TEACHING HOSPITALS AND FQHCS CAN PARTNER TO ALLEVIATE COMMUNITY HEALTHCARE PROVIDER SHORTAGES AND REDUCE TRAINING COSTS.

Innovative healthcare leaders sometimes need to make unorthodox connections. Such is the case with a partnership that some organizations have been part of since the 1970s—a connection between teaching hospitals and federally qualified health centers (FQHCs) that offers financial advantages to both.

These relationships typically involve the teaching hospital moving its continuity clinic out of the hospital and into the FQHC. This model helps alleviate the FQHC’s shortage of primary care providers while offering real-world experience to the residents from the teaching hospital. Furthermore, the relationship helps FQHCs earn full enhanced reimbursement from Medicare and Medicaid, and helps teaching hospitals reduce training costs.

The success of teaching hospital/FQHC partnerships is largely contingent on the structure of the financial arrangement between the parties.

Meeting Demand for Primary Care Physicians

Recent statistics from the Association of American Medical Colleges (AAMC) suggest the looming physician shortage may be more complex than previously understood and is approaching faster than originally anticipated. By 2025, demand for physicians is predicted to exceed supply by 46,000 to 90,000 (Association of American Medical Colleges, “Physician Supply and Demand Through 2025: Key Findings,” 2015).

Exacerbating this problem is a shortage of residency opportunities. The 2015 National Resident Match Program included 41,334 total applicants, but only 30,212 positions, according to 2015 Main Residency Match Data Tables. These statistics show that, although more physicians are being trained than ever before, many cannot get the clinical experience necessary to be certified.

Teaching hospitals address the lack of new physicians entering the workforce by developing physicians in-house. However, to receive graduate medical education
(GME) funding for their residents from Medicare, most primary care residency programs are required to care for individuals who otherwise are unable to get care. They often fulfill this obligation through a continuity care clinic that provides consistent, longitudinal outpatient care regardless of the patients’ ability to pay.

While providing this access to the community is beneficial to population health, it does come with a significant financial cost to the teaching hospital. High expenses of clinic operations (including cost of faculty, nursing, administrative staff, facility etc.) coupled with a relatively poor payer mix cause significant ongoing losses for teaching hospitals. For example, two of our large teaching hospital clients located in major U.S. cities averaged only $31 per visit payment in their outpatient GME continuity clinics in 2014.

**FQHC Visit Goals**

Unlike other healthcare providers, FQHCs are financially incentivized to treat lower-income patients. FQHCs receive enhanced reimbursement for treating Medicare and Medicaid patients, and that reimbursement is typically twice or three times the rate received by a hospital-based clinic or freestanding practice. FQHCs also receive 330 grant funding (named for Section 330 of the Public Health Service Act), which helps offset some of the cost of providing uncompensated and poorly compensated services.

However, with FQHCs’ enhanced reimbursement there is also an expectation of patient throughput. If an FQHC does not meet productivity expectations, their enhanced reimbursement level for Medicare (and in some cases Medicaid) patients (Federal Register, Vol. 79, No. 85) could be at risk.

For many FQHCs, generating visits is problematic because of difficulty recruiting physicians. According to the Health Resources and Services Administration (HRSA), there were over 1,800 unfilled primary care physician positions at FQHCs and other National Health Services Corps sites as of April 2015 (HRSA Data Warehouse – HRSA Activity Summary).

Partnerships with teaching programs offer FQHCs an avenue to reduce this shortage. One study found that 91 percent of residents who train under the Teaching Health Center Graduate Medical Education program (75 percent of the training sites are FQHCs) remain in primary care practice, and about 76 percent practice in underserved regions of the country ("One Million Patients Could Lose
The Partnership Structure

On the surface, teaching hospitals and FQHCs make for strange bedfellows since they have traditionally competed for the same lower-income patient population. But with proper arrangements in place, these entities can decrease each other's cost of serving the community.

The ideal method for structuring a teaching hospital/FQHC relationship is to move the continuity clinics out of the hospital and place them in an FQHC setting. In these situations, the FQHC manages the new clinical operations while the hospital manages the remaining academic activities of the residency programs.

This model alleviates the FQHC's difficulty in securing providers as it guarantees at least one board-certified physician and up to four residents in the clinic. It also allows for more patients to be seen. A physician typically sees 16 patients in a four-hour session. However, if that same physician gave up seeing patients and instead supervised the care provided by three residents (a first-year, a second-year, and a third-year resident), the team could take care of 24 patients in a four-hour session.

**PHYSICIAN PRODUCTIVITY IN A TEACHING HOSPITAL-FQHC MODEL**

For teaching hospitals, the FQHC partnership provides an opportunity to expose residents to a real-world (i.e., volume-based) training model, while maintaining relatively stable costs for outpatient training. One of the complaints about many primary care residency programs is that residents do not receive enough clinical experience to make them productive private practice physicians after graduation.

Our data from family medicine programs in eight states show that typical family medicine residents in their third year of training see only four to seven patients during a half-day session. In comparison, a family medicine physician in an FQHC setting needs to see nine patients per half-day session to meet the unofficial 4,200 annual visit threshold.

In addition, training in FQHCs extends beyond simply seeing more patients; FQHCs are required to provide medical, dental, diagnostic/lab, emergency, and pharmaceutical services, as well as non-medical services such as social services.
and transportation. Thus, residents in FQHCs learn to coordinate their patients’ care, which results in better quality outcomes, and they gradually become more comfortable treating a multitude of patients with chronic and co-morbidity complexities.

**The Financial Arrangement**

By rule, FQHCs are not allowed to enter into agreements that could harm them financially. This presents an interesting challenge to the partnership, since one of the main reasons teaching hospitals pursue this type of arrangement is to control clinical training costs. The solution is for the teaching hospital to provide a variable clinical teaching payment (VCTP) to the FQHC that accounts for the inherent costs of integrating teaching programs into an FQHC setting.

While multiple factors go into calculating the VCTP payment, the fundamental goal of the model is to determine the cost of providing a teaching visit compared to the cost of providing a non-teaching visit in the FQHC. Once these two figures have been calculated, the cost of the non-teaching visit is subtracted from the cost of the teaching visit and the remainder is multiplied by the annual visits produced by the FQHC.

**CALCULATING VARIABLE CLINICAL TEACHING PAYMENTS**

To ensure that the VCTP covers the actual cost, the cost-per-visit figures are reconciled every six or 12 months. If the reconciliation shows that the actual cost of a teaching visit is equal to or less than the cost of a non-teaching visit, the VCTP payment is discontinued until the next reconciliation. However, there is no “refund” to the teaching hospital; this provides a financial incentive to the FQHC and ensures compliance with FQHC Safe Harbor regulations.

The use of VCTP minimizes the financial impact of teaching for the FQHC. And for the teaching hospital, the VCTP limits clinical training costs, assuming the program is managed in a cost-effective manner.

**Worthwhile Benefits**

Partnerships between teaching hospitals and FQHCs represent one solution for addressing the shortage of primary care physicians, while also lessening the shortage of residency opportunities for student physicians. It may appear to be an unusual partnership, but its benefits are worthwhile.