



Collaborations between Federally Qualified Health Centers and Residency Programs

presented by:

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Reasons to Collaborate

- Offers an attractive, unique training environment offering some of the best and evolving models of care
- Creates a dynamic clinical environment
- Enhances the status/reputation of each party
- Enhances physician recruitment and retention
- Stepping stone to other collaborations
- Financially and otherwise beneficial to parties and the community

Residency Collaboration Options

- Rotations in health center site
- Close hospital ambulatory site(s) and transfer continuity clinic rotations to health center site(s)
- Acquisition of residency clinics
- Start new clinics
- Start new residency program

Terminology Matters: Teaching Activities

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

Terminology Matters: Clinical Operations

- 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

Reach Common Understanding of Key Accreditation Council for Graduate Medical Education (ACGME) Requirements

- ACGME Program has particular and unique requirements for:
 - Internal medicine
 - Obstetrics and gynecology
 - Family medicine
 - Pediatrics

Reach Common Understanding of Key Accreditation Council for Graduate Medical Education (ACGME) Requirements

- Residency Program Director must
 - Have authority and accountability for the operation of the Residency Program
 - Oversee and ensure the quality of didactic/clinical education in all rotation sites
 - Approve all Residency Program faculty
 - Evaluate Residency Program faculty
 - Monitor resident supervision
 - Be familiar with and ensure compliance with ACGME and Review Committee policies and procedures

Reach Common Understanding of Key Accreditation Council for Graduate Medical Education (ACGME) Requirements

- Residency Program Faculty must
 - Devote sufficient time to the Residency Program to fulfill their supervisory and teaching responsibilities
 - Demonstrate a strong interest in the education of residents
 - Possess current medical licensure
 - Establish and maintain an environment of inquiry and scholarship

- ACGME Program Requirements specify that
 - Service demands must not adversely affect educational objectives
 - Plan should be in place to ensure fiscal stability of the Residency Program

The FQHC must:

- Serve a medically underserved area (MUA) or medically underserved population (MUP)
- Provide, or arrange for the provision of, the required services, which includes comprehensive primary and preventive health care services (including essential ancillary and enabling services) across all life cycles
 - basic health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology
 - diagnostic laboratory and radiologic services
 - preventive health services (e.g., prenatal and perinatal services; cancer and other disease screening; eye, ear, and dental screening for children; family planning services; and preventive dental)
 - emergency medical services
 - pharmaceutical services as may be appropriate
 - referrals to providers of other health-related services (including substance abuse and mental health services)

Reach Common Understanding of Core Requirements for FQHCs

- The FQHC must:
 - Have a schedule of charges designed to cover the reasonable costs of operation and consistent with locally prevailing (community) rates
 - Have a corresponding schedule of discounts
 - Adjusted based on ability to pay for all persons or families earning annual incomes at or below 200 % of poverty
 - Full discounts or “nominal” charges for persons or families earning annual incomes at or below 100 % of poverty

Reach Common Understanding of Core Requirements for FQHCs

- The FQHC must:
 - Have a governing board (comprised of 9-25 individuals)
 - Composition
 - Majority are active consumers of the FQHC services and are demographically representative of the populations served by the FQHC
 - Non-consumer Board members must represent the community served and be selected for expertise in areas such as finance and banking, legal community affairs, *etc.*
 - Autonomously exercises all authorities and approvals for the FQHC, including selecting the CEO, approval of the annual budget, approval of financial management policies and internal control systems, personnel policies, and health care policies (including scope, schedule and location of services, eligibility for services), compliance policies, Q/A, and more

Reach Common Understanding of Core Requirements for FQHCs

- Section 330 grantees (not look-alikes) must comply with the requirements and standards set forth in 45 CFR Part 74 regarding
 - Procurement of goods and services utilizing Federal funds (in whole or in part)
 - Acquisition, management and disposition of property and equipment, acquired or improved with Federal funds (in whole or in part)

Implementing Agreements

- A residency collaboration should be implemented through a written Residency Training Agreement (including Master Affiliation and/or Program Letter of Agreement terms)
- A collaboration may also necessitate one or more of the following additional agreements, particularly if FQHC assumes financial and operational responsibility for a residency program clinic (or starts a new clinic) :
 - Community Benefit Grant
 - Lease of clinical personnel and/or administrative support staff
 - Alternative: transfer workforce
 - Lease of space and/or equipment
 - Medical Records Agreement

Residency Training Agreement

- Residency Program maintains control over, and responsibility for, the costs of teaching activities performed at the FQHC's sites
 - Classroom teaching, orientation programs, curriculum development, resident recruitment and evaluation, faculty appointment/evaluation, and program administration
- FQHC maintains responsibility and authority over activities related to direct patient care services
 - Scope, location, hours of service, quality assurance, management, oversight of clinical care delivery, billing and collections
 - Services are provided in accordance with FQHC policies and procedures and under clinical direction of CMO

Residency Training Agreement

- GME recipient retains responsibility for salaries and benefits (including malpractice insurance) of residents
- Residency Program is responsible for all costs related to time spent by clinicians / residents, etc. in teaching activities
- Patient volume, preceptor productivity, space/support needed for residency must be carefully considered
- A three party Residency Training Agreement including the hospital, as GME recipient, may be necessary

Residency Training Agreement

- Address Program Letters of Agreement Requirements (ACGME Programs)
 - Identify the faculty with educational and supervisory responsibilities for residents;
 - Specify faculty responsibilities for teaching, supervision, and formal evaluation of residents
 - Specify duration and content of the educational experience
 - Identify policies and procedures that will govern resident education at the FQHC

Residency Training Agreement: Preceptor Billing

- FQHC pays for clinical time of precepting faculty in supervising residents while providing services for which it bills (as well as directly providing services to patients without residents*); it does not pay for (nor bill for) residents' time/services
- FQHC bills payors and collects (and keeps) payments for clinical services provided to health center patients by faculty supervising residents
 - * A preceptor may not supervise residents and provide direct service simultaneously

Preceptor Billing Requirements

- 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

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:
 - Each resident must have completed more than 6 months of residency program
 - Resident’s time at clinic must be included in determining hospital GME payments
 - 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

Community Benefit Grant

- Defrays a portion of the costs of providing otherwise uncompensated care to the FQHC's patients
- Health Center Safe Harbor under Federal Anti-Kickback statute: final OIG rule issued October 4, 2007 [42 C.F.R. 1001.952(w)]
 - Applies only to FQHC grantees, but considerations are presumably the same for FQHC look-alikes
 - Purpose: protect from prosecution under the federal anti-kickback law certain arrangements between FQHC grantees and providers/suppliers of goods, items, services, donations and loans

Note: In order to obtain HRSA approval to add a site to the FQHC's scope of project, it must document it can operate the site on a break-even basis

Community Benefit Grant

- The arrangement contains safeguards to protect against prohibited referrals or generation of other business
 - Must contribute to the FQHC's ability to maintain or increase the availability, or enhance the quality, of services provided to the FQHC's medically underserved patients
 - Fixed amount/methodology
 - Does not limit or restrict patient's freedom of choice or the provider's professional judgment

Lease of Clinical and/or Administrative Services

- The FQHC leases the capacity of physician(s) and/or other clinical professionals and support personnel to provide services at the FQHC's sites on the FQHC's behalf
- The FQHC is responsible for billing and collecting from third parties / patients and retains all revenue secured for services provided by contracted personnel
- The FQHC pays a set fee (assessed at fair market value) for leased services

Lease of Clinical and/or Administrative Services

- Contracted clinicians provide services in accordance with the FQHC's applicable health care and personnel policies, procedures and standards (*e.g.*, clinical guidelines, productivity and QA standards, standards of conduct, record-keeping)
- Contracted clinicians must meet the FQHC's professional standards and qualifications, including credentialing and privileging

Lease of Clinical and/or Administrative Services

- The FQHC's (with the CMO) maintains ultimate authority for monitoring / evaluating the performance of contracted clinicians (and the support personnel) and whether they are compliant with the FQHC's policies, procedures, standards and qualifications
- The FQHC retains the right to terminate the contract or to request / require removal, suspension and/or replacement of any contracted clinician and/or support personnel who lacks qualifications, is non-compliant with policies and procedures, provides sub-standard care or otherwise performs unsatisfactorily

Collaboration Process

- Memorandum Of Agreement (including appropriate confidentiality terms)
- Planning and development (steering committee, task forces)
- Due Diligence
- Definitive agreements
- Board approvals
- Regulatory approvals

Health Reform: Patient Protection and Affordable Care Act

- Title VII Teaching Health Centers Development Grants
 - Grants will cover the costs of establishing or expanding a primary care residency training program, including costs associated with:
 - curriculum development;
 - recruitment, training and retention of residents and faculty;
 - accreditation by the Accreditation Council for Graduate Medical Education, the American Dental Association, or the American Osteopathic Association; and
 - faculty salaries during the development phase
 - \$25,000,000 for FY 2010, \$50,000,000 for FY 2011, and \$50,000,000 for FY 2012

Health Reform: Patient Protection and Affordable Care Act

Title III - Payments to THC's that Operate Graduate Medical Education Programs

- Establishes mechanism for paying teaching health centers for costs of training residents in their facilities
- Mandatory appropriation capped at \$230 million for 2011 through 2015
- THC's that are listed by accrediting institutions as program sponsors are eligible to be paid for direct and indirect expenses of new or expanded residency training programs
- Payment limited to expenses for residents above a "base level" of primary care resident positions
- Payments are in addition to those made to hospitals for DME and IME costs and payments made to non-hospital providers, but residents' time may not be double-counted

Relevant Laws, Regulations, Policies: FQHCs

- Section 330 of the Public Health Service Act (42 USC §254b)
- Implementing regulations: 42 C.F.R. Part 51c
- HRSA Policies (<http://bphc.hrsa.gov/policy/>)
 - PINs # 97-27 and # 98-24: Affiliation Policies
 - PIN # 98-23: Program Expectations
 - PIN # 2008-01: Scope of Project Policy
- 45 C.F.R. Part 74 (or Part 92): Procurement and property standards (incorporating OMB Circulars A-110 and A-122)
- Notice of Grant Award (“NGA”) and special terms and conditions
- Federal Tort Claims Act (42 U.S.C. §233; 42 C.F.R. Part 6)
- Section 340B discount drug pricing (Section 340B of the Public Health Service Act; 42 U.S.C. § 256b)

Other Legal Considerations

Hospital Medicare Direct/Indirect GME

- Sections 1886(d)(5)(B) and 1886(h)(4)(E) of the Social Security Act; 42 U.S.C. §1395ww
- Amendments set forth in Sections 5504 and 5505 of the Patient Protection and Affordable Care Act (PPACA)
- Implementing regulations: 42 CFR §413.75 *et seq.*; 42 CFR §412.105

FQHC Direct GME reimbursement

- 42 C.F.R. §405.2468(f)

Teaching Health Centers Program

- Section 5508 of the PPACA

ACGME Website: <http://www.acgme.org/>

Other Legal Considerations

Fraud and abuse

- Federal Anti-Kickback Statute
 - 42 U.S.C. §1320a–7b; regulations at 42 C.F.R. §1001.951 through §1001.952
- Federal False Claims Act
 - 31 U.S.C. §3729-3733
- Stark Law (Physician anti-self-referral)
 - 42 U.S.C. §1395nn; regulations at 42 C.F.R. §411.350 through §411.389.



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