AMC/FQHC Partnerships: A Mutually Beneficial Model of Care

All Academic Medical Centers (AMCs) inherently pursue the tripartite missions of clinical care, research and education; but when it comes to the clinical mission, most AMCs have historically focused on quaternary care (and not primary care) for a variety of financial, cultural and competency reasons. That is generally why primary care at many AMCs is organized as an arms-length subsidiary. The one exception: continuity clinics. Continuity clinics are designed to teach residents the practice of general ambulatory medicine in a longitudinal setting. These clinics are under the direct operational control of the AMC to serve two purposes: first, to provide primary care access to an underserved patient population and second, to meet ACGME requirements by providing residents exposure to an adequate volume of patients that are often managing multiple complex conditions.

As funding for all three missions continues to get squeezed, AMCs have been forced to evaluate all aspects of their business to strengthen their financial position. Through this process it has become clear that these continuity clinics are operating at a substantial annual loss, often in the millions of dollars. Closing the clinics is not an option because of the critical role they play in supporting the education mission and providing essential clinical access to the local community. There is a practical solution that is gaining traction with some of the top AMCs around the country and that is to leverage the Federally Qualified Health Center (FQHC) Model.

FQHCs are non-profit, community-based entities that are created under section 330 of the Public Health Service Act and governed by the Health Services and Resources Administration (HRSA) with a mission to deliver care to the Nation's most vulnerable individuals and families. Key fundamentals of an FQHC include:

- Delivering high quality, culturally competent, comprehensive primary care, as well as supportive services such as health education, translation, and transportation that promote access to health care
- Providing services regardless of patients' ability to pay and charging for services on a sliding fee scale
- Operating under the direction of patient-majority governing board
- Developing systems of patient-centered and integrated care that respond to the unique needs of diverse medically underserved areas and populations
- Meeting various requirements regarding administrative, clinical, and financial operations

AMCs have two options when pursuing an FQHC model: 1) Convert its existing clinic(s) into FQHC Look-alikes; or 2) Partner with existing FQHC(s) in the area to manage its existing clinic(s). The primary difference between traditional FQHCs and FQHC Look-alikes is that Look-alikes do

not receive HRSA Health Center Program funding. However, FQHC Look-alikes are eligible to apply to CMS for FQHC Medicare and Medicaid reimbursement provided they meet all of the Health Center Program requirements outlined above. AMCs cannot not seek traditional FQHC status because they already have one or more clinics in operation and traditional status is reserved for greenfield entities/sites. The decision to pursue option one or two is primarily driven by market conditions. Generally speaking, if an existing FQHC's service area overlaps with the AMC clinic's service area (which is usually the case), the AMC should first pursue the partnership model. HRSA will not support the introduction of a competing FQHC or FQHC Look-alike if the existing FQHC is meeting program requirements to HRSA's satisfaction. In the rare case that the FQHC is not in good standing with HRSA or the AMC clinic is serving a medically underserved population with no other existing FQHC in the area, the FQHC Look-alike option is preferred.

Most AMCs are located in urban environments with clinic service areas that overlap with multiple FQHCs, so they pursue option two, the partnership model. Pursuing this model and converting AMC continuity clinics into FQHC managed sites benefits patients, FQHCs and AMCs.

Benefits of an AMC/FQHC Partnership

Patients	FQHCs	AMCs
Patients have assurance as required by HRSA that an FQHC will provide them: › Access to a full suite of primary care, preventative and enabling services › Integrated behavioral health services › Streamlined access to specialists › After hours access to care › Improved access to medications › Access to health education services › Culturally sensitive service › Coordination with other community-based entities focused on addressing the social determinants of health › Sliding fee scale financial support	› Access to incremental volume generating greater economies of scale › Access to a strong backbone of infrastructure provided by AMC for a fraction of the cost (e.g., IT systems, patient engagement tools, purchasing, payroll, insurance, etc.) › Streamlined access to specialists › Integrated training program offers pipeline of future providers › Access to capital to improve physical environment of care › Joint physician recruitment efforts › Brand enhancement associated with AMS › Potential for additional grant funding associated with a New Access Point (NAP) application › Better access to research grants related to population health	› Trainees gain exposure to contemporary care models (e.g., PCMH, team-based care, etc.) not typically seen in traditional continuity clinics › Better access to research grants related to population health › FQHC Prospective Payment System reimbursement for services provided to Medicare and Medicaid beneficiaries that is often 50% higher than traditional Medicare and Medicaid reimbursement › Reimbursement for multiple services (e.g., primary care and behavioral health) provided within the same visit (only allowed to bill once under traditional Medicare and Medicaid) › Reduction of inappropriate ED and inpatient utilization due to the FQHC model of care › Access to medical malpractice coverage under the Federal Tort Claims Act (FTCA) if faculty members directly contract with FQHC

AMC/FQHC partnerships are still relatively rare despite the vast number of benefits, though interest is growing rapidly given financial pressures. Historically there have been several hurdles AMCs have faced in getting to yes.

- **Scalable Management Structure:** Converted continuity clinics introduce a significant number of new patients into the FQHC's infrastructure and patient management systems providing substantial growth overnight. The FQHC management structure must be prepared to flex up to meet new demands.
- **Protection of the Teaching Program:** AMCs want assurance that resident panel sizes won't increase diminishing the educational experience, that they will maintain control in determining preceptors and that faculty will continue to have protected time. Preceptors are typically more productive than non-teaching faculty on a per FTE basis because of the resident leverage model (though they require more space) so FQHCs will not be concerned about increasing panel sizes. Faculty are still employed by the AMC and then leased to the FQHC, so the AMC still has full control over faculty time.
- **Operational Control:** AMCs are consistent in their fear of relinquishing control, even in areas outside their core competency. In order to get access to section 330 grant dollars and enhanced Medicaid and Medicare funding, the FQHCs must assume operational control of the clinics. However, contractual arrangements can be made to provide the AMC with input into a variety of key decisions.
- **FQHC Stigma:** AMCs fear faculty and/or staff will not want to work at an FQHC even though they are still AMC employees due to perceptions about care quality and provider turnover.
- **Merging of Compensation Structures:** Different compensation packages for FQHC and AMC staff can create issues.
- **Reporting Relationships:** Faculty will continue to report up through their departments but will have a dotted line to the FQHC clinic manager. AMCs want clarity on if and how operational and performance expectations may change.
- **Unwind Agreement:** AMCs want assurance that should the partnership fail, there is a clear unwind agreement in place that prevents any disruption to their teaching programs.

These challenges can be overcome through AMC/FQHC discussion, contract development and implementation planning. And if implemented successfully, AMC/FQHC partnerships yield a comprehensive, coordinated care delivery system that provides greater access to care for patients. Both the AMCs and FQHCs will enjoy improved financial health, greater alignment and influence with policymakers, and potentially even a mechanism for future risk-based contracting.