC program/movement
- Relationship between HRSA and the community it seeks to serve
- FQHC funding over time—bipartisan support
- FQHC look-alikes, RHCs

Impact of Health Center Movement



What are the advantages of FQHC status?

- 330, 330H grants
- PPS cost-based reimbursement
- Federal tort claims act (FTCA)
- 340B pharmacy pricing
- Federal loan repayment
- Priority for other federal grants (HRSA, etc.)

FQHC Program requirements

- The 19 program requirements
 - Needs assessment (1)
 - Required services (different than RRC)(5)
 - Sliding fee scale (1)
 - QI (UDS reporting) (1)
 - Management and finance (8)
 - **Board authority and composition (2)**

What are advantages of a GME program?

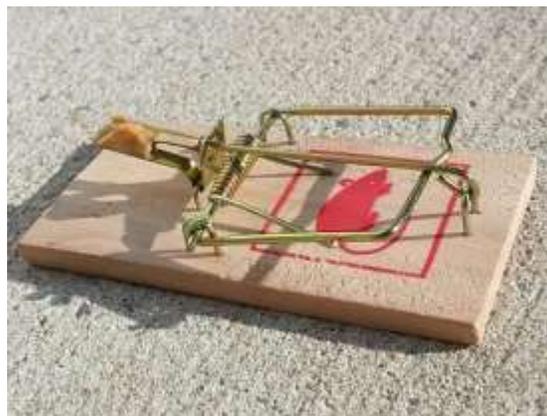
- Quality clinicians
- Payer mix
- Pipeline to future clinicians
- Key partnerships (hospital systems, universities)
- Infrastructure
- Status/branding
- GME funding/other funding streams

11

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What are the pitfalls?

- Control—FQHC vs. RRC/sponsoring inst.
- Discordant missions
- Different partnerships/alignment
- Different operating norms
- Fair market value requirements



12

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Control

- FQHC Board authority
- RRC requirements for program directors
- ACGME requirements for sponsoring institutions
- Vested interests

Discordant missions

- GME programs—teaching, scholarship, patient care
- FHQC—patient care, community service

Partnerships and alignment

- GME programs—usually aligned with hospitals, hospital systems, universities
- FQHCs—aligned with other FQHCs, government agencies, multiple hospital systems. May be competitors with GME program

Operating norms

- GME programs: Hospital system or university policies, fee schedules, HR structure and salaries, infrastructure, EHR, **Culture X**
- FQHCs: FQHC policies, fee structures, HR, leaner infrastructure, different EHR, **Culture Y**

Organizational culture questions

- Who are we?
- What do we do?
- How do we do things here?
- What makes us special/different?
- The answers to each are different for GME programs and FQHCs even if similar values

Fair market value

- GME programs: May in-kind contributions for infrastructure support, etc. from system
- FQHCs: May have in-kind or below market value partner contributions
- Stark requires fair market value of exchange of services between entities that could benefit from referrals

What are the strategies to becoming an FQHC?

- New Access Point (NAP)
- Merger or collaboration with existing FQHC
- FQHC look-alike



New Access Point (NAP)

- Highly competitive process
 - Priority based on need
- Intermittent, depending on available funding
- Almost always resisted by existing FQHC
- 120 days to implement after grant award
- Must have a corporation and FQHC board in place to apply

Merger or collaboration with existing FQHC

- Complete takeover by the FQHC
- Clinical operations taken over by FQHC, faculty/resident clinical service by professional service agreement (PSA)
- Subrecipient

FQHC Look-alike

- Not subject to competitive process, but must demonstrate need
- Must meet all the 19 program requirements
- Does not qualify for 330 grant, or FTCA
- Usually opposed by existing FQHC

Keys to Success

- CAREFUL PLANNING!!
 - Board(s) and key decision-maker education and alignment
 - Governance structure
 - Joint management
 - Supporting education and scholarly activity



Education and alignment

- Identification of opportunities
 - “Must haves”; “Would like to have”
- Long-term timeframe
- Linked to enduring institutional values
- Win-win-win basis
- Contingency planning

Protection for education and scholarly activity

- RRC requirements for:
 - Program director and core faculty protected time.
 - Scholarly activity
- ACGME requirements for Sponsoring Institution
 - DIO responsibilities
 - CLER visits

Financial arrangements

- Revenue
 - GME \$: Paid to hospitals
 - Patient revenue: Paid to FQHC and to other entities
- Costs
 - Salaries of resident, faculty, DIO
 - Clinic infrastructure

Bottom line: Revenue and costs need to line up for each partner without violating Stark

Governance structure

- FQHC Board authority and composition
- Avoid potential Stark violations
- Built-in incentives to continue collaboration
- Pre-nup
- **Align expectations, authority, and responsibility**

Operational Management

- Who makes what decisions?
- How are problems identified and addressed?
- How are conflicts resolved?
- **Align expectations, authority, and responsibility**

Conclusions

- FQHCs and FM residency programs have a lot in common.
- There are advantages to collaboration or merger.
- Careful planning and working through all the issues are the key to a successful joint program.



Questions?



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