THE PENNSYLVANIA COMMUNITY HEALTH CENTER MANUAL

A guide to running a great FQHC in Pennsylvania

August 2013

DEDICATION

The Pennsylvania Association of Community Health Centers (PACHC) dedicates this manual to the Community Health Center "pioneers" in Pennsylvania, who with inspiration and perspiration led the development of FQHCs into quality, efficient, effective, trusted, and emulated providers of care in the communities they serve and, by doing so, improved health and lives. Their passion, compassion and willingness to share lessons learned with the "community of Community Health Centers" both informed and inspired this publication.

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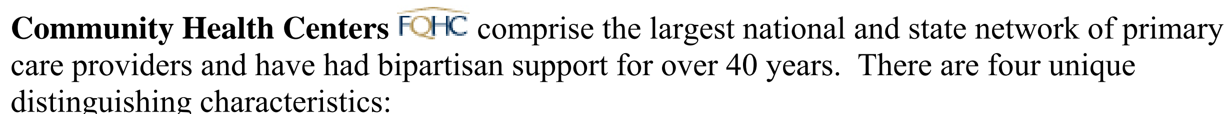
FOREWORD

A healthcare delivery system, whether local, state, or national, is an extremely complex and living entity. It has elements of science, technology, education (basic and higher), personnel management, facility, and much more. This manual is about a particular, generally local, type of delivery system. It focuses on primary health care, but may extend through collaborative or other arrangements to many other clinical care areas. It is a small business in the communities where its sites are located but is part of a large and extraordinary network. This exceptionally diverse and, for some of us, exciting organization is interchangeably called a Community Health Center, federally qualified health center or FQHC.

FQHCs began in the mid-1960s as an experiment to see if they could address the primary care needs of the underserved—individuals and families with inadequate access to primary health care for a variety of reasons. They may be uninsured or have health insurance, such as Medicaid, that many providers do not accept. Sometimes, the issue is cultural or linguistic. The original experiment began in Mississippi and Boston. By proving their value, there are now FQHCs in every state in the nation with more than 1100 FQHC organizations in the U.S. and its territories. In 2011, the nation's FQHCs served approximately 20.2 million people through 77,000,000 visits at over 8,500 service sites.



Community Health Centers comprise the largest national and state network of primary care providers and have had bipartisan support for over 40 years. There are four unique distinguishing characteristics:

- **F**ees based on **ability to pay** (*FQHCs must offer a sliding fee scale and individuals are expected to pay what they can afford*)
- **Q**uality primary health care open to **all** (*FQHCs are open to all and must meet federal reporting, performance and accountability requirements*)
- **H**ighly competent **health professional team** (*FQHCs offer comprehensive, culturally competent, quality* ***medical, dental and behavioral health care****. Staff must be appropriately licensed, credentialed, and privileged.*)
- **C**ommunity governed and **patient-centered** to ensure they are **responsive** to their patient population (*at least 51% of people serving on the governing board of an FQHC must be patients served by the FQHC*)

Pennsylvania's community of Community Health Centers cares for more than **700,000** Pennsylvanians through more than **2.5 million** visits annually. There are 47 organizations with 245 delivery sites state-wide located in 48 counties both **urban** (60%) and **rural** (40%) areas serving federally designated medically underserved areas. The patient base that is **70%** Medicaid and uninsured combined with **92%** of patients having incomes at or below 200% of the Federal Poverty Level.

The benefits of designation as an FQHC may include grant funds, fairer Medicaid and Medicare reimbursement, access to reduced pharmacy costs, and provider recruitment and retention support. However, to qualify for these benefits, FQHCs must meet stringent program and reporting requirements.

Because of the validated success of the Community Health Center model over its long history, many communities, when responding to local health care need, look at this model as a partial solution to better their residents' health. This begins a journey—a very difficult one—to plan, develop and fund an FQHC.

This manual is designed as a guide to developing or leading a Community Health Center in Pennsylvania. It does not intend to duplicate or replicate the other excellent resources that exist—in fact this manual will direct you to those resources—but instead, gives Pennsylvania-specific guidance to supplement that information.

Finally, we repeat a common FQHC mantra: when you've seen one FQHC, you've seen one FQHC. FQHCs have common features and program requirements; however, the model is designed to be responsive to and reflect the uniqueness of each community.

INTRODUCTION

This manual is designed as a resource for individuals, organizations and communities interested in establishing a Community Health Center (FQHC grantee or Look-Alike) in Pennsylvania, and as a resource for new leaders in established FQHCs. The terms Community Health Center and FQHC will be used interchangeably throughout this document.

Community Health Centers are complex organizations that are not easy to develop or maintain, but are worth the effort because of the impact they make on access to quality primary health care and health status, especially for the most vulnerable residents of Pennsylvania and our nation.

The Community Health Centers of today are not the organizations they were in the past. The health care system in the United States and in our Commonwealth continues to change and evolve and FQHCs are responding to those changes in a myriad of ways. They are earning recognition as Patient Centered Medical Homes, implementing electronic health records, adding services and improving processes—all to better meet their mission of improving access to quality primary health care for all.

There are Community Health Centers in every state across the nation and all must meet the requirements of the federal Health Center Program in order to continue to be recognized as FQHCs and receive the benefits of that designation. While Community Health Centers share the program requirements and other commonalities, there are notable differences in how the Health Center Program is operationalized at the state level.

There are many resources available through the Health Resources and Services Administration (HRSA), the National Association of Community Health Centers (NACHC) and others offering general guidance on becoming a Community Health Center and meeting the Health Center Program requirements. This manual is not intended to duplicate those efforts, but rather to provide state-specific guidance to augment that information for those who want to establish or who will lead a Community Health Center in Pennsylvania and want it to be a GREAT FQHC!

HISTORY OF THE HEALTH CENTER PROGRAM

The Health Center Program has a 45-year history. What is remarkable about Community Health Centers FQHC is that they have enjoyed bipartisan support for their entire history—one of the few areas of health care that can with honesty claim that!

There are good reasons for that bipartisan support of the Community Health Center model of care—both clinical and financial. Clinically, multiple studies have validated the effectiveness of Community Health Centers in reducing health disparities and improving outcomes, even though these health centers generally serve more medically complex patients who are also challenged by the social determinants of health.

On the financial side, multiple studies have also validated the cost effectiveness of Community Health Centers. A recent study by the Geiger Gibson Center of George Washington University concluded that the health system saves on average $1263 per patient who has a Community Health Center as their medical home. In Pennsylvania, when you multiply that number by the more than 700,000 individuals who health centers serve, that translates into more than $880 million in savings annually to the health system, and consequently the Commonwealth and taxpayers!

The goal of Community Health Centers is to help the individuals they serve get well and stay well so they don't require more costly emergency and hospital care. Services provided include prevention services, like screenings and immunizations, as well as management of acute and chronic medical conditions. In addition to primary medical care across the lifespan, FQHCs also offer access to dental and behavioral health services as well as discounted medications, either on site or through arrangement with a pharmacy.

Community Health Centers provide comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations, across Pennsylvania and across the country. Because of the success of the model, Community Health Centers have developed into the largest primary care network in the state and in the nation, with locations in every state. Today, the "community of Community Health Centers" serves more than 23 million people nationwide. Because the health center model offers access to care, regardless of ability to pay, many of the individuals served by the nation's health centers are the most vulnerable.

PACHC works with individuals, organizations and communities across the Commonwealth interested in establishing a Community Health Center. With PACHC's help, access to quality primary health care has improved substantially in Pennsylvania and we will continue to work to improve access through development of Community Health Centers and other safety net organizations.

SO WHAT IS A COMMUNITY HEALTH CENTER?

We've mentioned the long history of Community Health Centers, the strong bipartisan support and the fact that Community Health Centers have grown to become the state's and nation's largest primary care network. Despite those impressive statistics, too few people know what Community Health Centers are and what makes them different from other primary care organizations. To address that, and support better patient outreach, recruitment, and partnership, PACHC, in partnership with the National Association of Community Health Centers (NACHC) and other primary care associations across the nation, is working to improve "brand recognition" of Community Health Centers.

Community Health Centers across the nation are being encouraged to use the logo below, developed by PACHC and then adopted by NACHC, to identify themselves as FQHCs and increase public and policymaker awareness.

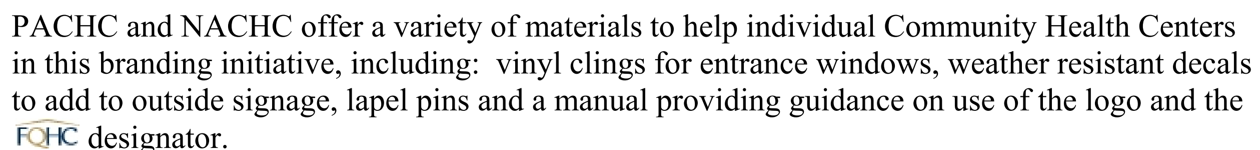
The long-term goal is for this symbol to become as ubiquitous as the blue "H" for hospitals and for the public to have general knowledge that the symbol represents some of the core tenets of the Community Health Center model:

Fees based on ability to pay (FQHCs must offer a sliding fee scale)

Quality health care for all (FQHCs are open to all and must meet federal reporting, performance and accountability requirements)

Highly competent health professional team (FQHCs offer other services to help patients stay well, such as dental and behavioral health care, case management, health education, pharmacy and social services)

Community control to ensure health centers are responsive to their patient population (at least 51% of people serving on the governing board of an FQHC must be patients served by the FQHC)

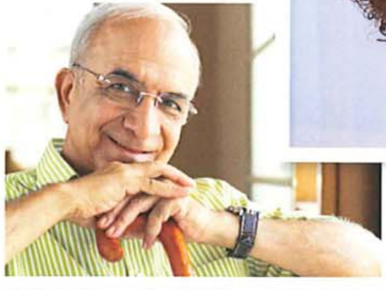


PACHC and NACHC offer a variety of materials to help individual Community Health Centers in this branding initiative, including: vinyl clings for entrance windows, weather resistant decals to add to outside signage, lapel pins and a manual providing guidance on use of the logo and the FQHC designator.

PACHC PENNSYLVANIA ASSOCIATION of COMMUNITY HEALTH CENTERS
"Supporting access to affordable, high quality health care"

COMMUNITY HEALTH CENTER FQHC QUALITY

COMMUNITY HEALTH CENTERS *quick facts*



COMPREHENSIVE

- Provide comprehensive, culturally competent, quality **primary medical, dental and behavioral health** care for all ages
- Services include prevention services as well as management of acute and chronic medical conditions
- Offer services such as health education, care management, translation, eligibility assistance, transportation, and after hours coverage

AFFORDABLE

- Fees based on ability to pay - FQHCs must offer a sliding fee discount and individuals are expected to pay what they can afford
- Average costs per medical patient per year were \$369; per dental patient per year were \$365 for a total of \$527 in 2011
- Discounted medications either on site or through arrangement with a pharmacy

COMMUNITY

- Care for more than **700,000** Pennsylvanians through more than **2.5 million** visits annually
- 47 organizations with 245 delivery sites state-wide located in 48 counties
- Located in both **urban** (60%) and **rural** (40%) areas serving federally designated medically underserved areas
- Non-profit organizations governed by consumer-based Boards where at least 51% of the Directors must be patients of the health center
- Patient base that is **70%** Medicaid and uninsured combined
- **92%** of patients have incomes at or below 200% of the Federal Poverty Level

QUALITY

- Community Health Centers FQHC follow stringent standards with transparent and accountable quality outcomes reported annually through Health Resources and Services Administration
- 75% of PA health centers are either recognized as or working toward Patient-Centered Medical Home, a model of care coordination that is dedicated to continuous quality improvement and strengthens the primary care clinician-patient relationship
- Almost 75% of FQHCs are using electronic medical records to improve quality outcomes and deliver more personalized, coordinated, effective and efficient care

GLOSSARY OF TERMS

Community Health Center - a federally qualified health center (FQHC) grantee or Look-Alike

DOH – the Pennsylvania Department of Health, the agency responsible for disease surveillance, the primary care practitioner state loan repayment and J-1 visa physician programs, and other healthcare initiatives in the Commonwealth

DPW – the Pennsylvania Department of Public Welfare (DPW), the agency that administers the Commonwealth's Medicaid program

HealthChoices - Pennsylvania's mandatory Medicaid managed care program

HRSA - Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, provide oversight and administration of the Health Center Program through the Bureau of Primary Health Care (BPHC).

MAC/FI – Medicare Administrative Contractor/Fiscal Intermediary

Medical Assistance (MA) - Pennsylvania's Medicaid program

Medicare - federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). The different parts of Medicare cover specific services:

PA Primary Care Career Center – The PA Primary Care Career Center, a partnership of the PA Department of Health and the Pennsylvania Association of Community Health Centers, is designed to be a one-stop portal to primary care practice opportunities in PA.

PA PROMISe™ System – the PA Department of Public Welfare provider portal that allows providers, alternates, billing agents, and out-of-network providers with the proper security access to submit claims, verify recipient eligibility, check on claim status, and update enrollment information

PACHC – the Pennsylvania Association of Community Health Centers

PAL – HRSA Program Assistance Letter

Pennsylvania Association of Community Health Centers – also known as PACHC; the state's primary care association that provides support to Community Health Centers, rural health clinics (RHC) and like-mission non-profit primary care providers

Pennsylvania Health Law Project (PHLP) - PHLP is a nationally recognized expert and consultant on access to health care for low-income consumers, the elderly, and persons with disabilities

PIN – HRSA Policy Information Notice

Quality Assurance (QA) - Refers to a broad spectrum of evaluation activities aimed at ensuring compliance with minimum quality standards

Quality Improvement (QI) - Consists of systematic and continuous actions leading to measurable improvement in healthcare services and in the health status of targeted population groups.

Continuous Quality Improvement (CQI) - The ongoing monitoring, evaluation, and improvement processes. It is a patient driven philosophy and process that focuses on preventing problems and maximizing quality of care. It also encompasses ongoing improvement activities and the management of systems that foster such activities through communication, education, and commitment of resources**.**

THE “Becoming an FQHC” CHECKLIST

There are so many “to dos” in getting your Community Health Center from conception to reality that we thought we’d give you a jump start with a high-level checklist that is by no means comprehensive.

Overall:

- ☐ Contact the Pennsylvania Association of Community Health Centers (PACHC) so we can work together and help you on this journey
- ☐ When in doubt, contact PACHC! pachc@pachc.com or (717) 761-6443
- ☐ Read and understand the 19 Health Center Program requirements
- ☐ Gather and read recommended Resources
- ☐ Keep a Key Information Binder
    - Key numbers
    - Key identifications: NPI, PROMISe ID, EIN, etc.
    - HRSA Notice of Award
- ☐ Look for FQHC training opportunities
    - PACHC, NACHC, HRSA
- ☐ Do a “Patient Perspective Evaluation” of everything—access, communication, processes, signage, policies, facility, etc.
- ☐ Develop your own “Advisory Committee”
    - Look for people with expertise in governance, finance, operations, that you can turn to for advice but that are not on your governing board
- ☐ Visit existing Community Health Centers and their leaders
    - In person or by phone
    - What were there biggest mistakes?
    - What do they wish they had done differently?
    - What are they most proud of?

Operations:

- ☐ IRS Tax Exempt Application, Letter of notification, and Articles of Incorporation.
- ☐ Charitable Exemption Certificate or whatever required to solicit donations.
- ☐ Tax I. D. #
- ☐ Any local tax identification numbers required?
- ☐ DUNS #
- ☐ SAM, or the System for Award Management https://www.sam.gov/portal/public/SAM/
- ☐ Table of Organization—formal and by relationships.
- ☐ Establish a record-keeping system
    - Identify significant documents that they should be kept in special locations or locked files, such as corporate records, Notice of Awards, audits, board minutes, etc.
    - Each grant must have its own file—application, Notice of Award, Project Officer correspondence, site reviews, Federal Financial Reports, semi-annual reports, annual audits, and other documents significant to the grant.
- ☐ Secure legal counsel
- ☐ Secure necessary Insurances
    - Directors and Officers
    - Professional Liability/Malpractice (FTCA and/or other)

- Corporate or general liability
- Worker's Compensation

☐ Negotiate service contracts
☐ Apply for CLIA license for on-site laboratory services
☐ Develop Policy Manuals
  - Remember to get board approval

☐ Negotiate referral agreements
  - Work with legal counsel to develop a stock template
  - Refer to NACHC manual on Collaborative Arrangements for guidance
  - Collaborative Arrangements: A Guide for Health Centers and Their Partners; NACHC and Feldesman Tucker Leifer Fidell LLP; August 2011

☐ Contract with insurance companies
☐ Medicaid identification #--for both entity and providers?
☐ CMS—Medicare Enrollment, check in with Part A Intermediary and Part B Intermediary for anything special
☐ Enrollment with Medicare Advantage plans
☐ Technical Assistance resources set-aside—just start thinking about this
☐ Simple service area map
☐ For IT—Uniform Data Set (UDS) requirements

Human Resources:

☐ Develop staffing plan
☐ Develop salary and benefit matrix
☐ Develop personnel policies
☐ Equal Employment Opportunities reports required?
☐ State insurance requirements—comprehensive (general liability, fire, natural disaster, theft (bonding), worker's comp., employment practices, directors and officers, flood).
☐ Unemployment compensation
☐ Fringe benefits—bid, preliminary estimates, enroll
☐ Family Medical Leave applicable?

Community & Communication:

☐ Identify community partners and stakeholders
☐ Conduct a thorough Needs Assessment
☐ Develop a communication plan and strategies
  - Identify ALL elected officials—mayor, commissioners, township supervisors, state and federal legislators—and make time to contact them, visit them and invite them to visit
  - Develop a media contact list—for news releases, announcements, etc.
  - Reach out to your HRSA Project Officer early and regularly

☐ Identify potential referral resources
☐ Important local memberships (Chamber of Commerce, others)?

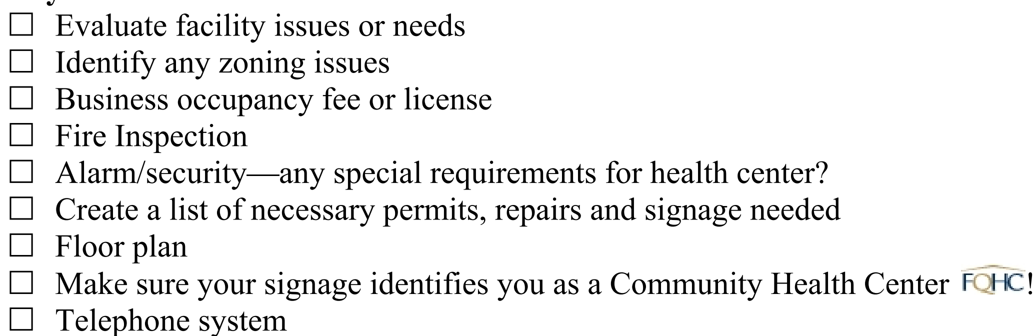
Finance & Payment:

☐ Develop an good understanding of FQHC payment
☐ Develop a budget
  - Identify all the variables

- Develop several budget scenarios and projections

☐ Develop an understanding of the process and timeline for enrollment with all payers
☐ Select a Practice Management System
☐ Payroll tax deposit
☐ Which payers accept and/or require electronic billing?
☐ Seek billing service? Do billing in-house?
☐ For electronic billing, HIPAA compliant system
☐ Choose audit firm
☐ Develop financial format and reports
☐ For CFO—some simple budget preparation forms
☐ Fee Schedule with sliding fee discount system
☐ Billing/Collection Policies

Facility:

☐ Evaluate facility issues or needs
☐ Identify any zoning issues
☐ Business occupancy fee or license
☐ Fire Inspection
☐ Alarm/security—any special requirements for health center?
☐ Create a list of necessary permits, repairs and signage needed
☐ Floor plan
☐ Make sure your signage identifies you as a Community Health Center  !
☐ Telephone system

Clinical:

☐ Evaluate Electronic Health Record (EHR) needs
☐ Identify clinical staffing needs and begin recruitment
☐ Establish credentialing process for clinicians
  - Begin a list of steps/outcomes

☐ Develop a QI Plan
☐ DEA Numbers for providers
☐ Malpractice insurance—amounts/levels.
☐ Hospital privileges for physicians?
☐ Any physician dispensing license, enrollment, etc. for pharmaceuticals given out in office required?
☐ **Clinical Laboratory Improvement Amendments** (CLIA) —Level 1?
☐ National Practitioner Data Bank—register, check provider
☐ Healthy People 2020—download a copy

Governance:

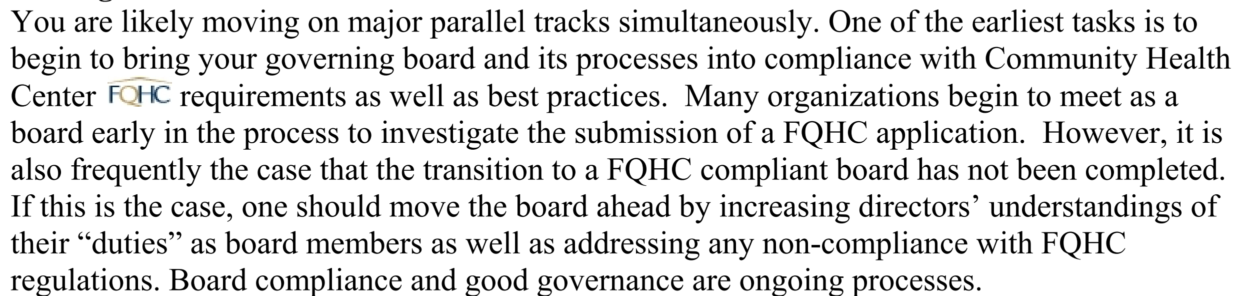
☐ Draft bylaws for Board approval
☐ Develop a matrix of desired Board representation
  - Patient representatives reflecting demographics of service area
  - Skills (e.g. finance, marketing, human resources)
  - Specific organizational representation (e.g. local hospital)

Templates:

- ☐ Provider Contract—with and without incentives
- ☐ Patient billing form—superbill?—with codes
- ☐ Patient receipt if separate from bill
- ☐ Job description for Program Director
- ☐ Job description for Chief Executive Officer
- ☐ Job description for Chief Medical Officer
- ☐ Procurement policy—bids, purchase of services, selecting lowest price <u>or</u> best offer, etc.
- ☐ Conflict of Interest Policy
- ☐ 330 Compliant By-Laws
- ☐ Measuring process quality
- ☐ Problem Lists—acute, chronic
- ☐ Medication Lists
- ☐ Consultations/Referrals
- ☐ Case Management—forms, plans, etc.
- ☐ Billing/collection policies—proof of patient eligibility requirements, how to bill, when to send to collection, etc.
- ☐ Human Resource policies
- ☐ Compliance
- ☐ Risk Management
- ☐ Other?

GOVERNANCE

Getting Started—Governance



You are likely moving on major parallel tracks simultaneously. One of the earliest tasks is to begin to bring your governing board and its processes into compliance with Community Health Center FQHC requirements as well as best practices. Many organizations begin to meet as a board early in the process to investigate the submission of a FQHC application. However, it is also frequently the case that the transition to a FQHC compliant board has not been completed. If this is the case, one should move the board ahead by increasing directors' understandings of their "duties" as board members as well as addressing any non-compliance with FQHC regulations. Board compliance and good governance are ongoing processes.

General Expectations of Directors

There are frequently used statements about the general obligations of board members. This is not a set of steps toward perfection. Rather, they are general statements about the individual and collective efforts of board members to do what is best to help the organization achieve its mission. These include:

- Duty of Care. If one is being asked to make important decisions based upon good information and discussion, it is important to attend meetings and read the materials supplied before the meeting. In reading the materials, even if not an expert, one must make a reasonable effort to understand them and, if needed, ask questions to clarify. If the information does not appear sufficient to make a decision, it is important to ask for supplemental information to assist decision-making. The information may come from staff, legal counsel, auditors, or others that are expert in a specific area. At the point of making a decision, it is important to come to a decision independently and in the organization's best interest.

- Duty of Loyalty. This requires a director to make a decision based upon the organization's best interest rather than a personal or another's best interest. If one has an apparent conflict of interest, it should be openly declared. It is important that the organization have a properly drawn conflict of interest statement to handle such situations as well as to define what a conflict of interest is. This may require legal counsel to navigate what is sometimes difficult terrain. The conflict of interest concern is so significant that it is important to formalize a policy and have all directors (and all staff) complete a conflict of interest statement no less than annually or more often if needed. A second aspect of loyalty is confidentiality. A director should not reveal the organization's confidential matters. Committees, with few exceptions, do not make decisions for the board or communicate them prior to board action.

Frequently, in these general statements, the word "**fiduciary**" arises. This refers to the board acting in good faith on behalf of a person s/he represents. In this sense, the director is acting on behalf of center patients, potential patients, employees, and general community members. They monitor the programs, protect assets, review investment plans, etc. They attempt to approve policies that promote quality, are financially sound, and promote the goals of the organization.

Compliance

Another function of governance is to insure compliance with law and regulations relevant to the health center program. It is probably most helpful to look at the Health Center Site Visit Guide section on governance to see what the major requirements are and the questions that you need to answer about your present governing board operations. These are Health Center Program Requirements 17-19 and begin on p. 44 of the guide. However, it is important to remember that the overall board role is to guide the organization through policies, planning, and study in ways that achieve the overall mission. This means that any of the Health Center Site Visit Guide described elements at some point relate to board activity. It may be that a committee of the board reviewed a particular policy; evaluated the CEO; approved a fee schedule or a grant, etc. In this sense, therefore, the Site Visit Guide is also a "guide" to board action and behavior.

Important Points:

1- Focus on both FQHC requirements and good governance practices.
2- Conflict of Interest merits special consideration.
3- Review Health Center Program Requirements on Governance (#s 17-19) for specific HRSA direction on board composition and responsibilities, as well as conflict of interest.

Structural Considerations

Step 1: Bylaws should be compliant when you compare them to Health Center Program Requirements 17-19. Be strict in your evaluation. Consider:

- Does the board meet monthly?
- Are the minutes clear?
- Did the board approve the grant application as well as the budget?
- If there are changes to be proposed to the approved budget, did the board study and approve them?
- Have the services and hours of operation been approved by the board, and is this approval documented in the minutes?
- In terms of board composition, what is the percentage of users on the board? Is the board size between 9 and 25 members?
- Is the board packet comprehensive?
- Are the committees appropriate to the governance needs? Is there a strong conflict of interest policy?
- Have conflict of interest statements been completed?

We recognize that the board at this stage may not have developed all of its practices. However, begin thinking about what this may mean now.

Step 2: Operationalizing Committees

Board committees should be the "working groups" in specific functional areas. They study issues or examine reports as the first line of examination. Usually, their assignment is to prepare a recommendation to the entire board on specific topics or assigned tasks. Some examples:

- Does the proposed change to the human resource policies seem reasonable?
- Did the financial report show any variances or significant financial problems that should be noted or require special action?

- Did the quarterly clinical performance indicator goals show continued improvement? If so, or if not, why?

Committee composition—size and membership—should be commensurate with each committee's charge. Based upon the committee's work, a recommendation is made to the Board of Directors for their action. Committee work assists but does not replace board action.

Important Points:

1- The 19 Health Center Program Requirements may suggest functional areas for committee work. It may be a helpful review for staff and the board to review these requirements and note which committees are responsible for each requirement.
2- The by-laws should include a process for establishing ad hoc committees in addition to standing committees. These are specially approved board committees to address a special problem of usually a time limited nature. For instance, if a special renovation project is proposed and it does not seem to fit an existing committee function, a group of board members can be assigned this monitoring function.
3- "Consent agendas" can be an effective tool to keep the board focused on the most important topics for discussion and to allow enough time to discuss them.
4- It is typical for well-functioning boards to have processes established for public communications that define who the particular spokesperson is for the board.

Resources:

Funded! Now What? NACHC September 2011
The Consent Agenda: A Tool for Improving Governance, Board Source
Handbook for Directors of Nonprofit Corporations in the United States: A Primer on Directors' Duties and Rights and Minimizing Risk by K & L Gates, LLD. (contact PACHC for free copies)

Composing Your Community Health Center Board

Step 1: Consider development of a job description for FQHC board members and a prospective board member information sheet (for samples, see pp. 15-17 in Funded! Now What?). This provides explicit information for both existing and potential board members and will have two benefits. First, for an individual that might be interested in becoming a potential director, the job description may cause stronger and more accurate consideration of his/her interest in serving. The second is that existing board members charged with the recruitment of new directors have more guidance as to the skills being sought.

Step 2: As you work to compose your board, ensure that it meets the special requirements for FQHC boards:

1- Patient Majority
   A majority of a health center's directors must be users of the FQHC. This means that the center is the source of the director's or family members' primary health care. (If a director is a guardian of a patient, the director is also classified as a consumer.)
2- Provider Limit
   No more than 50% of the non-user members of the board can derive 10% or more of their income from health care.

3- Representative
The third requirement is that the board be roughly demographically representative of the patient population served. This is not a rigid quota system. Rather the goal is that the board represents the broad demographic categories of these individuals.

Step 3: Look at the board in terms of requisite skills and expertise helpful to meet the mission and goals of the organization.

Step 4: New Member Orientation and Training
A new board member should participate in a new board member orientation program and training. We recommend a manual or notebook that contains key documents helpful to the new board member. The content should include, at a minimum:

- Articles of Incorporation and bylaws;
- Determination letter from the Internal Revenue Service
- The most recent organizational tax return and Form 990
- The most recent financial audit including management letter
- Most recent annual report
- List of current officers and directors of the organization
- Summary of applicable insurance (including a review of any policies of Directors and Officers Fiduciary Liability Insurance
- Latest Mission Statement
- A Table of Organization, including a chart showing any relationship with affiliated organizations.
- The summary of HRSA's 19 Health Center Program requirements
- Other items that help to explain the organization, its history and mission, and key elements of its operation.

Consider strongly who should conduct board orientation. We do not recommend that the CEO only perform the orientation. However, this individual can be extremely helpful to the process in explaining operational features of the FQHC. The orientation need not be performed at a single meeting as the content can be overwhelming. It may be wise to hold several meetings or have the new director meet with various individuals over an initial 3 month period. As the new director may attend several board meetings during this period, this provides an opportunity for the new director to see the board in operation and ask questions during the orientation visits.

Improving the Board
Step 1: Board Self-Evaluation
Each year, board self-evaluation is a crucial activity to determine, based upon explicit standards, how the board did in the period since the last self-evaluation. It is important to consider what measures should be used to evaluate the board. For example:

- Has the board size and composition remained in compliance with FQHC regulations?
- Has the Board approved the annual budget, any grants submitted, reviewed any new policies implemented, etc.?
- Some are also more of a process nature. How often did the various committees meet? Does this appear to be sufficient for their committee mandate? Do committees or the board have any trouble achieving quorums?

It may be helpful to survey the board members for their impressions and use the results for a board improvement planning session. This evaluation brings together multiple functions including, but not limited to, human resources policies, job descriptions, compensation, strategic planning and goals, and effective board functioning.

Step 2: Re-evaluation of Board Composition
If the board were to identify its major needs or challenges including those "emerging issues," what skills and expertise would permit it to address them more effectively? Are these skills present on the Board of Directors? Add to this list mission passion. Does the Board of Directors provide strong support for the organizational mission and to comply with those duties that support it?

Step 3: Board Policy Manual
There is a growing trend to develop a manual for board functions. The manual can explain various operational processes and rules internal to the board; reemphasize how meetings are conducted; the committee duties, etc. It does create an additional workload as it must be part of the periodic self-assessment process. Any change made to improve board functioning should be reflected in the manual.

Step 4: Discuss Ways Board and CEO Work Together Effectively
There are different roles for the board and the CEO. Some describe the board's role as that of approving policy and monitoring its implementation. The CEO's duty is to implement the approved policy or to provide helpful information and make recommendations about policies that the board is considering. As a governance library is established, it would be helpful to seek descriptions of effective board-chief executive functioning. Whatever the example, the board and CEO should address their roles through constant and mutually respectful conversation.

One of the major FQHC requirements as well as part of good nonprofit governance is to evaluate the CEO's job performance annually. Look for arrangements or agreements that others have used to inform this extremely important and difficult task. We offer some general comments. First, most boards find it difficult to develop a set of CEO evaluation measures. As it is important and fair to inform the CEO in advance of the measures to be used, some care must be taken to develop these with the CEO's participation. It may be helpful to start with activities that the board does not wish to see and to convert these into positive statements. The negative statement might be, "Do not violate federal, state, or local laws and regulations." Convert this into a positive statement, such as, "The CEO will insure that the organization will be in compliance with all relevant federal, state, and local laws and regulations." A second source of measures will come from the strategic plan or, perhaps, an operational work plan included in a grant application. If a particular service is to be added in a specific timeframe, it can become a CEO evaluation measure. It might read, "A new service site in (location) was identified or established or made operational by (date)." If a patient or visit target was deemed to be important, this might become a measure of job performance. However, the progress toward job performance success must not be evaluated rigidly. This is where the board and committee work is extremely important. As the search for the new service site proceeds, special constraints might have arisen. The goal or target date might have been changed. The mutually respectful discussion in a committee between members and the CEO or designated staff is helpful when such situations arise. The evaluation might take on a different tone, such as did the staff inform the board in a timely fashion of obstacles met and how they were addressed? Did the staff seek

alternatives? In short, was a reasonable effort made, even if it failed or something caused other than the desired outcome?

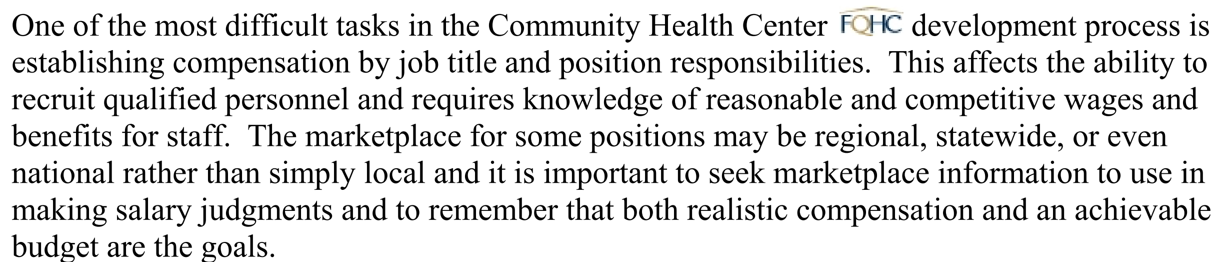
Board Education

High functioning boards are constantly learning more about topics that promote or inhibit achievement of their mission. Some have retreats where they can receive training on these needs. Others make education a part of each board meeting or offer topic-specific educational sessions. It is important to provide the board and committees information helpful to both its decision-making and functioning. The information may be topic specific or about board functioning. Some resources are free; others may cost, and their value must be considered. As feasible, the development of a corporate "library" should be considered. In this electronic age, many resources can be easily copied and sent to board members. As the FQHC becomes a mature organization, it may be a periodic (quarterly?) project to distribute some of these materials to the directors. Ultimately, this is a board decision, but staff and board should collaborate on this effort.

Some potential resources:

- HRSA Technical Assistance resource page from the Bureau of Primary Health Care templates and samples related to board authority, bylaws, board composition, corporate responsibility and more.
- The National Association of Community Health Centers (NACHC) has several resources for governance - http://www.nachc.com/Governing%20Board%20Responsibilities.cfm. It lists some of the tasks boards must perform and provides links to additional materials organized around program requirements. A second NACHC governance resource - http://www.nachc.com/health-center-info.cfm offers board education videos and governance information bulletins.
- NACHC also offers a "Board Boot Camp". This usually occurs in conjunction with a national conference or, occasionally, through your Primary Care Association. This training is comprehensive and addresses expectations, regulations, and best practices. It is an excellent opportunity for directors and senior leadership to learn more about governance as well as the latest legal requirements.
- In Pennsylvania, there is an excellent organization for nonprofit organizations called the Pennsylvania Association of Nonprofit Organizations, www.pano.org. As this membership does have a cost, its benefit should be examined. Its services are not restricted to health centers, but represent a "best practices" approach for nonprofit organizations.

DEVELOPING YOUR PERSONNEL BUDGET AND HIRING YOUR TEAM



One of the most difficult tasks in the Community Health Center FQHC development process is establishing compensation by job title and position responsibilities. This affects the ability to recruit qualified personnel and requires knowledge of reasonable and competitive wages and benefits for staff. The marketplace for some positions may be regional, statewide, or even national rather than simply local and it is important to seek marketplace information to use in making salary judgments and to remember that both realistic compensation and an achievable budget are the goals.

Step 1: Data Gathering
Salaries and benefits represent a significant portion of a health center's budget, generally, 65-75 percent. If the compensation packages are too high, the financial viability of the health center may be threatened. If they are too low, qualified and desirable personnel may not be interested in the positions you seek to fill.

Important Points:

1- It is helpful in both the developmental and start-up phases of a FQHC to have local individuals that are knowledgeable about human resource issues on your planning team or board. For example, you might consider someone from the local state employment office, the Chamber of Commerce or the Economic Development Agency.

2- Job descriptions do not always have consistent definitions, making comparisons a bit difficult. Some caution should be exercised, especially when comparing information between public and private sectors or for-profit and not-for-profit organizations.

3- It is also helpful to identify the major health care employers in the county. This might include, in addition to the local hospital, private clinical practice offices that are likely to have employees performing tasks that you will also likely require. You might want to reach out to these organizations and see if they are willing to share some salary range and benefit information and data sources they use to support their salary decisions.

Resources:
NACHC Human Resources Clearinghouse
NACHC Health Center Salary & Benefits Report is compiled from an annual survey by the National Association of Community Health Centers (NACHC) of FQHC salaries and benefits, and covers many but not all potential job descriptions of interest. Information is divided into executive and clinical sections, with key positions in each category and is presented by urban and rural populations, annual encounters, total budget, region and state. Within each category the information is presented by lowest to highest compensation reported and in quartiles between the extremes. This can be purchased from NACHC at both member and non-member prices. It is published annually in May.

U.S. Bureau of Labor Statistics offers some compensation information by position, state and metropolitan statistical area for numerous job descriptions. From the website you can access wage data by area and occupation.

Step 2: Create Job Descriptions
If you're looking for some sample job descriptions for positions commonly found within health centers, visit the NACHC HR Clearinghouse. The clearinghouse offers a variety of other resources, and many of them are available at no cost. The PA Primary Care Career Center within PACHC is also here to help, so don't hesitate to contact Career Center Director, Angela Jefferies at angela@pachc.com.

Step 3: Salary & Benefit Determinations
This next step—determination of reasonable and competitive wage ranges for each of the positions the FQHC requires—is perhaps the most difficult.

Using the market data you have gathered, first look at the compensation figures strictly in terms of base salary. Base salaries need to be competitive in order to attract candidates. However, benefit packages also must be considered as they will be an important part of recruitment and retention and an essential element of the total compensation package.

Important Points:

1- Benefits packages may vary by position—more continuing education monies for physicians than billing clerks, for example.
2- From a budgetary perspective, it is important to understand total compensation costs, because as benefits increase, so does the need to generate revenue to cover them.
3- For some clinical positions, the candidates may have eligibility for National Health Service Corps or state loan repayment assistance. You should not use these benefits to reduce provider compensation as this will make net pay lower and less attractive, however, you can certainly highlight them as a benefit in recruiting.
4- Your board should determine the target level of compensation – for example, "The target for salaries for XYZ health center will be the 60th percentile of prevailing wages for employees of non-profit organizations of similar size."
5- For key positions, the board might consider a higher target.
6- Don't underestimate the value of passion for the mission for some candidates.
7- If you are starting up a FQHC or a new site in an existing organization, you will likely not hire all staff in year 1 and won't achieve full capacity staffing levels until year 2 or early year 3.
8- To recognize early the budget implications of ranges created, as well as the time it takes to reach full staff complement, create budgets for the first three years of operation. You can then adjust your timeframes or prepare for key points along the way.

Step 4: Advertising Open Positions
You have established the compensation ranges and benefit packages and now it's time to find the right people to fill the positions. If the market for a position is local, you can generally advertise locally. If you're trying to attract candidates from across the state or nation, different advertising options need to be considered.

Important Points:

1- Continually evaluate the effectiveness of different advertising venues and your recruitment strategy. For example,
   - Are qualified individuals responding?
   - Are you losing qualified candidates because of the salary and benefit package?

2- Contact the PA Primary Care Career Center within PACHC to help you with your clinical and key leadership position recruitment needs.

Step 5: On-Boarding

Making your new employees quickly feel part of the organization is important. It's helpful to develop an "on-boarding checklist" which covers the key areas that will be covered during orientation to ensure vital information isn't overlooked. While a good orientation to your organization is essential, equally important for employees new to your community is help in quickly making them feel part of the community.

Important Points:

1- Remember, the stronger the roots they and their families develop in your organization and in the community, the more likely your new employees are to stay and flourish!

Step 6: Retention

The PA Primary Care Career Center within PACHC has a number of excellent retention resources available to help you keep the qualified individuals you are fortunate to recruit. Having a good retention plan in place is important and too often overlooked. The cost of a physician leaving a practice can easily reach almost $500,000. Recruitment costs alone run between $20,000 to $30,000 and the loss in annual gross billings as a result of lost productivity and a new physician's start-up expenses can reach $300,000 to $400,000.

Cost is just one negative factor to physician turnover. Family practice physicians comprise fewer than 15 percent of the U.S. outpatient physician work force, yet they perform 23 percent of the patient visits that Americans make each year. When a physician leaves a health care facility, this disrupts the delivery of health care for future patients, the continuity of care for existing patients as well as the patient loyalty to the facility

Resources:

PA Primary Care Career Center offers a variety of resources to help you in your recruitment efforts, particularly recruitment of clinical and key leadership positions. The Career Center offers an award-winning video that highlights the benefits of working in a Community Health Center, provides information on the National Health Service Corp and Pennsylvania's loan repayment program, hiring a J-1 visa physician in Pennsylvania and many other resources including a Retention Manual. The Career Center will post your openings to a national database as well as to its website and reaches out to potential candidates through career fairs, visits to health professional education programs and other venues.

NACHC HR Clearinghouse offers job descriptions, a sample retention plan, sample policies and procedures, hiring and credentialing guidance and much more.

COMMUNITY HEALTH CENTER REIMBURSEMENT

GENERAL INFORMATION

Most Community Health Center revenue falls into the following categories:

- Medicaid
- Medicare
- Third party commercial insurances
- Special service contracts
- Individuals responsible for paying their own bills (self-pay)
- Grants
- Fundraising

Each community is different; each center has its unique challenges and opportunities. According to data reported to the Uniform Data System (UDS), in calendar year 2011, 637,928 individuals received services from Pennsylvania FQHCs (data does not include Look-Alikes). Medicaid beneficiaries represented 43.9% (279,860) of those served; 9.7% (62,013) were covered by Medicare; 19.7% (25,983) were enrolled with private insurances; and 25.8% (164,857) were uninsured or self-pay patients.

However, the revenues actually collected tell a different story. Medicaid revenues represented 61.9% of the total; Medicare 11.1% of the total; private insurances 19.6%; and self-pay monies 6.9% of the total collections. In large part, this is because Community Health Centers receive fairer Medicaid and Medicare reimbursement than some other primary care providers and the self-pay patients they serve are largely low income individuals: 92% of the individuals served had incomes at or below 200% of the federal poverty level. These low income uninsured individuals are often eligible for a sliding fee discount program mandated of these safety net providers. The goal is to insure that the ability to pay does not interfere with the patients' use of services. Though we will discuss sliding fee discount requirements a bit later, it is clear revenues collected from this cohort are substantially less than full charges or costs.

Important Notes:

1- It is important to know your payer mix—the number of visits by payer category and amounts actually collected from each—and reevaluate it regularly.

2- Your budget, PPS rate determination, productivity, and contracts with the various payers all have consequences. It is important to monitor budget projections to actual, projected encounters to actual, provider productivity, and the impact of contract terms so that necessary modifications can be made on a timely basis that will support the long-term financial health of the organization.

COMMUNITY HEALTH CENTER REIMBURSEMENT

ESTABLISHING A FEE SCHEDULE

One of the most important and challenging decisions every health center must make is the setting of an appropriate schedule of fees for its services. Although there is no generally applicable "formula" for setting fees, there are statutory and regulatory requirements that all health centers must follow in establishing their fee schedules. Within these parameters, a health center must be able to realize revenue from its activities sufficient to remain financially viable while maintaining patient access to services without regard to any patient's insurance status or ability to pay.

Resources:
Establishing and Collecting Fees for Health Center Services, NACHC, July 2009

The Community Health Center statute and regulations contemplate that a health center will follow a three-step process in establishing a schedule of fees or payments for its services:

Step 1: The fees or payments must be set so as to cover the health center's reasonable costs in providing the service

Step 2: The fees or payments must be consistent with locally prevailing rates or charges for the service

Step 3: There must be a corresponding schedule of discounts applied to the fees or payments for uninsured and underinsured persons whose incomes are at or below 200% of the then current federal poverty income guidelines.

Important Points:

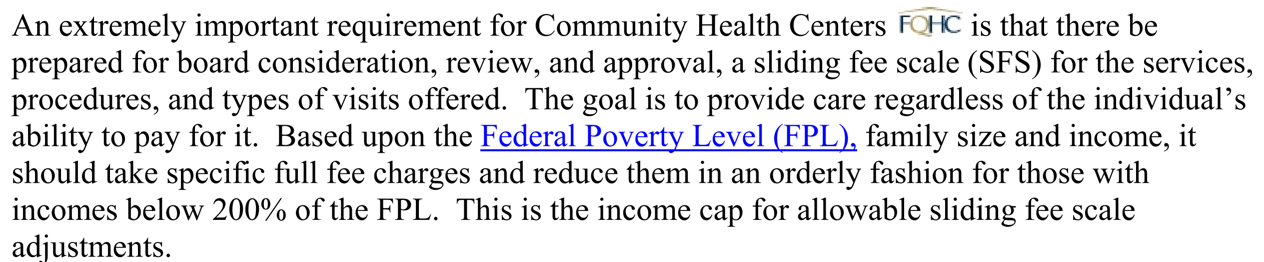
1- "Nominal fee" is not defined in statute or regulations and is defined by each health center's board of directors.
2- How a health center is to develop its fee schedule is also not defined in statute, regulation or policy.
3- Each health center has substantial discretion in developing its fee schedule.
4- A fee for a specific service, procedure, or visit type should cover the costs of providing this care. It is important, once the cost is determined, to consider an additional amount that will, in an ideal situation, provide additional revenues for future growth. Some FQHCs start by looking at Medicare allowable amounts and adding 10-15% more.
5- It is important to recognize that if all payers reimbursed at this full fee level, the center's revenues would likely be sound. However, different payers reimburse at different levels. Therefore, when the fee schedule is completed, it is important to hypothesize (create a report) projecting what your actual revenues are likely to be. Form 3 (Income Analysis) in the New Access Point (NAP) or Service Area Competition application guidance is a helpful format (the form is available on the HRSA NAP website by scrolling down to the "Program Specific Forms" section or by sending an email to pachc@pachc.com).

It outlines a series of steps and adjustments to estimate the revenues likely to be generated from your case mix.

6- Some health centers create a fee schedule by utilizing prior year billing experience and relative value units. A relative value unit represents the same value regardless of service, visit, or procedure type. One then assesses the activity in terms of multiple variables, such as time and complexity, and assigns a value. Medicare RVUs are typically used for this. The steps are:

   a) Obtain the total costs for your scope of practice for the prior fiscal year. This can be checked against your audit.
   b) Obtain the total visits and their aggregate relative value unit amount (using the Medicare RBRVS: The Physician's Guide.
   c) Divide the total RVUs into the total expenses to determine a cost/RVU.
   d) Take the projected costs for the coming year as well as the visits anticipated. Unless a major change is to occur, one may distribute RVUs among the visits in the same percentages as the prior year. This gives a new total RVUs amount to be divided into the total costs. You now have the cost/RVU for the coming year.
   e) Consider what, if any amount of additional charge, you might wish to add to the cost/RVU.
   f) Insert the cost/RVU back into the visit distribution and multiply each times the cost/RVU. This gives a preliminary full fee charge.
   g) Assess whether any of the charges seem "outside a reasonable range." It is good to compare your results with Medicare allowable reimbursements in your area. If a charge seems too high or too low, consider an adjustment.
   h) The final step, before taking this to the board of directors, is to estimate revenues for the year again if the fee schedule amounts were actually collected. Again, Form 3 is helpful. Though your goal is to cover costs, it is important to examine the fee schedule in terms of revenue impact. This is something that should be monitored throughout the year.

SLIDING FEE SCALE PREPARATION

An extremely important requirement for Community Health Centers  is that there be prepared for board consideration, review, and approval, a sliding fee scale (SFS) for the services, procedures, and types of visits offered. The goal is to provide care regardless of the individual's ability to pay for it. Based upon the Federal Poverty Level (FPL), family size and income, it should take specific full fee charges and reduce them in an orderly fashion for those with incomes below 200% of the FPL. This is the income cap for allowable sliding fee scale adjustments.

For those individuals responsible for paying for their own bills (self-pay), the steps are:

Step 1: Determine eligibility for Sliding Fee Scale
Step 2: For services offered, total the full-fee charges
Step 3: Apply proper discount per policy, based upon family size and income
Step 4: Determine amount for which the individual is responsible

The steps sound simple; however, it can be complicated. The Health Resources & Services Administration (HRSA) is in the process of finalizing a Policy Information Notice (PIN) that will address most issues and assist the FQHC to understand regulatory requirements. A draft PIN was issued July 2012, and comments provided by interested parties. It is anticipated that the final PIN will be released sometime this year.

Resources:
Establishing and Collecting Fees for Health Center Services, NACHC, July 2009

Important Points:

1- The sliding fee scale is for those individuals whose income is below 200% of the FPL, which is updated annually. For FQHCs, anyone with an income at or above 200% of poverty should be charged full fee for services rendered and offered no discounts. (If the FQHC receives federal support for HIV care, this cap may be higher for those services).
2- For those individuals whose income is between 0% and 100% of the FPL, a nominal fee, at most, should be charged.
3- A nominal fee is a board approved amount that does not pose a barrier to the individual's utilization of the FQHC services. This amount varies among centers. It is helpful to discuss this with your colleagues and project officer to obtain suggestions. It is hoped that the anticipated final PIN will clarify this.
4- Health center boards have much discretion in how the sliding fee scale will be developed; multiple scales are permitted.
5- It is important that the SFS availability be known to your patients. Consider where to place notices about this and descriptions of whom to contact for information in your materials and at appropriate places in your facilities. It should be in the languages spoken by your patients.

6- The Community Health Center board should review the organization’s sliding fee scale policies and procedures no less than annually (ideally, after the annual update of the FPL) and make any necessary changes.
7- It is also helpful to perform periodic reports to determine what impact the SFS is having on operations, patient compliance, and revenues.

COMMUNITY HEALTH CENTER REIMBURSEMENT

PA PROMISe™ SYSTEM

In order to participate in the Department of Public Welfare (DPW), Medical Assistance Program, Community Health Centers FQHC must first enroll. To enroll, the Base Provider Enrollment form and any applicable addenda documents dependent on the provider type must be completed.

Medicaid Enrollment for Community Health Centers:

In addition to the completed application and required documents, the following documents and supporting information are required by the DPW Bureau of Fee-For-Service Programs to enroll your facility as an FQHC provider:

• Signed FQHC Provider Agreement (must be "FQHC Provider Agreement" not the "Provider Agreement for Outpatient Providers"

• Copy of Medicare Certification Letter (if available).

• Copy of Medicare Rate Letter (if available).

• Copy of Fee Schedule charged to private patients and all third party payers.

• Copies of any contracts or agreements between the health center and all licensed practitioners of all types relating to services provided by the health center; as well as a statement indicating which practitioners, if any, are salaried to provide services outside the FQHC.

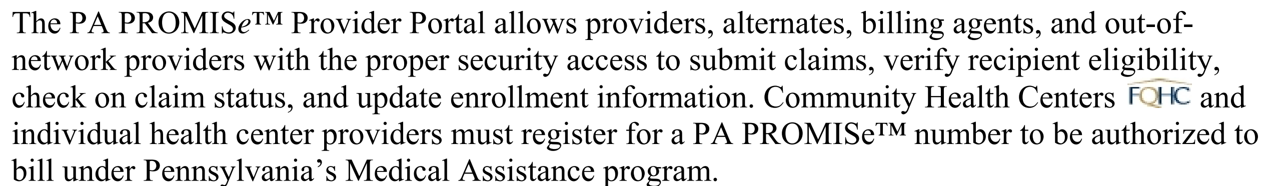
All forms necessary for FQHC enrollment can be found on the DPW enrollment website.

Processing of a PA PROMIS*e*™ application can take as long as 90 days, but the approval to bill under the Medical Assistance program is retroactive to the date of application. However, the Medicaid managed care organizations (MCO) will not begin their credentialing process until the organization and/or individual has a valid PA PROMIS*e*™ identification number. Once the application is approved, you will be notified with a welcome letter which includes the enrollment date (effective date), PA PROMIS*e*™ number and practice location information.

Important Notes:

1- See section on Mandatory Medicaid Managed Care in Pennsylvania for more information on MCOs and their credentialing processes.
2- PACHC has developed a process to request expedited PA PROMIS*e*™ credentialing for Community Health Centers that have an urgent need for their organization and/or provider(s) to be authorized to bill.
3- Medicare enrollment is not required prior to enrollment with PA Medicaid.
4- To add a service location where actual recipient services are performed, complete a PROMISe™ Provider Enrollment Base Application and any required related forms.
5- PROMISe™ Service Location Change Request must be completed for the following:

- To close an existing service location.
- To change a Mail-To address for an existing service location.
- To change a Pay-To address for an existing service location.
- To change a Home Office address for an existing service location.
- To change an IRS address for an existing service location.
- To change an e-mail address for an existing service location.
- To terminate association (fee assignment) with a Provider Group by an individual.
- To add or terminate participation with a Provider Eligibility Program (PEP).

The PA PROMIS*e*™ Provider Portal allows providers, alternates, billing agents, and out-of-network providers with the proper security access to submit claims, verify recipient eligibility, check on claim status, and update enrollment information. Community Health Centers  and individual health center providers must register for a PA PROMISe™ number to be authorized to bill under Pennsylvania's Medical Assistance program.

With the PA PROMIS*e*™ system, users can use the Internet to:

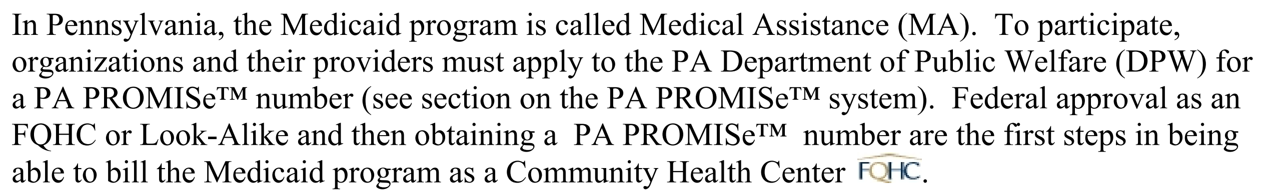
- Electronically file claims for all claim types and adjustments in either a real-time or an interactive mode from any location connected to the Internet
- View the status of any claim or adjustment regardless of its method of submission
- Access computer-based training programs that will let users complete training courses from your desktop at your convenience
- Update specific provider enrollment information electronically
- Verify recipient eligibility within seconds of querying

The interactive features on the PA PROMIS*e*™ Provider Portal provide easy access and exchange of up-to-date information between providers, DPW, and drug manufacturers. You do not need to purchase, install, or develop special software or applications to use the PA PROMIS*e*™ Internet application. The system allows you to log on using a standard Internet browser to enter or request information. Any information you pull from the application is specific to your provider number and will not be shared with others.

Resources:
PA PROMIS*e*™ Provider Internet User Manual

COMMUNITY HEALTH CENTER REIMBURSEMENT

MEDICAID



In Pennsylvania, the Medicaid program is called Medical Assistance (MA). To participate, organizations and their providers must apply to the PA Department of Public Welfare (DPW) for a PA PROMISe™ number (see section on the PA PROMISe™ system). Federal approval as an FQHC or Look-Alike and then obtaining a PA PROMISe™ number are the first steps in being able to bill the Medicaid program as a Community Health Center FQHC.

FQHC Payment in Pennsylvania

To prove to Medicaid that your organization is an FQHC, you will need one of two documents. One is a notice of award (NOA) as an FQHC. This will come through the HRSA Electronic Handbook (EHB) as an electronic document upon success with a New Access Point award or Look-Alike application. The second is an electronic communication that goes to both the organization and DPW indicating that the organization, after application and formal review, is operating in compliance with FQHC regulations and requirements. This letter gives the organization FQHC status, which makes it eligible for the FQHC Medicaid reimbursement system. With either of these two documents, you begin a process to establish the fairer Medicaid reimbursement rate available for FQHC encounters. This is called the Prospective Payment System (PPS) and has several steps. First we offer some caveats, and then we will provide the overview.

PPS is not a cost-based reimbursement system. Rather, it is a system that establishes a baseline per encounter reimbursement on an interim basis, re-examines this rate after a year of operation, makes adjustments, and then alters the PPS rate **only** based upon an inflationary factor and addition or deletion of a **service** which re-opens the process and computations. (This is a critical sentence which we will examine later. If you are an existing FQHC and add a site, this will not change your PPS rate. If an existing service grows in intensity—your pediatric visits grow substantially and you consider additional staff—this will not change your PPS rate. You can re-open your rate only when you add a new service or delete an existing one.

PA DPW pays each Community Health Center a PPS rate for eligible encounters. The PPS rate is individual for each FQHC, with an initial interim rate established for new FQHCs and those that have had an approved Change of Scope of services subsequent to their PPS rate being established. The interim PPS rate for a new FQHC is based on its projected budget coupled with a comparison of rates for like size and location facilities in the Commonwealth. An FQHC with an established PPS rate that adds or deletes a service through the Change in Scope process will work with DPW on establishment of an interim PPS rate. Interim PPS rates are converted to final PPS rates based on submission of a cost report reflecting a full year of operation with the added service or without the deleted service reflected in the Change in Scope and after an audit by DPW.

Establishing Your PPS Rate:

Please keep in mind through all of the following steps that PACHC is here to be of help to you. Don't hesitate to call with questions or for clarification.

Step 1: The first step is to download and read Appendix E of the PROMISe Handbook, revised June 20, 2012.

Step 2 - The second step is to contact two individuals at the Department of Public Welfare, Office of Medical Assistance Programs (OMAP). Jerry Pashke will assist you to register your organization in the Medicaid PA PROMISe™ system or change its classification to that of an FQHC if previously enrolled as a different provider type; he can be reached at jpashke@pa.gov, (717) 265-7830. Sam Caramela is responsible for PPS rate development and managed care organization (MCO) cost settlement reports (also referred to as "wraparound" reports) and will provide you with a format through which you will submit the required information to establish, after review and acceptance, the PPS rate. He can be reached at scaramela@pa.gov, (717) 265-7831.

Important Points:

1- Mr. Caramela and Mr. Pashke work closely together and will help you navigate the process. Though processes can change periodically, you will need to complete the enrollment form and a spreadsheet for DPW to establish an interim PPS rate.
2- Some centers schedule a visit with Mr. Caramela in Harrisburg to learn more about the requirements and have their questions answered prior to completion and submission of forms.
3- Other centers have had good experiences using accounting firms with experience completing both the enrollment and cost report forms. These firms, having repeated this process numerous times, may complete the activities with fewer mistakes. You may wish to discuss with PACHC possible firms recommended by other health centers and contact them to determine affordability.

Step 3 – Tally total allowable expenses.

Important Points:

1- The PPS system is built upon actual allowable expenses—those for which a check has been written for a purchase, salary, contract, etc. Depreciation amounts, for example, are not to be recorded in the computation forms. Even where an expense has occurred, it is imperative that the instructions in Appendix E are carefully read and followed. There may be expenses that are recorded that your audit validates. However, these may or may not be allowed in PPS computations.
2- Allowable expenses are broken into two types: direct and administrative. Direct expenses relate to the provision of primary care. The provider's expenses related to seeing and caring for patients are included totally. A medical director, however, may have administrative duties for part of the work week. Patient care expenses are included in one portion of the report. Administrative duties (medical direction in this case) are included in a separate section.
3- Some expenses, whether direct or administrative, have limitations on the amount that can be allowed. Read the instructions carefully.

Step 4 - The next step is to capture allowable encounters. To do this, it is likely that your practice management system will be queried for the relevant data. The instructions to identify allowable encounters begin on page 9 of Appendix E of the PROMISe handbook.

Important Points:

1- Read the instructions about allowable encounters in Appendix E.
2- Generally, allowable encounters include face-to-face encounters in which allowable providers used independent clinical judgments. The providers include physician, certified registered nurse practitioner, certified nurse midwife, physician assistant, licensed clinical social worker, licensed psychologist, podiatrist, psychiatrist, dentist, dental hygienist, and public health dental hygiene practitioner.
3- In Pennsylvania, a patient may have one medical, one dental and one other encounter in the same day.
4- Certain encounters are not counted in the computation to achieve a PPS rate. Some examples of such encounters are included on page 11 of Appendix E.

Step 5: As you did with allowable expenses, add up allowable visits. Some visits and expenses may be reclassified. As mentioned above, that portion of a Chief Medical Officer's salary and benefits that is administrative must be reclassified from direct care. Dental expenditures must be reclassified in order to achieve a dental PPS rate.

Important Notes:

1- DPW has established productivity expectations as to the number of encounters each full time provider should provide in a 12 month period (4200/physician, 2100/nurse practitioner or physician assistant). If the provider exceeds these thresholds, the actual number of encounters should be entered. If the provider generates fewer encounters than the threshold, the threshold is used in the calculation rather than actual encounters.
2- If the provider productivity is below the threshold, this will negatively impact the health center's PPS rate. Productivity levels should be monitored and processes optimized to improve productivity as indicated.

Step 6: Once you have total expenses computed as the instructions dictate, divide these by the total number of projected encounters. This gives you a preliminary PPS rate.

Step 7: Before submitting figures for DPW review, check and double check numbers.

Important Notes:

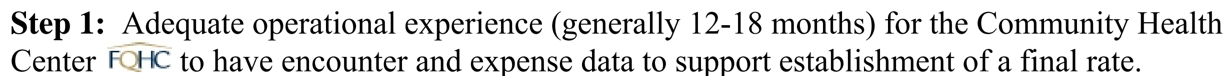
1- In summary, the PPS formula is allowable expenses divided by allowable encounters. Allowable expenses include 100% of direct care costs plus a portion of total allowable administrative costs.
2- DPW will be conservative in setting an interim PPS rate to mitigate the risk of a Community Health Center having to make a significant payback when the rate is finalized.
3- DPW's previous process to move rates from interim to final has been compromised over the past few years, resulting in multiple years at an interim rate for a number of health centers. PACHC is working with DPW on strategies to resolve this issue.
4- Once your PPS rate is established, it is set in stone except for an annual increase (or occasionally decrease) October 1 of each year based on the Medicare Economic Index

(MEI) or for an approved Change in Scope for addition or deletion of a service. For this reason, it is critical that you engage someone knowledgeable in the PPS rate establishment process early in your new Community Health Center's operation and/or prior to deleting or adding a service. PACHC can provide a list of consultants that other health centers have used and provided positive feedback on.

5- Often, new Community Health Centers will receive monetary or in-kind support from local hospitals, health systems or other organizations. Please contact PACHC early to discuss the implications of this support and strategies to mitigate its impact on your PPS rate.

ESTABLISHING YOUR FINAL PPS RATE

The interim PPS rate functions as your FQHC encounter rate for the first 12-18 months. It is an acceptable level that preliminary and projected information suggest is fair initially. In conversations with DPW staff, you can explore when a follow up cost report should be submitted. This, along with your CPA audit of the relevant time frame, will be necessary to get a final rate established. Before DPW sets your health center's final PPS rate, you will have established your center, initiated activities, and have encounter and expense data to support establishment of a final rate.

Step 1: Adequate operational experience (generally 12-18 months) for the Community Health Center 

to have encounter and expense data to support establishment of a final rate.

Step 2: A CPA audit, which will be used to validate the data submitted to DPW to develop a final PPS rate

Step 3: Submission of cost report form to DPW

Step 4: Respond promptly to questions raised by DPW during its review of your data.

Step 5: The DPW Office of Medical Assistance Programs establishes a preliminary final PPS rate

Step 6: DPW auditors review the cost report and rate calculation before the PPS rate is finalized

Step 7: Notification by DPW of your health center's final PPS rate, which will be the rate the health center is paid for all encounters and that will only be adjusted:

- Annually on October 1 of each year based on the Medicare Economic Index (MEI)
- For a Change in Scope, if the health center adds or deletes a service

Step 8: Retroactive cost reconciliation to the final PPS rate.

Important Points:

1- Your first 12-18 months of expenses may be somewhat distorted from "the norm." For example, you will potentially be spending some additional monies during the start-up phase that will not re-occur and/or your staffing in year 1 may not achieve the level that you anticipated achieving. Put differently, be cognizant that your early expenses and experience, though they might not be reflective of your costs when fully operational, will influence your final PPS rate.

2- How quickly your visits increase also may affect your final PPS rate. This suggests that marketing your services must be effective.

3- It is important to be aware of your projected visits when compared to actual for any time frame. As mentioned in the section on establishing an initial PPS rate, DPW has established expectations (4200/FTE physician, 2100/FTE nurse practitioner or physician assistant) as to the number of encounters each full time provider should provide in a 12

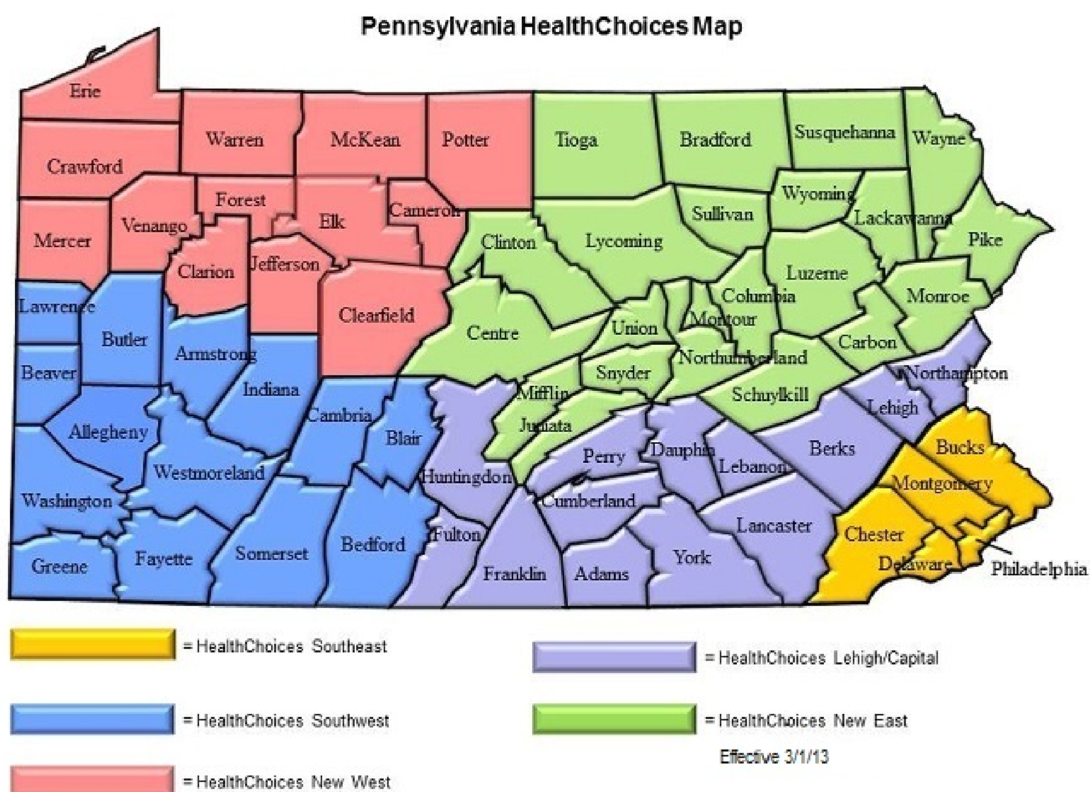
month period. If the provider exceeds these thresholds, the actual number of encounters anticipated should be entered. If the provider generates fewer encounters than the thresholds, DPW's established productivity standards are used in the computation.

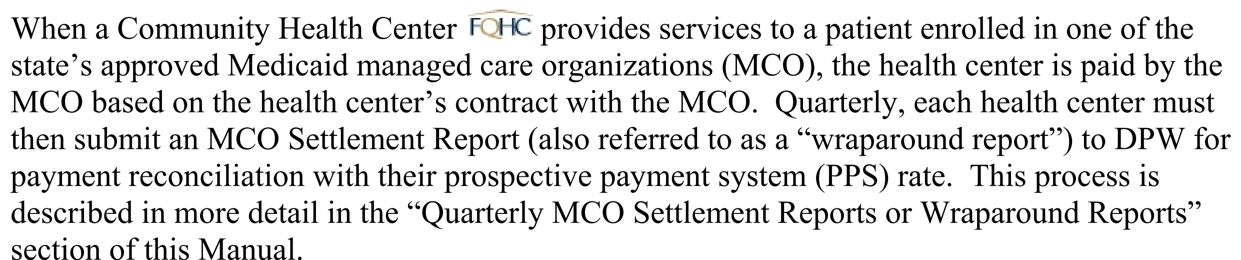
4- Monitor your first year expenses. While not exceeding your budget limits, it is important to achieve the timelines for the project as delays may affect your PPS rate.
5- Spend your grant monies if you are a New Access Point (NAP) grant-supported FQHC as they will not automatically be carried over.
6- Do not be frivolous; do be aware and seek implications, however, for year 2. It is helpful to have a year 2 draft budget in development throughout year 1. Some examples: In year 1, examination room equipment purchases may be larger than in year 2. At the same time, you will have malpractice insurance expense for a part or all of year 1. Assuming FTCA deeming, it will not be an expense for year 2.
7- Look carefully at the projections made in the initial PPS rate computations. As your rate might be adjusted up or down when you move from interim to final, this has implications (positive and/or negative) for year 2 and year 3.
8- Reevaluate your payer mix regularly—the number of visits by payer category and the amounts be collected from each. If, for instance, the uninsured numbers are higher than anticipated and Medicaid patients and visits are lower than estimated, revenues are likely to be less than ideal.

COMMUNITY HEALTH CENTER REIMBURSEMENT

MANDATORY MEDICAID MANAGED CARE IN PENNSYLVANIA – HealthChoices

Most Medical Assistance recipients in Pennsylvania are now enrolled in HealthChoices, the state's mandatory Medicaid managed care program. Medicaid managed care has been utilized in Pennsylvania for more than a dozen years, both for physical and behavioral health. However, until recently this model was only utilized for physical health in the larger urbanized areas of the state—Philadelphia, Pittsburgh, Allentown and Harrisburg. In 2012, the Department of Public Welfare (DPW) made the decision to expand the HealthChoices Physical Health Program statewide, with implementation of the final zone beginning March 1, 2013.





When a Community Health Center FQHC provides services to a patient enrolled in one of the state's approved Medicaid managed care organizations (MCO), the health center is paid by the MCO based on the health center's contract with the MCO. Quarterly, each health center must then submit an MCO Settlement Report (also referred to as a "wraparound report") to DPW for payment reconciliation with their prospective payment system (PPS) rate. This process is described in more detail in the "Quarterly MCO Settlement Reports or Wraparound Reports" section of this Manual.

The DPW Office of Medical Assistance Programs oversees the HealthChoices Physical Health Program; the DPW Office of Mental Health and Substance Abuse Services oversees the HealthChoices Behavioral Health Program. The HealthChoices Program has three goals:

- To improve access to health care services for Medical Assistance recipients;
- To improve the quality of health care available to Medical Assistance recipients; and
- To stabilize Pennsylvania's Medical Assistance spending.

Medicaid managed care organizations (MCO) receive a per member per month payment from DPW to cover physical health services and medications for their members. DPW requires all individuals except those that fall into an exempt group to enroll with a HealthChoices MCO or be auto-assigned to one of the MCOs. The MCOs must each develop a provider network and contract with enough providers across the continuum to meet the needs of their enrollees. Different MCOs are approved for different HealthChoices zones and Community Health Centers and other organizations have the option to contract with one, some or all.

Contact information for each of the approved HealthChoices MCOs in zones served by your Community Health Center can be found online. Careful review of MCO contract terms is essential, and particular attention should be paid to payment rates, credentialing and other terms and conditions as they can significantly impact your health center's cash flow and financial health. Each MCO contract will have its own format, requirements, and expectations.

Important Notes:
Some questions to consider in reviewing and negotiating of contracts include:

1- Is the reimbursement reasonable—not necessarily equal to your costs, but acceptable and not harmful?
2- Is the reimbursement methodology capitation, fee-for-service, or both? How might the methodology affect revenue flow?
3- Are performance bonuses included? If so, are they reasonable? Are bonuses "attractive"—doable and of such an amount that the effort required is acceptable? How are any audits for any bonuses performed? Again, consider the administrative impact upon your center.
4- What billing format is required? Is this standard? Does your practice management system have the capacity to use the format?
5- What reports are required—in both directions? Are they helpful? What operational impact might they have?
6- Do your referral hospitals have a contract with the MCO?
7- How does the MCO manage provider relations? Will a specific person be assigned to your organization? Do they use a single representative for all Community Health Centers in the region?

The HealthChoices Enrollment Program website provides information on health plans, doctors, health care services, enrollment and more. Individuals who do not choose an MCO are auto-assigned to one, however, at the present time individuals have the option to change MCOs at any time. All MA recipients, whether enrolled in HealthChoices or not, receive an ACCESS card.

While most Medical Assistance recipients in Pennsylvania are now enrolled in HealthChoices, a small number are excluded from the HealthChoices program and will continue to access care through the fee-for-service delivery system using their ACCESS card. These MA recipients include:

- ► Those newly eligible while they are awaiting enrollment in an MCO
- ► Those enrolled in Health Insurance Premium Payment (HIPP) Program
- ► Those admitted to a state-operated facility (i.e. Intermediate Care Facility)
- ► Those placed in a nursing home beyond 30 days
- ► Those enrolled in the Pennsylvania Department of Aging (PDA) Waiver beyond 30 consecutive days
- ► Those enrolled in the Autism Capitated Assistance Program (ACAP)
- ► State-funded General Assistance MA recipients who are eligible for medical employability assessment only (TD/55 category)
- ► Most "dual eligibles," that is, those also eligible for Medicare
- ► Non-citizens eligible only for MA coverage of emergency medical conditions.

There is typically a four-to-six week period between the recipient's initial MA eligibility determination and the effective date of their enrollment in the HealthChoices physical health MCO (commonly referred to as the FFS eligibility window), and providers participating in an MCO's network are prohibited from denying medically necessary services to a newly eligible MA recipient during his/her FFS window.

Important Notes:

1- Take the time to read, understand and negotiate contract terms.
2- Find a qualified attorney to evaluate the contract with you.
3- Try to negotiate payment at your PPS rate. Even though if you are paid less than PPS by an MCO, DPW will pay the difference through your quarterly wraparound report, receiving your PPS payment from the MCO will improve your health center's cash flow.
4- Negotiating contracts with multiple MCOs gives your patients more choice and will perhaps help your health center attract and retain patients.
5- It might be helpful for comparison purposes to develop a spreadsheet of terms and conditions by insurer if your health center contracts with multiple MCOs.

COMMUNITY HEALTH CENTER REIMBURSEMENT

QUARTERLY MCO SETTLEMENT REPORTS OR "WRAPAROUND REPORTS"

The Department of Public Welfare (DPW) uses a quarterly reconciliation process to connect reimbursement to a Community Health Center FQHC by the Medicaid managed care organizations (MCO) with the health center's PPS rate. If the MCO reimburses the FQHC through monthly capitation checks or a fee schedule that is below what the PPS rate per encounter reimbursement would represent, FQHCs are "made whole" to their full PPS rate by DPW though submission of quarterly MCO Settlement Reports.

Important Notes:

6- Timely submission of accurate MCO Settlement Reports is critical to a health center's cash flow and financial health. Health centers that don't meet the timeliness requirements are penalized with significant delays in payment. Follow the instructions, check and double check numbers and submit on time!

Resources:
Complete guidance on submitting these reports accurately and timely is included in PACHC Memo 11-05 and its attachments which we highly recommend you review and use.

The Process:
Step 1: Submission of report to Sam Caramela, Office of Medical Assistance Programs (OMAP)

Important Notes:

- Deadline for submission is the 25th day of the month following the end of the quarter: March quarter is due April 25; June is due July 25; September is due October 25; and December is due January 25
- A separate report must be submitted for each month in the quarter
- The reporting instructions and forms begin on page 47 in Appendix E
- By MCO and provider type within MCO, the number of Medicaid encounters must be entered on each monthly report (p. 53 of Appendix E)
- Using the same MCO order, all monthly payments to the FQHC from each MCO must be entered (p. 54 of Appendix E)

Step 2: OMAP review of report. If it is completed per the instructions and the data is deemed accurate, OMAP will compare the amount received to the amount the health center would have received had the allowable encounters been paid at the PPS rates. If the report is not completed in full accordance with the instructions and/or there are data errors, OMAP will return the report to the health center for correction and significant processing delays can be expected.

Step 3: Reconciliation to the health center's PPS rate will occur. If monies are owed to the FQHC, it will receive the difference in 4 to 8 weeks through a DPW remittance advice. If the FQHC owes money to Medicaid, a different process for reconciliation will occur. Those monies owed back to DPW will be deducted from future Medicaid payments to the FQHC.

Important Notes:

1- Please keep PACHC informed of reimbursement problems, questions or concerns. Through good communication with Pennsylvania's Community Health Centers, we are able to track problems and trends with Medicaid reimbursement and work closely with both health centers and DPW to help resolve identified issues.

COMMUNITY HEALTH CENTER REIMBURSEMENT

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

In Pennsylvania, the Children's Health Insurance Program (CHIP) is administered by the Pennsylvania Insurance Department (PID). Ten insurance companies offer CHIP, with at least two health insurance contractors offering coverage in every county of the Commonwealth. In 2007, Pennsylvania expanded eligibility for CHIP calling it *Cover All Kids.*

- free CHIP coverage is available to eligible children in households with incomes no greater than 200% of the Federal Poverty Level (FPL)
- low-cost CHIP coverage is available for those with incomes greater than 200% but not greater than 300% of the FPL
- families with incomes greater than 300% of the FPL may buy into coverage at 100% of the cost negotiated with each of the approved CHIP health insurance companies

In 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) reauthorized CHIP, including a provision that requires FQHCs be reimbursed based on a Prospective Payment System (PPS) rate, effective October 1, 2009. Separate CHIP programs (those not an expansion of state Medicaid) could utilize one of three methods: adopt Medicaid PPS Rates; construct a separate CHIP PPS rate; or use an Alternative Payment Methodology (APM). PID, working with PACHC as a subcontractor under two Centers for Medicare & Medicaid (CMS) grants to aid with the transition to PPS, decided to use health center Medicaid PPS rates.

Implementation of PPS in PA falls into three stages: Stage 1- payment reconciliation for PPS retroactive to October 1, 2009 through September 30, 2010; Stage 2- payment reconciliation from October 1, 2010 through to PID new contracts with CHIP insurers late 2013; and then Stage 3- on a go-forward basis, requiring PPS payment rates at the time of service for CHIP encounters provided by FQHCs/FQHCLAs/RHCs with annual payment reconciliation.

The DPW Information Technology (IT) Development Team and PID personnel are currently working to finalize system screens, the IT architecture and functionality needed to support automation of the reporting schedule management process and the interface to support the quarterly input of encounter and payment data by the CHIP insurers. This system will support: tracking of the quarterly data submission process; management of the reporting period schedule; submission of encounter and payment data by CHIP insurers; CHIP encounter and payment data dispute tracking; and reports (such as PPS rates, payment reconciliation/wraparound summaries and aggregate payments); as well as any changes health centers need to make to their demographic or contact information.

Important Points

1- CHIP PPS to date is not resolved. PACHC continues to work with PID. Contact PACHC with any questions related to CHIP.

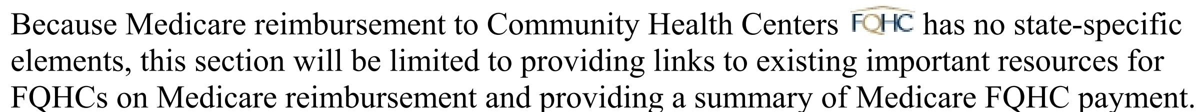
2- Health centers must have a system in place to internally track CHIP encounters and reimbursement in order to verify CHIP insurer data during the reconciliation process.

Resources:

PACHC Memo 11-09 CHIP Prospective Payment System (PPS) Implementation

COMMUNITY HEALTH CENTER REIMBURSEMENT

MEDICARE



Because Medicare reimbursement to Community Health Centers FQHC has no state-specific elements, this section will be limited to providing links to existing important resources for FQHCs on Medicare reimbursement and providing a summary of Medicare FQHC payment.

Medicare Site Registration – It is important to note that Medicare requires that each permanent and seasonal site be registered separately with the Centers for Medicare & Medicaid Services (CMS). This means that, while you may consider that the FQHC has a main site with satellite locations, Medicare considers an FQHC as being composed of multiple independent sites. A crucial resource about this is HRSA Program Assistance Letter 2011-04 . HRSA has also put together a one page document about this topic that describes key points of this policy.

Important Notes:

1- Failure to enroll sites separately and using a single number for billing is considered fraud and will have consequences that affect your reimbursement or even ability to bill Medicare and Medicaid.
2- It is the FQHC's responsibility to notify CMS of changes in address, licensing, or adverse legal actions. You are also required to notify CMS of board membership changes.

FQHC Medicare Resources

The following are critical Medicare resources for Community Health Centers:
HRSA Program Assistance Letter 2011-04: Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit
Medicare Benefit Policy Manual, Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services
Federally Qualified Health Centers (FQHC) Center
CMS Federally Qualified Health Center Fact Sheet
Medicare University FQHC Billing and Claims Scenarios

Medicare Payment Process Summary

1- Medicare pays FQHCs an all-inclusive rate (AIR) for medically-necessary, face-to-face, one-on-one visits with an FQHC practitioner for FQHC services.
2- The AIR is subject to a payment limit. The current payment limit is $109.90 for rural FQHCs and $126.98 for urban FQHCs. There are no exceptions.
3- An interim rate is established based on the FQHC's anticipated average cost for direct and supporting services. At the end of the reporting period, the Medicare Administrative Contractor or Fiscal Intermediary (MAC/FI) determines the total payment due and reconciles payments made with the total payments due.
4- FQHCs are required to file a Medicare cost report annually in order to determine their payment rate and reconcile interim payments. If an FQHC is in its initial reporting period, the MAC/FI calculates an interim rate based on a percentage of the per-visit limit, which is then adjusted when the cost report is filed.

5- Medicare, like PA Medicaid, holds FQHCs to provider productivity standards—currently, 4,200 visits per FTE physician and 2,100 visits per FTE non-physician practitioner (NP, PA, or CNM).
6- Physician services under agreements are not subject to the productivity standards but are instead subject to a limitation on what Medicare would otherwise pay for the services under the Physician Fee Schedule.
7- In general, the AIR for an FQHC is calculated by the MAC/FI by dividing total allowable costs by the total number of visits for all patients. Productivity, payment limits, and other factors are also considered in the calculation.
8- Allowable costs must be reasonable and necessary and may include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of FQHC services.
9- Services furnished incident to an FQHC professional service are included in the AIR and are not billed as a separate visit. The costs of covered services provided incident to a billable visit may be included on the FQHC cost report.
10- In general, Medicare pays 80 percent of the FQHC's AIR, subject to a per-visit payment limit. The patient in an FQHC is responsible for the coinsurance amount, but there is no Part B deductible in FQHCs for FQHC-covered services.
11- FQHCs must charge Medicare beneficiaries the same rate that non-Medicare beneficiaries are charged. FQHCs may waive collection of all or part of the copayment, depending on the patient's ability to pay. A sliding fee scale is required for individuals with incomes below 200 percent of the federal poverty level.
12- Payment for Medicare-covered Part B drugs that are not usually self-administered and are furnished by an FQHC practitioner to a Medicare patient are included in FQHC AIR.
13- Payment for the professional component of allowable preventive services is made under the AIR when all the program requirements are met. The Affordable Care Act (ACA) waives the copayment for certain preventive services.
14- The Affordable Care Act revised the list of preventive services paid for in the FQHC setting.
15- The cost of providing the required preventive services may be included in the FQHC cost report but they do not by themselves constitute a billable visit.

Important Note: The Affordable Care Act – the healthcare reform law enacted in 2010—includes provisions that will change the way Medicare pays FQHCs, beginning in 2014. The ACA requires CMS to establish a prospective payment system (PPS) for Medicare payments to FQHCs, which, in effect, will eliminate the Medicare FQHC all-inclusive payment rate, upper payment limits, and productivity guidelines currently in effect. Under the new PPS, FQHC payment rates will be based on their estimated reasonable costs for each covered service.

COMMUNITY HEALTH CENTER SCOPE OF PROJECT

MEDICAID CHANGE IN SCOPE OF SERVICE

The HRSA change in scope of project process is NOT the same as change in scope of services for purposes of the Medical Assistance (MA) Program. MA defines "a change in scope of services as the addition of a service that has never been provided or the discontinuance of an existing service. Other changes, including the opening or closing of a service location, a change in the intensity of a particular service, or capital expenditures, do not qualify as a change in scope of services. In addition, an increase or decrease of provider's costs does not constitute a change in scope of services".

If HRSA approves a request for a change in scope of services involving the addition of a service that has never been provided or the discontinuance of an existing service, the FQHC must notify MA within 30 days of the issue date identified in block 1 of HRSA's Notice of Award (NoA), so MA can begin the PPS rate adjustment process. The effective date of the rate adjustment based on the change in scope of services will be the effective date specified in the NoA from HRSA.

Until a new final rate is determined, the FQHC's existing PPS rate will be considered an interim rate.

An FQHC may request an interim rate adjustment pending determination of a final rate if the health center can provide documentation (see Bulletin for details) indicating that the PPS rate would be increased by more than 20%.

A cost report must be submitted within 120 days after the close of the FQHC's first full fiscal year of operation with the change in scope of services. The FQHC's final rate will be determined via a desk review and/or audit of the cost report. The final rate will be used for final reconciliation and will be the PPS rate going forward.

A final reconciliation process will be conducted to determine if there has been any underpayment or to recover any overpayment based on the difference between the new final PPS rate and the old rate.

Important Points

1- PACHC has clarified with DPW that it is mandatory to notify DPW of a change in scope of service for the addition of a service added to the HRSA scope of project even if the health center does not want to request a change in PPS.

Resources:

Medical Assistance Bulletin 08-12-31 FQHC Change in Scope of Service

COMMUNITY HEALTH CENTER SCOPE OF PROJECT

DENTAL SERVICES

A Community Health Center FQHC in Pennsylvania that decides it would like to address the oral health needs of its service area must do so in an informed, thoughtful and deliberative way to ensure that the financial health of the organization is not jeopardized by addition of this service.

Dental Services

A core FQHC requirement is the identification of dental needs of patients and access to preventive dental services either directly or through referral or contract. The assessment may come from a patient visit history, preventive care form completion, or provider examining the mouth. If there is any indication that there is an oral health need, the Community Health Center must have a system in place for the patient to access required preventive dental services. The health center can offer dental services on site or if dental services are not available on site or within the organization, the FQHC must have a formal written referral arrangement or contract for the provision of these services. In the early stages of FQHC development or implementation, this is a typical model.

As the FQHC grows or community need dictates, it is likely that a more comprehensive dental care program will be planned. These are Additional Services shown as restorative and emergency services on page two of Form 5A. If not present at the time of the initial funding, these will require a change of scope application to HRSA, whether provided by staff or through a contract. Significant planning and preliminary budget analysis should occur before taking this step for a variety of reasons:

- Offering dental services is expensive. The design of a dental suite and the equipment required to operate it create a cost per square foot that is more expensive than most medical suites.
- For revenue estimation, it is not uncommon for patients seeking this care to have uneven appointment attendance patterns.
- These services will likely require special scheduling processes as well as a determination of how to provide certain dental procedures. Some of these procedures require external laboratory services for which the FQHC pays and which must be reflected in the expenses as well as the fee schedule established.
- Dental services require a separate Medicaid PPS rate development. When this process is begun, be prepared to see a redistribution of administrative and overhead costs between medical and dental services. This redistribution could potentially reduce the medical PPS rate.

Important Points:

1- Special considerations should go into planning for restorative, emergency, and possibly other dental services (crown and bridge, orthodontics, other dental specialty services, etc.).
2- Consider visiting existing FQHCs with an experienced dental program and leadership.

3- Run the numbers before requesting a change in scope to add dental services. Some PA health centers expected their PPS rate would go up by adding the service and were distraught to learn that because of reallocation of administrative and overhead costs, their medical PPS rate went down when they added dental.
4- PA DPW implemented adult dental benefit restrictions in 2011. This payment policy should be factored in when evaluating the addition of dental services.
5- Any disallowed service for a Medicaid beneficiary will be managed as the sliding fee scale process dictates for self-pay patients.
6- Help in establishing or improving a dental program might be available through PACHC, as we have received grant funding from the DentaQuest Foundation to support health centers in improving their dental operations. Send an email to Cheryl@pachc.com for more information

Resources:
DPW Dental Care Provider Information
State Medicaid Manual, Dental Services
Medical Assistance Bulletin 11-1672
PACHC Memo 09-03 and PACHC Memo 13-02 provide information on use of PA's new category of dental hygienist—the Public Health Dental Hygiene Practitioner—and PA Medicaid's adult dental benefit restrictions

COMMUNITY HEALTH CENTER SCOPE OF PROJECT

BEHAVIORAL HEALTH SERVICES

Behavioral health and substance abuse services by formal written referral arrangement are a Community Health Center FQHC required service, but a health center has the option to provide the services directly itself or through formal contract in addition to any referral agreement. To the extent that the FQHC decides to provide these services on site, there are two factors to evaluate: special billing issues for PA Medicaid regarding eligible providers that can bill behavioral health services at the PPS rate and the model of care delivery. We discuss each briefly below.

Special Behavioral Health Billing Issues in Pennsylvania:

1. **Providers eligible to bill for behavioral health services at the PPS rate**

In Pennsylvania, three provider types are able to bill for behavioral health services at the medical PPS rate: licensed psychiatrists, licensed psychologists (PhD plus passed test), and licensed clinical social workers (Master's degree plus passed a test). When establishing the PPS rate, the expenses that relate directly to these providers will be included in direct expenses. After completing a projected cost report for Medical services and a desk review by DPW, an interim rate is established. The providers are enrolled in Medicaid and given a Medicaid PROMISe™ ID#. **Note:** Behavioral health services are only considered a specialty service under you Scope of Project if the services are provided by a psychiatrist.

2. **Utilization of Non-eligible Providers**

An FQHC must utilize caution if it wishes to use other provider types (drug and alcohol counselors, licensed professional counselors, family therapists, etc.). Even though a Medicaid behavioral health managed care organization may reimburse for other various levels of provider services, those encounters are not allowable on the Medicaid MCO Settlement Report while the reimbursement is counted. PACHC is working with DPW on the expansion of behavioral health professionals eligible for FQHC reimbursement to include licensed professional counselors (LPC) and licensed marriage and family therapists (LMFT). Contact PACHC to discuss this issue and/or check on the status of this effort.

3. **Mandatory Medicaid Behavioral Health Care**

The PA Department of Public Welfare offers behavioral health care to Medicaid beneficiaries through the mandatory Medicaid managed care program, Behavioral HealthChoices. This part of the managed care program is overseen by the DPW Office of Mental Health and Substance Abuse Services. Under the program:

- There is a single contractor for each county or joinder unit.
- The behavioral health managed care organization (BHMCO) is responsible for the entire Medicaid population in the contract area, eliminating adverse selection issues and ensuring that funds are appropriately focused on people that are most in need.
- The collaboration between counties and BHMCOs uses the expertise of Pennsylvania's county public behavioral health system, other county-level human services, local providers, and managed care partners, which have many local nonprofit roots.

See more information on HealthChoices, see that section of the manual.

Behavioral Health Models of Care Delivery Options:

1- On-site and provided by FQHC
2- By referral
3- By contract

To discuss the pros and cons of each of these options, contact PACHC. PACHC can also connect you with health centers offering behavioral health services using these different models of providing the services to help you make a more informed decision on the right option for your health center.

Important Notes:

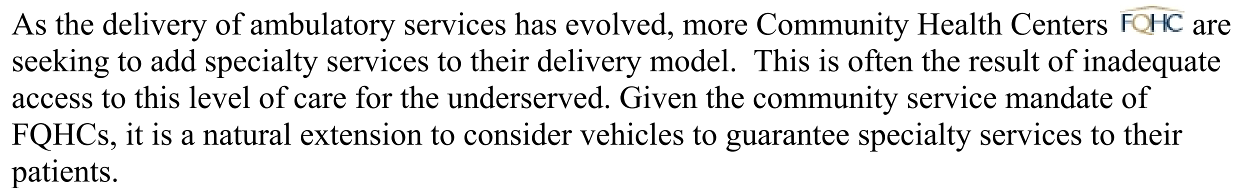
1- It is important to find out as much as possible about outpatient mental health clinic requirements prior to deciding which model of care delivery you will choose. There are several FQHCs in the Commonwealth that have much experience in these areas. PACHC is happy to facilitate conversations with them.
2- Most PA counties have an administrative agency that contracts with organizations to provide these services. This is also a good information resource.
3- Much work is being done by Pennsylvania health centers to integrate medical and behavioral health care and some of the managed care organizations (MCOs) are supporting this model by paying for "warm hand-offs" of health center medical patients screened by their primary care clinician to have a behavioral health need. Contact PACHC for more information.

Resources:

Regional Field Offices for the Office of Mental Health and Substance Abuse Services in the Department of Public Welfare
MH/MR Program Administrators Association of Pennsylvania for a list of county MH/MR office locations and contact information
Program Information Notices, PIN 2008-01 and PIN 2009-03
Collaborative Arrangements: A Guide for Health Centers and Their Partners; NACHC and Feldesman Tucker Leifer Fidell LLP; August 2011

COMMUNITY HEALTH CENTER SCOPE OF PROJECT

SPECIALTY SERVICES



As the delivery of ambulatory services has evolved, more Community Health Centers FQHC are seeking to add specialty services to their delivery model. This is often the result of inadequate access to this level of care for the underserved. Given the community service mandate of FQHCs, it is a natural extension to consider vehicles to guarantee specialty services to their patients.

Step 1: From a regulatory perspective, the key HRSA policy guidance on specialty services is HRSA Program Information Notice 2009-02 , and we recommend a careful reading of this document as you consider the addition or inclusion of specialty services.

Step 2: A key element in the presentation of the proposed change in scope is that the specialty services contribute to and strengthen primary health services offered. In the PIN, examples are provided. As you evaluate whether to add a specialty service, consider its impact on primary care. For example, if there are significant numbers of diabetics in your practice, how would specialty care by an endocrinologist be helpful?

Step 3: When considering the addition of specialty services, the first step is to contact your Project Officer. Inform him/her about this planning and ask for guidance on the change in scope of project that is being considered. The service must be provided at an approved site within the Federal scope of project. If a different location is being considered, the site would need to be added to the scope of project. The new service must be accessible to health center patients.

Step 4: We recommend an initial conversation with Sam Caramela at DPW on how DPW might handle the addition of the specialty service to your scope of project if HRSA approves it.

Step 5: If HRSA approves the change in scope, a copy of the approval must be sent to Sam Caramela in the PA Department of Public Welfare Office of Medical Assistance Programs. Just because HRSA approved the service as a change in scope of project, does not guarantee that DPW will approve it as an FQHC service. If DPW does, and it is a new service, you will need to submit a cost report, and your PPS rate will become interim (see section in Manual on Medicaid payment in Pennsylvania).

Step 6: Health centers need to consider the benefits and risks of the staffing arrangement that will provide the specialty service and its impact on health center costs and operations.
Is the best option to directly employ or contract with the specialist and/or have an arrangement with another organization?

Step 7: The specialty service must be available equally to all patients regardless of ability to pay and available through a sliding fee scale.

Important Points:

1- As you consider addition of specialty services, remember that a change of scope of project does not provide additional HRSA grant monies. Budget carefully as you project both costs and benefits.

2- Addition of a specialty service does not guarantee FTCA coverage. You may be required to submit a deeming application revision. You are required to credential and privilege this provider, and the employment contract must be with the individual provider rather than the provider's parent organization. Study carefully information in the FTCA Manual regarding covered providers and covered entities.

3- Should HRSA approve the specialty service as part of your scope of project, there is no guarantee that the PA Department of Public Welfare will permit adding the service as an FQHC service. If it does agree to this addition, a new interim cost report must be submitted.

Resources:

Policy Information Notice 2009-02
Federal Tort Claims Act Manual

COMMUNITY HEALTH CENTER SCOPE OF PROJECT

340B PHARMACY

This program is managed by the 340B Drug Pricing Program & Pharmacy Affairs in HRSA (OPA). This program provides FQHCs and other eligible "covered entities" outpatient pharmaceuticals at reduced prices. They can be used only for the covered entity's patients. Covered pharmaceuticals include:

- FDA-approved prescription drugs;
- Over-the-counter (OTC) drugs written on a prescription;
- Biological products that can be dispensed only by a prescription (other than vaccines); or
- FDA-approved insulin.

340B Models

There are multiple implementation models, including:

- In-House Pharmacy. The health center owns the drugs, pharmacy and license; purchases drugs; pays pharmacy staff; and is fiscally responsible for the drugs, inventory management and program compliance.
- Contract Pharmacy Services. In this model, the FQHC owns and purchases the drugs; pays a dispensing fee to the pharmacy (may be more than one contract pharmacy); and retains responsibility to insure that the pharmacy is delivering their services in a manner that is compliant with the 340B requirements.
- Physician Dispensing Model. The health center purchases the drugs; maintains an on-site inventory; and dispenses the drugs in house. The health center is responsible for operating and dispensing costs as well as 340B program compliance.
- Alternate Methods. These must be approved by OPA. For instance, some FQHCs have some pharmaceuticals on site for distribution as needed by the patient. To the extent that these medications are for chronic disease patients and will be required on an ongoing basis, mail order pharmacy services may be an appropriate model to use.

Important Points:

1- Recent New Access Point grantees and Look-Alikes have shared with PACHC that the OPA is extremely helpful. They generally assign a designated individual to help the FQHC navigate both enrollment and other issues that it may have to face.
2- Enrollment periods with the 340B program occur quarterly, and annual recertification is required.
3- If you are considering participation in the 340B program and want to talk to some Pennsylvania FQHC peers that are already doing so, let PACHC know and we will facilitate conversations with health center leaders using different 340B models and vendors to support your decision-making process.
4- Some factors to consider in choosing a 340B model include: facility space; startup costs; availability of community pharmacies that could serve as contract pharmacies; whether an RFP might be appropriate to provide better comparative data on contract pharmacy options, such as dispensing fees, hours and locations, responsiveness, electronic interface capabilities, and willingness to work with the FQHC on maintaining a separate inventory.

5- Reach out to OPA early as you will find them very helpful in navigating the decision-making and implementation processes. The individual assigned by OPA to assist the FQHC with enrollment will have helpful thoughts about issues to be considered.
6- Regardless of which model your Community Health Center chooses, compliance with program requirements is critical. 340B covered entities are subject to audit.
7- Changes that may make the entity ineligible must be reported immediately and purchases of 340B drugs must cease.
8- If a health center will be billing Medicaid (FFS and managed care) for drugs purchased under the 340B Program and dispensed to MA recipients, the health center must be listed on HRSA's Medicaid Exclusion File on the HRSA website

Resources:
340B Drug Pricing Program & Pharmacy Affairs in HRSA (OPA)
APEXUS 340B Prime Vendor Program
The Bridge to 340B Comprehensive Pharmacy Services Solutions in Underserved Populations
Medical Assistance Bulletin 99-13-08, 340B Drug Pricing Program Provider Requirements and Billing Instructions - Pharmacy Services

PLANNING FOR QUALITY

One of the Health Center Program core requirements is a Quality Improvement/Assurance Plan. A health center must have an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and periodic assessment of the appropriateness of service utilization and the quality of services provided to individuals served by the health center. In this chapter, we provide an outline to assist in designing a quality improvement (QI) program and a summary of the support available to Pennsylvania health centers in their quality improvement efforts.

The Quality Journey

The Institute of Medicine (IOM) defines quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. The IOM defines six aims of health care: safe, effective, patient-centered, timely, efficient and equitable. For health centers, that requires a system where senior leadership embraces quality as an organizational priority that informs all other activities and creates a culture and mechanism for promoting safe, high quality care.

In multiple ways, HRSA is extremely clear about its expectation that FQHCs will provide patient centered, affordable, and safe patient care. HRSA encourages health centers to attain some type of third party accreditation and/or become recognized as Patient-Centered Medical Homes (PCMH). Quality improvement (QI) programs are necessary to meet Uniform Data System expectations, which include clinical performance measures. A QI program is required for the Federal Torts Claim Act (FTCA) deeming/re-deeming process. A health center's QI program will also be reviewed as part of HRSA Operational Site Visits.

Health center quality results are now transparent and available for public review and this data will increasingly be used by patients, insurance plans and potential health system partners. FQHCs are learning that they must not only have positive patient outcomes, but that organizational performance and target population health status must improve. The quality function of the health center is ongoing and includes monitoring, evaluation and improvement processes while implementing a patient centered philosophy and a process focusing on prevention and maximizing quality, evidence-based care.

Getting Started:

Step 1: Leadership

As mentioned previously, leadership buy-in is critical. This means not just the President/CEO of the organization but the board itself, which is responsible for approving the QI plan and receives reports at least quarterly. Responsibility for quality begins and ends with the board. The board authorizes the CEO to provide resources to support quality programs and assigns responsibility to the Medical Director and Quality Committee. The organization as a whole must allocate time and resources to be successful in any quality project. "Champions" who understand and can help create a culture of quality in the organization are also absolutely essential.

Step 2: Designation of a Quality Coordinator
Day to day activities will usually be assigned to the Quality Coordinator, who may or may not also be the Medical Director. If the coordinator is someone other than the medical director, there needs to be regular communication between that individual and the medical director.

Step 3: Developing the Quality Team
The Quality Committee will be chaired by the health center's Medical Director or a physician designee, as this is a requirement for Federal Tort Claims Act (FTCA) coverage. In addition to the chair and QI coordinator, other committee members may include representatives from: risk/compliance/safety, medical and other clinical staff, finance, front office, medical records, and in-house lab staff.

To comprise a team for a specific quality improvement project, identify the skills that will be required and identify the individuals who can provide them to the process. A successful team is usually three to six members and should be comprised of staff from all affected areas as it ensures understanding of projected improvement and promotes buy-in for changes.

Sub-committees/workgroups should also be created to work on issues such as privileging, peer review, safety, compliance, infection control/risk management, and other quality initiatives such as Patient-Centered Medical Home recognition or accreditation in which your health center chooses to engage.

Important Points:

1- Make sure to have staff rotate on and off teams so that all staff learn to value and understand quality improvement goals and efforts.
2- Make time to meet at least once a month for at least an hour.
3- Ensure representation from all sites and service areas.

Step 4: The Plan
The Quality Improvement Plan should be a "living document" and not sit on a shelf and only be annually reviewed. Every staff member should know where to locate the plan, and each site should have its own copy. The HRSA Quality Improvement Toolbox provides excellent guidance on development of your plan.

Step 5: Rapid Cycle Changes for Improvement
The Plan/Do/Study/Act Cycle (PDSA) is one improvement methodology for rapid cycle changes in your center. There are also other models that health centers can choose to use such as FOCUS (F = Find a problem; O = Organize a team; C = Clarify the problem; U = Understand a problem; S = Select an intervention), PDCA (Plan- Do-Check-Act), and FADE (Focus – Analyze – Develop - Execute). Improvement requires you answer these questions:

- What are you trying to accomplish?
- How will you know that the change is an improvement?
- What changes can you make that will result in the improvement

Visit the Institute for Healthcare Improvement (IHI) site for more on PDSA and improvement.

Step 6: Validation of Health Center Quality
Validation of health center quality is becoming increasingly important to retain and attract patients, to qualify for bonuses and to be preferred partners with insurers and other providers across the continuum. HRSA, in recognition of this, provides health centers with funding to receive Joint Commission or Accreditation Association for Ambulatory Health Care (AAAHC) accreditation through their Accreditation Initiative. This initiative is designed to encourage and support health centers to undergo a rigorous and comprehensive survey process in order to achieve national benchmarks that demonstrate the highest standards of health care quality. Program Assistance Letter (PAL) 2009-12 explains this in more detail.

HRSA also provides health centers with funding to acquire Patient-Centered Medical/Health Home (PCMH) recognition through their PCMH Initiative. This initiative supports and encourages health centers to gain recognition under the medical home program offered in partnership with the National Committee for Quality Assurance (NCQA). Program Assistance Letter (PAL) 2011-01 describes this in more detail.

Currently there are several PCMH initiatives on-going in Pennsylvania. The PA Academy of Family Physicians (PAFP) Community Health Center Collaborative and PA SPREAD are two collaboratives that health centers can engage in for support and guidance in achieving PCMH recognition. PACHC can also help to connect health centers interested in this recognition with other health centers that have already gone through the PCMH transformation process. Also remain alert for training and technical assistance programs offered by PACHC through individual programs as well as during the PACHC Annual Conference & Clinical Summit. PACHC is also in the process of creating an online "learning community," the PACHC My Community Health Connection, to support networking and idea and document exchange.

Resources:
Below you will find a list of resources to help guide you on your journey. Cheryl Bumgardner, PACHC Clinical Coordinator, is also a helpful resource to guide you in your quality journey; she can be reached at cheryl@pachc.com or (717) 761-6443, ext. 208.

Health Center Program Requirements
HRSA Policies
HRSA/BPHC Performance Measures
HRSA Site Visit Guide
HRSA Quality Toolkit
CDN Learning Opportunities
NACHC free downloads quality, risk & clinical publications
The Role of the Board in Quality – NACHC
The Joint Commission
Qualis Health Care Safety Net Initiative Tools
NCQA Patient-Centered Medical Home
National Association for Healthcare Quality
Institute for Healthcare Improvement
Crossing the Quality Chasm – full report
Crossing the Quality Chasm – brief report

Quality Indicators
National Quality Center is a HRSA website for HIV Quality Improvement and has excellent tools and tutorials to help staff understand quality management – just insert "primary care" for HIV in most places and they are applicable.
Evidence-based Measures and quality tool kits
Eight Key Steps to Implementing a Quality Improvement Project - Amelia Broussard, PhD, RN, MPH
Quality the New Paradigm – Janice Wilkerson, RN, CPHQ

COMMUNICATION PLANNING

In this section, we outline some of the essential elements of an effective communication plan for your Community Health Center FQHC. As with all of the sections of this manual, we recommend that you review what you have done thus far and refine it as you learn and grow. Types of communication include internal and external, strategic, and crisis. There will be diverse messages and audiences. An effective communication plan requires strong planning, management, and a focus on results-oriented improvement.

Initial
The initial idea for a Community Health Center in your community probably began in a conversational fashion, perhaps among a small number of individuals exchanging information. This building block is the foundation of much of your communication effort. Who might be interested in this idea? Where can I find more information—who might be able to help me gather it? Should we have a casual meeting or a more formal one? Who is the convener?

This approach likely led to a growing list of names and contributors to your FQHC effort. At some point, the conversations became meetings, and notes became minutes. Minutes outlined action plans, and finally a decision to examine more deeply what an FQHC is. A decision was made, and steps were taken to establish FQHC status. You were successful, and a grant or designation of Look-Alike status was received.

Stop for a minute. Trace this quick evolution from idea to reality in terms of how the various aspects of your communication effort evolved over time. The number of individuals represented in your "address book" has grown rapidly. You have learned that different individuals have different interests; your messaging varies and has grown more complex. Possibly, and sometimes painfully, you have learned how not to discuss this effort.

Operational
With the FQHC designation, suddenly there is more to do to operationalize the ideas: hire staff, develop policies and procedures, build a budget, establish an encounter rate, and more. Clinicians must see patients, billing for services occurs, board meetings are held, and the list goes on. In the midst of this, it can become difficult to consider effective communication as demanding the same urgency and thorough planning as the other tasks, but it does. Effective—or ineffective—communication impacts every aspect of your health center. Some examples:

<u>Human Resources:</u> When human resources manuals are prepared, they must be precise, accurate, legal, and beneficial. The same is true of the employee handbook, but can it also be comfortable or welcoming? What do you want the message and tone to be?

<u>Internal & External Publications:</u> A second example might be the frequency that different communications are scheduled and different formats used for your health center's communication vehicles. Just as some meetings are held weekly, monthly, quarterly, etc., different communications require different frequencies. Consider the nature of the communication, its audience, and its purpose in determining an appropriate frequency and style.

Organizational Performance Reports: How are you going to share progress toward your health center's quality and financial goals with the board, staff, patients? What data does each target audience need and how often? Much of the data submitted through the Uniform Data System (UDS) is now publicly available, so staff and board understanding of the measures and how your health center is doing in meeting them is increasingly important.

Important Points:

1- A helpful step as the FQHC considers its communication plan is to contact both PACHC and some health center colleagues.

2- PACHC publishes a weekly electronic newsletter, *News CHCs Can Use,* which offers timely information about the health care environment in the state and nation, trainings, events, funding opportunities, good news about FQHC achievements and more. There is no limit to the number of individuals who work for a PACHC member health center who can receive the publication, so one way to ensure that your health center board and staff have the timely and important information they need is to request that they be added to the email distribution list for this newsletter.

Communication with and through PACHC

PACHC views information as a two-way street: we need your experience and feedback to be most effective in the work we do on behalf of all Pennsylvania health centers. Questions and requests for technical assistance, for instance, can lead to identification of training needs for FQHCs. One health center sharing a problem they are encountering can help us work to resolve the issue for all PA health centers.

When PACHC is aware of challenges health centers are facing and successes health centers are experiencing, we can facilitate networking across the "community of Community Health Centers" and offer effective and relevant education and training. One tool PACHC uses to encourage networking, identify successful practices and track trends is the "Peer Query." Any health center executive can pose a Peer Query question anonymously through PACHC and aggregate results are shared with all health centers that respond. On request, responses to the Peer Query are also kept anonymous.

Internet and Social Media

Is your health center going to have a website? A Facebook page? Use Twitter? Will staff have access to the Internet during work hours? What will your policy be on use of social media? Ideally, you want to think these issues through and be proactive and strategic in your approach.

Strategic Plan

Periodically, the FQHC's board and administrative and clinical leaders will gather as a strategic planning body to discuss and evaluate its goals, how well the FQHC is performing, what new needs or challenges it should address in the future, and other topics that are crucial for the FQHC to meet its mission of expanding access to quality affordable primary health care. A communication strategy will be part of the strategic plan. What information should be communicated to patients, partners, and/or the community? Who and how is this information communicated?

Branding
Branding is an effort to establish a positive reaction or identification with a "product"—in this case, your health center. PACHC at the state level and NACHC at the national level are working to improve brand identification and loyalty for the "community of Community Health Centers FQHC" to increase the likelihood that clinicians seeking employment, other providers seeking partners, patients seeking a healthcare home and insurers seeking providers will proactively look to FQHCs to fulfill these roles. (See Manual section, So What Is A Community Health Center?, for more on this statewide and national initiative). This national initiative is not intended to supplant or replace branding for individual health centers, but rather to supplement that branding and serve as a unifier. Your health center should as part of its communication plan both align with this broad branding initiative as well as develop your own brand identity.

Early and effective branding of your health center is one key to business success. It is the quickest way for your organization to express what it is and what it can offer. Inaccurate branding can make it difficult for people to grasp why the organization exists in the first place. A brand is a company's face to the world. It is the company's name, how that name is visually expressed through a logo, and how that name and logo are extended throughout the organization's communications. A brand is also how the organization is perceived by its customers (or patients)—the associations and inherent value they place on your health center.

A brand is a kind of promise. It is a set of fundamental principles as understood by anyone who comes into contact with a company. A brand is an organization's reason for being and how that reason is expressed through its various communications media to its key audiences

Education
Education of key stakeholders, policymakers, and others on your health center, Community Health Centers at large, and the important role you play in access to quality affordable health care, control of healthcare system costs and as an economic driver is an important element of any communication plan. You can't assume that those who need to know about your health center and the important work you do will, unless you make the effort to ensure key individuals are aware and knowledgeable.

As much of a health center's revenues come from grants or service reimbursements from national and state governments, it is important that local, state and national legislators and key decision makers are aware of what makes an FQHC different and why the FQHC model has enjoyed bipartisan support for its entire 45+ year history. Key decision makers must understand what each FQHC contributes to its community's health, welfare, and economy.

Properly, many health centers are concerned that they might be violating the law or put their not-for-profit status at risk if they reach out to legislators and others and provide this education, so it is important to understand the difference between lobbying and education. A National Association of Community Health Centers publication, Advocacy Restrictions and Limitations on Federally Funded Health Centers provides guidance on what is allowable and unallowable for health centers. It is important to read this document carefully and to seek legal counsel if the center wishes to have a more precise answer to this question. Internal Revenue Service guidance on lobbying by nonprofit organizations is also available online.

Policies

As with so much else in the FQHC, communication policies must be developed. The topics listed below are not comprehensive, but suggestive.

- Who communicates what? Generally, individual board members or staff are not expected to give media interviews. A policy delineating how a decision is made for media communications, content approval, and who gives media commentary should be developed. Generally, the CEO and/or board chairperson are assigned this duty.
- Preparation for media or communications efforts is essential. It is important to develop a list of do's and don'ts for specific situations.
- Communication can address positive or negative issues and it is important to prepare for both in policy development. A brief NACHC document, Managing Risks Related to the Media and Communication Crises, will be helpful.

Important Points:

1- Consider all communication modalities. If a newsletter is anticipated, responsibilities must be established, schedules selected, and editorial duties assigned.

2- Prepare for information requests, at least partially by knowing what information can legally be shared. If the request comes from a media outlet, there will be a desire for photographs or video. Anticipate this and know what consents should be obtained, particularly where patients are involved.

3- Social media is becoming an essential part of any communication strategy. It is important to establish how this is handled by the FQHC and its employees.

4- Finally, as with all that you do, consider how to review the impacts of these policies and to make changes for improvement.

Resources:

NACHC Social Media Guidance and Resources
Managing Risks Related to the Media and Communication Crises, NACHC
IRS Guidance on Political and Lobbying Activities by Non-Profits
Advocacy Restrictions and Limitations on Federally Funded Health Centers, NACHC

GENERAL RESOURCES & GUIDES

1. Health Center Site Visit Guide
This guide developed by the Health Resources and Services Administration contains an extensive list of specific questions designed to determine the health center's level of compliance with program requirements. In addition, it includes discussions on how to exceed basic compliance and achieve improved performance and excellence in each program area.

2. The Bureau of Primary Health Care (BPHC) Newly Funded Technical Assistance Guide
The BPHC New Start Web Guide is a self assessment tool designed to help new BPHC grantees provide high-quality primary health care from the day they open their doors for business. The Guide is a central hub for links to HRSA-approved templates, information pages, policy documents, and many other resources. The intent of the guide is to help FQHCs improve their quality and efficiency, work within Health Center Program Requirements, and access federal policies, programs and resources related to the specific needs of health centers.

3. So You Want to Start a Health Center…?
This practical guide developed by the National Association of Community Health Centers contains information that is very useful to communities interested in starting a Federally Qualified Health Center. It provides step-by-step information for planning and implementing a health center.

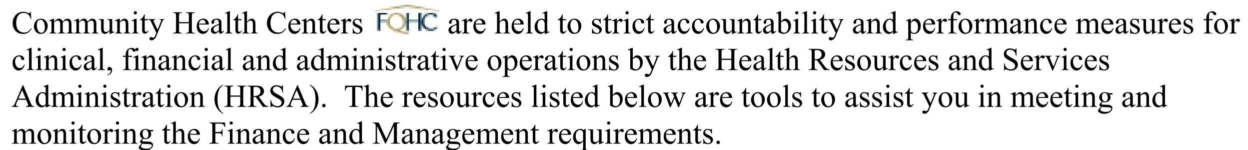
4. Federal Program Requirements
This document contains the19 key Health Center Program Requirements. These requirements are intended to ensure that health centers not only survive but thrive.

5. Policy Information Notices (PINS) and Policy Assistance Letters (PALS)
HRSA Policy Information Notices (PINs) define and clarify policies and procedures that Community Health Centers FQHC must follow. Program Assistance Letters (PALs) summarize and explain items of significance for health centers, including, for example, HRSA program implementation activities, recently enacted laws, final regulations, and/or new HHS initiatives.

6. Samples & Templates Resource Center
Offers a repository of vetted documents shared by HRSA's consultants, as well as documents from the HRSA Bureau of Primary Health Care (BPHC), the National Association of Community Health Centers (NACHC) and other BPHC Cooperative Agreement partners.

7. HealthCenterCompliance.com
This is the only website that provides FQHCs with access to a broad range of compliance and FTCA resources in a single location. The resources, developed by people who know FQHCs, focus on the most important risk areas faced by health centers.

FINANCE & MANAGEMENT PROGRAM REQUIREMENTS RESOURCES



Community Health Centers FQHC are held to strict accountability and performance measures for clinical, financial and administrative operations by the Health Resources and Services Administration (HRSA). The resources listed below are tools to assist you in meeting and monitoring the Finance and Management requirements.

To view all the *FQHC Finance and Management Program Requirements,* click here.

HRSA Financial and Management Technical Assistance Resource Page
This page provides information on management of health center finances, including billing, and sliding fee guidance.

HRSA Bureau of Primary Health Care (BPHC) Online Document Resource Center – Management and Finance
BPHC's Technical Assistance contractor, Management Solutions Consulting Group (MSCG), hosts online resources. While the Resource Center has many valuable templates and documents, all non-federal resources cited are meant to be used only as "sample" documents, and are not considered official guidance by BPHC.

The Center for Medicare & Medicaid Services (CMS) ICD 10 Information and Resources
The CMS website offers resources and timelines to help providers, payers, and vendors prepare for the U.S. health care industry's transitions to version 5010 and ICD 10.

National Association of Community Health Centers (NACHC) ACO Toolkit
This tool covers key topics in six parts, providing a path
for the implementation of Accountable Care Organizations (ACOs) across the country. The Toolkit strives to both be specific enough to allow organizations to clearly understand the steps needed to become an ACO while at the same time stay broad enough to make sure the path put forward for implementation is possible for a diverse range of health care provider groups.

NACHC Accounting Policy Manual
NACHC has published a financial training manual for FQHCs titled Accounting Policy, Procedures, and Operations Manual, which is available for purchase.

NACHC Training and Technical Assistance
The NACHC website offers a wide variety of finance and billing training opportunities.

GOVERNANCE REQUIREMENTS RESOURCES

All Community Health Centers FQHC must be governed by the community, and 51% of their board of directors must be patients of the FQHC. The resources listed below are tools to assist you in meeting and monitoring the Governance requirements.

To view all of the *Governance Program Requirements,* click here.

HRSA Governance - Technical Assistance Resource Page
Provides information regarding health center Board requirements, policies and structure.

BPHC Online Document Resource Center – Governance
BPHC's Technical Assistance contractor, Management Solutions Consulting Group (MSCG), hosts an online Resource Center that houses many resources. While the Resource Center has many valuable templates and documents, all non-federal resources are meant to be used only as "sample" documents. They are for use as aids to consultants and grantees, but are not considered official guidance by BPHC.

Health Resources and Services Administration (HRSA) Governing Board Handbook
Helps orient new members of FQHC governing boards about their roles and responsibilities. It explains the purpose and responsibilities of a nonprofit governing board and presents an overview of how board activities relate to day to day functions of health center operations.

National Association of Community Health Centers (NACHC) Board Education Video Series
This video series is a new resource developed for health center board members and is designed to be used at monthly board meetings to learn and discuss the board's role in assuring patient-centered services as well as compliance with funding requirements. Currently available are five "modules," each featuring brief video vignettes (approximately 5-6 minutes each) which demonstrate scenarios of health center and board meeting operations.

Board Source - Publication and Media Resources
This website houses a group of 9 booklets detailing the most important roles and responsibilities of nonprofit board members.

National Association of Community Health Centers (NACHC) Publications and Reports
NACHC's online publications include monographs, comprehensive manuals, handbooks, issue briefs, reports and information bulletins on operations, management, finance, special populations and a host of additional topics. Some can be downloaded for free while others are available for purchase, with members receiving a discount.

The Community Health Association of Mountain Plains - CHAMPS
CHAMPS has compiled and developed a selection of online resources for community health center Executive Directors (EDs) and Board of Directors (BOD) members, in an effort to help FQHCs in its region build and maintain strong and effective governing structures.