WHITE PAPER

The number of Federally Qualified Health Centers in the United States – and the comprehensiveness of services they provide – are on the rise and should skyrocket in the next five years as $11 billion in new funding is made available through the health reform package. While these FQHCs will provide critical primary care services to the nation's poor and underserved, they could also significantly impact the financial viability and sustainability of rural and critical access hospitals (R/CAHs).

Federally Qualified Health Centers:

Threat or Collaborative Opportunity?

In anticipation of the growth and expansion of services of FQHCS nationwide, R/CAHs must consider:

1. Are you closely collaborating with an existing FQHC in your market to assure an orderly development and provision of primary care services?
2. Has an existing FQHC become a competitor for primary manpower and lucrative outpatient services?
3. Is there a collaborative relationship between FQHC leadership and governance, and the R/CAH's leadership and governance?
4. Does the R/CAH have meaningful input into regional and local health planning for primary care services?
5. Has the R/CAH considered the strategic opportunities associated with FQHC development and collaboration?

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The Federally Qualified Health Center (FQHC) designation was originally created to greatly expand access to high-quality primary care healthcare, while reducing patient load on hospital emergency rooms. Today, FQHCs continue their efforts in these areas with tremendous success, but with a clear mission of serving low income and medically underserved communities, regardless of their ability to pay.

In March 2010, as a part of the Obama Administration's health reform package, $11 billion in new funding became available for FQHCs. This new funding will support program and facility expansion, and improvement of existing FQHCs, as well as enable the establishment of new FQHCs. While these new and improved FQHCs will help provide access and services to millions of citizens in our nation's underserved areas, they will also challenge rural and critical access hospitals (R/CAHs) like they've never been challenged before. Those that want to remain viable despite the growing number of FQHCs – and the potential for duplication of services and increased competition for the outpatient services business that come with them – must:

- Become involved in health planning to ensure a voice in the planning and development of new FQHCs;
- Pursue collaboration and integration tactics with existing FQHCs to secure their market share; or
- Create a competitive environment by developing a new, competing FQHC (and even consider restructuring the existing R/CAH to conform to FQHC requirements).

WHAT IS A FQHC?

A Federally Qualified Health Center is a reimbursement designation that refers to several health programs funded under the Health Center Consolidation Act (Section 330 of the Public Health Service Act), which defines federal grant funding opportunities for organizations to provide care to underserved populations. Organizations that may qualify to receive 330 grants include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs and Public Housing Primary Care Programs.

FQHCs (most often Community Health Centers) are non-profit, community-directed organizations that provide comprehensive primary care and preventive care, including health, oral and mental health/substance abuse services, to a "medically underserved area or population." In return, they receive a number of benefits, including consideration from the federal government in the form of a cash grant, cost-based reimbursement for Medicare patients, Medicaid reimbursement typically exceeding Medicaid professional fee reimbursements, 340 B drug pricing and free malpractice coverage.

Specifically, FQHCs serve areas and populations with:

- Too few primary care providers
- High infant mortality rates
- High poverty levels
- Concentrations of elderly residents

Did You Know?

In 2015, health centers are projected to:

- Reach 40 million patients;
- Save $122 billion in total health care costs over 5 years;
- Generate $54 billion in total economic activity;
- Create 284,000 new full-time equivalent jobs in their local communities.

Source: NACHC Primary Care Revolution

FQHC KEY FEATURES

FQHCs provide access to persons of all ages, regardless of their ability to pay, and charge for services on a community board-approved sliding-fee scale that is based on patients' family income and size.

- Discounted fee schedule for incomes <200% poverty level
- Full discounts for incomes at or <100% poverty level

FQHCs are required to provide the following clinical services:

- Primary care
- Diagnostic x-ray and lab
- Health screenings and immunizations
- Emergency medical services

- OB/GYN services, including prenatal and perinatal and well child
- Preventive dental
- Pharmacy
- Mental health, substance abuse and specialty services, via referral

They are also required to provide these non-clinical services:

- Case management and counseling
- Follow-up and discharge planning
- Support for Medicaid enrollment
- Health education
- Transportation, translation and outreach

In addition, FQHCs are required to offer professional coverage during hours when the center is not open; physicians must typically maintain admitting privileges at one referring hospital, or arrangements for hospital-based coverage and services; relationships with other providers; and a fully-staffed management team.

Did You Know?

President George W. Bush launched the Health Centers Initiative in 2002 to significantly increase access to primary health care services in 1,200 communities through new or expanded health center sites. Health Centers served more than 16 million patients in 2007, an increase of more than 5.8 million over 2001.

HOW ARE FQHCs ESTABLISHED?

An application to receive a FQHC grant and designation is made through and reviewed by the "Primary Care Officer" at the State Department of Health. Often, the Director of the State Primary Care Association cooperates with the Primary Care Officer in the review process prior to submission to the Federal Government for approval. (State rules may vary.)

HOW ARE FQHCS GOVERNED?

FQHCs operate under a consumer Board of Directors governance structure and function under the supervision of the Health Resources and Services Administration, which is part of the United States Department of Health and Human Services. FQHC governance requirements stipulate that the board must include:

- A majority (at least 51%) of active, registered clients of the health center, who are representative of the populations served by the center; and
- At least nine, but no more than 25 members.

Of the non-patient board members, only a limited number of those members may earn more than 10 percent of their income from healthcare-related industries (effectively limiting the number of non-patient healthcare providers who may be included on the FQHC board). Employees of the FQHC and their spouses, children, parents or siblings (through blood or marriage) cannot be members of the board.

WHAT BENEFITS EXIST FOR FQHCS?

There are a number of benefits that come with being a FQHC, including:

- Section 330 Health Center Grants – up to $650,000 annually, with additional grant funding available for service and capacity expansions
- Minimum per encounter payments for services
  - Medicare cost reimbursed with a Cost Per Visit Cap of approximately $126.22
  - Medicaid systems vary somewhat, but, generally, reimbursements higher than Medicaid fee schedule reimbursements
- Federal medical malpractice coverage under the Federal Tort Claims Act
- 340B drug pricing
- Loan guarantees
- Opportunities to recruit National Health Service Corp. personnel

Additional financial benefits include:

- ♦ A dedicated budget of $2.5B in FY 2011
- ♦ Additional funds via the Patient Protection and Affordable Care Act – Section 10503's Community Health Center Fund, including:

Community Health Center Operations Funding, 2011-2015			
Fiscal Year	Trust Fund +	Discretionary Funding (est.)	Total Annual Funding (est.)
FY 2011	$1 Billion	$2.19 Billion	$3.19 Billion
FY 2012	$1.2 Billion	$2.19 Billion	$3.39 Billion
FY 2013	$1.5 Billion	$2.19 Billion	$3.69 Billion
FY 2014	$2.2 Billion	$2.19 Billion	$4.39 Billion
FY 2015	$3.6 Billion	$2.19 Billion	$5.79 Billion

Other Things You Should Know About FQHCs

- ♦ A FQHC can own and operate a R/CAH.
- ♦ A city/county/hospital district public hospital (entity) can own a FQHC, if FQHC governance requirements are achieved, i.e. the "Public Entity Model" (see below).
- ♦ A non-public, state-owned or independent 501c3 R/CAH can own a FQHC, if the governing body (Board of Directors) is reconstituted to meet the governance requirements of a FQHC.
- ♦ A R/CAH can develop and own a Rural Health Clinic (RHC), but the R/CAH cannot convert the RHC to a FQHC and maintain control unless the R/CAH's governing body is reconstituted to meet the governance requirements of a FQHC.
- ♦ A 501c3 can operate a R/CAH and develop a FQHC to control the respective "system" by reconstituting the board to meet the governance requirements of a FQHC. (For example: Minnie Hamilton Health System, Grantsville and Glenville, WV)

THE REAL CHALLENGE:

How Will The Expansion of FQHCs Impact R/CAHs?

The $11 billion in new funding for FQHCs will support considerable growth and expansion of FQHCs nationwide. This, in turn, will challenge the sustainability of R/CAHs in that they will be forced to compete in small markets where many have traditionally been sole providers; where the R/CAH has the ongoing responsibility for inpatient and emergency services; and where the R/CAH will be providing services nearly identical to those provided by FQHCs, but without the grant support, medical liability coverage and recruiting leverage that comes with the FQHC designation.

Comparison	R/CAH	FQHC
Primary Care Responsibility		X
Cost-based Reimbursement	X	X
MMC / Tort Protection		X
Recruitment Leverage		X
Access to Grants for Program / Capacity Expansion		X
ED / Inpatient Safety Net Provider	X	
Collaboration on Recruiting / Shared Services / Education / IT	X	X

ACHIEVING FQHC GOVERNANCE REQUIREMENTS

Public Entity Model:

- Non-state owned (city/county) public entity
- Public Health Department the most common entity
- Could be a public hospital, if the hospital board is appointed by elected officials
- Board membership of the hospital/FQHC entity must conform to the FQHC governance requirements

Public Entity Co-applicant Model:

- Public hospital (R/CAH) that does not desire to reconstitute board governance to meet FQHC requirements
- A new 501c3 entity is created (NEWCO) to house the FQHC, with a board structure that meets the FQHC governance requirements, but could have some common board membership with the public R/CAH
- NEWCO and Public Hospital enter a "shared services agreement" for employees and other services

501c3 Model:

- A 501c3 reconstitutes its board to meet the FQHC governance requirements and manages both a hospital and FQHC, where the hospital and FQHC have advisory boards for general oversight
- All policy, capital and budgetary decisions are made by the 501c3 Board (i.e. system model)

DETERMINING YOUR "LEVEL OF THREAT" AND/OR COLLABORATIVE OPPORTUNITY

For a R/CAH with no existing FQHC in the county or primary service area, the level of threat is Low.

Strategic imperatives:

- Become a strong voice in the strategic planning and development of a FQHC;
- Consider corporate and governance restructuring to meet FQHC requirements to control the "system" of care;
- Explore collaborative opportunities to create a FQHC via one of the public entity or 501c3 models (see "Achieving FQHC Governance Requirements" above); and
- Pursue opportunities to become more active in health planning and licensure in the community to ensure an adequate voice representing R/CAH issues and interests.

For a R/CAH with a FQHC in the county or primary service area – where the R/CAH championed and assisted in the development of the FQHC, and where there is active collaboration – the level of threat is Medium. In these types of situations there may be:

- No integrated governance that meets FQHC regulation
- R/CAH providing lab and imaging services
- Joint recruiting
- Integrated IT
- Call coverage participation by FQHC providers

Strategic imperatives:

- Pursue collaborations and integration of tactics to ensure full participation of the FQHC in the R/CAH and its medical staff;
- Pursue leadership and influence in local health planning;
- Restructure governance, so that the R/CAH and FQHC are governed by a single board that meets the FQHC governance requirements;
- Create a competitive environment through the development of a competing FQHC, using a public entity or 501c3 model to meet FQHC governance requirements;
- Restructure the existing R/CAH-owned RHC to FQHC via creation of the 501c3 or public entity model; and
- Pursue opportunities to become more active in health planning and licensure in the community to ensure an adequate voice representing R/CAH issues and interests (to the extent permitted under applicable guidelines).

For an independent R/CAH and FQHC competing in a small market for patients and resources – where the FQHC duplicates and competes in a broad spectrum of outpatient services (especially imaging and lab), and where FQHC medical staff do not participate on R/CAH medical staff, provide "after hours" call coverage or cover inpatient admissions – the level of threat is High. Strategic imperatives should include those listed above in the Medium threat section.

Additional Activities and Strategies

All R/CAHs – no matter the level of threat they are experiencing – should also take steps to:

- Educate local Congressional delegations regarding FQHC threats to R/CAHs;
- Educate local and state elected and appointed health officials about duplicative services and competition in small markets; and
- Support the proposal by the "Hospital Constituency Group" of the NRHA to make 330 Grants available to R/CAHs

Moving Beyond Strategy to Proven Business Tactics

In addition to embracing the strategies above to help position the R/CAH for long-term success, there must be a clear and immediate focus on implementing business tactics that either drive a collaborative relationship or support a competitive response in the absence of a cooperative agreement.

For R/CAHs in **Low** threat situations, the most important tactic moving forward is to ***focus on exceptional customer service*** in outpatient services, especially ER, lab, imaging and outpatient surgery. Other tactics should include:

- Study primary needs in the market and develop new access points before other competitors, i.e. RHCs and

- Evaluate providing lab and imaging services at RHCs and primary care centers;
- Evaluate primary care manpower needs and add capacity through employment to cover shortfalls;
- Bolster primary care capacity through the recruitment and employment of extenders to serve in critical primary care clinic sites in the market; and
- Explore a collaborative opportunity with the local health department, and assess potential restructuring to enable participation in a "friendly" FQHC ahead of the competition.

R/CAHs in **Medium to High** threat situations should:

- Focus on exceptional customer service in outpatient services, especially ER, lab, imaging, and outpatient surgery
- Consider off-site outpatient lab and imaging site
- Collaborate with FQHC to provide IT, lab, imaging, and other outpatient services to FQHC facilities
- Meet monthly with the FQHC Administrator (CEO) and create collaborative activities consistent with requirements of applicable anti-trust laws
- Assist FQHC with hospital privileges and involve in medical staff activities
- Explore use of state Flex Grant Program to develop programs in quality improvement, infrastructure enhancement, renovations, and provider recruitment
- Evaluate using FQHC staff for supplemental R/CAH hospitalist services
- Collaborate in educational activities
- Assess shared services, including joint recruitment and employment
- Build relationships to leverage fair treatment in licensure issues, health policy, and local/state grant opportunities
- Make sure the FQHC follows the rules and regulations established by Health Resources and Services Administration (HRSA)
- Evaluate creating a competitive FQHC via restructuring

At the End of the Day

While FQHCs may be perceived by some as nothing more than a competitive threat, R/CAHs with an eye toward the future understand that FQHCs can also provide myriad opportunities for friendly and/or collaborative relationships. **These relationships can improve access to primary care; support physician recruiting and retention efforts; serve as a platform for primary care physician employment; reduce medical malpractice coverage costs and liability; provide access to grants and loans to support program and facility expansion; and mitigate future competition in financially critical outpatient services.**

At QHR, we have three decades of hospital management experience and expertise to help your hospital identify and address the potential threats and opportunities associated with the expansion of the FQHC program. Our seasoned strategy/leadership, physician services and clinical operations consultants are ready to help guide you in developing and implementing solutions that will help ensure you survive and thrive in this changing marketplace. For more information, visit www.qhr.com.

This presentation is a general overview of some possible strategies for partnering with FQHCs, but is not a comprehensive discussion of all FQHC-related issues, and is not a substitute for legal advice. Any facility considering implementation of these strategies should consult their legal counsel; consider having their legal and business counsels consult with the HRSA field office during the planning process; and secure appropriate counsel related to health law and other regulation issues (i.e. Stark and anti-trust).