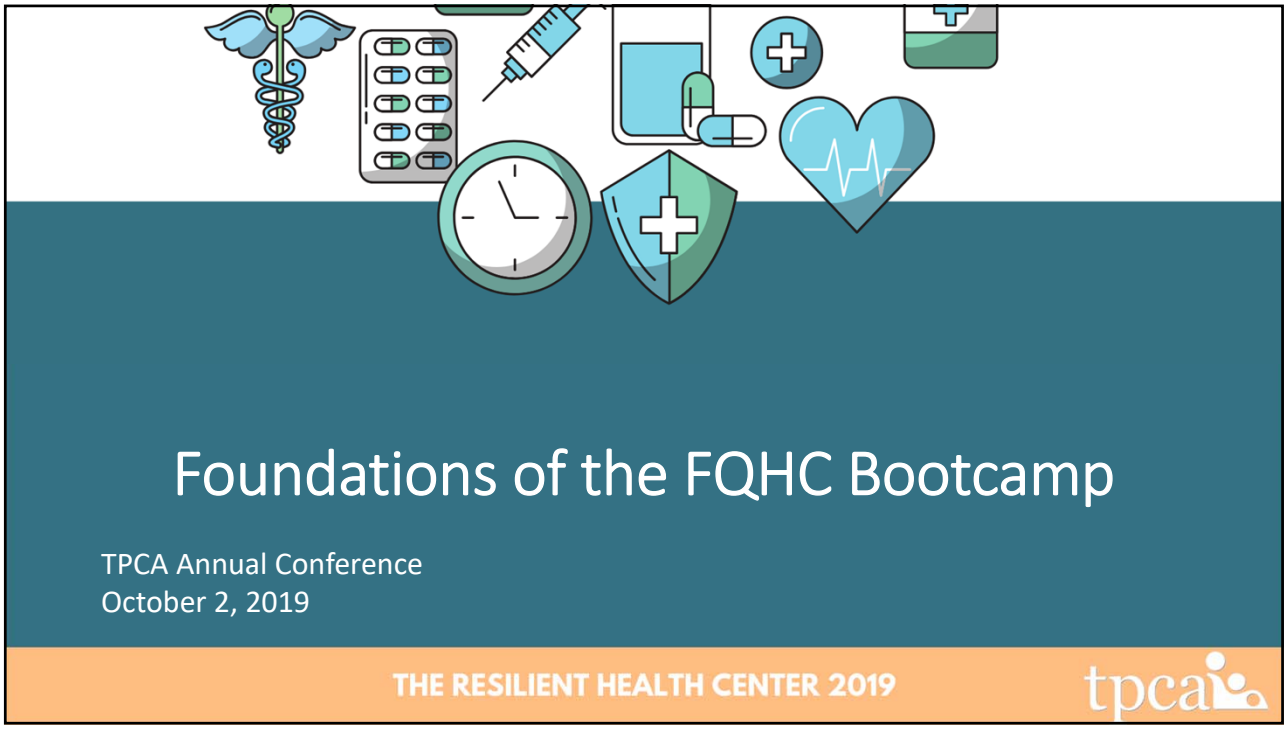
Foundations of the FQHC Bootcamp
TPCA Annual Conference
October 2, 2019
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Welcome and Introductions
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Disclaimers

- This presentation is not endorsed by Management Strategists Consulting Group (MSCG)
- This presentation is not endorsed by Health Resources Services Administration (HRSA) or Bureau of Primary Health Care (BPHC)
- Not employed by MSCG or BPHC
- Independent Consultant who is contracted to do Operational Site Visits (OSV)s and Technical Assistance (TA)

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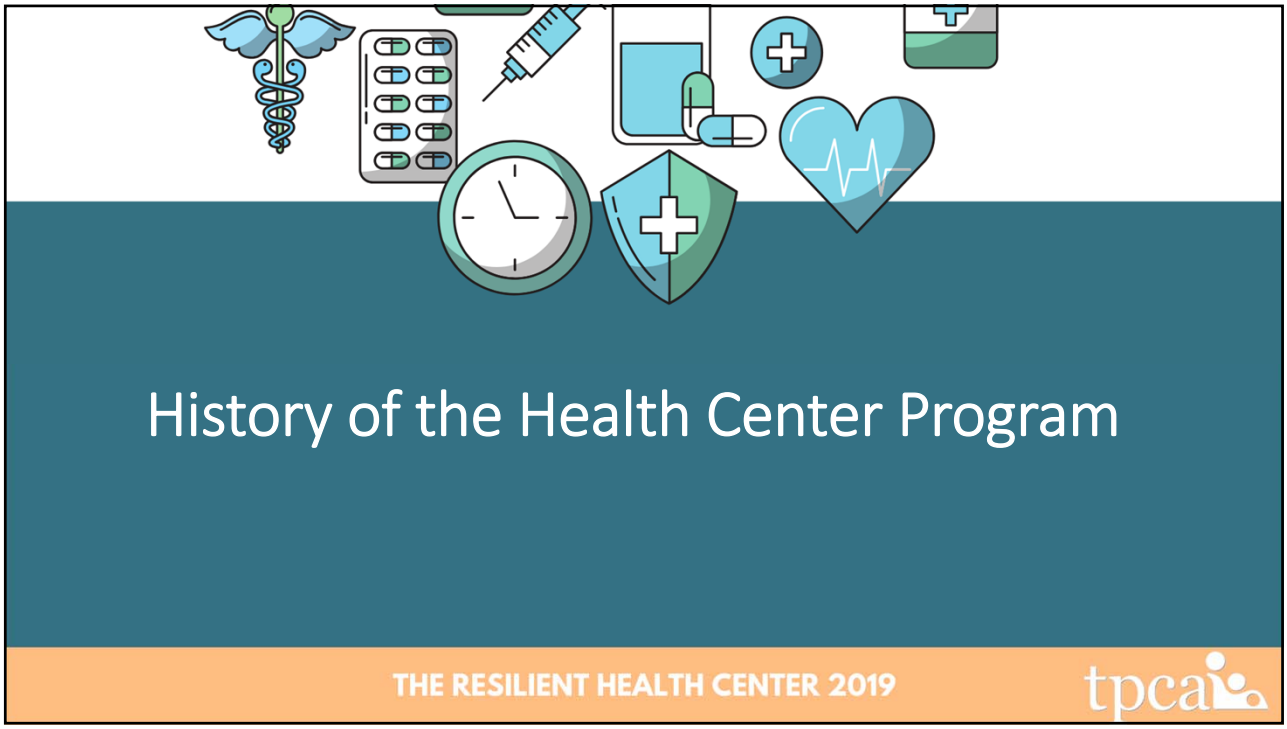
Purpose of the Bootcamp

- Provide foundational training to equip attendees with the building blocks required to learn and understand the Health Center Program.
- Provide information to assist attendees in recognizing the health center program structure, intentions and requirements.
- Assist new and existing health center staff in generally understanding the Health Center Program so they can contribute to the operational excellence and resiliency of their health center.

Available Resources

- HRSA Health Center Program Compliance Manual
- HRSA Site Visit Protocol
- Form 5A
- Service Descriptors
- Sample Budget


History of the Health Center Program
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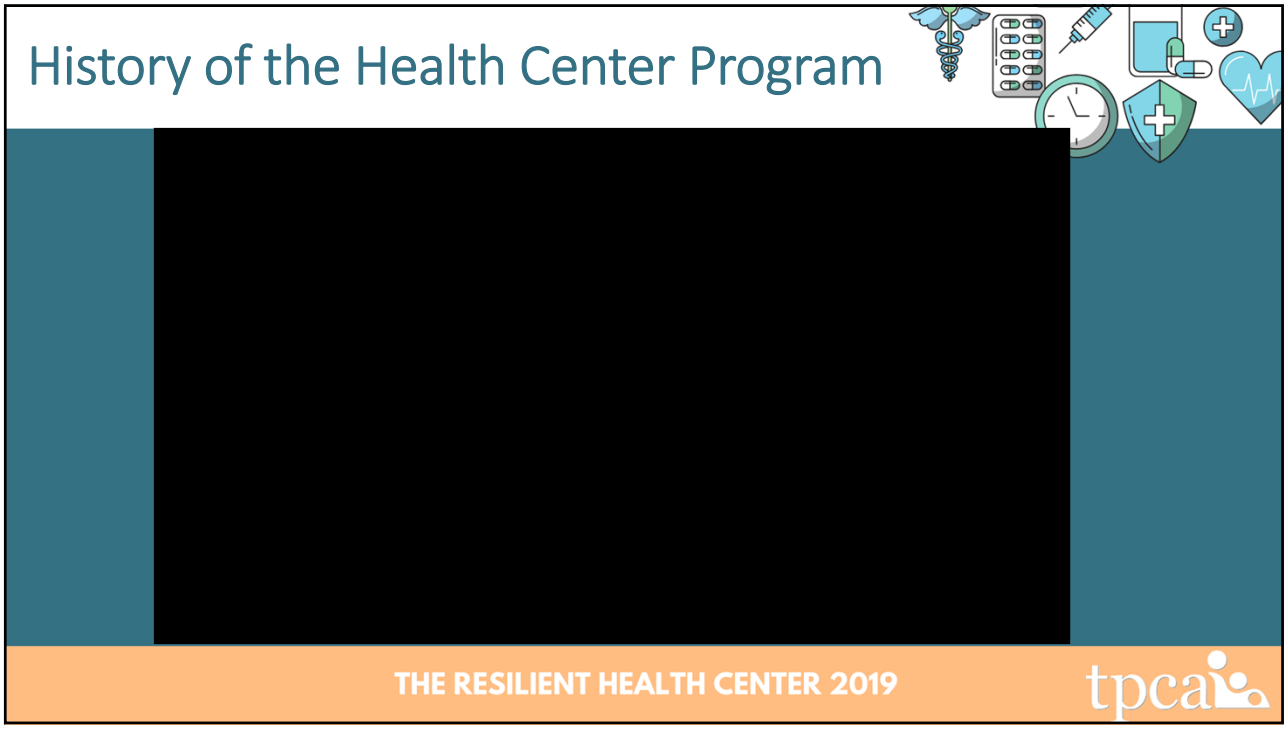
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What is a Federally Qualified Health Center?
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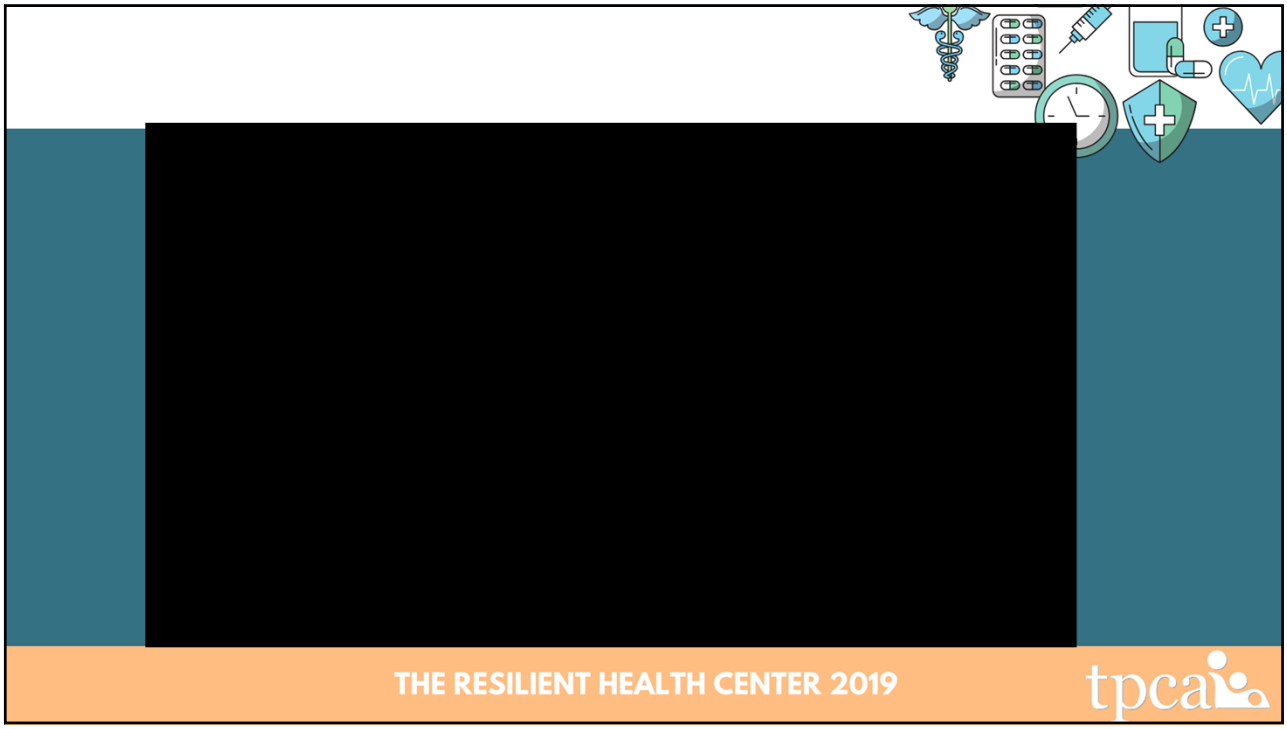
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Health Center Program Fundamentals

- Deliver high quality, culturally competent, comprehensive primary care, as well as supportive services such as health education, translation, and transportation that promote access to health care.
- Provide services regardless of patients' ability to pay and charge for services on a sliding fee scale.
- Operate under the direction of patient-majority governing boards of autonomous community-based organizations. These include public and private non-profit organizations and tribal and faith-based organizations.
- Develop systems of patient-centered and integrated care that respond to the unique needs of diverse medically underserved areas and populations.
- Meet requirements regarding administrative, clinical, and financial operations.

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How Health Centers Work

- Receive Health Center Program Federal grant funding to improve the health of underserved and vulnerable populations.
- Some additionally receive funding to focus on special populations or special issues.
- Majority of health center operating funds come from Medicaid, Medicare, private insurance, patient fees, and other resources
- Deliver coordinated and comprehensive primary and preventative services
- Reduce health disparities by emphasizing care management of patients with multiple health care needs and the use of key quality improvement practices

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How Health Centers Work

- Some health centers meet all program requirements but do not receive federal health center program funding; these are called Health Center Program Look-Alikes (LALs).
- Health centers receiving federal grant funding may gain access to medical malpractice coverage under Federal Tort Claims Act (FTCA).
- Some may receive federal loan guarantees for capital improvements.

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How Health Centers Work

- All health centers, including look-alikes, gain access to:
  - Federally Qualified Health Center Prospective Payment System reimbursement for services to Medicare and Medicaid beneficiaries;
  - 340B Drug Pricing Program discounts for pharmaceutical products;
  - Free vaccines for uninsured and underinsured children through the Vaccine for Children Program; and
  - Assistance in the recruitment and retention of primary care providers through the National Health Service Corps.

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The Health Center Program Impact

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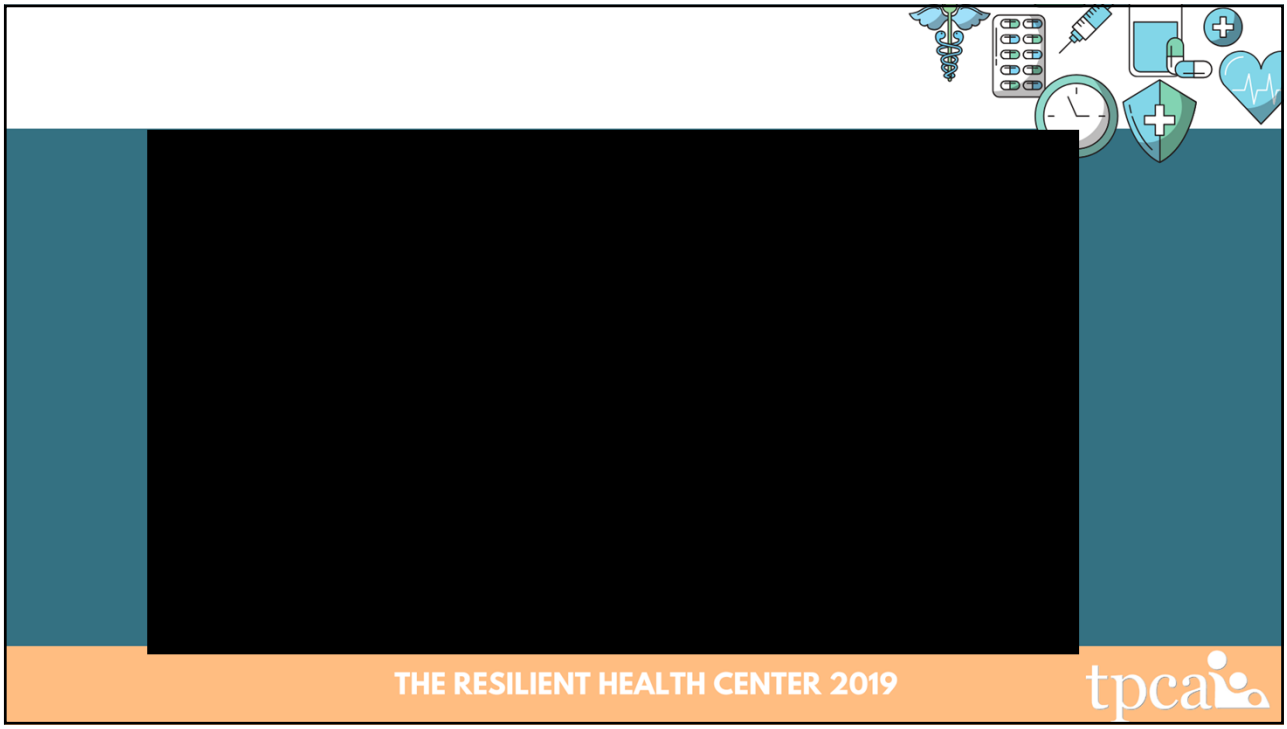
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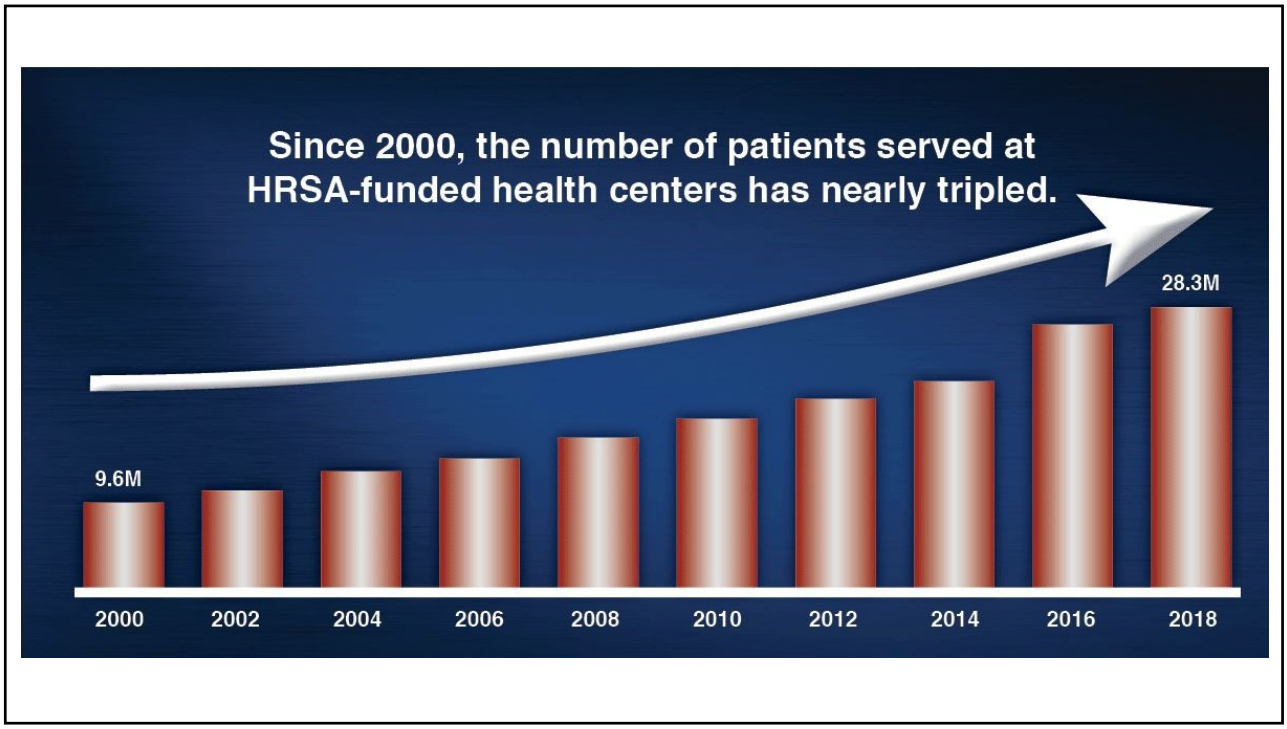
More than 28 million people rely on a HRSA-funded health center for care, including:
1 in 12 PEOPLE
1 in 9 CHILDREN
1 in 5 RURAL RESIDENTS
1 in 3 LIVING IN POVERTY
more than 385K VETERANS
more than 800K SERVED AT SCHOOL-BASED HEALTH CENTERS
nearly 1M AGRICULTURAL WORKERS
about 4.5M LIVING IN OR NEAR PUBLIC HOUSING


Since 2000, the number of patients served at HRSA-funded health centers has nearly tripled.
9.6M
28.3M
2000
2002
2004
2006
2008
2010
2012
2014
2016
2018


Statutes and Regulations that Govern the Health Center Program
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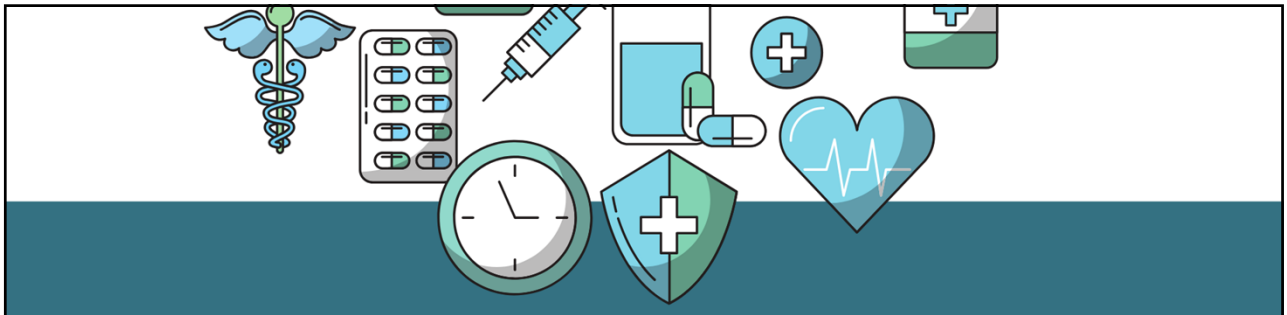
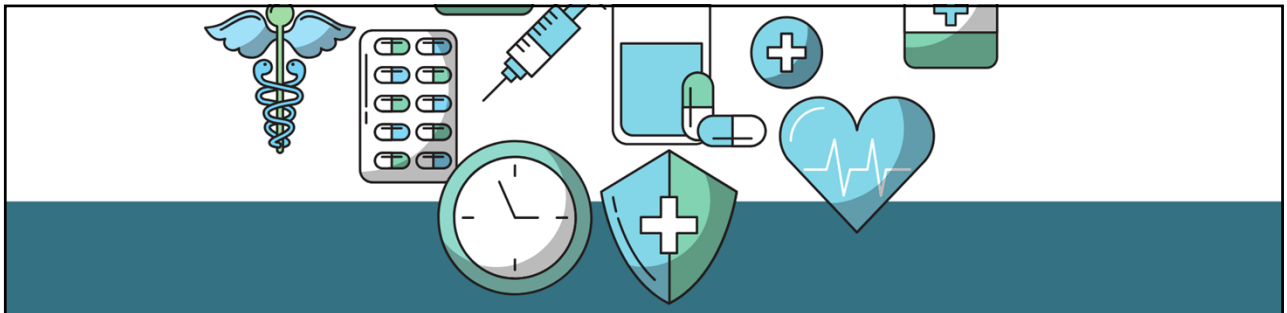
Statutes and Regulations

- Health Center Program Statute: Section 330 of the Public Health Service Act (42 U.S.C 254b)
- Health Center Program Regulations
  - 42 CFR 51c
  - 42 CFR 56.201 – 56.604
- Grant Regulations
  - Uniform Administrative Requirements for HHS Awards: 45 CFR 75



Health Center Program Fundamentals



The "Community" in Community Health Center: The Governing Board of Directors

HRSA Compliance Manual Chapters 3 and 20

Covered in this Section

- Needs Assessment (Chapter 3)
- Board Composition (Chapter 20)

Both of these chapters encompass content that HRSA has determined demonstrate in-depth knowledge of the community of need and committment to community/patient linkage at the governance level.

Chapter 3: Needs Assessment
Why is the Needs Assessment Important?

- Demonstrates an in-depth knowledge of the community
- Informs the understanding of high-priority needs
- Informs the design and organization of the delivery system
- Informs the development of the clinical services
- Provides focus for the organization
- Serves as the basis of the HRSA applications and strategic planning

Chapter 3: Needs Assessment Geographic Boundaries

Requirements

- The health center **must define and annually review the boundaries of the catchment area to be served** [service area], including the identification of the medically underserved population or populations within the catchment area in order to ensure that the:
  - **Size of this area is such that the services** to be provided through the center (including any satellite service sites) are **available and accessible to the residents of the area promptly** and as appropriate;
  - **Boundaries** of such area **conform**, to the extent practicable**, to relevant boundaries** of political subdivisions, school districts, and areas served by Federal and State health and social service programs; and
  - **Boundaries of such area eliminate, to the extent possible, barriers** resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation.

Chapter 3: Needs Assessment Target Population Characteristics

Requirements (continued)

• The health center must **assess the unmet need for health services** in the catchment or proposed catchment area of the center based on the population served, or proposed to be served, utilizing, but not limited to, the following factors:

◦ **Available health resources in relation to the size of the area and its population,** including appropriate ratios of primary care physicians in general or family practice, internal medicine, pediatrics, or obstetrics and gynecology to its population;

◦ **Health indices for the population of the area**, such as infant mortality rate;

◦ **Economic factors** affecting the population's access to health services, such as percentage of the population with incomes below the poverty level; and

◦ **Demographic factors** affecting the population's need and demand for health services, such as percentage of the population age 65 and over.

Chapter 3: Determining Compliance Period Update

- Does the health center **utilize patient origin data to identify and review its service area** (as reflected by the zip codes included in the Form 5B site entries)?
- Is this service area review process completed at least **annually**?
- Does the health center complete or **update a needs assessment of the current population at least once every three years**?
- Is the needs assessment **based on the most recently available data** for the service area and, if applicable, special populations?
- Was the health center able to provide **at least one example of how it utilized the results** of its needs assessment(s) to inform and improve the delivery of health center services?

Chapter 20: Board Composition

HRSA insures the Board represents the patients and community by establishing expectations concerning:

- Board Member Selection and Removal
- Required Board Composition
- Current Board Composition
- Prohibited Board Members
- Waiver Requests
- Utilization of Special Population Input

Chapter 20: Required Board Composition (Bylaws/Articles of Incorporation)

- Independently Selects Members
- At Least 9 and No More Than 25
- At Least 51% Patients
- Patient Members Represent Those Served(Race, Ethnicity, and Gender)
- Non-patients Represent the Community (Svc. Area)(Relevant Expertise and Skills)
- Non-patients: Limits on income from health care
- Not Employee and Not Related to Employee

Chapter 20: Confirm Patient Majority Board Composition

- At least one in-scope service at an in-scope site within the past 24 months that generated a health center visit
- Verify Documentation of Patient Status
- Verify Special Population Representative, if applicable.

Chapter 20: Do Patient Members Represent Those Served?

- Use Information from Most Recent UDS
- Develop Race, Ethnicity, and Gender Profile
- Compare Actual Patient Members to UDS-based Profile
- Report to the Board and Document Discussion

Chapter 20: Do Non-Patient Members Represent the Community?

- Verify Who Lives or Works in the Service Area
- If No, Verify "Demonstrable Connection" to Svc. Area
- Confirm Relevant Skills and Expertise
- Confirm Who Earns More Than 10% of Income from the Health Care Industry (no more than half of non-patients)

Chapter 20: Policy Defining Health Care Industry and Collection of Income Information

Governance Policy Example

Policy title: Employment and Income from the health care industry

No more than one-half of non-patient board members may derive more than 10% of their annual income from the health center industry.

For purposes of the health center board composition at XYZ Health Center, the health care industry is defined as being comprised of providers of diagnostic, preventive, remedial, and therapeutic services such as doctors, nurses, hospitals and other private, public, and voluntary organizations. It also includes medical equipment and pharmaceutical manufacturers and health insurance firms.

XYZ Health Center relies on self-reporting by its board members of employment and percentage of annual income to verify and confirm compliance with this policy. Annually, the health center will obtain verification from board members.

Chapter 20: Verify Status and Relationships to Employees

- Verify Representative of Special Population (homeless, migrant, public housing)
- Obtain Verification Prior to Election to the Board (Board Member Application or Profile)
- Verify annually thereafter (Annual Profile Update)
- Maintain Applications and Profiles in Permanent Files

EXAMPLE OF

HEALTH CENTER BOARD MEMBER ANNUAL PROFILE and SELF-DISCLOSURE

Name: _____ Date: _____

Home Address: _____

Employer: _____

Work Address: _____

Health center employees and immediate family members (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage) of employees may not be health center board members.

Are you an employee of the health center: Yes _____ No _____

Are you related to an employee of the health center as defined above: Yes _____ No _____

At least 51 percent of board members are patients served by the health center. For the purposes of board composition, a patient is an individual who has received at least one service in the past 24 months that generated a health center visit, where both the service and the site where the service was received are within the HRSA-approved scope of project.

Have you been a patient of the health center within the past 24 months: Yes _____ No _____

Patient members of the board, as a group, reasonably represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender.

Race: _____ Ethnicity: _____Gender: _____

The questions below must be completed if you are not a current health center patient.

As applicable, non-patient board members are:

- **representative of the community in which the health center is located, either by living or working in the community, or by having a demonstrable connection to the community;**
- **have relevant skills and expertise in areas such as community affairs, local government, finance and banking, legal affairs, trade unions, other commercial and industrial concerns, or social services within the community; and**
- **no more than 50 percent earn more than 10 percent of their annual income from the health care industry.**

The service area of the health center is composed of the zip codes included on the attached list.

Do you live in the defined service area: Yes _____ No _____

Do you work in the defined service area: Yes _____ No _____

If you do not live or work in the service area, describe your demonstrable connection to the community:

_____

_____

Relevant skills or expertise you bring to the health center:

_____

_____

For purposes of the health center board composition at XYZ Health Center, the health care industry is defined as being comprised of providers of diagnostic, preventive, remedial, and therapeutic services such as doctors, nurses, hospitals and other private, public, and voluntary organizations. It also includes medical equipment and pharmaceutical manufacturers and health insurance firms.

XYZ Health Center relies on self-reporting by its board members of employment and percentage of annual income to verify and confirm compliance with this policy. Annually, the health center will obtain verification from board members.

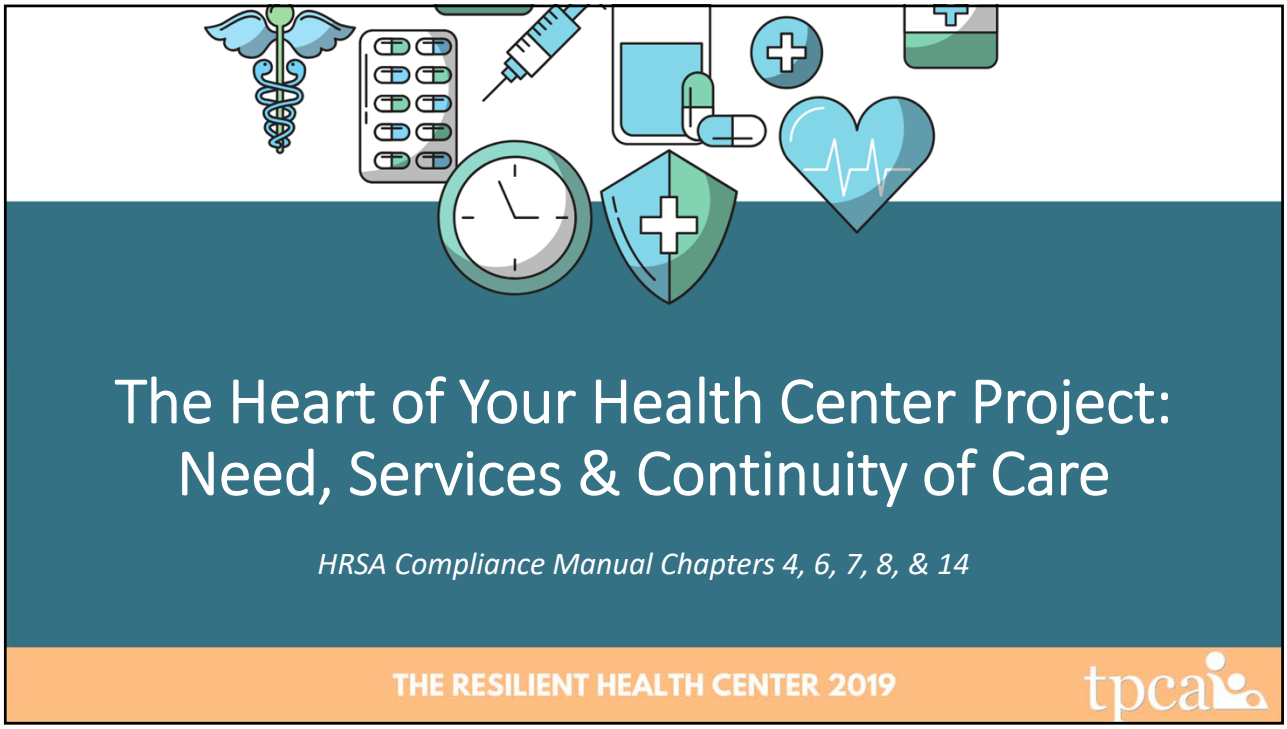
Are you employed in the health care industry as it is defined above: Yes _____ No _____

Do you earn more than 10% of your annual income from the health care industry:

Yes _____ No _____

_____ _____

Signature Date



The Heart of Your Health Center Project: Need, Services & Continuity of Care

HRSA Compliance Manual Chapters 4, 6, 7, 8, & 14

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Covered in this Section

- Accessible Locations and Hours of Operation (Chapter 6)
- Required and Additional Services (Chapter 4)
- Coverage for Medical Emergencies (Chapter 7)
- Continuity of Care and Hospital Admitting (Chapter 8)
- Collaborative Relationships (Chapter 14)

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Chapter 6: Accessible Locations & Hours of Operation

Requirements

- The health center's service site(s) are **accessible to the patient population relative to where this population lives or works** Specifically, the health center considers the following factors to ensure the accessibility of its sites:
  - **Access barriers** (for example, barriers resulting from the area's physical characteristics, residential patterns, or economic and social groupings); and
  - **Distance and time taken** for patients to travel to or between service sites in order **to access the health center's full range of in-scope services**.

Chapter 6: Accessible Locations & Hours of Operation

Requirements (continued)

- The health center's **total number and scheduled hours of operation** across its service sites are **responsive to patient needs** by facilitating the ability to schedule appointments and access the health center's full range of services within the HRSA-approved scope of project
- The health center **accurately records the sites** in its HRSA-approved scope of project on its **Form 5B**: Service Sites in HRSA's Electronic Handbooks (EHB).

Chapter 6: Accessible Locations & Hours of Operation

- Logic and rationale for the locations
- Logic and rationale for services located at each location
- Accuracy of Form 5b

Chapter 6: Accessible Locations & Hours of Operation

All Services Available to All Patients

- Access Barriers/Needs Assessment
- Time and Distance for Travel

Hours of Operation

- Patient Needs/Needs Assessment
- Patient Opinion

Annual Review of Locations, Hours of Operation, and Accessibility of Services to All Users including Special Populations

Location Name	7th St. Health Center	Ash Lawn Health Cntr	Millington Health Center
Address	2952 S. 7th St. Memphis TN 38109	5496 Shelby Dr Memphis TN 38117	321 Main St Millington TN 38053
Days and Hours	M-W, F 8AM-4PM TH 8 AM-8PM SAT 8AM-Noon 48 hours/week	M 8AM-8PM T-F 8AM-5PM SAT 9AM-1PM 52 hours/week	M 8AM-8PM W,F 8AM-Noon 20hours/week
Required Services			
General Primary Medical Care	X	X	X
Diagnostic Laboratory	X	X	X
Diagnostic Radiology	XYZ Imaging Cntr 3.5 miles	XYZ Imaging Cntr 7.25 miles	Flynn's Imaging Co-located with health center
Screenings	X	X	X
Coverage for Emergencies During and After Hours	Answering Svc/On Call MD ; Med Cntr ER 4.25 miles	Answering Svc/On Call MD ; St. James ER 2.25 miles	Answering Svc/On Call MD ; Med Cntr ER 15 miles
Voluntary Family Planning	X	X	X
Immunizations	X	X	X
Well Child Services	X	X	X
Gynecological Care	X	X	X
Obstetrical Care			

Has the health center taken patient needs into consideration in setting the hours of operation of its sites (e.g., within available resources, the hours correspond to most requested appointment times or align with the most in-demand services)?

- Patient Satisfaction Results (info documented in Board minutes)
- User/Patient Board Members (input documented)
- Focus Groups/Interviews (info documented in Board minutes)

Confirm Accuracy of Form 5b

- Physical Site Address
- Hrs. of Operation
- Svc Area Zip Codes

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Chapter 4: Required and Additional Services

- Ensure programs align with scope on Form 5A (Together with MOUs)

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Chapter 4: Required and Additional Services

- Ensure programs align with scope on Form 5A (Together with MOUs)
- Does the health center maintain formal written contracts/agreements for services listed in Columns II and II?
- Do the contracts document how the health center will pay for the service (Column II) and how it will be documented in the record?
- Ensure referral processes in place (making, management, tracking)
- Ensure interpretation and/or appropriately-translated documents in place for all areas in scope
- Provide cultural competency training to staff and ensure able to demonstrate culturally-competent care.

Chapter 4: Required and Additional Services

- **Required Services**
  - General Primary Medical Care
  - Diagnostic Laboratory
  - Diagnostic Radiology
  - Screenings
  - Coverage for Emergencies During and After Hours
  - Voluntary Family Planning
  - Immunizations
  - Well Child Services
  - Gynecological Care
- OB-Prenatal Care
- OB-Intrapartum Care (L&D)
- OB-Postpartum Care
- Preventive Dental
- Pharmaceutical Services
- Case Management
- Eligibility Assistance
- Health Education
- Outreach
- Transportation
- Translation

Chapter 4: Required and Additional Services

- **Service Delivery Types**
  - Direct Services (W-2 Employee)
  - Contracted Services (Another entity provides services, health center pays)
  - Referral Arrangement (Another entity provides services, entity pays/bills)

Chapter 4: Required and Additional Services

- **Key Take-Aways:**
  - Review Form 5A
  - Review Contracts MOU Agreements
  - Ensure all Services are Accessible (language, etc.)
  - Ensure cultural competency training is provided

Chapter 7: Coverage for Medical Emergencies

- Ensure that documentation is maintained indicating at least one staff member (trained in basic life support) is onsite at every HRSA-approved service delivery site whenever the site is open.
- Maintain operating procedures for responding to patient medical emergencies during regular hours and after normal business hours.
- Be prepared to give examples of how staff followed those procedures in responding to medical emergencies.
- Maintain information that is provided to all patients at all sites on how to access after-hours care (that has addressed barriers of language or literacy).

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Chapter 7: Coverage for Medical Emergencies

- Maintain an after-hours call program that:
  - Connects patients to an individual with the qualification and training necessary to exercise professional judgment to address an after-hours call;
  - Is able to refer patients to a covering licensed independent practitioner for further consultation and to locations such as emergency rooms or urgent care facilities for further assessment or immediate care, and;
  - Maintains provisions for calls received from patients with LEP.
- Maintain documentation of after-hours calls in the patient record.
- Ensure staff are providing necessary follow-up based on the nature of the after-hours calls.

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Chapter 7: Coverage for Medical Emergencies

- **Key Take-Aways:**
  - Ensure BLS staff are present when doors open
  - Maintain and practice emergency procedures
  - Inform patients about after-hours care
  - Frequently check after-hours call experience
  - Audit after-hours documentation and follow-up

Chapter 8: Continuity of Care & Hosp. Admit.

- Maintain hospital admitting privileges for health center providers and/or formal agreements with non-health center providers that address hospital admissions.
- Maintain internal operating procedures and/or arrangements with non-health center providers that address how the health center will obtain or receive patient/hospital visit-related info and record info in the EHR, as well as details on follow-up by the health center staff.
- Ensure staff are documenting medical info related to the hospital or ED visit (discharge follow-up, lab, radiology, other results) and follow-up actions.

Chapter 8: Continuity of Care & Hosp. Admit.

- **Key Take-Aways:**
  - Ensure documentation is flowing between hospital and health center
  - Audit documentation in medical record after hospitalizations

Chapter 14: Collaborative Relationships

Chapter 14: Collaborative Relationships

Requirements

- The health center has made and must continue to **make every reasonable effort to establish and maintain collaborative relationships**, including with other health care providers that provide care, local hospitals, and specialty providers in the catchment area of the center, to provide access to services not available through the health center and to reduce the non-urgent use of hospital emergency departments.
- To the extent possible, the health center must **coordinate and integrate project activities** with the activities of other federally-funded, as well as State and local, health services delivery projects and programs **serving the same population.**

Identify Your Collaborators

- Social Services (food, shelter, clothing, etc)
- Hospitals
- Specialty Providers
- Primary Care Providers
- Governmental Entities, incl. health dept.

Compile Documentation of Collaboration

- **MOUs/MOAs**
- **Brochures**
- **Media Reports**
- **Records of Meetings/ Email Communications**
- **Letters of Support**

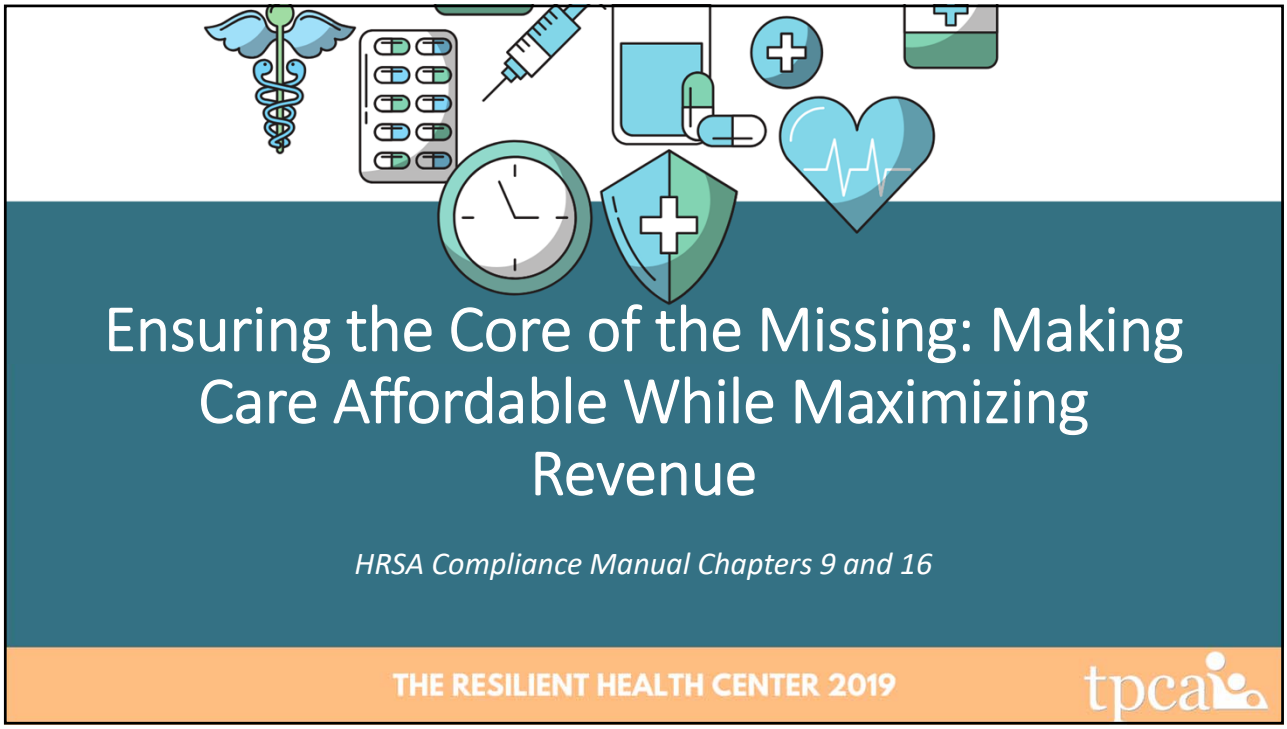
Documented Collaboration HRSA Requires

Specific Documentation

- Reduction in Non-Urgent ED Use
- Continuity of Care Across Community Providers
- Access to Other Services Impacting Patients

Other Health Centers

- Overlapping Service Area
- Adjacent Service Area



Ensuring the Core of the Missing: Making Care Affordable While Maximizing Revenue

HRSA Compliance Manual Chapters 9 and 16

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Covered in this Section

- Sliding Fee Discount Program (Chapter 9)
- Billing and Collections (Chapter 16)

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Chapter 9: Sliding Fee Discount Program

What is a Sliding Fee Discount Program?

Basically, The Sliding Fee Discount Program ensures that patients have access to all primary care services regardless of their ability to pay. The Sliding Fee Scale Program allows patients who are uninsured or underinsured to receive healthcare services at a reduced cost.

Chapter 9: Sliding Fee Discount Program

- The health center must operate in a manner such that no patient shall be denied service due to an individual's inability to pay
  - Has a sliding fee discount program[2] that applies to all required and additional health services[3] within the HRSA-approved scope of project for which there are distinct fees.[4]
- The health center must prepare a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and must prepare a corresponding schedule of discounts [sliding fee discount schedule (SFDS)] to be applied to the payment of such fees or payments, by which discounts are adjusted on the basis of the patient's ability to pay.
  - Determines whether to establish a nominal charge for individuals and families at or below 100% of the FPG.

Chapter 9: Sliding Fee Discount Program

- Nominal charges are not "minimum fees," "minimum charges," or "co-pays.
- The setting of a flat nominal charge(s) at a level that would be nominal from the perspective of the patient (for example, based on input from patient board members, patient surveys, advisory committees, or a review of co-pay amount(s) associated with Medicare and Medicaid for patients with comparable incomes) and would not reflect the actual cost of the service being provided

Chapter 9: Sliding Fee Discount Program

- The health center must establish systems for [sliding fee] eligibility determination.
- The health center must establish Board-approved Policies/Procedures
- The health center's schedule of discounts must provide for:
  - A full discount to individuals and families with annual incomes at or below those set forth in the most recent Federal Poverty Guidelines (FPG) [100% of the FPG], except that nominal charges for service may be collected from such individuals and families
  - No discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines [200% of the FPG

Chapter 9: Sliding Fee Discount Program

- The health center determines whether to establish a nominal charge for individuals and families at or below 100% of the FPG.
- The health center determines how to document income and family size in health center records.
- The health center must define income and family size
- The health center must have procedures for assessing patient eligibility for SFDS.
- The health center determines how and with what frequency to re-assess patient eligibility for the SFDS.

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Chapter 9: Sliding Fee Discount Program

- The health center determines whether to identify individuals who refuse to provide information on income and family size as ineligible for SFDS.
- The health center determines how to make patients aware of sliding fee discounts (for example, signage, registration process).
- The health center determines:
  - Whether to establish more than three discount pay classes above 100% of the FPG and up to and including 200% of the FPG;
  - What income range to establish for each discount pay class above 100% of the FPG and up to and including 200% of the FPG;
  - What method to use for discounting fees above 100% of the FPG and up to and including 200% of the FPG (for example, percentage of fee, fixed/flat fee per discount pay class); and
  - Whether to establish multiple SFDSs (for example, separate SFDSs for medical services and dental services) including, if appropriate, different nominal charges for each SFDS.

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Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	Charge					
	Nominal Fee ($5)	20% pay	40% pay	60% pay	80% pay	100% pay
1	0-$12,490	$12,491-$15,613	$15,614-$18,735	$18,736-$21,858	$21,859-$24,980	$24,981+
2	0-$16,910	$16,911-$21,138	$21,139-$25,365	$25,366-$29,593	$29,594-$33,820	$33,821+
3	0-$21,330	$21,331-$26,663	$26,664-$31,995	$31,996-$37,328	$37,329-$42,660	$42,661+
4	0-$25,750	$25,751-$32,188	$32,189-$38,625	$38,626-$45,063	$45,064-$51,500	$51,501+
5	0-$30,170	$30,171-$37,713	$37,714-$45,255	$45,256-$52,798	$52,799-$60,340	$60,341+
6	0-$34,590	$34,591-$43,238	$43,239-$51,885	$51,886-$60,533	$60,534-$69,180	$69,181+
7	0-$39,010	$39,011-$48,763	$48,764-$58,515	$58,516-$68,268	$68,269-$78,020	$78,021+
8	0-$43,430	$43,431-$54,288	$54,289-$65,145	$65,146-$76,003	$76,004-$86,860	$86,861+
For each additional person, add	$4,420	$5,525	$6,630	$7,735	$8,840	$8,840

Maximum Annual Income Amounts for each Sliding Fee Percentage Category (except for 0% discount)												
Poverty Level*	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
	DISCOUNT											
Family Size	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
1	12,490	13,739	14,988	16,237	17,486	18,735	19,984	21,233	22,482	23,731	24,980	24,981+
2	16,910	18,601	20,292	21,983	23,674	25,365	27,056	28,747	30,438	32,129	33,820	33,821+
3	21,330	23,463	25,596	27,729	29,862	31,995	34,128	36,261	38,394	40,527	42,660	42,661+
4	25,750	28,325	30,900	33,475	36,050	38,625	41,200	43,775	46,350	48,925	51,500	51,501+
5	30,170	33,187	36,204	39,221	42,238	45,255	48,272	51,289	54,306	57,323	60,340	60,341+
6	34,590	38,049	41,508	44,967	48,426	51,885	55,344	58,803	62,262	65,721	69,180	69,181+
7	39,010	42,911	46,812	50,713	54,614	58,515	62,416	66,317	70,217	74,119	78,020	78,021+
8	43,430	47,773	52,116	56,459	60,802	65,145	69,488	73,831	78,174	82,517	86,860	86,861+
For each additional person, add	4,420	4,862	5,304	5,746	6,188	6,630	7,072	7,514	7,956	8,398	8,840	8,840

Chapter 9: Sliding Fee Discount Program

- For in-scope services provided via contracts (Form 5A: Services Provided, Column II, Formal Written Contract/Agreement), the health center ensures that fees for such services are discounted as follows:
  - full discount is provided for individuals and families with annual incomes at or below 100% of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100% of the FPG.
  - Partial discounts are provided for individuals and families with incomes above 100% of the current FPG and at or below 200% of the current FPG, and those discounts adjust based on gradations in income levels and include at least three discount pay classes.
  - No discounts are provided to individuals and families with annual incomes above 200% of the current FPG.

Chapter 9: Sliding Fee Discount Program

- For services provided via formal referral arrangements (Form 5A: Services Provided, Column III), the health center ensures that fees for such services are either discounted as described in element "c." above or discounted in a manner such that:
  - Individuals and families with incomes above 100% of the current FPG and at or below 200% of the FPG receive an equal or greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule; and
  - Individuals and families at or below 100% of the FPG receive a full discount or a nominal charge for these services.

Chapter 9: Sliding Fee Discount Program

- Health center patients who are eligible for sliding fee discounts and have third-party coverage are charged no more for any out-of-pocket costs than they would have paid under the applicable SFDS discount pay class.[9] Such discounts are subject to potential legal and contractual restrictions.[10]

Chapter 9: Sliding Fee Discount Program

- For example for Patients with Third-Party Coverage
- An insured patient receives a health center service for which the health center has established a fee of $80, per its fee schedule. Based on the patient's insurance plan, the co-pay would be $60 for this service. The health center also has determined, through an assessment of income and family size, that the patient's income is 150% of the FPG and thus qualifies for the health center's SFDS. Under the SFDS, a patient with an income at 150% of the FPG would receive a 50% discount of the $80 fee, resulting in a charge of $40 for this service. Rather than the $60 co-pay, the health center would charge the patient no more than $40 out-of-pocket, consistent with its SFDS, as long as this is not precluded or prohibited by the applicable insurance contract.

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Chapter 9: Sliding Fee Discount Program

- The health center evaluates, at least once every three years, its sliding fee discount program. At a minimum, the health center:
  - Collects utilization data that allows it to assess the rate at which patients within each of its discount pay classes, as well as those at or below 100% of the FPG, are accessing health center services;
  - Utilizes this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys of patients at various income levels) to evaluate the effectiveness of its sliding fee discount program in reducing financial barriers to care; and
  - Identifies and implements changes as needed.

Chapter 9: Sliding Fee Discount Program

Utilization Data example:

Utilization Report - 2018					
Sliding Category	**Poverty Level**	**Amount Charged Per Visit**	**Number of Patients**	**Amount Collected in 2018**	**%**
A	Up to 100%	**$25**	**696**	23,925	78
B	101-125	$30	69	3180	8
C	126-150	$35	72	2835	8
D	151-175	$40	27	1360	3
E	176-200	$45	13	315	2
F	>200	Full Fee	16	569.87	1
			894	32,185	100

Chapter 16: Billing and Collections

- Did you know REVENUE generation begins with the Patient Customer Representatives?

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Chapter 16: Billing and Collections

- The health center must prepare a schedule of fees for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation.
    - Consider both locally prevailing charges and actual costs for services when setting the fee schedule, (for example, Medicare, Medicaid, private providers, or commercial sources).

Chapter 16: Billing and Collections

- The health center must assure that any fees or payments required by the center for health care services will be reduced or waived in order to assure that no patient will be denied such services due to an individual's inability to pay for such services.
    - Waiving and Reducing Fee policy must be available to all patients
    - Policy must include specific criteria for waiving or reducing fees; it must also identify individuals who can authorize and approve

Chapter 16: Billing and Collections

- The health center must make every reasonable effort to enter into contractual or other arrangements to collect reimbursement of its costs with the appropriate agency(s) such as:
  - A State Medicaid plan
  - The Children's Health Insurance Program (CHIP)
  - Third Party Payors

Chapter 16: Billing and Collections

- The health center has systems, which may include Board-approved Policies and operating procedures, for billing and collections that address:
  - Educating patients on insurance and, if applicable, related third-party coverage options available to them;
  - Billing Medicare, Medicaid, CHIP, and other public and private assistance programs or insurance in a timely manner, as applicable;[1] and
  - Requesting applicable payments from patients, while ensuring that no patient is denied service based on inability to pay.

Chapter 16: Billing and Collections

- The health center has billing records that show claims are submitted in a timely and accurate manner to the third party payor sources with which it participates (Medicaid, CHIP, Medicare, and other public and private insurance) in order to collect reimbursement for its costs in providing health services[2] consistent with the terms of such contracts and other arrangements.
  - Claims submission within 14 business days
  - Operating procedures for processing Denials and Error Claims

Chapter 16: Billing and Collections

- If a health center elects to limit or deny services based on a patient's **Refusal to pay,** the health center has a board-approved policy that distinguishes between refusal to pay and inability to pay and notifies patients of:
  - Amounts owed and the time permitted to make such payments;
  - Collection efforts that will be taken when these situations occur (for example, meeting with a financial counselor, establishing payment plans); and
  - How services will be limited or denied when it is determined that the patient has refused to pay.
  - Determines when the patient may return to the Health Center for services

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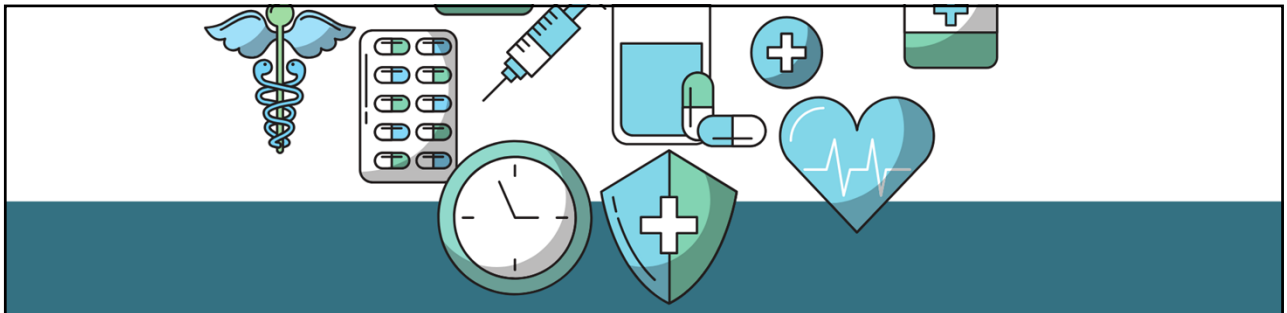

Internal Controls and Ensuring Fiscal Viability

HRSA Compliance Manual Chapters 12, 13, and 15

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Covered in this Section

- Contracts and Subawards (Chapter 12)
- Conflict of Interest (Chapter 13)
- Financial Management and Accounting Systems (Chapter 15)

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Chapter 12: Contracts and Subawards

Contracts: Procurement and Monitoring – Health Centers MUST

- The health center must determine[2] whether an individual agreement that will result in disbursement of Federal funds will be carried out through a contract or subaward agreement [3]
  - **Obtain valid contracts or subaward which include Scope of Services, Fees, effective & expiration dates, termination clause and signed by all appropriate parties.**
- The health center must request and receive approval from HRSA to contract for [substantive programmatic] work[4]
  - **Substantive programmatic work applies to contracting with a single entity for the majority of health care providers**
- The health center must use its own documented procurement procedures which reflect applicable State, local, and tribal laws and regulations
  - **Full and Open Competitive Bid Process, perform a cost or price analysis, Monitoring of Contract, Records Review, Access and Retention**

Chapter 13: Conflict of Interest

Conflict of Interest – Procurement, Contracting, Gifts Health Must

- The health center must maintain written standards of conduct covering conflicts of interest[1] and governing the actions of its employees engaged in the selection, award, or administration of contracts.
  - Applies to: Officers, employees, and agents of the health center may neither solicit nor accept gratuities, favors, or anything of monetary value from contractors or parties to subcontracts.
- The health center's standards of conduct must provide for disciplinary actions to be applied for violations of such standards by officers, employees, or agents of the health center.
  - Organizational conflicts of interest mean that because of relationships with a parent company, affiliate, or subsidiary organization, the health center is unable or appears to be unable to be impartial in conducting a procurement action involving a related organization.

Chapter 15: Financial Management and Accounting Systems

- The health center must maintain effective control over, and accountability for, all funds, property, and other assets in order to adequately safeguard all such assets and ensure that they are used solely for authorized purposes
  - The health center has and utilizes a financial management and internal control system that reflects Generally Accepted Accounting Principles (GAAP) that ensures at a minimum:
    - Expenditures are consistent with the HRSA-approved total budget[2]
    - Re-allocation of funds are applicable to HRSA approvals that have been requested and received;

Chapter 15: Financial Management and Accounting Systems

- The health center must have written policies and procedures in place to ensure the appropriate use of Federal funds in compliance with applicable Federal statutes, regulations, and the terms and conditions of the Federal award.
- Develop and utilize financial management and control systems in accordance with sound financial management procedures which ensure at a minimum:
  - The fiscal integrity of grant financial transactions and reports; and
  - Ongoing compliance with Federal statutes, regulations, and the terms and conditions of the Health Center Program award or designation.
  - Qualified and adequate staffing
  - Establish Effective channels of communication

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Chapter 15: Financial Management and Accounting Systems

- The health center's financial management system must specifically identify in its accounts all Federal awards, including the Federal award made under the Health Center Program, received and expended and the Federal programs under which they were received. This financial management system must also provide for all of the following:
  - Accurate, current, and complete disclosure of the financial results of each Federal award or program in accordance with the reporting requirements (see 45 CFR 75.341 and 75.342)
  - Records that identify the source (receipt) and application (expenditure) of funds for federally-funded activities. These records must contain information pertaining to Federal awards, authorizations, obligations, unobligated balances, assets, expenditures, income, and interest, and be supported by source documentation
    - Maintain Chart of Accounts
    - Effective Accounting System

Chapter 15: Financial Management and Accounting Systems

- Written procedures that minimize the time elapsing between the transfer of Federal award funds from HHS and the disbursement of these funds by the health center (see 45 CFR 75.305) and expenditures are allowable
  - Timely drawing down of Federal award funds in a manner that minimizes the time elapsing between the transfer of the Federal award funds from HRSA and the disbursement of these funds by the health center

Chapter 15: Financial Management and Accounting Systems

- If a health center expends **$750,000 or more in award funds from all Federal sources** during its fiscal year, the health center ensures a single or program-specific audit is conducted and submitted for that year in accordance with the provisions of 45 CFR Part 7
  - Audit Findings, Corrective Action Plan, the role of Board

Personnel Dynamics: Appropriate Management and Staff

HRSA Compliance Manual Chapters 11 and 5

Covered in this Section

- Key Management (Chapter 11)
- Clinical Staffing (Chapter 5)

Chapter 11: Key Management Staff

Requirements

- The health center must have position descriptions for key personnel [also referred to as key management staff] that set forth training and experience qualifications necessary to carry out the activities of the health center.
- The health center must maintain sufficient key personnel [also referred to as key management staff] to carry out the activities of the health center.
- The health center must request prior approval from HRSA for a change in the key person specified in the Health Center Program award or Health Center Program look-alike designation.
- The health center must directly employ its Project Director/CEO.

Updated and Current Documentation; Interviews of Key Management

- Organizational Chart including relationship to "out of scope" services or third-party entities
- Identification of Key Management Positions
- Job Descriptions for Key Management
- Justification for part-time Responsibilities (such as CFO or Medical Director)

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Determining Compliance

- Was the health center able to justify how the distribution of functions and allocation of time for each key management position is sufficient to carry out the approved scope of the health center project (e.g., Is there a clear justification for a part-time Project Director/CEO or for the lack of a dedicated CFO position)?
- Does the health center have any vacant key management positions? If Yes: Will or has the health center implement(ed) a process for filling this position?
- Is the Project Director/CEO directly employed by the health center?
- Does the Project Director/CEO report to the health center board? Does the Project Director/CEO oversee other key management staff in carrying out the day-to-day activities of the health center project?

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Chapter 11: Key Management Staff Compliance

- Organization Chart Up to Date
- Job Descriptions Up to Date
- Responsibilities Designed to Carry Out Scope of Project/Distribution of Functions
- Allocation of Time (FT/PT/Shared) Reasonable
- Documented Plan to fill Vacant Positions
- CEO (Proof of Employment)

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Chapter 5: Clinical Staffing

- Ensure clinical staffing enables CHC to carry out scope on Form 5A
- Ensure that the clinical staffing mix and number is responsive to the size, demographics and needs (access, language, etc.) of its patient population.

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Chapter 5: Clinical Staffing

Patient Access and Clinical Staff Evaluation

Patient Population Considerations (Measurement Year: 2017)

Size

Unique Patients	Patient Visits

Demographics

Demographics	Unique Patients
Race	
Black/AA	
Caucasian	
Other	
Other	
Other	
Ethnicity	
Hispanic	
Non-Hispanic	
Other	
Other	
Language	
Spanish	
English	
Other	
Other	
Other	
Sexual Orientation	
Text	
Text	
Text	
Gender Identity	
Male	
Female	
Transgender (Male to Female)	
Transgender (Female to Male)	

Health Needs

Common Health Needs	Unique Patients
Diabetes	100
Hypertension	90
Other	0

HRSA Health Center Program Compliance Manual, Chapter 5.b., p. 27

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Chapter 5: Clinical Staffing

- Ensure clinical staffing enables CHC to carry out scope on Form 5A.
- Ensure that the clinical staffing mix and number is responsive to the size, demographics and needs (access, language, etc.) of its patient population.
- Ensure health center credentialing procedures require proper identification, verification of education and training, queries through NPDB, DEA registration, BLS training, upon hire or recurring/ongoing procedures.
- Ensure CHC procedures address initial granting and renewal of privileges and evaluate upon hire (and recurring) fitness for duty, immunization/communicable disease, clinical competence, and has a process for modifying or removing privileges based on assessments.

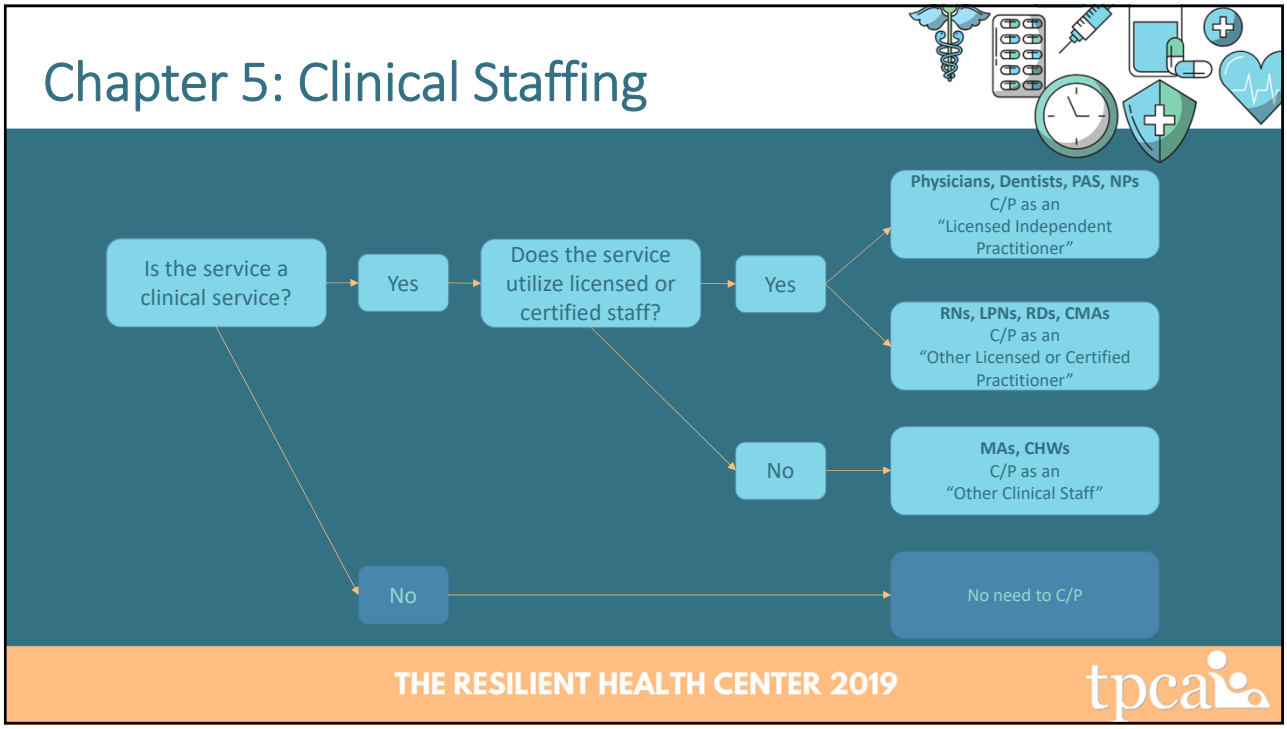
Chapter 5: Clinical Staffing

- Maintain up-to-date documentation of licensure, credentialing, and privileging of all clinical staff.
- Ensure contracts for contracted (Form 5A, Column II) and referral (Column III) services require that the organizations appropriately credential and privilege their providers.

Chapter 5: Clinical Staffing

- So who should be Credentialed and Privileged?
  - Licensed Independent Practitioners
    - Physicians, Dentists, Physician Assistants, Nurse Practitioners
  - Other Licensed or Certified Practitioners
    - RNs, LPNs, Registered Dietitians, Certified Medical Assistants
  - Other Clinical Staff (Unlicensed, uncertified)
    - Clinical staff providing services on behalf of the health center who are not licensed or certified (MAs, CHWs, etc. in states, territories or jurisdictions that do not require licensure or certification)

Chapter 5: Clinical Staffing



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Chapter 5: Clinical Staffing

- **Key Take-Aways:**
  - Demonstrate Appropriate Staff Mix
  - Stay Up-To-Date on Credentialing and Privileging

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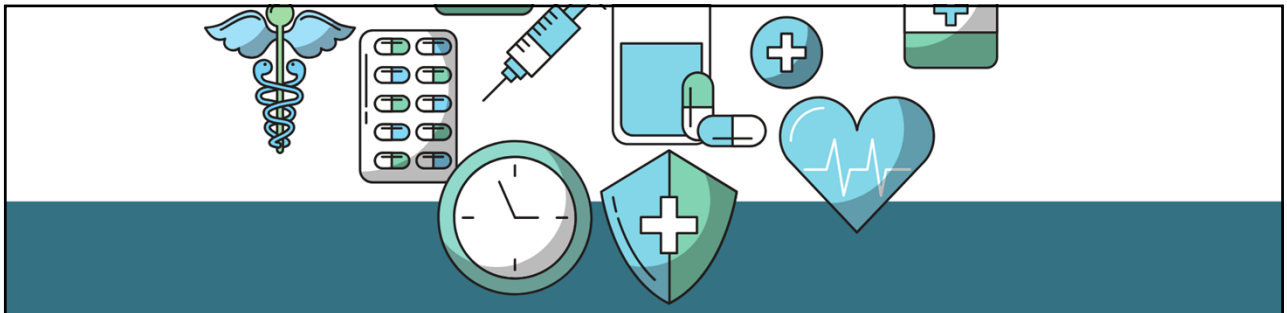

Quality is Key: Better Care, Healthier Communities, Lower Costs

HRSA Compliance Manual Chapter 10

Covered in this Section

- Quality Improvement/Assurance (Chapter 10)

A Framework of Compliance

A Framework for a Compliant QI/QA Program of Excellence

Documentation	EMR Doc. of Referred Pts EMR Documentation of Care Referral Tracking Log Cultural Competency Training Log	Provider Panel Evaluation Visits/Pt Analysis Cred/Priv Tracking Timelines/Log	Accessible Services Evaluation	After-Hours Info After-Hrs Call Logs After-Hrs Care in Pt Charts	Hospital visit documentation	340B Pharmacy Audits	
Board			Board approval of Hours/Sites			Report 6x/yr to Board	Risk Mgmt activities, status of performance relative to goals, proposed RM activities (Annual)
Reporting	Tracking and Referral Follow-Up					Pt Satisfaction UDS Clinical Outcomes Peer Review	Quarterly Risk Mgmt Assessments
Personnel	Staff to Carry-Out Services CMO/Clinical Staff CHC Leadership	CHC Leadership HR Staff CMO/Clinical Staff	CHC Leadership	Clinical Staff (BLS Trained) CMO/Clinical Staff	CMO/Clinical Staff Referral Follow-Up Staff	CMO/Clinical Staff QI Manager/Director	Risk/Claims Manager CMO/Clinical Staff CHC Leadership
Programs & Services	Staff Training: Cultural Competency Language/Interpretation Svcs 340B Pharmacy Required Additional Services	Credentialing and Privileging		After-Hours Call Services	Post-Hosp. Tracking and Follow-up	Patient Safety Program QI Committee QI/Board Interaction Peer Review (Quarterly) 340B Pharmacy Incident Report Tracking/Trending EHR/EMR Program Staff Training: HIPAA	Referral/Dx/Hosp Tracking Claims Management Staff Training: Risk Mgmt Training Incident/Grievance/Near-Miss Reporting
Documents & Forms	After-Hrs Care Instructions Form 5A Income eligibility documents Intake Forms for Clinical Svcs MOUs Sliding Fee Discount Form (Multiple lang. as appropriate)	Cred/Priv Forms and Files Current Staffing Profile CVO Contract Form 5A Needs Assessment/Staffing Eval Peer Review Forms Provider contracts Recruitment/Retention Plan Website URL UDS Summary Report CHC Presentation	Accessible Services Evaluation Patient Satisfaction Surveys Form 5B Service Area Map Needs Assessment	After-Hours Info (For LEP) On-Call Provider Logs	Hospital Admitting Documents	QI Director/CMO Job Descriptions QI Plan QI Work Plan HIPAA/Privacy Forms	FTCA Application Risk Mgmt Training Plan Risk Mgmt Training Tracking Documents informing pts of FTCA
Policies & Procedures	Tracking and Referral Language Services Cultural Competency Training	Credentialing/Privileging Peer Review HR Policies/Procedures Process for considering staffing mix		P/P for Medical Emergencies (During and after hours) After-Hours Coverage P/P	Hospital follow-up doc P/P	QI/QA P/Ps, Clinical Guidelines, Standards of Care, Patient Safety, Patient Satisfaction, Pt Grievances, Periodic QI/QA Assmts, QI/QA report generation and oversight, HIPAA/Confidentiality	Claims Mgmt P/Ps
Models of Care: (2017 NCQA PCMH Standards)	CC 01: Lab & Imaging Test Mgmt CC 02: Newborn Screenings CC 03: Appropriate Use of Labs/Imaging CC 04: Referral Mgmt CC 05: Appropriate Referrals CC 06: Commonly Used Specialists ID CC 07: Referral Tracking to Specialist Ref CC 08: Specialist Referral Expectations CC 09: BH Referral Expectations CC 10: Behavioral Health Integration CC 11: Referral/Monitoring CC 12: Medication Management CC 13: Treatment Options and Costs CC 14: Elting Unplanned Hospital/ED Visits CC 15: Sharing Clinical Info CC 16: Post-Hosp/ED Visit F/U CC 17: Acute Care After Hrs Coordination CC 18: Info Xchng During Hospit. CC 19: Xchng Info with Pts CC 20: Care Plan Collab. For Practice Transitions CC 21 External Exchange of Info KM 09: Diversity KM 10: Language KM 11: Population Needs KM 12: Clinical Decision Support KM 21: Community Resource Needs KM 22: Access to Edu Resources KM 23: Oral Health Edu KM 24: Shared Decision-Making Aids KM 25: Patient Goals Engagement KM 26: Community Res Inv KM 27: Community Res Assessment KM 28: Case Conferences	TC 01: PCMH Transformation Leads TC 02: Structure and Staff Responsibilities TC 03: External PCMH Collaborations TC 04: Patient/Family/Caregiver Involvement in Governance TC 05: Certified EHR System TC 06: Use of Health IT Prog. TC 07: Staff Involvement in QI TC 08: Bah Health Care Mg TC 09: Med Home Info	AC 01: Access Needs & Preferences AC 02: Same-Day Appointments AC 07: Electronic Pt Requests AC 08: Two-Way Elec. Comm. AC 09: Equity of Access	AC 03: Appts. Outside Bus. Hrs AC 04: Timely Clinical Advice by Tel. AC 05: Clinical Advice Doc. AC 06: Alternative Appts.	AC 10: Personal Clinician Select. AC 11: Pt Visits with Clinician AC 12: Continuity of EMR AC 13: Panel Size Reas & Mgmt AC 14: Ext Panel Reas and Rec. CM 01: ID Pts for Care Mgmt CM 02: Man. Pts for Care Mg CM 03: Use Registry to Man. Pt Lost CM 04: Person-Centered CPs CM 05: Written Care Plans CM 06: Pt Preferences and Goals CM 07: Pt Barriers to Goals CM 08: Self-Mgmt Plans CM 09: Care Plan Integration CM 10: Support Tools KM 02: Comp. Health Assmt KM 03: Depression Scrng KM 04: BH Screening KM 05: Oral Health Assmt/Svcs KM 06: Functional Stat. KM 07: Tox Envt of Health KM 08: Pt Materials KM 12: Proactive Reminders KM 13: Excellence in Perform. KM 14: Med Reconciliation KM 15: Med Lists KM 16: Med Errors KM 17: Med Responsive/Iter. KM 18: Controlled Sub KM 19: Rx Claims Data	QI 01: Clinical Quality Measures QI 02: Resource Stew. Measures QI 03: Appt Availability Assmt QI 04: Patient Experience Assmt QI 05: Health Disparities Assmt QI 06: Validated Pt Exp Survey QI 07: Vulnerable Pt Feedback QI 15: Reporting Within Pract. QI 16: Reporting Publicly QI 17: Pt Fam Involvement in QI QI 18: Incentives for QI & MS QI 19: Value-Based Contracts Goals/Actions to Improve: QI 08: Clinical Quality Measures QI 09: Resource Stewardship QI 10: Appt Availability QI 11: Pt Experience QI 13: Disparities in Care/Svc Actual Improvements in: QI 12: Performance QI 14: Disparities in Care/Svc	
Foundational Compliance Requirements	Required and Additional Services (Ch4)	Clinical Staffing (Ch5)	Accessible Hours & Location (Ch6)	Coverage for Med. Emerg. During/After Hrs (Ch7)	Continuity of Care & Hospital Admitting (Ch8)	QI/QA (Ch10)	FTCA (Ch21)

Chapter 10: Quality Improvement/Assurance

- Maintain a QI/QA program that addresses the quality and utilization of health center services, patient satisfaction and patient grievance processes, patient safety and adverse events.
- Designate an individual to oversee the QI/QA program.

Chapter 10: Quality Improvement/Assurance

- The QI/QA program overseer should ensure the implementation of the QI/QA procedures, that QI/QA assessments are conducted, monitor QI/QA outcomes, and update QI/QA operating procedures as needed.
- Maintain operating procedures that:
  - Address the adherence to current, applicable evidence-based clinical guidelines and standards of care/practice,
  - Outline a process for staff to follow for identifying, analyzing, and addressing overall patient safety (including adverse events),
  - Outline a process for follow-up actions related to adverse events,
  - Maintain a process for assessing patient satisfaction, resolving patient grievances, and completing QI/QA assessments [peer review] at least quarterly.

Chapter 10: Quality Improvement/Assurance

- Share reports on QI/QA, including data on patient satisfaction and safety with key management staff and the governing board (>6x/yr – FTCA only).
- Ensure QI/QA assessments are conducted by physicians or other licensed health care professionals and are based on data systematically collected from patient records.
- Ensure assessments demonstrate that the health center is tracking and addressing issues related to the quality and safety of care.

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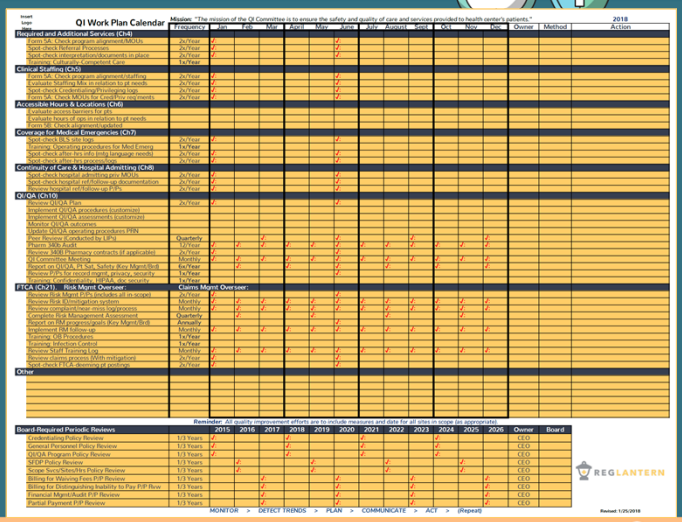
Chapter 10: Quality Improvement/Assurance

- Maintain an individual health record for each patient that is in a structured format and easily retrievable.
- Maintain a process for ensuring that the format and content of health records are consistent with applicable federal and state laws and requirements (Certified EHR).
- Ensure there are health center procedures that address current federal and state requirements related to confidentiality, privacy and security of protected health info (PHI) including safeguards against loss, destruction, or unauthorized use.
- Ensure staff are trained in confidentiality, privacy, and security.

Tools of the Trade

- **QI Work Plan**
  - Brings the QI Plan to life!
  - Visible and actionable
  - Spread the workload



Chapter 10: Quality Improvement/Assurance

- **Key Take-Aways:**
  - Read your QI Plan
  - Ensure evidence-based practices
  - Report to the Board (6x/yr)
  - Perform Peer Review quarterly
  - Demonstrate that you respond to findings
  - Monitor patient satisfaction
  - Track and trend incidents
  - Train staff on confidentiality

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Putting it All Together: The Budget, Data Collection, and Board Authority

HRSA Compliance Manual Chapters 17, 18, and 19

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Covered in this Section

- Budget (Chapter 17)
- Program Monitoring and Data Reporting Systems (Chapter 18)
- Board Authority (Chapter 19)

Chapter 17: The Budget

The health center must develop an annual budget that:

- Identifies the projected costs to be supported by Health Center Program [award] funds
- Includes all other non-Federal revenue sources that will support the Health Center Program project, including:
  - State, local, and other operational funding
  - Fees, premiums, and third-party reimbursements which the health center may reasonably be expected to receive for its operation of the Health Center Program project.

Chapter 17: The Budget

- The health center must submit this budget annually by a date specified by HRSA for approval through the Federal award or designation process.
- If the health center organization conducts other lines of business (i.e., activities that are not part of the HRSA-approved scope of project), the costs of these other activities are not included in the annual budget for the Health Center Program project
  - As these other lines of business are not included in the health center's total budget, they are not subject to Health Center Program requirements and not eligible for related Health Center Program benefits (for example, payment as a FQHC under Medicare/Medicaid/CHIP, 340B Program eligibility, Federal Tort Claims Act (FTCA) coverage).

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Budget Justification		FY 2018 Budget Period	
		Federal Grant Request	Non-Federal Resources
REVENUE – *Should be consistent with information presented in Budget Information: Budget Details form and Form 3: Income Analysis.*			
PROGRAM INCOME (fees, third party reimbursements, and payments generated from the projected delivery of services)			5,671,000
FEDERAL BPHC 330 GRANT		3,324,218	
XXX Uncompensated Care			482,070
Local, Private and Foundation Grants			455,000
Other Revenues, e.g. 340B Pharmacy; Incentives; etc			147,380
TOTAL REVENUE		**3,324,218**	**6,755,450**
EXPENSES: *Object class totals should be consistent with those presented in Section B of the Budget Information: Budget Details form.*			
PERSONNEL			
ADMINISTRATION		-	2,134,240
MEDICAL STAFF		2,334,790	932,980
DENTAL STAFF		386,090	
BEHAVIORAL HEALTH STAFF (i.e., Mental Health and Substance Abuse)		-	147,010
ENABLING STAFF		-	125,680
OTHER STAFF			
TOTAL PERSONNEL		**2,720,880**	**3,339,910**
FRINGE BENEFITS			
FICA (ceiling of $130,500 in 2018)	7.65%	188,070	230,850
XX Unemp. Ins. (First $33,700/emp ceiling)	2.98%	40,260	49,410
Disability Insurance	0.70%	19,050	23,380
Health & Life	12.38%	335,008	415,430
Workers	0.77%	20,950	25,720
TOTAL FRINGE (Composite)	24.48%	**603,338**	**744,790**
TRAVEL			
Travel to NACHC and XXPCA Conferences: Staff (5x2 @$1,250 = $12,500) Board Member (2x2 @$1,250 = $5,000)			17,500
Provider Training/CME: (Trainings in Q&QA @ $1500 per FTE x 12.61 FTEs)			18,920
Nursing CME ($ 500 per FTE x 11.96 FTEs)			5,980
Travel expenses funded under Other Programs and Contracts ($2,875 per month x 12 months)			34,500
TOTAL TRAVEL			**76,900**
EQUIPMENT – *Include items of moveable equipment that cost $5,000 or more and with a useful life of one year or more.*			
N/A			
TOTAL EQUIPMENT			
SUPPLIES			
Office Supplies ($2.00 per Total visits, total of 53,500 visits)			107,000
Facility Supplies ($2.50 per Total visits, total of 53,500 visits)			134,000
Educational Supplies ($0.50 per Total visits, total of 53,500 visits)			27,000
Medical Supplies ($8.00 per Medical visits, total of 46,700 visits)			374,000
Dental Supplies ($15.00 per Dental visits, total of 6,800 visits)			102,000
Pharmaceuticals ($1.50 per Medical visits, total of 53,500 visits)			70,000
TOTAL SUPPLIES		-	**814,000**
Budget Justification		**FY 2018 Budget Period**	
		Federal Grant Request	**Non-Federal Resources**
CONTRACTUAL – *Include sufficient detail to justify costs.*			
Laboratory Services ($5.75 per SP visits, total of 10,165 SP visits)			58,450
Legal Services ($4,100 per month x 12 months)			49,200
Audit Services with CohnReznick ($4,200 per month x 12 months)			50,400
Specialty (Podiatry) ($6,000 per month x 12 months)			72,000
Management Fee/Consultants ($35,100 per month x 12 months)			421,200
Computer Consultants ($2,000 per month x 12 months)			24,000
Medical Records Archiving ($600 per month x 12 months)			7,200
Translations/Language ($3,500 per month x 12 months)			42,000
TOTAL CONTRACTUAL		-	**724,450**
OTHER – *Include detailed justification. Note: Federal funding CANNOT support construction, fundraising, or lobbying costs.*			
Space Costs (Rent=$27,000 and Utilities=$15,000 per month x 12 months			504,000
TeleCommunications/Cable ($9,500 per month x 12 months)			114,000
Data Processing ($4,600 per month x 12 months)			55,200
Property Insurance ($10,000 per month x 12 months)			120,000
Membership Dues (NACHC=$20,000; NJPCA=$10,000)			30,000
Printing, Postage and Publications ($3,750 per month x 12 months)			45,000
Personnel Recruitment ($1,850 per month x 12 months)			22,200
Repairs and Maintenance ($10,000 per month x 12 months)			120,000
Equipment Leases-Copiers ($3,750 per month x 12 months)			45,000
TOTAL OTHER		-	**1,055,400**
TOTAL DIRECT CHARGES (Sum of TOTAL Expenses)		**3,324,218**	**6,755,450**
INDIRECT CHARGES – *Include approved indirect cost rate.*			
X% Indirect cost rate (Includes utilities and accounting services)			
TOTALS (Total of TOTAL DIRECT CHARGES and INDIRECT CHARGES)		**3,324,218**	**6,755,450**

Chapter 18: Program Monitoring and Data Reporting Systems

- The health center must establish systems for monitoring program performance to ensure:
  - Oversight of the operations of the Federal award -supported activities in compliance with applicable Federal requirements;
  - Performance expectations [as described in the terms or conditions of the Federal award or designation] are being achieved; and
  - Areas for improvement in program outcomes and productivity [efficiency and effectiveness] are identified.

Chapter 18: Program Monitoring and Data Reporting Systems

- The health center must compile and report data and other information as required by HRSA, relating to:
  - Costs of health center operations;
  - Patterns of health center service utilization;
  - Availability, accessibility, and acceptability of health center services; and
  - Other matters relating to operations of the Health Center Program project
  - How Data is used in the decision-making process

Chapter 18: Program Monitoring and Data Reporting Systems

- The health center must submit required data and information to HRSA in a timely manner and with such frequency as prescribed by HRSA.
  - Uniform Data System (UDS) reporting
  - Effective Use of Practice Management, Financial Management Systems and other data collection tools.

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Chapter 19: Board Authority

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Chapter 19: Board Authority Maintenance of Board Authority

The organizational structure, articles of incorporation, bylaws, and other relevant documents ensure the governing board maintains the authority for oversight of the Health Center Program project, specifically:

- The organizational structure and documents do not allow for any other individual, entity or committee to reserve approval authority or have veto power over the health center board with regard to the required authorities and functions;
- When collaborating with other entities, such collaboration or agreements with the other entities do not restrict or infringe upon the health center board's required authorities and functions; and
- For public agencies with a co-applicant board, the health center has a co-applicant agreement that delegates the required authorities and functions to the co-applicant board and delineates the roles and responsibilities of the public agency and the co-applicant.

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Chapter 19. Board Authority Required Authority and Responsibility

The health center's articles of incorporation, bylaws, or other relevant documents outline the following required authorities and responsibilities of the governing board:

- Holding monthly meetings;
- Approving the selection (and termination or dismissal, as appropriate) of the health center's Project Director/CEO;
- Approving the annual Health Center Program project budget and applications;
- Approving health center services and the location and hours of operation of health center sites;
- Evaluating the performance of the health center;
- Establishing or adopting policy related to the operations of the health center; and
- Assuring the health center operates in compliance with applicable Federal, State, and local laws and regulations.

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Chapter 19. Board Authority: Exercising Required Authorities and Responsibilities

The health center's board minutes and other relevant documents confirm that the board exercises, without restriction, the following authorities and functions:

- Holding monthly meetings where a quorum is present
- Approving the selection, evaluation and, if necessary, the dismissal or termination of the Project Director/CEO
- Approving applications related to the Health Center Program project, including approving the annual budget,
- Approving the Health Center Program project's sites, hours of operation and services, including decisions to subaward or contract for a substantial portion of the services;
- Monitoring the financial status of the health center, including reviewing the results of the annual audit, and ensuring appropriate follow-up actions are taken;

Chapter 19. Board Authority: Exercising Required Authorities and Responsibilities

- Conducting long-range/strategic planning at least once every three years, which at a minimum addresses financial management and capital expenditure needs; and
- Evaluating the performance of the health center based on quality assurance/quality improvement assessments and other information received from health center management and ensuring appropriate follow-up actions are taken regarding:
  - Achievement of project objectives;
  - Service utilization patterns;
  - Quality of care;
  - Efficiency and effectiveness of the center; and
  - Patient satisfaction, including addressing any patient grievances.

Chapter 19. Board Authority: Exercising Required Authorities and Responsibilities

- The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies in the following areas: Sliding Fee Discount Program, Quality Improvement/Assurance, and Billing and Collections
- The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies that support financial management and accounting systems and personnel policies.

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Board Authority Problem Areas

- Quality of the Documentation
- Monthly Mtgs. With Quorum Present
- CEO Evaluation Policy and Documented Practice
- HRSA Apps, Budget and Scope Changes
- Services, Locations and Hours

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Exercising Req. Authorities and Responsibilities

- Achievement of Project Objectives
- Service Utilization Patterns
- Quality of Care
- Efficiency and Effectiveness
- Patient Satisfaction and Patient Grievances
- How does the Board evaluate? Is follow-up reported?

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The Board Must Adopt, Evaluate, and Update Policies

- Sliding Fee Discount Program*
- QI/QA Program*
- Billing and Collection Policies*
- Financial Mgmt and Acctg Systems
- Personnel
- *What are examples of changes made based on evaluation? Can Board members describe any changes when asked?

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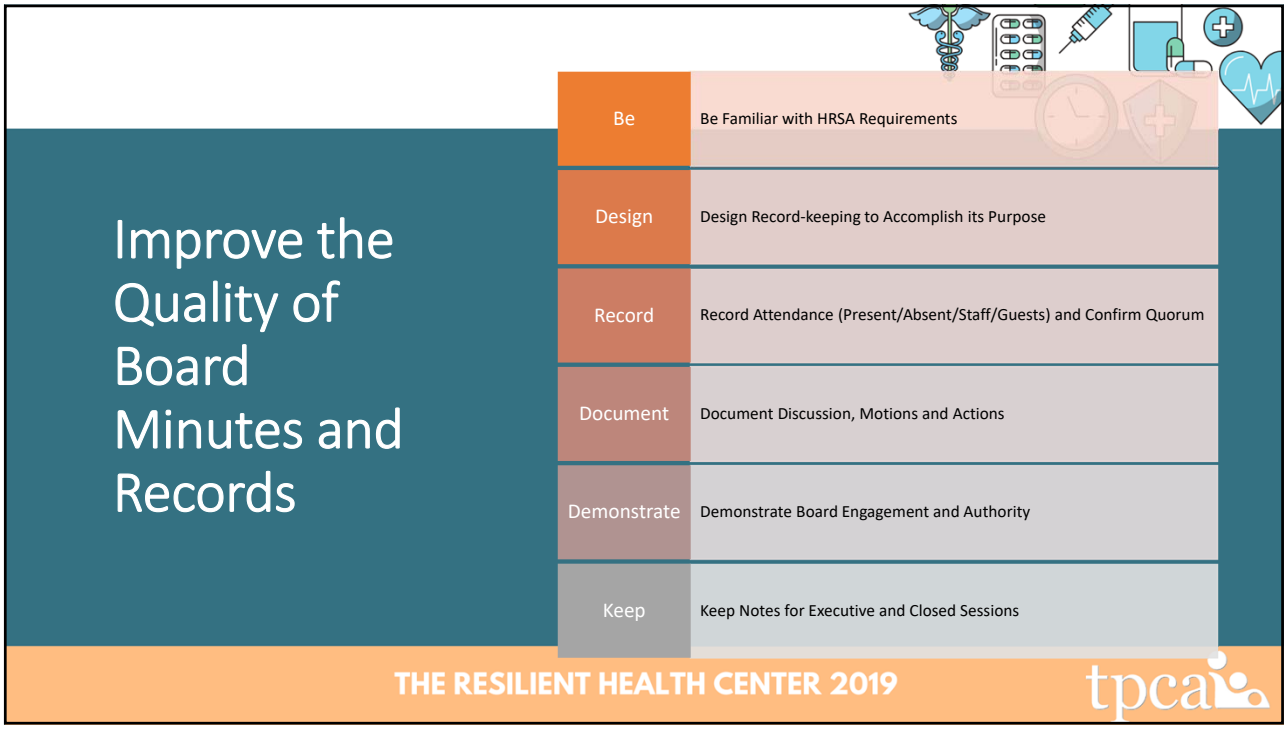
Improve the Quality of Board Minutes and Records
Be
Be Familiar with HRSA Requirements
Design
Design Record-keeping to Accomplish its Purpose
Record
Record Attendance (Present/Absent/Staff/Guests) and Confirm Quorum
Document
Document Discussion, Motions and Actions
Demonstrate
Demonstrate Board Engagement and Authority
Keep
Keep Notes for Executive and Closed Sessions
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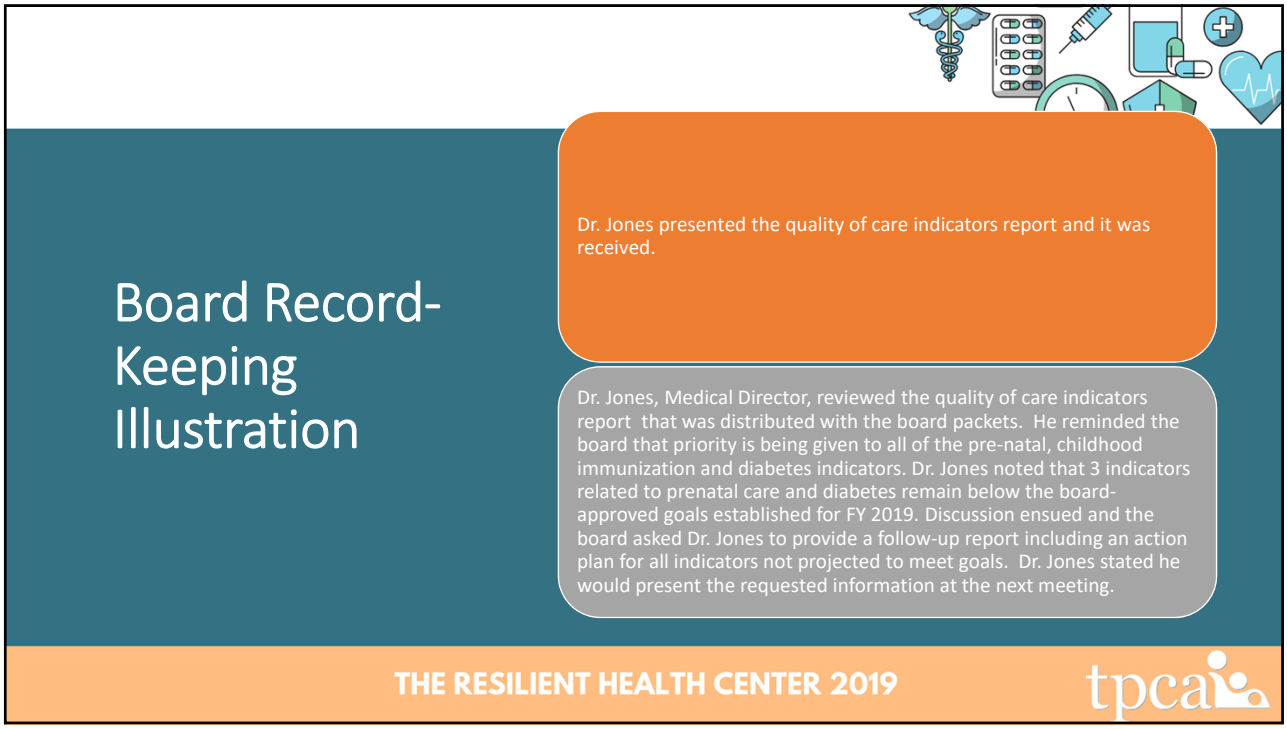
Board Record-Keeping Illustration
Dr. Jones presented the quality of care indicators report and it was received.
Dr. Jones, Medical Director, reviewed the quality of care indicators report that was distributed with the board packets. He reminded the board that priority is being given to all of the pre-natal, childhood immunization and diabetes indicators. Dr. Jones noted that 3 indicators related to prenatal care and diabetes remain below the board-approved goals established for FY 2019. Discussion ensued and the board asked Dr. Jones to provide a follow-up report including an action plan for all indicators not projected to meet goals. Dr. Jones stated he would present the requested information at the next meeting.
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2018 CALENDAR

15 M.L. King, Jr. Day

25 Board of Directors
- ✓ Conflict of Interest Stmt
- ✓ Update board info form
- ✓ Plan for CEO Eval
- ✓ Review CEO job description
- ✓ Rev goals/objctv of Calendar Year

January

S	M	T	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	**25**	26	27
28	29	30	31			

19 Presidents Day

22 Board of Directors
- ✓ Review FY Budget Proposal
- ✓ Board Self Eval Form
- ✓ Questionnaire RE Users of Sliding Fee Pgrm.

Board In-Service (Topic TBA)

FEBRUARY

S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	**22**	23	24
25	26	27	28			

30 Good Friday

22 Board of Directors
- ✓ Review/approve annual/updated SFS
- ✓ Review/approve Agrmts w/specialists
- ✓ Review/approve annual Patient Service Fee Sched (Chargemaster)

MARCH

S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	**22**	23	24
25	26	27	28	29	30	31

JULY

S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	**26**	27	28
29	30	31				

04 Independence Day

26 Board of Directors
- ✓ Review/approve annual audit report
- ✓ Review goals/objectives of Fiscal Year

AUGUST

S	M	T	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	**23**	24	25
26	27	28	29	30	31	

23 Board of Directors

Board In-Service (Topic TBA)

SEPTEMBER

S	M	T	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	**27**	28	29
30						

03 Labor Day

27 Board of Directors
- ✓ Schedule Grant budget work session
- ✓ Update Board verification consumer member status

2016 Board of Directors' Annual Work Plan

Work Item	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Election of Officers												☐
Confidentiality/COI Execution												
Approve Annual Audit	☒											
Approve Annual Budget									☐			
Approve Annual Work Plan	☒	☒										
Approve Discount Schedules				☒								
Approve FQHC Application									☐			
Approve Federal Financial Report				☒								
MN Charitable Organization Report			☐									
Approve IRS Form 990			☒									
Approve last month's BOD minutes	☒	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Approve last month's Financials	☒	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Approve Charges/Fees				☐								
Board Self Evaluation											☐	
CEO Evaluation (for Previous Year)				☐								☐
Corporate Compliance Report								☐				
Credentialing/Privileging Updates					☐							


Thank you!
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