COPE HEALTH SOLUTIONS

Webinar Q&A

How to Manage a Growing Medicaid Population with an FQHC Strategy

May 27, 2020

1. **Can you speak to the potential value of 340B pricing?**

   The 340B Drug Pricing Program is a safety net program that enables provision of medications for the uninsured and underinsured at much lower costs than if they were to go to a non-340B pharmacy. The cost for the pharmacy to purchase the drugs are based on federal guidelines, which are much lower than retail purchases. A health system (covered entity) can generate revenue with this program from their insured patients who get their medications from a 340B contracted pharmacy.

   The pharmacy orders drugs on covered entities' accounts with the pharmaceutical wholesalers at the 340B formulary on behalf of the covered entity and can only dispense the drugs to patients of the covered entity. The pharmacy then submits claims to the insurances companies, collects the payment and sends the insurance payments (net of a dispensing fee) to the covered entity. There are many compliance regulations that need to be followed, so use of a third party agency (TPA) and audits are recommended.

2. **With regard to the recommendation for specialty care in the FQHC, can you expand on how the rate structure is developed? In your experience, how has the negotiation for the percentage of the PPS rate been successful?**

   While percent sharing of the PPS rate is not permitted, you can leverage the enhanced reimbursement to fairly compensate the specialists through a higher flat fee (for example). The FQHC would work with the current rate or if there is a qualifying event (i.e., requiring a change in scope) that could change the PPS rate.

   More important is understanding the overall business model, including downstream revenues; mindful that those RVUs or revenues may accrue to a different specialist from the referral, requiring some credit to the provider in the FQHC. Further, the PPS rate is (hopefully) only a part of a broader value-based relationship and should be put in context of the overall business relationship.

3. **Do FQHC Look-Alikes have special facility structural requirements, similar to fully funded FQHCs?**

   Yes, the requirements vary state to state but the facility structural requirements are the same.

4. **Do clinics need to comply with OSHPD3 requirements in terms of facility/construction to become a community clinic first?**

   Yes, it is required to qualify first as a community clinic site in the state of California. Facility requirements vary by state.

5. **Under this model, why not become a fully funded FQHC? Why become an FQHC Look-Alike?**

   To become a fully funded FQHC, Health Resources and Services Administration (HRSA) would need to open up the process and award new access points, the timing of which opportunities are not predictable.

   By becoming an FQHC Look-Alike, organizations are prepared to apply and become a 330 grant funded FQHC should the funding round present itself.

6. **How can specialists get the PPS rate if they see patients at an FQHC if the approved scope of services does not include those specialties?**

   The FQHC would need to apply for a change in scope to be permitted to bill those services and would then fairly compensate the specialists.

7. **Are you aware of any FQHCs that provide dialysis services as part of the scope of service?**

   No, we are not. Dialysis would not necessarily lend itself to benefit significantly from the FQHC PPS rate, however, with the right configuration and leveraging of related visits and 340B it could probably be done.

8. **What are the steps to converting a for-profit entity into a non-profit? Do you recommend creating a new non-profit to purchase the clinics before becoming an FQHC look-alike?**

   To apply for the FQHC or FQHC Look-Alike, the entity would need to be nonpoint. It is possible to transfer to an existing nonprofit or create a new nonprofit organization. A management or independent contractor agreement can be the foundation of the business relationship between a for-profit and an FQHC.