Western Region Symposium – HFMA

Developing Models and Affiliation Strategies with FQHCs

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January 15th, 2019

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Today’s Agenda

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Objectives of Presentation

What is a FQHC?

Basic FQHC Eligibility Rules

Why Would Hospitals Want to Work with FQHCs?

What Information You Should Know Before Working with FQHCs?

Examples & Models of Hospitals & FQHCs Working Together

FQHC Reimbursement Landscape

Co-Applicant Model for Public/District Hospitals

Objectives of Today's Presentation

- Understand the basic rules, regulations, and reimbursement of the FQHC model
- Understand why you may or may not want to explore informal or formal arrangements with FQHCs
- Understand examples and the various models hospitals and FQHCs utilize
  - Both urban and rural
- Understand the intrinsic and financial benefits of aligning with FQHCs
- Understand how public hospitals can actually develop these entities
- Understand how a major academic medical center (UCI) operates a public model FQHC and the benefits they accrue from this collaboration

Hospitals and FQHCs tried competing. Now, they're collaborating instead.

8:00 AM - June 8, 2018

While federally qualified health centers (FQHCs) and hospitals once served largely distinct populations, they're now frequently competing for the same patients—but some see the change as an opportunity for collaboration, Susannah Luthi reports for *Modern Healthcare*.

Make your patients healthy and your ED happy with community paramedicine →

The rise of FQHCs

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Health care IT cheat sheets: Digital health systems

8:44 AM - January 8, 2019

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11:07 AM - January 8, 2019

The $24K bike crash (and what it reveals about an 'unusual' ED billing strategy)

10:30 AM - January 8, 2019

America's waistlines, charted. (Yes, they're getting bigger.)

9:30 AM - January 8, 2019

Why Hospital-FQHC Partnerships Make Sense

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Amid changes introduced by the Affordable Care Act, community health centers, also known as Federally Qualified Health Centers or FQHCs, are assuming a more prominent role in the delivery of healthcare. Long the leaders in indigent care, community health centers are becoming pivotal players in population health management strategies and accountable care organizations.

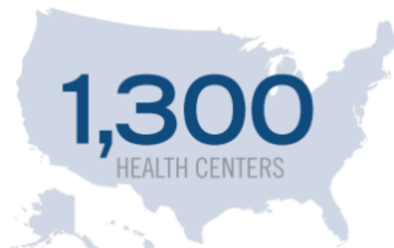
More than ever before, hospitals, health systems and community health providers need to understand each other and work together. This by-the-numbers look at FQHCs, brought to you by Avanza Healthcare Strategies, is a starting point for those important conversations.

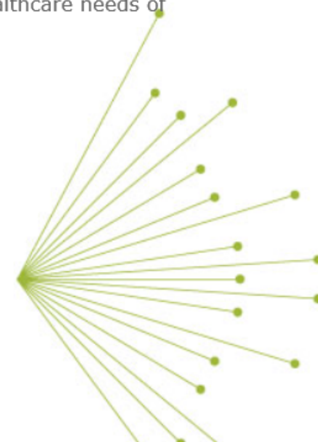
For help building collaborations between hospitals and FQHCs, contact Avanza at hello@avanzastrategies.com or 512.479.6700.

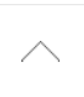
Interested in learning more about hospital-FQHC partnerships? Read "Community collaborations: 6 areas of focus for hospital and federally qualified health center partnerships" in *Becker's Hospital Review*, featuring insight from Avanza President and CEO Joan Dentler and Community Health Centers Consultant Maria Serafine.

PREVALENCE

Nearly 1,300 FQHCs are delivering care through more than 9,200 clinic locations across the U.S. As primary care providers (PCPs), they are well positioned to work with other local organizations, including hospitals, academic medical centers and public health departments, to identify, address and meet the overall healthcare needs of a community.







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HOW HOSPITALS AND FEDERALLY QUALIFIED HEALTH CENTERS SHOULD COLLABORATE

BY SUSAN PATTON, FOR HEALTHLEADERS MEDIA | APRIL 16, 2010

TOPICS

Business

Drowning in losses from uncompensated emergency room care? Collaborative relationships between hospitals and federally qualified health centers can benefit both provider types by allocating scarce resources effectively and efficiently to lift the health status of a community and decrease hospital losses from avoidable ER visits.

Reflecting a stagnant economy and entrenched unemployment and underemployment, most hospitals have experienced a significant increase in uncompensated or undercompensated care. One third of all ER visits are estimated to be avoidable. Nationally, more than $18 billion is spent annually on avoidable ER visits. Avoidable ER visits are those which are non-urgent or ambulatory care sensitive and therefore treatable in primary care settings. Avoidable ER care is also care that could be provided more effectively from an outcomes standpoint and more cost efficiently at another site.

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Opinion: Help for containing health care costs

Opinion: Costs convert hospitals into one-stop shops

What is a FQHC?

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What is a FQHC?

Federally Qualified Health Centers

- The FQHC benefit under Medicare was added effective October 1, 1991 to enhance the provision of primary care services in underserved urban and rural communities
- Can be Community Health Centers, Homeless, Migrant, Indian Health Service, and Public Housing recipients

- Types of FQHCs
  - Private Non-Profit
  - Public Entity
    - Can be:
      - 330 Grantees
      - Look-alikes
      - Sub-Recipients
      - Co-Applicant - Public Model only

What is a FQHC?

- Community based clinics – neighborhood health centers to community health centers
- Non-profit corporation
- Pediatrics to Geriatrics services
- Enhanced reimbursement from Medicaid and Medicare
- Patient Board Requirements
- Grantees versus look-alikes
- HRSA or federal versus state authority
- State would only be involved with regards to licensing, reimbursement and covered services
- 25 million Americans use FQHCs
- 1,400 FQHC organizations

FQHC’s in the US

Federally Qualified Health Centers (FQHCs)

A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes.

● Federally Qualified Health Center

Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; Quarter 4, 2009.

Note: Alaska and Hawaii not shown to scale

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What are the Basic FQHC Eligibility Rules?

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FQHC Eligibility Rules

Eligibility

- Underserved designation
  - MUA/MUP – not physically located in, but draw patients from these designations
- UDS – need in community as defined as number of low income patients going to other health centers
- CON type application
- Extremely easy to add sites once designated
- Urban or rural
- Private or Public Models
- 500 page application

Why Would a Hospital Want to Work with a FQHC?

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Why?

- Many Reasons
  - Relief from non-emergency room visits
    - Uninsured, undocumented, mentally ill, frequent fliers
  - Avoidance of re-admissions
  - Full risk hospital contracts
  - Community benefit contribution
  - Sharing resources & information, HIE
  - Referrals
  - Recruitment of physicians
  - Access to a PCMH
  - Avoidance of ED admissions if clinic goes under
  - Local politics
  - Extension of Primary Care network, e.g., ACO
  - Lack of internal hospital clinic structure
  - Partner in medical residency training

What Information You Should Know Before Working with FQHCs?

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What Information You Should Know?

- Know the key FQHC players in community
  - Size, site locations, payer mix
- What sort of interaction do you have now?
  - What has been the history?
- Where are referrals from FQHC going today?
- Where are new FQHCs being built – across the street?
- Start informal and then go formal
  - Financial contribution would be a good start
- Does hospital have network of HBOC's
- What does your medical staff think?
- What services do the FQHCs offer, e.g., OB
- Does your outpatient services overlap or are they complementary?
- Now, you are ready to go or not!

Examples of Models - Hospitals and FQHCs Working Together

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Community collaborations: 6 areas of focus for hospital and federally qualified health center partnerships

May 12, 2015 | Print | Email

In the emerging landscape of accountable care, with its emphasis on population health and preventive care, healthcare services will be delivered not only through private physicians and hospitals, but also in collaboration with community providers.

Community health centers (CHCs) are uniquely positioned to be an important partner for hospital systems as healthcare delivery systems seek out new methods to improve health outcomes. It is imperative for hospitals and health centers to understand how to form collaborations, the role they should play in these collaborations and what is needed to maximize the benefits of collaborating with federally qualified health centers (FQHCs) to create integrated delivery models of care that provide a coordinated continuum of services to targeted patient populations.

By collaborating and working in partnership with FQHCs, hospital systems will be better positioned to provide high-quality, cost-effective and patient-centered care. Here are six areas of focus for hospital/FQHC partnerships.

1. Completing and implementing a Community Health Needs Assessment (CHNA). It is important to break down communication barriers between hospital systems and FQHCs, and engage leaders in both organizations to collaborate. If these organizations must complete a CHNA, why not work together to identify and prioritize the health needs of the community?

10 Most-Read Articles

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Best Buy has quietly grown a home healthcare business: 4 things to know

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Patient dies hours after being turned away from Wisconsin hospital

Flu shot gets spotlight at Golden

Emergency Department (ED) Diversion Examples

- Hospital in Long Beach, CA and FQHC had a formal emergency room diversion program - lasted four years
  - FQHC bought 2 hours a day of the case managers time at the hospital
  - Trained them in eligibility, registration, PCMH focus
  - FQHC converted 50% of uninsured diverted patients to insurance, e.g., Medi-Cal

- Sutter Solano Medical Center, Vallejo and La Clinic de la Raza, Oakland has a formal emergency room diversion program
  - FQHC (urgent care), is located directly across the street from ED
    - Location of FQHC not a coincidence!

What is a ED Diversion Program?

- Gets low acuity patients out of ED
- Reduces wait time in ED
- Assigns every non assigned ED patient to a FQHC or other social/medical network
  - Patient navigator concept
- Reduces non urgent ED visits
- Directs patients to a PCMH
- Can reduce re-admission's to hospital
- Will foster health information exchange (HIE) for on-going ED admissions

ED Diversion Article

Emergency Department Triage of Low Acuity Patients to a Federally Qualified Health Center

Nghia D. Nguyen, DO; Justin B. Moore, MD; Nathan P. McIntosh, MD; Michael L. Jones, RN; Jason Zimmerman, RN; Richard L. Summers, MD

Abstract

Many emergency departments (ED) are experiencing ever increasing volumes as they serve as a safety net for patients without established access to primary care. Impending physician shortages, our aging population, and recent changes in national healthcare policy are expected to further exacerbate this situation and worsen ED overcrowding. These conditions could result in a dilution of ED resources and significantly impact the ability of emergency personnel to provide quality care for patients with serious illnesses. Previous studies have demonstrated that low acuity patients without emergencies can be safely and legally identified in triage and can be sent away from the ED for further outpatient treatment and evaluation. However, without a specific designated clinic follow up, these patients often fail to get the appropriate care required. In this study, we couple the ED medical screening exam process with a timely medical referral system to a local Federally Qualified Healthcare Clinic (FQHC). We monitored these referred patients for subsequent success in satisfaction with their primary care needs and their rate of recidivism to the ED. Most of the non-emergent patients who were judged to be appropriate to refer to the FQHC were satisfied with their medical screening process (89%) and most elected to attend the same day clinic appointment at the FQHC (85%). Only 17% of these patients who were referred out of our ED returned to be seen in our ED within the three-month interval. We concluded that referring low acuity patients out of the emergency department to a primary care clinic setting provided an opportunity for these patients to establish a medical home for future access to non-emergent health care.

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Introduction

In hospitals across the United States, emergency departments (ED) are experiencing increasing volumes as they serve as a safety net for patients without ready access to primary care.[1] Because of these increases in patient volumes, overcrowding has been a topic of great interest for the past decade with the expectation that this problem will worsen with impending physician shortages and recent changes in national healthcare policy.[2,3] These ever-increasing ED volumes could result in a dilution of resources and significantly impact the ability of emergency personnel to provide quality care for patients with serious conditions.[4] Multiple factors have been identified as causes for the ED overcrowding problem including our aging population and logistical systems problems inherent in current hospital practices.[3,5]

Perhaps one of the most commonly cited causes for ED overcrowding is an implicit requirement for care of the "non-emergent patient".[1,2,3,4,5] Often, these patients would be better served by seeing a primary care practitioner in an established medical home. However, these patients believe primary services are unavailable or the patients do not know where to find them.

In helping to solve the ED overcrowding problem, some institutions have tried to identify non-emergent patients and refer them to a clinic setting where they could receive health care in a more cost effective manner. Derlet, et al, demonstrated that these "non-emergent patients" could be safely and legally discharged from the ED without a full medical workup and with directions for them to be seen by a primary care provider in a non-emergent setting.[6] These emergency physicians used an EMTALA compliant medical screening exam (MSE) in combination with a strict set of local guidelines and previously published screening criteria in their triage process[3] (see figure 1). It has been suggested that this protocol will reduce ED congestion and avert a costly and unnecessary hospital bill for some

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Medical Residency Programs

- Many Hospitals (especially Academic & County Hospitals) use community based FQHCs to rotate their medical residents through
- Trend in recent years has been hospital residency programs partnering with FQHCs to rotate medical residents to primary care locations
- Recent trend – hospitals just giving (or sometimes converting) their residency clinics to FQHCs
  - Minimizes or caps financial risk
- District hospital in California in process of converting their residency clinic to a FQHC look-alike – will lose $5 mil less!

Medical Residency Affiliations Examples

- AltaMed (Los Angeles FQHC) – actually provides the medical director to Children's Hospital Los Angeles for their medical residency clinic
- Kaiser Hospital Oakland rotates residents to LifeLong clinic sites
- Kaiser Santa Rosa Hospital rotates medical residents to Petaluma Health Center
- Kaiser Vallejo Hospital rotates medical residents to La Clinica de la Raza
- LifeLong – is in process of developing medical residency program – plans to have rotation back to Kaiser Oakland for their residents

Long History of Hospitals Giving Clinics to FQHCs (examples)

- Dignity Health, Sacramento gave several clinics to Well Space, Sacramento
- California Pacific Medical Center, SF gave clinic to South of Market Health Center
- St. Rose Hospital, Hayward gave their pediatric clinic to Tiburcio Vasquez
- Alameda County Medical Center gave two clinics to Children's Hospital of Oakland
- St. Mary's Hospital, SF was exploring giving their free clinic to a local FQHC
  - A lot more in the works!

Long History of Hospitals Giving Clinics to FQHCs (examples)

- O'Connor Hospital, San Jose – gave their family practice residency clinic to Indian Health Center of the Santa Clara Valley
- Community Regional Medical Center, Fresno gave their medical residency clinics to Family Healthcare Network, Visalia
- Lucille Packard Children's Hospital, Palo Alto gave their medical resident clinic to Gardner Family Health Network, San Jose
- Children's Hospital Los Angeles gave multiple clinics to AltaMed, LA

All These Transactions Had a Common Theme

- ?????
- $$$$$
- Medicaid goes from the least payer to the best payer!
  - Fee for service to enhanced reimbursement
- Usually a 1 to 3 year subsidy involved
- Otherwise, change is seamless to community

Risk versus Control – can't have both – pick one!

Financial Subsidies, Grants and Direct Giving

- Many hospitals give annual grants to FQHCs
  - Various reasons: *(sometimes strings are attached!)*
- One hospital gives a specific amount of money for every patient FQHC sees in designated zip codes in hospital's service area
- One hospital made FQHC do a study to ascertain their costs per visit before giving grant donation
- Other hospitals give money to fulfill their community benefit standard

Financial Subsidies, Grants and Direct Giving

- Kaiser – major donor to FQHCs - $190 mil over last ten years (Northern California)
- Sutter – major donor to FQHCs
  - Kaiser (NC), & Sutter providing outpatient surgeries for free to uninsured FQHC pts (application based)
- Cottage Hospital, Santa Barbara – gives annual grant to local FQHC – clinic would have closed otherwise
  - Where would the 51,000 patient visits go?
- Annual hospital grants are pretty common in industry, other hospitals have stopped giving grants as they would like to tie it to some outcome

Full Risk Contracts

- San Francisco Health Plan – has full risk professional contract with a MSO
  - MSO contracts with:
    - FQHC Northeast Medical Services (professional risk)
    - Health Plan Contracts with two hospitals (for inpatient risk) – 38,000 Patients
      - FQHC & Hospital performance effects each other

Ancillary Referral Agreements

- At some FQHCs, the hospital's outpatient laboratory, x-ray departments and pharmacy are all located in or adjacent to the FQHC
- Built in referrals for hospital
- Many hospitals lease space to FQHCs literally next door, across the street and even in unused hospital space
- Strategy could backfire if one entity encroaches on the other in terms of competitive or overlapping services
- For hospitals, you don't want local FQHCs to use Lab Core!

Health Information Exchange (HIE)

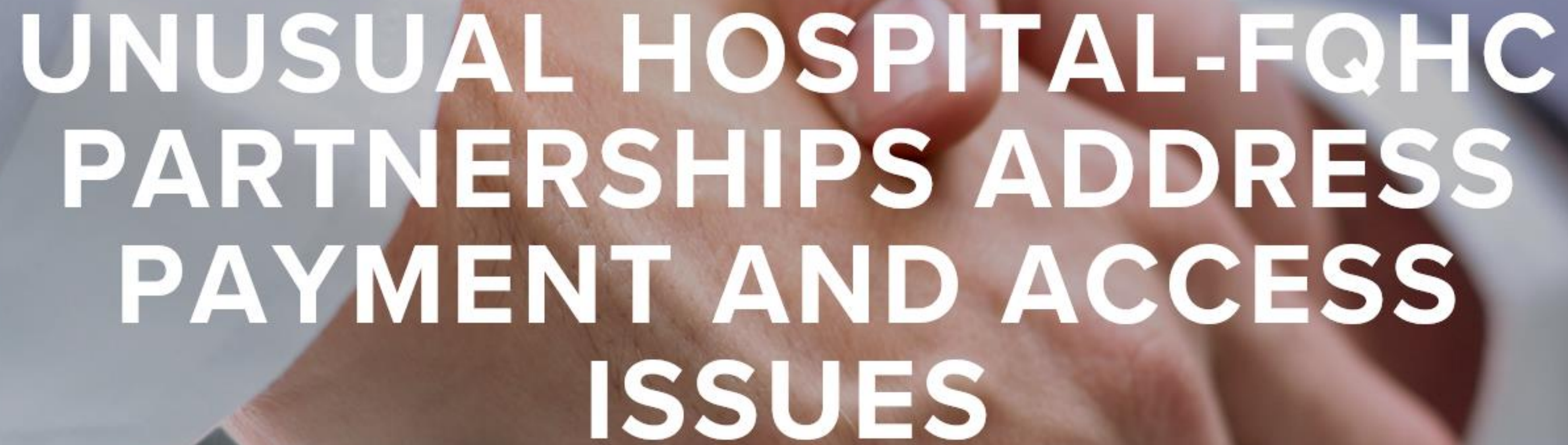
- 299 Collaborative
  - Three critical access hospitals (and two more pending hospitals), one FQHC and one RHC have formed this collaborative to facilitate HIE

- Care transition using HIE
  - Benefit: avoid re-admissions
- Hospitals need to share data in this arrangement
  - most resistant but have most to lose

- Other items collaborative is looking at:
  - ACO development
  - Shared health insurance among employees
  - Rural medical residency program

Health Information Exchange (HIE)

- Redwood Community Health Coalition
  - FQHC consortium (Redwood Community Health Coalition, Petaluma, CA, 8 eight health centers) has developed formal arrangements for case management, HIE, QA, QI with St. Joseph Health Hospitals – Northern California
- Created health center “hub” to share patient data
- Prior visits to any FQHC will be available for future ED admissions
- Sounds great but very expensive



UNUSUAL HOSPITAL-FQHC PARTNERSHIPS ADDRESS PAYMENT AND ACCESS ISSUES

Other Innovative Strategies Between Hospitals & FQHCs

Kaiser (NC)

- Kaiser members being seen for primary care by a FQHC (experimented)
- Kaiser placing retired physicians at FQHCs *(workforce innovation project)*
- Kaiser funding intensive case management for high cost patients at a local FQHC

Sutter

- Sutter paying for a RN (Care Transition Nurse) to facilitate discharges back to five FQHCs in Bay area
  - On-site RN at FQHCs
    - Ensures smooth transition back to primary care home
    - All follow up coordination
    - Single point of contact
    - Medication management
    - Reduced re-admissions

Other Innovative Strategies, cont.

- Sutter and Kaiser - providing financial assistance to Alameda Consortium FQHC clinics in purchasing EPIC
  - Improving care coordination
  - Access to all prior history of FQHC patient if patient arrives in Sutter or Kaiser hospitals emergency room
  - Kaiser and Sutter will have ability to schedule follow up appointments at FQHC
  - Sutter paying FQHC for eligibility specialist to be located on-site at hospital

Other Innovative Strategies, cont.

- Fire departments/paramedics/ambulance services in Hayward, Washington State and Los Angeles experimenting with dropping off patients at FQHCs and other social service agencies rather than local ED
  - Patient acceptance
  - Non-emergent condition
- Hospital discharge patients being triaged to Nurse Practitioners at FQHC's rather than going back to their PCP's – grant supplied by hospital
- Hospital created insurance product and used FQHC as the Medi-Cal network exclusive provider

Other Innovative Strategies, cont.

- Hospital in California has the FQHC CMO come to regular medical staff meetings
  - *Use to give just money but CEO wanted collaborative strategy*
- Hospital CEO sits on FQHC Board
- FQHC uses hospitalist group at local hospital to see the FQHC OB patients Hospitalist group has separate contract with FQHC for this service
  - Four walls policy for FQHCs enables them to bill PPS rate rather than Medi-Cal fee for service – win/win!

Kaiser Innovative Strategies

- Kaiser – signed statement of partnership with all FQHC consortiums in California
  - Collaboration, bi-directional, financial, technical support, population health, clinical ops, etc.
- Capital grants to FQHCs – very unusual
- Technical grant to design new FQHC
- Non monetary support
  - Workforce recruitment
  - Provide signage expertise
- Garfield Center of Innovation
  - Bringing FQHCs to Center

Rural Hospital Affiliation Strategies with FQHCs

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Rural Hospital Affiliations with FQHCs

Rural Hospitals have some unique opportunities in working with FQHCs

Shared Credentialing

- In some of the rural communities, the local hospital and FQHC have been discussing joint credentialing in sharing both money and resources since many of the providers work at both entities

Telehealth

- At Mayers Memorial Hospital, (Fall River Mills, CA), they have an extensive telehealth program that includes most specialty area
- The local FQHC, Mountain Valleys, doesn't offer telehealth services and being remote, don't have access to specialists
- Mountain Valleys uses exclusively Mayers Memorial for all telehealth service's

Rural Hospital Affiliations with FQHCs

On-Call

- In some of the rural communities, the local hospital and FQHC physicians share call coverage

FQHC/Hospital Joint Medical Staff

- Mayers Memorial Hospital, Fall River Mills, CA entire medical staff is comprised of Mountain Valleys Health Centers (FQHC) physicians
  - Continuity of care is better
  - Politics is zero
  - No competition per say

Rural Hospital Affiliations with FQHC's

- Locums
  - FQHCs and rural hospitals sharing cost of Locums

- Recruitment
  - Several rural hospitals and the local FQHCs have joined forces to recruit specialists
  - Mayers Memorial Hospital, Modoc Hospital and Lake District Hospital in Oregon has a joint recruitment program with Mountain Valleys (FQHC), Canby (RHC) for recruiting primary care and specialists to region
  - They have a joint recruitment budget – personnel, social media

FQHC Reimbursement

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FQHC Reimbursement

- Medicare
  - G code reimbursement system
  - Rates will vary depending on geographic location and G code billed (acuity)
  - Rates higher for new patients, annual wellness exam
  - Range from $160 to $220 a visit
  - LRC rule in effect

- Medicaid
  - SPA (state plan amendment) will dictate state PPS rates but most states have cost based reimbursement system and one other alternative to set initial PPS rates
  - Rates range from $150 to $400 a visit
  - Why is this important to know?

Co-Applicant FQHC Model

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CO-APPLICANT MODEL FOR FQHC's

- Developed primarily for public agencies as boards for these government entities did not meet the FQHC board requirements

- Allowed public agencies to "go in" with non profit (incorporated or not), to meet the FQHC board requirements
  - *9 to 25 members, 51% being patients*

- The two entities together comprise the co-applicant arrangement

- The public entity receives the FQHC designation and the co-applicant entity serves as the "health center board"

- HRSA considers both the public agency and the co-applicant as the "Health Center"

- Majority of California Counties use this FQHC model

Who can develop a co-applicant FQHC model?

- Example of Public Agencies
  - Districts
  - Counties
  - Cities
  - State Academic Medical Centers

  - So in effect, a “public hospital” can develop a FQHC under specific circumstances

UCI Case Study and Model

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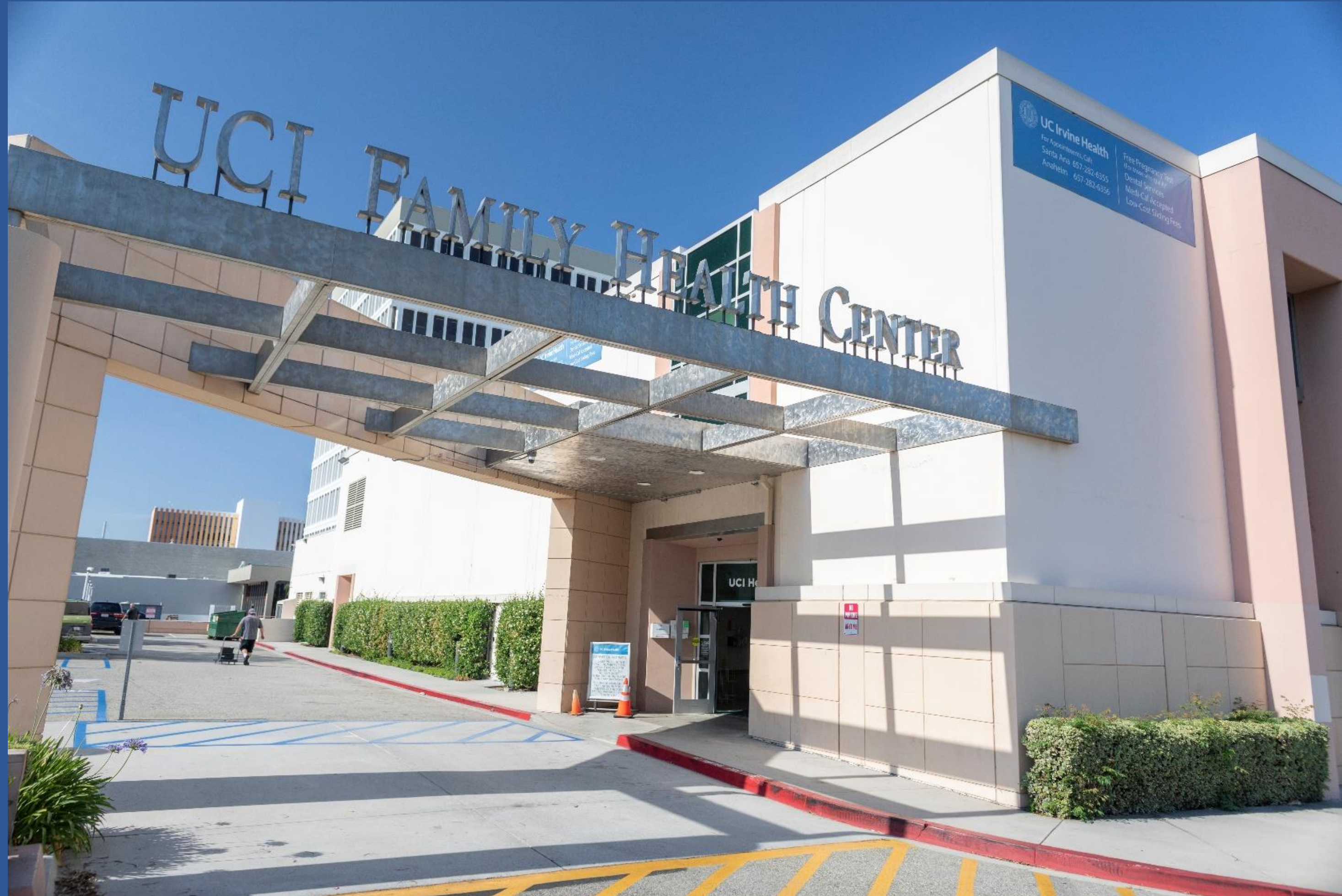
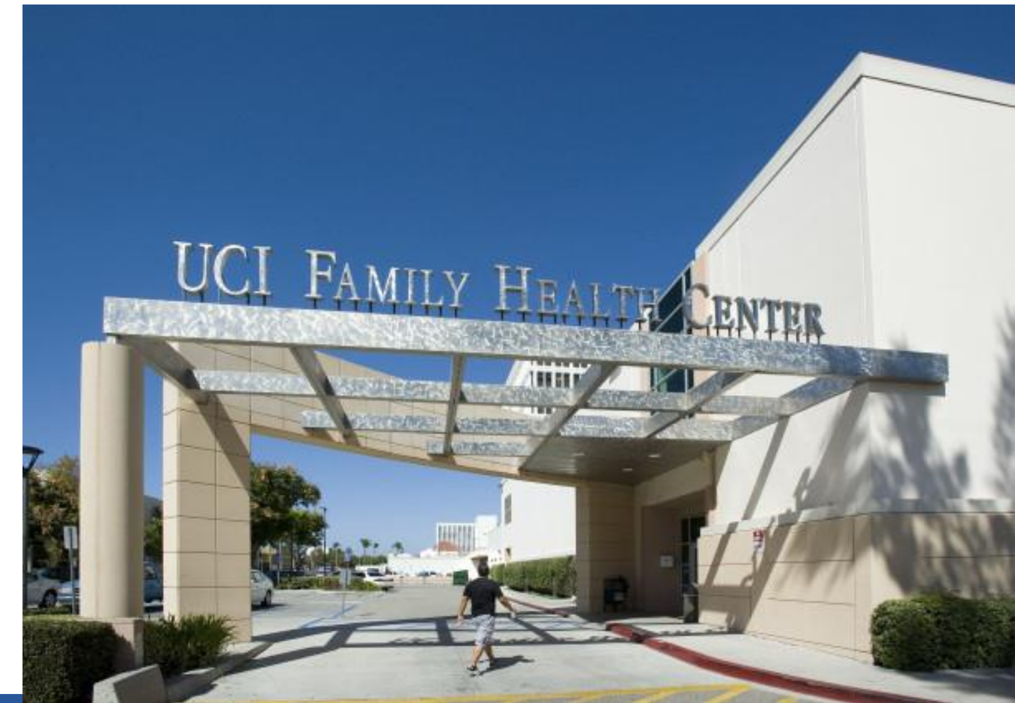
FQHC Partnerships



UCI Health

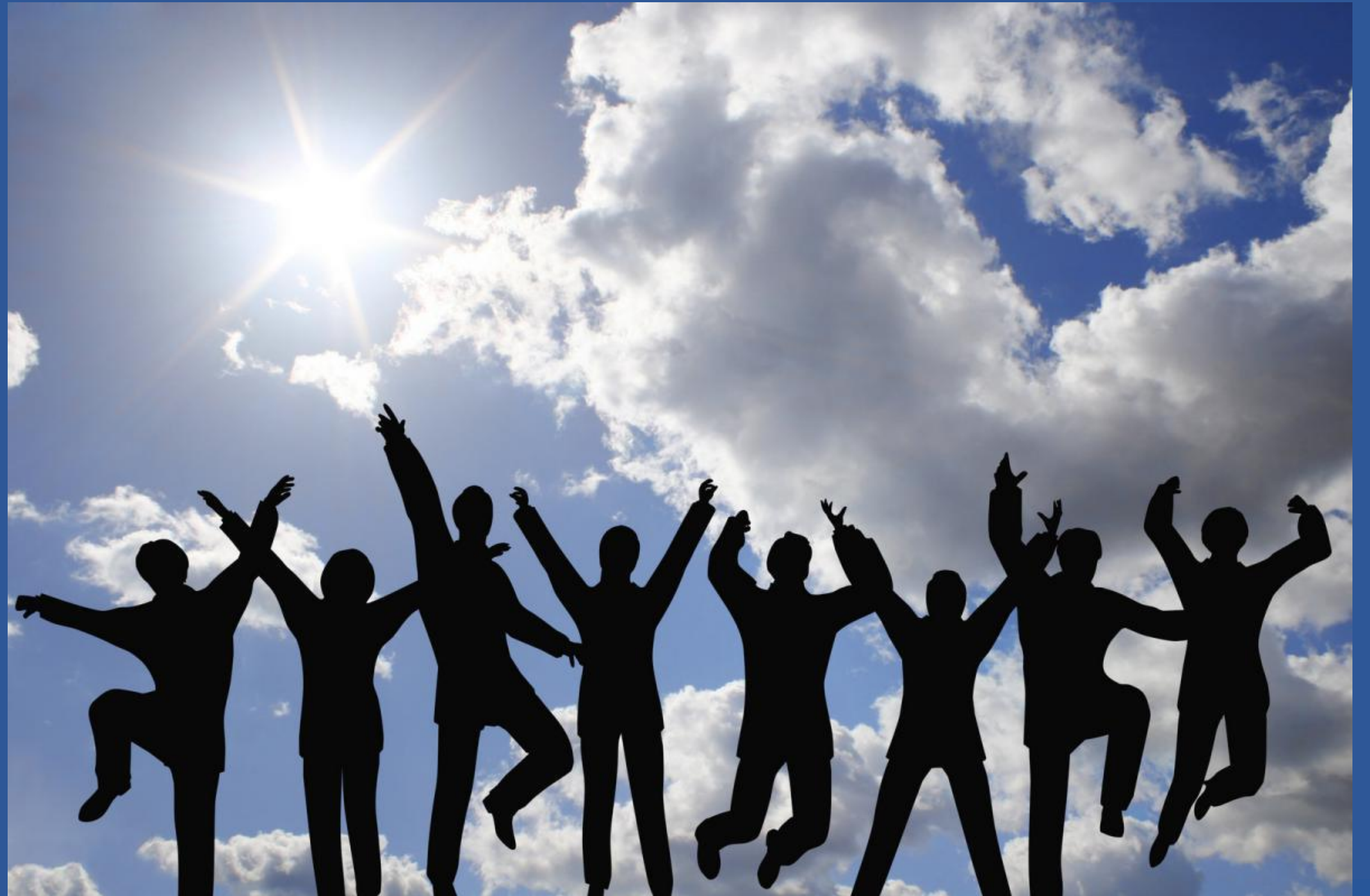
History

- Oldest FQHC in Orange County
- Outpatient training ground
- Delivering over 80,000 visits
- Integrated services



UCI Health

Advantages



Revenue Enhancements

- Higher Medicaid and Medicare PCP reimbursements
  - Average non FQHC Medicaid payment = $40
  - PPS rate for FQHC vary across the country
    - Illinois = $140
    - California = North of $215
- Base Grant dollars to serve uninsured population
  - $650,000 base grant per approved site
  - Additional grants are available for programs typically not available to others

Revenue Enhancements

- Payor and government incentive payments
  - FQHCs typically out perform non FQHC practices on clinical outcomes leading to higher annual incentive payments
  - Incentive payments are typically used to support greater outreach and population health initiatives

Expense Reductions for Medical Centers

- FQHC ability to sustain walk in hours
  - UCI FHC is projecting nearly 8,000 annual visits in next FY reducing ED visits
- Reduced admits and readmits on Medicaid population
  - FQHC have additional resources to ensure appropriate care and follow up services to free up beds for Medical Centers

Ultimate Educational Training Ground

- PPS rates offset loss of residency training programs
- FQHC provide support services reducing stress on residents
- FQHC are focused on population health and integrative medicine increasing annual resident match
- Residents learn how to manage the most complex patients

Challenges

Governance

- FQHC are required to have separate governing boards
- Balance
  - FQHC requirements and initiatives
  - Medical Center goals and objections
  - School of Medicine Teaching requirements and objectives

Knowledge of FQHCs

- HRSA compliance standards
- Billing practices and regulations
- State compliance standards

Large Institution Flexibility

- Grant Opportunities
  - Submission deadlines are typically 90 days
  - From award date FQHC has 120 days to implement
  - Institutional red tape makes these difficult to achieve

Conclusion

- Many innovative strategies between hospitals and FQHCs are already underway in both urban and rural communities and there will be more of these affiliations, partnerships and arrangements as integrated health systems are increasingly emphasized and realization that these two entities serve the same patients in their respective communities

Questions?

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Today's Presenter

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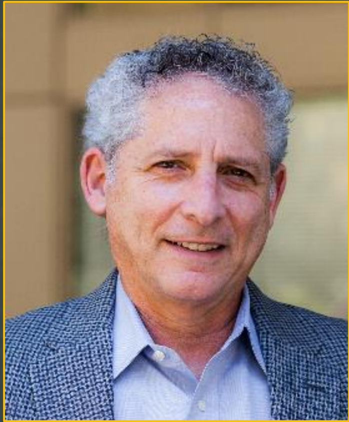

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