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Negotiating A Successful FQHC Collaboration

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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 Section 330 grants
 - Federal Tort Claims Act coverage vis-à-vis medical malpractice claims (grantees only)



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2

Options for Collaboration: Generally

- Referral agreements
- Co-location arrangements
- Lease of clinical personnel, administrative support staff, space and equipment, and/or management / administrative services contracts
- Transfer of primary care practices
- Establishing new access points
 - Limited services sites
 - Emergency Room Care Coordination sites
- Formation of new entities
- Residency training agreements



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3

Options for Collaboration: FQHC-Residency Program Partnerships

- FQHC-Residency Program collaborative models include:
 - Residency Program rotation is established in an existing FQHC site(s)
 - A new FQHC site(s) is established to serve as a residency training site
 - FQHC assumes operational authority over a teaching hospital's ambulatory care site(s) and the teaching hospital continues to operate the Residency Program



Residency Program Considerations: Teaching Activities

- Teaching activities typically include:
 - Classroom teaching
 - Retreats
 - Orientation programs
 - Faculty/program meetings
 - Curriculum development
 - Publication activities
 - Resident recruitment and selection
 - Resident/program evaluation
 - General residency program administration



Residency Program Considerations: Clinical Operations Activities

- Clinical operations activities typically include:
 - At the individual clinician level
 - Diagnosis/treatment-related activities (*i.e.*, history, examination and medical decision-making) by employed and/or contracted clinical staff
 - Direct patient involvement/interaction
 - The generation of a bill for the services provided
 - Quality assurance activities related to primary care clinical service delivery



Key Considerations

- Critical points:
 - Defined schedule for resident rotations
 - Productivity expectations
 - Residents must be exposed to sufficient variety/number of patients
 - All patient care activities must be supervised by a teaching faculty member who needs to review and sign-off on all resident patient care
 - Rotation site must be appropriately staffed with faculty and other clinical and administrative personnel adequate to meet patient care and educational requirements
 - Defined Residency Program Director



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Key Considerations

- Critical Points (cont.):
 - Reporting relationships
 - Selecting, evaluating, and disciplining Residency Program faculty
 - Selecting, evaluating, and disciplining residents
 - Facility space and equipment
 - Access to medical records
 - Conditions for termination



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8

Preceptor Billing

- Absent a primary care waiver, the preceptor must
 - Be physically present during the "key portion" (*i.e.*, the portion that determines the level of service billed) of the services provided
 - Participate in the three key components of the primary care service (*i.e.*, history, examination and medical decision-making)
 - Personally document such presence in the medical records



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Primary Care Exception to Physical Presence Requirement

- Applies to certain evaluation and management codes of low/mid-level complexity
- Certain conditions must be met, including but not limited to:
 - Resident's time at clinic must be included in determining hospital GME payments
 - Each resident must have completed more than 6 months of Residency Program
 - Preceptor must supervise not more than 4 residents and must be immediately available
 - Preceptor must have no other responsibilities at the time
 - Preceptor must review with each resident during or immediately after each visit, patient's medical history, physical examination, diagnosis, and record of tests/therapies
 - Preceptor must document his/her participation in reviewing/directing the services furnished to each patient



Financial Considerations

- GME rules require that the GME recipient incur all of the costs of the residents' salaries and fringe benefits
- Direct GME costs are not allowable FQHC costs
 - Costs associated with faculty/staff time that is associated with teaching activities should be borne by GME recipient



Residency Training Agreement

- Teaching Hospital maintains control over, and responsibility for, the costs of teaching activities performed at the FQHC's sites
- FQHC maintains responsibility and authority over activities related to direct patient care services
- Teaching Hospital retains general responsibility for salaries and benefits (including malpractice insurance) of Residency Program faculty and residents and other GME costs, but the FQHC pays for clinical time of faculty for which it bills (need to implement systems that prevent "double billing" of Medicare / Medicaid and Federal grants)
- Teaching Hospital is responsible for all costs related to time spent by clinicians and residents in teaching activities
- Teaching Hospital pays a fair market value fee to FQHC for any time spent by FQHC clinicians and support staff that participate in teaching activities, as well as associated overhead, equipment and space costs



Questions?

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13
