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Excellence, Equity, Effectiveness

Section 3(1) and section 3(6) justifications:

One of the major battles that Urban Indian Health Program has had to fight under the previous Administration revolved around the Congressional intent to fund and maintain the Urban Indian Health Program. While Congress was explicit in its intent to maintain the program in the FY2007, FY2008, and FY2009 Budget Appropriations Acts, the underlying argument that it is not the federal's responsibility, and should not be the federal government's policy to provide health care to Indians off the reservation, is still very much alive.

Due to the structure of the Indian Health Care Improvement Act separate definitions for Indians who live on the reservations or near their tribal homes ('Indians') and Indians who live off the reservations ('Urban Indians') were necessary despite the fact that the distinction is largely legal and academic rather than reflecting and actual distinction. However, under the previous Administration, Executive branch agencies such as DHHS began actively interpreting any law that did not specifically include urban Indians or urban Indian organizations to exclude the urban Indian community. This causes particular problems with regard to third party billing, conferring with agencies on issues impacting urban Indian health, and fully developing the urban Indian health program. The automatic assumption when interpreting IHCIA that urban Indians are excluded if not explicitly included is a long running issue and not one easily solved on the administrative level. Given this interpretive rubric used by the Executive branch for interpreting federal Indian law, it is particularly important to specifically include urban Indians in any statement of federal policy or Congressional intent as the absence of urban Indians will be interpreted as a specific intent to exclude.

Section 3(1) and 3(6) are explicit demonstrations of Congressional intent and will be binding federal policy with regard to providing health care to AI/AN and providing funding to support Indian health care providers. It is especially important to include urban Indians in these provisions in order to assure that the trust responsibility continues to be extended to them as the absence of the words 'urban Indians' and 'urban Indian organizations' could potentially be used to justify the abolition of the program by a hostile Administration. The UIHP was able to refute the previous Administrations' attacks because of clear Congressional intent expressed in the Indian Health Care Improvement Act of 1976 which established the program. Removing urban Indians from this critical provision would greatly weaken the UIHP's legal argument for continued existence and support.

In section 3 Congress declares its explicit intent to honor the trust responsibility and provide health care to "assure the highest possible health status for Indians." Omitting urban Indians from this provision could be used to suggest a significant limiting of the trust responsibility. While Indian Country and most members of Congress believe the trust responsibility expands beyond the borders of the reservation and follows Indians regardless of where they reside, not all Administrations have held this view. Enacting a new law without urban Indians in this key provision would be a clear and marked

retraction from the powerful statement upholding the trust responsibility for urban Indians found in previous enactments of the Indian Health Care Improvement Act.

NCUIH suggests the following technical amendment language:

Section 3 page 7 line 23, **INSERT** "and urban Indians,"

Section 3 page 8 line 19, **INSERT** "and urban Indian organizations"

Section 201 technical amendments:

Section 201, page 348 line 8-9, **INSERT** "and urban Indian organizations"

Section 201, page 349 line 23-24, **INSERT** "or an urban Indian organization"

Section 201, page 350 line 25, **INSERT** "and urban Indian organizations"

Section 201, page 352 line 20, **INSERT** "or an urban Indian organization"

Inserting urban Indian organizations into these sections will, without changing the definition of Indian health program—which is the other potential way of including urban Indian organizations—ensure that urban Indian organizations will enjoy the benefits of this section including direct billing of Medicaid/Medicare. This provision is particularly important to urban Indian health programs not included as FQHCs, RHC or FQHC look-alikes (differences explained below) as programs which are not included as 340(b) organizations are unable to bill Medicaid/Medicare. Moreover, UIOs will be able receive payment for medical assistance provided under a State plan or under waiver authority. These are two major provisions for urban Indian organizations as developing strong third party billing capacity will help the UIHP programs and clinics achieve financial stability.

Non-FQHC or FQHC look-alike or RHC clinics:

As explained in previous testimony, 8 urban Indian health programs have FQHC status through the 330 grant, 2 programs are FQHCs as tribal exceptions[1], 15 are FQHC look-alikes, and 2 are RHCs. The befits to FQHC status include increase reimbursement for Medicaid, Medicare, and CHIP as well as mandatory reimbursement for certain services otherwise deemed as up to the discretion of the state such as adult dental services. However, not all urban Indian health programs are able to develop the comprehensive health care services required for FQHC or FQHC look-alike status. HRSA's definition of 'comprehensive'—as explained in form 4 of the application for FQHC look-alike status—are quite extensive. Some programs do not have the funds to provide the services necessary, and some programs,

[1] The Tulsa and Oklahoma City urban Indian health programs are able to access the FQHC program through a limited tribal exemption that Tulsa and Oklahoma City are able to access because Oklahoma has been declared a CHISDA.

such as some of the Montana programs, are unable to recruit the necessary providers to their areas to provide the services.

The distinction between FQHC and FQHC look-alikes under section 340(b) of the Public Health Service Act is quite distinct to be an FQHC an entity must have a 330 grant or meet the tribal exception. The difference between a non-profit health program that isn't an FQHC look-alike and one that is FQHC look-a-like eligible is much more vague; however HRSA, working in cooperation with CMS, have developed very detailed requirements for FQHC status. In order to be deemed an FQHC look-a-like by the Centers for Medicaid and Medicare Services, a health provider must:

1.) be a public or a private nonprofit entity;
2.) serve, in whole or in part, a federally-designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP). (The list of MUAs and MUPs is available through the BPHC Web site: http://www.bphc.hrsa.dhhs.gov/databases/newmua/);
3.) meet the statutory, regulatory and program requirements for grantees supported under section 330[2]
of the PHS Act; and
4.) comply with the policy implementation documents specified in Section II of this PIN for the BBA of 1997 amendment which added the requirement that an FQHC Look-Alike entity may not be owned, controlled or operated by another entity.

Those programs that do not have FQHC, RHC or FQHC look-a-like status are:

Program Name	Area	Service Level
American Indian Health & Family Services	Bemidji	Full ambulatory
United Amerindian Center	Bemidji	Outreach/referral/Mental Health & AODA
Missoula Indian Center	Billings	Outreach/referral/Mental Health & AODA
Helena Indian Alliance & Leo Pocha Clinic	Billings	Limited Ambulatory
United American Indian Involvement	CA	Limited Ambulatory
Fresno Native American Health Center	CA	Outreach & referral
Friendship House Assoc of American Indians	CA	Limited ambulatory
American Indian Health Project Bakersfield	CA	Outreach & referral
American Indian Community House	Nashville	Outreach & referral
North American Indian Center of Boston	Nashville	Outreach & referral
Native American Lifelines Foundation	Nashville	Substance abuse & mental health
Native Americans for Community Action	Navajo	Limited Ambulatory
Indian Walk-in Center	Phoenix	Full Ambulatory
Nevada Urban Indian Center	Phoenix	Limited Ambulatory
Tuscon Indian Center	Tucson	Outreach & Referral

Most of these programs are unable to seek FQHC look-alike status because they do not reach the level of 'comprehensive primary care' services required by the regulation and statute either because of their status as an outreach and referral program, or because of limited ambulatory service due to lack of

[2] See appendix A for a complete list of these requirements.

funds. Some programs have been unable to navigate the joint HRSA-CMS application process. However, NCUIH believes that this is an issue of technical assistance that is otherwise easily overcome.

Federal Tort Claims Act Coverage for FQHC look-alike & RHC Urban Indian Health Programs:

In developing our ask for FTCA coverage for urban Indian health programs, we envisioned the protections largely applying to urban Indian health programs in a manner analogous to the Federally Qualified Health Clinic (FQHC) FTCA protections[3], which would mean that only those programs providing comprehensive primary care would be eligible for FTCA protections. NCUIH does have a great deal of experience with the FQHC requirements for FTCA coverage as 8 urban Indian health providers are FQHCs. Another 13 are FQHC look-a-likes and 2 are Rural Health Clinics (RHC). Under current law neither FQHC look-a-likes nor RHCs receive FTCA coverage, meaning the majority of urban Indian health programs providing comprehensive primary care services are currently ineligible for FTCA coverage despite meeting all other requirements for FQHC status except receiving a section 330 grant. Some urban Indian health providers have made a principled decision not to pursue 330 status as it would require serving non-Indians. Some urban Indian health providers have decided not to pursue 330 status as they do not have the support staff necessary to maintain the necessary accounting firewall between their Title V grant funds and funds received through a potential 330 grant. These programs have FQHC look-a-like status which confers upon them higher Medicaid/Medicare reimbursement, but does not include FTCA coverage.

Full FQHC programs receive FTCA coverage under the theory that as 330 grant or contract recipients they are contracting with the federal government to provide a service and thus deserve protection from liability for those services. NCUIH believes that those programs that meet the requirements for FQHC look-a-like status and receive a grant/contract under Title V of the Indian Health Care Improvement Act should be treated in an analogous manner as they, like a Community Health Clinic (CHC), are providing clinical health services as part of a grant/contract with the federal government. The 13 FQHC look-alikes and 2 RHCs already met all necessary requirements for FQHC status except for a 330 grant.

Sections 224 of the Public Health Service Act (42 USC s. 233) will need to be amended to allow urban Indian health programs to apply for FTCA coverage in a manner similar to a Community Health Clinic operating under a section 330 grant. In 1995 Congress extended FTCA coverage to CHCs operating under a 330 grant under the theory that these public or non-profit private entities were carrying out federal mandates and thus deserved and required the same protections as federal or state employees[4]. Similarly UIOs are carrying out federal contracts that fulfill the federal government's trust obligations to American Indians and Alaska Natives. The cost of medical malpractice insurance is prohibitive for many programs and greatly restricts their ability to expand their services. NCUIH proposes that FTCA coverage should be extend to those UIOs qualifying for FQHC look-alike or RHC status in a similar manner as

[3] 42 USC section 233, 224
[4] Federally Supported Health Centers Assistance Act of 1995

required of 330 funded health programs—meaning requiring an annual application for FTCA coverage to HRSA[5]. The federal government could then determine whether the services provided by the UIO qualified for FTCA coverage in the same manner that HRSA make determinations regarding FTCA coverage to 330 FQHCs.

Draft Language:

"Section 522: Federal Tort Claims Act coverage for Urban Indian Health Programs

(a) section 224 (42 USC 233) is amended—
    (1) in subsection (4) by striking "." in the first sentence and inserting the following: ", or an entity receiving Federal funds under Title V of the Indian Health Care Improvement Act which otherwise meets all the requirements of public or non-profit privet entity under section 254b of this title."

[5] 42 C.F.R. Part 6; HRSA PAL 99-15, and PINs 99-08 and 2001-11 (discussing the requirements for health center coverage eligibility under the FTCA); PIN 2008-01 (Scope of Project guidance); and PINs 2001-16 and 2002-22 (discussing FQHC credentialing and privileging requirements for health center FTCA coverage eligibility).

Appendix A

REQUIREMENTS FOR DESIGNATION AS A FQHC LOOK-ALIKE

It is important that the applicant fully address ALL requirements within the narrative component of the application. Submission of data tables without supportive narrative information may result in an application being returned to the applicant as an incomplete application. Health Center Program Expectations (PIN 98-23, dated August 17, 1998) contains a detailed description of the requirements for grantees under section 330 of the PHS Act and provides the basis for FQHC Look-Alike requirements. The FQHC Look-Alike entities are to be governed by these expectations to the same extent as federally supported health centers. This PIN, and others, are available through the BPHC Web site http://www.bphc.hrsa.gov/pinspals/.

Listed below are the required areas to be addressed in each of the four narrative sections and the information the applicant must provide to demonstrate compliance with the program requirements.

SECTION A. NEED AND COMMUNITY IMPACT

Each FQHC Look-Alike is expected to gain a thorough knowledge of the community and populations groups it intends to serve. In particular, the entity must assess and understand the needs, resources and priorities of the underserved populations residing in its community and design a health care program that is culturally and linguistically appropriate to those populations. Needs and resources should be monitored on an ongoing basis and comprehensively assessed on a periodic basis.

Requirements:

1. Applicants must demonstrate the need for primary health care services in the community(ies) that make up its service area based on geographic, demographic, and economic factors.
2. Applicants must justify the need for FQHC Look-Alike designation by documenting the lack of sufficient health care resources in the service area to meet the primary health care needs of the target population. If there are other FQHCs located in the applicant's proposed service area, the applicant should address the need for additional FQHC services, as well as any efforts to collaborate with existing FQHCs.
3. Applicants must demonstrate that the health center location will permit it to provide services to the greatest number of those in need in the service area.
4. Applicants must demonstrate that it is serving those most in need within the service area, including low income and special need individuals/groups, such as the uninsured, minorities, pregnant women, the elderly, and, where applicable, migrant or seasonal farmworkers, HIV-infected persons, the homeless, and substance abusers.
5. Applicants must serve, in whole or in part, a designated MUA or MUP.

In order to demonstrate that it meets the requirements of 1 - 5 above, the applicant should provide, at a minimum, the following information:

A. A narrative description of the Service Area, which includes:

- the geographic boundaries of the service area of the health center, e.g., the names of counties, localities and/or census tracts;
- a description of the major health problems and special health needs of the target population within the service area, and a description of any unique health status indicators or barriers to their accessing health care;
- identification of the unserved and underserved populations in the community;

- the geographic area and/or population groups that constitute its principal target population, including any unique populations (for example migrant/seasonal farmworkers);
- the characteristics of the target population in terms of age, gender, socioeconomic status, health insurance status, ethnicity/culture, education, language, health status, unemployment, poverty level, etc.;
- other providers of health and social services accessible to the population; and
- gaps in services and health disparities the health center proposes to address.

B. A narrative description of the user population, which includes:

- total number of users and total number of encounters for the most recent 12-month period available (state the period covered by the data);
- economic, demographic and other characteristics identified in Section A above, as they apply to the user population, and;
- the major health needs of the user population, including any special health care needs among population segments (migrant/seasonal agricultural workers, public housing residents, homeless persons, low-income school children, etc.).

C. A map of the service area that clearly shows the location of the applicant's service area; the applicant's service delivery site(s); the designated MUA/MUP(s) served; and the other providers (including other FQHCs) in the area available to the target population.

Tables 1-5 are required formats for providing demographic information on the service area and user populations. Information provided in the Tables should also be described in the narrative. As previously noted, organizations that provide services through more than one service delivery site must submit the information from sections A and B above, including all tables, for each site included in the application. Please identify other FQHCs in the proposed service area and the need for additional FQHC services, as well as any efforts to collaborate with existing FQHCs.

SECTION B. HEALTH SERVICES

The FQHC Look-Alikes must have a system of care that contributes to the availability, accessibility, quality, comprehensiveness and coordination of health services in the service area. They must ensure that basic primary health care and support services appropriate to the health needs of the target population are available and accessible to all persons in the service area, regardless of ability to pay. They must also have a sufficient number and range of qualified providers and a clinical management system that ensures quality and continuity. Program accountability must be maintained by the applicant.

Applicant organizations are expected to collaborate appropriately with other health and social service providers in their area. Such collaboration is critical to ensuring the effective use of limited resources and for achieving the mission of assuring access to primary and preventive health care for the underserved and vulnerable populations. While health centers are encouraged to collaborate with other entities, they must ensure that all laws, regulations and expectations regarding the health center governing board member selection process, composition, functions and responsibilities are protected. Accountability must be maintained by the health center and its governing board. The BPHC PINs 97-27, 98-24, 99-09 and 99-10 provide policy clarification regarding limits on FQHC Look-Alike affiliation relationships. Information regarding any proposed affiliation arrangements will be used to assure that organizations comply with the requirements and guidelines set forth in the above BPHC PINs, including the center directly employs the Chief Financial Officer, Chief Medical Officer and the core staff of full-time primary care providers, the center directly employe es all non-provider health center staff, and the arrangements presented in affiliation agreements do no compromise the Governing Board authorities or limit its legislative and regulatory mandated functions and responsibilities.

Requirements:

1. Required Primary Health Services: The applicant must demonstrate that it provides the following services, either directly, through contract, or through documented cooperative arrangements (see Table 1) and access must be assured for all patients regardless of ability to pay:

A. Primary health care services by physicians, and, where appropriate, mid-level practitioners

- family medicine
- internal medicine
- pediatrics
- obstetrics
- gynecology

B. Diagnostic laboratory services
C. Diagnostic radiologic services
D. Preventive health services

- prenatal and perinatal services
- screening for breast and cervical cancer
- well-child services
- immunizations against vaccine-preventable diseases
- screenings for elevated blood lead levels, communicable diseases, and cholesterol - pediatric eye, ear and dental screenings to determine the need for vision and hearing correction and dental care
- voluntary family planning services
- preventive dental services

E. Emergency medical services
F. Pharmaceutical services as may be appropriate for the health center
G. Referrals to providers of medical services and other health related services

- substance abuse services
- mental health services
- oral health services

H. Patient case management including a system for tracking and follow-up
I. Enabling services

- outreach
- transportation
- language interpretation if a substantial number of patients are of limited English proficiency

1. Education regarding the availability and proper use of health services Additional services may be critical to improve the health status of a specific community or population group. Services beyond the required health center services should be provided based on the needs and priorities of the community, the availability of other
resources to meet those needs, and the resources of the organization.

2. The applicant must demonstrate that all contracted services (including management agreements, administrative services contracts, etc.) remain under the governance, administration, clinical management and quality assurance of the applicant organization.

3. The applicant must assure all required services are available to all persons in the service area or target population. Services may not be limited by race, group affiliation, age, gender, or the patient's ability to pay. This requirement may be achieved directly by the applicant or through established arrangements that meets the collaboration and/or contracting arrangements described on page 15.

4. The applicant must demonstrate that the organization maintains, either directly or through contractual arrangements, a core staff of full- time primary care providers appropriate for the population served (i.e., family practice, pediatricians, internists, etc., physicians and midlevel practitioners). (See Table 3 for required format). A core staff of several part-time employees does not meet this requirement. Applicants that do not directly employ a core staff of primary care providers are subject to the requirements in PIN 98-24 regarding contracting for core staff.

5. All of the primary care providers working at the health center must be licensed to practice in the State where the center is located.

6. The applicant's physicians should obtain admitting privileges at their referral hospital(s) so health center patients can be followed as inpatients by health center clinicians in order to ensure continuity of care. When this is not possible, the applicant must have firmly established arrangements for patient hospitalization, discharge planning and patient tracking.

7. The applicant must provide assurance that services are available to all persons within the service area, regardless of their ability to pay.

8. The applicant must demonstrate use of a charge schedule with a corresponding discount schedule based on income for persons between 100 percent and 200 percent of the Federal poverty level (see Appendix A for a sample schedule of discounts). Patients below 100 percent of the Federal poverty level should not be charged more than a nominal fee.

9. The applicant's health center should be open at least 32 hours per week, with services provided at times that meet the needs of the majority of potential users (including evenings and/or weekends as appropriate).

10. The applicant must provide professional coverage during hours when the health center is closed. Applicant must demonstrate firm arrangements for after- hours coverage by their own providers and/or, if necessary, by other community providers. The arrangements must ensure telephone access to a health care provider who is part of the health center's after-hours system;

11. The applicant must have an ongoing quality assurance program that identifies problems and allows for necessary actions to remedy problems. In order to demonstrate that it meets the requirements of 1-11 above, the applicant should provide, at a minimum, the following information:

A. A check list showing which of the required services are provided directly, by contract, or by a documented cooperative arrangement (see Table 1), and a discussion in the narrative of how each of these services is provided. For services provided through contracting arrangements, the applicant must demonstrate that the services remain under the governance, administration and clinical management of the applicant organization. All contracts should state the time period during which the agreement is in effect, the specific services it covers, any special conditions under which the services are to be provided, and the terms for billing and payment. Copies of all contract documents must be submitted with the application. Health centers may be eligible for FQHC reimbursement of the cost of contracted services; however, they are not eligible to receive FQHC reimbursement for referred services not paid for by the health center.

B. A description of its clinical staff, including:

- Who provides clinical leadership, their training and skills, and the reporting relationship between that individual and the Chief Executive Officer (CEO).
- Authorities and responsibilities of the clinical director are expected to include: 1) leadership and management for all health center clinicians whether employees or contractors; and 2) ability to function as an integral part of the management team.
- The current physician and mid-level staffing (i.e., the number, FTEs and discipline of providers, licensure, board certification/eligibility status or completed residency training program), hospital admitting privileges, whether directly employed or provided under contract, and the reporting relationship of contract providers to the clinical director and/or CEO. (See Table 3 for the format. Describe all aspects in the narrative section.)
- The availability of specialty medical and diagno stic services through a system of contractual or organized referral arrangements. These services must be available to all regardless of ability to pay.

C. Written clinical policies and procedures, which address, at a minimum:

- Days and hours per week of operation which assure accessibility for the population being served. Applicant should provide a schedule of the days and hours each site is open each week, and the schedule of days and hours that providers are available to see patients.
- After-hours coverage arrangements which assure a continuum of care for center users, i.e., patients must have direct access to a provider.
- Assurance of the availability of services to all persons in the service area or target population, regardless of their ability to pay, and the organization's sliding fee schedule.
- The use of clinical protocols.
- Procedures for assessing patient satisfaction.

D. A description of the case management system that demonstrates care coordination at all levels of health care, including arrangements for referrals, hospital admissions, discharge planning and patient tracking. The system must ensure a continuum of care.

E. A description of the ongoing quality assurance program, including patient satisfaction and patient grievance procedures. The applicant should discuss how it integrates and applies the components of the quality assurance system into its planning and management, as well as into the evaluation of its overall program effectivene ss, i.e., utilization and peer review.

F. A description of the arrangements or plan to provide services for individuals with limited English-speaking ability with respect to bridging language and cultural differences. The applicant should discuss assurances that care is provided in a culturally, linguistically and appropriate manner.

SECTION C. MANAGEMENT AND FINANCE

To meet the challenge of efficient and effective operation, FQHC Look-Alikes must have a strong management team. Center management must work with the governing board and operationalize the health center's mission and strategic objectives. They must operate within available resources, respond to opportunities, and plan for future events. Management involves a team process, and must be supported by strong personnel, financial, information and clinical systems. Health centers are encouraged to affiliate with other entities to strengthen their ability to achieve their mission of assuring access to primary and preventive health care for the underserved and vulnerable populations. The BPHC recognizes that there are certain situations in which there are exceptions to the BPHC's preference that health centers directly employ personnel in certain positions (CFO, CMO, clinicians) may be necessary and appropriate in order to maximize access to comprehensive, efficient, cost-effective, and quality health care.

PIN 98-24 clarifies PIN 97-27 with respect to affiliation arrangements that involve a community and migrant health center contracting fo r the services of a Chief Financial Officer, Chief Medical Officer and/or the majority of its primary care clinicians The requirement that the health center directly employ the Executive Director remains in effect.

Requirements:

1. Management Structure:

The applicant must demonstrate a line of authority from the Governing Board to a chief executive (President, CEO or Executive Director) who delegates, as appropriate, to other management and professional staff. The CEO must be directly emp loyed by the health center. NOTE: It is preferable, but not required, that all other key management staff be directly employed by the health center (see PIN 98-24).

The other key management staff should include: a) a Fina nce Director (Chief Financial Officer (CFO), Fiscal Officer) who is responsible for financial affairs and reports to the CEO, and b) a Clinical and/or Medical Director who is responsible for clinical services and programs and who participates actively in management activities and decisionmaking. In some situations (i.e., small centers) the CEO may also serve as the Finance Director or Medical Director; in other situations (i.e., integrated service delivery networks), the Finance Director or Medical Director may operate at the network level.

2. Management Information Systems:

The applicant must have systems which accurately collect and organize data for reporting and which support management decision- making. The applicant must be able to integrate clinical, utilization and financial information to reflect the operations and status of the organization as a whole.

3. Financial Systems:

The applicant must have accounting and internal control systems separate and specific to the proposed FQHC Look-Alike entity, and appropriate to the size and complexity of the organization. An accounting system reflecting Generally Accepted Accounting Principles which accurately reflects financial performance must be in place. Separation of function appropriate to organizational size should be implemented to safeguard assets. Appropriate
and regular financial reports to reflect the current financial status of the organization are necessary to good management.

While FQHC Look-Alikes are expected to ensure access to their services without regard for a person's ability to pay, they are also expected to maximize revenue from third party payers and from patients to the extent they are able to pay. To meet these expectations, each FQHC Look-Alike must have in place written billing, credit and collection policies and procedures, which include:

- a system for billing patients and third parties within 45 days of a service being rendered;
- a procedure for aging accounts receivable;
- a procedure for producing appropriate aging reports;
- a procedure for following up on overdue accounts to ensure collection;
- a procedure for handling bad debts on a regular basis; and
- a procedure for internal controls.

4. The applicant must demonstrate that it is responsible for ensuring that an annual independent financial audit is performed in accordance with Federal audit requirements. Audits for nonprofit organizations must follow Office of Management and Budget (OMB) Circular A-133 "Audits of Institutions of Higher Education

and Other Nonprofit
Institutions." Audits of public entities and those nonprofit organizations under mandate OMB No. by the State (i.e., those also receiving a threshold level of state financial assistance) must comply with the Single Aud it Act of 1984 and, therefore, are subject to the audit requirements of OMB Circular A-128, "Audits of State and Local Governments." The audit report must provide an opinion on the scope of the audit, the fairness of the applicant's financial statements, and an evaluation of the applicant's system of internal accounting controls. The auditor shall determine whether the applicant is operating in accordance with generally accepted accounting principles. The applicant should receive an unbiased opinion to that effect. Any problems cited in the audit or report on internal controls must be explained, and adequate procedures must be in place to correct those problems.

5. As a test of fiscal soundness, the applicant must demonstrate that revenues for the proposed FQHC Look-Alike equal at least 90 percent of expenditures. Revenues and expenditures are to be reported in the application and substantiated by an independent financial audit.

6. The applicant must be, or has applied to be, a Medicaid provider.

7. The applicant must be, or has applied to be, a Medicare provider.

In order to demonstrate that it meets the requirements of 1-7 above, the applicant must provide, at a minimum, the following information:

A. An organizational chart showing the organizational and management structure and lines of authority, key employee position titles and names, and the actual FTEs devoted to the health center operation. The Board and individuals with the following responsibilities should be clearly identified: CEO, Clinical Director, and CFO/Financial Manager.
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B. A description of data systems in place to accurately collect and organize data for required reporting of program related statistics, as well as for internal monitoring, quality improvement and the support of manageme nt decisions and planning.

Applicant should be able to integrate clinical, administrative, and financial information to allow adequate monitoring of the operations and status of the organization as a whole.

C. A description of financial systems, including accounting and internal controls in place that ensures the fiscal integrity of financial transactions and reports. Specifically, this should include a description of:

1. the accounting and internal control systems appropriate to the size and complexity of the organization;

2. the billing, credit and collection policies and procedures (i.e., patient and third party billing, aging accounts and producing reports, following up on overdue accounts and the handling of bad debts), including current fee schedules for all billable services, which should be updated annually, covering all reimbursable costs and comparable in the aggregate to prevailing fee schedules in the area;

3. the financial checks and balances for accounts receivable; and provisions for ensuring that an annual independent audit is performed.

D. A complete copy of the applicant's most recent annual audit, including the auditor’s opinion statement (cover letter.)

The application should list the applicant's Medicaid and Medicare provider numbers. Applicants that do not have a Medicaid and/or Medicare provider number at the time of application should demonstrate that applications have been submitted.

SECTION D. GOVERNANCE

An FQHC Look-Alike must be governed by a Board of Directors which is representative of the community and users being served and which has full authority and responsibility as required by the section 330 of the Public Health Service Act governing regulations and program policies. The governing board is legally responsible for ensuring that the FQHC Look-Alike is operated in accordance with applicable Federal, State and local laws and regulations. It carries out its legal and fiduciary responsibility by providing policy level leadership and by monitoring and evaluating all elements of the FQHC Look-Alike's performance.

The governance requirements under section 330 are unique among health service programs and are the basis for ensuring that each FQHC Look-Alike is responsive to the needs of the community. The requirements presented below are essential for assuring a responsive board with the necessary authority and responsibility over the FQHC Look-Alike's operations. The requirements are expected to be addressed in the applicant's bylaws.

Requirements:

1. Applicant must demonstrate that it is either a private non-profit organization or a public entity.

2. Applicant must demonstrate that it has a governing Board that:

a. Is comprised of at least 9 but no more than 25 members.

b. At least 51 percent of the governing board's members must be active users of the FQHC Look-Alike's services and must reasonably represent the individuals served by the health center in terms of such factors as race, ethnicity, and gender. These factors are not, however, meant to impose quotas. As a general rule, user board members should live and/or work in the service area.

c. No more than one-half of the non- user members may be health professionals, which is defined as deriving more than 10 percent of the ir income from the health care industry. An individual's leadership role in the community and functional expertise should be major criteria in selecting non-user members. As a general rule, non-user board members should live and/or work in the service area.

3. a. For private, non-profit organizations, the governing board must meet at least once a month, and be vested with full authority and responsibility for health center operations. At a minimum, the board must have the authority to:

1. select the services to be provided by the center;
2. schedule the hours during which such services will be provided,
3. approve the center's budget and major resource decisions,
4. establish general policies for the center, and
5. select, dismiss and evaluate the performance of the Executive Director/CEO for the center.

b. For public entities, the governing board must meet at least once a month and have the following authorities:

1. select the services to be provided by the center;
2. approve the center's budget;
3. approve the selection and dismissal of the CEO/ Executive Director;
4. adopt health care policies;
5. assure center is operated in compliance with applicable laws and regulations, and
6. evaluate center activities. A public entity may achieve compliance in two ways.

First, the public entity Board may itself meet all the requirements of section 330 of the Public Health Service Act. In the second form of public center, there is a public entity applicant with a co-applicant entity which, when combined, meet all the requirements of section 330 of the Public Health Service Act. In co-applicant arrangements, the public entity receives the FQHC Look-Alike designation and the co-applicant entity serves as the "health center board," with the two collectively referred to as the "health center." Where responsibilities are split between the co-applicant board and the public entity, the public agency and the board MUST execute an agreement which defines each party's role, responsibilities and authorities. For example, the public entity may retain authority to establish general fiscal and personnel policies for the center. (See PIN 99-09 for specific requirements).

4. The applicant's by-laws must demonstrate compliance with the requirements of section 330 of the Public Health Service Act and include provisions that prohibit conflict of interest or the appearance of conflict of interest by board members, employees, consultants and those who provide services or furnish goods to the applicant. No board member may be an employee of the center or be an immediate family member of an employee. In order to demonstrate that it meets the requirements of 1 – 4 above, the applicant should provide, at a minimum, the following information:

A. For a private, non-profit organization, evidence of non-profit status (e.g., a letter from the State or the Federal government, or a copy of the Articles of Incorporation filed with the State, designating the organization as having such, or evidence that an application for non-profit status has been submitted).

B. For a private, non-profit organization, evidence of current or pending tax exempt status (Internal Revenue Service (IRS) Tax Exempt Certification for the Applicant or acknowledgement of request to the IRS for exemption). For a public entity applicant, evidence of the Co-Applicant Board's current or pending tax exempt status (IRS Tax Exempt Certification or acknowledgement of request from IRS) if independently incorporated.

C. A list of board members, including user status, occupation, area of professional expertise, and residence and/or employment within the service area (see Table 5). Board officers should be indicated on this list as well. Applicants with a formal affiliation relationship with another entity must demonstrate compliance with PIN 97-27 regarding the board selection process (no other entity or entities may select a majority of the health center board members or select a majority of the non-user members), composition, authorities, and committee structure. These issues should be addressed in the narrative if not fully covered in the attached corporate documents or affiliation agreements.

D. A description of the governing board's authorities and responsibilities. There must be documentation (i.e., in the bylaws) that the governing board has the authority to, at a minimum, 1) select the services to be provided; 2) schedule the hours during which services will be provided; 3) approve the center's annual budget and major resource decisions; 4) adopt administrative, health care, financial and personnel policies; and 5) select, dismiss and annually evaluate the performance of the CEO for the FQHC Look-Alike. The governing board's authorities, meeting schedule, composition and selection process must also be specified in the organization's by-laws.

E. For public entities with a co-applicant board, a copy of the written agreement between the public agency and the co-applicant board, identifying the authorities, duties and responsibilities of each entity must be submitted.

F. A description of procedures for avoidance of Conflict of Interest. This description must be included in the organization's by- laws.

G. Indicate whether the entity is currently a hospital outpatient department or part of a hospital outpatient department, and whether it is currently certified by Medicare or Medicaid as part of a hospital.

ATTACHMENT B

REQUIREMENTS FOR ANNUAL RECERTIFICATION FOR FQHC LOOK-ALIKE DESIGNATED ORGANIZATIONS

To fulfill the requirements for recertification, all designated FQHC's must submit updated information, by site if applicable, which reflects the previous 12 months and includes information on the following:

1. Completed Form 1-B – notarized
2. A brief description of and any changes in:

- the number of users and encounters;
- characteristics of the user population;
- demographic characteristics of the service area and user population;
- economic characteristics of the service area and user population;
- insurance status of the user population;
- description of services provided;
- description of professional staff;
- description of board members;
- the number and location of all service delivery sites; and
- completed Health Center Affiliation Checklist signed and dated by the Board Chair with copies of most recent corporate Articles of Incorporation, bylaws and affiliation agreements if not currently on file.

3. Completed Forms 2 - 5
4. Updated Tables 1-5 (for each site if applicable).
5. A copy of their most recent audit which includes a statement of revenues and expenditures for the audit period and auditor's letter.
6. Copies of Change in Scope requests approved during the previous 12 months, under which the health center added a site(s), decreased existing sites and/or reduced approved services.