

August 25th Stakeholder Meeting Q&A

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Tonya Bowers AM Session Q&A

Q: If an organization has several sites can more than one site apply to become an FQHC?

A: No. It's one application per organization, not site. Even if the organization is a medical system – the level that can apply is the single EIN number; one organization with a single governing body.

Q: How do health centers have a community board if the entity is a public agency?

A: Public agencies often can't meet the required governance structure. They are expected to create a "co applicant" with a co-applicant board – this is the board which meets all requirements listed for the health center program. Soon a governance communication will go out on this. The public entity, together with co-applicant board is expected to demonstrate they are governing the health center. Co-applicant board must have decision making ability over services, sites, other essential functions; public entity retains responsibility over the grant. PIN to be released shortly.

Q: If our community doesn't have a designated underserved area but has a pocket of need, could you have a look-alike program?

A: No. You must be designated – examine your data closely to create that designation, and submit a request through the State Primary Care Office. The requirements for a look-alike are exactly the same as requirements for a community health center. If there is an existing center in the area, they can use their money to target that area.

Q: Can you re-state the appropriate uses for the first year \$150,000 one- time costs?

A: Yes. The \$150,000 can be used for basic facility needs – equipment purchases, one time renovation and alteration. No major construction – you cannot add square footage, only basic upkeep, updating. You are not expected to use any money for these purposes in subsequent years.

Q: Do you have to provide services for all? Meaning you can't just have a women's center, or HIV center?

A: Yes, you have to provide services for all. Only exceptions are federally defined special populations, which include migrant/seasonal farmworkers, homeless, and residents of public housing. You can to some degree target a particular population, and may have some special programs in place, but you must be able to serve everyone in the community.

Q: Are there possibilities for collaboration between public health departments and CHCs?

A: Yes. There are many opportunities to partner - Partnership with local health department is essential; build on each other's strengths and collaborate, e.g. emergency management and planning

Q: Is there a non-federal cash match requirement for planning grant or operational grant?

A: No. There is no federal match for either. But you must maximize all sources of income (billing for services: Medicaid, medicare, third parties, billing individuals). The federal grant usually accounts for 18-19% of a health centers budget.

Q: Can we have access to National Service Corps if a facility is built outside of a medically underserved area?

A: To be eligible for NHSC, you must be located within a designated Health Professional Shortage Area. There is no way around that – it's federal law. However, if you are an existing FQHC, and the site is in your scope of project (Form 5 part B), it automatically becomes a HPSA.

Q: One of the key issues for a successful grant is readiness. In the north, the ground freezes, load limits on roads, etc. If the award comes out March 1st, the ground is still frozen – could you address that?

A: Yes. Keep in mind that grant dollars cannot be used for construction – you must already have a facility in place. If your plan is to significantly renovate an existing facility, you can bring in a trailer or something else to ensure that services are being provided while you site is under construction. The awards will be released around August 1st.

Q: Example of collaborations between FQHC and Hospital?

A: Under health center program, one organization is responsible for the grant itself. There are examples where one board governs both the hospital and FQHC – there are often a lot of issues, and need for strict separation for financial purposes (billing for Medicaid, for example). You can be both an FQHC and hospital – it's not easy, but it can be done. If it works best for the community, then there are opportunities to make it happen.

Also, there is a new program authorized by PPACA – not currently funded – Community Based Collaborative Care Networks – looking at integration of Hospitals and FQHCs and other safety-net providers. Looking at integrating providers to improve access.

Q: Why does it take so long for grant awards to be released?

A: The awarding of grants is extremely complex – large volume of applications this year. There are many levels of review (related to environmental protection, historic preservation, etc.)

Q: What does “fully operational” mean in 120 days?

A: Fully operational means that the Community Health Center must be able to demonstrate that it is providing care. Meaning the site is open, there is a provider in place, and patients are being served.

Q: Timeline for planning grants?

A: Working on it now – will be a 2011 funding opportunity. Hopefully will be available sometime this fall – but keep in mind that DC's fall is a long season. Also, register now for grants.gov.

Q: Given the increase in insurance coverage, what kind of impact do you see that having on demand for services from FQHCs?

A: Increase in funding for the health center program is partly intended to help FQHCs prepare for increased demand.

Q: Can an existing free clinic become an FQHC?

A: Yes, any providers can make a transition into FQHC model! But, sometimes it's a question of mission – as an FQHC you MUST bill for your services. It may not fit the needs for EVERY community. Anyone can become an FQHC, you just have to be prepared for the change in culture and mission.

Q: Is the 11 million dollars allocated to the Community Health Center program dependent on continuation of the Patient Protection and Affordable Care Act?

A: I can't speak to future. However, the dollars were automatically appropriated, and will become available in 2011, and should continue to be available for the next 5 years. That's how we are planning for the next 5 years, and how we are encouraging others to plan.

Q: Can you describe what technical assistance looks like from HRSA?

A: New starts receive 1-2 on site visits, assessment of compliance; consultants who come to your site visit will help determine where you are and how to best get to the place you need to be. From the State perspective, the Wisconsin Primary Health Care Association can help as well with additional resources.

Q: Where can past grantee applications can be viewed?

A: Any funded grant is a public document (except proprietary documents) and is available under the Freedom of Information Act. You can submit request to HRSA's Freedom of Information Office. I would, however, encourage you to talk with an existing health center and go directly through them, as they may volunteer more information than HRSA is allowed to give.

Q: When is cost-based reimbursement for Medicaid available? In 2014?

A: Health Centers currently receive cost-based reimbursement. There are expected to be a few changes in the future. There are caps under Medicare are higher than they are for Rural Health Clinics. PPACA is getting rid of the caps.

Pamela Byrnes AM Session Q&A

Q: We are a current FQHC. Under the contract model – I’m contracting with an individual to provide a required service – can that individual that service at their clinic? (not a CHC) and do I have to bring them into my scope of project?

A: The Department of Health Services is reviewing this question in relation to Wisconsin Medicaid policy for cost-based reimbursement for federally qualified health centers and will follow-up with WPHCA and FQHCs

Q: In our community there is an effort from an existing FQHC to open a satellite, and our local providers are feeling threatened – is this common and what can we do about it?

A: There is nothing to stop an outside organization of any kind from opening a satellite in a given community. We hope that the health center did their due diligence with that community, will bring on board members from that community, etc. In terms of private providers feeling threatened, it’s common across the US. It’s important to learn what their issues are, and try to partner with them. If the provider community doesn’t support the FQHC, that’s their choice.

Q: We have a huge disparity in mental health. But FTCA coverage won’t provide coverage for collaborating provider, or they won’t cover the health center or location when we have tried to collaborate – what to do?

A: Contact Triton Group – Marty Bree. Keep in mind that you only have so many dollars to provide comprehensive services. Need to make strategic decisions as to what services you’ll provide. To illustrate: think about what’s more important – covering root canals, or covering vaccinations for children? Try to fund those “above and beyond” services without bringing them into your scope of service (psychiatry, for example). Think strategically!

Stephanie Harrison PM Session Q&A

Q: What are your funding sources, and who are your board members?

A: 60% HRSA base grant, 30% state grants or contracts for specific work in chronic diseases and shortage designations, and 10% membership dues. Our board is the CEOs of 17 CHCs, 4 at-large members, plus fiscal ops member and clinic operations members (23 members total).

Q: Good collaborative arrangement examples?

A: Milwaukee has a hospital and CHC that have worked on a comprehensive needs assessment as part of growth plan for the city. Hayward CHC is co-located with a critical access hospital and a private clinic. In the southwest there is an example of free clinic, critical access hospital and CHC collaboration. We can direct you to other examples.

Comment: We need to look to Community Health Improvement Plans and what the counties themselves have prioritized. Need to develop map for the whole state indicating where people have indicated access to primary care and dental care as high needs.

Q: Can you provide technical assistance for community health assessments?

A: We are working to build our capacity on that. In particular, the Form 9 Needs for Assistance worksheet. We'd be happy to talk off line.

Pam, Tonya, and Stephanie Q&A session

Q: What is the function and definition of a Rural Health Clinic?

A: RHCs are a provider type. On WI PCO website, there is a section which outlines different safety net provider types. Check your resource list for the website. RHCs don't need a community based board, also can be non-profit, unlike FQHCs.

Q: Is there a risk of FQHCs and RHCs duplicating missions, and is there a good way for FQHCs and RHCs to collaborate?

A: They can collaborate well – should try to collaborate over duplicating.

Q: What is the estimated volume of clients and payer mix to be operational?

A: No minimum standards, but CHCs are expected to be efficient and sustainable, and assure continuity of care. Suggestion to look at UDS information on HRSA website and see state and national profiles. This is very specific to the community.

Q: Examples of CAP agencies and FQHC collaboration?

A: Pam Byrnes had an example of two CAP agencies which ran primary care services. They ended up merging, and opening two satellite sites at their original locations. They can work very well together. Must have a compliant board of directors (51% health center patients)

Q: What can WPHCA offer to communities who want to do a planning session?

A: Introductory webinar which describes benefits and limits to several models of safety net providers. WPHCA can do strategic planning, specific assistance with needs assessments, data collection. NOT able to write grants, project management, though we can connect you with experts. Please email us with additional questions.

Q: Examples of FQHCs working with hospitals?

A: Hesitant to give examples. Specific models work in specific communities – doesn't necessarily parallel what happens in another community.

Q: We know BPHC is looking for collaboration between different orgs and FQHCs, are reviewers looking for that as well?

A: Reviewers are aware of BPHC expectations. They have been provided with several instructions to look at a variety of approaches as long as they are within regulations. Read the guidance of the NAP grant – there are extra points for collaboration if you follow the specific criteria outlined in the guidance.

Q: What will an organization experience when transitioning to an FQHC?

A: First, the organization needs to understand what they are committing to – both committing to getting a grant, but more importantly, committing to provide care to the community. There are lots of reporting requirements, standards, expectations, etc. Also experience challenges related to serving entire populations if they had only been serving women or children. Make sure the board has read the application – must understand they need to serve everyone, and charge

patient. Organizations must know what the mission is. Employees transitioning over may not have the same benefits packages, retirement packages, etc.

Q: Is it practical to begin developing an FQHC if all will have insurance in the future?

A: Yes. FQHCs are a place for people to get care – just because someone has an insurance card doesn't mean they have access to care. FQHCs are a label for high-quality, patient-focused primary care delivery point.

Q: If you have an existing site, and are thinking about a new access point for a satellite, but you're pinched for space in the interim, is it reasonable to look at a change in scope and a lease location for a temporary solution and still apply for a NAP, or does that eliminate eligibility?

A: Important to tease out concepts. As an existing FQHC, to be eligible for a NAP, the location must not be in your scope of project at the time you apply. If the site you're considering is space limited, you can propose to establish at that location or another temporary location, but that you have identified a larger place where you ultimately plan to be. However, if you first make a commitment to a community by bringing them into your scope of project before you have grant funds to cover it, know that you are expected to maintain services in that community without any additional funds.

An organization applying for a NAP – whether a new start or satellite – often times has an existing clinic. If that organization is already operational, they must show what the additional grant money and funds will provide IN ADDITION to what they are already doing – money is not meant to supplant what's already being done. If an existing CHC grantee submits a grant to put up a satellite in a community, and decides to enter that community through a change of scope before being funded – they have already made a commitment to provide services in that community regardless of whether they receive grant funding. They may never receive additional funds to help cover costs in that community, so the CHC must think long and hard about whether they can really commit to a community (through a change in scope) without actually increasing the amount of money coming in. Make sure the community understands this VERY CLEARLY.

Pam: You're possibly better off bringing that community into your scope of project, and then applying for Expanded Medical Capacity to grow it, because you can use that to relocate in total to a new site.

Q: What is Plan B if there are not health care providers to staff health centers?

A: HRSA is aware that this is an issue. They are working on building capacity by incentivizing providers to work in underserved areas. There has been a stronger vocalization from Academics of Family Physicians and Pediatrics to make reimbursement equal for primary care docs as they are for specialists. NACHC is working on workforce issues as well.

Q: Do you know when Expanded Medical Capacity Grants will be released?

A: Shortly. We are actively working on expansion opportunities now. Trying to make the grant release as community oriented as possible – will definitely be released in FFY 2011 – likely this fall.

Q: How can health centers do strategic plans without knowing what the timeline is for grant releases? It's difficult to lay out a five-year plan without any guidance.

A: The federal budgeting process is so complex, we cannot predict what we can or cannot do. The priorities and decisions about when funds become available happen on a year to year basis. We have to balance how to do expansion efforts, when we are operating on a month to month budget with the federal government. We don't want to create expectations before we know if we can support them. You can still plan within your community based on needs – lay out those aspects now so you can build a logical plan and see how funding unwinds. Strategic planning is about developing needs assessment in communities, and creating a blueprint for where you want to be. The next step is prioritizing those needs, and then looking for funding. Strategic planning should never be reactive based on funding opportunities. This is why collaboration is so important, instead of searching out funding opportunities – funding may or may not continue to be available.

Q: How can psychosocial rehabilitation services be billed through an FQHC?

A: I'm not very familiar with psychosocial rehabilitation services. There are plenty of health centers which provide enhanced behavioral health services, but when it streams more toward what we would call "specialty services", there is a bit higher expectation about what's being provided. Not sure how billing works.

Q: Does primary care have to be at each FQHC site?

A: It depends on the needs of the community. This is a comprehensive primary care program – it doesn't mean that comprehensive primary care services at each site – it may be that you have one site which provides only oral health, but you have a documented plan that assures that patients receiving oral health care at your clinic have access to primary care services on a sliding fee scale elsewhere regardless of their ability to pay. You can have a site that's only pediatric or only seeing women, it just means you have to have networks in place to assure care for the rest of the population.

Q: Are there examples of counties partnering with an FQHC to provide psychosocial rehabilitation services, and what is the billing mechanism?

A: Yes, there are many great examples of FQHCs partnering with county mental health agencies. I would look to the national council for behavioral health. They may be able to talk from their side how they partner with FQHCs better than we can.

Q: We are an independent free clinic, looking to become a satellite clinic of an FQHC. If we hire someone to get off this project off the ground, can we apply for a planning grant to do so and reimburse ourselves?

A: If you are going to become a part of the FQHC, it is THEIR grant application, not yours. Existing grantees are not eligible for planning grants. It's the CHCs responsibility to make sure they can have the systems in place to absorb your organization. It would be difficult and awkward for another organization to get a planning grant for another CHC to come in. The organization which will exist in the end is the one which needs to have the plans in place.

Q: Base grant funding adjustment to be expected any time?

A: NACHC is working very hard from and advocacy standpoint to support the sustainability of existing FQHCs. Grassroots advocacy works! Several decisions on priorities come from direction from Congress. The more you do on base adjustments the less you do on New Access. Base adjustments don't mean new patients, but New Access Points do. It's hard choosing priorities.

Q: Psychosocial rehabilitation is like a wraparound program for individuals with mental health or substance abuse issues who are recovering from a disability – may need a case manager, specialized services, etc., In Wisconsin, our program is called CCS – it’s very similar to the FQHC model.

A: It sounds like you’re talking about enabling services, but many of those services are not billable. As long as it’s a Medicaid reimbursable service... FQHCs are probably able to work with the program, and enhance what they are already doing in those areas. Not sure how billing works.

Q: Could you speak about the ER Diversion program in more detail? Do you have examples of biggest issues as we think about it?

A: EMTALA regulations – making sure you’re providing appropriate choice and are going through required screening process. Other issues are appropriate protocol for who gets referred, and making sure that services are within the scope of the CHCs purview.

Q: Can NAP money be used to recruit providers?

A: Yes. The federal grant is the creation of a primary care service delivery site – those dollars are supporting a much larger effort, but part of that is recruitment.

Q: When do you see Health Information Exchanges taking off the ground, and how will they impact CHCs? Along with that, how can we be sure that all provider types are included in the exchanges?

A: The most important thing is to ensure that CHCs are improving their systems. Approximately 60% of CHCs have implemented EMRs – the first part is making sure every provider is taking advantage of incentive programs, meaningful use, etc. All safety net providers need to take advantage of those opportunities first.

Q: For a Critical Access Hospital that has a clinic, and want it to become a provider-based RHC, or perhaps a CHC, but they are under a large hospital system; can they not become a CHC?

A: They could re-align their board. But that’s not likely to happen. The health center needs independent decision-making authority. More than likely, a large system needs to spin off a separate organization, create an FQHC, and then collaborate. The FQHC could contract with the hospital system for certain services, but when so much of their operation is tied to another organization there comes a tipping point where there clearly is no longer a independent community health center.