American Osteopathic Association

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Opportunities for Collaboration with FQHCs

presented by:

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of

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FQHC Basics: A Refresher

- A Federally qualified health center (FQHC) is a public or non-profit private entity that provides primary and preventive health care, including enabling services, to a medically underserved population or residents of a medically underserved area
- Has a governing board with majority consumer membership
- Offers discounts off charges for those patients who are uninsured or underinsured with annual incomes below 200% of the Federal Poverty Level
- FQHCs receive certain benefits
  - Cost-related reimbursement from Medicaid, Medicare, and CHIP programs
  - 340B program favorable drug pricing
  - Opportunity to apply for federal grants
  - Federal Tort Claims Act coverage vis-à-vis medical malpractice claims (grantees only)

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Why Collaborate?

- Expand and enhance the amount, type and quality of services available in underserved communities, including access to affordable drugs
- Enhance access to the full continuum of care and reduce service gaps
- Add access locations and expand patient bases
- Maintain and improve providers' ability to deliver care in the appropriate setting
- Enhance and improve clinical, administrative and managerial capacities, resources, expertise and systems
- Ensure fair payment for preventive and primary care services from Medicare, Medicaid, and CHIP
- Increase sources of, and access to, capital and optimize opportunities to obtain federal grants under Section 330 of the Public Health Service Act to support otherwise uncompensated care costs

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Why Collaborate?

- Section 330 legislation and the implementing regulations require FQHCs to demonstrate appropriate collaboration and cooperation with providers of ancillary, secondary, and tertiary care, as well as Federal, State, and local health and social services delivery projects/programs (including other HRSA grantees, Section 330 grantees and FQHC look-alike entities)

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Range of Collaboration Options

- Referral agreements
- Co-location arrangements
- Lease of clinical personnel, administrative support staff, space and equipment, and/or management / administrative services contracts
- Residency training agreements* (this topic will be covered in Part III of this series)
- Transfer of primary care practices
- Establishing new access points
  - Limited services sites
  - Emergency Room Care Coordination sites
- Formation of new entities

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Key Terms: Referral Arrangements

- Formal Written Referral Arrangements
  - Referral provider agrees to furnish services to all FQHC patients who are referred to it by the FQHC regardless of ability to pay (subject to capacity limitations).
    - NOTE: in some instances, FQHCs have agreed contractually to pay the party receiving referrals for some portion of charges to uninsured or uninsured patients with incomes below 200% FPL
    - Patients receiving services are the referral provider's patients for the referred services
    - The referral provider (not FQHC) is financially, clinically and legally responsible and is solely liable for claims related to services
    - In general, the referral provider's policies, procedures, standards govern its provision of services
    - The referral provider (not FQHC) bills and collects payment for the services

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Key Terms: Referral Arrangements

- Formal Written Referral Arrangements
  - The referral provider agrees to provide services consistent with, at a minimum, prevailing standards of care and provide assurances regarding professional qualifications, licensure, and eligibility to participate in federal programs
  - The referral provider agrees to refer patients back to FQHC for clinically appropriate care and share medical notes/records/feedback regarding diagnosis and treatment to assist follow-up care by FQHC
  - Neither party should guarantee a specific number or level of referrals (no minimums/maximums)

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Co-location Agreements

- Similar to referral relationship, but
  - One party is physically located in and provides services to its own patients at the other party's facility, subject to applicable State law
  - The co-locating party would typically lease space (and possibly equipment, staff support)
- Circuit Riding
  - Co-location on a sporadic or as-needed basis, rather than full-time.
- The parties must ensure that the patient can distinguish between the FQHC and the co-located provider (e.g., separate signage, entrances, etc.)

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Key Terms: Co-location Agreements

- In addition to the key terms for any referral arrangement
  - Each party should retain the right to request removal of any health care professional engaged by the other party who fails to meet qualifications or who provides sub-standard care
  - The parties may consider co-branding efforts and conduct joint outreach activities to educate the public on the services available through the co-location arrangement

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Key Terms: Lease of Personnel

- FQHC contracts with another provider to furnish services to FQHC's patients on behalf of FQHC
  - May be used to procure clinical, administrative and/or managerial expertise and experience that FQHC cannot obtain directly
  - FQHC is financially, clinically, and legally responsible for the services purchased
  - Patients receiving services are FQHC patients
- Health center is responsible for billing and collecting from third parties/ patients and retains all revenue secured for services provided by contracted personnel
- FQHC pays a fair market value fee to the other party (not a pass-through of PPS or cost-related reimbursement rates)

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Key Terms: Lease of Clinical Services

- Contracted clinicians agree to provide services in accordance with the FQHC's applicable health care and personnel policies, procedures and standards
- Contracted clinicians must meet the FQHC's professional standards and qualifications, including credentialing and privileging, and cooperate/participate in an FQHC's clinical quality activities
- FQHC's CEO (and CMO) maintains ultimate authority for monitoring/evaluating the performance of contracted clinicians
- Health center retains the right to terminate the contract or to request/require removal, suspension and/or replacement of any contracted clinician who lacks qualifications, is non-compliant with FQHC policies and procedures, provides sub-standard care, or otherwise performs unsatisfactorily
  - Q: Why wouldn't a hospital typically lease services from the FQHC?

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Key Terms: Transfer Agreements

- Formal agreement to transfer a hospital or health system's primary care clinic(s) to an FQHC
- Parties should consider
  - Whether assets (facility/equipment) will be sold to the FQHC
  - Whether the FQHC will lease clinical or administrative services of the hospital's personnel to staff the clinic(s)
  - How medical records will be addressed
    - Pursuant to HIPAA and state law, patients must be notified of the transfer of the clinic to the FQHC
    - May require a separate Medical Records Agreement

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Key Terms: Transfer Agreements

Parties should consider (cont.)

- Whether the hospital or health system will provide financial support to the FQHC, generally in the form of a community benefit grant agreement
  - Key Terms for a Community Benefit Grant Agreement include
    - Amount of funding
    - Term of the agreement (e.g., 10 years)
    - Funding may not be tied to the volume/value of referrals
    - Hospital or health system may not interfere with FQHC's independent governance
- How the parties will collaborate post-transfer (e.g., Joint Steering Committee)

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Emergency Room Care Coordination

- CMS guidance pertaining to 2006-2009 $50 million demonstration grant program to support alternate non-emergency services provider arrangements:
  - Stated that, after an appropriate EMTALA screening and non-emergency determination, patient can be offered choice whether to receive care from hospital or from alternative non-emergency services provider that is contemporaneously available
  - Explicitly recognized FQHCs (among other types of primary care providers) as appropriate alternate non-emergency services providers

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Emergency Room Care Coordination

- **Potential Models:**
  - Hospital refers patients who present with non-emergent/urgent conditions to FQHC's existing site(s), possibly with transportation linkage.
    - Q: before or after treating the patient?
  - FQHC locates personnel in hospital (or on campus) for purposes of intake, registration, making appointments for patients who present with non-emergent/urgent conditions.
    - Q: for contemporaneous appointment in lieu of treatment in the ER or for follow-up appointment?
  - FQHC assumes operator status for hospital-owned ambulatory clinic or establishes FQHC site on or near hospital campus to provide an alternative to patients determined to have non-emergent/urgent conditions
    - Q: for full scope of FQHC services or limited service?
    - Q: 24 hours per day, 7 days per week or part-time?

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Key Terms: Emergency Room Care Coordination

- The parties should address whether or not EMTALA screening personnel will be the ER treating clinicians (preferably not)
- FQHC clinicians should not perform EMTALA screenings
- Post-EMTALA screening should be established, including required documentation of patient choice
- Development, maintenance and sharing of medical records should be addressed

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Limited Services Sites

- Site with limited scope of services and extended hours of operation
- Designed to be cost-efficient and convenient
  - FQHC offers same discounts off charges for uninsured and underinsured patients
  - Patients served at the limited services site must have reasonable access to the FQHC's full scope of services at a nearby site

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Formation of a New Entity

- Types of entities
  - PMN – practice management network
  - Multi-purpose networks – integrated service delivery initiatives, healthy communities access programs
  - MCNN - managed care negotiating network
  - MCO – managed care organization (e.g. HMO)
  - PHP - prepaid health plan
  - ACO – accountable care organization

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Formation of a New Entity

- Characteristics of new entity
  - Controlled by partnering entities (shareholders, Board of Directors, Management committee – depends on structural option)
  - Corporate independence of new entity's participating members/owners maintained
  - Should not preclude collaborations with other partners for other purposes

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Questions?

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