

OLDE TOWNE MEDICAL AND DENTAL CENTER: FINAL REPORT

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Executive Summary

Objective

This report is intended to provide Olde Towne with a summary of our findings and recommendations concerning their federal designation and business model.

Scope

In this report, we analyze several possibilities facing Olde Towne. These options include: remaining a Rural Health Clinic (RHC), losing designation as an RHC, becoming a Federally Qualified Health Center (FQHC), becoming a subsidiary or satellite of an existing FQHC, and joining the Virginia Association of Free and Charitable Clinics (VAFCC).

Structure

The report is structured into four sections. Section I provides background information on Olde Towne's unique problem and some of the different options for federal designation, Section II discusses the cost benefit analysis, and Section III outlines a business plan for an FQHC conversion.

Findings

The main costs associated with becoming an FQHC would be the "core staff requirement," reporting requirements, a Board of Advisors with 51% patient composition, a sliding fee scale offered only to those below 200% of the federal poverty line, offering emergency after hours and weekend care, and offering the necessary preventive services. The main benefits would be access to the New Access Point (NAP) grant, a much higher Medicare and Medicaid reimbursement rate, access to discounted prescription drugs, miscellaneous grants offered for additional services offered, and continued Federal Tort Claims Act (FTCA) malpractice insurance. Our main cost benefit analysis assumed a transition to FQHC status by FY 2018 with an observation period of FY 2018-2021, the assumed length of the NAP grant. When examining the possibility of receiving a lower bound NAP grant, only six of the thirty possibilities yielded net costs. Of those, five assumed the costliest staffing changes considered.

Conditional Recommendation

We encourage Olde Towne to complete a needs assessment and apply for the NAP grant. If there is no award announcement in the near future or if they are not awarded the competitive grant, we encourage them to continue searching for the RHC exemption process discussed in the report or finding existing FQHCs that would be willing to accept Olde Towne as a subsidiary.

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Glossary

CMS: Centers for Medicare and Medicaid Services
CNM: Certified Nurse Midwife
DHHS: Department of Health and Human Resources
FPL: Federal Poverty Level
FTCA: Federal Tort Claims Act
FQHC: Federally Qualified Health Center
GAO: Government Accountability Office
HPSA: Health Professional Shortage Area
HRSA: Health Resources and Services Administration
KFF: Kaiser Family Foundation
MUA: Medically Underserved Area
MUP: Medically Underserved Population
NACHC: National Association of Community Health Centers
NAP: New Access Point
NP: Nurse Practitioner
NRHA: National Rural Health Association
OMB: Office of Management and Budget
OSV: Operational Site Visit
PA: Physician Assistant
PPS: Prospective Payment System
RHC: Rural Health Clinic
UDS: Uniform Data System
VAFCC: Virginia Association of Free and Charitable Clinics
VCHA: Virginia Community Health Association
VRHA: Virginia Rural Health Association
QI/QA: Quality Improvement/Quality Assurance

Section I: Background

The Problem

Currently, Olde Towne Medical and Dental Center faces a unique problem. The Centers for Medicare and Medicaid Services (CMS) classify Olde Towne as a Rural Health Clinic (RHC). As such, it receives an advantageous reimbursement rate from CMS and should be eligible for various federal grants. However, the Government Accountability Office (GAO), which administers federal grants, has denied Olde Towne's grant application because the U.S. Census Bureau no longer considers Olde Towne's zip code, 23188, to be rural. As a result, Olde Towne is at risk for losing its RHC status with CMS.¹

The Opportunity

This crisis also provides a valuable opportunity to transition to a new business model. As such, this report presents a cost-benefit analysis in order to determine the best strategy for Olde Towne moving forward. The options that we consider in this report include: remaining a Rural Health Clinic (RHC), becoming a Federally Qualified Health Center (FQHC), or becoming a subsidiary or satellite of an existing FQHC. We also briefly analyze the option of joining the Virginia Association of Free and Charitable Clinics.

Rural Health Clinics

RHCs were established by the Rural Health Clinic Services Act of 1977 to increase the supply of physicians and non-physician practitioners serving Medicare patients in rural areas. To qualify as an RHC, a clinic must meet several requirements:²

Location – Clinics must be in a rural and underserved area.

- Clinics must be classified by the U.S. Census as non-urbanized.
- Clinics must be classified by the Health Resources and Services Administration (HRSA) as a federally designated Health Professional Shortage Area (HPSA), or as a Medically Underserved Area (MUA) within the previous four years.

Staffing – Clinics must utilize non-physician practitioners in addition to physicians.

- Clinics must employ at least one physician.
- Clinics must employ at least one NP, PA, or CNM.
- Clinics must have a NP, PA, or CNM working at the clinic 50% of the time the clinic is in operation.

¹ 42 U.S.C. 1395x(aa)(1)

² Ibid.

Services – Clinics must provide primary care and preventive health services.

- Clinics must directly provide the following diagnostic and laboratory services: hemoglobin or hematocrit testing, blood sugar testing, examination of stool specimens for occult blood, pregnancy tests, and primary culturing for transmittal to a certified laboratory.
- Clinics must be able to provide first-response services in the case of a life-threatening emergency and must have access to medications that are commonly used in life-saving procedures.
- Clinics must have an arrangement with at least one hospital to provide medically necessary services that are not provided by the clinic.

Record Keeping – Clinics must maintain detailed patient records and comply with HIPAA privacy standards

- Clinics must maintain confidential records that include the following information: identification data, physical exam findings, social data, consent forms, health status assessment, physicians' orders, consultative findings, diagnostic and laboratory reports, medical history, signatures of the physician or other health care professionals.

To this end, Olde Towne meets all of the above requirements, except being located in a non-urbanized location according to the U.S. Census Bureau. As a result, Olde Towne is at risk for losing its designation as an RHC. However, according to the Section 1861 of the Social Security Act, there may be a way for Olde Towne to avoid losing its designation (and possibly even obtain access to federal grants for RHCs).³

In particular, a facility that has been designated as an RHC that no longer meets the location requirements shall be considered as still satisfying those requirements if it is determined that the facility is “essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic.” In order to obtain this exemption, Olde Towne must seek assistance from a state or local agency. Under Section 1864(a) of the Social Security Act, the state or local agency must make a determination (or reaffirmation) to the U.S. Department of Health and Human Services that Olde Towne is an RHC that is “essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic.” After obtaining such a determination, Olde Towne would be eligible to apply for the exemption from the Department of Health and Human Services, subject to the approval of the Secretary. After the state or local agency has determined, pursuant to section 1864(a) of the Social Security Act, that a facility is an RHC and the facility has applied to the Department of Health and Human Services for an exemption for the location requirement, the clinic will be notified within 60 days whether or not the exemption was approved.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) were established in Section 1861(aa)(1) of the Social Security Act as amended by the Omnibus Budget Reconciliation Act of 1990.⁴ However, FQHCs

³ Ibid.

⁴ Ibid.

receive federal grant funding under Section 330 of the Public Health Services Act as amended by the Affordable Care Act.⁵ This program serves as a “safety net” to providers in underserved urban and rural communities. According to the Bureau of Primary Healthcare and the Health Resources and Services Administration, Section 330 of the Public Health Service Act describes 19 requirements that a health center must meet in order to be considered an FQHC.⁶ These requirements are listed in their entirety in Appendix 1, but are also summarized below.

Location – Centers must be in an underserved urban and rural community.

- Centers must also provide services at times and locations that are accessible to meet the needs of the population served

Staffing – Centers must maintain a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary.

- Centers must also maintain a fully staffed health center management team as appropriate for the size and needs of the center.
- Centers must also make an effort to establish and maintain collaborative relationships with other health care providers in the service area of the center.
- Centers must have a governing board composed of individuals, a majority of whom (51%) are being served by the center, and this majority as a group, represent the individuals being served in terms of demographic factors such as race, ethnicity, and sex.

Services – Centers must provide physician services.

- Clinics must provide the following services: medical social services, nutritional assessment, preventative health education, children’s eye and ear examinations, well child care, immunizations, voluntary family planning, blood pressure measurement, weight measurement, physical examination targeted to risk, visual acuity screening, hearing screening, cholesterol screening, stool testing for occult blood, tuberculosis testing for high risk patients, dipstick urinalysis, risk assessment and counseling, prenatal and postpartum care, prenatal services, clinical breast exam, referral for mammography, and thyroid function test.
- Centers must operate on a sliding fee discount scale so a patient’s discounts are adjusted on the basis of the patient’s ability to pay.
- Centers must also have an ongoing Quality Improvement/Quality Assurance (QI/QA) program that maintains the collection and confidentiality of patient records.

To this end, Olde Towne already meets many of these requirements. However, Olde Towne may need to make several substantial changes in order to qualify to become an FQHC. Some of these adjustments will be costly, but becoming an FQHC would also have many benefits, such as the NAP Grant, higher Medicaid and Medicare reimbursement limits, and access to the 340(B) Drug Pricing Program. The costs and benefits are described in more detail below.

⁵ 42 U.S.C §254b

⁶ “Program Requirements,” *Health Resources and Services Administration*, Accessed December 1, 2015, <http://www.bphc.hrsa.gov/programrequirements/index.html>

Section II: Cost Benefit Analysis

Applying to become an FQHC would have numerous benefits. Assuming the process to take a full 2 years, realistically Olde Towne may be able to begin operation as an FQHC beginning FY 2018-2019. Our analysis finds the total net benefit or cost that would accrue under multiple assumptions at the end of FY 2020-2021. We assume a modest 3% discount rate.

Factors Analyzed

Identified costs and benefits are summarized in Table 1. The only costs that could be assigned a concrete monetary cost were the “core staff requirement” as well as the necessary reporting requirements. Costs that do not have assigned values include the restructuring of the Board of Advisors, the elimination of copays for individuals with household incomes below 100% of the Federal Poverty Line (FPL), the elimination of the sliding-scale discount for individuals with household incomes above 200% of the FPL, and the provision of after-hours care, weekend care, and required preventive services. The benefits include the NAP Grants, more favorable reimbursement rates for Medicare and Medicaid patients, and the Public Health Service Act Section 340(B) Drug Pricing Program. The benefits not directly analyzed include miscellaneous grants available for FQHCs for additional services and continued Federal Tort Claims Act (FTCA) coverage.

Table 1: FQHC Costs and Benefits

| Costs | Factor in Cost-Benefit Analysis | Sources Considered |
|---|--|--|
| "Core Staff Requirement" | Yes | Law, VAFCC, NACHC, HRSA, Medicare Benefit Policy Manual |
| Reporting Requirements | Yes | Law, HRSA |
| Board of Advisors Composition: 51% Patent | No | Law, HRSA |
| Sliding Fee Scale not Offered to Those Above 200% FPL | No | NACHC, Olde Towne |
| After Hours and Weekend Care | No | Law, VCHA |
| Necessary Preventive Services | No | Law, Olde Towne |
| Benefits | Factor in Cost-Benefit Analysis | Sources Considered |
| NAP Grants | Yes | Law, VCHA, HRSA |
| FQHC CMS Reimbursement Rate | Yes | Law, VCHA, NACHC, VRHA, HRSA, Arbor Research Collaborative |
| Section 340(B) Prescription Drug Purchasing Program | Yes | Law, MedPAC |
| Miscellaneous Grants for FQHCs | No | HRSA |
| Continued FTCA Coverage | No | Law, NACHC |

Interest Group Interviews

During the course of this report, our team conferred with multiple contacts and community health associations (see Appendix 2). The Virginia Community Healthcare Association provided us with background information on the NAP grants, the core staff requirement, the recent changes to Medicare reimbursement and possible future changes to Medicaid reimbursement, the after-hours service requirement, and the success of Virginia FQHCs in attracting National Health Service Corps medical professionals. VCHA confirmed that no RHC to FQHC transition had ever occurred in Virginia, and it was still unclear if such a transition had ever occurred in other states. The NAP application should be based on total patients, while potentially estimating some growth. Furthermore, it is their belief that Olde Towne’s existing site may *benefit* their chances of receiving NAP funding for “new” patients.

The National Association of Community Health Centers (NACHC) provided invaluable assistance through their publications as well as interviews. They confirmed certain ambiguities surrounding the core staff requirement and outlined necessary steps, such as the needs assessment, to be taken before the grant application. NACHC clarified that while the Medicare reimbursement limit for FQHCs will continue to be adjusted annually according to the Medicare Index, it is currently not advisable to assume the limit will be removed. NACHC also provided a rough estimate of the Virginia Medicaid limit for most services around \$128 per visit, which was confirmed by VCHA. NACHC informed us of the necessity to use the Uniform Data System mapper, provided by HRSA, for Olde Towne’s needs assessment. The group further informed use that an FQHC sliding scale may not offer a specific rate for those above 200% of the federal poverty line. In this case Olde Towne’s level F offered to those between 200-250% FPL, with under 300 visits last year, could no longer be offered. One option would be an across the board “discount”, yet this would be required for all patients. NACHC specified that with the Medicare prospective payment system for FQHCs under-coding was definitely a problem, so a skilled administrator may prove valuable.⁷

Costs

Staffing Changes

The largest predicted cost in this analysis stems from the “core staffing requirement” dictated by HRSA’s program requirements. Currently HRSA simply refers to federal code and statutory language for this requirement and no known metric exists to determine this definition.⁸ According to the Medicare Benefit Policy Manual, “full-time employee” may refer to those working 40 hours a week for 52 weeks of the year, or to those working 40 hours a week for 40 weeks of the year.⁹ Vanessa Easter at VCHA has clarified that “the appropriate number of staff needed to perform all the services listed on Form 5 will be measured by HRSA particularly during the first Operational Site Visit (OSV),” that is, after applying for FQHC status. Ted Henson at the National Association of Community Health Centers confirmed that there was no known metric to determine appropriate

⁷ Ted Henson seemed slightly surprised that a full-time administrator was being considered solely for FQHC functions.

⁸ 42 U.S.C §254b (a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I). Medicare Benefit Policy Manual. Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, 30.2.

⁹ Medicare Claims Processing Manual. Chapter 9 – Rural Health Clinics / Federally Qualified Health Centers. 40.3.

staff, other than that it should be considered reasonable for the population being served. Our current data reflects staffing information shared by Dr. Mann during our initial meeting as well as information presented to us by Denise Bowles, the business manager at Olde Towne. For staffing changes, we also consider the reporting requirements for FQHCs and assembling materials for the re-application to the NAP grant and other federal grants. Dr. Mann indicated that this may be accomplished through an additional full-time administrator. We assume a start date of the administrator beginning FY 2018, with any additional consulting received for the NAP application not considered.

Three different staffing scenarios are outlined in Table 2 on page 10. The least costly scenario assumes solely the cost of the administrator. The total cost of the administrator is based on the current salary and benefits of Olde Towne's business manager in the absence of further information. The "middle scenario" also assumes an additional full-time nurse practitioner. This does not take into account any accompanying grant for the practitioner, only if they are determined by HRSA to be necessary for the patient population. The cost of said practitioner is also based on current personnel. The costliest scenario assumes the hiring of one full-time obstetrician, one full-time dentist, and the administrator. This would assume either a transition of current part time staff into full-time employees working 40 weeks out of the year (the lowest amount allowed for full-time equivalents), or their replacement with full-time employees. Currently, we know that Olde Towne employs a dentist for 764 authorized hours and employ an obstetrician for 416 authorized hours. In both cases, these staff are paid an hourly rate, which we use to estimate the cost of hiring the dentist and obstetrician full-time. This may be an underestimate of potential costs, considering the mean annual salary of a full-time obstetrician in Virginia is \$218,650 compared to our estimated cost of \$162,878.¹⁰ The mean annual salary for Virginia dentists is equal to \$158,780 and is not markedly higher than our estimated dentist cost of \$154,878.¹¹ It is our understanding that the new full-time employees are not required to begin work until the site is operational and receiving the new Medicare and Medicaid reimbursement rates. FQHCs billing for reimbursement under the new PPS system are not subject to productivity standards, and therefore we do not assume any costs from exceeding the previous productivity standard limit. We estimate the net present value of the total cost for each of these three scenarios for a three-year period using a 3% discount rate.

Board of Advisors Changes

The Board of Advisors for an FQHC must be between 9-25 people and have at least a 51% patient composition. Furthermore, of those non-patients no more than half may derive 10% or more of their total income from the medical profession. As the Board would have to approve this step, it seems to be the biggest practical hurdle, yet outside the scope of this cost-benefit analysis. However, if Board members who currently contribute significant amounts to Olde Towne no longer feel inclined to do so after leaving, there would be additional monetary costs.

¹⁰ "Occupational Employment and Wages, May 2014: 29-1064 Obstetricians and Gynecologists," *Bureau of Labor Statistics*, Accessed December 1, 2015, <http://www.bls.gov/oes/current/oes291064.htm>.

¹¹ "Occupational Employment and Wages, May 2014: 29-1021 Dentists, General," *Bureau of Labor Statistics*, Accessed December 1, 2015, <http://www.bls.gov/oes/current/oes291021.htm>. Known median salary for Virginia dentists is \$139,580.

Table 2: Present Value of the Costs Associated with Potential Staffing Scenarios

| Staffing Costs | Salary and Benefits | Net Present Value (3 years) |
|-----------------|------------------------------|-----------------------------|
| Low Estimate | Administrator | 76,963 |
| | Total Gross Cost (Annual) | 76,963 |
| Middle Estimate | Administrator | 76,963 |
| | Nurse Practitioner | 97,119 |
| | Total Gross Cost (Annual) | \$174,082.00 |
| High Estimate | Removals | |
| | Part Time Dentist | 61,787 |
| | Part Time Obstetrician | 35,886 |
| | Total Gross Savings (Annual) | 97,673 |
| | Additions | |
| | Administrator | 76,963 |
| | Dentist | 154,878 |
| | Obstetrician | 162,878 |
| | Total Cost | 394,719 |
| | Total Gross Cost (Annual) | 297,046 |

Source: Olde Towne

After Hours and Weekend Care

We assume the administrative costs of operating a phone referral service for after hours and weekend emergency care to be negligible. It may be possible to adjust schedules of current staff in such a way to provide a “skeletal staff” and avoid overtime payment, as other FQHCs currently do.¹²

Necessary Preventive Services

Based on Olde Towne publications and our understanding of the clinic, we currently believe that Olde Towne offers all of the necessary preventive services required of an FQHC. Section 330 of the Public Health Service Act requires “medical social services, nutritional assessment and referral, preventive health education, children’s eye and ear examinations, prenatal and postpartum care, prenatal services, well child care (including periodic screening), immunizations, and voluntary family planning services.”¹³ This also includes “preventive dental services.” As such, no costs are assumed to stem from this requirement.

¹² Virginia Community Healthcare Association

¹³ 42 U.S.C. §254b(a)(1) and §254b (b)(1)(A)(i)(III) (hh).

Benefits

New Access Point Grants

Given the low share of Medicaid patients visiting Olde Towne, we do not necessarily believe the higher reimbursement rate to be the largest benefit. Grants are awarded on a competitive basis, and Olde Towne would be required to reapply for funding every three years in order to receive this aid for their fourth to sixth years as an FQHC. We assume that the full grant amounts are awarded at the beginning of operation as an FQHC at this point. The most recent NAP awards to Virginia clinics for new sites are described in Table 3. From these amounts, we construct a total of different grant scenarios outlined in Table 4.

Table 3: Virginia 2015 New Access Point Grant Awards

| Clinic | Award Amount | Number of Patients | % Medicaid/CHIP | % Medicare | % Uninsured | Cost /Patient |
|---|--------------|--------------------|-----------------|------------|-------------|---------------|
| August 2015: 3 awards totaling \$1,199,999 to serve a proposed 10,264 new patients | | | | | | |
| Central Virginia Health Services, Inc | \$483,333.00 | 40,819 | 18.60% | 19.70% | 32.90% | \$661.81 |
| Peninsula Institute For Community Health, Inc | \$358,333.00 | 22447 | 28.60% | 10.90% | 46.40% | \$543.68 |
| Richmond, City Of | \$358,333.00 | N/A | N/A | N/A | N/A | N/A |
| May 2015: 2 awards totaling \$1,216,667 to serve a proposed 5,670 new patients | | | | | | |
| Greater Prince William Community Health Center | \$566,667.00 | 10897 | 20.90% | 3% | 62.70% | \$525.23 |
| Portsmouth Community Health Center, Inc. | \$650,000.00 | 11917 | 32.60% | 4.60% | 49.20% | \$554.92 |

Sources: HRSA

Table 4: New Access Point Grant Calculations

| Award per Patient | Amount Available by Time of Application | | |
|---------------------|---|--------------|--------------|
| | 50% | 75% | |
| Low Award | \$116.91 | \$276,752.07 | \$415,128.10 |
| Middle Award | \$151.67 | \$359,230.40 | \$538,845.59 |
| High Award | \$214.58 | \$508,876.47 | \$763,314.71 |

Sources: Health Resources and Services Administration, DHHS Budget Proposal

Reimbursement Changes

For most FQHCs, the largest benefit of their federal status is the very favorable Medicare and Medicaid reimbursement rate. The 2016 reimbursement limit for RHCs is \$81.32 per patient visit. FQHC Medicare payments were changed to a prospective payment system (PPS) implemented in October 2014. For “rural” FQHCs, this reimbursement limit was \$109.24 per visit, while for “urban” FQHCs, this reimbursement limit was \$126.22.

The new system requires that Medicare pay FQHCs a national encounter-based per diem rate of \$160.60, or total charges furnished, whatever is less. However, it is likely that this rate will be raised by FY 2018. The average cost per visit at Olde Towne is \$169.12 per visit. The Geographic Adjustment Factor for determining Virginia’s reimbursement rate is 0.992. Thus the cap of \$159.32 per patient visit is lower than the average cost per patient. We do not account for the 34% increased reimbursements for new patients in this analysis. While we do not have the information to estimate services provided, we know that unusually high and low costs are excluded from the Medicare PPS system.¹⁴

As of December 2014, Virginia was still using an alternative payment methodology for Medicaid rather than PPS. However, Vanessa Easter has stated that this rate was based on the previous Medicare cap. As it has changed, she believes that it is likely Medicaid rates of reimbursement will need to also be raised. Interviews with Sherri Goemmer at NACHC as well as with Janice Fisher at VCHA have corroborated a rough \$128 estimate for many Medicaid services. We are unaware of the current RHC Medicare-Medicaid reimbursement gap, which varies from state to state, but know that it is generally based on costs that existed in 1999 and 2000 when the PPS rates were set.¹⁵ We also know that for Virginia, all Medicaid services are reimbursed on average at 80% of Medicare services.¹⁶ For this reason we assume a low RHC Medicaid reimbursement rate of around \$65.06 by FY 2018.

Table 5: Reimbursement Limits for Medicare and Medicaid for RHCs and FQHCs

| | Reimbursement Limit | Source |
|--|---------------------|-------------|
| RHC Reimbursement Medicare Limit (2016) | \$81.32 | HRSA, VRHA |
| FQHC Medicare Reimbursement Limit (2016) | \$159.32 | HRSA |
| RHC Medicaid Reimbursement Limit | ≈\$65.06 | KFF, NRHA |
| FQHC Medicaid Reimbursement | ≈\$128 | NACHC, VCHA |

While the average visit cost of \$169.12 is known, we are unaware of how widely these visit costs vary. The encounter-based per diem rate provides reimbursements based on the visit limit or actual costs, whichever is lower. This payment is increased by 34% for new patients or annual wellness visits, but we found no reliable way to factor in this increase. We present a range of reimbursement scenarios, predicting that Olde Towne is reimbursed between 50%-90% of average patient costs in Table 6 on page 13. From these estimates, we provide a range of increased revenue amounts, based on the ratio of estimated current reimbursements (at the limit) to expected reimbursement amounts per patient in Table 7 on page 13. These results range from roughly \$50,000 per year to over \$200,000 per year.

¹⁴ “Overview of the Medicare FQHC PPS Proposed Rule,” *National Association of Community Health Centers*, <http://www.nachc.com/client/documents/10.13%20Medicare%20FQHC%20PPS%20proposed%20rule%20-%20summary%20-%20FINAL.pdf>.

¹⁵ “National Rural Health Association Policy Brief – Rural Health Clinics,” *National Rural Health Association*, 2014, <http://www.ruralhealthweb.org/index.cfm?objectid=D64EF917-3048-651A-FEF9BAC415FD5BE7>.

¹⁶ Stephen Zuckerman and Dana Goin, “How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees,” *Kaiser Family Foundation*, 2012, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8398.pdf>.

Table 6: Expected Reimbursement Amount by Percentage of Average Patient Costs

| Percent of Patient Cost | 90% | 80% | 70% | 60% | 50% |
|-------------------------|----------|----------|----------|----------|---------|
| Patient Cost | \$152.21 | \$135.30 | \$118.38 | \$101.47 | \$84.56 |
| Medicare Reimbursement | \$152.21 | \$135.30 | \$118.38 | \$101.47 | \$84.56 |
| Medicaid Reimbursement | \$128.00 | \$128.00 | \$118.38 | \$101.47 | \$84.56 |

Source: Authors' Calculations

Table 7: Total Increases in Reimbursements by Percentage of Average Patient Costs

| Percent Patient Costs | 90% | 80% | 70% | 60% | 50% |
|-----------------------|--------------|--------------|--------------|--------------|-------------|
| Medicare | \$61,021.89 | \$46,465.81 | \$31,901.13 | \$17,345.06 | \$2,788.98 |
| Medicaid Dental | \$35,794.34 | \$35,794.34 | \$30,323.39 | \$20,706.58 | \$11,140.95 |
| Medicaid | \$116,089.76 | \$116,089.76 | \$98,346.14 | \$67,156.47 | \$36,132.80 |
| Total | \$212,906.00 | \$198,349.92 | \$160,570.67 | \$105,208.11 | \$50,062.73 |

Source: Authors' Calculations

The methods used in this report yields proportionally similar results to Arbor Research Collaborative for Health's study on the impact of changing from fee for service to a prospective payment system for FQHCs. The estimated change in payment rates as a result of all statutory and policy changes for FQHCs overall is 30.17%, while for rural FQHCs with lower upper payment limits would be 37.40%.¹⁷

340(B) Prescription Drug Purchasing Program

As an FQHC, Olde Towne would have access to the section 340B prescription drug discount purchasing program. According to a May 2015 report to Congress by MedPAC, a lower bound reduction in average sales price for drugs is 22.5%.¹⁸ The formula for said discount compute as ceiling price based on the average manufacture price minus some unit rebate amount, multiplied by the drug package size. The only requirement is that these drugs go to patients at the center, regardless of insurance type. Covered entities may keep any revenue is reimbursements for drugs from payers exceed discounted prices, though this amount should be negligible given Olde Towne's patient base. Most entities may provide 340B though in house pharmacies, which we assume for this analysis.

¹⁷ "Results of Research on the Design of a Medicare Prospective Payment System for Federally Qualified Health Centers," *Arbor Research Collaborative for Health*, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/PPS-Design-FQHC.pdf>.

¹⁸ MedPAC: Medicare Payment Advisory Commission, "Report to the Congress – Overview of the 340B Drug Pricing Program," May 2015, <http://www.medpac.gov/documents/reports/may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program.pdf?sfvrsn=0>.

Miscellaneous Grants for FQHCs

In addition to the New Access Point grants, the Bureau of Primary Health Care (BPHC) offers a variety of grant and cooperative agreement funding.¹⁹ These include such opportunities as expansions of services such as dental or substance abuse treatment, or those centered on supporting electronic health record modernization. Many of these grants are contingent on being an existing Health Center Program award recipient. It is unclear if Olde Towne would be eligible for many of these opportunities if granted the rural health clinic exception. Furthermore, some of these grants are not available if awarded the New Access Point grant in the same fiscal year.²⁰ The Service Area Competition (SAC) grant is a similar route to apply for health center program funding. However, HRSA awards only one grant to each announced service area, and the possibility of Olde Towne receiving this grant is slim. The FY 2016 SAC Service Area announcement lists only Newport News as an area of consideration with the zip code 23188 (although it is still technically outside of the current grantee’s defined service area).²¹

Benefit-Cost Analysis

Table 8 describes the low grant scenario, with 6 of the 30 scenarios (20%) resulting in a net loss and 24 of the 30 scenarios resulting in a net benefit to Olde Towne by the end of FY 2021. Five of the six scenarios that yield a net loss assume the costliest staffing changes. As Olde Towne’s staff is already arguably appropriate for the population they currently serve, it appears that any changes to medical staff would be unlikely. These results reinforce our conditional recommendation to begin gathering the necessary information for the NAP grant application.

Table 8: Final FQHC Conversion Results – Low Grant

| Percentage of Grant | Staff Costs | Percentage of Patient Costs Received as Reimbursement | | | | |
|---------------------|-------------|---|----------------------|----------------------|--------------|--------------|
| | | 50% | 60% | 70% | 80% | 90% |
| 50% of Grant | High | -\$337,985.00 | -\$261,767.54 | -\$100,470.39 | \$9,598.32 | \$52,007.00 |
| | Middle | -\$64,180.03 | \$96,484.35 | \$257,781.49 | \$367,850.21 | \$410,258.89 |
| | Low | \$218,773.23 | \$379,437.61 | \$540,734.76 | \$650,803.47 | \$693,212.15 |
| 75% of Grant | High | -\$284,055.89 | -\$123,391.51 | \$37,905.64 | \$147,974.35 | \$190,383.03 |
| | Middle | \$74,196.00 | \$234,860.38 | \$396,157.53 | \$506,226.24 | \$548,634.92 |
| | Low | \$357,149.26 | \$517,813.65 | \$679,110.79 | \$789,179.50 | \$831,588.18 |

¹⁹ U.S. DHHS Health Resources and Services Administration, “BPHC Funding Opportunities,” <http://bphc.hrsa.gov/programopportunities/fundingopportunities/default.aspx>.

²⁰ U.S. DHHS Health Resources and Services Administration, “Substance Abuse Service Expansion,” <http://bphc.hrsa.gov/programopportunities/fundingopportunities/default.aspx?id=5eb8b6e3-6c30-4162-80f9-68fd9d0f56df>.

²¹ U.S. DHHS Health Resources and Services Administration, “FY 2016 SAC Service Area Announcement Table (SAAS),” <http://bphc.hrsa.gov/sac/#fn4>.

Contingencies

Consortium Option – The Virginia Association of Free and Charitable Clinics

The VAFCC offers a grant formulary to their members based on the number of uninsured patients served as well as prescriptions filled. The amount that the organization may distribute varies wildly each year: this year they were granted \$6.4 million in state funds compared to \$3.2 million the previous year. VAFCC was unwilling to share any further metric or estimates for their formulary given its adjustment each year. Furthermore, Kathryn Zapach, director of membership support, informed our group that Olde Towne’s current support from VCHA would in fact be an unallowable “double dipping” into state funds. We were unable to locate the exact amount currently received from VCHA by Olde Towne on their revenue projections for FY 2015-2016, but were informed by Dr. Mann that it was roughly \$100,000 for this year. Attempting to join VAFCC would require Olde Towne to endure a three-year period without receiving any membership funds. Given the information available, we do not advise that Olde Towne pursue this route.

Loss of RHC Designation

The loss of RHC designation is viewed as unlikely in the near future. However, its two main costs would be the loss of the somewhat favorable reimbursement rate as well as FTCA malpractice insurance coverage. Dr. Mann estimates that reimbursements for services would be about 20% lower for Medicare and Medicaid patients without RHC designation. Given projected revenue for FY 2015-2016, we estimate expected CMS revenue would decrease from \$227,000 to \$181,600. This would work out to a loss of \$45,500 per year, with further losses possible if more Medicare and Medicaid patients seek care at Olde Towne. While we were not able to estimate the market rate for malpractice insurance premiums in the area, NACHC estimates that the average community health center saves \$175,000 per year in premiums from federal coverage.²² This may be over estimating the potential cost given Olde Towne’s relatively small size, but it is the most reliable estimate we have found. This scenario may yield a total loss of \$220,400 per year. If analyzed over FY 2018-2021, this would have a total net cost of \$642,129. By contrast, our costliest scenario for the FQHC transition would yield a net cost of \$337,985, over \$300,000 less than the costs Olde Towne would face if its RHC designation is terminated.

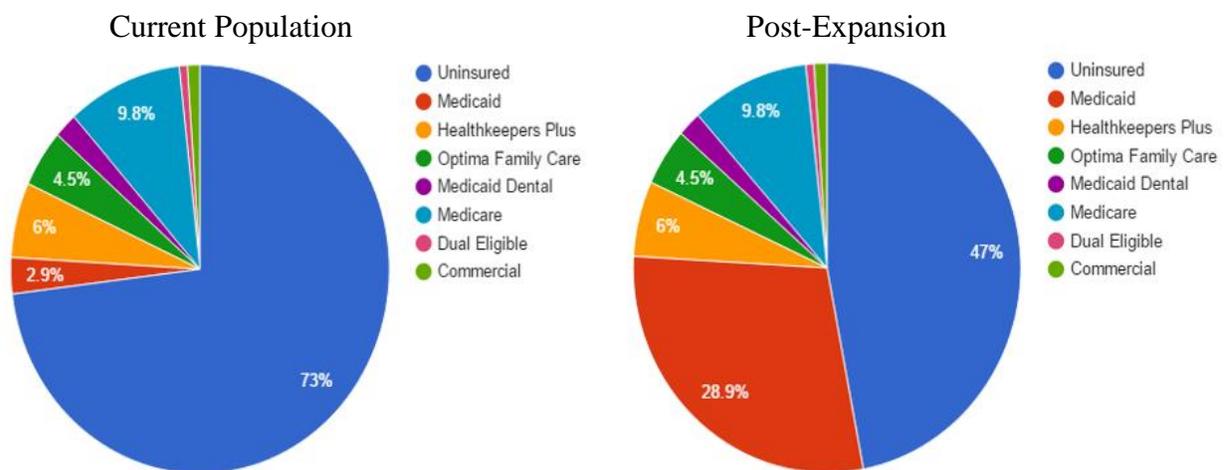
Medicaid Expansion

We cannot realistically assign a probability to Medicaid expansion in Virginia, and it is likely to remain a hotly contested issue in Richmond. That said, the benefits to Olde Towne of a Medicaid expansion are likely to be enormous. Last year’s sliding scale for uninsured patients indicates that 7,520 visits were charged under levels B and C, for families under 100% FPL and between 100%-133% of the FPL, respectively. This is a full 52% of total visits and 71% of uninsured visits to Olde Towne that would be eligible for Medicaid status. We assume that most of these patients are

²² Keith Horwood and Ron Yee Pariler, “The Nuts and Bolts of FTCA,” National Association of Community Health Centers, June 6th, 2014, <http://www.nachc.com/client/Nuts%20and%20Bolts%20of%20FTCA%20for%20New%20Medical%20Directors%20June%206%202013.pdf>.

U.S. citizens given known demographic information. Sommers and colleagues estimated the take up rates for the Medicaid expansion population in each state shortly before *NFIB v. Sebelius* (2012), which ruled that the “all or nothing” Medicaid expansion was not a valid exercise of Congress’ spending power. Given Virginia’s current strict eligibility for Medicaid, this was particularly devastating for the 400,000 estimated to be in the expansion population. The authors estimated a 50%-60% take up rate for Virginians newly eligible based on previous Current Population Surveys, namely the 2005-10 Annual Social and Economic Supplements.²³ Figure 1 demonstrates the lower bound 50% take up rate. Medicaid and Medicaid Dental patients would change from roughly 5% of patient share to over 30%. Furthermore, we do not account for the fact that Olde Towne shares the building of James City County’s Department of Social Services, which could very well increase the take up rate of that expansion population.

Figure 1: Medicaid Expansion Population as Percentage of Patient Visits



Source: Sommers and colleagues (2012), Olde Towne

While we currently know that levels B and C face \$10 and \$15 co-pays, it did not seem feasible to estimate how such a change from insured would affect expected patient revenue. “Back of the envelope” calculations are encouraging, especially for an FQHC. Assuming a 50% take up rate spread evenly across levels B and C, Medicaid expansion for Olde Towne as an FQHC would represent a “loss” of \$41,327.50 in patient income and a gain of between \$318,284 and \$572,309.60 in reimbursements. As an RHC, with expected reimbursements around \$65.06 for Medicaid patients, Medicaid expansion would mean a gain of around \$244,635.60.

Subsidiary Status

If Olde Towne were to find an FQHC willing to sponsor them as a subsidiary, they would have the opportunity to receive the generous reimbursements while accepting partial or no funds from the NAP grant. At this time our group is unaware of any such offer.

²³ Sommers, Benjamin D., Meredith Roberts Tomasi, Katherine Swartz, and Arnold M. Epstein. "Reasons for the wide variation in Medicaid participation rates among states hold lessons for coverage expansion in 2014." *Health Affairs* 31, no. 5 (2012): 909-919.

Conditional Recommendation

Given the encouraging results of the main cost-benefit analysis, we would encourage Olde Towne to begin their needs assessment and the application process to become an FQHC. This would require waiting for the next funding announcement issues by HRSA. If Olde Towne applies and is not awarded any funds, we would suggest they continue to operate as an RHC if possible. Any plans to become an FQHC subsidiary or the subsidiary of a larger medical provider would be at the discretion of the Board and would likely hinge on the terms offered, which fall outside the scope of this report.

Section III: Business Plan for an FQHC Conversion

Should Olde Towne receive HRSA funding, the next step would be to begin the FQHC conversion process. This process will have many steps that will occur over the next 18 to 24 months, so it is important to develop a time-framed work plan to ensure all tasks are being accomplished in a timely manner. If there are ever any questions along the way, the National Association of Community Health Centers is a great resource. Contacts for this report are listed under Appendix 2.

Needs Assessment

Olde Towne will be required to complete a needs assessment for their NAP grant application. This should also be a continuous process, regardless of status as an FQHC. NACHC provides a useful guide to organize primary data and typical secondary data sources.²⁴

Administration

It is recommended that Olde Towne consider hiring a consultant to work with them throughout this entire conversion process. While it would be an additional cost, a consultant would serve as a valuable resource throughout the process.²⁵

It is expected that its employees understand the policies and procedures of Olde Towne. If HRSA determines that new staff members need to be hired, it is important for Olde Towne to spend time training its members to ensure a high quality of service and high employee morale. Useful tools for new employees include an employee handbook to outline life as an Olde Towne employee, allowing new employees to shadow current staff and ask questions, and finally to provide an orientation day to review handbook materials. It can be hard to attract medical professionals to clinics in underserved areas, so some benefits that may attract qualified candidates are:²⁶

- Health insurance

²⁴ Pamela Byrnes, Jennifer Jones Santos, and Judith Shea, "Community Needs Assessment and Data-Supported Decision Making: Keys to Building Responsive and Effective Health Centers," November 2012, <http://www.nachc.com/client/documents/2012%20Data%20Supported%20Decision%20Making.pdf>.

²⁵ "The Clinic's Tale: Chasing FQHC Status Not for the Faint-Hearted." *California HealthCare Foundation*, 2012.

²⁶ Byrnes, Pamela, and Jaime Hirschfeld. "Funded! Now What?" *National Association of Community Health Centers*, 2011, 30.

- Dental insurance
- Life insurance
- Disability insurance
- Vision coverage
- Retirement or pension plan
- Tax-deferred annuity
- Vacation
- Holidays
- Sick leave
- Leave without pay
- Military leave
- Bereavement leave
- Maternity/paternity/adoption leave
- Educational leave (CME or CE)
- Sabbatical leave
- Compensatory time off
- Payment for jury duty
- Professional licensing fees
- Membership dues to professional societies
- Reimbursement for professional textbooks, manuals and journals
- Conference registration, travel and per diem for professional meetings
- Allowance for tuition, travel and per diem related to CME/CE
- Automobile expenses
- Cellular phone/smart phone

Governance

The board needs to be comprised of 51% patients of the center, and the limit on board size is 25 members. HRSA designates that a “patient” of the center is someone who uses its services as their principal source of primary healthcare. If Olde Towne feels that they need an exemption for this requirement, they have the ability to apply for a waiver for this request. However, this is mainly used when clinics are serving a medically underserved population that is predominately homeless, mentally ill, migratory, etc. It is unlikely that Olde Towne would be granted this exemption.²⁷

According to NACHC, Olde Towne will need to recruit patient board members that:²⁸

1. Have clarity on the mission and values of Olde Towne
2. Participate actively and attends calls and meetings consistently
3. Engage in healthcare policy discussion at the state, regional and national level
4. Are active on committees and subcommittees – these are training grounds for new board leadership
5. Come to board and committee meetings prepared
6. Are in tune with the needs of the community

²⁷ Ibid., 8

²⁸ Ibid, 7

7. Have the ability to evaluate relevance and the application of emerging issues to the work of the board
8. Articulate the voice of the customer (i.e. patients and community), and service as an advocate for stakeholder groups
9. Maintain confidentiality
10. Understand how to channel and direct complaints
11. Are able to manage the conflict between individual values/ interests and those of the health center

A good way to plan for unexpected board changes is to consistently advertise to potential board members. Board suggestions can come from both board members and staff. Suggested individuals can gain loyalty for the center through discussions with staff and board members, lunch meetings, tours of the clinic, and visits to board meetings. Potential recruits can also serve as non-voting members of the board to shadow the members.

If a new board member has not shadowed the board in the past, an orientation is crucial to ensure that the members are brought up to speed immediately. A Board Development Committee should be composed to develop a board member handbook that includes:²⁹

- Bylaws
- Articles of incorporation
- A thorough description of programs and services
- Overview of Health Center Program Requirements
- The current budget, last audited financial statements
- A list of board members and their addresses
- Lists of committees and any staff assignments
- Copies of minutes for the previous year
- A copy of the organization's strategic plan

In addition to the Board Development Committee, other committees should be formed to ensure that the board is completing all of its required tasks. This allows for committees to share consolidated information during group meetings, and cuts down on discussion time. Some suggested committees are:³⁰

- Board Development
- Quality Assurance
- Executive
- Finance
- Fundraising
- Marketing
- Personnel
- Public Relations

Boards should also not be afraid to establish temporary committees if unique issues arise.

²⁹ Ibid., 9-10

³⁰ Ibid., 10

Finance

HRSA requires that FQHCs maintain accounting and internal control systems appropriate to the size and the complexity of the organization. It also requires that a system be in place to maximize collections and reimbursement for costs in providing health services. In order to meet these two requirements, Olde Towne needs to ensure that its finance department:³¹

- Ensures that adequate financial controls are in place
- Produces annual budgets that reflect goals and policies
- Includes board approval of financial reports and investment policies
- Requires monthly and quarterly review of financial reports
- Requires review of audited statements
- Requires review and revision of the budget periodically
- Includes monitoring of organization's cash flow
- Documents all financial policies and procedures
- Requires board members to be well-informed about organization's finances

FQHCs are required to report to the following agencies on a regular basis:³²

- Bureau of Primary Health Care
- State and Local Funding Agencies
- Medicaid/ Medicare Cost Reports
- Tax Returns – IRS
 - Form 990
 - Form 5500
 - State/ Local Tax Authorities

In addition to these agencies, the Board should be kept up to date on the financial status.

FQHCs are required to submit Uniform Data System (UDS) reports annually in the first quarter of the year.³³ The data is reviewed to make sure that Olde Towne is complying with regulations, improving the Center's performance, and is improving the health of the general Williamsburg population.

Olde Towne also will need to have an OMB A-133 audit if Olde Towne receives more than \$500,000 in federal funds per year.³⁴ The Board can serve as a resource to find an auditor for this requirement.

According to the Section 330 statute, FQHCs must have a sliding fee pay schedule that is available for all individuals and families that have an annual income of below 200% of the federal poverty line. Individuals and families with annual incomes of at or below 100% of the federal poverty line must receive a full 100% discount.³⁵

³¹ Ibid., 42

³² Ibid., 44

³³ Ibid., 46

³⁴ Ibid.

³⁵ Ibid., 51

Clinical

FQHCs are required to submit Quality Assurance and Quality Improvement plans that include:³⁶

- Patient satisfaction and access
- Quality of clinical care
- Quality of the work force and work environment
- Cost and productivity
- Health status outcomes
- Performance measurements using standard performance measures and accepted scientific approaches that compares results with comparable providers serving similar populations at the state and national level
- Improvement goals and progress
- Responses to advances or changes in clinical care
- Utilization management and maximizing value, quality improvement of appropriate specialty, pharmacy, hospital and other services

FQHCs are eligible to participate in the 340B Drug Pricing Program if they run an operational pharmacy. It is estimated that Olde Towne can save 20% to 50% on pharmaceuticals for their patients.³⁷ This function does not have to be enacted right away. Olde Towne can add the benefit on a quarterly basis when their pharmacy is up and running.

Clinical Operations

Olde Towne will be required to submit an annual report to HRSA involving demographic data on patients, operations data, financial information including revenues, clinical and financial measures and other indicators on conversion progress. In order to comply with this requirement, the Center should ensure that the consultant or another staff member retain this information for easy access.

³⁶ Ibid., 61

³⁷ Ibid., 21

Appendix 1: FQHC Program Requirements

According to HRSA, there are 19 requirements that must be met in order to obtain FQHC status. These requirements are divided four categories and listed below (Note: the primary source for the list below is HRSA, but references to the Public Health Service Act and the Code of Federal Regulations have also been included where applicable).³⁸

Need

1. Needs Assessment – FQHCs must demonstrate and document the needs of its target population and update its service area when appropriate.^{39, 40}

Services

2. Required and Additional Services – FQHCs must provide all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals.⁴¹ Required services include: medical social services, nutritional assessment, preventative health education, children’s eye and ear examinations, well child care, immunizations, voluntary family planning, blood pressure measurement, weight measurement, physical examination targeted to risk, visual acuity screening, hearing screening, cholesterol screening, stool testing for occult blood, tuberculosis testing for high risk patients, dipstick urinalysis, risk assessment and counseling, prenatal and postpartum care, prenatal services, clinical breast exam, referral for mammography, and thyroid function test.⁴² In addition, centers that request funding to serve the homeless must provide substance abuse services.⁴³
3. Core Staff – FQHCs must maintain a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals (all medical staff must be appropriately licensed, credentialed, and privileged).^{44, 45, 46, 47}
4. Accessible Hours of Operation and Location – FQHCs must provide services at times and locations that assure accessibility and meet the needs of the population to be served.⁴⁸

³⁸ “Program Requirements,” *Health Resources and Services Administration*, Accessed December 1, 2015, <http://www.bphc.hrsa.gov/programrequirements/index.html>

³⁹ 42 U.S.C §254b(k)(2)

⁴⁰ 42 U.S.C §254b(k)(3)(J)

⁴¹ 42 U.S.C §254b(a)

⁴² 42 U.S.C §254b(a)

⁴³ 42 U.S.C §254b(h)(2)

⁴⁴ 42 U.S.C §254b(a)(1)

⁴⁵ 42 U.S.C. §254b(b)(1)-(2)

⁴⁶ 42 U.S.C. §254b(k)(3)(C)

¹² 42 U.S.C. §254b(k)(3)(I)

⁴⁸ 42 U.S.C. §254b(k)(3)(A)

5. After-Hours Care – FQHCs must provide professional coverage for medical emergencies during hours when the center is closed.^{49, 50}
6. Hospital Admitting Privileges and Continuum of Care – FQHCs must have admitting privileges at one or more referral hospitals or make other such arrangements to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking.⁵¹
7. Sliding Fee Discounts – FQHCs must determine eligibility for patient discounts adjusted on the basis of the patient’s ability to pay. FQHCs must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged). For those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income. No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines. No patient will be denied health care services due to an individual’s inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived.^{52, 53, 54}
8. Quality Improvement/Quality Assurance Planning – FQHCs must have an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include:^{55, 56}
 - a. A clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;
 - b. Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall:
 - i. Be conducted by physicians or by other licensed health professionals under the supervision of physicians;
 - ii. Be based on the systematic collection and evaluation of patient records; and
 - iii. Identify and document necessary changes in the provision of services by the health center as a result of the QI/QA program.

⁴⁹ 42 U.S.C. §254b(k)(3)(A)

⁵⁰ 42 C.F.R. 51c.102(h)(4)

⁵¹ 42 U.S.C. §254b(k)(3)(L)

⁵² 42 U.S.C. §254b(k)(3)(G)

⁵³ 42 C.F.R. 51c.303(f),

⁵⁴ 42 C.F.R. 51c.303(u)

⁵⁵ 42 U.S.C. §254b(k)(3)(C)

⁵⁶ 42 CFR 51c.303(c)(1-2)v

Management and Finance

9. Key Management Staff – FQHCs must maintain a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director, Executive Director, or CEO position is required.^{57, 58, 59}
10. Contractual/Affiliation Agreements – FQHCs must exercise appropriate oversight and authority over all contracted services. FQHCs must also ensure that any subsidiary(s) and or sub-recipient(s) meet FQHC program requirements.^{60, 61, 62, 63, 64}
11. Collaborative Relationships – FQHCs must establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing FQHCs and FQHC Look-Alikes in the service area or provides an explanation for why such letter(s) of support cannot be obtained.^{65, 66}
12. Financial Management and Control Policies – FQHCs must maintain accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and must separate functions appropriate to organizational size to safeguard assets and maintain financial stability. FQHCs must assure an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses.^{67, 68, 69}
13. Billing and Collections – FQHCs must have systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.^{70, 71}

⁵⁷ 42 U.S.C. §254b(k)(3)(I)

⁵⁸ 42 C.F.R. 51c.303(p)

⁵⁹ 45 C.F.R. 75.308(c)(2)(3)

⁶⁰ 42 U.S.C. §254b(k)(3)(I)(ii)

⁶¹ 42 C.F.R. 51c.303(n)

⁶² 42 U.S.C. §1395x(aa)(4)

⁶³ 42 U.S.C. 1396d(l)(2)(B)

⁶⁴ 45 C.F.R. 75

⁶⁵ 42 U.S.C §254b(k)(3)(B)

⁶⁶ 42 C.F.R. 51c.303(n)

⁶⁷ 42 U.S.C. §254b(k)(3)(D)

⁶⁸ 42 U.S.C §254b(q)

⁶⁹ 45 C.F.R. 75.300-309, Subparts E and F

⁷⁰ 42 U.S.C. §254b(k)(3)(F)

⁷¹ 42 U.S.C. §254b(k)(3)(G)

14. FQHCs must develop a budget that reflects the costs of operations, expenses, and revenues (including the federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served.^{72, 73, 74, 75}
15. Program Data Reporting Systems –FQHCs must implement systems that accurately collect and organize data for program reporting and to support management decision making.^{76, 77}
16. Scope of Product – An FQHC must maintain its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards.⁷⁸

Governance

17. Board Authority – FQHC governing boards must maintain appropriate authority to oversee the operations of the center, including:^{79, 80, 81}
 - a. Holding monthly meetings;
 - b. Approval of the health center grant application and budget;
 - c. Selection and dismissal and performance evaluation of the health center Project Director, Executive Director, or CEO;
 - d. Selection of services to be provided and the health center hours of operations;
 - e. Measuring and evaluating the organization’s progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization’s mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance; and
 - f. Establishment of general policies for the health center.

Note: In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center.

⁷² 42 U.S.C. §254b(k)(3)(D)

⁷³ 42 U.S.C. §254b(k)(3)(I)(i)

⁷⁴ 45 C.F.R. 75.308

⁷⁵ 45 C.F.R. 75 Subpart E

⁷⁶ 42 U.S.C. §254b(k)(3)(I)(ii)

⁷⁷ 45 C.F.R. 75.342

⁷⁸ 45 CFR 75.308

⁷⁹ 42 U.S.C. §254b(k)(3)(H)

⁸⁰ 42 CFR 51c.304

⁸¹ CFR 51c.304(d)(iii)-(iv)

18. Board Composition – FQHC governing boards must be composed of individuals, a majority of whom are being served by the center and, this majority as a group must be representative of the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically:^{82, 83}
- a. Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.
 - b. The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.
 - c. No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.

Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to Section 330(g), Section 330(h), Section 330(i), or Section 330(p) of the Public Health Service Act. These subsections refer to special grants for the planning and delivery of services to a special medically underserved population comprised of migratory or seasonal agricultural workers, homeless individuals, residents of public housing, or individuals living in sparsely-populated rural areas.^{84, 85, 86, 87}

19. Conflict of Interest Policy – FQHC bylaws or written corporate board approved policy must include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center. No board member shall be an employee of the health center or an immediate family member of an employee. The Project Director, Executive Director, or CEO may serve only as a non-voting ex-officio member of the board.^{88,89}

⁸² 42 U.S.C. §254b(k)(3)(H)

⁸³ 42 CFR 51c.304

⁸⁴ 42 U.S.C. §254b(g)

⁸⁵ 42 U.S.C. §254b(h)

⁸⁶ 42 U.S.C. §254b(i)

⁸⁷ 42 U.S.C. §254b(p)

⁸⁸ 45 CFR 75.327

⁸⁹ 42 CFR 51c.304(b)

Appendix 2: Industry Interviews

National Association of Community Health Centers

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42 C.F.R. 51

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