THE PENNSYLVANIA

COMMUNITY HEALTH CENTER MANUAL

A guide to running a great FQHC in Pennsylvania

January 2024

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DEDICATION

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

This resource is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,220,839 with 20% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

FOREWARD

A healthcare delivery system, whether local, state, or national, is an extremely complex and living entity. It has elements of science, technology, education (basic and higher), personnel management, facility, and much more. This manual is about a particular national health care delivery system model. It focuses on primary health care, but often extends through collaborative or other arrangements to many other clinical care areas. It is a small business in the communities where its sites are located but is part of a large and extraordinary network. This exceptionally diverse organization is interchangeably called a Community Health Center, federally qualified health center or FQHC. [1]

FQHCs began in the mid-1960s as an experiment to see if they could address the primary care needs of the underserved - individuals and families with inadequate access to primary health care for a variety of reasons. They may be uninsured or have health insurance, such as Medicaid, which many providers do not accept. Sometimes, the issue is cultural or linguistic. The original experiment began in Mississippi and Boston. As proof of their value, FQHCs are present in every state in the nation with more than 1,400 FQHC organizations in the U.S. and its territories. In 2022, the nation's FQHCs served more than 30 million people across 13,000 service sites.

Community Health Centers FQHC comprise the largest national and state network of primary care providers and have had bipartisan support throughout their more than 50-year history. There are four unique distinguishing characteristics:

Fees based on **ability to pay**
Quality primary health care for **all**
Health professional **team**
Consumer **governed** and patient-centered

Pennsylvania's "community of Community Health Centers" cares for nearly **1 million** Pennsylvanians through more than **3 million** visits annually. There are 52 FQHC organizations with more than 395 delivery sites statewide with locations in 54 of the state's 67 counties, in both **urban** (60%) and **rural** (40%) areas serving federally designated medically underserved areas. Pennsylvania's FQHCs stay true to their mission of serving the most vulnerable:

- **47%** of patients are insured through Medicaid/CHIP
- **67%** have incomes at or below 100% of the Federal Poverty Level
- **15% are** uninsured

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

[1] In this manual, the term FQHC includes both FQHCs and Look-Alikes unless specifically noted otherwise

Because of the validated success of the Community Health Center model over its long history, many communities, when responding to local health care needs, look at this model as a potential solution to better their residents' health. This begins a journey, often a very challenging one, to plan, develop and obtain funding as an FQHC.

This manual is designed as a guide to developing or leading a Community Health Center in Pennsylvania. It does not intend to duplicate or replicate the other excellent resources that exist, in fact this manual will direct you to those resources. This manual gives Pennsylvania-specific guidance to supplement that information. It is also not intended to stand alone without consultation with and support and technical assistance from the state's designated Primary Care Association (PCA), the Pennsylvania Association of Community Health Centers (PACHC).

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

INTRODUCTION

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

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

The Community Health Centers of today are not the organizations they were in the past. The healthcare system in the United States and in our Commonwealth continues to change and evolve and FQHCs are at the forefront of responding to those changes in a myriad of ways. They are earning recognition as Patient-Centered Medical Homes, joining health information exchanges, expanding services to include substance use disorder treatment and vision care, and engaging in value-based care – all to better meet their mission of improving access to quality primary health care for all. Many FQHCs serve as training facilities for the next generation of healthcare professionals, providing a unique experience in a community-based setting.

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

PACHC works with individuals, organizations and communities across the Commonwealth interested in establishing a Community Health Center as well as with the leaders of existing FQHCs. Together, we work to strengthen this important network that means access to care for so many.

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

HISTORY OF THE HEALTH CENTER PROGRAM

The Health Center Program has a more than 50-year history.

"In 1965 the nation's first community health centers were launched as a small demonstration program as part of the President Johnson's Office of Economic Opportunity. With roots in the both the civil rights movement and the War on Poverty, the earliest health centers had as their mission no less than using the health care system to change the health and lives of their communities' residents." Community Health Centers: Chronicling Their History and Broader Meaning

Funding for the first two "Neighborhood Health Centers" (as they were then called) – one in Boston, Massachusetts, and the other in Mound Bayou, Mississippi – was approved in 1965, and the Community Health Centers Program was launched.

Today health centers have become one of the largest primary care networks, distinguished by their mission to community, the quality of their care, their affordability and accessibility to all community residents, and perhaps most uniquely, their community governance. All health centers have patient-majority governing boards; more than half of every Community Health Center's board is comprised of patients of the health center.

Health centers have greatly flourished over the past 55 years. In 2008, there were more than 1,200 health centers, operating over 7,500 sites, providing health care to 17 million patients, including migrant farmworkers, persons experiencing homelessness, and public housing residents, throughout the 50 states, the District of Columbia, and the U.S. territories. In 2022, the nearly 1,400 health centers with nearly 13,000 delivery sites served more than 30 million people –1 in 11 people across the U.S.

Visit https://www.chcchronicles.org/histories

SO WHAT IS A COMMUNITY HEALTH CENTER?

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

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

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

- **F**ees based on ability to pay (*FQHCs must offer a sliding fee discount program and individuals are expected to pay what they can afford*)
- **Q**uality primary health care for all (*FQHCs are open to all and research has validated the overall high quality of health center care and surveys consistently show high patient satisfaction. Each health center's data is also publicly available online.*)
- **H**ealth professional team (*FQHCs offer comprehensive, culturally competent, quality medical, dental, and behavioral health care. Staff must be appropriately licensed, credentialed, and privileged*.)
- **C**ommunity governed and patient-centered to ensure health centers are responsive to their patient population and community need (*at least 51% of people serving on the governing board of an FQHC must be patients served by the health center*)

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

Also, watch our 2-minute video, What are Community Health Centers and How Can They Help You?

For more information or questions on how to obtain the branding materials, contact pachc@pachc.org or visit the NACHC Branding Campaign for Health Centers. (This link no longer goes to the branding information)

GLOSSARY OF TERMS/ACRONYMS

Bureau of Primary Health Care (BPHC): the bureau of the Health Resources & Services Administration (HRSA) charged with oversight of the Health Center Program.

Certified application counselor designated organization (CDO): in the federally facilitated Marketplaces (FFMs), CDOs oversee certified application counselors (CACs) who are trained and able to help consumers seeking health insurance coverage options through an FFM.

Centers for Medicare and Medicaid Services (CMS): the federal agency within the U.S. Department of Health and Human Services (HHS) that administers Medicare and works in partnership with state governments to administer Medicaid and the Children's Health Insurance Program (CHIP).

Community Health Center (CHC): refers to both a federally qualified health center (FQHC) Section 330 grantee or a Look-Alike.

Children's Health Insurance Program (CHIP): a state-federal partnership that provides no cost or low-cost health insurance to uninsured, low-income children and teens who are not eligible for or enrolled in Medical Assistance.

Pennsylvania Department of Human Services DHS: (formerly the Department of Public Welfare or DPW) responsible for administration of the Commonwealth's Medicaid and CHIP programs.

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

Enrollment Assister: an individual who completes the annual Pennie (Pennsylvania's state-based insurance exchange) training and is registered with the Pennsylvania Insurance Department to provide Health Insurance Marketplace enrollment assistance. Analogous to individuals in state that use the federal Marketplace and complete the Centers for Medicare & Medicaid Services (CMS) navigator curriculum.

Federal Tort Claims Act (FTCA): also known as the *Federally Supported Health Centers Assistance Act (FSHCCA):* The FSHCCA of 1992 and 1995 granted medical malpractice liability protection through the FTCA to HRSA-supported health centers. Under the Act, eligible health centers are "deemed" to be federal employees and are immune from lawsuits, with the federal government acting as their primary insurer.

Health Center Controlled Network (HCCN): a coalition of a minimum of 10 HRSA-funded health centers that work together to use health information technology to improve operational and clinical practices and to support health centers leverage health IT to increase participation in value-based care.

HealthChoices: Pennsylvania's mandatory Medicaid managed care program

- PH-MCO – physical health managed care organization
- BH-MCO – behavioral health managed care organization
- CHC – Community HealthChoices for individuals dually eligible for Medicare & Medicaid

Health Information Organization (HIO): an information technology organization certified by the PA eHealth Partnership to exchange health information data between at least two unaffiliated provider and/or payer (private or public) organizations and enable users to satisfy health information exchange-related Meaningful Use requirements.

Health Professional Shortage Area (HPSA): federal designations that indicate healthcare provider shortages in primary care, dental health, or mental health; shortages may be geographic, population, or facility based.

Health Resources and Services Administration (HRSA): an agency of the U.S. Department of Health and Human Services charged with the provision of health care services to geographically isolated, economically disadvantaged, and vulnerable populations. The HRSA Bureau of Primary Health Care (BPHC) administers the Health Center Program.

FQHC Look-Alike (LAL): operates and provides services consistent with Health Center Program requirements, however, does not receive federal section 330 grant funding nor do they qualify for Federal Tort Claims Act (FTCA) medical liability coverage. Look-Alikes do qualify for reimbursement under FQHC Medicare and Medicaid payment methodologies. Look-Alikes are also eligible to participate in the 340B Discount Drug Pricing Program, receive automatic Health Professional Shortage Area (HPSA) designation, and may access National Health Service Corps (NHSC) providers.

Medical Assistance (MA) - Pennsylvania's Medicaid program in partnership with the Centers for Medicare and Medicaid Services that pays for healthcare services, including medical, dental, and behavioral health, for eligible individuals.

Medicare Administrative Contractor/Fiscal Intermediary (MAC/FI): a private healthcare insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries. Also, serves as the primary operational contact between the Medicare FFS program and healthcare providers enrolled in the Medicare program.

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

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs): federal designation identifying geographic areas or specific sub-groups of people living in a defined geographic area with a lack of access to primary care services.

National Health Service Corps (NHSC): a HRSA program that administers health professions scholarship and loan repayment programs that connect primary healthcare clinicians to high-need communities through a service commitment in exchange for academic scholarship or loan repayment.

Operational Site Visit (OSV): an onsite evaluation by reviewers engaged and trained by the HRSA Bureau of Primary Health Care (BPHC) to evaluate health center compliance with the Health Center Program requirements as specified in the Health Center Compliance Manual.

Pennsylvania Patient & Provider Network (P3N): the state health information exchange "highway" network that exchanges data among the five health information organization members across Pennsylvania.

Pennsylvania Primary Care Career Center: a partnership of the PA Department of Health and the Pennsylvania Association of Community Health Centers, designed to be a one-stop portal to primary care practice opportunities, recruitment and retention resources and workforce education.

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

Pennie: Pennsylvania's state-based Health Insurance Marketplace

Policy Information Notice (PIN): HRSA communication that defines and clarifies policies and procedures required of grantees funded under Section 330. Several PINs and program assistance letters (PALs) are no longer considered current policy; please refer to the HRSA Compliance Manual for current HRSA policy.

Prospective Payment System (PPS): refers to the way FQHCs are paid under Medicaid whereby each health center's costs are converted to a per encounter rate and then health centers are paid for an "FQHC visit" rather than by individual evaluation and management or service/procedure codes. This rate is updated annually on October 1 by the Pennsylvania Department of Human Services based on the Medicare Economic Index (MEI), and other than this annual adjustment can only be modified if a health center adds or deletes a service to their scope of project. FQHCs also qualify for Medicare reimbursement via a PPS methodology.

Program Assistance Letter (PAL): HRSA communication that summarizes and explains items of significance for health centers such as HRSA program implementation activities, final regulations, and/or new HHS initiatives. Several policy information notices (PINs) and PALs are no longer considered current policy; please refer to the HRSA Compliance Manual for current HRSA policy.

Quality Improvement (QI)/ Quality Assurance (QA): also, continuous quality improvement (CQI), consists of systematic and continuous evaluation actions leading to measurable improvement in healthcare services and in the health status of targeted population groups. Health Center Program Terms and Definitions - HRSA recommends the use of this resource in conjunction with the glossary in the HHS Grants Policy Statement

NEEDS ASSESSMENT

The core precept of a community health center is to serve the community in which it is located. This starts by defining the proposed service area. Because of the unique traits of health centers, especially community responsiveness, the health center must serve a geographic area that contains at least one Medically Underserved Area (MUA) or Medically Underserved Population (MUP).

The journey of establishing a health center or expanding sites and/or services begins with a needs assessment that, at a minimum, addresses:

- Factors associated with access to care and service utilization
- Significant causes of morbidity, mortality, as well as any associated health disparities
- Unique health care needs or characteristics impacting health status, access, and utilization

Important Points:

- The health center identifies and annually reviews its service area based on where current or proposed patient populations reside as documented by patient origin data reported by ZIP code and service delivery site location ZIP codes. At least 75% of the health center's patients must come from the service area as defined by the health center.
- A review and update of the needs assessment must be completed at least once every three years utilizing the most recent available data for the service area and/or special population, if applicable, for the purposes of informing and improving the delivery of health center services.
- The health center determines the most appropriate methodologies, tools, and formats for conducting needs assessments (for example, quantitative or qualitative data sources, focus groups, patient surveys or participation in community-wide needs assessments).

Resources:

- So You Want to Start a Health Center…? (Sept. 2019)HRSA/BPHC Health Center Program Compliance Manual - Updated: Aug. 20, 2018
- Capital Link Market Assessment
- UDS Mapper
- PA Dept. of Health – Health Statistics

HEALTH CENTER STAFFING/WORKFORCE

Working in a Community Health Center is an opportunity for professionals to "Earn a Living Where Your Heart Is." That means providing high quality care to a population that otherwise might not have medical, dental, and behavioral health care.

A health center must ensure that it has qualified staff or has contracts or formal referral arrangements in place with other providers or provider organizations to carry out all required and additional services included in their HRSA-approved scope of project.

The health center should consider size, demographics, and health needs of its patient population in determining the number and mix of clinical staff necessary to ensure reasonable patient access to healthcare services.

The health center governing board must approve the selection and termination/dismissal of the health center's executive director or chief executive officer.

The health center determines the makeup and distribution of functions among its key management staff. Examples of key management staff may include clinical director/chief medical officer, chief financial officer, chief operating officer, nursing/health services director, and chief information officer.

Developing Your Personnel Budget and Hiring Your Team

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

Step 1: Data Gathering

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

Important Points:

- It is helpful in both the developmental and start-up phases of an FQHC to have local individuals who are knowledgeable about human resource issues on your planning team or board. You might consider someone from the local state employment office, the chamber of commerce or an economic development agency.
- Job descriptions do not always have consistent definitions, making comparisons a bit difficult. Caution should be exercised, especially when comparing information between public and private sectors or for-profit and not-for-profit organizations. PACHC maintains an archive of job descriptions shared by our member FQHCs.

- Medical Group Management Association (MGMA), NACHC, PACHC and other sources offer salary and benefits surveys.

Resources:

- 2023-24 Pennsylvania Health Center Salary & Benefits Survey: To be published in early 2024, the survey contains a list of approximately 80 jobs that could be found in a Community Health Center. The report, assembled by ElementOne Consulting Inc. offers a great resource for not only salaries but also benefits such as PTO, insurances, and retirement funds. Contact the Pennsylvania Primary Care Career Center for more information. pachc@pachc.org.
- NACHC Online Library Workforce
- NACHC Health Center Salary & Benefits Report is compiled from an annual survey by the National Association of Community Health Centers (NACHC) of FQHC salaries and benefits and covers many but not all potential job descriptions of interest. Information is divided into executive and clinical sections, with key positions in each category and is presented by urban and rural populations, annual encounters, total budget, region, and state. This can be purchased from NACHC at both member and non-member prices. It is published annually in May.
- U.S. Bureau of Labor Statistics offers some compensation information by position, state, and metropolitan statistical area for numerous job descriptions. From the website you can access wage data by area and occupation.

Step 2: Create Job Descriptions

If you're looking for some sample job descriptions for positions commonly found within health centers, the PA Primary Care Career Center within PACHC is here to help, so don't hesitate to contact Career Center Director, Judd Mellinger-Blouch at judd@pachc.org or email pachc@pachc.org. The Career Center maintains a large library of job descriptions and can also solicit samples from other health centers.

Resources:

- Community Health Center Association of Connecticut job description library
- Community Health Association of Mountain/Plain States job description samples

Step 3: Salary & Benefit Determinations

This next step—determination of reasonable and competitive wage ranges for each of the positions the FQHC requires—is perhaps the most difficult.

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

Important Points:

- A successful health center will study local prevailing rates and propose to the board of directors a salary band that allows recruitment of the best candidates. In the past, it was

maintained that health centers cannot and should not attempt to meet prevailing rates, but in today's competitive environment, this is no longer a viable strategy.

- The board of directors must approve salary bands, but the CEO (or designee) determines the actual rate within the band.
- Benefits packages may vary by position. This allows you to incentivize harder to recruit professionals, such as giving continuing education allowances to physicians and dentists.
- PACHC has PACHC Preferred Vendor – Alliant Employee Benefits – that can assist with employee benefits such as medical and dental insurance, group term life and disability insurance and other insurance options. For more information or questions, contact pachc@pachc.org.
- From a budgetary perspective, it is important to understand total compensation costs, because as benefits increase, so does the need to generate revenue to cover them. The STAR[2] Center's Compensation Self-Assessment Tool is a helpful resource.
- For most clinical positions, candidates may be eligible to apply for National Health Service Corps or the Pennsylvania Primary Care Loan Repayment Program. Candidates may also be eligible for the Public Service Loan Forgiveness Program if they meet the program's stringent requirements. These benefits should not be used to reduce provider compensation as this will make net pay lower and less attractive. However, these benefits can certainly be highlighted as a benefit in recruiting.
- Do not underestimate the value of passion for the mission for some candidates. It's the reason why PACHC launched the "Earn a Living Where Your Heart Is" campaign.
- Foreign-trained physicians and dentists in the United States on a J1 or H1-B visa offer a pool of candidates that should be explored. The Career Center can help you with resources including referrals to immigration attorneys who will guide you through the process.
- If you are a new start-up FQHC or a new site in an existing organization, develop a ramp up plan or phase in period that does not overcommit resources on day one but considers growth over time. "Some health center experts recommend staffing for about 115% of expected provider productivity (as it relates to patient volume). Additional provider and provider support staffing (i.e. medical assistants) should be planned for when the health center is consistently outperforming volume expectations by 10% (e.g. every week for six weeks)." [2]
- Recognize early the budget implications of salary ranges, as well as the time it takes to reach full staff complement, create budgets for the first three years of operation. You can then adjust your staffing targets and timeframes along the way.

Step 4: Advertising Open Positions

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

[2] So You Want to Start a Health Center? September 2019

PACHC and the Pennsylvania Primary Care Career Center have developed a full suite of marketing tools you can use under the "Earn a Living Where Your Heart Is" campaign. Contact the Career Center to gain access to these resources.

Important Points:

- Continually evaluate the effectiveness of different advertising venues and your recruitment strategy. For example,
  - Are you quickly responding to referrals and inquiries, contacting candidates immediately after learning about them?
  - Are qualified individuals responding?
  - Are you losing qualified candidates because of the salary and benefit package?
  - Do not forget the impact and effectiveness of social media and other digital marketing channels
- The PA Primary Care Career Center within PACHC is the Pennsylvania network coordinator for the National Rural Recruitment and Retention Network (3RNET.org). The Career Center will post your jobs on 3RNET.org, provide you lists of candidates and help you with your clinical and key leadership position recruitment needs. It is important to note that 3RNet is no longer only a rural recruitment resource.
- Your team of health center supporters can be recruitment advocates by distributing recruitment materials and provide referrals.
- You have access to 3RNET's four-part "Recruiting for Retention Guide." Contact the Career Center at pachc@pachc.org.
- Develop a Workforce Recruitment workplan using tools from the STAR^2 Center.

Step 5: Orientation and On-Boarding

Making new employees quickly feel part of the organization is important. It is helpful to develop an "on-boarding checklist" including the key areas that will be covered during orientation to ensure vital information is not overlooked. Remember, orientation is what happens during an employee's first few days on the job. Onboarding, however, is an intentional, long-term process that helps the employee reach their full potential and productivity. For example, learning your Electronic Health Record system may take weeks not days.

While a good orientation to your organization is essential, equally important for employees and their families new to your community is help in quickly making them feel part of the local community. NACHC, in collaboration with the University of Virginia, has put together on Onboarding Essentials toolkit.

Important Points:

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

Step 6: Retention

The PA Primary Care Career Center within PACHC has several excellent retention resources available to help you keep the qualified individuals you are fortunate to recruit. Having a good retention plan in place is important and too often overlooked. The cost of a physician leaving a practice can easily reach almost $500,000. Recruitment costs alone run as high as $50,000 for

certain professions and the loss in annual gross billings as a result of lost productivity and a new physician's start-up expenses can reach $300,000 to $400,000.

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

Resources:

- Pennsylvania Primary Care Career Center at PACHC offers a variety of resources to help your recruitment efforts, particularly recruitment of clinical and key leadership positions. The Career Center uses a variety of methods – online job postings, career fairs and events, databases of candidates, networking with residency and other professional education programs – to assist health centers in their recruitment and retention efforts. The Career Center can provide you with information on the National Health Service Corps (NHSC) and Pennsylvania's loan repayment program, hiring a J-1 visa physician in Pennsylvania and many other resources.
- The STAR² Center is a project of the Association of Clinicians for the Underserved (ACU), a transdisciplinary membership organization working on behalf of the NHSC and clinicians who provide care to the underserved. It is a clinician workforce center for recruitment and retention at community health centers providing free resources, training, and technical assistance to health centers with workforce needs.
- 3RNET (The National Rural Recruitment and Retention Network) powers the Career Center job board and offers many resources and tools you can use to recruit and retain providers. Most of these resources are free to you as a member of PACHC.

LICENSURE, ENROLLMENT AND CREDENTIALING

Let's start by clarifying the terms used in this manual:

Licensure: Provider/professional licenses issued by the PA Department of State, Bureau of Occupational and Professional Affairs

Enrollment: Provider and service delivery site enrollment in the PA Department of Human Services (DHS) Medicaid PROMISe system

Credentialing: the process of performing a background investigation, as well as validation and assessment of a practitioner's/provider's credentials and qualifications to provide care or services in or for a healthcare organization; provider/professional credentialing must be completed with the appropriate insurer/managed care organizations (MCOs). Professional and board certifications should be part of the credentialing process where applicable.

Privileges: Provider privileges authorize and allow medical providers to practice certain patient care in a specified healthcare facility. Privileges are granted to providers based on their current medical credentials and known competence.

Licensure. Clinical staff providing services on behalf of the health center must be licensed and certified as per Pennsylvania law and regulations. Clinical staff subject to licensure and certification in the state of Pennsylvania include licensed independent practitioners such as physician, dentist, physician assistant, nurse practitioner, licensed professional counselor, licensed clinical social worker, licensed clinical psychologist; and other licensed or certified practitioners such as, registered nurse, licensed practical nurse, registered dietitian, and other clinical staff. See the PA Dept. of State, Bureau of Professional and Occupational Affairs for more details

Prescriptive Authority. Pennsylvania is considered a "restricted practice" state for nurse practitioners (NPs) due to the requirement for a collaborative agreement to practice and a collaborative agreement to prescribe. In addition to the collaborative agreements, two separate licenses are required: a CRNP license and a Prescriptive Authority license. Drugs and therapeutic measures available for prescribing must be outlined in the written collaboration agreement and relevant to the NP's specialty. An NP may prescribe Schedule II-V controlled substances. BPOA - Pennsylvania Licensing System (pa.gov)

A similar situation exists for Physician Assistants within their Scope of Practice (State Law Chart - Physician Assistants' Scope of Practice (ama-assn.org) and Prescriptive Authority and 49 Pa. Code § 18.158.

Important Points:

- As a member service, PACHC, in partnership with the Department of State, has developed a process to expedite provider licensure, practitioner prescriptive privileges, and NP/PA collaborative agreements. All applications must be completed online through the PALS portal. Once the application has been submitted, visit the PACHC website

Health Center Operations/Expedited Provider Licenses, to submit a expedite request. Make sure you are logged into the website, then complete and submit the form.

Enrollment. In order for providers and service delivery sites to participate with the Department of Human Services (DHS) and provide services to Medical Assistance (MA) or Children's Health Insurance Program (CHIP) recipients, they must first enroll and receive a Medicaid/PROMISe number.

The most efficient and effective way to submit a new application, revalidation or reactivation of enrollment in the MA program is through the online provider enrollment portal, Medical Assistance (MA) and Children's Health Insurance Program (CHIP) On-line Provider Enrollment Application.

Using the secure online portal:

- Allows documents to be uploaded directly to the portal
- Permits providers to see the status of their submission
- Decreases wait time for review of applications

To access enrollment or revalidation applications and requirements for each Medical Assistance provider type, visit the Provider Enrollment Documents page.

Providers may call the Office of Medical Assistance Programs, Provider Enrollment at 1-800-537-8862 to request a paper application should the PDF version of the application no longer be accessible on the DHS Provider Enrollment website. Paper applications will continue to be accepted for processing but cannot be expedited.

Important Points:

- As a member service, PACHC, in partnership with the Department of Human Services (DHS), has developed a process to expedite provider enrollment, licensure and credentialing (forms) for individuals working in a Community Health Center FQHC or rural health clinic (RHC). As part of this agreement, DHS requires that all requests go through PACHC to ensure that submissions are complete and consolidated.
- Requests for expediting should not be submitted sooner than 5 business days after an enrollment application has been submitted to DHS. Please note, DHS is not able to expedite *revalidations* at this time.
- Note: DHS will only expedite enrollment applications submitted through the online portal.
- Medicare enrollment automatically enrolls the provider into CHIP. PACHC does not expedite enrollment applications for CHIP only.

Resources:

- PACHC Memo 19-02 Licensure, Enrollment and Credentialing. Please contact pachc@pachc.org to request a copy.
- CHIP Provider Enrollment Information
- DHS Provider Enrollment FAQs

Medicare Enrollment. For Medicare enrollment, an FQHC uses application CMS-855A, Medicare Enrollment Application for Institutional Providers or the Internet-based Provider Enrollment, Chain and Ownership System (PECOS).

Use of PECOS is encouraged instead of the paper Medicare enrollment application for several reasons. PECOS is a completely paperless process, including electronic signature and digital document feature, it's faster than paper-based enrollment, you have more control over your enrollment information, including reassignments, and it's easy to check and update your information for accuracy.

PA is part of the Novitas A/B MAC Jurisdiction L. A Medicare Administrative Contractor (MAC) is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries.

Important Points:

- The Centers for Medicare and Medicaid Services (CMS) considers each HRSA-approved health center site to be its own FQHC for Medicare registration and reimbursement purposes.
- One enrollment cannot contain more than one practice location, so multiple enrollments must be created for FQHCs that have multiple locations.
- To be reimbursed under the Medicare FQHC benefit, an entity must:
  - For each site, submit a complete application package (Form CMS-855A and supporting documents) to the appropriate Medicare Administrative Contractor (MAC)
  - Receive from the CMS Regional Office in Philadelphia a CMS Certification Number, a signed Medicare agreement, and an effective date.
- Do not forget the Supporting Documentation for Federally Qualified Health Centers - Form CMS-855A.

Credentialing. Health centers must have operating procedures for the initial and recurring review of credentials for all clinical staff members (licensed independent practitioners, other licensed or certified practitioners, and other clinical staff providing services on behalf of the health center who are health center employees, individual contractors, or volunteers.

Important Points:

- Refer to HRSA Health Center Program Compliance Manual, Chapter 5: Clinical Staffing.
- HRSA credentialing procedures require completion of a query through the National Practitioner Data Bank (NPDB).
- HRSA, when mentioning recurring credentialing, consistently uses every 2 years as the example.

Pennsylvania is a mandatory Medicaid managed care state with multiple managed care organizations (MCOs) holding contracts with DHS. (See PA HealthChoices Statewide Managed Care Map) Each MCO is responsible to ensure proper credentialing of new practitioners, as well as the recredentialing of participating practitioners. This results in multiple credentialing applications for one provider with several MCOs. Each MCO has established credentialing and

recredentialing policies and procedures that adhere to all applicable state and federal standards and regulations including the Centers for Medicare and Medicaid, PA Dept. of Health, PA Dept. of Human Services and NCQA standards.

- All practitioners must be credentialed with the MCO before rendering services and submitting claims for patients of that MCO.
- All practitioners must be recredentialed at least every three years from the date of initial credentialing in order to continue participation
- An initial on-site evaluation of practice site(s) and/or medical record documentation will be conducted at all PCP and dental practitioner office sites as part of the credentialing process.

Important Points:

- The health center determines how credentialing is to be implemented -- contract with a credentials verification organization (CVO) to perform activities or have own staff conduct credentialing -- including whether to have separate credentialing processes for licensed independent practitioners versus other provider types.
- Note: Please ensure you know the credentialing requirements of the various MCOs. Example: What are the credentialing requirements for NPs and physician assistants? What is the MCO's stance related to board certification?
- One of the messages PACHC has clearly heard from several MCOs is that health center participation in the system offered by the Council for Affordable Quality Healthcare (CAQH) is very helpful to ensure efficient credentialing and reasonable credentialing timeframes. CAQH is a single portal for sharing information needed for credentialing with all CAQH-participating MCOs. CAQH's ProView may be of most interest to PACHC members and their providers. CAQH ProView is a valuable credentialing tool that participating organizations use for network directories, claims processing, quality assurance, emergency response, member services and more.
- PACHC has been successful in convincing DHS to add a 60-day benchmark for completion of credentialing to MCO HealthChoices contracts and in getting new language added outlining required communications and timeframes. PACHC can assist with holding the MCOs accountable to that 60-day benchmark.
- If you are having difficulty with an MCO credentialing a provider and have not been able to get a response from the MCO within the 60-day benchmark, please visit Health Center Operations > MCO Delays and Challenges on the PACHC website. Make sure you are logged into the website, complete the form providing details on the timeline of communications to and from the MCO and submit the form. PACHC will investigate and follow-up.
- PACHC offers a Credentialing Peer Networking Group. The individual(s) responsible for the provider onboarding process at your health center should join this group that meets monthly meeting to discuss all things enrollment, licensure, MCO credentialing and more. To learn more or to join the group, please contact pachc@pachc.org.

Privileging. Health centers are required to have a policy and procedures for the initial granting and renewal (for example, every two years) of privileges for clinical staff providing services on behalf of the health center who are health center employees, individual contractors, or

volunteers. Privileging is the process of authorizing a practitioner's specific scope and content of patient care services.

These privileging procedures should address verification of fitness for duty; immunization and communicable disease status; for initial privileging, verification of clinical competence via training, education, and, as available, reference reviews; for renewal of privileges, verification of current clinical competence via peer review, supervisory performance reviews or other comparable methods; and a process for denying, modifying or removing privileges based on assessments of clinical competence and/or fitness for duty.

Important Points:

- Credentialing and privileging files and records for clinical staff (employees, individual contractors, and volunteers) must be maintained. Documentation of licensure, credentialing verification, and applicable privileges must be consistent with the written procedures.
- The health center determines how it assesses clinical competence and fitness for duty of its staff.
- The health center determines whether to disallow individual providers or organizations from providing health services on the health center's behalf.

COMMUNITY HEALTH CENTER OPERATIONS

REQUIRED & ADDITIONAL SERVICES

A health center must provide the required primary health services listed in section 330(b)(1) of the PHS Act. (42 U.S.C. §254b)

A health center that receives a Health Center Program award or Look-Alike designation under section 330(h) of the PHS Act to serve individuals experiencing homelessness must, in addition to these required primary health services, provide substance use disorder services.

The health center governing board determines which, if any, additional health services are needed and appropriate to meet the health needs of the population and community served by the health center, subject to review and approval by HRSA.

HRSA Form 5A lists several additional services:

- Additional Dental Services
- Behavioral Health Services
    - Mental Health Services
    - Substance Use Disorder Services
- Optometry
- Recuperative Care Program Services
- Environmental Health Services
- Occupational Therapy
- Physical Therapy
- Speech-Language Pathology/Therapy
- Nutrition
- Complementary and Alternative Medicine
- Additional Enabling/Supportive Services

All required and applicable additional health services must be provided through one or more service delivery method(s): directly; through formal written contracts/agreements – health center pays; or formal written referral arrangement – health center does not pay. See Form 5A, the Service Descriptors for Form 5A, and the Column Descriptors for Form 5A: Services Provided for additional information.

Important Points:

- Frequent findings on HRSA Operational Site Visits (OSVs) are non-compliance related to an incomplete and inaccurate Form 5A: services not reflected in the correct column; lack of current contracts/agreements. Examples: Need to adjust some items to be both Column I and II, only had in column 1, but portions of the services are contracted; specialists in Column I with no up-to-date or actual contracts.
- Health Center Self-Assessment Worksheet for Form 5A: Services Provided: This worksheet is a self-assessment tool for health centers to evaluate the accuracy of their HRSA scope of project, specifically the accuracy of Form 5A: Services Provided
- For services delivered via Column II of the health center's Form 5A (whether the service is also delivered via Column I and/or Column III), contracts/agreements should address how the service will be documented in the patient's health center record; and how the

health center will pay for the service. (Note: The same sample of contracts/agreements will be utilized for HRSA operational site visit (OSV) review of both Required and Additional Health Services and Sliding Fee Discount Program Patient Records.)

- For services delivered via Column III of the health center's current Form 5A (whether the service is also delivered via Column I and/or Column II), referral arrangements must contain provisions as to how referrals will be made and managed. Also provided is the process for tracking and referring patients back to the health center for appropriate follow-up care (for example, exchange of patient record information, receipt of lab results). Note: The same sample of contracts/agreements will be utilized for the review of both Required and Additional Health Services and Sliding Fee Discount Program.
- The patient records of patients who received a required and additional service(s) via contract or referral agreement – Column II and Column III—will be reviewed for compliance.
- The health center governing board determines which, if any, additional health services to offer in order to meet the health needs of the population served by the health center (subject to review and approval by HRSA).

Enabling Services. Enabling services, required for participation in the Health Center Program, are critically important non-clinical services that improve patient access to health care and social services, help reduce barriers to care, and encourage healthy behavior. The required enabling services include case management, eligibility assistance, health education, outreach, transportation, and translation. Additional enabling services are determined by the health center governing board as necessary to meet the needs of the population served by the health center (subject to review and approval by HRSA.

Respect for cultural sensitivities and bridging linguistic and cultural differences is a key tenet of the health center program. Health centers that serve a substantial proportion of individuals with limited English-speaking ability must have arrangements for interpretation and translation that are responsive to the needs of those populations to the extent practicable in the language and cultural context most appropriate for those individuals.

Change in Scope of Project. HRSA defines scope of project as the approved service sites, services, providers, service area(s) and target population(s) which are supported (wholly or in part) under the total section 330 grant-related project budget. A grantee's scope of project must be consistent with applicable statutory and regulatory requirements, Health Center Program compliance requirements, and the mission of the health center.

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

Resources:

- PIN 2008-01 Defining Scope of Project and Policy for Requesting Changes
- PIN 2009-05 Policy for Special Population-Only Grantees Requesting a Change in Scope to Add a New Target Population

Specialty Services. HRSA considers specialty services to be within the broad category of "additional" health services, defined in section 330 as services that are not included as required primary health care services and that are (1) necessary for the adequate support of primary health services and (2) appropriate to meet the health needs of the population served by the health center.

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

HRSA guidance for adding specialty services is outlined in PIN 2009-02 Specialty Services and Health Centers' Scope of Project.

When evaluating the addition of a specialty service to the Federal scope of project, consider these factors: necessity for the adequate support of primary care; demonstrated need for the proposed specialty service; financial risk; location; state regulations; and any FTCA implications.

Important Points:

- When considering the addition of specialty services, the first step should be to contact the HRSA Bureau of Primary Health Care (BPHC) through the BPHC Contact Form.
- As you consider the addition of specialty services, remember that a change in scope of project does not provide additional HRSA grant monies. Budget carefully as you project both costs and benefits.
- In assessing the financial impact of adding a specialty service, consider whether this new service will be considered an FQHC service eligible for enhanced FQHC Medicaid and Medicare reimbursement.
- Should HRSA approve the specialty service as part of your scope of project, there is no guarantee that the PA Department of Human Services will permit adding the service as a Medicaid FQHC service.
- In circumstances where the provider arrangement does not meet the criteria for FTCA coverage, health centers should ensure that the health center/provider has sufficient alternative malpractice insurance.
- The specialty service must be available equally to all patients regardless of ability to pay and available through a sliding fee scale.

Resources:

- PIN 2009-02 Specialty Services and Health Centers' Scope of Project
- Federal Tort Claims Act Manual

Dental. Preventive dental services are a required Health Center Program service, whether provided directly by the health center or through a referral or contractual agreement. At a minimum, these services should include all the following: basic dental screenings and recommendations for preventive intervention; oral hygiene instruction and related oral health education; oral prophylaxis, as necessary; and topical application of fluorides and the prescription of fluorides for systemic use when not available in the water supply. Services may also include application of sealants, and diagnostic screening for caries and periodontal disease through the use of dental x-rays.

Additional dental services are basic services at a general practice level to diagnose and treat disease, injury, or impairment in teeth and associated structures of the oral cavity and include any diagnostic x-rays or imaging. These services may include fillings and single unit crowns, non-surgical endodontics, extractions, periodontal therapies, bridges, or dentures. Complex dental services such as oral surgery, surgical endodontics, dental implants, and orthodontics are considered specialty services.

A Community Health Center FQHC in Pennsylvania that directly serves the oral health needs of their population must do so in an informed, thoughtful, and deliberate way to ensure that the financial health of the organization is not jeopardized by the addition of this service. As the FQHC grows or community need dictates, it is likely that a more comprehensive dental care program will be needed. If specific/additional dental services were not present at the time of initial funding, a change of scope application to HRSA will be required, regardless of if proposed services will be provided by staff or through a contract. Meaningful planning and preliminary budget analysis should occur before taking this step for a variety of reasons:

- Offering dental services is an investment. The design and the equipment required to set up an operatory is more expensive (cost per square foot) than most medical suites.
- For revenue estimation, it is not uncommon for patients seeking dental care to have unreliable appointment attendance patterns.
- There are operational impacts on scheduling, staffing needs, external laboratory services and technology (medical records) to be evaluated.
- Dental services require a separate PA Medicaid PPS rate development. Through the rate setting process, you may notice a redistribution of administrative and overhead costs between medical and dental services. This redistribution may reduce the medical PPS rate.

Important Points:

- Thorough evaluation and planning are necessary for adding restorative, emergency, and other dental services such as crowns and bridges, and other dental specialty services.
- HRSA is encouraging “comprehensive” services (dental, behavioral and substance use disorder, and vision) beyond the required services be offered by health centers.
- Consider visiting existing FQHCs with proficient dental programs.
- Use the MA Cost Report template to “run the numbers” before requesting a change in scope to add dental services to see a preliminary dental PPS and any impact on the medical PPS rate due to the reallocation of administrative and overhead costs.

- The PA Dept. of Human Services implemented adult dental benefit restrictions (benefit limit exceptions) in 2011. See the Medicaid Payment Policy section and the Medicaid Bulletins under resources.
- A separate dental sliding fee scale will need to be established and approved by the board of directors.
- Medicaid and CHIP cover the majority of dental services for children.
- Medicaid and CHIP will cover medically necessary orthodontics for dental problems if a child is diagnosed with a significant handicapping malocclusion that interferes with speaking, eating, or breathing, not for cosmetic purposes. Check with the HealthChoices MCO, dental subcontractor or CHIP health plan on the procedure (e.g., subject to prior authorization) for orthodontics.
- Under Physical HealthChoices, dental benefits are subcontracted by each MCO to a dental benefit manager (e.g., United Concordia, DentaQuest, SkyGen/Scion and Avesis). Each will also have their own policies and procedures and claims submission guidelines.
- Help in establishing or improving a dental program is available through PACHC; email pachc@pachc.org for assistance.

Pennsylvania has, by regulation, allowed some dental services to be provided by ancillary dental professionals. See licensure of dentists and dental hygienists and certification of expanded function dental assistants and minimum standards of conduct and practice.

Act 51 of 2007, with final regulations effective in December 2009, implemented a new classification of State Board of Dentistry-regulated practitioner, the "public health dental hygiene practitioner" (PHDHP); revised the dental hygienist's scope of practice to include the addition of the administration of local anesthesia with a required board-issued permit; and revised the supervision requirements for dental hygienists.

Dental Hygienist

- A dental hygienist shall possess a current permit issued by the Board of Dentistry before administering local anesthesia to a patient in a dental office.
- A local anesthesia permit issued by the Board will expire at the same time as the permit holder's dental hygiene license and may be renewed biennially at the same time the dental hygiene license is renewed.
- The administration of local anesthesia by regional injection is permitted only under direct supervision of the dentist. For administration of local anesthesia, direct supervision means supervision by a dentist who has examined the patient and authorized the procedure to be performed, is physically present in the dental facility and available during the performance of the procedure and takes full responsibility for the completed procedure.
- The placement of subgingival agents, some of which require a prescription by a dentist, would be permitted only under direct supervision unless the dentist has reviewed the patient's dental records and medical history and has written a prescription or given an order for the placement of subgingival agents in which case general supervision is required.
- A dental hygienist may provide professional services under general supervision when the patient is free of systemic disease or suffers from mild systemic disease as determined by the dentist with input from the dental hygienist and upon review of the patient's medical history. General supervision can only apply for patients who have had an exam in the previous year.

Direct supervision is required when the patient is suffering from systemic disease which is severe, incapacitating or life threatening.

- It is important to note that currently in Pennsylvania, FQHC dentists and hygienists are held to separate productivity benchmarks and failure to meet the benchmarks can impact payment. Speak to PACHC prior to proceeding to get the latest information and guidance.

Public Health Dental Hygiene Practitioner (PHDHP):
By definition, this category of practitioners provides dental hygiene services in certain public health settings without the authorization, assignment, or examination of a dentist. PHDHPs are licensed dental hygienists who are certified by the Pennsylvania State Board of Dentistry and may render certain services without supervision of a dentist including dental prophylaxis, radiographic procedures, polishing fillings, completing dental screenings, making molds for dental prosthetics, evaluating patients, and educating patients about oral health. A PHDHP may not administer subgingival agents or local anesthesia.

Important Points:

- PA Department of Human Services (DHS) recognizes Public Health Dental Hygiene Practitioners (PHDHPs) as providers eligible to generate an FQHC encounter, meaning that PHDHP visits are billed as T1015-U9 encounters.
- PHDHPs are to document the referral of each patient to a licensed dentist on an annual basis.

Expanded Function Dental Assistant (EFDA)
Scope of professional practice and services:

- Placing and removing rubber dams
- Placing and removing matrices
- Placing and removing wedges
- Applying cavity liners and bases
- Placing and condensing amalgam restorations
- Carving and contouring amalgam restorations
- Placing and finishing composite resin restorations or sealant material, or both
- Performing coronal polishing
- Performing fluoride treatments, including fluoride varnish
- Taking impressions of teeth for study models, diagnostic casts, or athletic appliances

EFDAs must perform under the direct supervision of a dentist. Direct supervision means that a dentist is in the dental office or facility, personally diagnoses the condition to be treated, personally authorizes the procedure, and remains in the dental office or facility while the procedure is being performed by the EFDA, and, before dismissal of the patient, personally evaluates the work performed by the EFDA.

Resources:

- Medical Assistance Dental Care Provider Information
- Title 49 - Professional and Vocational Standards, Part I Dept. of State, Subpart A - Professional and Occupational Affairs Chapter 33 - State Board of Dentistry
- PA State Board of Dentistry Online Applications

- Supervision Requirements for Dental Hygienists vs. Public Health Dental Hygiene Practitioners April 2010
- 49 PA Code Section 33.205a - Practice as an expanded function dental assistant
- 49 PA Code Section 33.205 - Practice as a dental hygienist
- 49 PA Code Section 33.205b - Practice as a public health dental hygiene practitioner
- See Medical Assistance Bulletin 27-11-47, 08-11-51, Medical Assistance Dental Benefit Changes, issued September 26, 2011 for how to request a dental BLE for MA recipients in the Fee-for-Service delivery system and the appeal process for BLE request denials.
- See Medical Assistance Bulletin AB 08-19-100, 27-19-92, Electronic Submission of Dental Prior Authorization, Dental Program Exception and Dental Benefit Limitation Requests issued December 5, 2019 for electronic submission instructions.
- Special thanks to Helen Hawkey, RDH, PHDHP, Executive Director, PA Coalition for Oral Health and Kelly Braun, RDH, MSDH, Rural Primary Care Integration Coordinator at Pennsylvania Office of Rural Health for reviewing the Dental Section of this manual.

Behavioral Health Services. These service descriptions are from HRSA's Service Descriptors for Form 5A: Services Provided: "Behavioral health services encompass a wide array of services that address both mental health and substance use disorders. Mental health services are the prevention, assessment, diagnosis, treatment/intervention, and follow-up of mental health conditions and disorders (e.g., depression, anxiety, attention deficit and disruptive behavior disorders) including care of patients with severe mental illness who have been stabilized. These services may include treatment and counseling for health center patients such as individual or group counseling/psychotherapy, cognitive-behavioral therapy or problem solving therapy, 24-hour crisis services, and case management services. Psychiatry is considered a specialty service."

"Substance use disorder services are screening, diagnosis, and treatment services for substance use disorders (e.g., abuse of alcohol, tobacco, prescription drugs). These services may include:

- age appropriate, harm/risk reduction and age-appropriate counseling to address identified risk factors, support abstinence and/or decrease negative consequences of substance use disorder
- detoxification to manage withdrawal symptoms associated with substance use disorders
- treatment/rehabilitation to include individual and/or group treatment, counseling, and case management. Treatment may occur in out-patient or in short-term residential settings and may include medication-assisted treatment (e.g., buprenorphine products, methadone, naltrexone)"

Behavioral health and substance abuse services are classified as "additional services" by HRSA except for Health Care for the Homeless grantees who are required to provide substance use disorder services.

When an FQHC decides to provide these services on site, there are two factors to evaluate:

- Payment policy for PA Medicaid behavioral health services such as eligible providers that can bill behavioral health services at the PPS rate.
- Model of care delivery:
  - On-site and provided directly by the health center and for which the health center pays and bills.

- Services provided on behalf of the health center by another entity via a formal written contract/agreement, where the health center is accountable for paying and/or billing for the direct care provided via the agreement
- Services provided by an entity other than the health center with which the health center has a formal written referral arrangement or other formal written arrangement. The actual service is provided and paid/billed for by the other entity (the referral provider).

The PA Department of Human Service, Office of Mental Health and Substance Abuse Services (OMHSAS) monitors, develops policies and procedures, and regulates mental health and substance use disorder services provided to Medical Assistance recipients as well as oversees the behavioral health managed care organizations.

Mental health services in Pennsylvania are administered through county Mental Health and Developmental Services (MH/DS) program offices, which are part of county government and overseen by a county MH/DS administrator. The county MH/DS office determines a person's eligibility for service funding, assesses the need for treatment or other services and makes referrals to appropriate programs to fit service needs. Actual mental health services are delivered by the county or local provider agencies under contract with the county MH/DS office.

For Medical Assistance mental health and drug and alcohol services, each county contracts with a Behavioral HealthChoices Managed Care Organization (BH-MCO). The BH-MCO is responsible for the entire Medicaid population in the contract area. Counties are required to ensure high quality care and timely access to appropriate mental health and drug and alcohol services, and to facilitate effective coordination with other needed services. Each HealthChoices consumer is assigned a BH-MCO based on his or her county of residence. Members, then, have a choice of behavioral healthcare providers within the BH-MCO's network. This website shows which BH-MCO operates in each county.

Drug & Alcohol Services. The PA Department of Drug & Alcohol Programs' (DDAP) mission is "to engage, coordinate and lead the Commonwealth of Pennsylvania's effort to prevent and reduce drug, alcohol and gambling addiction and abuse; and to promote recovery, thereby reducing the human and economic impact of the disease."

DDAP oversees the network of single county authorities (SCAs) and performs central planning, management, and monitoring duties at the state level, while the SCAs provide planning and administrative oversight for the provision of substance use and problem gambling disorders at the local level. DDAP provides state and federal funding to SCAs through grant agreements. SCAs assess the need for treatment or other services and make referrals to match treatment and/or service needs. These services may be provided either directly or by contract with private entities.

Opioid Crisis. In October 2017, the opioid crisis was declared a national public health emergency. Various initiatives and supplemental funding were available to fight this deadly epidemic. In January 2018, Pennsylvania issued an Opioid Disaster Declaration. Health centers have been at the forefront of the opioid crisis providing Medication Assisted Treatment and functioning as Opioid Use Disorder Centers of Excellence.

Important Points:

- Each health center needs to evaluate the level of behavioral health services to be offered: integrated medical and behavioral health services receiving Medicaid PPS reimbursement as an FQHC versus becoming a licensed facility
- Educate staff on models of care and implement which model makes the most sense for your patients and workflow. Medication Assisted Treatment is considered & reimbursed under Physical Health HealthChoices (PH-MCO)
- See Medicaid Payment Policy section for billing behavioral health and substance use disorder services
- Please feel free to contact PACHC at pachc@pachc.org with questions and for information.

Resources:

- DDAP Get Help Now | Care Provider
- HRSA Opioid Crisis website
- PIN 2009-02: Specialty Services and Health Centers' Scope of Project

GOVERNANCE

Getting Started. One of the earliest tasks to be tackled in establishing an FQHC/FQHC Look-Alike is the establishment of a governing board of directors that meets all the Community Health Center FQHC compliance requirements as well as best practices. The governing board has specific responsibility for oversight of the Health Center Program project. The overarching board role is to guide the organization toward a sustainable future, as well as to make sure it has adequate resources to advance its mission. The early board composition of many organizations aspiring to become an FQHC is often not HRSA-compliant but knowledge of HRSA's governance requirements will support the transition to an FQHC-compliant board. Education and understanding of the requirements are key. Board compliance and good governance are ongoing processes even for established health centers. The health center governing board must assure that the center is operated in compliance with applicable federal, state, and local laws and regulations. For questions or assistance with the HRSA governance requirements, please do not hesitate to contact PACHC at pachc@pachc.org.

The Basics. Nonprofit boards of directors have three fiduciary responsibilities: the duty of care; the duty of loyalty; and the duty of obedience, as mandated by state and common law. "A fiduciary is a person or organization that acts on behalf of another person or persons, putting their clients' interest ahead of their own, with a duty to preserve good faith and trust. Being a fiduciary thus requires being bound both legally and ethically to act in the other's best interests." (Investopedia). In this sense, the board of directors is acting on behalf of health center patients, potential patients, employees, and general community members.

Duty of Care: Actively participate in board meetings and on committees and be prepared for meetings by reading supplied materials. Board members should work together to advance the health center's mission and goals as well as oversee and monitor health center activities. Board members should be able to read and understand reports and be willing to question or ask for clarification about any submitted information. If the information does not appear sufficient to make a decision, it is important to ask for supplemental information to assist decision-making.

Duty of Loyalty: Any conflicts of interest must be recognized and disclosed so that decisions are made in the best interest of the health center and not in the best interest of an individual board member or any other individual or organization. The health center/board of directors must have a conflict of interest statement/policy to define what a conflict of interest is and how any conflict will be handled. This may require legal counsel assistance to complete. Another aspect of loyalty is confidentiality. A director should not reveal health center confidential matters.

Duty of Obedience: Ensure that the health center obeys all applicable federal, state, and local laws and regulations; follows its own bylaws and adheres to its stated purposes/mission.

Resources:

- Health Center Program Compliance Manual (Last updated August 2018) – especially Chapters 13, 19 and 20

- Health Center Program Site Visit Protocol (Last updated: April 13, 2023) will help focus on major health center governance requirements, governing board operations and responsibilities.

Board Composition (Chapter 20: Board Composition). One of the most important and distinguishing features of the health center model is the community-based, patient-majority governance structure mandated by federal statute. A majority (at least 51%) of board members must be individuals who use the health center as their regular source of health care. The HRSA Compliance Manual, Chapter 20: Board Composition outlines the requirements for health center board composition.

Important Points:

- A best practice, not a program requirement, is that the bylaws stipulate a range of members so that additions and deletions do not require bylaw changes.
- Another best practice, not a program requirement, is to have more than nine members so if one person needs to step down from the board, the health center does not fall out of compliance with the HRSA program requirements.
- The Health Center Program Compliance Manual defines "patient" for board representation purposes as an individual who has received at least one service in the past 24 months that generated a health center visit with both the service and the site included within the HRSA-approved scope of project.
- A legal guardian of a patient who is a dependent child or adult, a person who has legal authority to make health care decisions on behalf of a patient, or a legal sponsor of an immigrant patient may also be considered a patient of the health center for purposes of board representation.
- Patient board members must represent the demographics (race, ethnicity, and gender) of individuals served by the health center consistent with the demographics reported in the health center's Uniform Data System (UDS) report.
- No more than one half of the non-patient board members may be individuals who derive more than 10% of their annual income from the health care industry. It is the discretion of the health center and its board to define the term "health care industry," provided it is applied uniformly.
- Please note that no board member may be an employee of the health center or the spouse, child, parent, brother, or sister of a health center employee by blood, marriage, or adoption. This includes in-laws and extends to same- and opposite-sex marriages.
- Health centers that serve exclusively migrant or seasonal agricultural workers, persons experiencing homelessness, or public housing residents (does not include those with a designation under Section 330(e) who are required to serve all residents of the center's service area) may request approval from HRSA for a waiver of the patient majority board composition governance requirement by showing good cause. (see Compliance Manual).
- Consider development of a "job description" for FQHC board members and a prospective board member information sheet.
- Assess and evaluate the board composition in terms of essential skills and expertise helpful to meet the mission and goals of the health center. The board may find it helpful to develop a "skill matrix" -- for example, grassroots community expertise, finance, and audit, legal or other skills.

New Board Member Orientation and Training. A new board member should participate in a new board member orientation program and training. One recommendation is a manual or notebook that contains key documents helpful to new board members. The content should include, at a minimum:

- ✓ Articles of Incorporation
- ✓ Health Center Bylaws
- ✓ The most recent organizational tax return and Form 990
- ✓ The most recent financial audit including management letters
- ✓ Most recent annual report
- ✓ List of current officers and directors of the organization
- ✓ Organizational chart
- ✓ Summary of applicable directors and officers insurance
- ✓ Mission statement
- ✓ Strategic plan
- ✓ A listing of any affiliated organizations
- ✓ HRSA Compliance Manual
- ✓ Commonly used acronyms
- ✓ Other items that help to explain the organization, its history and mission, and key elements of its operation

Consider who should conduct board orientation. It is recommended that the CEO not be the only person to perform the orientation. Orientation need not be performed at a single meeting as the content can be overwhelming. It may be wise to hold several meetings or have the new director meet with various individuals over an initial 3-month period. As the new director attends several board meetings during this period, this provides an opportunity for the new director to see the board in operation and ask questions during the orientation.

Requirements of the Governing Board (Chapter 19: Board Authority).

- Develop bylaws which specify the responsibilities of the board
- Hold monthly meetings and record in meeting minutes the board's attendance, key actions, and decisions
- Approve the selection and termination/dismissal of the health center's Project Director/Chief Executive Officer (CEO)
- Adopt policies for the conduct of the Health Center Program project and update these policies when needed. Specifically, the health center governing board must have authority for:
    - Adopting policies for financial management practices and a system to ensure accountability for center resources, including periodic review of the health center's financial status and results of the annual audit
    - Adopting policies for eligibility for services including criteria for partial payment schedules (the sliding fee discount program)
    - Establishing and maintaining general personnel policies for the health center including those addressing selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices
    - Adopting health care policies including quality-of-care audit procedures

- Adopt health care operational policies including:
    - Scope and availability of services to be provided within the Health Center Program project, including decisions to subaward or contract for a substantial portion of the services
    - Service site location(s)
    - Hours of operation of service sites
- Review and approve the annual Health Center Program project budget
- Provide direction for long-range planning, including but not limited to identifying health center priorities and adopting a three-year plan for financial management and capital expenditures
- Assess the achievement of project objectives through evaluation of health center activities, including service utilization patterns, productivity, efficiency and effectiveness of the center, and patient satisfaction
- Ensure that a process is developed for hearing and resolving patient grievances.

Important Points:

- Review the HRSA Compliance Manual & Operational Site Visit Guide thoroughly. It is important to remember that the overarching board role is to guide the organization through policies and planning that achieve the overall mission. Therefore, many areas of the Compliance Manual and Site Visit Guide address board action and behavior e.g., sliding fee discount program, QI/QA program and other policies that require Board approval and documentation in the minutes.
- "Consent agendas" can be an effective tool to keep the board focused on the most important topics for discussion and allow time for sufficient discussion.
- Ensure the bylaws address all compliance requirements and responsibilities of the board.
- It is typical for well-functioning boards to have processes established for public communications that define who may speak on behalf of the board.

Board Committees. Board committees should be the "working groups" in specific functional areas. In general, committees support the work of the board and based upon the committee's work, recommendations are then made to the Board of Directors for action. Committee work assists but does not replace board action. Standing committee composition, size and membership should be proportional with each committee's charge. The HRSA Compliance Manual may suggest functional areas for committee work e.g., finance, quality improvement and evaluation. The by-laws should include a process for establishing ad hoc committees in addition to standing committees to address special topics/issues of a time-limited nature. For instance, if a renovation project is proposed and it does not seem to fit an existing committee function, a group of board members can be assigned this renovation project monitoring function.

Ongoing Training and Improvement of the Board.

- Board Self-Evaluation and Re-evaluation of Board Composition
  Annual board self-evaluation is a beneficial and valuable activity to determine strengths, weaknesses, opportunities, and threats. Is the Board functioning in accordance with HRSA compliance requirements? Is the Board supporting the sustainability, success, and community mission of the health center? Are there "emerging issues" that require special

Board skill and expertise? The results of board self-evaluation can then be used to address any strategic needs and inform board improvement or educational needs.

- Continuing Board Education
  High functioning boards are constantly learning about topics/issues that promote or inhibit achievement of their mission. Some boards organize retreats (length of retreat varies based on availability of the board members – maybe one or 1½ days over a weekend) to receive training, federal and state healthcare environment status updates and do strategic planning. Others make education a part of each board meeting or offer topic-specific educational sessions. There is essential return-on-investment from board continuing education helpful to both board decision-making and functioning. Some resources are free while others may have a cost. PACHC can assist with board education information, referrals, and actual training.
- Board Policy Manual
  There is a growing trend to develop a manual for board functions. Contents of board policy manuals will differ among different health centers, depending on the needs and nature of the organization. This manual greatly helps to orient and train new board members and can serve as the "go-to" place for HRSA compliance and OSV documents. The following items are not required for all manuals but provide a reference for consideration about what to include in the manual.

  - ✓ Legal documents: articles of incorporation (if applicable); IRS letter granting 501(c)(3) status; and any state charitable solicitation documents
  - ✓ Strategic plan
  - ✓ Board organization/operations: board bylaws & policies; conflict-of-interest policy; organization chart of board; job descriptions of board officers and other members; board member biographies; board calendar; board meeting agendas and minutes; committee meeting agendas and minutes; and reports from the chief executive
  - ✓ Financial records and data; financial audits; and fundraising information
  - ✓ Personnel policies; job descriptions; and organizational chart
  - ✓ Health center operations policies and sliding fee discount program policy

  It does create an additional workload as it must be part of the Board self-assessment process and any changes/updates made to improve board functioning or health center operations must be revised and updated in the manual.
- Board-CEO Relations
  There are distinct, different roles for the board and the CEO. The board is responsible for finding and maintaining a strong CEO. The CEO is responsible for health center management and operations, leadership, and development of the health center. The CEO must maintain strong working relationships with the community that the health center serves, staff, and the board. The CEO is the only health center employee who is selected, evaluated, and, if necessary, dismissed by the board. It is important to have boundaries in place for board/CEO interaction that respects the roles and authority of the board and the role and authority of the CEO.

Important Points:

- If there is a post-award change in the CEO position, the health center must request and receive prior approval from HRSA for the newly hired CEO.
- Ideally the board has an emergency succession plan and a CEO succession policy in place which it can look to for guidance on the CEO search process and in the case of a sudden event.
- An evaluation of the CEO is a HRSA compliance requirement, however, frequency is not expressly stated. The recommendation/best practice is an annual CEO evaluation. The annual evaluation should address individual performance goals and priorities of the board. These goals and priorities are ideally linked to the health center's multi-year strategic plan and annual operating plan. The board approves the evaluation, and it is shared with the CEO both in writing as well as verbally.

Resources:

- The National Association of Community Health Centers (NACHC) has several governance resources, many of which can be accessed on the Health Center Resource Clearinghouse website, a "one-stop" shop for materials developed with HRSA funding support by HRSA National Training and Technical Assistance Partners (NTTAPS), like NACHC.
  - Governance Guide for Health Center Boards -- Sample Board Work Plan, Sample Board Self-Assessment, Sample CEO Evaluation
  - Health Center Governance
  - Health Center Governance – Areas of Concentration
  - MyNACHC (need a user account) for paid resources and for registering and checking credits for the Certificate in Health Center Governance.
  - NACHC also offers "Board Boot Camps," generally in conjunction with its national conferences
- Sample Nonprofit Board Policies and Procedures
- Board Orientation
- Handbook for Directors of Nonprofit Corporations in the United States: A Primer on Directors' Duties and Rights and Minimizing Risk by K & L Gates, LLD
- Consent Agenda
- National Council of Non-Profits – Board Roles & Responsibilities
- Pennsylvania Association of Nonprofit Organizations (PANO)
- Board Source - Publication and Media Resources
- The Community Health Association of Mountain Plains - CHAMPS - Community Health Center Board Resources

Conflict of Interest (Chapter 13). "A conflict of interest occurs when an entity or individual becomes unreliable because of a clash between personal (or self-serving) interests and professional duties or responsibilities. Such a conflict occurs when a company or person has a vested interest—such as money, status, knowledge, relationships, or reputation—which puts into question whether their actions, judgment, and/or decision-making can be unbiased. When such a situation arises, the party is usually asked to remove themselves, and it is often legally required of them." (Investopedia)

The health center must maintain written standards of conduct covering conflicts of interest and governing the actions of employees and the board engaged in the selection, award, or administration of contracts. Disciplinary actions for violations of these standards by employees, governing board members, or contractors acting on behalf of the health center must also be addressed in policy. The policy must define conflicts of interest, note how they are addressed and lay out processes for how board members should be recused from discussion, deliberation, and voting if a conflict of interest does exist. No employee, officer, or agent/board member of the health center may participate in the selection, award, or administration of a contract supported by a federal award if he or she has a real or apparent conflict of interest.

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.

FINANCIAL MANAGEMENT

General Information. Most Community Health Center FQHC revenue falls into the following categories:

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

Each community is different; each center has its unique payer mix. According to data reported to the Uniform Data System (UDS) for calendar year 2022.

- 992,412 individuals received services from Pennsylvania FQHCs and Look-Alikes
- Medicaid and CHIP beneficiaries represented 48.6% of those served
- 14.4% were covered by Medicare
- 24.0% were enrolled with private insurances
- 13.1% were uninsured or self-pay patients
- 88.4% of the individuals served had incomes at or below 200% of the federal poverty level; these low income uninsured individuals are often eligible for the sliding fee discount program

However, revenues collected tell a different story. Medicaid revenues represented 52.5% of the total; Medicare 18.3% of the total; private insurances 20.1%; and self-pay monies 8.1% of the total collections.

"Health centers are responsible for providing their patients with comprehensive services – from primary care to mental and behavioral health, vision care and dental care, as well as enabling services that include transportation, translation and case management services. In recognition of the critical role health centers play and the value they deliver for Medicare, Medicaid and CHIP patients and state programs, Congress, on a bipartisan basis, created a specific payment methodology for health centers, the FQHC Prospective Payment System (PPS). This payment system is central to the successful relationship between health centers, Medicaid, and Medicare and to health centers' continued viability." NACHC FQHC Payment

Important Points:

- It is important that health centers know their payer mix, the number of visits by payer category and amounts actually collected from each and reevaluate regularly.
- The health center budget, PPS rate determination, productivity, and contracts with various payers all have significance. It is important to monitor budget projections to actual, projected encounters to actual, provider productivity, and the impact of contract terms so that needed modifications can be made on a timely basis to support the long-term financial health of the organization.

One of the most important and challenging operational functions every health center must do is the establishment of an appropriate fee schedule for its services. Although there is not a generally applicable "formula" for setting fees, there are statutory and regulatory requirements that all health centers must follow in establishing their fee schedules. Within these parameters, a health center must be able to realize revenue from its activities sufficient to remain financially viable while maintaining patient access to services without regard to any patient's insurance status or ability to pay—not an easy balance. Community Health Centers FQHC are held to strict accountability and performance measures for clinical, financial, and administrative operations by the Health Resources and Services Administration (HRSA). The health center mission is to ensure that the ability to pay does not interfere with the patients' use of services.

To view all the Health Center Program Finance and Management Compliance Requirements, reference the HRSA Compliance Manual:

- Chapter 9 Sliding Fee Discount Program
- Chapter 12 Contracts and Subawards
- Chapter 15 Financial Management and Accounting System
- Chapter 16 Billing and Collections
- Chapter 17 Budget

Establishing a Fee Schedule.

- The schedule of fees for the provision of services that are within the HRSA-approved scope of project must be consistent with the local healthcare market prevailing rates or charges and cost-based, designed to cover reasonable costs of operation.
- Fees or payments required for services must be reduced or waived to assure no patient will be denied services due to an inability to pay (See Chapter Sliding Fee Discount Program).

Important Points:

- Establishing a fee schedule involves complex analyses and health centers are encouraged to consult with financial advisors, PACHC or other HRSA cooperative agreement-supported organizations for assistance.
- There is no accepted best practice for establishing a fee schedule, however recommended is using the Resource-Based Relative Value Scale (RBRVS) and the most common is payers' reimbursement plus margin and using the Medicare fee schedule
    - Relative Value Unit (RVU) reflects the relative resources required to furnish a physician fee schedule service. Three separate RVUs are associated with the calculation of a payment under the Medicare Provider Fee Schedule:
        - Work RVUs reflect the relative time and intensity associated with providing a service and equal approximately 50 percent of the total payment
        - Practice Expense (PE) RVUs reflect costs such as renting office space, buying supplies and equipment, and staff
        - Malpractice (MP) RVUs reflect the relative costs of purchasing malpractice insurance
    - Services are ranked according to the relative provider effort and the costs involved in providing them; the RVUs convert into dollars by multiplying the RVU for a particular service by a dollar amount conversion factor; the conversion factor is based on practice and provider costs

    - When using payer reimbursement, compare differences in payer reimbursement across plans and products, check health center charges often to ensure they are capturing all available reimbursement, and compare your costs to the fees you determine
- Once the cost of a service is determined, the fee should reflect "cost plus margin" to ensure financial stability and future growth. Some FQHCs start by looking at Medicare fee schedules and add an additional 10-15%.
- A fee schedule is necessary for FQHC Medicare PPS billing. Medicare pays FQHCs based on the lesser of their actual charges or the FQHC Medicare PPS rate for all FQHC services furnished to a beneficiary on the same day when an FQHC furnishes a medically necessary face-to-face FQHC visit to a Medicare beneficiary.
- When the fee schedule is completed, it may be useful to create a report projecting likely actual revenues. Form 3: Income Analysis (sample from Service Area Competition Application 2020-21) is a tool that can be used for those projections.

Resources:

- Medicare RBRVS 2023: The Physicians' Guide: (cost involved)
- The CMS Physician Fee Schedule look-up website allows you to:
    - Search pricing amounts, various payment policy indicators, RVUs, and Geographic Practice Cost Indices (GPCIs) by a single procedure code, a range and a list of procedure codes.
    - Search for the national payment amount, a specific Medicare Administrative Contractor (MAC) or a specific MAC locality.

Budget. The health center must develop an annual budget that:

- Identifies the projected costs of the Health Center Program project
- Identifies the projected costs to be supported by Health Center Program award funds, consistent with Federal Cost Principle (45 CFR Part 75 Subpart E: Cost Principles) and any other requirements or restrictions on the use of Federal funding
- Includes all other non-Federal revenue sources that will support the Health Center Program project, including state, local, and other operational funding; and fees, premiums, and third-party reimbursements that the health center reasonably expects to receive for operation of the Health Center Program
- The budget must be submitted annually for approval through the Federal grant award or Look-Alike designation process.
- If the health center conducts other lines of business (activities 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.
- The health center governing board must review and approve the annual Health Center Program project budget and board minutes reflect that.

Billing & Collections.

- Health centers are required to enter into contracts or other arrangements to participate and receive full reimbursement from the State Medicaid program, Children's Health Insurance Program (CHIP) and Medicare.

- Health centers have discretion as to whether to participate in other third party-specific insurances based on the health center's patient population and the costs and benefits of that participation.
- Every reasonable effort (as defined in a board-approved policy) to secure payment for services from patients, in accordance with health center fee schedules and corresponding schedule of discounts must be made.
- To offer additional billing or payment options such as payment plans, grace periods, prompt or cash payment incentives, operating procedures for implementing these options must be in place (as defined in a board-approved policy) and available to all patients regardless of income level or sliding fee discount classification.
- For supplies or equipment related to, but not included in, the service itself as part of the standards of care (eyeglasses, prescription drugs, dentures), the patient must be made aware of the "out-of-pocket costs" for these items prior to the service.
- Health centers may elect to limit or deny services based on a patient's refusal to pay, however, there must be in place a board-approved policy that distinguishes between refusal to pay and inability to pay. The policy must address how patients will be notified of amounts owed and the timeframe to make payments, collection efforts that will be taken when these situations occur, and how services will be limited or denied when it is determined that the patient has refused to pay.

Financial Management & Accounting.

The HRSA Compliance Manual Chapter 15: Financial Management and Accounting Systems outlines the following:

- Health Centers must use a financial management and internal control system that:
  - Reflects Generally Accepted Accounting Principles (GAAP) for private non-profit health centers or Government Accounting Standards Board (GASB) principles for public agency health centers
  - Has the capacity to track the financial performance of the health center, including trends or conditions that may warrant action by the organization to maintain financial stability.
  - Can account for all Federal award(s), including the Health Center Program Federal award, by identifying the receipt and expenditure of funds for federally funded activities in whole or in part.
- Health center expenditures must be consistent with the HRSA-approved total budget and with any additional applicable HRSA approvals that were requested and received and in accordance with the terms and conditions of the Federal award and with the Federal Cost Principles in 45 CFR Part 75 Subpart E.
- Health center's financial records must contain information and related source documentation pertaining to authorizations, obligations, unobligated balances, assets, expenditures, income, and interest under the Federal award(s).
- Written policies and procedures must include the process for drawing down Federal funds and minimize the time lapse between the transfer of the Federal funds from HRSA and the disbursement of these funds by the health center. Several health centers recommend the best practice of three days from drawdown to disbursement.
- If a health center expends $750,000 or more in funds from all Federal sources during its fiscal year, the health center must conduct a single or program-specific audit and submit

for that year in accordance with the provisions of 45 CFR Part 75, Subpart F: Audit Requirements.

- HRSA's Division of Financial Integrity (DFI) uses 18 management control areas to complete Financial Capability Reviews (FCR) of new and prospective grant recipients that expend less than $750,000 a year in federal awards and are exempt from federal audit requirements, as well as targeted recipients that have single audits but were determined by HRSA to be at risk of having inadequate financial management systems or financial instability.
- The health center must document and demonstrate that any non-grant funds generated from Health Center Program activities, in excess of what is necessary to support the HRSA-approved total Health Center Program budget, were used to further the mission of the project, and were not utilized for purposes specifically prohibited by the Health Center Program.

Important Points:

- The health center determines which accounting software and related systems to use for financial management.
- It is recommended that a new health center contact other health center chief financial officers for advice on selecting a finance system that works and consider integration with the EHR system for patient accounting.
- A financial system will need to have accounting, treasury, and inventory control functions, and be able to be adjustable in terms of the chart of accounts.
- The health center determines the type, frequency, and format of financial reports used to support the board and the key management staff's ability to carry out its oversight responsibilities.
- Each year the Appropriations Acts funding the U.S. Department of Health and Human Services (HHS) contain statutory provisions that prohibit or limit the use of federal grant funds to support certain specific activities. These restrictions, called "the legislative mandates," recur on an annual basis with the passage of a new Appropriations Act, and are restated in guidance issued by the Office of Federal Assistance Management ("OFAM") within HRSA. NACHC has a sample Policy and Procedure to address these Legislative Mandates.

Resources:

- Uniform Administrative Requirements, Cost Principles, and Audit Requirement for HHS Awards (45 CFR Part 75)
- Grants Policy Bulletin Legislative Mandates in Grants Management for FY 2020
- HRSA Manage Your Grant website
- Financial Management Requirements for Award Recipients reviews the 18 management areas that must be included in written policies (PDF)
- Developing Effective Financial Management Practices to help avoid misspending grant funds
- Internal Controls Tip Sheet (PDF)
- Audit Confirmation Procedures

Contracts and Subawards.

A **contract** is used for the purpose of obtaining goods and services needed to carry out the project or program under a federal award. Characteristics of a contract:

- Provides goods and services that are part of normal business operations
- Provides similar goods or services to many different purchasers
- Operates in a competitive environment
- Provides goods or services that are ancillary to the operation of the Health Center Program
- Is not subject to Health Center Program compliance requirements because of the relationship

A **subaward** is a pass-through to a subrecipient so that the subrecipient can carry out part of the Federal award received by the pass-through entity (grantee). The health center must request and receive approval from HRSA to make a subaward under the federal Health Center Program award. The health center must monitor the ongoing activities of the subrecipient to ensure the subaward is used for authorized purposes and that the subrecipient maintains compliance with all applicable requirements specified in the federal award including those in PHS Act Section 330 of the PHS Act, operational program regulations, and grants regulations in 45 CFR Part 75.

"Specifically, the purpose of a subaward is to carry out a portion of the Federal award and creates a federal assistance relationship with the subrecipient, while the purpose of a contract is to obtain goods or services for the health center's own use and creates a procurement relationship with the contractor." (HRSA Compliance Manual. Chapter 12, footnote 3)

Important Points:

- The health center must have written procurement policies and procedures that reflect applicable state and local laws and regulations as well as comply with Federal procurement standards in 45 CFR Part 75 including a process to ensure all procurement costs directly attributed to the Federal award are allowable and consistent with Federal Cost Principles.
- The health center must perform a cost or price analysis in connection with every procurement action paid for in whole or in part by the Federal award in excess of the Simplified Acquisition Threshold. "*Simplified acquisition threshold* means the dollar amount below which a non-Federal entity may purchase property or services using small purchase methods. Non-Federal entities adopt small purchase procedures in order to expedite the purchase of items costing less than the simplified acquisition threshold. The simplified acquisition threshold is set by the Federal Acquisition Regulation at 48 CFR subpart 2.1 and in accordance with 41 U.S.C. 1908. The acquisition threshold is periodically adjusted for inflation." (HRSA Compliance Manual, Chapter 12, footnote 5)
- The health center must maintain records for procurement actions paid for in whole or in part under the Federal award that include the rationale for the method of procurement, selection of contract type, contractor selection or rejection, and the basis for the contract price. This also includes documentation related to noncompetitive procurements.
- Health center contracts with other clinical providers for the provision of healthcare services within the HRSA-approved scope of project must include a schedule of rates and

method of payment for such services including provisions for a sliding fee discount. (See HRSA Compliance Manual, 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 must ensure that service fees are discounted as follows:
    1. A full discount is provided for those patients with annual incomes at or below 100 percent of the current Federal Poverty Guidelines (FPG), unless a nominal charge is chosen, which is less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
    2. Partial discounts are available for patients with incomes above 100 percent of the current FPG and at or below 200 percent of the current FPG, and those discounts adjust based on gradations in income levels and include at least three discount pay classes.
    3. No discounts are provided to individuals and families with annual incomes above 200 percent of the current FPG.
- For services provided via formal referral arrangements (Form 5A: Services Provided, Column III), the health center must ensure service fees are either discounted as described above for services provided via contracts or discounted in a manner such that patients with incomes above 100 percent of the current FPG and at or below 200 percent of the FPG receive an equal or greater discount for these services than if the health center's sliding fee discount schedule were applied to the referral provider's fee schedule and patients at or below 100 percent of the FPG receive a full discount or a nominal charge for these services.

Important Point:

- A frequent finding during HRSA OSVs involves contracts and referral agreements and sliding fee discount program language. Please pay close attention to the contract/referral agreement language for services provided via Form 5A Column II and Column III. Contact pachc@pachc.org with questions or for technical assistance in the area.

Resources:

- NACHC Financial Management Trainings
- NACHC Online Library, Financial Management, to access available training and technical assistance resources, including documents, podcasts, archived webinars, and eLearning modules.
- NACHC Membership
- FQHC Payment web page

SLIDING FEE DISCOUNT PROGRAM

A key requirement of the Health Center Program is that the health center must operate in a manner that no patient will be denied services due to an individual's inability to pay. The health center must have a board-approved schedule of fees or payments for the provision of services consistent with locally prevailing rates or charges and designed to cover reasonable costs of operation (see the Financial Management section of this manual) upon which sliding fee discounts are based. The health center must then prepare a board-approved, corresponding schedule of discounts (sliding fee discount schedule or SFDS) that applies to all required and additional health services in the HRSA-approved scope of project for which there are distinct fees.

- The health center must establish policies and procedures for sliding fee eligibility determination, both the initial assessment and reassessments.
- The schedule of discounts must provide for:
    - A full discount to individuals and families with annual incomes at or below 100 percent of the Federal Poverty Guidelines (FPG) **OR**
    - A health center may choose to have a nominal charge, which must be less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
    - "Nominal fee" is not defined in statute or regulations and is defined by each health center's board of directors.
    - Partial discounts are provided for individuals and families with incomes above 100 percent of FPG and at or below 200 percent of FPG based on gradations in income levels. There must be at least three discount pay groups in this category.
    - No discount to individuals and families with annual incomes greater than 200 percent of the FPG
    - The health center must calculate the SFDS based on the most recent FPG.
- A health center may choose to have more than one SFDS. These SFDSs would be based on broad service categories, distinct subcategories of services or service delivery methods
    - For example, a separate SFDS for medical services and dental
    - A SFDS for preventive dental and a separate SFDS for additional dental services
- For in-scope services provided via contracts (Form 5A: Services Provided, Column II, Formal Written Contract/Agreement), the health center must ensure that fees for these services are discounted:
    - A full discount is provided for those with annual incomes at or below 100 percent of the current FPG, unless a nominal charge is elected.
    - The nominal fee must be less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
    - Partial discounts are provided for above 100 percent of the current FPG through at or below 200 percent of FPG with discounts 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 percent of the current FPG.

For services provided via formal referral arrangements (Form 5A: Services Provided, Column III), the fees for these services are to be discounted in a manner so that those patients with incomes above 100 percent of FPG and at or below 200 percent 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 those at or below 100 percent of the FPG receive a full discount or a pay nominal charge.

- The health center must evaluate its sliding fee discount program at least once every three years including utilization rates, the effectiveness of the sliding fee discount program in reducing financial barriers to care and identify and implement changes as needed.
- Information about the sliding fee discounts must be readily available to patients. Materials must be in language(s) and at literacy levels appropriate for the patient population and included as part of the registration/intake process as well as published on the health center's website.
- 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. Such discounts are however subject to any legal and contractual restrictions such as a private third-party payer contract.
- The health center must have a board-approved policy for the sliding fee discount program that includes:
    - Definition of income and family
    - Uniform application to all patients
    - Procedures for assessing/re-assessing all patients for SFDP eligibility based on income and family size
    - Description of how the sliding fee discount schedule (SFDS) will be structured ensuring that patient charges are adjusted based on ability to pay
    - For those health centers that choose to have a nominal charge for patients at or below 100 percent of the FPG, the flat nominal charge(s) must be nominal from the patient's perspective and not reflect the actual cost of the service being provided.

Important Points:

- The steps sound simple; however, it can be complicated. Noncompliance with the Sliding fee Discount Program is a frequent operational site visit finding. Contact PACHC at pachc@pachc.org with questions or for technical assistance.
- The sliding fee discount is for those individuals whose income is below 200% of the FPG, which is updated annually. An update of the Department of Health and Human Services (HHS) poverty guidelines is published annually in the Federal Register.
- Those with an income at or above 200% of poverty should be charged full fee for services rendered and offered no discounts unless non-federal money or other specific program funds are available to support additional discounts.
- An FQHC or Look-Alike is not a "free clinic." Best practices show that those individuals whose income is between 0% and 100% of the FPL should be charged a nominal fee.
- A nominal fee is a board-approved amount that does not pose a barrier to the individual's utilization of the FQHC services. This amount varies among centers.

- The health center determines the process and how often to reassess patient eligibility for the SFDS and how to document income and family size in the medical record. Some health centers permit self-declaration of family size and income.
- The SFDS should be reviewed and updated annually based on the annual release of the FPG and then reviewed and approved by the board annually.
- A health center has discretion as to whether to establish more than three discount pay classes between 100 percent and 200 percent of the FPG; what the income ranges should be for each discount pay class between 100 percent and 200 percent of the FPG; whether to discount fees as a percentage of fee or establish a fixed/flat fee per discount pay class; and whether to establish multiple/separate SFDSs for various services

Resources:

- Health Center Program Compliance Manual -- Last updated: August 20, 2018
- Health Center Program Site Visit Protocol – Last updated: April 13, 2023
- Contact PACHC for possible samples of HRSA-approved health center SFDSs or to network with other health centers on this topic.

CLINICAL OPERATIONS & QUALITY

The core purpose and mission of a Community Health Center FQHC is the provision of quality primary medical care as well as a wide array of other services (oral health, behavioral health, substance use disorder and other medical and/or social services) to Pennsylvanians in underserved areas of the state, both rural and urban. There is a targeted focus on patient-centered, evidence-based, and data-informed intervention and prevention efforts that result in a person's full physical, mental, and social well-being.

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

HRSA is very clear about its expectation that FQHCs provide patient centered, affordable, quality patient care.

- HRSA encourages health centers to attain some type of third-party accreditation and/or become recognized as patient-centered medical homes (PCMH).
- The annual Uniform Data System (UDS) collects "Quality of Care Measures," data on health outcomes and disparities, and information about health information technology, telehealth and Medication Assisted Treatment (MAT) for Opioid Use Disorder. (More on UDS later in this section).
- Health Center Program grantees applying for Federal Tort Claims Act (FTCA) coverage for the entity and any covered individuals must demonstrate they meet applicable requirements related to risk management and quality improvement.
- The HRSA Compliance Manual has several chapters that address clinical operations and quality improvement. These compliance elements are all reviewed during HRSA Operational Site Visits.
- Historically, HRSA has also awarded monetary quality awards.

Health center quality data are now transparent and publicly available. This data is used by patients, health insurance plans and potential health system partners. Performance and quality improvement functions and expectations are ongoing and include monitoring, evaluation and improvement processes while implementing a patient-centered philosophy and processes focused on prevention and maximizing quality, evidence-based care.

Validation of health center quality is becoming increasingly important to retain and attract patients, to qualify for performance bonuses and incentives, and to be preferred partners with insurers and other providers across the continuum. Clinical quality, patient outcomes and performance benchmarks are all key principles of value-based service delivery and value-based reimbursement.

Pennsylvania-specific quality initiatives and value-based reimbursement are discussed further in a separate section under PA Medical Assistance and CHIP.

In 2001, the Institute of Medicine (IOM) published *Crossing the Quality Chasm: A New Health System for the 21st Century*, an examination of the divide between what is known to be good health care and the health care that people actually receive.

Then in 2008, the Triple Aim framework was introduced by Berwick and colleagues. The Triple Aim Framework focuses on improving patient care quality and satisfaction, advancing population health, and reducing per capita health care costs.

A fourth dimension, care team well-being and improving the work life of those who deliver care was added in 2014, creating the Quadruple Aim. Most recently, in 2022, Nundy and colleagues proposed expanding the Quadruple Aim to the Quintuple Aim, adding a fifth aim of advancing health equity.

The following chapters in the HRSA Compliance Manual address clinical operations:

- Chapter 4: Required and Additional Health Services (See Required and Additional Health Services section of this manual)
- Chapter 5: Clinical Staffing
- Chapter 6: Accessible Locations and Hours of Operation
- Chapter 7: Coverage for Medical Emergencies During and After Hours
- Chapter 8: Continuity of Care and Hospital Admitting
- Chapter 10: Quality Improvement/Assurance
- Chapter 21: Federal Tort Claims Act (FTCA) Deeming Requirements

Clinical Staffing.

- Consider community size, demographics, and health needs to determine the number and mix of clinical staff necessary to ensure reasonable patient access to health center services.
- Clinical staff includes licensed independent practitioners such as physician, dentist, physician assistant, nurse practitioner, clinical psychologist, licensed clinical social worker; other licensed or certified practitioners, for example registered nurse, licensed practical nurse, public health dental hygiene practitioner, registered dietitian; and other clinical staff providing services on behalf of the health center including medical assistants or community health workers.
- Contracts or formal referral arrangements must be in place with providers or provider organizations to carry out all required and additional services included in the HRSA-approved scope of project if not provided directly by the health center.
- Operating policies and procedures for initial and recurring credentialing of licensed independent practitioners, other licensed or certified practitioners, and other clinical staff providing services on behalf of the health center who are health center employees, individual contractors, or volunteers are required.
- The credentialing policy & procedures must also include operating procedures for the initial granting and renewal of privileges for clinical staff members and verification of fitness for duty.

Important Points

- Refer to the FTCA Health Center Policy Manual to ensure provider contracts and employment relationships meet the FTCA Medical Malpractice Program requirements for coverage.
- The health center must maintain files/records for its clinical staff (employees, individual contractors, and volunteers) that contain documentation of licensure, credentialing verification, privileging and fitness for duty consistent with policies and procedures.
- HRSA does not "mandate" how often to review and renew credentialing, privileges and fitness for duty but consistently uses the example of every two years.
- Please note that the requirements and timeframes for recurring credentialing and privileges by PA Medicaid managed care organizations (MCOs) may vary. Those specific MCO requirements must be followed.
- Peer review, conducted by the health center's providers or contracted with other organization, may be used to assess clinical competence and fitness for duty
- The health center may determine the processes for corrective action, denial, modification, or removal of privileges of its staff, but it must be consistent with its established privileging policy.

Accessible Locations and Hours of Operation.

- Health center service sites must be accessible to the target patient population as documented in the funded application.
- Access barriers to the health center's full range of in-scope services that should be considered are the services area's physical characteristics, residential patterns, travel distance and travel time.
- The total number and scheduled hours of operation across all service sites must be responsive to patient need, facilitate timely scheduled appointments and provide access to the full scope of project services.

Important Points:

- Not every service delivery site must offer the full range of scope of project services or have the same hours of operation, but patients must have access, without barriers, to the full scope of project services.
- All service delivery sites providing HRSA-approved scope of project services must be accurately recorded on Form 5B: Service Sites in the Electronic Handbook.
- HRSA's prior approval requirement (change in scope of project) applies to the addition, deletion, or replacement of a service site.

Coverage for Medical Emergencies During and After-Hours.

- At least one staff member must be trained and certified in basic life support at each HRSA-approved service site.
- Health center patients must have access to after-hours coverage. This may include telephone coverage by health center providers, after-hours phone coverage formal arrangements with other community providers, use of "nurse call" lines or actual after-hours services to address urgent medical care on a 24-hour basis.

- All patients, including those with limited English proficiency, must be informed and able to access after-hours coverage in the language(s) and literacy levels appropriate to the health center's patient population.
- Documentation of after-hours calls and any follow-up resulting from these calls for the purposes of continuity of care must be maintained.

Important Points:

- Patients must know about the availability of after-hours coverage and know how to access this coverage after hours. This may be accomplished by including:
    - Instructions as part of the automated message on the center's main phone line
    - Instructions posted on the door of the center or in the waiting areas
    - Instructions provided as part of the initial patient registration process
    - Instructions posted on the health center's website
    - Instructions provided in patient brochures or rack cards
- During an operational site visit, one of the reviewers will test the after-hours coverage such as calling in after the center is closed.

Continuity of Care and Hospital Admitting.

- A health center provider must have hospital admitting privileges at one or more hospitals and/or the health center must have formal arrangements with one or more hospitals or entities such as hospitalists or obstetrics practices for hospital admission of health center patients.
- The health center must have policies and procedures for tracking of patient hospitalization/emergency department usage and continuity of care or provisions in its formal arrangements with non-health center providers or entities that address the receipt and recording of medical information related to the hospital or emergency department visit, such as discharge follow-up instructions, laboratory, radiology, or other results.
- There must be documentation/evidence in the medical record of follow-up actions taken by health center staff based on the information received, when appropriate.

Quality Improvement/Assurance. A health center must have an ongoing quality improvement/assurance (QI/QA) program that covers management of clinical services, periodic utilization assessment of services, measurement, and assessment of the quality of services provided, and maintenance of patient records confidentiality.

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

In multiple ways, HRSA is clear about its expectation that FQHCs will provide patient centered, affordable, and safe patient care. HRSA encourages health centers to attain some type of third-party accreditation and/or become recognized as patient-centered medical homes (PCMH). Quality improvement (QI) programs are necessary to meet Uniform Data System expectations,

which include clinical performance measures. A QI program is also required for the Federal Torts Claim Act (FTCA) deeming/re-deeming process. The QI program will be reviewed as part of a HRSA operational site visit.

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

- The health center must have a board-approved policy(ies) that establishes a QI/QA program to address the quality and utilization of health center services; patient satisfaction and patient grievance processes; and patient safety, including adverse events.
- The QI/QA program must:
    - Adhere to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services
    - Identify, analyze, and address patient safety and adverse events and contain a process for implementation of follow-up corrective actions
    - Assess patient satisfaction
    - Provide a procedure to hear and resolve patient grievances
    - Contain a process to conduct QI/QA assessments on at least a quarterly basis to inform any needs for modification of service provision
    - Produce and share reports on QI/QA activities to key management and the governing board to support decision-making and oversight of health center services.
- An individual(s) must be designated to oversee the QI/QA program.
- The health center's physicians or other licensed health care professionals must conduct QI/QA assessments at least a quarterly, using patient records data, to ensure adherence to evidence-based clinical guidelines, standards of care, standards of practice, and to identify any patient safety and adverse events and the corrective action implemented.
- The health center must maintain easily retrievable, individual health records for each patient with the format and content consistent with federal and state laws and regulations.
- Health information technology systems including certified electronic health records (EHRs) and corresponding standard operating procedures must be maintained to protect the confidentiality, privacy, and security of protected health information and to safeguard this information against loss, destruction, or unauthorized use, consistent with federal and state requirements.

Important Points:

- The position designated with responsibility for the QI/QA program may be full time or part time or combined with another position.
- This QI/QA responsibility/position may be filled by a physician, other licensed healthcare professional (registered nurse, nurse practitioner), or other qualified individual such as an individual with a Master of Public Health or a Master of Healthcare Administration.

- If day-to-day activities are assigned to a quality coordinator, who is not the medical director, the quality coordinator should maintain regular communication with the medical director.
- FTCA deeming/redeeming requirements (PAL 2020-02: Calendar Year 2021Requirements for Federal Tort Claims Act (FTCA) Coverage for Health Centers and Their Covered Individuals) include QI/QA provisions
    - Upload documentation that QI/QA assessments have been performed on a quarterly basis; for example, QI/QA report(s), QI/QA committee minutes, or QI/QA assessments reflective of the last 12 months
    - Upload the most recent QI/QA report from the current calendar year or the previous calendar year that was provided to key management staff and to the governing board.
    - Upload governing board minutes or other documentation to demonstrate that the QI/QA report was shared with and discussed by key management staff and by the governing board to support decision-making and oversight regarding the provision of health center services.
- The format, content, and focus of QI/QA reports may be determined by the health center, however shared reports with key management staff and the governing board must include data on patient satisfaction and patient safety.
- QI/QA assessments must document that the health center is tracking and addressing issues of quality and safety of care provided to patients. For example, use of appropriate medications for asthma, early entry into prenatal care, HIV linkages to care, and responses initiated as a result of an adverse event.
- All health center staff must be trained in confidentiality, privacy, and security of protected health information (PHI) including safeguards against loss, destruction, or unauthorized use.

The Quality Committee. Most, if not all, health centers have a Quality Committee chaired by the health center's medical director or designee. In addition to the chair and QI coordinator, other committee members may include representatives from medical, dental, behavioral health and other clinical staff, finance, risk management/compliance/safety, front office, and information technology. Additionally, there is often a Board Quality Committee.

Sub-committees/workgroups should be created to work on issues such as privileging, peer review, safety, compliance, infection control, risk management and other quality initiatives such as patient-centered medical home recognition or accreditation.

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

Important Points:

- A "best practice" is to have staff rotate on and off quality teams/committees so that all staff learn to value and understand quality improvement goals and efforts.
- Representatives from all sites and service areas should serve on the committee.
- Make time for the committee to meet at least once a month for at least an hour.
- Ensure good communication between the health center quality committee and the board quality committee.

PCMH & Accreditation. Validation of health center quality is becoming increasingly important to retain and attract patients, to qualify for performance bonuses and incentives, and to be preferred partners with insurers and other providers across the continuum. Clinical quality, patient outcomes and performance benchmarks are all key principles of value-based service delivery and value-based reimbursement.

The HRSA Accreditation and Patient-Centered Medical Home Recognition Initiative supports health centers working towards ambulatory health care accreditation and/or patient-centered medical home (PCMH) recognition. This initiative is designed to encourage and support health centers to undergo a comprehensive survey process in order to achieve national benchmarks that demonstrate the highest standards of health care quality.

HRSA supports certain fees associated with initial accreditation and re-accreditation for ambulatory health care accreditation and PCMH recognition, initial, renewal, and add-on surveys. HRSA contracts with three organizations to provide technical assistance and training for their respective recognition processes.

- The National Committee for Quality Assurance (NCQA) for PCMH recognition
- The Joint Commission for ambulatory health care accreditation and PCMH recognition
- The Accreditation Association for Ambulatory Health Care (AAAHC) for ambulatory health care accreditation and PCMH recognition

NCQA's Patient-Centered Medical Home (PCMH) recognition program is the most widely adopted PCMH evaluation program in the country. The patient-centered medical home (PCMH) model of care puts patients at the forefront of care. PCMH builds better relationships between patients and their clinical care teams; improves quality and the patient experience; increases staff satisfaction; and reduces health care costs. Health centers that achieve recognition make a commitment to continuous quality improvement and a patient-centered approach to care. Health centers, using the NCQA PCMH Standards and Guidelines, demonstrate evidence of compliance through virtual reviews and uploading evidence such as policies and procedures.

The Joint Commission and its Gold Seal of Approval™ is a widely recognized benchmark representing the most comprehensive evaluation process in the health care industry. The Joint Commission Ambulatory Care accreditation process aids organizations in improving the safety and quality of care and services. The process includes an on-site survey that assesses compliance with Joint Commission standards; follows the patient's experience looking at services provided by various providers and departments; reviews "hand-offs" between providers; interviews staff and patients; review of documents; and assessment of the physical facility. Health centers are eligible to pursue Primary Care Medical Home Certification after obtaining Joint Commission Ambulatory Care accreditation.
Similarly, health centers seeking recognition from The Accreditation Association for Ambulatory Health Care (AAAHC) must pursue Accreditation with Medical Home. This is the least used accreditation method by health centers in Pennsylvania.

UDS & Measuring Quality. Annually, all FQHCs and FQHC Look-Alikes complete required standard data collection via the Uniform Data System (UDS). This core set of information includes patient demographics, services provided, clinical processes and health outcomes,

patients' use of services, costs, and revenues. It is the source of unduplicated data for the entire scope of services included in the grant or designation for the reporting year. PACHC coordinates and facilitates UDS training each year.

Examples of the clinical and quality data reported in the UDS are:

- Selected diagnoses and services rendered
- Early entry into prenatal care
- Breast and cervical cancer screening rates
- Childhood immunization status
- High blood pressure and diabetes control
- Body mass index and depression screening rates
- Dental sealants for children

Annual performance reporting in the UDS is vital to achieve HRSA's mission and to understand the impact of the Health Center Program. This data is a key educational and advocacy tool used with federal and state policy makers. HRSA strives to increase data standardization across national programs, reduce reporting burden, increase data quality, and expand data use to improve clinical care and operations. Each year HRSA releases a Program Assistance Letter (PAL) that details any approved changes to the UDS to be reported for a specific calendar year.

Health Center Program Data is publicly available on data.hrsa.gov. This data is used by patients, health insurance plans and potential health system partners.

UDS Modernization Initiative: The UDS Modernization Initiative aims to reduce reporting burden, improve data quality, and better measure program services and outcomes. The goal is to expand the value and utility of UDS data for the Health Center Program while improving how health centers prepare and submit UDS data by focusing on four main areas:

- **Reporting Modernization.** Improve UDS reporting through advances in health information technology. This effort includes the UDS Patient Level Submission (UDS+) Initiative to move from aggregate reporting of UDS patient demographics and clinical quality measures to reporting of de-identified patient-level data.
- **Content Review.** Update UDS tables and content to improve data standardization and quality, including clinical quality measure (CQM) alignment with specification updates.
- **Stakeholder Engagement.** Get feedback from UDS stakeholders on proposed changes to UDS reporting processes, tables, and measures.
- **Testing.** Before implementing changes, testing innovations with health centers and other UDS reporting stakeholders through the UDS Test Cooperative (UTC).

For more detailed information about the initiative, visit UDS Modernization Frequently Asked Questions.

Calendar Year 2023 UDS Reporting Requirements

All health centers are required to submit a full, aggregated UDS Report through HRSA's Electronic Handbooks (EHBs) by February 15, 2024. Additionally, beginning with the calendar year 2023 UDS reporting, health centers may also voluntarily submit de-identified patient-level data (UDS+) using Health Level Seven International (HL7®) developed Fast Healthcare Interoperability Resources (FHIR®) version release 4 (R4) standards. The UDS+ FHIR ®

Implementation Guide (IG), which provides technical specifications for UDS+, is available on the HL7® website. View the UDS Training and Technical Assistance webpages for 2023 UDS reporting resources.

Resources:

- Health Center Quality Improvement
- Federal Tort Claims Act (FTCA)
- NACHC Quality Center
- Institute for Healthcare Improvement (IHI)
- Agency for Healthcare Research and Quality
- National Association for Healthcare Quality
- Uniform Data System (UDS) Modernization Initiative | Bureau of Primary Health Care (hrsa.gov)
- Uniform Data System (UDS) Modernization Frequently Asked Questions (FAQ) | Bureau of Primary Health Care (hrsa.gov)

340B DRUG PRICING PROGRAM

The 340B Drug Pricing Program is authorized in Section 340B of the Public Health Service Act (PHS). Section 340B of the PHS requires pharmaceutical manufacturers participating in Medicaid to provide outpatient drugs to covered entities at significantly reduced prices.

Those covered entities eligible to participate in the 340B Drug Program are community health centers (FQHCs and FQHC Look-Alikes), Ryan White HIV/AIDS Program grantees**,** children's hospitals, critical access hospitals, disproportionate share hospitals, free standing cancer hospitals, rural referral centers, sole community hospitals, Black Lung Clinics, comprehensive hemophilia diagnostic treatment centers, Title X family planning clinics, sexually transmitted disease clinics, and tuberculosis clinics.

The 340B Program enables these covered entities to purchase outpatient drugs at significantly reduced costs and stretch scarce federal resources reaching more eligible patients and providing more comprehensive services.

Generally, the 340B Program covers the following outpatient drugs:

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

Notably, vaccines are not covered under 340B. However, the Prime Vendor, some state programs, and other group purchasing arrangements for FQHCs offer reduced prices on vaccines.

Core 340B Requirements

- No diversion. Using a drug purchased under 340B to fill a prescription for an individual who is not a patient of the FQHC andthat does not meet 340B eligibility standards is considered diversion.
- FQHCs (and other covered entities) may only provide 340B purchased drugs to individuals who are "patients" of the entity.
- HRSA's Office of Pharmacy Affairs (OPA) current 3-part updated eligibility test (*NACHC 340B Manual for Health Centers– Second Edition*)
    - The covered entity has established a relationship with the individual and maintains records of the individual's health care.
    - The individual receives health care services from a healthcare professional who is either employed by the covered entity or provides health care under contractual or other arrangements (such as referral for consultation) and the responsibility for care provided remains with the covered entity.
    - The individual receives a healthcare service or range of services from the covered entity that is consistent with the services or range of services for which the grant funding or FQHC Look-Alike status has been provided to the entity.
- No duplicate discounts. "Duplicate discounts" occur when a health center purchases a drug at the 340B price and provides it to a Medicaid patient, and then the State Medicaid

agency requests a manufacturer rebate on the same drug. Manufacturers are prohibited from providing a discounted 340B price and a Medicaid drug rebate for the same drug. Covered entities must accurately report how they bill Medicaid fee-for-service drugs on the Medicaid Exclusion File. See Chapter 9 of the *NACHC 340B Manual for Health Centers– Second Edition* for additional information.

- The Medicaid Exclusion File (MEF) is an online list, maintained by OPA and available on the Office of Pharmacy Affairs Information System (OPAIS) as a means to prevent duplicate discounts for drugs subject to Medicaid rebates. The MEF lists health centers that carve-in Medicaid for fee-for-service. If a health center is listed on the MEF, then state Medicaid agencies and manufacturers know that drugs provided by that organization were purchased under 340B.
    - The MEF applies only to fee-for-service.
    - At present, OPA does not require FQHCs to make the same carve-in/ carve-out decision for Medicaid managed care. There is no official list of health centers that carve-in for Medicaid managed care.
    - However, some states, including Pennsylvania, may incorrectly assume that the Medicaid Exclusion File applies to managed care. FQHCs should work closely with PACHC to ensure an understanding of PA Medicaid managed care and 340B to avoid the possibility of duplicate discounts.
    - It is the FQHC's responsibility to ensure information in the MEF is accurate. Incorrect information in the MEF can lead to an audit finding, as well as to duplicate discounts.
- There are two general models that covered entities use to describe how drugs are provided to Medicaid patients.
    - **Carve-In**: The FQHC **includes** Medicaid patients in their 340B program, dispensing drugs purchased under 340B to these patients.
    - **Carve-Out**: The FQHC **excludes** Medicaid patients from its 340B program; in other words, the drugs dispensed to Medicaid patients were purchased outside of the 340B program.
- Covered entities must be registered in the OPA database (OPAIS) and all information must be accurate and up-to-date.
- The Office of Pharmacy Affairs Information System (OPAIS) is HRSA's official repository of organizations participating in the 340B Program, including covered entities, contract pharmacies, and manufacturers.
- All care delivery sites as listed on the health center's Scope of Project Form 5B and all contract pharmacy arrangements must be registered in OPAIS.
- The service site's "effective date" must be reached before participating in 340B.
- Health centers should ensure that their sites are "associated" with each other by registering all sites under the correct grant number.
- 340B program registration for new covered entities and the addition of outpatient facilities is open and available quarterly:
    - January 1-January 15 for an effective start date of April 1.
    - April 1-April 15 for an effective start date of July 1.
    - July 1-July 15 for an effective start date of October 1.
    - October 1-October 15 for an effective start date of January 1.

- In 2017, OPA began offering flexibility in the registration timelines for health centers. OPA permitted health centers to register new clinical sites up until the first week of the third month of each quarter and become effective on the first day of the following quarter. For example, a health center was permitted to register new clinical sites through the first week of March and have those sites effective on April 1. Please note however, there is no guarantee that OPA will continue to offer these extended registration timelines in the future. Therefore, health centers should monitor and follow the standard registration timelines.
- All information in OPAIS must be always kept up to date; failure to do so can result in audit findings.
- On an annual basis, HRSA requires health centers to recertify and verify the accuracy of the information in OPAIS and to attest to compliance with all 340B requirements. Failure to recertify in a timely manner leads to a loss of 340B eligibility.
- Maintain auditable records documenting compliance with 340B Program requirements. Health centers are required to maintain records demonstrating compliance with all 340B Program requirements for all its sites, as well as for all contract pharmacy locations that dispense 340B drugs. Covered entities are subject to audit by manufacturers or HRSA. A covered entity that fails to comply with 340B Program requirements may be liable to manufacturers for refunds of the discounts obtained.

Designating Contract Pharmacies

Pharmaceutical companies have continued to place restrictions on the number of contract pharmacies a covered entity may use to deliver 340B drugs. However, there is a compliant way for multi-site CHCs to expand the number of contract pharmacy (CP) sites where they receive 340B-priced drugs from most manufacturers with CP restrictions. When manufacturers have limited 340B pricing to a "single CP site," that limit has generally been implemented at the organizational level -- meaning that each CHC could designate only one CP site for its entire organization (for each manufacturer.) However, all manufacturers except Eli Lilly and Bristol Myers Squibb allow CHCs to have one CP site for each CHC care delivery site, enabling CHCs with multiple care delivery sites to have multiple "single" CP sites. For more information on this approach, see:

i. These detailed instructions on how to implement this change.
ii. This video demonstrating the process.

The 340B Prime Vendor Program (PVP) has a contract with HRSA and is responsible for supporting the 340B Drug Pricing Program. The Prime Vendor negotiates pricing discounts below ceiling price with participating pharmaceutical manufacturers and wholesalers on behalf of 340B providers. The PVP also provides education and resources such as 340B University and offers technical assistance through Apexus Answers. The PVP is a voluntary program for covered entities and manufacturers alike. There is no fee for eligible covered entities to enroll and participate in the program. HRSA currently contracts with Apexus to manage the PVP.

Pharmacy Models Used by Health Centers

- In-House Pharmacy: The health center owns the drugs, pharmacy, and license; purchases drugs; pays pharmacy staff; and is fiscally responsible for the drugs, inventory

management, and program compliance. An in-house pharmacy can be co-located with a clinical site or be a stand-alone site.
    - In-house pharmacies can choose to serve only patients who are eligible for 340B or have an "open door" (aka "open retail") component, meaning they serve members of the public as well as their own patients.
- Contract Pharmacy: This pharmacy is owned by an organization other than the health center. Contract pharmacies include both large retail chains and independent community pharmacies. These pharmacies are generally located at a site that is separate from the FQHC; however, an FQHC may arrange to have a contract pharmacy site co-located with one of its clinical sites.
    - OPA policy currently permits FQHCs to have arrangements with multiple contract pharmacies to provide 340B drugs.
    - In this model, the FQHC owns and purchases the drugs and pays a dispensing fee to the pharmacy(ies).
    - Health centers retain full responsibility for their contract pharmacies' compliance with all 340B requirements. Health centers using contract pharmacies must ensure a robust compliance framework is in place and that the health center has the capacity to monitor compliance within that framework, particularly around issues of diversion and duplicate discounts.
- Physician Dispensing Model: The health center purchases the drugs through an arrangement/contract with a pharmacy, maintains an on-site inventory, and dispenses the drugs on site. A patient takes their prescription to the onsite dispensary, a dispensary administrator enters the necessary information into the physician dispensing system. The insurance claim is processed just like at a drugstore. The dispensary administrator then obtains the prepackaged medication from a locked drug cabinet, bar-code scans it to verify the correct compound and strength, affixes the proper labels, and hands it to the patient along with instructions for its use. The health center is responsible for operating and dispensing costs as well as 340B program compliance.

Some factors to consider in choosing a 340B model include facility space, startup costs, availability of community pharmacies that could serve as contract pharmacies, and whether a request for proposal might be appropriate to provide better comparative data on contract pharmacy options, such as dispensing fees, hours and locations, responsiveness, electronic interface capabilities, and willingness to work with the FQHC on maintaining a separate inventory.

Important Points: Updated November 30, 2023

- 340B compliance is highly complex and resource intensive. In many key areas of the 340B program, there is a lack of clear policy on what HRSA and the Office of Pharmacy Affairs (OPA) expect. In some areas there is conflicting information on the same issue. HRSA's interpretations for compliant operation of 340B programs are fluid and can change.
- In February 2016, CMS issued a final regulation (commonly called the "Medicaid Covered Outpatient Drug Rule") on the Medicaid drug rebate program. This regulation stated that under Medicaid fee-for-service, states must reimburse 340B covered entities for drugs at an amount equal to their "actual acquisition cost" (AAC) plus an "appropriate

professional dispensing fee." These requirements became effective on July 1, 2017, and effectively ensured that Medicaid receives the full benefit of the mandatory manufacturer discount with no benefit to covered entities to "carve-in" for Medicaid fee-for-service.

Pennsylvania Department of Human Services and 340B

- On Dec. 22, 2022, DHS issued MA Bulletin 01-22-78: 340B Drug Pricing Program - Dispensing 340B Purchased Drugs, effective January 1, 2023.
- On January 19, 2023, DHS rescinded MA Bulletin 01-22-78: 340B Drug Pricing Program.
    - The rescission was a direct reflection of the advocacy work done by PACHC and its members with DHS to educate the Department on the negative impact MA Bulletin 01-22-78 would have on
    - The recission of MA Bulletin 01-22-78 put MA Bulletin 99-13-08: 340B Drug Pricing Program Provider Requirements and Billing Instructions - Pharmacy Services back into place.
    - According to DHS, "This (original) bulletin did not reflect any change to the Department's policy. As per the 2013 MA Bulletin (link added), and as reflected in the current bulletin, authorized 340B entities are still able to dispense and bill 340B eligible drugs in both FFS and Managed Care."
    - To determine the path forward on 340B and contract pharmacies, DHS convened a workgroup of representatives of covered entities and other stakeholders for the purpose of developing potential solutions that will allow for the appropriate identification and recognition of medications dispensed to eligible 340B patients through contract pharmacies.
    - At DHS' request, PACHC submitted a list of health center representatives to serve on the workgroup. The list represents a good mix of 340B experts, compliance, CEO, IT and finance/billing representatives to support the work, as well as reflects good geographic, small/large and rural/urban representation.
    - At this first meeting, Sally Kozak, OMAP Deputy Secretary, reiterated that DHS' goal is to ensure covered entities can access the 340B savings through contract pharmacies under Medicaid Managed Care. The workgroup is scheduled to meet almost weekly through February and March and is tasked with helping DHS identify a process to acknowledge contract pharmacies and accurately and effectively identify and exclude 340B drug claims to allow 340B covered entities and the patients they serve to continue to receive the benefits of 340B savings.
    - Through the DHS 340B Workgroup meeting, three options for identification of 340B drugs dispensed to MA MCO members were discussed. To date, DHS has not committed to implementing any of the options.
        - Option #1: When 340B is known at POS, pharmacy includes 340B indicator, i.e., currently 20 code, on claims. If not known at the Point of Sale (POS), no indicator included on claims at POS. After claims are reconciled by the Covered Entity (CE) and reported back to the pharmacy, the pharmacy voids original claim and resubmits with the 340B indicator for confirmed claims.
        - Option #2: The contract pharmacy would submit no indicators on any claims at POS. All claims submitted as non-340B. The CE then reconciles all contract pharmacy claims to identify 340B eligibility. The CE submits a file

identifying all 340B claims to DHS for exclusion from drug rebate. This is the method used during the 2018 pilot. It was cumbersome and manual for both the CEs and the Department. For this to work, a streamlined and automated process is needed for efficiency. Suggestion is to model the file on the current ESP file requirements.

- Option #3: The MCOs and/or their subcontracted PBMs would establish a method for identifying 340B eligible drug claims. The MCOs would then transmit the 340B information to DHS for applicable drug claims. To learn more about the third option, Alan Glazer from CaptureRX presented on the company's experience in California Medicaid (prior to 2022 pharmacy carve out).

- 340B Program and Medicaid MCOs Update: On September 5, 340B Workgroup members received the following communication from the Pennsylvania Department of Human Services (DHS) this week regarding the 340B Program and Medicaid MCOs.

  We wanted to provide an update on the Department's work surrounding the 340B program. We appreciate the time everyone has taken to participate in the workgroup meetings, individual meetings, as well as sharing information and feedback between meetings.

  CMS is currently considering a method for identifying 340B purchased drugs within the Medicare Program. As we often mirror Medicare, and to avoid duplicate work, we have decided to hold on any decision until CMS announces the Medicare method. At that time, we will review the applicability of that process and decide how to proceed.

  Thank you again for your engagement and feedback.

- PACHC is working on the next steps and connecting with our national experts to learn more about steps being taken by CMS.
- For questions and before starting a 340B Drug Discount Program, please contact pachc@pachc.org

NACHC Takes Bold Move to Save 340B for Health Centers: Forms ASAP 340B: Alliance to Save 340B The National Association of Community Health Centers (NACHC), in March 2023, formally announced that they are partnering with PhRMA on a strategy to save the intent of the 340B Drug Discount Program to help FQHCs and other safety-net providers. After three years of increasing covered entities restrictions that have had a significant impact on the stability of the program, it has been clear that FQHCs have been the most impacted covered entities even though FQHCs represent only 5% of the program. To avoid matters getting worse, NACHC is working with PhRMA to develop compromise solutions that address long-standing issues in the program and amend the 340B statute to incorporate these solutions. The new group—the Alliance to Save the 340B Program or ASAP 340B—currently also includes the National Hispanic Medical Association and anticipates other partners joining. ASAP 340B seeks to:

a. Make 340B a true safety-net program for patients.
b. Ensure 340B prescriptions are offered to patients at a discount.
c. Update the 340B patient definition with strong safeguards.
d. Establish clear criteria for 340B contract pharmacy arrangements to improve access.
e. Prevent middlemen and for-profit entities from profiting off of the 340B program.

f. Update and strengthen 340B hospital eligibility requirements.
g. Address standards for 340B child sites and subgrantee eligibility.
h. Create a neutral 340B claims data clearinghouse.
i. Facilitate public reporting on 340B program data.
j. Establish enforceable rules and enhance federal administration and oversight of the 340B program.

Court Ruling on 340B Drugs and Contract Pharmacies

On January 30, 2023, a federal appeals court in Philadelphia ruled unanimously that HRSA "overstepped the statute's bounds" by requiring drug makers to ship 340B drugs to an "unlimited number of contract pharmacies." The publication *340B Report* described the decision as "a major victory for the pharmaceutical industry and a significant blow for the government and 340B health care providers" that could "quicken hearings and votes on 340B in Congress." This is the first of three decisions, from three separate Appeals Courts, regarding contract pharmacy issues. While this decision officially only applies to three drug makers – Astra Zeneca, Sanofi, and Novo Nordisk - it makes it highly unlikely that HRSA will continue any enforcement action against any manufacturers. Meanwhile, decisions are expected soon from the Washington DC and Chicago Appeals Courts, and intel suggests that drug manufacturers are feeling optimistic about the outcome. The written decision clearly points to the need for Congress to explicitly address the contract pharmacy issue, stating "Statutory silences, like awkward silences, tempt speech. But courts must resist the urge to fill in words that Congress left out."

Court Ruling on Patient Definition

On Friday, November 3, 2023, a federal District Court issued its long-awaited ruling in the lawsuit filed by Genesis Health Care (a CHC based in South Carolina) regarding HRSA's "patient definition." The court ruled in Genesis' favor, concluding that that a covered entity (CE) may use 340B drugs to fill any prescription for any individual who meets the "plain language" definition of a patient -- regardless of whether the CE "initiated the healthcare service resulting in the prescription." While this decision will make it easier for CHCs to use 340B drugs for all their patients' prescriptions, it will also accelerate drug makers' efforts to place limits around the program.

New HRSA Webpage Consolidates Long-Standing Guidance Around Patient Definition and Audits

HRSA's 340B office recently published a new webpage entitled 340B Patient Definition Compliance Resources. The website does not provide any new information, but simply consolidates existing HRSA and Apexus resources around patient definition and audits. Stakeholders generally presume that HRSA compiled this list in response to a large volume of questions following the decision in the Genesis court case.

Background

The 340B statute says that for an individual to be eligible to receive a drug purchased under 340B, they must be a "patient" of the CE. In 1996 (four years after the program was established), HRSA issued its first official definition of a "patient," which had 3 prongs:

- The individual must receive a service(s) from a provider who is employed by or under contract with the CE.

- For grantees – The type of service received must be one for which the CE receives grant funding.
- The CE must maintain records of the individual's care.

In 2015, HRSA attempted to narrow this patient definition in its draft "mega-guidance," which proposed changing 340B eligibility from a *person* basis (where any person who met the definition of a patient could have all their prescriptions filled with 340B drugs) to a *prescription-by-prescription* basis (where each of a person's prescriptions were evaluated individually to determine if they were 340B eligible.) Specifically, HRSA proposed that to be 340B-eligible, a prescription needed to have been written by a provider who was employed by or under contract with the CE.

While the mega-guidance was never finalized, HRSA audits (and training and TA) began incorporating the prescription-by-prescription standard. CHCs found some wiggle room that allowed them to fill prescriptions written by specialists when they could demonstrate that they had "responsibility for the care" that generated them. CHCs typically demonstrate this "responsibility" by having a CHC provider refer a patient to the specialist and getting the notes back from the specialist to insert in the patient's EHR.

In 2019, HRSA audited Genesis' 340B program, and found that the CHC used 340B drugs to fill prescriptions written by non-Genesis providers, without demonstrating responsibility for the care that produced them. HRSA issued an audit finding, and eventually removed Genesis from 340B for non-compliance (involving this and other issues.) Genesis sued HRSA, arguing that the agency had overstepped its authority by defining "patient" too narrowly.

Starting January 1, Modifier Required for all 340B Drugs Separately Billed to Medicaid Part B

Effective January 1, 2024, all covered entities must include a 340B modifier on all Medicare Part B claims that bill separately for a drug that was purchased under 340B. Note that:

- This modifier requirement applies only if the claim includes a separate charge for the drug that was purchased under 340B. Thus, if the drug's cost is included in the Medicare PPS rate, there is no need to include a modifier on the claim.
- CHCs should use the "TB" modifier to indicate that a separately-billed drug was purchased under 340B.
- Medicare needs this information in order determine the amount of Part B "inflationary rebates" that manufacturers must pay on drugs whose prices have risen faster than inflation. (Drugs purchased under 340B are exempted from these rebates.)

November 3, 2023, Court Ruling

In its decision, the court found that HRSA's "patient" definition, as applied in Genesis' 2019 audit, was inconsistent with the plain meaning of the term "patient", as well as the legislative history behind the 340B program. The court held that "patient" should be defined using its "common everyday meaning", which meant that 340B-eligibility should be determined on *person-by-person* basis, not a a *prescription-by-prescription* basis. Thus, by defining "patient" more narrowly, HRSA had overstepped its authority and sought to deprive Genesis of 340B benefits to which it was entitled. The judge concluded "It is not the role of HRSA to legislate and

limit the 340B program by restricting the definition of the term "patients", thereby frustrating the ability of the 340B statute to accomplish its purpose."

The ruling also stated or implied the following points regarding who is a "patient":

- There must be an ongoing patient relationship between the individual and the CE
- There should be a time limit on how recently the individual has been seen by the CE to still be considered a patient.
- The original 1996 definition remains in effect

Implications

The implications of this ruling are not yet fully clear. However, at present we expect the following:

For CHC operations: Until the situation changes*:

- CHCs will be allowed to use 340B drugs for all prescriptions written for their patients, regardless of which provider wrote it. This means ***CHCs will no longer be required to demonstrate responsibility for the care that led to a prescription written by a non-CHC provider***.
- CHCs are strongly advised to have a policy that establishes how frequently an individual must receive care at the CHC to continue to be considered a CHC patient (and therefore 340B-eligible). While the court ruling does not specify a minimum time frame, it clearly implies that a timeframe (in the range of 2 to 3 years) is appropriate.
- There appears to be no change to HRSA's long-standing policy that simply getting a dispensed drug at a CHC-owned pharmacy does not qualify an individual as a CHC patient.

When considering policy changes, CHCs are also advised to consider optics. CHCs are widely considered to be "good actors" in the 340B space, and it's important that we not be seen as taking advantage of the program. (E.g., our "good actor" reputation has helped convince 2/3 of the drug makers who have contract pharmacy restrictions to exempt us from those restrictions.)

**This situation will change when one of the following occurs:*

- *Congress revises the 340B statute, or*
- *HRSA issues a new patient definition that can survive a court challenge (which will require that it adhere to the "plain meaning" of the word "patient")*

Drug Makers' Likely Response

Drug manufacturers have watched this case closely and will be very concerned by the outcome. For example, Janssen (the world's second-largest drug maker) predicted "If Genesis were successful here… the program will collapse. A court ruling supporting Genesis… would add billions of dollars of cost to the program." Thus, Genesis' victory will ***likely lead to drug makers being even more interested in reigning in the 340B program***, which could take at least two forms:

- More efforts to limit CEs' access to 340B drugs. Given how the ruling was written, it seems unlikely that drug makers will seek to impose a narrower "patient definition" (e.g., prohibiting 340B for referral prescriptions, or for insured patients.) However, they will

likely seek to tighten the program in other ways, such as by expanding contract pharmacy restrictions or forcing CEs to use specific wholesalers for 340B drugs.

- Increased lobbying to get Congress to amend the program-- including imposing a more restrictive patient definition. The Genesis ruling explicitly stated "If there is a desire to restrict the 340B Program… Congress is the appropriate entity to take the necessary action."

Additional Points

- The judge repeatedly emphasized that 340B's purpose is to enable covered entities to "stretch scarce Federal resources as far as possible" by enabling them to "receive their drugs at a discount and [be] reimbursed by insurers at the non-discounts price." That was positive news, as some 340B opponents contend that CEs were not supposed to be able to retain 340B savings on drugs dispensed to insured individuals.
- The judge consistently referred to 340B savings as "profit;" for example, he states that "the purpose of the 340B program was to provide a means to make 340B entities profitable" so that they could stretch scarce Federal resources.
- HRSA could appeal the ruling, but it seems unlikely.

Resources:

- HRSA's Office of Pharmacy Affairs (OPA)
- 340B Prime Vendor Program
- 340B University: in-person one-day educational program
- 340B University OnDemand: an online, self-paced, educational program
- 340B Call Center – APEX Answers:
  - apexusanswers@340bpvp.com
  - phone 888.340.2787
  - Chat Now feature
- 340B Peer-to Peer Program Archived Webinars
- 340B Peer-to-Peer Program Compliance Improvement Guide
- 340B FAQS
- 340B Manual *(NACHC is currently updating the manual. The 3rd edition is expected to be released soon)*
- 340B Drug Pricing Program Notice: Release No. 2014-1 (Replaces No. 2013-2 dated February 7, 2013) Clarification on Use of the Medicaid Exclusion File; December 12, 2014
- Medicaid Exclusion File by Quarter
- NACHC 340B Office Hours
- NACHC 340B Program
- PACHC 340B Subcommittee (contact PACHC at pachc@pachc.org)

FEDERAL TORT CLAIMS ACT (FTCA)

The Federally Supported Health Centers Assistance Acts (FSHCAA) of 1992 and 1995 extended Federal Tort Claims Act (FTCA) protections to eligible health centers funded under the Health Center Program, Section 330 of the Public Health Service (PHS) Act including Community Health Centers (CHC), funded under Section 330(e); Migrant Health Centers (MHC), funded under Section 330(g); Health Care for the Homeless (HCH) Health Centers, funded under Section 330(h); and Public Housing Primary Care (PHPC) Health Centers, funded under Section 330(i). The program is more commonly called the Health Center FTCA Medical Malpractice Program. It is important to note that Look-Alikes are not eligible to participate in FTCA.

The intent of the Health Center FTCA Medical Malpractice Program is to increase the availability of funds to health centers to provide primary health care service by reducing or eliminating health centers' malpractice insurance premiums.

Under FTCA deeming, a Section 330-funded health center, as well as its officers, directors, employees, and certain contractors, may be considered deemed as Federal employees for the purpose of medical malpractice coverage under the FTCA. As such, they are immune from personal liability for claims of medical malpractice arising from their deemed employment, contract for services, or duties as an officer or director of the deemed health center.

Should a claim be filed in a state court for actions arising within the scope of this deemed employment, prompt notification of the litigation must be given to the U.S. Department of Health and Human Services (HHS) so the action may be moved to Federal district court and the United States substituted as the named defendant. The covered entity and covered individuals will not be financially liable for any claims arising from their covered activities. However, this immunity does not preclude related actions by federal, state, and other licensing and certifying bodies. Examples: reporting of claims payments to the National Practitioner Data Bank or reporting to the applicable state licensing board are not precluded.

FTCA coverage is not assured from year to year. In order to obtain deemed Public Health Service employment status for the health center and "covered individuals," Health Center Program awardees and subrecipients must submit an annual deeming application that demonstrates compliance with FTCA Program requirements.

Compliance with FTCA requirements must be demonstrated in the following areas:

- Credentialing and Privileging
- Quality Improvement and Quality Assurance
- Risk Management
- Claims Management

Important Points:

- FTCA deeming/redeeming requirements are released annually by HRSA via a Program Assistance Letter (PAL).
- FQHC Look-Alikes are not eligible for FTCA deeming.

- A health center's deemed status does not imply FTCA coverage in all cases, as health center providers must also comply with statutory individual eligibility requirements.
- A health center may choose to obtain other types of liability coverage such as private "gap" or "tail" insurance, directors and officer insurance, and general liability insurance for activities that may not be eligible for FTCA coverage.
- The health center must inform patients using plain language that it is a deemed Federal PHS employee via website, promotional materials, and/or within an area(s) of the health center that is visible to patients.
- There is a separate FTCA program and deeming requirements for Health Center Volunteer Health Professionals (VHP) extending liability protection for the performance of healthcare services to volunteer health professionals at health centers that have also been deemed as employees of the Public Health Service (PHS).
- The Free Clinics FTCA Program received appropriations in 2004. This program has its own eligibility and deeming requirements. Free clinics sponsor each individual and apply to HRSA to "deem" the individual. Health centers, by contrast, are "deemed" as entities and receive automatic FTCA coverage for all qualified employees when the health center is "deemed."

Annual OB Training

Which health centers are required to conduct annual OB training in order to obtain or maintain FTCA deemed status?

The requirements and guidance for the annual FTCA OB training requirement can be found in Program Assistance Letter (PAL) 2023-01 (PDF - 900 KB), specifically in question 3(A) of the Risk Management section, as well as in Chapter 21 of the Health Center Compliance Manual. All health centers that are currently FTCA deemed, as well as those seeking FTCA deeming or redeeming status, must conduct OB training on an annual basis if they provide clinical services to any of the following individuals:

1. Pre-natal patients
2. Post-partum patients
3. Patients who are of reproductive age and childbearing age.

Please also refer to FTCA section of the HRSA Health Center Program Compliance FAQ, which also states "regardless of the provision of obstetrical services, if a FTCA-deemed health center has contact with reproductive age patients for other clinical services through FTCA-deemed providers (health center employees or individual contractor providers)".

Who is required to complete annual OB training at our health center to obtain or maintain FTCA deemed status, and what types of trainings are acceptable?

The Health Center Compliance Manual's Chapter 21 allows for flexibility when conducting risk management trainings, including annual FTCA OB risk management trainings. When organizing these trainings, health centers have the ability to determine the following:

1. **Which staff members who must complete OB training:** This should be based on an assessment of the roles and responsibilities of health center staff member in relation to OB services and/or clinical services provided to childbearing and reproductive age patients. The health center must also consider the specific type of OB training required based on each staff member's roles, responsibilities, and their level of contact with OB

patients and patients of reproductive age and childbearing age. For instance, an OB doctor would be required to undergo different OB training compared to a behavioral health provider who interacts with OB patients and/or patients of reproductive age and childbearing age.

2. **Source of the training:** Health centers may choose from various training sources, such as HRSA trainings, ECRI trainings, in-house trainings, or other public or private training resources.
3. **Delivery method and format of the training:** Health centers have the flexibility to choose the delivery method and format of the OB training. Options may include in-person, virtual, or hybrid trainings. Additionally, health centers may utilize different training formats, such as lectures, videos, presentations, labs, or online modules.
4. **Content covered during OB training:** Health centers can determine the specific content covered during each OB training session based on health center data, assessments, and other available information. For example, a health center may require applicable staff members to complete OB training focused on topics such as maternal mortality, post-partum depression, shoulder dystocia, pregnancy and diabetes, or pregnancy and obesity.

By considering these factors, health centers can tailor their OB training programs to effectively address the needs of their staff and meet the requirements for FTCA deemed status.

Resources:

- FTCA Frequently Asked Questions | Bureau of Primary Health Care (hrsa.gov)
- HRSA Federal Tort Claims Act (FTCA) website
- FTCA Health Center Policy Manual
- PAL 2022-02: Calendar Year 2023 Requirements for Federal Tort Claims Act (FTCA) Coverage for Health Centers and Their Covered Individuals
- Health Center Program Compliance Manual (Last Updated August 2018) Chapter 21 Federal Tort Claims Act (FTCA) Deeming Requirements

HEALTH INFORMATION TECHNOLOGY IN PA

The Pennsylvania eHealth Partnership is responsible, under Act 76 of 2016, for the creation and maintenance of Pennsylvania's secure health information exchange (HIE), known as the PA Patient & Provider Network, or P3N. As the state's HIE, P3N improves and coordinates patient care by providing access to patient medical records in real time anywhere on the P3N network.

To connect to the P3N, health centers must first join a certified regional network, called a health information organization, or HIO.

Five certified HIOs currently operate within Pennsylvania. Information about these HIOs -- including contacts, provider types served, structure, services provided, service areas, and financial/fee structure can be found here -- Choose Your HIO. The PA Department of Human Services (DHS) eHealth Partnership, which administers the P3N, also recommends you consider these questions to help choose from these HIO options:

- Central Pennsylvania Connect Health Information Exchange
- ClinicalConnect Health Information Exchange
- HealthShare Exchange
- Keystone Health Information Exchange
- Mount Nittany Exchange

The availability of data being shared will differ per HIO. Data may include allergies, clinical documents, diagnoses, inpatient emergency department, outpatient emergency department, immunizations, lab results, medications, pathology reports, patient demographics, problems, procedures, and radiology reports. Currently, emergency department Admission, Discharge, Transfer (ADT) messages are shared across the P3N as part of the statewide encounter notification service. Here is a list of facilities sending ADTs. A list of clinical documents available by each HIO and HIO member organizations is also available.

Important Point:

- Health centers should contact each HIO for detailed and the most current information related to services, fees, and implementation/operational requirements and timeframes.

Under Act 76 0f 2016, any patient whose health care provider is connected to the P3N will have his or her medical records automatically available for exchange across the P3N to other providers who need it. This is known as opt-in. However, a patient who does not want his or her medical information available for exchange across the network may opt-out of the P3N by completing and submitting a patient opt-out form (available in English and Spanish) to the eHealth Partnership. If a patient has opted out of the P3N, any query for the patient's medical records will generate a message confirming the patients opt-out status, and no medical information will be sent.

Important Point:

- The DHS Physical Health MCO Patient Centered Medical Home (PCMH) model of care requires participating providers to join a P3N certified health information organization (HIO) by 12/31/2020 in order to share health related data.

Resources:

- Provider Toolkit
- Connection and Certification Requirements for Health Information Organizations
- Health Information Exchange - Providers
- Health Information Exchange - Citizens

Medicaid Promoting Interoperability Program (PIP), formerly known as the Medicaid EHR Incentive Payment Program, ended in 2021. The Medical Assistance Provider Incentive Repository (MAPIR) System accepted Program Year (PY) 2020 applications through March 31, 2021. For questions concerning the Medicaid Promoting Interoperability Program, see resources on the Medicaid PIP website, email RA-mahealthit@pa.gov or email pachc@pachc.org.

Resources:

- CMS 2020/2021 Program Requirements Medicaid
- 2020 Medicaid Promoting Interoperability Program Meaningful Use Requirements

THE ASSURANCE OF HEALTH INSURANCE COVERAGE

HRSA Expectations Regarding Outreach & Eligibility Assistance. Health centers are expected to provide outreach and eligibility assistance to individuals within their service area regarding the availability of affordable health insurance coverage opportunities such as the Marketplace, Medicaid and CHIP, as well as other options such as Medicare and social service programs.

Eligibility assistance and outreach are among the required health center services listed on HRSA Form 5A: Services Provided. The Uniform Data System (UDS) collects health center outreach & eligibility assistance information.

For more example, see the 2020 UDS Manual. Health centers must report:

- Table 5
  - Outreach Workers (Line 26)
  - Eligibility Assistance Workers (Line 27a)
- Appendix E: Other Data Elements: Number of assists provided

Pennsylvania's State-Based Exchange. Act 42 of 2019 created the Pennsylvania Health Insurance Exchange Authority to transition Pennsylvania from the federally facilitated Exchange (FFE), Healthcare.gov, to a State-based Exchange, Pennie™, for the 2021 health insurance enrollment period to improve the accessibility and affordability of individual market health coverage for Pennsylvanians. Pennie™, Pennsylvania's new State-based Exchange, replaced Healthcare.gov for Pennsylvania customers starting in Plan Year 2021.

Pennie's initial goals were to: (1) provide a seamless transition for those using HealthCare.gov, (2) improve access to healthcare for all Pennsylvanians, (3) lower healthcare costs and premiums, (4) and ensure excellent customer assistance throughout the enrollment process.

The Open Enrollment Period runs from November 1 through January 15.

In 2020, Cognosante, a health IT and consultant company, reached out to PACHC to partner on the Pennsylvania Insurance Exchange (Pennie) Request for Proposal to provide navigator services through our health center network of enrollment assisters for this new endeavor. The Cognosante application, along with PACHC and three other subgrantees, was chosen by the Board of the Pennsylvania Health Insurance Exchange Authority (PHIEA) and awarded funding to provide assister and Navigator services in support of the Commonwealth's newly formed State-based Exchange. Under contract with Cognosante, PACHC and our network of community health centers throughout the state provide outreach and no cost enrollment assistance to individuals and families seeking health insurance coverage through the State-Based Exchange. PACHC, in turn, is offering financial assistance to all interested health centers and other partners to provide outreach and enrollment services, report enrollments via a new online, web-based reporting tool and participate in enrollment events. For information or questions related to this outreach and enrollment funding through PACHC, please email pachc@pachc.org.

PACHC and participating Health Centers continue to participate in the Pennie Assister Services contract for the 2024 Plan Year.

Prior to transition in Pennsylvania to a state-based exchange, PACHC was a Centers for Medicare and Medicaid Services (CMS) Navigator grantee for the federal Health Insurance Marketplace since 2013, bringing a coordinated, statewide approach to in-reach, outreach, and enrollment. Assisters are trained to help support customers either in-person or virtually and to walk through step-by-step the shopping and purchasing process.

PACHC provides training, education and support to all health center enrollment assisters through monthly virtual networking meetings and webinars on timely topics, not just related to the state-based exchange but also related to Medicaid, CHIP and Medicare enrollment.

Important Point:

- Please contact PACHC at pachc@pachc.org to find out what enrollment opportunities/programs exist for assisters and health centers.

Resources:

- PACHC Outreach and Enrollment web page
- Pennie.com
- Medical Assistance (Medicaid) or CHIP enrollment
- Department of Human Services
- PA MEDI
- Medicare.gov
- Enrollnow.net
- Dedicated Outreach and Enrollment SLACK page

EMERGENCY PREPAREDNESS

Background. In September 2016 CMS published the *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule.* Seventeen categories of healthcare providers, including FQHCs, and suppliers affected by these conditions of participation (CoP) and conditions for coverage (CfC) regarding emergency preparedness were to be compliant and implement all regulations by November 15, 2017. The regulations targeted four focus areas: risk assessment and emergency planning; policies and procedures; communications plan; and training and testing.

Many of these requirements reiterate recommendations from the Bureau of Primary Health Care Emergency Preparedness, Response, and Recovery Resources for Health Centers | Bureau of Primary Health Care (hrsa.gov), Health Center Emergency Management Program Expectations.

Current Requirements. In September 2019 CMS published another Final Rule which revised some of the emergency preparedness requirements for providers and suppliers. The following emergency preparedness/management requirements were effective November 29, 2019:

- An FQHC must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. The plan must be based on and include a documented, facility-based, and community-based risk assessment utilizing an all-hazards approach.
- An FQHC must develop and implement emergency preparedness policies and procedures, based on their emergency plan. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address:
    - Safe evacuation of the facility including appropriate placement of exit signs, staff responsibilities and needs of the patients
    - A means to shelter in place for patients and staff who remain in the facility
    - A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records
    - The use of volunteers in an emergency or other emergency staffing strategies such as the role for integration of state and federally designated health care professionals to address surge needs
- A communication plan must be developed and maintained and must be reviewed and updated at least every 2 years. The communication plan must include:
    - Names and contact information for staff, providers, other entities that would be providing services as well as federal, state, and local emergency preparedness staff
    - Primary and alternate means for communicating with staff and federal, state, regional, and local emergency management agencies
    - A method of providing information about the general condition and location of patients under the facility's care as permitted
    - A means of providing information about the health center's needs and its ability to provide assistance to the authority having jurisdiction

- A training and testing program must be developed, maintained, and reviewed and updated at least every 2 years.
    - Emergency preparedness training must be provided at least every 2 years and documentation maintained of all emergency preparedness training
    - The training and testing program must demonstrate staff knowledge of emergency procedures
    - If the emergency preparedness policies and procedures are significantly updated, the health center must conduct training for all staff on the updated policies and procedures.
- Exercises to test the emergency plan must be conducted at least annually. The FQHC must:
    - Participate in a full-scale exercise that is community-based every 2 years; or when a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years
    - If the health center experiences an actual natural or man-made emergency that requires activation of the emergency plan, they are exempt from engaging in the next required community-based or individual, facility-based functional exercise for 1 year following the actual event
    - An FQHC must conduct an additional exercise at least every 2 years opposite the year the full scale or functional exercise is conducted. That exercise may include, but is not limited to, a second full-scale exercise that is community-based or individual, facility-based functional exercise; or a mock disaster drill; or a tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically relevant emergency scenario designed to challenge the emergency plan
    - The health center must analyze its response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the emergency plan as needed.
- If an RHC/FQHC is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the RHC/FQHC may choose to participate in the healthcare system's coordinated emergency preparedness program.

PA Health Care Coalition (HCC). The Healthcare Preparedness Program of the Assistant Secretary for Preparedness and Response defines HCCs as: "A formal collaboration among healthcare organizations and public and private partners that is organized to prepare for, respond to, and recover from an emergency, mass casualty or catastrophic event."

HCCs are primarily planning organizations, with a limited role in incident response. Major responsibilities include:

- Regional emergency plan development
- Regional budget development and sustainment
- Membership sustainment and growth
- Incident response coordination at the regional level through communications and mutual aid facilitation
- Coordinating and facilitating HCC meetings and records

- Regional training and exercising facilitation

Each HCC works closely with the PA DOH Bureau of Emergency Preparedness and Response, the state field team of Public Health Preparedness Coordinators, the state and county Emergency Management Agencies and Emergency Medical Services (EMS) Regional Councils.

Pennsylvania has seven HCCs. Each sets their own membership criteria, but if you are part of the healthcare delivery system, you are welcome to join. FQHCs are encouraged to join the HCC that covers their county(ies) service area.

- ✓ EAST CENTRAL (Berks, Columbia, Luzerne, Montour, Northumberland, Schuylkill, Wyoming Counties)
- ✓ NORTH CENTRAL (Bradford, Clinton, Lycoming, Potter, Sullivan, Tioga, Union Counties)
- ✓ NORTHEAST (Carbon, Lackawanna, Lehigh, Monroe, Northampton, Pike, Susquehanna, Wayne Counties)
- ✓ NORTHERN TIER (Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Venango, Warren Counties)
- ✓ KEYSTONE (Adams, Bedford, Blair, Centre, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lancaster, Lebanon, Mifflin, Perry, Snyder, York Counties)
- ✓ SOUTHEAST (Bucks, Chester, Delaware, Montgomery, Philadelphia Counties)
- ✓ SOUTHWEST (Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Mercer, Somerset, Washington, Westmoreland Counties)

Effective July 2020, the PA Department of Health contracted with Public Health Management Corporation (PHMC) of Philadelphia as its health care emergency preparedness vendor as part of DOH's federal health preparedness grant. This includes statewide management of the HCCs. The Hospital and Healthsystem of Pennsylvania (HAP) previously held the contract.

The PA Bureau of Emergency Preparedness & Response (BEPR) works with PHMC to provide support to coalition members.

- HCC members are encouraged to contact their County Emergency Management Agency as the first line of support for emergencies or events impacting operations. View the list of county coordinators.
- HCC members are also encouraged to follow existing HCC plans and procedures to leverage coalition-level support systems that may be in place.
- Please contact PACHC at pachc@pachc.org if you have questions or would like additional information about HCCs and this current transition in management.

BPHC & Emergency Preparedness. The Bureau of Primary Health Care has requested Primary Care Associations (PCAs) – in Pennsylvania, PACHC -- to take the lead during any emergency that occurs in the state on gathering critical health center information and report impact data back to BPHC on the operational status of delivery sites. Health centers sign MOAs acknowledging their and PACHC's communication responsibilities during an emergency.

You can report emergency information and impact data to PACHC via pachc@pachc.org.

Visit HRSA's Emergency Preparedness, Response, and Recovery Resources for Health Centers website for guidance documents and resources including information on change in scope for temporary sites, 340B Program enrollment under emergency declarations, and FTCA coverage in emergency events, including volunteer health professionals.

Resources:

- CMS Emergency Preparedness Rule
- State Operations Manual Appendix Z- Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance
- HHS ASPR, the Technical Resources, Assistance Center, and Information Exchange (TRACIE) Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers (CMS EP Rule)
- TRACIE resources and guidance specific to FQHCs
- Rural Health Clinic / Federally Qualified Health Center Requirements CMS Emergency Preparedness Final Rule Updates Effective November 29, 2019
- The PA Health Alert Network (PA HAN) is part of the Pennsylvania Department of Health's Public Health Emergency Preparedness and Response Program. PA HAN serves as a secure communication network among state and local public health agencies, health care providers, hospitals and emergency management officials. Sign up for PA HAN to receive timely health alerts and advisories.
- PA DOH Public Health Preparedness

COMMUNICATIONS & MARKETING

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

Branding. Early and effective branding of your health center is one key to business success. A brand lives in the minds of everyone who experiences them: employees, investors, the media, and, perhaps most importantly, customers. A brand is comprised of various elements:

- Brand Compass: is a summary of the most fundamental truths about your brand. It's the outcome of the work done in the brand strategy phase, including research and positioning.
- Brand Archetypes: are timeless characters in stories that every human is familiar with, by virtue of being a human. By identifying which archetype your brand embodies, you can build a brand that audiences recognize at a profound and enduring level.
- Brand Personality: is the unique spectrum of characteristics and behaviors that are unique to a brand. Its personality is how your brand would look and sound if it were a person. A brand's personality is the reason it is identifiable to its loyal customers and the basis for the highly personal relationships they form with it.
- Competitive Advantage: is the thing you do better than any other business.
- Brand Promise: is the solemn pledge you make to those you serve. Your brand promise is expressed in many forms: taglines, messaging, advertisements, social media, and beyond. It can be explicitly stated or subtly implied.
- Verbal Identity: is the integrated system of words and messaging that differentiate your brand and make it recognizable to audiences. Your verbal identity includes things like your name, tagline, brand voice, brand story, and brand messaging.

Branding is the act of shaping how a company, organization, or individual is perceived. A brand is also how the organization is perceived by its customers – the patients, staff, collaborators, and community partners – and the inherent value they place on your health center. A customer's brand perception can change their decision on engaging with an organization. Inaccurate branding can make it difficult for people to grasp what the organization is and offers. A brand is a company's face to the world.

Branding is an effort to establish a positive reaction or identification with a "product;" in this case, your health center. PACHC at the state level and NACHC at the national level are working to improve brand identification and loyalty for the "community of Community Health Centers FQHC" to increase the likelihood that clinicians seeking employment, other providers seeking partners, patients seeking a healthcare home and insurers seeking providers will proactively look to FQHCs to fulfill these roles. (See So What Is a Community Health Center? for more on this statewide and national FQHC initiative). The national FQHC initiative is not intended to

supplant or replace branding for individual health centers, but rather to supplement that branding and serve as a unifier. Your health center should, as part of its communication plan, both align with this broad branding initiative as well as develop your own brand identity.

Marketing Plan.
A marketing plan is an operational document that outlines an advertising strategy that an organization will implement to generate leads and reach its target market. Marketing plans can vary depending on the industry, type of products or services, and goals you want to achieve, but there are certain essential elements that most plans include:

- Marketing goals and objectives
- Define your target audience
- Research your marketing tactics
- Plan your marketing tactics
- Develop your budget and timeline

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

As much of a health center's revenues come from grants or service reimbursements from national and state governments, it is important that local, state, and national legislators and key decision makers are aware of what makes an FQHC different and why the FQHC model has enjoyed bipartisan support for its entire 50+ year history. Key decision makers must understand what each FQHC contributes to its community's health, welfare, and economy.

Properly, many health centers are concerned that they might be violating the law or put their not-for-profit status at risk if they reach out to legislators and others and provide this education, so it is important to understand the difference between lobbying and education. A National Association of Community Health Centers publication, Advocacy Restrictions and Limitations on Federally Funded Health Centers provides guidance on what is allowable and unallowable for health centers. If necessary, seek legal counsel if there is any question about lobbying versus education.

Policies. As with so much else in an FQHC, communication policies must be developed. The topics below are not comprehensive, but are, at a minimum, policies that should be in place.

- Who communicates what? Generally, individual board members or staff are not expected to give media interviews. A policy delineating how a decision is made for media communications, content approval, and who gives media commentary should be developed. Generally, the CEO and/or board chairperson are assigned this duty.
- Crisis communication policy including roles, responsibilities as well as guidelines for communication during an emergency.
- Social media policy including policies for who handles the health center's social media posting as well as internal policies for staff posting on their own social media pages.

Websites & Social Media. Websites and social media are an essential part of any communication strategy. Does your health center have a website? A Facebook page? Use Twitter? Social media gives organizations the ability to engage audiences, foster relationships, reinforce the brand image and amplify reach.

- Number 1 issue – is the website up-to-date and current?
- Is the website easy to navigate?
- What services can patients access via the website and do those modalities function well?
- Post quality content and content of interest to "customers"
- Policies and guidelines are critical as to what information will be shared online; how will employee or patient negative comments be handled.

Important Points:

- Consider all communication modalities….print, social media, website, radio, television, outdoor advertising.
- Create consistent storytelling across platforms and bring your story to life.
- Ensure that language used is understandable by the audience, limit jargon.
- Preparation for media or communications efforts is essential. It is important to develop a list of the do's and do not's for specific situations.
- Know legal requirements related to use of photographs or video; know what consents should be obtained, particularly where patients are involved.
- Contact PACHC for information about the Communications Peer Networking Group; have staff member participate.
- Contact PACHC for brochures and infographics that can be used as part of a health center communications effort
- Contact PACHC for branding items – FQHC clings, FQHC pins – as well as guidance on use of FQHC logo

Resources:

- Social Media for Health Centers
- Communication Tools
- Managing Risks Related to the Media and Communication Crises
- Pennsylvania Statewide FQHC Marketing Campaign

HEALTH CENTER MERGERS AND ACQUISITIONS

HEALTH CENTER MERGERS AND ACQUISITIONS

In an ever-changing healthcare environment, mergers and acquisitions of FQHCs can occur for several reasons: to better serve and meet the needs of the community, provide financial stability, promote cost savings, increase access to services, and create workforce efficiencies. There are many aspects to consider when determining the best option for all parties involved. Mergers and acquisitions involve the transition of legal, financial, operational, and organizational elements. This chapter focuses on the process and provides insight and resources to assist health centers. The elements in this chapter reflect the experience of two Pennsylvania health centers that merged in March 2021.

What is the difference between a merger and an acquisition?

A merger is the act of combining two or more organizations. In contrast, acquisition is when one organization takes over one or more companies that become part of the acquiring organization. The right option is based on the individual circumstance, environmental factors and health centers involved.

Determination Process

Health center leadership should take time to explore and fully understand all options available to them when considering a merger or acquisition. Identifying a potential partner will include consideration of the following for both organizations:

- Contributing factoring and benefits
- Mission, vision, and values
- Overall culture and work environment
- Facilities and health center assets and liabilities
- Staff and Board of Directors

The determination process begins with seeking clarity on why the merger is in both parties' best interest. Overlapping service areas, unserved or underserved areas and lack of access for target populations can impact or precipitate a merger. Other considerations include the value to the community, patients, and health center staff. It is important for leadership at both organizations to have a similar vision for the long-term future and buy-in to the possibility of creating a stronger organization through a merger.

Legal counsel and an external consultant may be beneficial to this part of the process. Legal counsel can provide guidance on:

- Legal considerations that include but are not limited to name changes (and functioning as a "doing business as" or "dba" when applicable), agreements, data and information collection requirements, and legal issues that arise throughout the process.
- Dissolution and creation of business entity
- Bylaws and corporate documents
- Corporate liabilities and risks
- Legal issues that may arise. Note: each organization should have separate legal representation

Timeline – A timeline can help maintain organization and keep progress moving forward. The following timeline is an example based on the experience of two health centers that have merged but should not be taken as the only way the process can and should happen. Legal counsel will advise on the proper steps specific to each situation.

- Confidentiality agreement by authorized agents of both organizations
- Due Diligence – This is the information collection stage when leaders and Board members assess the potential value and risks of a merger. Health centers may benefit from establishing an ad-hoc committee with equal representation from both organizations to carry out the due diligence process.
- Letter of Intent Development
- Letter of Intent Approval by majority vote of both health centers
- Confidentiality agreement by select leaders within both organizations
- Analysis and Planning
- Merger Plan creation by legal counsel
- Merger Plan approval by majority vote of both health center
- Successor in interest process begins with HRSA
- Inform the PA Department of Human Services (DHS) of the impending merger to determine payment rate for successor or new organization
- Attorney General approval
- Orphan's Court (Optional) approval
- Coordination with HRSA for successor in interest process to end on merger consummation date
- Announcement of the Merger
    - Internal announcement to staff – covering why the merger is occurring, the benefits of merging, operational and human resource changes, sharing of the new name, brand, mission, vision and value, implications of the merger for staff, followed by a welcome letter from the CEO
    - External partners and legislators – notification of the merger including the effective dates and implications for the community
    - Patient communication – providing key information such as new name, branding, services, locations, provider changes and timeline
    - Donors and community leaders – notification of the merger including the effective dates and implications for the community
    - Stakeholders and public – information on the organization and effective date
- Launch of Internal Integration Plan
- Use of social and other media to promote new brand and express commitment

Due Diligence - The due diligence period evaluates the financial, legal, and operational aspects for both health centers. A best practice for this evaluation is to implement a subcommittee comprised of staff from both health centers. The subcommittee plays a vital role in determining where things stand and how to progress.

An external consultant can be helpful in handling the many components of this stage, as the process is susceptible to collapse under the weight of all the details. Confidentiality agreements

should be obtained for all individuals involved in this step of the process. Confidentiality allows for communication to be strategic, shared at an appropriate time and in a way that decreases concern and promotes positive outcomes.

Planning and Development –health center leadership and the subcommittee begin planning for the merger as well as the long-term future of the combined organization. Senior management for both health centers will be involved in planning and development. The planning and development process would assess leadership, staffing plan and board of directors' composition and dynamics.

The subcommittee should be comprised of staff with specific skills sets and experience, including:

- Project manager – internally identified or external consultant
- Legal counsel
- Financial, accounting or tax expert
- Information technology consultant
- Operations or organizational assessment team
- Compliance staff
- Human resources consultant or an employment specialist
- Facilities lead

The planning and development stage includes a significant amount of data and documentation that lays a strong foundation for moving forward and making informed decisions. The process is complex and identifying a project manager with a strong understanding of business operations is imperative to successful planning and development. An administrative point person and the use of a secured drop box is key to organizing and managing the information collected.

Important information and data collection to define actions:

- Identifying the successor organization - This is determined by whether one of the two organizations will be dissolved and absorb the other or both will be dissolved and an entirely new organization created.
- Tax ID
- Contracts
- Financial information and payer transition plan
- Asset distribution
- Valuation – if one organization is not an FQHC or LAL organization
- Organizational debt
- Needs assessment
- Consents and disclosures
- Strategic plans
- Naming, marketing and branding

Communication – The communication stage is a vital part of the process that can set the tone for how health center staff, patients and the community ultimately view and accept the merger. This is an opportunity to highlight the benefits and minimize concerns. However, this also takes

significant consideration and preparation to ensure communication is successful. This step is important to manage the people side and understand the emotional nature of transition. Proper communication is key to prevent or calm fears while focusing on empowerment and collaboration.

Involvement of a Chief Communication Officer is valuable to prepare talking points for consistent and accurate sharing of information, lead prep meetings with key staff, and ensure that confidentiality continues until a plan is in place and information can be shared at an appropriate time and manner.

- Internal
    - Staff from both health centers – Be prepared for staff to have lots of questions. Town hall forums can be a good way to share information and answer questions.
    - Internal Integration Plan
- External
    - Health systems
    - Political Officials
    - Patients
    - Donors and Community Leaders
    - Stakeholders
    - General Public

Health Center Integration – The short and long-term success of a merger relies not just on the planning and development, but also the execution of the transition. This can be a challenging component of the process being that there are cultural and political perspectives that can conflict or become difficult to navigate. Emerging senior leadership will need to utilize strong people skills to successfully manage the process.

- Service Line Integration
    - Primary care services
    - Behavioral health and SUD services
    - Dental services
    - Specialty care services
    - Referral partnerships
    - Credentialing and privileging process
- Human Resources
    - Understanding the risks and opportunities in regard to staffing
    - Compensation and benefits alignment – of high importance to staff and will generate questions
    - Update job descriptions and performance assessments
    - Focus on retaining top talent and make decisions on releasing staff
    - Consider cultural and organizational differences between merging organizations
    - Develop a new organizational chart
    - Combined employee handbook and implementation of orientation process
    - Recredentialing under the merged organization
- Information Systems
    - Transition to one electronic health record

    - System-wide IT/IS platform and network
    - Hardware inventory and software integration
    - Call center and scheduling system integration
    - Educate staff on HIPAA privacy and security
- Finance
    - Align financial policies and procedures
    - Integrate financial operations – accounts classification, general ledgers, profit centers, cost centers and accounts
    - Continue banking relationships and consolidate where applicable
    - Plan for audits
    - Insurance coverage review and confirmation
- Grants
    - Closing out grants or requesting carry-over
    - Will need to report pre-merger and post-merger amounts for any current grants based on effective date for the merger
- Logistics
    - Name change – IRS, CMS, Medicaid and state charitable organizations. Timing is imperative. It should be noted that the process to register a name change with the IRS takes a considerable amount of time.
    - Update and re-negotiate vendor contracts
    - Integrate physical inventory tracking and equipment maintenance
    - Facility maintenance, safety and environmental services operation
    - Combining of physical space logistics
- Communications
    - Website and social media
    - New brand unveiling and orientation
    - Update signage and business materials (letterhead, business cards) with new branding
    - Press release
    - Opportunity to engage existing and potential donors
- Quality and Compliance
    - Service line expansion opportunity – pharmacy, specialty services
    - Analysis of quality and compliance indicators
    - Performance goal determination and improvement plan
    - Compliance and risk management
- Operations
    - Policies and procedures
    - Grants management
    - Create efficient and effective processes that can be implemented at all sites and across all service lines and programs.
    - Staff engagement and orientation
- Community Initiatives
    - Creation of Community Advisory Boards
    - Assess partnerships and community engagement

Finalization of Merger – The finalization of the merger occurs when all elements of the transition are complete and all legal approvals granted. This is the point where the two (or more) health centers begin fully functioning as one integrated, and expectantly stronger organization.

By this point, HRSA's Successor-in-Interest process is complete and the 330 grants for the organizations have been merged into one grant. Approval from the Attorney General's office has been granted. The PPS rate has been approved by the PA Department of Human Services Medicaid Office and can be billed. In addition, all aspects of financial management have been merged. All payor contracts reflect the new organizational name and are inclusive of all sites under the new organization.

All operational areas including service lines, human resources, and information technology (platforms, networks, and electronic health records) have been combined and are functioning as one organization. Messaging has been developed for target audiences and all stages of communication have occurred. Advisory boards and sub-committees could remain in place for some time to identify and address issues that may arise post-merger.

Important Points:

- Mergers have an impact on billing for both organizations. Insurance payments should be paid retroactively following the recredentialing process, however there will be a temporary pause on reimbursement. Organizations should expect to be without revenue for several months during this process.
- Having 90 days cash on hand to cover expenses during the time Medicare enrolls the sites under the acquiring FQHC is recommended. In one health center's experience, it took about 50 days to get the sites moved over so the cash was essential to cover operational expenses while cash flow caught up. Once approved by Medicare and Medicaid, all claims for the newly acquired sites were processed and paid retro to the effective date of the merger.
- Recredentialing of providers cannot happen until after Attorney General approval and a merger date has been determined. This happens after the merger.
- The human factor is instrumental in a merger's success. It is important for leaders to recognize the need for strong people skills, effective communication and recognition of concerns and fears.
- Be prepared for challenges, disagreements, and feelings of fear and/or inequity.
- Communication is highly important. Frequent and mutually respectful communication between the CEOs is imperative. In addition, communication at all levels is pivotal to building trust, understanding the changes and expectations and creating an inclusive environment.
- Board engagement throughout the process and approval of the merger or acquisition is essential.

Resources:

- HRSA Technical Assistance Resource: Health Center Mergers, Acquisitions and Other Organizational Changes and Related Successor-in-Interest Requests
- CHCF Mergers and Acquisitions: A Practical Guide for Community Health Centers
- Mergers and Acquisitions Toolkit
- NACHC Guide for Boards

PA MEDICAL ASSISTANCE & CHIP

MEDICAID ENROLLMENT
PA PROMISe™ SYSTEM

In order for providers and service delivery sites to participate with the PA Department of Human Services (DHS) and provide services to Medical Assistance (MA) or Children's Health Insurance Program (CHIP) recipients and be authorized to bill, they must first enroll and receive a Medicaid/PROMISe number.

Medicaid enrollment is the same as PROMISe enrollment; a Medicaid identification (ID) number is the same as a PROMISe ID Number.

To be eligible to enroll, practitioners in Pennsylvania must be licensed and currently registered by the appropriate state board. Out-of-state practitioners must be licensed and currently registered by the appropriate agency in their state and must provide documentation that they participate in that state's Medicaid program. Other providers must be approved, licensed, issued a permit, or certified by the appropriate state board, and, if applicable, certified under Medicare.

The most efficient and effective way to submit a new Medicaid enrollment application or for revalidation or reactivation of enrollment in the MA program is through the online provider enrollment portal, Medical Assistance (MA) and Children's Health Insurance Program (CHIP) On-line Provider Enrollment Application

Using the secure online portal:

- Allows documents to be uploaded directly to the portal
- Permits providers to see the status of their submission
- Decreases wait time for review of applications

To access enrollment or revalidation applications and requirements for each Medical Assistance provider type visit the Provider Enrollment Documents page.

Providers can call the Office of Medical Assistance Programs, Provider Enrollment at 1-800-537-8862 to request a paper application if the PDF version of the application is no longer posted on the DHS Provider Enrollment website. Paper applications will continue to be accepted for processing.

When seeking to enroll a health center site or provider that is located within another provider's office, the instructions specified in MA Bulletin 99-16-04, Enrollment of Co-Located Providers must be followed. The Co-Location Attestation attached to the MA bulletin must be completed and submitted with proposed signage to DHS.

Important Points:

- To enroll with Medicaid as an FQHC or Look-Alike, you must have a HRSA notice of award (NOA) as an FQHC or Notice of Look-Alike Designation
- Medicaid managed care organizations (HealthChoices MCOs) effective Jan. 1, 2016 are required to begin their credentialing process concurrently with application for a PA

PROMIS*e*™ identification number. MCO credentialing can then be finalized after the PROMIS*e*™ number is obtained.

- Medicare enrollment is not required prior to enrollment with PA Medicaid.
- The Medicaid/PROMISe ID is a 13-digit number: nine (9) digit provider identification number and four (4) digit service location.
- As a member service, PACHC, in partnership with DHS, has developed a process to expedite issuance of Medicaid PROMISe numbers for individuals working in a Community Health Center FQHC or rural health clinic (RHC). As part of this agreement, DHS requires that all requests go through PACHC to ensure that submissions are complete and consolidated.
- Requests for expediting should not be submitted sooner than five business days after an enrollment application has been submitted to DHS. Please note, DHS is not able to expedite *revalidations* at this time.
- Note: DHS will only expedite enrollment applications submitted through the online portal

Criminal Background Checks.
On December 1, 2015, the PA Medical Society reported that it had confirmed with DHS that physicians and other employees of a medical practice or hospital (including administrative employees) are not required to obtain child abuse clearances under the law. However, you should consult your legal counsel before making an administrative decision for your health center.

Resources:

- PACHC Memo 19-02 Licensure, Enrollment and Credentialing
- CHIP Provider Enrollment Information
- DHS Provider Enrollment FAQs

PROMISe™, the Provider Reimbursement and Operations Management Information System, is the Department of Human Services' state of the art technology claims processing and management information system. You do not need to purchase, install, or develop special software or applications to use the PA PROMISe™ application. To access this site the first time, a short registration form must be completed using the 13-digit provider number, SSN or EIN number that is on your file.

The PA PROMIS*e*™ Provider Portal allows providers, alternates, billing agents, and out-of-network providers with the proper security access to:

- Submit online Fee-for-Service claims and check claim status
- Verify recipient eligibility
- Use this instruction to enter enrollment changes (birthdate, gender, Medicare A&B numbers), manage fee assignments, and terminate participation
- See revalidation due dates
- Request Attachment Control Numbers

Important Points:

- Claims submission via PROMISe is not available for CHIP providers/plans

How do I make changes to or close service locations or open new service locations?
Old or inactive service locations, mail-to, or pay-to addresses can be end-dated using the PROMISe™ Service Location Change Request Form. This form is also used to change pay-to or mail-to only addresses to already existing service locations. Make sure that the new Service Location Code is used for billing purposes.

Both adding a new service location or changing the service location address actions require an enrollment application. To open a new service location, a provider will need to use the PROMISe™ Provider Enrollment Base Application (same type of application) used for initial enrollment.

Resources:

- PA PROMISe™ Provider Portal
- PA PROMISe™ Provider Internet User Manual
- DHS – Provider Quick Tip #260: Provider Electronic Portal Update

For enrollment-related questions, you can call the appropriate phone number shown on the **Medical Assistance Desk Reference.**

MMIS 2020 Platform Project. The Medicaid Management Information System (MMIS) 2020 Platform Project is DHS' modernization initiative to make back-office systems more efficient and effective over the next few years. This Medicaid Management Information Systems (MMIS) 2020 Platform Project is a web-based, modular system that will provide automated support for department programs in both the fee-for-service and managed care organization delivery systems. The new MMIS 2020 Platform is intended to replace the Provider Reimbursement and Operations Management Information System (PROMISe™).

The primary users of the MMIS 2020 Platform will be similar to those who use the PROMISeTM system now -- providers, partners (e.g., MCOs), and commonwealth employees. The project is a multi-year project with staged releases of functionality. DHS will provide communication and training activities to prepare stakeholders for the transition. More information will be provided as the project progresses and DHS prepares to implement modules to the platform.

PACHC will also communicate information and updates on the MMIS 2020 Platform Project via our weekly newsletter.

MEDICAL ASSISTANCE & HEALTHCHOICES

HealthChoices is the name of Pennsylvania's managed care programs for Medical Assistance recipients. Pennsylvania is a mandatory Medicaid managed care state with multiple managed care organizations (MCOs) holding contracts with the PA Department of Human Services (DHS)

- Physical Health Managed Care Organizations (PH-MCOs) are selected and contract with the DHS Office of Medical Assistance Programs (OMAP) and are overseen by the DHS Office of Medical Assistance Programs (OMAP) to ensure delivery of the physical health component of the HealthChoices Program, including subcontracts for dental and vision services.
- Behavioral Health Managed Care Organizations (BH-MCOs) are selected and contract with DHS and are overseen by the Office of Mental Health and Substance Abuse (OMHSAS) to deliver mental health and drug and alcohol services.
- For Medical Assistance recipients who are 21 years or older and have both Medicare and Medicaid or receive long-term supports through Medicaid because of needed assistance with everyday personal tasks, those services are covered by Community HealthChoices (CHC) MCOs overseen by the DHS Office of Long-Term Living and the Department of Aging.

The HealthChoices Program has three goals:

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

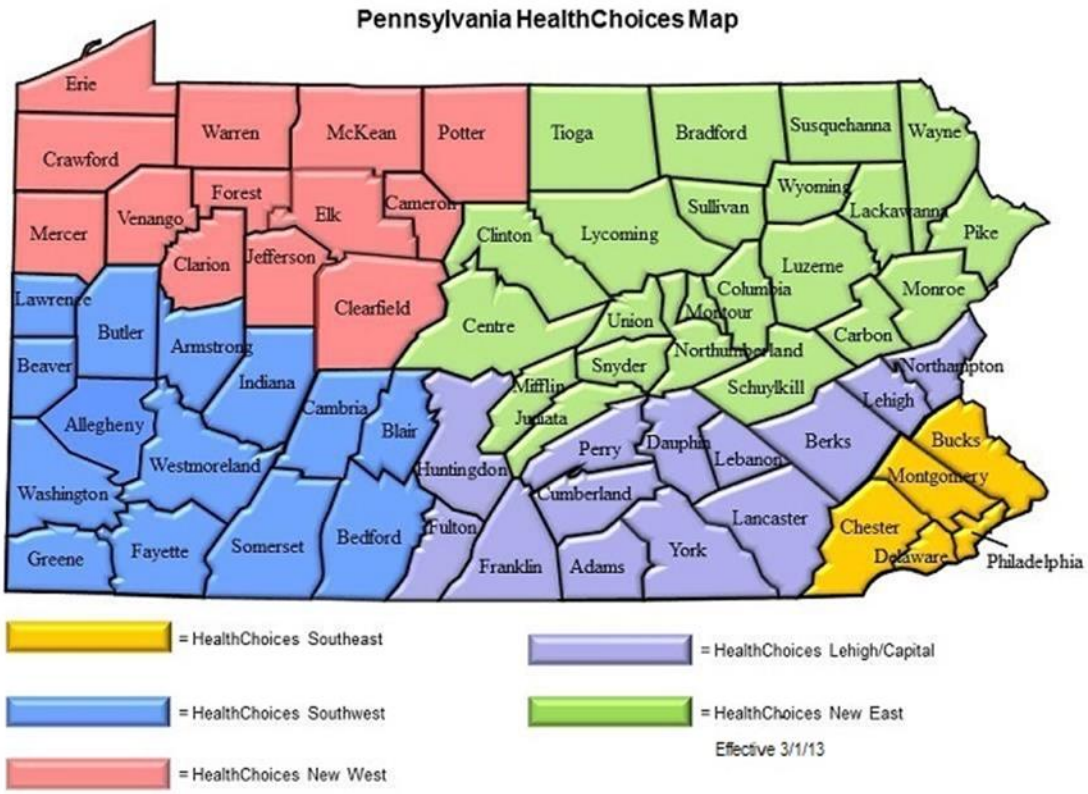
Physical Health HealthChoices. Each MCO is subject to the terms and conditions as outlined in the contract/agreement with DHS. However, there is flexibility as to processes and procedures implemented by each MCO. The MCOs must each develop a provider network and contract with enough providers across the continuum to meet the needs of their enrollees. Some highlights of the DHS/MCO agreement:

- The PH-MCO must ensure that all services provided are medically necessary.
- The MCO may but is not required to impose copayments; but only for those services, items, and pharmacy services that have a copayment in the MA Fee-for-Service (FFS) system. The MCO copayments may not exceed the FFS copayment amounts.
- At a minimum, the PH-MCO must provide in-plan services in the amount, duration and scope set forth in the MA FFS Program.
- The PH-MCO may provide expanded services subject to advance written approval by DHS.
- The PH-MCO is required to establish a Program Exception process, reviewed, and approved by DHS.
- If the PH-MCO chooses to require Prior Authorization of any services, written policies and procedures must be established and have advance written approval from DHS.
- The PH-MCO must establish and maintain a referral process to effectively utilize and manage the care of its members.
- The PH-MCO has the option to follow the same benefit limits or lesser benefit limits as DHS. For those services that are subject to an approved benefit limit exception (BLE),

the PH-MCO must use the same criteria as DHS or may use less restrictive criteria for review of BLE requests.

- The PH-MCO must develop, train, and maintain a Special Needs Unit (SNU) that is responsible to provide support and case management services to members with special needs.
- The PH-MCO must implement written agreements with each BH-MCO in the PH-MCO's zone(s) regarding the interaction and coordination of services.
- The PH-MCO must develop, implement, and maintain a member complaint and grievance process and a process of requests for DHS Fair Hearings

Different MCOs are approved for different HealthChoices zones and health centers have the option to contract with one, some or all. Contact information for each of the approved HealthChoices MCOs in zones served by your Community Health Center can be found online.



Important Points:

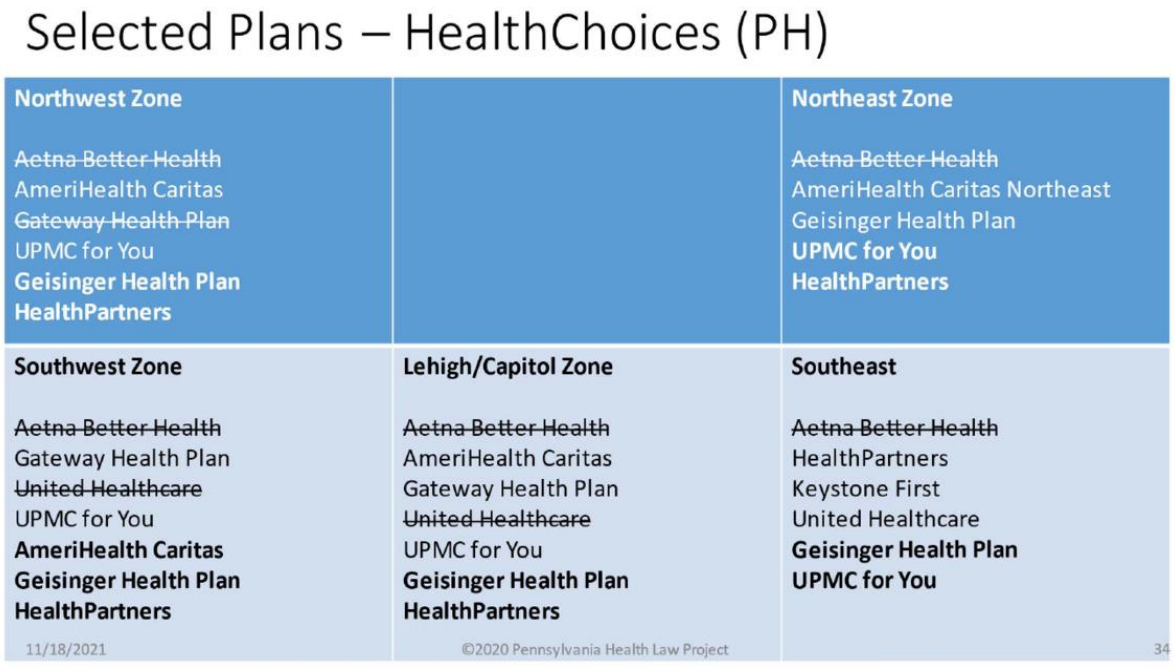
- PH-MCOs must include in their provider network every FQHC that is willing to accept PPS rates as payment in full and are located within the operational HealthChoices Zones in which the PH-MCOs have an agreement.
- If the PH-MCO's primary care network includes FQHCs, these sites may be designated as primary care provider (PCP) sites.

Resources:

- Pennsylvania Medicaid Managed Care Organization (MCO) Directory (physical health and behavioral health): contact information for each of the approved HealthChoices MCOs and zones covered plus pharmacy benefit manager and dental benefit manager subcontractors are listed. Behavioral health section includes county and MCO contact information.
- Community HealthChoices
- Medical Assistance Programs Dictionary - definitions/descriptions of acronyms, words, and terms that are frequently used within the Office of Medical Assistance Programs.

ALERT: The MCOs serving each of the zones for Physical HealthChoices had been the same since 2012 despite several reprocurement efforts by DHS. Previous reprocurements resulted in MCO disputes and lawsuits, but the most recent reprocurement in 2022 was successful and implemented. The 2022 HealthChoices Agreements went into effect September 1, 2022, with some significant changes to MCO assignment, resulting in more than 400,000 individuals having to select a new MCO. Individuals that did not select a new MCO were auto-assigned a new one.

Summary of the MCOs that entered (in bold) and left (crossed out) zones, effective Sept. 1, 2022:



It is important for health centers to be aware of the provisions that DHS holds the HealthChoices MCOs to through the HealthChoices Agreement. The 2023 HealthChoices Agreement is currently available and DHS will be posting the 2024 version as soon as it receives CMS approval.

Prior to the Implementation of the September 1, 2022 HealthChoices zones, DHS had a webpage devoted to information on the HealthChoices transition that includes a stakeholder toolkit

containing information like key dates, a high-level overview, instructions to direct consumers to change plans, and a map of which plans will be covering which counties. Scroll to the bottom of the page to access the toolkit. The consumer choice period was open from June 22 to August 16, 2022. Consumers who did not choose a plan by August 16 were auto-assigned to an MCO beginning August 17, 2022.

Contracting With Medicaid MCOs. Beginning Jan. 1, 2016, DHS' HealthChoices MCO agreements require MCOs to pay FQHC claims at each health center's PPS rate. For HealthChoices contracts, DHS provided FQHC encounter and rate information to its actuaries for calculation of the MCOs' per member/per month rates and delegated responsibility for payment at PPS to the MCOs. In addition, DHS requires all HealthChoices MCOs to contract with all FQHCs willing to accept their PPS rate (exclusive of bonus or pay-for-performance incentives). DHS' goals for the payment policy change were administrative simplification and better cash flow for health centers. (See Medicaid Payment Policy section)

Careful review of MCO contract terms is essential, and particular attention should be paid to payment rates, timely filing, credentialing and other terms and conditions as they can significantly impact a health center's cash flow and financial health. Each MCO contract will have its own format, requirements, and expectations.

Important Points:

- Take the time to read, understand and negotiate contract terms.
- Find a qualified attorney to evaluate the contract with you.
- Negotiating contracts with multiple MCOs gives your patients more choice and will help your health center attract and retain patients.
- Monitor regularly patient attribution trends by each HealthChoices MCO to your health center - only 35% of patients covered by the program choose their primary care provider and the remaining 65% rely on auto assignment.
- It can be helpful for comparison purposes to develop a spreadsheet of terms and conditions by insurer if your health center contracts with multiple MCOs.
- What performance bonuses are included in the contract? If so, are they reasonable? Are bonuses "attractive," doable and of such an amount that the effort required is acceptable?
- What are the timely claims filing requirements? Is this standard? Does your practice management system need any upgrades/revisions to accommodate the MCO billing?
- What reports and data are required? In both directions? Are they helpful? What operational impact might they have?
- Do your referral hospitals have a contract with the MCO?
- How does the MCO manage provider relations? Will a specific person be assigned to your organization? Do they use a single representative for all Community Health Centers in the region?

Provider enrollment with HealthChoices – see Licensure, Enrollment and Credential section of the manual.

Recipient enrollment. First the consumer needs to apply for Medical Assistance either by using the COMPASS website; the Consumer Service Center for Health Care Coverage at 1-800-692-4762; in-person at the local county assistance office (CAO); or on paper by downloading an application and then sending to the local CAO.

Individuals enrolled in the Medicaid program are automatically eligible for mental health and substance use services in the county of their residence. To find a county MH/DS office visit the Pennsylvania Association of County Administrators of Mental Health and Developmental Services.

Once the consumer is deemed eligible for Medical Assistance, they can visit/contact the Pennsylvania Enrollment Services website for information about HealthChoices and assistance with choosing a plan/enrollment and choosing a primary care provider.

Since HealthChoices is mandatory managed care for MA consumers, recipients must enroll in a managed care plan and get all their care through that plan unless they fall into an exempt group. Those who are exempt from managed care receive their MA through Fee-for-Service. Those excluded from managed care include: Health Insurance Premium Payment Program (HIPP) recipients; dual-eligible intellectual disabilities waiver recipients; immigrants in the General Assistance-related MA categories; and newly eligible MA recipients in the FFS "window" that usually lasts 2-4 weeks and does not apply to behavioral health MCO.

Important Points:

- Consumers may also get health insurance enrollment assistance at a Community Health Center FQHC. Support, expertise, and assistance is offered to aid consumers with state-based exchange insurance, Medicaid, Medicare, and CHIP enrollment.
- Recipients must renew Medicaid coverage annually.
- All eligible recipients, including those enrolled in an MCO, will have an ACCESS identification card in addition to an MCO card.
- Under HealthChoices, a person can change their plan at any time. Most changes can be processed within 4-6 weeks. When making a change, the recipient should ask about the specific effective date of the change.
- If a MA recipient does not select a primary care provider (PCP) within fourteen (14) business days of enrollment, the PH-MCO must make an automatic assignment.
- Providers participating in an MCO's network are prohibited from denying medically necessary services to a newly eligible MA recipient during his/her FFS window.

Community HealthChoices (CHC) also has consumer enrollment assistance. Recipients qualify for CHC if age 21 or older and qualify for: both Medicare and Medicaid; or Medicaid long-term services and supports (LTSS) because they need the level of care provided in a nursing facility or through one of the home and community-based waivers.

For long-term services and supports (LTSS) information and assistance, consumers should contact the Independent Enrollment Broker (IEB) at 1-877-550-4227 or go to www.paieb.com.

See CHC Application Guide and CHC Fact Sheet for further information.

Behavioral HealthChoices. The PA Department of Human Service, Office of Mental Health and Substance Abuse Services monitors, develops policies and procedures, and regulates mental health and substance use disorder services provided to Medical Assistance recipients as well as oversees the behavioral health managed care organizations.

Mental health services in Pennsylvania are administered through county Mental Health and Developmental Services (MH/DS) program offices, which are part of county government and overseen by a county MH/DS administrator. The county MH/DS office determines a person's eligibility for service funding, assesses the need for treatment or other services and makes referrals to appropriate programs to fit service needs. Actual mental health services are delivered by the county or local provider agencies under contract with the county MH/DS office.

For Medical Assistance mental health and drug and alcohol services, each county contracts with a Behavioral HealthChoices Managed Care Organization (BH-MCO). The BH-MCO is responsible for the entire Medicaid population in the contract area. Counties are required to ensure high quality care and timely access to appropriate mental health and drug and alcohol services, and to facilitate effective coordination with other needed services. Each HealthChoices consumer is assigned a BH-MCO based on his or her county of residence. Members, then, have a choice of Behavioral Health Care providers within the BH-MCO's network. This website shows which BH-MCO operates in each county.

Important Points:

- Each health center needs to evaluate the level of behavioral health services they will offer: integrated medical and behavioral health services receiving Medicaid PPS reimbursement as an FQHC; or become a licensed psychiatric outpatient clinic
- Discuss models of care delivery with various FQHCs utilizing those models.
- Please feel free to contact PACHC at pachc@pachc.org with questions and for information.

Telepsychiatry.

On February 20, 2020 the Office of Mental Health & Substance Abuse Services issued OMHSAS-20-02, Guidelines for the Use of Telehealth Technology in the Delivery of Behavioral Health Services. The bulletin applies to providers enrolled in MA FFS and the managed care delivery system as well as primary contractors and BH-MCOs in HealthChoices. It updates previous OMHSAS telehealth guidelines to expand the use of telehealth to behavioral health practitioners who provide services in the MA FFS system and expands the use of telehealth to include treatment provided by Certified Registered Nurse Practitioners (CRNPs) and Physician Assistants (PAs) certified in mental health; Licensed Clinical Social Workers (LCSWs); Licensed Professional Counselors (LPCs); and Licensed Marriage and Family Therapists (LMFTs). Updated, September 30, 2021: OMHSAS-99-23-08 Updates to Guidelines for the Delivery of Physical Health Services via Telehealth

NOTE: Prior to the COVID Public Health Emergency (PHE), the provision of telepsych services offered by an FQHC was limited to psychologists and psychiatrists only. PACHC is working to advocate for the expanded telehealth capability permitted during the PHE.

Details of the technology that must be used, consent and confidentiality as well as the delivery and quality of services are discussed in the bulletin. Providers including FQHCs seeking to provide behavioral health services using telehealth must complete and submit a "*Telehealth Attestation Form*" to RA-PWTBHS@pa.gov and to the appropriate OMHSAS Field Office. Upon receipt of the attestation form, OMHSAS will review the form for completeness and inform the provider whether it is approved to offer telehealth services based on the assurances in the attestation form. BH-MCOs may also have specific requirements related to the delivery of telehealth services in their networks.

Important Points.

- The OMHSAS Bulletin Guidelines for the Use of Telehealth Technology in the Delivery of Behavioral Health Services, does not specifically include or exclude Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes ---- does state *BH-MCOs may allow additional provider settings to utilize telehealth.* Also, Attachment A -- procedure codes in the FFS delivery system -- does not include FQHC codes -- T1015 with proper modifiers.
- Response from OMHSAS: *At this time, behavioral health services provided by FQHCs are not included in the FFS program for telehealth. However, FQHCs, RHCs and look-alikes can provide services utilizing telehealth under HealthChoices, subject to concurrence by the BH-MCO. This is consistent with the prior bulletin which only allowed the use of telehealth for behavioral health services under the HealthChoices program. FQHCs, etc. may still benefit from the other areas of expansion identified in the Bulletin and should continue to send in their attestations for any new requests for telehealth approval; OMHSAS will provide the needed authorizing signature (the BH-MCOs may require additional approvals). The two FQHCs that currently have approval for telehealth can continue to provide those services under HealthChoices.*
- Please contact PACHC at pachc@pachc.org for questions and/or clarification.

Drug & Alcohol Services. The PA Department of Drug & Alcohol Programs' (DDAP's) mission is "to engage, coordinate and lead the Commonwealth of Pennsylvania's effort to prevent and reduce drug, alcohol and gambling addiction and abuse; and to promote recovery, thereby reducing the human and economic impact of the disease." DDAP oversees the network of single county authorities (SCAs) and performs central planning, management, and monitoring duties at the state level, while the SCAs provide planning and administrative oversight for the provision of substance use and problem gambling disorders at the local level. SCAs may provide services either directly or by contract with private entities, including BH-MCOs.

Opioid Crisis. In October 2017, the opioid crisis was declared a national public health emergency. Various initiatives and supplemental funding have been available to fight this deadly epidemic. In January 2018, Pennsylvania issued its first Opioid Disaster Declaration.

Important Point:

- Medication Assisted Treatment is considered & reimbursed under Physical Health HealthChoices (PH-MCO)
- See the Medicaid Payment Policy section for billing behavioral health and substance use disorder services.

Centers of Excellence for Opioid Use Disorder (COEs), created and managed by the Dept. of Human Services, include primary care practices, hospitals, FQHCs, substance use disorder (SUD) treatment providers, and single county authorities. The COEs were designed to increase access to Medication Assisted Treatment (MAT), improve coordination between physical and behavioral healthcare providers, and keep individuals engaged in the recovery process using community-based care management teams to coordinate care. COEs use a blend of licensed and unlicensed, clinical and non-clinical staff to coordinate the care needs of an individual to ensure their treatment and non-treatment needs are met.

In 2016, the DHS awarded grants to forty-five MA-enrolled providers to provide care management services to individuals with opioid use disorder (OUD) as COEs. Then in 2019, DHS announced a transition from grant funding to billing Physical Health and Behavioral Health HealthChoices Managed Care Organizations for care management services.

Effective July 1, 2020, Medical Assistance issued MA Bulletin 01-20-08, 08-20-11, 11-20-02, 19-20-01, 21-20-01 and 31-20-08 outlining the process for currently enrolled Medicaid providers to enroll as an Opioid Use Disorder Centers of Excellence (COE) specialty type provider. This bulletin does apply to FQHCs. Beginning January 1, 2021, only providers with the COE specialty type will receive payment for care management services billed using the G9012 procedure code.

Providers must sign a Supplemental Provider Agreement for Participation as a COE and include a proposed service description that demonstrates the provider has developed policies, protocols, and procedures to operationalize the program requirements.

On June 7, 2022, DHS received approval of a State Plan Amendment, effective January 1, 2022, adding COE care management services to the Pennsylvania Medical Assistance Program State Plan. This State Plan Amendment was announced via MA Bulletin 01-22-02 on February 14, 2022 and via Public Notice at 52 Pa.B. 98 on January 1, 2022. As a result of this approval, DHS allowed the State Directed Payment Arrangement to expire on December 31, 2022. Exhibit G to the HealthChoices Physical Health Agreement was updated to reflect COE services as In Plan Services no longer subject to a State Directed Payment Arrangement.

Effective January 1, 2023, the PH-MCO should enter into agreements with providers designated as Specialty Type 232-Opioid Center of Excellence to satisfy Network Adequacy requirements and ensure for the provision of In-Plan Services to members. The PH-MCO should update any billing and auditing systems or processes to align with the requirements of Exhibit G to the HealthChoices Physical Health Agreement and this MC OPS Memo.

See the FAQs for additional information on applying to become a Center of Excellence or contact PACHC at pachc@pachc.org.

Community HealthChoices. Community HealthChoices (CHC) is the state's mandatory managed care program developed to enhance access to and improve coordination of medical care. The goal is also to create a person-driven, long-term services and support (LTSS) system, and give individuals choice, control, and access to a full array of quality services. CHC long-term services and supports (LTSS) help eligible individuals perform daily activities in their home such as bathing, dressing, preparing meals, and administering medications. Think of CHC as "HealthChoices Plus." In addition to the services offered through the current HealthChoices program, CHC beneficiaries can qualify for personal care services, pest eradication, home adaptions, vehicle modifications, etc., depending on their individual plan.

Individuals will be enrolled in CHC if they are 21 years old or over and are:

- Receiving both Medicare and Medicaid
- Receiving LTSS in the Attendant Care, Independence, or Aging waivers
- Receiving services in the OBRA waiver and determined nursing facility clinically eligible
- Receiving care in a nursing home paid for by Medicaid
- An Act 150 participant who is dually eligible for Medicare and Medicaid.

CHC does not change Medicare coverage at all. Dual eligible participants continue to have all of the Medicare options they had prior to CHC, including original Medicare and Medicare Advantage. A participant's Medicare coverage does not change unless the participant decides to change it. Beneficiaries with a Medicare primary care provider (PCP) do not need to change their PCP. 94% of CHC beneficiaries are dual eligible for Medicare & Medicaid; 64% are "healthy duals." CHC covers the same physical health benefits that are part of the Medicaid Adult Benefit Package.

Behavioral health services are not a part of CHC. The CHC MCO must coordinate care with their members' HealthChoices Behavioral Health MCOs. CHC MCOs have the same responsibility for coordination of members' Medicare coverage.

The CHC-MCO may not require prior authorization for services covered by Medicare. However, if a service is denied by Medicare or Medicare has a limit on a service, the CHC-MCO may require prior authorization for the equivalent Medicaid service, as long as the prior authorization policy was approved by the state. Service coordinators will work with participants to coordinate prior authorization of services when needed.

CHC value-added services (similar to Medicare Advantage plans) will vary by MCO. Every participant in CHC will choose a service coordinator who will coordinate Medicare, long-term care and supports, physical and behavioral health services

Three managed care organizations have contracts with DHS to provide statewide CHC services. Each CHC participant may choose his or her MCO.

- AmeriHealth Caritas Pennsylvania

- PA Health & Wellness
- UPMC Community HealthChoices

Physician certification for waiver eligibility. The recipient first applies for CHC waiver services through the statewide Independent Enrollment Broker (IEB). The IEB facilitates and aids the recipient with the eligibility process. A physician must certify that the recipient is Nursing Facility Clinically Eligible (NFCE). The applicant's physician completes the physician certification form and returns the form to the IEB. Once eligibility has been established, the applicant chooses a Service Coordinator who works with the participant to develop an individualized service plan and choose providers to deliver the services.

The needed care and services are either:

- skilled nursing or rehabilitation services as specified by Medicare regulations; or
- health-related care and services that may not be as complex as skilled nursing or rehabilitation services but are needed and should be provided on a regular basis in the context of a program of health care and management and were previously available only through institutional facilities.

Important Points:

- Physicians are under no obligation to sign the form, however, ONLY physicians (not CRNPs or PAs) may sign the form
- When completing the form, the following factors should be considered: mobility, toileting, cognition and eating
- Waivers are intended for individuals with long-term (over 180 days) disabling conditions
- Include as many diagnoses with ICD-10 codes as indicated
- Physician Certification Form
- Steps to Apply for Waiver Services

Resources:

- Community HealthChoices Questions and Answers Document
- Community HealthChoices Publications

MEDICAID PAYMENT POLICY

MEDICAID PROSPECTIVE PAYMENT SYSTEM (PPS): In November 2001, the Pennsylvania state plan amendment authorizing FQHC/RHC Medicaid PPS in PA was approved by CMS. PPS is not a cost-based reimbursement system nor fee-for-service. PPS is a single, bundled rate for each qualifying patient visit that pays for all covered services and supplies provided during the visit. The PPS rate is individual for each FQHC. See NACHC website for a national overview of Medicaid FQHC PPS.

Beginning Jan. 1, 2016, DHS required HealthChoices MCOs to begin paying FQHCs rates not less than the PPS rate determined by DHS and since that time, all MCOs have been paying at PPS. MCOs must pay on T1015 and T1015 with U9 modifier codes but can work with health centers to ensure claims also include the CPT codes the MCOs need for HEDIS data.

DHS has maintained the quarterly wraparound process – also referred to as MCO Settlement Reports – both to monitor proper PPS payment by the MCOs and as an "advance" to ensure health center cash flow until MCO claims payment. See **Medicaid Wraparound Report section** for more information.

The primary, "go-to" resource for PA Medicaid health center policy is the PA PROMISe™ Provider Handbook Appendix E – FQHC/RHC Revised April 22, 2014, replacing June 20, 2012 edition. As of the date of publication of this manual, DHS is updating the FQHC/RHC Provider Handbook Appendix E to incorporate changes made over the past few years, make it flow better and make it more user-friendly. PACHC convened an ad hoc subgroup of our Payment Policy Committee on Jan. 31, 2019 to go through the draft proposed manual page-by-page and we submitted comments to DHS on Feb. 11, 2019. The comments included feedback from the PACHC Payment Policy Committee and PACHC's billing and finance leaders peer network groups. The FQHC/RHC Provider Handbook Appendix E is still going through internal and legal review at DHS. Contact PACHC at pachc@pachc.org to find out the status of the new provider manual.

Establishing a PPS rate

To establish an initial PPS rate, the health center must complete a cost report form using budgeted expenses and estimated encounters. A simplified definition of PPS calculation is total allowable expenses divided by the total number of allowable encounters equaling a per encounter payment rate. The budget amounts must be for services and costs that HRSA is set to approve in the scope of project. This will determine an interim PPS rate (medical and dental) that the DHS Office of Medical Assistance Programs (OMAP) will enter into the state's system so billing can begin. Once the OMAP receives the HRSA Notice of Award/Determination Letter with the effective date, Medicaid enrollment & rate entry into PROMISe can be completed.

A health center can work on the cost report and submit it to OMAP rate setting staff for review and establishment of a rate BEFORE receipt of HRSA notification. When the HRSA letter and official effective date is determined, the health center will then fill out an ACTUAL cost report once a full year of services has been rendered. It is prudent to be conservative in setting an

interim PPS rate to mitigate the risk of having to make a significant payback when the rate is finalized.

Example timeline for interim PPS rate and actual cost report submission to OMAP:

- HRSA approval & effective date is August 15; health center fiscal year is July 1 through June 30.
  - Interim rate – Aug 15, 2020 – June 30, 2021
  - Interim rate – July 1, 2021 – June 30, 2022 (first full fiscal year)
  - Submit cost report with actual encounter and expense data for the 7/1/2021 – 6/30/2022 period.
- Once OMAP receives the fiscal year end 6/30/2021 cost report, the cost report will be sent to audit; audits are completed by a DHS outside subcontractor. Upon satisfactory completion of the audit, the PPS rate(s) are finalized.

Cost report instructions are included in the PA PROMISe™ Provider Handbook, Appendix E FQHC/RHC. The PPS is built upon actual allowable expenses as per the cost report instructions; carefully read and follow the instructions. There are health center expenses that may or may not be allowed or have limitations in the PPS computation. The cost report, a fillable Adobe form, can also be used as a PPS calculation tool to explore growth options and analyze the impact of various strategies on the PPS rate. Contact pachc@pachc.org to ensure you are using the most up-to-date cost report version.

Important Points:

- Respond promptly to questions or requests for additional information raised by DHS during review of your cost report.
- Be cognizant of and monitor first year expenses, staffing, and service/project implementation as these factors will impact the interim and final PPS rate. Also be aware that the PPS rate may be adjusted up or down when moving from interim to final.
- How quickly your health center visits increase also may affect your final PPS rate. Marketing and public relations are valuable and should be effective.
- DHS uses annual provider productivity standards in the calculation of PPS rates: 4,200 encounters/FTE physician; 2,100 encounters/FTE nurse practitioner or physician assistant; 2,600 encounters/FTE dentist; 2,600 encounters/FTE dental hygienist; 2,600 encounters/FTE public health dental hygiene practitioner; 4,200 encounters/FTE ophthalmologist; and -0- encounters/FTE optometrist,
- If the provider's encounter exceeds the standard, the actual number of encounters is used in the calculation. If the provider generates fewer encounters, then the DHS established productivity standard is used in the computation, which will negatively impact the PPS rate.
- Some visits and expenses will need to be reclassified. Examples: that portion of a chief medical officer's salary and benefits that is administrative must be reclassified from direct care; dental expenditures will be reclassified in order to formulate a dental PPS rate.
- When notification of the health center's final PPS rate is received from DHS, there is the opportunity to file an appeal if you believe the rate is not correct. If you accept the rate or you lose an appeal, then the rate is finalized.

- When a PPS rate is finalized, the health center is responsible for notifying the MCOs, who are responsible for reconciliation to the new rate retroactive to its effective date. There are variations in the MCO retroactive reconciliation process.
- PPS rates are adjusted annually on October 1 of each year based on the Medicare Economic Index (MEI) and any time a health center adds or deletes a service (change in scope). Per the Physical HealthChoices agreements beginning Sept. 1, 2022, MCOs have 90 days after notification by DHS to implement MEI and other rate changes.
- Contact PACHC for information about consultants who can assist with the cost report and establishment of a PPS rate.

MEDICAID BILLING POLICY

Definitions.

FQHC Services: Services are defined in sections 1905(a)(2)(C) of the Social Security Act and include services provided by practitioners identified in section 1861(aa)(3) of the Social Security Act, which includes physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and visiting nurses, and other ambulatory services. Other ambulatory services are services provided by podiatrists, optometrists, dentists, dental hygienists, chiropractors, licensed professional counselors, licensed marriage and family therapists, physical therapists, occupational therapists, and speech-language pathologists. (Per CMS approved PA State Plan Amendment effective July 1, 2018)

Encounter: a face-to-face contact between a patient and the physician, dentist or mid-level practitioner who exercises independent judgment in the provision of health care services. (per PA PROMISe™ Provider Handbook Appendix E – FQHC/RHC Revised April 22, 2014)

Medicaid Billing Codes.

T1015 -- a "clinic visit/encounter, all inclusive"
T1015/U9 – dental encounters
T1015/HE – mental health program
T1015/HF -- substance abuse program
T1015/HQ -- behavioral health group therapy (See MAB 08-20-03 Behavioral Health Group Therapy Provided in the Federally Qualified Health Center and Rural Health Clinic Settings, Sept. 15, 2020
T1015/U3 – vision encounters (see MAB 08-20-04, Vision Services Provided in the Federally Qualified Health Center and Rural Health Clinic Settings, Sept. 15, 2020)

PA Medicaid allows up to four (4) encounters on the same day for the same recipient: physical health, behavioral health, dental encounter, and vision encounter.

Important Points:

- When billing the MCOs, please refer to the MCO's Provider Manual and other provider resources. Each HealthChoices MCO will have its own specific provider guidance and billing instructions.

- When billing Medicaid Fee-for Service, use the 837 Professional / CMS-1500 Claim Form.
- Even though "visiting nurses" is included in the state plan amendment definition and appears at various locations in the PA PROMISe™ Provider Handbook Appendix E – FQHC/RHC Revised April 22, 2014, PA Medicaid does not allow billing for registered nurses or licensed practical nurses.
- PACHC was successful in getting DHS to add visits with a licensed professional counselor (LPC) or licensed marriage and family therapist (LMFT) as an eligible encounter.

- During the pandemic DHS permitted telehealth visits (audio-only and video) by eligible FQHCs providers to qualify as "face-to-face visits" eligible for payment at PPS and continues to do so. The PA Department of Health and Human Services (DHS) issued a new telehealth/telemedicine for physical health, MA Bulletin 99-23-08, effective Aug. 2, 2023, replacing MA Bulletin 99-22-02. The two primary changes are:
    - DHS will now refer to the remote delivery of services as telehealth, not telemedicine.
    - Based on the 2023 updates published by the Centers for Medicare and Medicaid Services (CMS) to the Healthcare Common Procedure Coding System, the Medical Assistance Program will now utilize two Place of Service (POS) codes to identify when services are rendered via telehealth – POS 02 when telehealth is delivered in a setting other than the individual's home and POS 10 when telehealth is delivered in the individual's home.

  The bottom line on telehealth at the state level is that DHS considers it a modality, not a service.

Resources:

- Medicaid Billing Information
- PA PROMISE Provider Handbook Appendix E - FQHC/RHC
- FQHC/RHC Third Party Billing instructions for Dental Encounters
- Common Billing Issues Which May Result in Denied Claims as of July 2019
- Federally Qualified Health Center (FQHC) / Rural Health Clinic (RHC) Prospective Payment System (PPS) Frequently Asked Questions
- Provider Quick Tips
- PACHC Memo - Medicaid Billing, December 2023

OB Alternative Payment Model (APM) Federally Qualified Health Center Alternative Payment Methodologies for Delivery Services, MAB 08-16-30, December 1, 2016.
Effective December 1, 2016, DHS authorized an alternative payment model (APM) to pay for delivery services for FQHCs that agreed to accept the APM. The FQHC must have a HRSA approved Scope of Service that includes obstetrical services to be eligible to participate in the APM. The FQHC fee for a delivery performed by FQHC personnel in a hospital inpatient setting will now use the MA Program Fee Schedule rate.

This APM applies to FQHC deliveries provided under the MA Fee-for-Service (FFS) program. For services provided to MA enrollees in managed care, coverage, billing, and payment are specific to the individual managed care organization.

A request to opt-in to the APM must be submitted by the FQHC's chief financial officer via email to OMAP at FinancialGatekeeper@pa.gov. The email must include the FQHC's nine-digit provider identification number and four-digit service location number for which the opt-in is to be applied. Any FQHC that wishes to opt-in must do so ten business days in advance of submitting a claim. An FQHC can opt-out and/or opt-in at any time by following these same directions. Any request to opt-in or opt-out must also include the requested effective date for the opt-in/opt-out. OMAP will review and process the opt-in/opt-out request and notify the FQHC of the effective date.

Medicaid Dental. The MA Program will pay FQHCs a PPS dental encounter rate for all FQHC dental services rendered by dentists, dental hygienists, and Public Health Dental Hygiene Practitioners (PHDHP). The MA Program will only pay for one dental encounter per day per MA recipient.

How to Establish a Dental PPS Encounter Rate.
After an FQHC receives HRSA approval for the addition of dental services via a new HRSA Notice of Award (for look-alikes, HRSA issues notification via the Electronic Handbook), a copy of that documentation should be submitted to DHS and then follow the instructions found in MAB 08-12-31 Change In Scope Of Service Procedure for FQHCs, June 20,2012 or also found in Appendix E. DHS will establish an interim PPS dental encounter rate that will later be converted to a final PPS dental encounter rate after DHS's review and audit of the first full fiscal year cost report including dental services.

Dental Claims Submission. Under the Fee-for-Service Program, FQHCs submit claims for a dental service encounter payment using the CMS-1500 Claim Form, 837 Professional (837P) Electronic Claim or via the PROMISe portal using procedure code T1015 defined as "clinic visit/encounter, all inclusive" with the U9 pricing modifier designating that a dental service was provided. A dental diagnosis code is required on the CMS-1500 Claim Form, the 837P or PROMISe portal claim.

Under managed care, each MCO has a subcontract for dental services. Billing and claims submission procedures are all determined by the individual dental benefit subcontractor. See the Pennsylvania Medicaid Managed Care Organization (MCO) Directory for each MCO's dental benefits manager. MCOs must pay all dental procedures at the PPS rate. This includes dentures, orthodontics, partials, crowns and root canals.

Important Points:

- Under Fee-for-Service (FFS), prior authorization approval is not required for FQHC dental services. However, a benefit limit exception (BLE) must be filed for those limited adult dental benefits (see Dental Benefit section below)

- See billing instructions, "FQHC/RHC Medicare Part B/Medicare Advantage/Private Third Party Billing Instructions for Dental Encounters" for MA recipients with private dental insurance, Medicare Part B only, and/or a Medicare Advantage Plan.
- Under FFS, FQHCs are paid the dental PPS rate for each visit for dental procedures that require multiple visits (dentures, root canals & crowns). Health center dental protocols for these services/procedures should be developed using evidence-based guidelines and documentation in the medical record should justify the necessity for multiple visits.
- However, each MCO can determine the number of allowable visits for certain procedures through the prior authorization process. Prior authorization is the development of a treatment plan based on clinical standards between the MCO, member and provider. Prior authorization policies are reviewed and approved by DHS and included in the MCO's handbook. The health center can always go back to the MCO to request additional visits if needed. The Benefit Limit Exception (BLE) is a limit on a covered service/benefit and the MCO cannot be more restrictive.

Dental Benefit Limit Exception

In PA, eligible adult MA recipients receive a broad array of dental services, which range from oral evaluations and preventive dental services to surgical extractions, crowns, and dentures. Under Federal law, states are not required to include dental services in their State Plan. Adult dental services may be furnished at the state's option.

In the fall of 2011, DHS introduced cost containment initiatives with the goal of having the least detrimental impact on the health care needs of the MA population. Rather than eliminating all dental services for the MA adult population, DHS instituted dental benefit changes that apply to adult MA recipients, 21 years of age and older and adult recipients 21 years of age and older who reside in personal care homes and assisted living facilities. Services provided beyond a recipient's benefit limits are not covered unless a benefit limit exception (BLE) is requested and approved by DHS. DHS limits the following dental services for adult recipients 21 years of age and older:

- Periodic oral evaluation (D0120) is limited to one (1) per 180 days, per recipient. Additional oral evaluations will require a BLE. NOTE: Providers will not be paid for a periodic oral evaluation (D0120) and a comprehensive oral evaluation (D0150) within the same 180-day time period. Prophylaxis, adult (D1110) will be limited to one (1) per 180 days, per recipient. Additional prophylaxis requires a BLE.
- Dentures are limited to one per upper arch, full or partial, regardless of procedure code (D5110, D5130, D5211, D5213) and one per lower arch, full or partial, regardless of procedure code (D5120, D5140, D5212, D5214), per lifetime. DHS reviews claims payment history to determine if the recipient previously received a denture for the arch. Additional dentures require a BLE.
- Eligibility for the following services occurs only if DHS approves a BLE request:
    - Crowns and adjunctive services (D2710, D2721, D2740, D2751, D2791, D2910, D2915, D2920, D2952, D2954, D2980)
    - Periodontic services (D4210, D4341, D4355, D4910)
    - Endodontic services (D3310, D3320, D3330, D3410, D3421, D3425, D3426)

DHS grants a BLE based on the following criteria:

- The recipient has a serious chronic systemic illness or other serious health condition and denial of the BLE would jeopardize the recipient's life.
- The recipient has a serious chronic systemic illness or other serious health condition and denial of the BLE would result in rapid, serious deterioration of the recipient's health.
- Granting the BLE is a more cost effective alternative for the MA Program.
- Granting the BLE is necessary to comply with Federal law.

See Medical Assistance Bulletin 27-11-47, 08-11-51, Medical Assistance Dental Benefit Changes, issued September 26, 2011 for how to request a dental BLE for MA recipients in the Fee-for-Service program and the appeal process for BLE request denials.

See Medical Assistance Bulletin AB 08-19-100, 27-19-92, Electronic Submission of Dental Prior Authorization, Dental Program Exception and Dental Benefit Limitation Requests issued December 5, 2019 for electronic submission instructions.

Under HealthChoices, any questions regarding dental benefit limits, procedures and payment must be addressed to the appropriate MCO.

Important Points:

- These dental benefit changes do not apply to children under 21 years of age or to adults who reside in a nursing facility, an intermediate care facility for persons with mental retardation or an intermediate care facility for persons with other related conditions.
- HealthChoices MCOs have the option to impose the same or lesser limits for dental services. To the best of PACHC's knowledge, all PH-MCOs are following the same dental benefit guidelines and limits as the Medicaid FFS Program.

Vision PPS. (MAB 08-20-04; Vision Services Provided in the Federally Qualified Health Center and Rural Health Clinic Settings; Effective October 1, 2020). OMAP issued new guidance effective Oct. 1, 2020 authorizing a provider-specific vision PPS encounter rate for vision services provided by an ophthalmologist or optometrist.

In order to receive a separate vision PPS encounter rate and be eligible to bill for vision encounters, an MA FQHC Cost Report must be submitted to OMAP. Then OMAP will determine the vision PPS rate. The medical and dental PPS encounter rate may also be adjusted as a result of the addition of vision services.

The U3 pricing modifier is to be added to the T1015 code on vision encounter claims provided by an ophthalmologist or optometrist. Vision services provided by a practitioner other than an ophthalmologist or optometrist do not qualify.

Important Points:

- An updated FQHC cost report template has been released that includes information specific to vision services
- Productivity standards have been added to the cost report for vision services: ophthalmologist, as a physician, is 4,200 encounters per FTE and the optometrist is -0- encounters.

- OMAP will not allow use of the medical PPS rate for vision services
- OMAP worked with each health center that provided vision services prior to Oct. 1, 2020 on an adjusted cost report.
- Please contact PACHC at pachc@pachc.org if you are interested in providing vision services or if you currently do provide vision services and have questions or need the most current Medicaid information on vision services.

Change in Scope & PPS. A change of scope of project as outlined by HRSA is not the same as change of scope of services for purposes of the MA Program. DHS "defines a change in scope of services as the addition of a service that has never been provided or the discontinuance of an existing service." Other changes, including the opening or closing of a service location, a change in the intensity of a particular service, increase or decrease of provider costs or capital expenditures, do not qualify as a change in scope of services.

The procedure to adjust the FQHC PPS rate(s) when an FQHC has a change in scope of services is defined in this bulletin, FQHC Change in Scope of Service 08-12-31 June 20, 2012.

Important Points:

- The expansion of services may put the current PPS rate at risk; example: the addition of dental may result in a decrease in the medical PPS because of administration and overhead costs allocated to dental that were previously medical-only costs.
- With a change in scope, if the rate change is projected to be greater than 20%, DHS can set an interim rate at the budgeted rate.
- Medication Assisted Treatment (MAT) is a physician service and would not require a change in scope; substance use disorder services, however, are recorded on a separate line on Form 5A and may require a change in scope – contact DHS to discuss.
- Health centers need to be timely in notifying DHS with the HRSA notice of award and then OMAP will work with the health center to identify the correct timeframe for the cost report…the first full fiscal year after the new service has been added.
- The effective date of the change in scope (CIS) rate adjustment is based on the effective date specified in the change in scope notice of award from HRSA, provided HRSA's approval of the CIS is received by OMAP within 30 days. If the HRSA CIS approval is not received by OMAP within 30 days of approval, the effective date of the PPS rate adjustment will be determined by OMAP. Contact pachc@pachc.org for assistance if OMAP was not notified within 30 days of receipt of the HRSA change in scope notification to discuss possible negotiation with OMAP on an effective date.
- PACHC has clarified with OMAP that it is mandatory to notify OMAP of a change in scope of service for the addition of a service to the HRSA scope of project even if the health center does not want to request a change in PPS.
- Health centers can examine and test the effects of service expansion on the PPS rate by using the new Adobe fillable cost report template. Check with PACHC to ensure that you have the most recent version of the cost report.

Opt-In/Out Process for MCO PPS Payments. Beginning Jan. 1, 2016, DHS has required HealthChoices MCOs to pay FQHCs at rates not less than the PPS rate determined by DHS. Initially, DHS believed CMS approval of this change in payment process would not require a

CMS-approved state plan amendment (SPA), but later discovered that it did. DHS obtained CMS approval of the SPA in mid-2016 (for more background, see PACHC Memo 17-01). The SPA requires an opt-in/opt-out process which is outlined in this DHS Medical Assistance Bulletin (MAB), MAB 07-17-01, 08-17-22, issued May 30, 2017. Whether an FQHC/RHC opted-in or not, DHS since 2016 has been requiring MCOs to pay at PPS. To come into compliance with CMS and the SPA, DHS issued notice in August 2019 that beginning Jan. 1, 2020, FQHC sites that have not opted-in will no longer receive the PPS rate from MCOs, but instead revert to the prior method of payment reconciliation to the PPS rate through the quarterly DHS wraparound process. All health centers in PA currently are opted in. Contact PACHC at pachc@pachc.org for questions or to discuss.

Quarterly MCO Settlement Reports or "Wraparound Reports." Beginning Jan. 1, 2016, DHS has required HealthChoices MCOs -- physical health, behavioral health and then Community HealthChoices -- to pay for eligible FQHC encounters at each health center's PPS rate. However, this change did not eliminate the need for the quarterly DHS reconciliation process. DHS made the decision to maintain the quarterly wraparound process because PPS payment by the MCOs was a new process at the time, all of the implementation challenges had yet to be resolved, and because DHS did not want to put FQHCs at financial risk. DHS continues to provide reimbursement for the difference between the established PPS and the amounts paid by the MCOs for encounters provided to MA recipients. This quarterly MCO Settlement Report process serves as an "advance" to avoid cash flow issues while FQHCs work with the MCOs on claims payment. In essence, the wraparound report permits an advance from DHS until MCO payments are received.

Important Points:

- There are five (5) Excel "Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Cost Settlement Reports:" Managed Care Physical Health; Managed Care Behavioral Health; Managed Care Dental; Community HealthChoices Managed Care Physical Health; and Community Health Choices Managed Care Dental.
- The definition of encounter is noted in the cost settlement report instructions.
- MCO denied claims are ineligible as encounters on the DHS cost settlement reports; however, it is important to report denied claims separately on the report for DHS follow up with MCOs.
- Several internal checks/tests are incorporated in the cost settlement spreadsheet to guide proper entries.
- Provider certification is completed first including the organization's Master Provider Index (MPI) number and service location.
- The template will then outline which MCOs the organization is eligible to report.
- DHS distributes updated wraparound report templates that reflect new PPS rates due to the October 1 application of the Medicare Economic Index (MEI) to all health centers.
- Quarterly wraparound reports are completed for physical health, behavioral health, CHIP, and Community HealthChoices (see CHIP section for more information).
- Timely submission of accurate MCO Settlement Reports is critical for cash flow and financial health. Follow the instructions, check and double check numbers and submit on time.

- Please keep PACHC informed of reimbursement problems, questions, or concerns. Through good communication, PACHC is able to track problems and trends with Medicaid reimbursement and work closely with both health centers and DHS to help resolve identified issues.
- An extension to the wraparound report submission deadline may be requested to allow time for receipt of more payments for the quarter from your MCO partners, minimizing the wraparound payment you would receive from DHS and then have to return when payment from the MCOs is made. Submit a request via email to DHS at FinancialGatekeeper@pa.gov.

Quarterly Wraparound Report Submission Timeline Changes, Effective 1/1/19. All health centers received a letter from DHS outlining changes to quarterly wraparound report due dates. Per the DHS letter:

- *Beginning with service dates January 1, 2016 and after, DHS requires the Managed Care Organizations (MCO) to make payment to the Federal Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) at their Prospective Payment System (PPS) rate. Per Federal regulation, DHS continues to require FQHCs and RHCs to file quarterly MCO Wraparound Reports. DHS has been closely working with the FQHCs and RHCs to ensure the MCOs are meeting their requirement. As the requirement approaches the completion of three years, DHS is moving the wraparound reporting requirements and reporting timeframe to align with the requirements used for the CHIP report. Beginning with the quarter ended March 31, 2019, DHS is requiring FQHCs and RHCs to match the payments received from the MCOs to the encounters incurred within each quarter. To allow for appropriate run out, the wraparound reports will be due 7 months after the end of the quarter. This means the March 31, 2019 report is due to the DHS on Oct. 31, 2019.*

Important Points:

- Although the new seven-month claims run-out period should decrease your liability for payment to DHS after PPS payment is received from the MCOs, remember DHS does give you options to:
  - Submit wraparound reports by deadline
  - Request an extension to the wraparound report submission deadline to allow time for receipt of more payments for the quarter from MCO partners, minimizing the wraparound payment you would receive from DHS and have to return when payment from the MCOs is made
  - Complete the wraparound report by deadline and in each MCO tab under payment "other," type in "accrued PPS" if your health center does not want to carry the liability.
  - The wrap reports have moved from Excel templates to an online portal. If you need access to the portal please contact RA-PWOMAPFQHC-RHC@pa.gov.

Resources:

- PACHC Memo – Medicaid Wrap Report, December 2023

Medicare Economic Index (MEI) Update Notices: Each year DHS will now distribute MEI adjustment letters electronically rather than by postal service. PPS rates are updated annually on Oct. 1, the beginning of the federal fiscal year, based on the Medicare Economic Index (MEI) published in the Medicare physician fee schedule. OMAP sends a list of all updated FQHC/RHC rates to all MCOs and that list from DHS is to be considered DHS authorization to implement the new rate. While DHS considers the rate lists that they share with MCOs to be official, implementable notices, all FQHCs are also encouraged to forward a copy of the rate letters received from DHS to all MCOs in their service area as further affirmation of revised rates. In addition to the annual MEI rate updates, DHS provides a quarterly update to MCOs of all FQHC rates. Health centers can request additional copies of the rate letters through financialgatekeeper@pa.gov.

Important Points:

- Health centers should forward a copy of the PPS MEI rate adjustment letters received from DHS to all MCOs and CHIP insurers in their service area as further affirmation of revised rates
- DHS beginning with 2022 HealthChoices contracts will include language requiring MCOs to implement FQHC payment changes (MEI or change in scope) within 90 days of notification of the rate change from DHS.
- DHS urges health centers to pay careful attention to and negotiate MCO contract language on rate change implementation.

Medicaid Behavioral Health & Substance Use Disorder Payment Policy - Providers eligible to bill for behavioral health services at the PPS rate

In Pennsylvania, those FQHC providers eligible to receive reimbursement for behavioral health services at the medical PPS rate are:

- psychiatrists
- licensed clinical psychologists
- licensed clinical social workers (LCSW)
- licensed professional counselors (LPCs)
- licensed marriage and family therapists (LMFTs)

Licensed Professional Counselor (LPC)/ Licensed Marriage & Family Therapist (LMFT)

A state plan amendment to expand the categories of behavioral health providers now eligible to receive PPS reimbursement was approved by CMS with an effective date of July 1, 2018. SPA PA-18-0015 designates licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs) as additional providers who can provide a billable encounter in FQHC/RHC settings. The SPA adds these provider types to the "other ambulatory services" part of the FQHC services definition.

Important Points:

- The Behavioral Health Managed Care Organizations (BH-MCOs) are required to accept claims from FQHCs with the FQHC as the billing and rendering provider.

- The LPCs/LMFTs that are employed by and/or provide service on behalf of the FQHC do not need to independently enroll in the MA Program through PROMISe™ as the FQHC is both the billing and rendering provider. In addition, LPCs/LMFTs do not have the authority to order, refer, or prescribe per their scope of practice, so they are not required to enroll in the MA Program. An MCO, however, might require that they be credentialed.
- If behavioral health services are not currently listed in the FQHC's HRSA approved scope of project, the FQHC will need to submit a change in scope to HRSA and gain HRSA's approval for the addition of the behavioral health services. Then a change in scope of service to OMAP will need to be submitted.
- When submitting a bill for a fee-for-service (PROMISe) encounter with an LPC/LMFT, health centers should bill using a T1015 code with a HE or HF modifier

Utilization of Non-eligible Providers. An FQHC must utilize caution if it wishes to use other levels of behavioral health provider types (bachelor level social workers, drug and alcohol counselors, peer support, etc.). Even though a Medicaid behavioral health managed care organization may reimburse for other various levels of provider services, those encounters are not eligible for PPS payment nor allowable on the Medicaid MCO Settlement Report for FQHCs. DHS asserts that the costs for utilizing these providers are captured in calculation of the PPS rate.

An FQHC may evaluate the pros and cons of becoming a Psychiatric Outpatient Clinic licensed by DHS and reimbursed accordingly as that provider type. There are a few health centers in the state that are licensed as an outpatient psychiatric clinic; contact pachc@pachc.org to learn more.

Behavioral Health Group Therapy. Medical Assistance Bulletin 08-20-03, Behavioral Health Group Therapy Provided in the Federally Qualified Health Center and Rural Health Clinic Settings, September 15, 2020 adds the HQ (Group Setting) modifier to procedure code T1015 (Clinic visit/encounter, all-inclusive) for behavioral health group therapy encounters, effective September 15, 2020. This applies to MA enrolled FQHCs in both the FFS and managed care programs. However, any billing or payment questions related to behavioral health group therapy provided to beneficiaries in the managed care programs should be directed to the appropriate MCO.

Tele-behavioral Health and Telepsychiatry

- The Consolidated Appropriations Act of 2022 expanded the permanent telehealth policy to allow for mental and behavioral health services to be provided in the home without geographic requirement applying, if certain conditions are met which are highlighted in the most recent Office of Mental Health and Substance Abuse Services **bulletin.**
- This bulletin has extended many of the telehealth flexibilities authorized during the COVID-19 public health emergency through December 31, 2024. OMHSAS is in the process of working on a new bulletin for 2023 but has provided interim guidance on requirements **here.**

Substance Use Disorders/Centers of Excellence (COE). Centers of Excellence for Opioid Use Disorder (COEs), created and managed by DHS, include primary care practices, hospitals, FQHCs, substance use disorder (SUD) treatment providers, and single county authorities. The

COEs were designed to engage the community, to identify all persons with Opioid Use Disorder (OUD) and ensure every person with OUD achieves optimal health. COEs take care of the whole person -- coordination of care across multiple domains, including physical, mental, and behavioral health, peer support and social needs including job training, housing and transportation support, education services, and childcare, among others. DHS will provide each MCO a list of all providers enrolled with the COE specialty type, and the MCOs will be required to contract with each enrolled provider that operates in the zone/counties in which the MCO operates. This is currently reflected in the 2021 HealthChoices Agreements and the program standards & requirements and will be reflected in 2022's agreements.

- The code for billing and reporting of COE care management services rendered is G9012.
- COEs that are FQHCs are able to bill the T1015 or G9012 codes depending on the services being provided. DHS will communicate with the MCOs to identify those FQHCs that are also COEs to help reduce claim denials.
- The current CMS approved directed payment arrangement for all care management services claims using procedure code G9012 is exactly $277.22 per member per month through 2021; no decision has been made yet about future years.
- During the first month of a new member's engagement, a COE must bill both an Evaluation & Management code and the G9012 procedure code. For subsequent months of engagement, the G9012 procedure code is sufficient to receive the PMPM payment.
- Payment will be paid for individual patients and should be submitted as a claim under the individual patient's name.
- The COE cannot bill for the PMPM payment unless a care management service is being provided face-to-face.
- Care management services can be provided throughout the month for Medicaid members with OUD, but the health center will only receive the PMPM payment once per month.
- The face-to-face encounter can take place anywhere as long as it is documented appropriately in the patient's medical record. Face-to-face encounters do not need to take place inside the COE location to qualify for the PMPM payment.
- The Medicaid fee-for-service program will not pay the PMPM amount. COEs will have to wait to bill for this type of member until they are enrolled in an MCO.
- Medication Assisted Treatment is billed as a physical health service

Please refer to the billing-specific Frequently Asked Questions document.

Community HealthChoices (CHC) Payment Policy.

- The CHC contract, like the physical and behavioral HealthChoices contracts, requires MCOs to pay FQHCs at PPS
- Health centers can negotiate pay-for-performance incentives above their encounter rate.
- If a health center sees a CHC-covered patient who is not attributed to them, DHS still requires the MCOs to pay at PPS if there is a contract with that MCO.
- Patients can change their PCP selection at any time, so if seeing patients who are not assigned to your health center, you can provide information on how to change PCP assignment.
- Under CHC, participants' Medicare coverage will not change and beneficiaries may keep their primary care physician

CHC Medicaid/Medicare Billing.

- Medicare continues to be the primary payer for any service covered by Medicare. Medicare and other 3rd party payers should be billed for eligible services prior to billing Medicaid.
- All Medicaid bills for CHC participants are submitted to the participant's CHC MCO, including claims for services after Medicare has denied or paid part of a claim.
- Claims must be submitted to the appropriate CHC-MCO to receive payment for any covered cost-sharing for Medicare services. Providers may not bill dual eligible participants for cost-sharing.
- CHC-MCOs must pay participants' Medicare co-insurance or deductible, whether or not the Medicare provider is included in the CHC-MCO's network.

Important Points:

- Health centers should contract with all 3 CHC-MCOs; contracts should reflect the requirement to pay PPS for FQHC eligible services; for non-contract MCOs and non-attributed patients, health centers must seek out-of-network payment
- Additional services/value-based payments outside of PPS may be negotiated between the health center and the CHC-MCO
- All CHC plans are required to pay FQHCs at their PPS rate; always bill with a T1015 for the full PPS rate.
- Anything not billed with T1015 will not be paid at PPS and is outside of the wraparound report and the revenue does not offset encounters.
- MCOs may require CPT codes, which are needed for MCO HEDIS reporting but the MCOs must still pay PPS on use of T1015.
- Submit T1015/T1015 U9 billing code to CHC-MCOs with the EOB showing what Medicare paid.
- MCO can reduce payment by the Medicare revenue and co-payment obligation; that is, health center payment would be PPS minus Medicare revenue minus co-pay obligation.
- DHS has added a CHC tab to the wraparound report as well as a field for Medicare revenue reporting.
- As you encounter questions or challenges, please let PACHC know so that we can work with DHS to help get them answered or resolved.

PENNSYLVANIA VALUE-BASED PAYMENT

Value-based care/payment is aimed at controlling the rising cost of health care and focuses on the quality of care provided to patients. As fee-for-service reimburses providers for each health care service/visit/encounter provided, value-based care targets positive outcomes of patient care, increased care coordination, reduction of costly duplication of service and assurance that patients receive the highest quality of care and achieve the best possible outcome.

Medical Assistance and Children's Health Insurance Program Managed Care Quality Strategy. Value Based Payment (VBP) is a DHS initiative to transition providers to being paid for the value of the services provided, rather than simply the volume of services. VBP strategies and VBP models are critical for improving quality of care, efficiency of services and reducing cost. As each of the DHS program offices are at different stages in the maturity of their VBP programs and vary in structure, DHS began working on a VBP alignment initiative in 2019.

The guiding principles of this alignment include:
(1) Bend the cost curve
(2) Improve quality of care
(3) Multi-payer alignment
(4) Meeting patients and providers where they are
(5) Promoting health equity

One of DHS' goals is to define a common framework with standardized payment strategies in which all program offices (e.g., OMAP and OMHSAS) can operate. These strategies include Performance-Based Contracting, Shared Savings, Shared Risk, Bundled Payments and Global Payments. Currently, OMAP and OMHSAS are implementing different VBP strategies, benchmarks and MCO reporting requirements. Additionally, each DHS program office does or will include VBP medical spend requirements in the agreements with its MCOs, with the goal of increasing the requirement each contract year.

Current VBP Environment. For several years now, Pennsylvania's contracts with physical health Medicaid MCOs have included VBP provisions with incremental increases in VBP requirements. In 2017, Medicaid HealthChoices MCOs needed to spend 7.5 percent of their medical spend dollars on value-based care/payment. This medical spend on VBP increased to 15% in 2018, 30% in 2019 and50% in 2020. Additionally, each year the investment in VBP was to move up the continuum of VBP models from pay for performance to PCMH to shared savings to bundled payments to full risk/accountable care organizations with less reliance on pay for performance and more VBP using shared savings, bundled payments and full risk/accountable care organizations.

In January 2018, the Office of Mental Health and Substance Abuse Services (OMHSAS) implemented contract amendments requiring an increased percentage of BH-MCO payments over time to fall within approved VBP models: CY 2018 5%; CY2019 10%; and CY 2020 20%.

Additionally, each year the investment in VBP was to move up the continuum of models from performance-based contracting to shared savings, shared risk to capitation to capitation plus performance-based contracting. OMHSAS for Value-Based Purchasing information.

Standardized DHS VBP Definitions.

- Pay for Performance (P4P): additional payments linked to provider performance; must be measured against quality benchmarks or incremental improvement benchmarks and must include contract incentives or penalties or both based upon meeting these benchmarks.
- Patient Centered Medical Home (PCMH): must meet all requirements for PCMH as defined in the Physical Health HealthChoice Agreement (see PH-MCO PCMH section below).
- Shared savings: supplemental payments to providers if they are able to reduce healthcare spending relative to benchmarks, either for a defined member population or the total MCO population served by the provider or practice site. The payment is a percentage of the net savings generated by the network provider.
- Bundled Payments: all payments for services rendered to treat Medicaid individuals for a defined, identified condition. The payments may be made in bulk or paid over regular predetermined intervals, so long as they are prospective.
- Global Payments: prospective, population-based payments that must cover all health needs of a defined Medicaid population; may also include covering all health delivered by a certain type of clinician such as primary care. These payments may be made in bulk or delivered over regular predetermined intervals (capitation payments).
- Full-risk models: these models provided prospective, population-based payments to cover the total cost of care of all members for certain providers, with all savings or losses staying with the provider group. Providers must be measured against quality benchmarks with incentives and penalties dependent upon meeting the benchmarks.
- Accountable Care Organization (ACO): This model must integrate both finance and delivery of care within the same organization so that both are collective responsible for the total cost of care of the MCO member. An ACO arrangement may include joint ventures between a PH-MCO and provider groups, PH-MCOs that own provider groups, or provider groups that offer healthcare coverage. An ACO may include shared shaving and shared risk. Providers must be measured against quality benchmarks with incentives and penalties dependent upon meeting the benchmarks.

The DHS Physical Health MCO PCMH model of care targets whole person focused care including behavioral health and physical health, comprehensive wellness care, acute care and care for chronic conditions, increased access to care, improved quality of care, team-based care management/coordination, and the use of electronic health records (EHR) and health information technology to track and improve care.

PH-MCOs have contracted with high volume providers in their network who meet the requirements of a PCMH as detailed in the HealthChoices contract (*please note this is not related to or the same definition/requirements as NCQA PCMH*); make monthly payments to each PCMH based on factors such as clinical complexity, age, medical costs, and composition of the care management; collect quality measurement data from the PCMHs; reward PCMHs with

quality-based enhanced payments; developed a learning network that includes PCMHs and other PH-MCOs; and report annually on the clinical and financial outcomes of their PCMH program.

Example: In the 2020 HealthChoices contract, requirements for participation in the PCMH initiative included (this is a sample but not the full list of requirements):

- Be a high-volume Medicaid practice participating in a PH-MCO provider pay-for-performance program or a defined set of practices willing to share care management resources
- Accept all new patients or be open for face-to-face visits at least 45 hours per week
- Have received a payment from the Medicaid or Medicare electronic health record meaningful use program
- Join a Pennsylvania Patient and Provider Network (P3N) certified health information organization (HIO) by 12/31/2020 in order to share health related data
- Deploy a community-based care management team that consists of licensed professionals and unlicensed professionals such as peer specialists, community health workers or medical assistants to work with individuals with complex care needs within the local community
- Collect and report annual quality data and outcomes pertinent to their patient population as defined by the PH-MCO provider and/or DHS
- Conduct internal clinical quality data reviews on a quarterly basis, report results and discuss improvement strategies with the PH-MCO
- See 75% of patients within seven days of discharge from the hospital with an ambulatory sensitive condition
- Complete a Social Determinants of Health assessment, at least annually and more frequently for patients who screen positive, using a nationally recognized tool and track referrals and outcomes
- The 2023 MCO HealthChoices agreements require the MCOs to discuss conceptual VBP models with any interested FQHCs, but do not require FQHCs to enter into these alternative payment methodology discussions. The 2024 HealthChoices agreement will require model implementation if an FQHC so chooses and the Centers for Medicare and Medicaid Services approves. For any VBP model, the PPS rate should remain the payment floor unless a different agreement is reached between the MCO and the FQHC and approved by CMS.

Resources:

- The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. The PA Dept. of Human Services uses HEDIS measures to hold PA HealthChoices programs accountable for the timeliness and quality of healthcare services delivered to the Medicaid membership.
- HealthChoices Physical Health Agreement effective January 1, 2023
- Physical HealthChoices HealthChoices General Information
- Value-Based Purchasing (VBP) BH-MCOs

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CHIP Basics. The Children's Health Insurance Program (CHIP) is Pennsylvania's program to provide health insurance to uninsured children and teens who are not eligible for or enrolled in Medical Assistance. CHIP was administered by the Pennsylvania Insurance Department (PID) until the end of 2015 when the state's CHIP reauthorization legislation transitioned administration of the program to the PA Department of Human Services (DHS) starting in 2016. As of April 2023, all CHIP determinations, applications or plan changes are no longer processed by CHIP Insurers.

In December 1992, former Gov. Robert P. Casey signed into law House Bill 20 (HB 20), known as the Children's Health Insurance Act. HB 20 created the Children's Health Insurance Program, a one-of-a-kind program designed to provide insurance coverage to children whose families earn too much to qualify for Medical Assistance, but who could not afford to purchase private insurance. Pennsylvania's CHIP program later was used as the model for the federal government's CHIP program. Legislation for the federal CHIP program was signed into law August 1997 by former President Bill Clinton.

With CHIP, parents have a choice of major insurance companies with networks of physicians, specialists, and care facilities based on county of residence. CHIP insurers are county specific; see the website to find which insurance companies offer CHIP in each county. CHIP applications may be completed online via COMPASS, on the phone or using a paper application by downloading a PDF application. When the paper application is completed, including all supporting documentation, the application should be mailed to the local county assistance office.

Eight insurance companies offer CHIP, each with a unique identifier for its CHIP product:

- Aetna – Aetna Better Health Kids
- Highmark Choice Company – Highmark Healthy Kids (Regional Identifier)
- Capital BlueCross (coverage provided by Keystone Health Plan Central HMO) – Capital Cares 4 Kids
- Geisinger Health Plan – GHP Kids
- Health Partners Plans --- KidsPartners
- Independence Blue Cross (coverage provided by Keystone Health Plan East HMO) – PA Kids
- UnitedHealthCare Community Plan of Pennsylvania
- UPMC Health Plan --- UPMC for Kids

For most families, it's free. Families with incomes above the free CHIP limits will pay low monthly premiums and co-pays for some services. View comprehensive income information. Payment is based on household annual gross income and age of the children. However, coverage for grandchildren is not based on grandparent income, unless the grandparents have legally adopted the children. For families whose incomes fall in the Full Cost CHIP range, comparable insurance must be either unavailable or unaffordable.
Once enrolled, children are guaranteed 12 months of CHIP coverage. Coverage must be renewed every year in order to maintain coverage.

Eligibility.

- Under 19 years of age
- A U.S. citizen, U.S. national or qualified alien
  - Immigrant children are eligible to apply for CHIP if they meet the following criteria: child lawfully entered U.S. and has legal immigrant or lawfully present immigrant status; is a refugee, asylee, Cuban – Haitian entrant, Amerasian immigrant, child of a veteran or active-duty U.S. military serviceman, certified by the Office of Refugee Resettlement (ORR) as Victims of Trafficking, or is a lawfully present immigrant whose deportation is being withheld by INS
- A resident of Pennsylvania
- Uninsured and not eligible for Medical Assistance

CHIP Benefits.

- Immunizations
- Routine Checkups & Well Visits
- Prescription Drugs
- Dental, Vision, Hearing Services
- Emergency Care
- Mental Health Benefits
- Hospitalization
- Durable Medical Equipment
- Substance Abuse Treatment
- Partial Hospitalization for Mental Health Services
- Rehabilitation Therapies
- Home Health Care
- Maternity Care
- Hospice and Palliative Services
- Medically Necessary Orthodontia
- Autism Spectrum Disorder and Related Services

Resource:

- Children's Health Insurance Program (CHIP) Eligibility And Benefits Handbook
- CHIP vs Medicaid Insurance Cards – What's the Difference

CHIP Payment Policy.

In 2009, the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) reauthorized CHIP, including a provision that requires FQHCs to receive payment at least equivalent to the Medicaid Prospective Payment System (PPS) rate for all CHIP encounters, effective October 1, 2009. Separate CHIP programs (those not an expansion of state Medicaid) could utilize one of three methods: adopt Medicaid PPS rates; construct a separate CHIP PPS rate; or use an Alternative Payment Methodology (APM). The PA Insurance Department, working with PACHC as a subcontractor under two Centers for Medicare & Medicaid (CMS) grants to aid with the transition to PPS, decided to use health center Medicaid PPS rates. The December 1, 2013 contract between PID and the CHIP MCO contractors included the provision

that MCOs contractors would be responsible for paying FQHCs at the Medicaid PPS rate effective January 1, 2014. CHIP MCOs were to have the ability to reimburse at the PPS rate in place by April 30, 2015. This requirement faced many implementation challenges and was one of the reasons for transfer of administration of the program from the Insurance Department to DHS in House Bill 857, signed into law in December 2015. After discussion between PACHC and DHS it was decided that CHIP would be added to the quarterly wraparound reports starting with the first and second quarters of 2016 so that DHS could hold the CHIP insurers accountable for accurate payment.

The entire process of implementing CHIP PPS has been rife with challenges, issues, and unanswered questions. The current status is that PACHC continues to communicate with DHS to resolve outstanding issues and ensure correct and timely payment to FQHCs.

Important Points:

- Health centers should have a system in place to internally track CHIP encounters and reimbursement by each CHIP insurer in order to verify or dispute data during any reconciliation process.
- CHIP wraparound reports include physical health, dental and behavioral health.
- CHIP wraparound reports are to include "what the health center got paid" for vaccines by each CHIP plan. Vaccine reimbursement rates should be part of the CHIP contract as per the MCO fee schedule.
- When compiling the wrap report, only count claims and claims payment where the FQHC billed, and the insurer paid procedure codes T1015 and T1015/U9. No other claims or claims payment should be counted on this report.
- To complete the wraparound report, match payments with the encounters that were incurred for the quarter. This will help when determining if a certain plan is not in compliance with paying PPS rate.
- The due date for CHIP wrap reports is seven months after the quarter end date. This will allow time to match payments with dates of encounter.

Reporting Periods:	Due Date:
Q1 = January 1 - March 31	Q1 = October 31
Q2 = April 1 - June 30	Q2 = January 31
Q3 = July 1 - September 30	Q3 = April 30
Q4 = October 1 - December 31	Q4 = July 31

- On the UDS report, PA CHIP should be reported under "Other Public Insurance CHIP."
- *Since accurate payment is still a work in progress, please contact PACHC with questions or for a status update.*

MEDICARE & COMMUNITY HEALTH CENTERS

Medicare is the federal health insurance program for:

- People who are 65 or older
- Certain younger people with disabilities
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)

The different parts of Medicare cover specific services:

- **Medicare Part A (Hospital Insurance)** covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
- **Medicare Part B (Medical Insurance)** covers certain doctors' services, outpatient care, medical supplies, and preventive services.
- **Medicare Part D (prescription drug coverage)** covers the cost of prescription drugs (including many recommended shots or vaccines).

The Center for Medicare & Medicaid Services (CMS) Federally Qualified Health Centers (FQHC) Center is the "go to" website for information related to Medicare and FQHCs.

Medicare Site Registration & Enrollment.

- The Centers for Medicare and Medicaid Services (CMS) considers each HRSA-approved health center site to be its own FQHC for Medicare registration and reimbursement purposes.
- One enrollment cannot contain more than one practice location, so multiple enrollments must be created for FQHCs that have multiple locations.
- Medicare classifies an FQHC as an Institutional Provider
- To be reimbursed as an FQHC under Medicare, an entity must:
  - For each site, submit a complete application package (Form CMS-855A and supporting documents) to the appropriate Medicare Administrative Contractor (MAC)
  - Receive from the CMS Regional Office in Philadelphia a CMS Certification Number, a signed Medicare agreement, and an effective date.
  - Each FQHC site location must be separately enrolled and will receive its own CMS Certification Number
- FQHCs are required to pay an application fee when initially enrolling, revalidating, or adding a practice location.

Important Points:

- Use the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) online Medicare enrollment management system to enroll as a Medicare provider; revalidate (renew) enrollment; withdraw from the Medicare program; review and update information; report changes to your enrollment record; and electronically sign and submit information
  - PECOS applications are processed more quickly than paper applications; it is tailored to ensure that only information relevant to your application is requested; and has video and print tutorials to get you started.

- It is the FQHC's responsibility to keep enrollment information up to date to avoid having Medicare billing privileges revoked. Report the following changes within 30 days:
    - a change in ownership
    - an adverse legal action
    - a change in practice location
- All other changes must be reported within 90 days.
- If your application was completed online, you can use PECOS to update your information. If you applied using a paper application, you must resubmit a paper form to update information.
- Multiple FQHC sites may share an NPI, however, it is not recommended.
- Each FQHC site location must be separately enrolled and will receive its own CMS Certification Number
- FQHCs must revalidate their facility enrollment every 5 years.

Resources:

- Medicare Enrollment Guide For Institutional Providers
- Medicare Enrollment Application Institutional Providers - CMS-855A
- Medicare Enrollment Guide - Table of Contents
- National Provider Enrollment Conference, March 2019, Frequently Asked Questions (FAQs)
- Also review the Licensure, Enrollment and Credentialing section of this manual

Medicare FQHC Payment. In 2010 the Affordable Care Act added Section 1834(o) of the Social Security Act establishing a payment system for the costs of FQHC services under Medicare Part B based on prospectively set rates. In the PPS for FQHC Final Rule published in the Federal Register on May 2, 2014, CMS implemented a methodology and payment rates for FQHCs under the PPS beginning on October 1, 2014.

- There is one national PPS rate for all FQHCs. Each FQHC rate is then adjusted based on the location of where the services are furnished applying the FQHC GAF (Geographic Adjustment Factor) to the base FQHC PPS rate. (see CMS FQHC Center)
- Each year Medicare issues a Change Request (CR) to inform Medicare Administrative Contractors (MAC) about updates to the PPS base payment rate and the GAFs for FQHCs using the FQHC market basket. Make sure billing staff are aware of these changes.
- The FQHC base PPS rate is also adjusted/increased for a new patient visit to an FQHC called an Initial Preventive Physical Exam (IPPE) and for an Annual Wellness Visit (AWV).
- FQHCs must use these codes when submitting claims to Medicare under the FQHC PPS: G0466 – FQHC visit, new patient; G0467 – FQHC visit, established patient; G0468 – FQHC visit, IPPE or AWV; G0469 – FQHC visit, mental health, new patient; and G0470 – FQHC visit, mental health, established patient.
- Medicare reimburses at 80 percent based on the lesser of actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day.
- Coinsurance is 20 percent of the lesser of the FQHC's charge for the specific payment code or the PPS rate, except for certain preventive services.

- Part B coinsurance and deductible is waived for the Initial Preventive Physical Examination (IPPE), and Annual Wellness Visit (AWV) as well as other U.S. Preventive Services Task Force-recommended preventive services….see the FQHC Preventive Services Chart.
- There is no payable Part B deductible for services under the FQHC benefit, except for telehealth services.

Several new Medicare reimbursement opportunities become effective on January 1, 2024.

- Services provided by Licensed Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)
- Intensive Outpatient Program (IOP) Services for behavioral health. (These services are less intensive than partial hospitalization but more intensive than weekly therapy.)
- Remote monitoring
- Three types of SDOH-related services.
- Details on these new opportunities are on the attached chart – Medicare 2024 Reimbursement Opportunities

Important Points:

- FQHCs set their own charges for their services and determine which services to include with each FQHC G code. Patient charges must be uniform.
- Medicare pays influenza, pneumococcal and COVID vaccines and their administration at 100 percent of reasonable cost through the cost report. The cost is included in the cost report and no visit is billed.
- Under Medicare, FQHCs are able to bill for both a medical and mental health visit on the same day.
- Outpatient diabetes self-management training (DSMT) or medical nutrition therapy (MNT) services are reimbursable if provided by a qualified practitioner and all relevant program requirements are met.
- Visiting nurse services conducted by a registered nurse or licensed practical nurse to homebound patients in an area certified by CMS as having a shortage of home health agencies may qualify as an FQHC service.

Resources:

- Frequently Asked Questions on the Medicare FQHC PPS (Rev. 11-21-19)
- Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2020 - Recurring File Update
- Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS) (Rev. 12-06-17)

Medicare Cost Reports.

- FQHCs participating in the Medicare program are required to maintain adequate financial and statistical records and submit annual cost reports to achieve settlement of costs for healthcare services rendered to Medicare beneficiaries as well as payment for graduate medical education adjustments, bad debt, and influenza and pneumonia vaccines and their administration.

- The FQHC cost report must be submitted to the Medicare administrative contractor (MAC) in a standardized electronic format.
- Medicare requires submission of annual cost reports covering a 12-month period of operations based upon the provider's accounting year. The provider may select any annual period for Medicare cost reporting purposes regardless of the reporting period it uses for other programs.
- Cost reports are due on or before the last day of the fifth month following the close of the cost reporting period. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.
- Form CMS-224-14 must be used by all FQHCs for cost reporting periods beginning on or after October 1, 2014. FQHC cost reports were previously submitted on CMS-222-92

Resources:

- Chapter 44-(T3) -- Federally Qualified Health Center Cost Report (Form CMS-224-14) (ZIP)
- Form CMS-224-14

PPS Payments to FQHCs under Contract with Medicare Advantage Plans. FQHCs with a written contract with a Medicare Advantage (MA) plan are paid by the MA organization at the rate specified in their contract. If the MA contract rate is less than the Medicare PPS rate, Medicare (through the MAC) will pay the FQHC the difference, less any cost sharing amounts owed by the beneficiary. The supplemental (wraparound) payment is only paid if the contracted rate is less than the adjusted PPS rate.

- A MA contract with an individual physician does not qualify for supplemental payment
- The following is needed by the MAC in order to establish a supplemental wrap payment:
    - A copy of the MA contract signed by both parties (the FQHC and the MA) including a valid MA contractor number with each contract
    - An average MA per-visit payment rate for each MA plan they are under contract with.
    - If the MA rate is not contracted as a per-visit rate, the health center will need to convert fee schedules or capitation amounts to a per-visit either actual or estimate with justification/documentation.

Other FQHC Medicare Services. Transitional Care Management (TCM), Chronic Care Management (CCM), general Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Model (CoCM) services are structured care management services in addition to any routine care coordination services already furnished as part of an FQHC visit. These services are not required.

Chronic Care Management (CCM): CCM services may be provided to Medicare patients with two or more chronic conditions who are at significant risk of death, acute exacerbation/decompensation, or functional decline. CCM reimburses healthcare practitioners for the time and resources used to manage Medicare patients' health between face-to-face appointments. CCM services are typically provided outside of face-to-face patient visits and focus on characteristics of advanced primary care such as maintaining a comprehensive electronic care plan; a continuous relationship with a designated member of the care team;

patient support for chronic diseases to achieve health goals; 24/7 patient access to care and health information; receipt of preventive care; patient and caregiver engagement; and timely sharing and use of health information.

Transitional Care Management (TCM): The goal of TCM is to improve care coordination of Medicare patients between an acute care setting and community setting including management and coordination of services, as needed, for all medical conditions, psychosocial needs, and activity of daily living support. TCM requires initial contact with the patient within two business days after discharge, a face-to-face visit within a specified period of time, and moderate or high medical decision making during the 30-day service period.

General Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Model(CoCM): Behavioral Health Integration (BHI) focuses on individuals with any behavioral health or psychiatric condition being treated by an FQHC practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants BHI services. These services include an initial assessment, the use of applicable validated rating scales, behavioral health care planning, the facilitation and coordination of treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation and continuity of care with a designated member of the care team.

Psychiatric CoCM is behavioral health integration that enhances primary care by adding care management support for patients with any behavioral health or psychiatric condition being treated by an FQHC practitioner, including substance use disorders, that, in the clinical judgment of the FQHC practitioner, warrants CoCM services. The care team must also include a Behavioral Health Care Manager and Psychiatric Consultant. Care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.

Virtual Communication Services.

- Effective January 1, 2019, FQHCs can receive payment for virtual communication services
    - Must be at least 5 minutes of technology-based communication or remote evaluation services
    - To a patient who has had an FQHC billable visit within the previous year.
    - The virtual communication is for a condition not related to an FQHC service provided within the previous 7 days
    - The communication does not lead to an FQHC visit within the next 24 hours or at the soonest available appointment.
- To receive payment for Virtual Communication services, the claim must use HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services.
- Payment for G0071 is set at the average of the national non-facility Physician Fee Schedule payment rates for HCPCS code G2012 (communication technology-based services) and HCPCS code G2010 (remote evaluation services) and is updated annually

- Face-to-face requirements are waived when these services are furnished to an FQHC patient, and coinsurance applies.
- Payment for virtual communication services now include digital assessment services. Digital assessment services are non-face-to-face, patient-initiated, digital communications using a secure online patient portal.

Resources:

- Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions
- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)
- FAQs for billing the Psychiatric Collaborative Care Management (CoCM) codes (99492, 99493, 99494, and G0512 in FQHCs/RHCs) and General Behavioral Health Intervention (BHI) code (99484, and G0511 in FQHCs/RHCs)
- Virtual Communication Services Frequently Asked Questions (PDF)

General Medicare Resources:

- Novitas JLProvider Specialty: Federally Qualified Health Centers
- Novitas Solutions Part A
- Novitas Solutions Part B
- Federally Qualified Health Centers (FQHC) Center
- MLN Booklet Federally Qualified Health Center – Sept. 2019
- Medicare Learning Network

Important Point:

Please refer to the Medicaid Community HealthChoices sections for information related to patients dually eligible for both Medicare and Medicaid.

COVID ADDENDUM.

CMS has implemented many changes, removed some regulatory requirements, and added additional flexibilities to help health centers respond to the COVID-19 public health emergency (PHE). The most notable is New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE).

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), Section 3704, authorized FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. Distant site telehealth services can be furnished by any healthcare provider working for the FQHC within their scope of practice; can be furnish from any location, including their home; and includes any telehealth service approved as a distant site telehealth service under the Physician Fee Schedule (PFS). Note that the changes in eligible originating site locations, including the patient's home during the COVID-19 PHE are effective beginning March 6, 2020.

HCPCS code G2025 is the new FQHC specific G code to identify services furnished via telehealth beginning on January 27, 2020. Payment for distant site telehealth services is set at

$92.03, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.

For additional information:
RHC/FQHC COVID-19 FAQs
COVID-19 Public Health Emergency (PHE) - Updates for FQHCs

PACHC - WHO WE ARE & WHAT WE DO

As the state primary care association (PCA), the Pennsylvania Association of Community Health Centers (PACHC) represents and supports the largest network of primary health care providers in the commonwealth. This network of health centers includes Community Health Centers FQHC (FQHCs and FQHC Look-Alikes), Rural Health Clinics and other like-mission providers serving more than 900,000 patients annually at more than 400 sites in underserved rural and urban areas throughout Pennsylvania. Since 1981, PACHC programs and services have supported health centers in their mission to improve health equity and access to affordable, quality primary care for all. PACHC is governed by a representative Board of Directors composed of Community Health Center chief executive officers elected by PACHC's Organizational Members. The PACHC staff consists of professionals with a variety of skills and expertise that enables PACHC to advance our vision and mission of "Health Equity and Access to Health Care for All" and "Support Pennsylvania's Community Health Centers in Improving Health Equity and Access to Affordable High-Quality Health Care."

The following core functions are vital as PACHC continually works to increase the value of membership and support Pennsylvania's Community Health Centers:

- **Communication**: Ensuring health centers are up to date through a weekly newsletter, current website content, social media, and peer networking
- **Conferences and Education**: Serving as the education resource of choice for health centers by providing relevant and timely education and information shared through our Annual Conference, seminars, webinars, and printed materials
- **Financial and Operational Technical Assistance**: Supporting health centers to increase access to a broad scope of health services, enhance efficiency, effectiveness, and exceptional service, maintain financial stability and visiting health centers to understand their unique challenges and environments
- **Furthering the FQHC Brand**: Working with our members and partners across the commonwealth and the nation to make sure the public and key stakeholders view FQHCs as valued healthcare organizations.
- **Healthcare Quality**: Supporting health centers in maintaining the FQHC reputation of comprehensive, high-quality care within a patient-centered care model, as well as effectively using data to quantify and benchmark
- **Legislative, Regulatory and Policy Advocacy**: Offering knowledgeable, organized, and energetic advocacy in Harrisburg and Washington D.C. on behalf of health centers
- **Member Services**: Supporting health centers in running the best organizations possible, working with a variety of Annual Corporate Sponsors and PACHC Preferred vendors
- **Recruitment and Retention**: Helping primary care providers find meaningful career opportunities and helping our members find staff, providers and leaders who will serve into the future

There are two categories of membership: Organizational, with a tiered membership dues structure, and a flat-rate PACHC Partner membership. Contact pachc@pachc.org if you have questions related to membership or would like additional information.

Organizational Members: Eligibility limited to the following community-based healthcare provider:

- Federally Qualified Health Centers (FQHCs)
- FQHC Look-Alikes (LAL)
- Non-profit Rural Health Clinics (RHCs)

Full benefits of Organizational Membership

- Technical assistance at no charge related to all aspects of health center operations (clinical, finance, policy, operations, outreach and enrollment, workforce, etc.)
- Guidance on HRSA Bureau of Primary Health Care expectations, requirements, policies, and planned funding opportunities
- High quality education and networking opportunities, including the PACHC Annual Conference & Clinical Summit at member registration rates
- Advocacy at the state and national level
- Grassroots advocacy support
- Direct connection to key contacts within the HRSA Bureau of Primary Health Care, Department of Health, Department of Human Services, PA Insurance Department and other agencies for timely information and responses to questions
- Free and unlimited postings of position openings through the PA Primary Care Career Center and 3RNet with a state and national reach to potential candidates
- Opportunity to exhibit at the PA Primary Care Career Fairs
- Group purchasing opportunities and other discounted products and vendors
- A subscription to the PACHC weekly e-newsletter, *News CHCs Can Use*, that keeps health centers informed of the latest information (PACHC news, state and federal legislative updates, policies, healthcare news, clinical quality, workforce, and more) impacting health centers at the state and national level, as well as funding opportunities
- PACHC Memos providing detailed information on relevant healthcare environment policies
- Peer Queries, provide opportunities to query the "community of Community Health Centers" to get questions answered and identify successful practices and trends
- Peer Network Groups: CEO/Executive Directors; Finance Leaders; COO/Operations/Purchasing; CMO/Medical Directors; Quality & PCMH; Human Resources/Recruitment; Credentialing; Dental Directors; Communications; Behavioral Health & SUD; Billing Managers; Compliance; Outreach & Enrollment; and more
- Continuing education credits
- Eligible to participate on various PACHC committees
- FQHCs and FQHC Look-Alikes are also eligible to serve on the PACHC Board of Directors

PACHC Partners:

- Any health care agency or organization that provides primary, preventive, and other health services to the medically underserved, that does not qualify as an FQHC, LAL or RHC. Examples include free and partial pay clinics, nurse managed health centers, aspiring FQHCs or Look-Alikes and other community-based health care providers.
- Any other public or private non-profit agency, organization or foundation with like-

mission or interest in the medically underserved and safety net healthcare delivery system not eligible for organizational membership and committed to the purpose/mission and goals of the PACHC.

Benefits of PACHC Partners Membership

- Conferences and trainings at member registration rates
- Weekly electronic "News CHCs Can Use"
- Continuing education credits
- Networking opportunities including participation with Peer Networking Groups

Peer Networking Groups. A strategy PACHC has implemented to meet the request of health center leaders for PACHC assistance in the growth, development, and retention of key individuals within the health center organization is the development of a variety of Peer Networking Groups.

Peer Networking Groups are designed as an opportunity for cohorts of individuals with similar responsibilities in Pennsylvania health centers to meet regularly, collaborate, network, learn and grow. Each group, in addition to meeting regularly, has the opportunity to share information on key topics through our "Peer Query" process. Through the Peer Networking Groups, we work together as a community of Community Health Centers to raise all ships and work to become the providers, partners, and employers of choice.

Initiated less than two years ago, the portfolio of Peer Networking Groups has grown in response to requests and feedback from health centers and now includes 15 groups. The groups all meet virtually, so participation does not require travel or undue time commitment. PACHC Peer Networking Groups are open for membership solely to employees of PACHC health centers. PACHC Peer Networking Groups are not open to consultants or employees or representatives of non-health center entities. PACHC may occasionally grant an exception and permit a consultant or representative of a non-health center entity engaged by PACHC to support the education and training of a specific Peer Networking Group to participate in that group's meetings with the awareness and authorization of that Peer Networking Group.

Current Peer Networking Groups:

- Behavioral Health
- Billing Managers
- CMO/Medical Directors
- Communications
- Compliance
- COO/Operations
- Credentialing
- Dental Directors
- Dieticians/Nutritionists
- Finance Leaders
- Human Resources/Recruitment
- Outreach & Enrollment
- Purchasing

- Quality/PCMH

See PACHC MEMO 20-02 PACHC Peer Networking Groups. Please contact pachc@pachc.org to request a copy.

Communication with and through PACHC. PACHC views information as a two-way street: we need your experience and feedback to be most effective in the work we do on behalf of all Pennsylvania health centers. Questions and requests for technical assistance, for instance, can lead to identification of training needs for FQHCs. One health center sharing a problem they are encountering can help us work to resolve the issue for all PA health centers. When PACHC is aware of challenges health centers are facing and successes health centers are experiencing, we can facilitate networking across the "community of Community Health Centers" and offer effective and relevant education and training.

Important Points:

- PACHC publishes a weekly electronic newsletter, *News CHCs Can Use,* which offers timely information about the healthcare environment in the state and nation, trainings, events, funding opportunities, good news about FQHC achievements and more. There is no limit to the number of individuals who work for a PACHC member health center who can receive the publication, so one way to ensure that your health center board and staff have the timely and important information they need is to request that they be added to the email distribution list for this newsletter. Send the name, job title and email of any staff or board member you would like added to the newsletter distribution list to pachc@pachc.org..
- One tool PACHC uses to encourage networking, identify successful practices, and track trends is the "Peer Query." Any health center staff can pose a peer query question anonymously through the Peer Networking Groups and aggregated results are shared with participants of the peer group. On request, responses to the Peer Query are also kept anonymous.

RESOURCES & GUIDES

So You Want to Start a Health Center…? (Sept. 2019)
This practical guide developed by the National Association of Community Health Centers contains information for healthcare providers and organizations, public agencies, or community-based organizations and individuals interested in becoming part of the Health Center Program. It provides step-by-step information for planning and implementing a health center.

HRSA/BPHC Health Center Program Compliance Manual - Updated: Aug. 20, 2018
This Compliance Manual is the principal resource to assist health centers in understanding and demonstrating compliance with Health Center Program requirements. It applies to all health centers that receive Federal award funds under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e), (g), (h), and (i)), as well as subrecipient organizations and Look-Alikes. Look-Alikes do not receive Federal funding under section 330 of the PHS Act; however, to receive Look-Alike designation and associated Federal benefits, Look-Alikes must meet the Health Center Program requirements.

Health Center Program Site Visit Protocol
This guide developed by the Health Resources and Services Administration (HRSA) is the tool used for assessing compliance with Health Center Program requirements during Operation Site Visits (OSVs). It provides an objective assessment and verification of the status of each Health Center Program awardee or Look-Alike's compliance with the statutory and regulatory requirements of the Health Center Program. It lists required OSV documents and details the site visit team methodology and required questions used to determine compliance.

OSV Sampling Resource Guide
HRSA has released the Health Center Program Site Visit Protocol: Sampling Review Resource Guide to help FQHCs understand the sampling process when given flexibility to decide which subset of documents to provide a site visit team.

FTCA Policies and **Manual**
The Federal Tort Claims Act Health Center Policy Manual, updated 7/21/2014, is the primary policy source for information on FTCA for Health Center Program grantees and related stakeholders. It is divided into three sections: Section I: Eligibility and Coverage; Section II: Claims and Lawsuits; and Section III: Appendix. It will be updated as new policy and program guidance are issued. The website will contain the most recent Program Assistance Letter (PAL) addressing the process that health centers must take in order to submit their FTCA deeming and redeeming applications for the upcoming calendar year.

Policy Information Notices (PINS) and Policy Assistance Letters (PALS)
HRSA Policy Information Notices (PINs) define & clarify policies & procedures grantees funded under Section 330 must follow. Program Assistance Letters (PALs) summarize, clarify, and explain items of significance for health centers, including, for example, HRSA program implementation activities, recently enacted laws, final regulations, and/or new HHS initiatives. Since the publication of the Compliance Manual, the most recent communication from HRSA

has been in the form of PALS related to Uniform Data System (UDS) and Federal Tort Claims Act (FTCA) Deeming.

National Resource Center/Health Center Resource Clearinghouse
The National Resource Center (NRC) was established by HRSA to support communication, coordination, and collaboration among HRSA-funded training and technical assistance (T/TA) providers serving health centers. The NRC serves as the vehicle through which 20 National Training and Technical Assistance Partners (NTTAPs) collaborate and coordinate activities to support health centers. Led by an Advisory Group including representatives from NTTAPs, Primary Cate Associations (PCAs), and Health Center Controlled Networks (HCCNs), the NRC seeks to foster, amplify, and leverage each organization's T/TA efforts for greater collective impact for health centers.

The Health Center Resource Clearinghouse is an online resource repository providing access to high quality resources developed by the NTTAPs for community health center staff and other public health professionals to meet information needs and build stronger and healthier health centers and communities.

NACHC Online Library
Provides access to online, free resources, tools, and webinars to support the health center mission. Categories include financial management, operational management, leadership, governance, clinical, workforce, telehealth, policy and research, health information, and managed and accountable care.

NACHC 340B Manual--Second Edition
This 340B manual was created as a central resource for all relevant information and policies to assist health centers with managing the 340B Program and to ensure compliance with federal requirements. Issues covered in the manual include: 340B basics, registration and recertification, Medicaid and 340B, policies and procedures, audit and compliance requirements, the latest policies from HRSA and some "best practices" from health center peers. This manual is well worth the price. If you have questions about the manual, contact pachc@pachc.org.

Funded! Now What? NACHC November 2019
This publication is a guide for newly funded health centers receiving 330-funding for the first time. The guide discusses the first 120 days and the rest of the year as well as best practices and other considerations, implementation checklists and lessons learned from the field.

Governance Guide for Health Center Boards (Governance Guide) NACHC 2019
Designed to support health center boards in implementing effective governance and adhering to HRSA governance compliance standards.

THE "Becoming an FQHC" CHECKLIST

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

Overall:

- ☐ Contact the Pennsylvania Association of Community Health Centers (PACHC) so we can work together and help you on this journey
- ☐ When in doubt, contact PACHC! pachc@pachc.org or (717) 761-6443
- ☐ Read and comprehend the HRSA Health Center Program Compliance Manual
- ☐ Gather and read recommended resources
- ☐ Look for FQHC training opportunities through PACHC, NACHC, or HRSA
- ☐ Do a "Patient Perspective Evaluation" of everything—access, communication, processes, signage, policies, facility, etc.
- ☐ Develop an "Advisory Committee:" Look for people with expertise in governance, finance, operations, that you can turn to for advice but that are not on your governing board
- ☐ Visit existing Community Health Centers and their leaders
  - In person or by phone
  - What were their biggest mistakes?
  - What do they wish they had done differently?
  - What are they most proud of?

Operations:

- ☐ Keep a "Key Information Binder" including business documents and key identification numbers such as NPI, PROMISe ID, EIN, and HRSA Notice of Award, IRS Tax Exempt Application, letter of notification, and Articles of Incorporation
- ☐ Charitable Exemption Certificate or whatever is required to solicit donations
- ☐ Tax I.D. number
- ☐ Any local tax identification numbers that may be required
- ☐ UEI number (replaced DUNS number)
- ☐ SAM, or the System for Award Management registration
- ☐ Organizational Structure/Matrix — formal and by relationships
- ☐ Establish a record-keeping system
  - Identify significant documents that should be kept in special locations or locked files, such as corporate records, Notice of Awards, audits, board minutes, etc.
  - Each grant should have its own file—application, Notice of Award, Project Officer correspondence, site reviews, Federal Financial Reports, semi-annual reports, annual audits, and other documents significant to the grant.
- ☐ Secure legal counsel
- ☐ Secure necessary insurances
  - Directors and Officers
  - Professional Liability/Malpractice (FTCA and/or other)
  - Corporate or general liability

- Worker's Compensation
- Cyber Insurance

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

☐ Negotiate referral agreements and contracts
- Work with legal counsel to develop a template
- Make sure referral agreements and contract are compliance with HRSA requirements

☐ Contract with insurance companies
☐ Medicaid PROMISe identification numbers for both organization and providers
☐ CMS Medicare Enrollment, check in with Part A Intermediary and Part B Intermediary for anything special
☐ Enrollment with Medicare Advantage plans
☐ Simple service area map
☐ Ensure IT can meet Uniform Data Set (UDS) data requirements
☐ Electronic Health Record

Human Resources:

☐ Develop staffing plan
☐ Develop salary and benefit matrix
☐ Develop personnel policies
☐ Research and follow federal and state regulations such as Equal Opportunity guidelines, Family Medical Leave Act
☐ State insurance requirements—comprehensive (general liability, fire, natural disaster, theft (bonding), worker's comp., employment practices, directors and officers, flood).
☐ Unemployment compensation
☐ Fringe benefits—bid, preliminary estimates, enroll

Community & Communication:

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

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

Finance & Payment:

☐ Develop a good understanding of FQHC payment
☐ Develop a budget
- Identify all the variables
- Develop several budget scenarios and projections

☐ Develop an understanding of the process and timeline for enrollment with all payers

- ☐ Select a Practice Management System
- ☐ Payroll tax deposit process/system
- ☐ Which payers accept and/or require electronic billing?
- ☐ Seek billing service? Do billing in-house?
- ☐ For electronic billing, HIPAA compliant system
- ☐ Choose an audit firm
- ☐ Develop financial format and reports
- ☐ Develop fee schedule with sliding fee discount program
- ☐ Develop billing/collection policies

Facility:

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

Clinical:

- ☐ Evaluate Electronic Health Record (EHR) needs
- ☐ Identify clinical staffing needs and begin recruitment
- ☐ Establish credentialing process for clinicians and other staff
  - Ensure compliance with HRSA and insurer processes
- ☐ Develop a quality improvement plan
- ☐ DEA numbers for providers
- ☐ Malpractice insurance in addition to FTCA
- ☐ Hospital privileges for physicians
- ☐ Policy for pharmaceuticals and 340B participation
- ☐ Clinical Laboratory Improvement Act (CLIA) status and certification
- ☐ National Practitioner Data Bank—register, check provider
- ☐ Register with the Council for Affordable Quality Healthcare (CAQH) to support more timely credentialing of your physicians and other clinical staff

Governance:

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

Templates & Policies:

- ☐ Provider Contract (with and without incentives)
- ☐ Patient billing form—superbill/encounter form—with codes
- ☐ Job descriptions for all staff categories
- ☐ Procurement policy (bids, purchase of services, selecting lowest price or best offer)
- ☐ Conflict of Interest Policy
- ☐ Electronic health record templates and modules
- ☐ Consultation/Referral/Contract templates
- ☐ Billing/collection policies
- ☐ Sliding Fee Discount Program Policy
- ☐ Human Resource policies
- ☐ Compliance
- ☐ Risk Management

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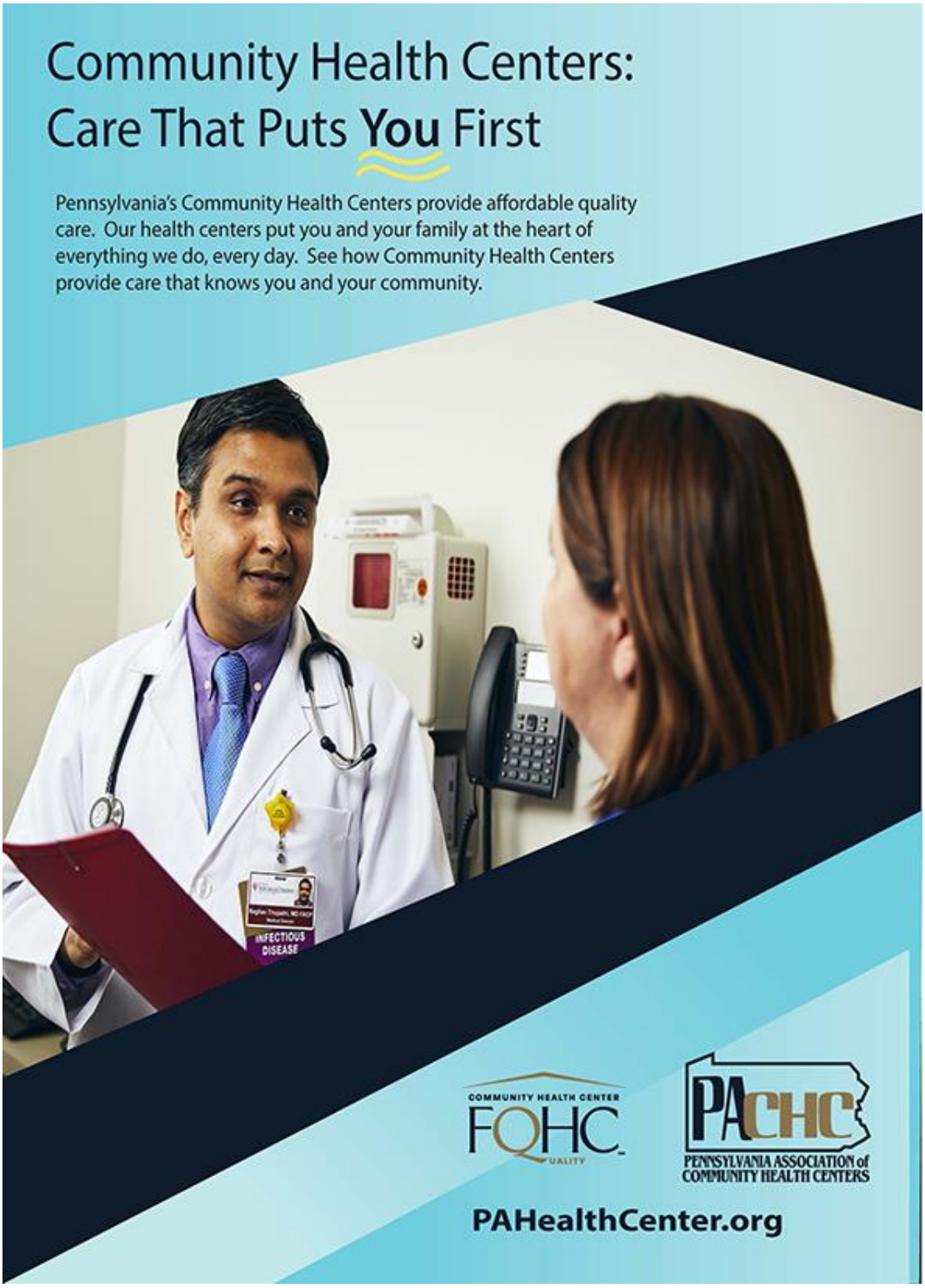

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PACHC

PENNSYLVANIA ASSOCIATION of COMMUNITY HEALTH CENTERS

2023 Annual Report

April 1, 2022 -
March 31, 2023*

*PACHC Fiscal and Organizational Membership Year

COMMUNITY HEALTH CENTER FQHC QUALITY