



**Residency Training Partnership  
Opportunities between  
Federally Qualified Health Centers  
and  
Residency Programs**

presented by:

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of



# 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)
- Health center becomes operator of residency clinics
- Start new clinics
- Start new residency program

# What's New in Health Reform

- 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

# What's New in Health Reform

## Title III - Payments to THCs 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
- THCs 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

# New Models of Care

- **Patient-Centered Medical Homes:**
  - Personal physicians
  - Whole person orientation
  - Coordinated and integrated care
  - Safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements
  - Expanded access to care
  - Payment that recognizes added value from additional components of patient-centered care
- **Accountable Care Organization:**
  - Group of providers jointly responsible for the quality and cost of healthcare services for a population of patients
  - Combination of one or more hospitals, physician groups (primary care and specialty), and other providers
  - Financial incentives to meet quality benchmarks or cost-savings
  - Shared governance structure
  - Formal legal structure that allows organization to receive and distribute payments for shared savings to participating providers
  - Leadership and management structure that includes clinical and administrative systems

# New Models of Care: Grant Opportunities

- **Community Transformation Grants**
  - Funds for five years, beginning FY 2010, to support evidence-based prevention and wellness services
  - Goal is to strengthen prevention activities, to reduce chronic disease rates, and to address disparities, especially in rural areas
- **Community-Based Collaborative Care Networks**
  - Grants to support community-based collaborative care networks to provide comprehensive coordinated and integrated health care services for low income populations
    - Consortium of health care providers with joint governance structure; must include a hospital and all FQHCs located in the community
- **Community Health Teams and Patient-Centered Medical Homes**
  - Grants or contracts with States to create “health teams” that contract with PCPs to provide primary care support services and to support patient-centered medical homes

- **Center for Medicare and Medicaid Innovation (CMI)**
  - Begins January 1, 2011
  - \$10 billion appropriated during FY 2011-2019
  - Tests innovative payment and service delivery models to reduce program expenditures while preserving or enhancing quality of care
  - Preference for models that improve the coordination, quality, and efficiency of healthcare services
  - Models should address defined populations for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures

# New Models of Care: Payment and Delivery System Reforms

- **Medicaid Global Payment System Demonstration**
  - Up to five states
  - States may adjust payments to eligible safety net hospital systems or networks from a FFS structure to a global capitated payment model
- **Medicare Pilot Testing of Bundled Payments**
  - An eligible entity consists of providers and suppliers, including a hospital, physician group, a SNF, and a home health agency
  - Bundled payment would cover costs of all services furnished to a beneficiary during an episode of care
- **Medicare Shared Saving (ACO) Program**
  - Participating ACOs will be eligible to receive payments for shared savings if it achieves quality and cost containment standards

# 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

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

- 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 Residency Program faculty as appropriate
  - Evaluate Residency Program faculty
  - Monitor resident supervision
  - Be familiar with and comply with ACGME and Review Committee policies and procedures

- Residents must be exposed to sufficient variety/number of patients
  - Across the Residency Program, a resident must have at least 1,650 patient visits, with at least 150 visits occurring in the first year

- 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

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

- Clinic must be appropriately staffed with faculty, other clinical and administrative personnel adequate to meet patient care and educational requirements
- Generally, 1 preceptor for every 4 residents

## Reach Common Understanding of Core Requirements for FQHCs

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)

# Maximizing FQHC Benefits for Community Benefit

- Section 330 grantees and FQHC look-alikes
  - Opportunity to apply for Federal grants to support the costs of otherwise uncompensated comprehensive primary and preventive health care and enabling services delivered to medically underserved populations
  - Access to favorable drug pricing under Section 340B of the Public Health Service Act
  - Access to reimbursement under the Prospective Payment System (PPS) or other state-approved alternative payment methodology (which is predicated on a cost-based reimbursement methodology) for Medicaid and CHIP services and cost-based reimbursement for services provided under Medicare; “wraparounds” for difference between Medicaid and CHIP managed care capitation and PPS; wraparound on Medicare managed care payments effective FY 2006 and on CHIP payments effective FY 2010

# Maximizing FQHC Benefits for Community Benefit

- Section 330 grantees and FQHC look-alikes (cont.)
  - Absent an alternative approved by the Centers for Medicare and Medicaid Services (CMS), right to have State Medicaid agencies outstation Medicaid eligibility workers on an FQHC's sites (or right to contract with Medicaid for FQHC staff to carry out eligibility activities)
  - Reimbursement by Medicare for "first dollar" of services rendered to Medicare beneficiaries, *i.e.*, deductible is waived

# Maximizing FQHC Benefits for Community Benefit

- Section 330 grantees and FQHC look-alikes (cont.)
  - Safe harbor under the Federal anti-kickback statute for waiver of co-payments to the extent a patient's income is below 200% of Federal poverty guidelines
  - Access to providers through the National Health Service Corps if the FQHC's service area is designated a Health Professional Shortage Area (HPSA)
  - Access to the Federal Vaccine For Children program and eligibility to participate in the Pfizer Sharing the Care Program

# Maximizing FQHC Benefits for Community Benefit

- Section 330 grantees only
  - Opportunity to apply for expanded medical capacity grants and earmarked service grants
  - Access to Federal grants to support the costs of planning/developing practice management or managed care networks/plans, as well as operating costs for networks/plans owned and/or controlled by Section 330–funded FQHCs

# Maximizing FQHC Benefits for Community Benefit

- Section 330 grantees only (cont.)
  - Access to Federal loan guarantees of the principal and interest on loans made by non-Federal lenders for the costs of developing and operating managed care and practice management networks or plans, which are majority owned and/or controlled by Section 330-supported FQHCs
  - Access to grant support/loan guarantees for capital improvements

# Maximizing FQHC Benefits for Community Benefit

- Section 330 grantees only (cont.)
  - Access to Federal Tort Claims Act (FTCA) coverage, in lieu of purchasing malpractice insurance
  - Safe Harbor under the Federal anti-kickback statute for certain arrangements with other providers or suppliers of goods, services, donations, loans, *etc.*, which benefit the medically underserved populations served by the FQHC

# Financial Considerations

- GME rules require that the hospital GME recipient incur all of the costs of the residents' salaries and fringe benefits
- Costs associated with faculty/staff time or space/equipment that is solely or substantially associated with teaching activities should be borne by Residency Program
- Patient volume, preceptor productivity, space/support needed for residency must be carefully considered

# Financial Considerations

- 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

# Implementing Agreements

- For most residency collaboration arrangements, a Residency Training Agreement (including Master Affiliation and/or Program Letter of Agreement terms) is needed
- 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
  - Referral Agreement
  - Co-location 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) to the vendor 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 (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

# Other Agreements (as needed)

- Referral Agreement
  - The FQHC agrees to refer patients to the Hospital
  - Hospital maintains separate financial system from the FQHC and bills and collects from patients and third party payors for services it renders
  - Hospital agrees to:
    - Furnish services to the FQHC's patients regardless of ability to pay (subject to capacity limitations)
    - Provide services consistent with, at a minimum, the prevailing standards of care
    - Provide assurances regarding professional qualifications, licensure, eligibility to participate in Federal programs
    - Refer patients back to the FQHC for clinically appropriate care

# Other Agreements (as needed)

- Key terms for formal referral agreements:
  - Manner by which referral will be made and managed
  - Responsibility of the rendering provider to bill and collect payment
  - Liability for services provided
  - Non-exclusivity
  - Sharing of medical notes / records / feedback regarding diagnosis and treatment to assist follow-up care by the FQHC

**DO NOT GUARANTEE REFERRALS!!**

# Other Agreements (as needed)

- Co-Location Agreement
  - Similar to referral relationship, but one entity is physically located in and provides services to its own patients at the other entity's facility
  - Circuit Riding
    - Co-location on a sporadic or as-needed basis, rather than full-time
  - Must ensure that the patient can distinguish between the FQHC and the Hospital (i.e., separate signage, entrances, etc.)

# Other Agreements (as needed)

- Key terms for formal co-location agreements:
  - Same as for referral agreements
  - Lease of space / equipment
  - Terms related to other shared resources
  - Right to request removal of any health care professional who fails to meet qualifications or who provides sub-standard care
  - HIPAA security and other confidentiality provisions for protection of patients' privacy
  - Confidentiality commitments regarding each provider's proprietary information
  - Non-exclusivity

**DO NOT GUARANTEE REFERRALS!!**

# Collaboration Process: Getting to Yes

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

# Planning Process: Getting Started

- Memorandum Of Agreement
  - Defines agreed objectives/purpose for collaboration
  - Establishes regular joint planning process (Joint Steering Committee)
  - Should include flexibility to collaborate with other providers and require disclosure of other negotiations effecting collaboration
  - Typically nonbinding, final collaboration terms subject to each party's due diligence review and each Board's approval of all implementing definitive agreements
  - Protect each party's proprietary information that will be shared in planning/development

# Planning Process: Joint Steering Committee

- A Joint Steering Committee, composed of representatives from the FQHC, the hospital and the residency program, as applicable, will be convened to:
  - Assess the feasibility of, and coordinate, the planning activities required to achieve the proposed affiliations
  - Make recommendations to the parties' management with regard to the affiliations
  - Establish charges, membership and deadlines for task forces
  - Develop communication for patients, staff, agencies, public
- The Joint Steering Committee's decisions are subject to final approval by the applicable Boards

# Planning Process: Task Force Charges

## Clinical / Teaching

- Assure that clinical activities will meet both FQHC/residency accreditation requirements
- Determine optimal clinical staffing mix and schedule
- Evaluate scope of services to ensure there are no “gaps” and all FQHC services are available
- Review clinical policies/practices of each party to identify and resolve areas of divergence
- Integrate FQHC’s quality assurance program with training activities

# Planning Process: Task Forces

- Finance
  - Identify and makes recommendations regarding financial issues affecting the proposed collaboration
  - Conduct/oversee appropriate financial analyses and verifies the underlying documentation supporting any key financial analyses/reports
  - Assess teaching versus clinical costs
  - Project changes in volume/payor mix associated with collaboration (e.g., projected increase in uninsured, possible change in commercial patients), including any projected deficits that may require ongoing financial subsidy (e.g., community benefit grant)
  - Determine fair market value rates for space/equipment or personnel, as necessary

# Planning Process: Task Forces

- Operations/Human Resources/Facility
  - Identify and makes recommendations regarding operational issues
  - Address HR issues (particularly if involves workforce transfer), orientations
  - Assess IT system needs/compatibility/connectivity
  - Conduct facility analysis (against FQHC/residency standards); space needs, layout
  - Analyze equipment/supplies/vendors arrangements

# 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.

# Questions?

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