

Collaboration and Federally Qualified Health Centers (FQHC)

This paper is intended to provide non-FQHC health care providers with a better understanding of what is motivating FQHCs to expand.

March 2011

STROUDWATER ASSOCIATES

Purpose of this Paper

“... what is motivating FQHCs to expand the number of service sites and provide non-FQHC reimbursed services ...”

With the recent and anticipated expansion of the Community Health Center (CHC) / Federally Qualified Health Center (FQHC) program many rural health care providers find their organizations in direct competition with FQHCs. The dramatic expansion of the FQHC program is certainly one reason for this increased competition, but a change in Medicaid reimbursement, increasing costs and access to larger and larger grant dollars also play a role in the increasingly competitive situation that rural health care providers and FQHCs find themselves in.

Simultaneously, FQHCs are being directed to collaborate with other rural health care providers. Non-FQHC providers should understand this environment and be prepared to proactively initiate collaborative projects with FQHCs or be ready to react when FQHCs approach them with collaboration projects.

This paper is intended to provide non-FQHC health care providers with a better understanding of what is motivating FQHCs to expand the number of service sites and provide non-FQHC reimbursed services, such as laboratory and other diagnostic services. This paper does not provide an extensive explanation of the regulatory and operational requirements required to operate an FQHC. Information on the FQHC operational and programmatic regulatory requirements is available from Stroudwater (www.stroudwater.com) and other sources.

Historical Perspective

“...the Accountable Care Act of 2010 legislated an additional \$11B for CHCs through 2014...”

Historically, FQHCs — also known as Community Health Centers — and hospitals have encountered difficulties when collaborating. There are examples of good collaboration between FQHCs and hospitals, but these examples have not been the rule. In fact, in the early days of the CHC program, which began over four decades ago, CHCs were established specifically to address the concern that certain disadvantaged populations were not being afforded adequate access to health care services in hospitals and other private health care providers.

Throughout its existence, the CHC program has enjoyed congressional, presidential and state support. The CHC program has rarely experienced a funding reduction and those few funding reductions that did occur were quickly restored in subsequent years. The CHC program has experienced significant expansion over the past decade. Under the G.W. Bush administration the CHC program doubled in size and most recently, the Accountable Care Act of 2010 legislated an additional \$11B for CHCs through 2014. This is expected to again double the number of CHC service delivery sites over 5 years.

CHCs Required to Become More Financially Viable

“...CHCs are expanding their scope of service to include non-FQHC reimbursed services, which historically may have been provided by other health care providers.”

Over the past two decades, the Health Resources and Services Administration (HRSA), the Federal agency that oversees and manages the CHC program, has emphasized the need for CHCs to improve their financial viability. HRSA provides extensive technical assistance to CHCs specifically to improve their financial viability, especially to those CHCs that experience chronic financial difficulties. HRSA understands that continuing to put scarce resources into financially fragile CHCs is not sustainable. As a result, with HRSA’s encouragement, CHCs have been broadening their patient population base beyond the Medicare, Medicaid and self-pay patients, and increasingly compete for the commercial patient populations. In addition, CHCs are expanding their scope of service to include non-FQHC reimbursed services.

Disappearance of a Financial Disincentive to Provide non-FQHC Services

“... the Medicare reimbursement rate caps have not kept up with the accelerating costs of providing FQHC services.”

Prior to the mid-nineties, on average, the cost of providing FQHC services remained at or below FQHC Medicare and Medicaid reimbursement rate caps. As a result, providing non-FQHC reimbursed services could potentially negatively impact the FQHC’s cost-based reimbursement. If an FQHC’s cost per visit were below the Medicare and Medicaid reimbursement rate cap, then adding non-FQHC covered services pulled overhead out of the FQHC cost-per-visit calculation, which reduced the financial advantage of providing non-FQHC reimbursed services

In the BIPA 2000 legislation, Medicaid FQHC reimbursement methodology changed. In almost all states, Medicaid rates were set prospectively and, once established, were no longer tied to actual costs. In addition, over this period, the Medicare reimbursement rate caps did not keep up with the accelerating costs of providing FQHC services. As a result, in the past decade or so, the cost-per-visit for most FQHCs has exceeded the Medicare reimbursement rate cap. When the actual cost per visit exceeds the Medicare FQHC rate cap it is likely that the provision of non-FQHC reimbursed services may result in a lower FQHC allowable cost-per-visit, but this lower cost remains higher than the Medicare reimbursement rate cap.

In addition, diagnostic lab and radiology services were excluded from the Medicare reimbursement, and in most states, Medicaid FQHC all-inclusive payment mechanism. These diagnostic services are now carved out and billed to Medicare and Medicaid on a fee for service basis.

As a result of these changes, the historic, financial disincentive for an FQHC to provide non-FQHC services has disappeared.

Need to Address Service Duplication and Costly Competition with CHCs

“...HRSA has initiated an effort to limit duplication of services, primarily in rural areas, that may result from CHC service expansion efforts.”

As CHCs have expanded services and increased competition with small rural hospitals and other health care providers, there has been an increasingly louder outcry from the rural, non-FQHC providers who are finding it difficult to compete with CHCs that annually receive hundreds of thousands or millions of dollars in Federal 330 grants, along with enhanced Medicare and Medicaid reimbursement, to support their operations.

As a result of this outcry from individual providers and the organizations that represent them, HRSA has initiated an effort to limit duplication of services, primarily in rural areas, that may result from CHC service expansion efforts.

Although CHCs provide a range of outreach and non-billable support services that are not typically provided by other health care providers, and CHCs must provide care to all patients regardless of ability to pay, politicians and HRSA administrators recognize that there are many other rural safety net providers that also provide services to the uninsured and underinsured patient populations and often do so with less of the financial support experienced by CHCs.

New Efforts at Collaboration

“The grant applicant is directed to obtain and submit letters of support from other health care providers in the CHC’s proposed service area and if such letters are unattainable, clearly state the reason why they are unattainable.”

On November 23, 2010, HRSA published a Program Assistance Letter (PAL), number 2011-02 concerning Health Center Collaboration. In this PAL, HRSA provides an overview of the CHC collaboration initiative that was mandated by the ACA. These efforts are specifically directed towards CAHs, RHCs, sole community hospitals, low-volume hospitals and Medicare dependent share hospitals.

Beginning with this year’s most recent round of CHC grant applications, including existing CHC renewal grant applications and New Start and New Access Point applications, grant scoring related to collaborative efforts has been incorporated into the Section 330 grant scoring methodologies. The grant applicant is directed to obtain and submit letters of support from other health care providers in the CHC’s proposed service area and if such letters are unattainable, clearly state the reason why they are unattainable.

The Accountable Care Act of 2010 includes language that specifically provides permission for a CHC to contract with a CAH, RHC, sole community hospital, low-volume hospital or Medicare dependent share hospital to provide FQHC services, as long as the contracted entity has policies that ensure nondiscrimination based on the ability of a patient to pay and establishes a sliding fee scale for low-income patients. (A hospital’s free-care policies should be sufficient for this purpose.)

Where is the Collaboration Effort Headed?

“Until proven otherwise, it is unlikely that a CHC will be defunded because it refuses or at the least, doesn’t initiate a move to collaborate with other health care providers.”

HRSA appears to be very committed to increasing collaborative efforts between CHCs and other health care providers, specifically in order to reduce costly duplication of services as well as the real and perceived unfair competitive advantage for the CHCs. CHC program advocates do not want to see the historically high levels of support for the CHC program erode as other health care providers increase the numbers and volume of the complaints sent to their Congressional delegations.

This said, for those existing CHCs that do not apply for new 330 grants to expand services or to develop a New Access Point, there may be little in this effort to coerce existing CHCs to initiate or expand a collaborative effort with health care providers in their service areas. Until proven otherwise, it is unlikely that a CHC will be defunded because it refuses or at the least, doesn’t initiate a move to collaborate with other health care providers.

What Should non-FQHC Providers do with this Information?

“The recent change in legislation ... should be viewed as a very positive step toward the reduction of overt competition and duplication of services between CHCs and other rural health care providers.”

Non-FQHC healthcare providers should be aware of the potential for collaboration with CHCs. The recent change in legislation, which specifically removes any legal barriers from allowing a CHC to contract with another rural health care provider to provide FQHC or non-FQHC services, should be viewed as a very positive step toward the reduction of overt competition and duplication of services between CHCs and other rural health care providers.

Non-FQHC, rural health care providers should understand that this change in the FQHC program is occurring and proactively explore ways to collaborate with the CHCs within their service areas.

The non-FQHC rural health care providers need to understand that it may take several years for some CHCs to embrace this change. During a recent Rural Open Door Forum audio conference on this topic, it was obvious from the tone of several of the participants that there is some skepticism about this collaboration requirement. But change will come and many rural communities will benefit from this change.

Well thought out collaborative projects should benefit FQHC and non-FQHC health care providers alike and most importantly have the positive impact of providing quality health care services to the vulnerable safety net populations.

About the Author



ROBERT ELLIS, M.B.A.
SENIOR CONSULTANT

207-592-0863
Rellis@Stroudwater.com

Mr. Ellis joined Stroudwater Associates in November 2004 and has been involved in the healthcare industry for over 34 years, providing healthcare consulting services for the past 18. Bob specializes in financial analyses and business plans for healthcare providers, with a particular emphasis on enhanced reimbursement associated with the Medicare and Medicaid programs available to providers in medically underserved areas. With particular expertise in the Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Critical Access Hospital (CAH) and hospital provider-based physician programs, Bob has assisted well over one hundred community health centers, small hospitals, primary care medical practices and safety net oral health practices to improve their revenue streams while simultaneously providing improved access to needed healthcare services.

Bob earned a Bachelor's degree in psychology from Bowdoin College in Brunswick, Maine, and a Masters in Business Administration from the Whittemore School of Business at the University of New Hampshire in Durham.