Laura: HRSA, and the FOA will be for, we'll just call it a new access point. FQHC regulations are in section 330 of the Public Health Service Act. Health centers are community based and patient directed organizations that deliver comprehensive, culturally competent, high quality primary healthcare services. Health centers also often integrate access to pharmacy, mental health, substance abuse, and oral health services in areas where economic, geographic, or cultural barriers limit access to affordable healthcare services. Health centers deliver care to the nation's most vulnerable individuals and families including people experiencing homelessness, agricultural workers, residents of public housing, and the nation's veterans.

There are four types of community health centers, each with some unique requirements, though all must follow the 19 general requirements. We will go over all the 19 requirements in this webinar and these requirements really are the backbone of the community health centers. I do want to note that an exception may be applied for through a waiver application on the board composition for healthcare for the homeless and migrant health program.

Why would an organization consider this? Why do they think about becoming an FQHC? On this slide you'll see the benefits for becoming an FQHC. You'd receive 330 grant funding of up to $650,000, you get enhanced Medicare and Medicaid reimbursement, you'd receive medical malpractice coverage through the Federal Tort Claims Act, you get reduced cost prescriptions through the 340(b) Federal Drug Pricing Program, you get access to the National Health Service Corps, you get access to the Vaccine for Children program, and you are eligible for various other federal grants and programs. For example, there have been opportunities for FQHCs to receive quality awards, there have been oral health grants and grants for outreach and enrollment.

Throughout this webinar we are going to look at one organization's road to achieving the health center designation. The organization is called APICHA Community Health Center. APICHA took 20 years to gain designation, which is unusually long. New York's Asian and Pacific Islander Coalition on HIV and AIDS, otherwise known as APICHA, went from a community-based behavioral prevention organization in the 1990s to a federally qualified health center lookalike in 2012, to FQHC status in 2015.

I'd like to make a quick note that a lookalike application process is different than applying for new access point funding and the benefits are also a little different between an FQHC and an FQHC lookalike. More information on the lookalike application process and benefits is available on the HRSA website.

In 2003 APICHA became the first community based organization receiving [inaudible 00:03:33] title pre-funding to create the freestanding primary healthcare clinic for people living with HIV and AIDS. In 2009 APICHA opened it's general primary care clinic. Obtaining FQHC status was a massive project that entailed a large investment in

APICHA's infrastructure, an expansion of staffing, and the development of new capacities and expertise by staff.

Additionally, in 2010 the Affordable Care Act and the National HIV/AIDS Strategy were introduced. APICHA looked for opportunities with the new law and strategy and in response they advocated for people living with HIV and AIDS at all levels of government. They also advocated for recognition of the LGBT as an underserved status. APICHA also opened a trans health clinic in 2011 which serves primarily transgender and gender-nonconforming, gender variant, genderqueer individuals of color regardless of ethnicity or HIV status.

In 2012 APICHA was serving a geographically defined target population as an FQHC. They changed their name and opened their doors to low income residents while maintaining care for their legacy population.

The chart on this slide shows APICHA's client numbers from 2005 to 2013. During this time APICHA's client base increased from around 100 to more than 1,000 individuals. While Asian and Pacific Islanders and HIV positive clients were no longer the majority, they increased from 43 Asian and Pacific Islander patients in 2005 to 357 in 2013. They increased from 76 HIV positive patients in 2005 to 440 in 2013. The original legacy population of HIV positive Asian and Pacific Islanders reflects a similar pattern. While HIV positive Asian and Pacific Islanders decreased from 55 to 16% of APICHA's total patients between 2005 and 2013, the absolute number increased from 42 in 2005 to 158 in 2013 which represents a 376% [inaudible 00:06:14].

In APICHA's journey to becoming a community health center they learned that there is a role to play for HIV prevention organizations and they can continue their mission while moving to a model that embraces comprehensive care. They also learned that the Affordable Care Act offered opportunities to leverage their experience serving Asian and Pacific Islander patients living with HIV, to serve other populations at risk for HIV infection in their area, including LGBT individuals and racial and ethnic minority populations. Through this work they have been able to expand on and fulfill their original mission.

Let's take a look at what is required for APICHA and others to achieve the designation. We noted several of the benefits to the FQHC designation earlier and saw why it was a good move for APICHA. However, there are many strict requirements for FQHCs so it may not be a good fit for all organizations. Organizations should not apply to become an FQHC if it's like trying to hammer a square peg into a round hole. In the slides that follow we will go over, in detail, the requirements for FQHC.

The first set of requirements are to demonstrate that there is a need in your community for an FQHC specific to your target population. Health centers are located in areas where economic, geographic, or cultural barriers limit access to affordable healthcare services. That limited access must be documented as the need.

An application for a grant for a health center must include a description of the need for health services in the service area of the center, a demonstration by the applicant that the area or the population group to be served by the applicant has a shortage of primary care providers, and a demonstration that the center will be located so that it will provide services to the greatest number of individuals residing in the service area or included in such population group.

The center needs to periodically review the area it serves to ensure that the size of the area is such that the services being provided through the center, including any [inaudible 00:08:48], are available and acceptable to the residents of the area promptly and as appropriate, and ensure that the boundaries of the area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics and available transportation.

Another requirement is that FQHCs provide specific services which we will further define in the next slide. FQHCs are required to deliver high quality, culturally competent, comprehensive primary care as well as supportive services such as health education, translation, and transportation that promote access to care.

FQHCs must provide required primary care services, meaning basic health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians or physician assistants, nurse practitioners, and nurse midwives, as well as laboratory and emergency services. They must also provide a range of preventive services including prenatal and perinatal, appropriate cancer screening and other screening, well child visits and pediatric screenings, immunizations, family planning, and preventive dental services.

Additional services include case management, behavioral and mental health, transportation, education, outreach, and environmental health. Health centers requesting funding to serve homeless individuals and their families must also provide substance abuse services among their required services.

Staff must be appropriately licensed, credentialed, and privileged. Credentialing is a broad term that can refer to a practitioner's license, certification, or education. Government agencies grant and monitor licenses and each state has unique requirements for granting a license. Those vary considerably. Privileging is accomplished through each facility and is the process by which the provider's scope of services at the facility is defined. The granting of privileges is based on the provider's training and experience, practice history, and the ability of the facility to provide the support and services for which he or she is privileged.

In healthcare facilities with an organized medical and dental staff, a committee of healthcare providers and peers recommend the privileges to be granted based on the qualifications of the applicant. The final authority for granting privileges generally rests with the governing body or the board of directors.

Community health centers must provide services at times and locations that meet the needs of the population they serve. Health centers must also provide professional coverage for medical emergencies after hours when the center is closed.

In case of hospital arrangements, including admitting privileges and membership are not possible, health centers must firmly establish arrangements for hospitalization, discharge planning, and patient tracking.

The system must provide a full discount to individuals and families with annual income at or below 100% of the federal poverty guidelines when only nominal fees may be charged. For those with incomes between 100 and 200% of poverty these must be charged in accordance with the sliding discount policy based on family size and income.

All health centers must have systems in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. No discounts may be provided to patients with incomes over 200% of the federal poverty guideline.

Health centers must also have an ongoing quality improvement and quality assurance program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include a clinical director whose focus of responsibility is to support the quality improvement and quality assurance program and the provision of high quality patient care.

How did APICHA ensure they've met these first eight requirements? APICHA expanded its service area to include the low income community in its service area. That was defined as Chinatown and the lower east side of New York City, as well as the organization's core population through New York City including people living with HIV and AIDS. As we noted there were at times conflicts as some staff and clients worried that the organization was abandoning its original commitment.

Also, in 2013 APICHA received a grant from the New York State Department of Health to enable the organization to scale up its operations in order to meet the FQHC requirements. Additionally, an area where it was a struggle for APICHA, they advocated for changes that would enable their organization to pursue the FQHC status.

Stacey: All right, well let's take a break from learning about the core requirements to take a quick poll. Up on your screen you'll see the question. If you can select which requirement listed below is not a requirement to become an FQHC. On the right side you have your choices, A, B, C, or D. I'll give you a moment to fill that in.

A is that they must provide all required primary, preventive, and enabling healthcare services. B is that they must have core staff on site because patient referrals through established arrangements are not allowed. C is that they must provide services at

locations and during times that met the needs of the population being served. D, they must not deny services because patients are unable to pay.

All right, we'll give you a few more seconds to select your answer on the right side. Okay, looks like we've had about half of you complete the poll. We're going to close it at this time and wait for the responses to come up. Okay, it's going to take a few seconds as the answers come up for us here. Okay, let's see. It looks like ... The correct answer was B. It is not a requirement of FQHCs to have core staff on site because it is allowable for health centers to have an established arrangement where they're able to refer clients or patients for certain services.

B was the correct answer for this and it looks like we did have a couple answer A and B. Health centers are required to provide all primary and preventive and enabling healthcare services, and that's the requirement of their 330 funding. Then also they are not allowed to deny an services because of a patient's inability to pay.

All right, so let's continue on with the remaining health center requirements. Health centers must maintain a fully staffed management team as appropriate for the size and needs of the center. They must also exercise appropriate oversight and authority over all contracted services. In addition, health centers must make efforts to establish and maintain collaborative relationships with other health providers, including other health centers in the service area of the center. Lastly, health centers must maintain accounting and internal control systems appropriate to the size and the complexity of the organization.

A health center must remain fully staffed with a management team that reflects the size and need of the health center. Prior approval by HRSA of a change either in the project director, executive director, or CEO position is required.

With approval from HRSA, health centers may carry out some activities by setting up contracts or sub-awards with other providers to deliver services. The health center will include a schedule of rates and a method of payments for such services. The health center is responsible for overseeing these sub-recipients to ensure that they meet the terms and conditions, and the specifications of their contract, and to ensure that their subcontractors are complying with all federal requirements as well.

The health center must maintain collaborative relationships with other providers in the service area, and this includes other health centers that are serving patients in the same service area that they are proposing. Usually this is demonstrated by getting letters of support from the existing health centers in the service area when the applicant applies for a new access point.

The health center must maintain accounting and internal control systems reflecting Generally Accepted Accounting Principals and separate functions appropriate to the organizational side to safeguard its assets to maintain its financial stability.

The next requirements on billing and collections, health centers must have systems in place to maximize collections and reimbursements for cost in providing health services. This includes billing and the collections from payers such as health plans and self pay from patients based on sliding scale.

The health center must develop a budget that reflects the cost of its operations, the patterns and use of its services, and the availability, accessibility, and expect-ability of its services. The health center must submit this budget annually by a date specified by HRSA for approval through the federal award or designation process.

15, health center program requirements requires health centers to have program data reporting systems in place. These systems must accurately collect and organize data for program reporting to help the management in the organizational decision making. Annually health centers are required to report on their patients the number of visits and the staff at their health centers, as well as certain outcomes on clinical measures.

The health center must maintain the scope of services that were included in their original application, or approved for funding. If there are any changes to the services that they're providing or the locations at which they're providing those at they have to submit the change in scope.

How did APICHA do it? Remember, it took 10 years for APICHA to build their infrastructure to become an FQHC and they received funding to help them. Specific to building they hired a consultant to help them learn how to do it and during the period when they were an FQHC lookalike they learned how to carry out many of these requirements.

Let's stop again and take a quick poll. The question is: which of these is not correct? An FQHC must A, obtain independent financial audits on a regular basis, B, maintain an accurate data reporting system, C, have billing and collecting systems in place, and D, maintain a collaborative relationship with the local Medicaid department. All right, and we'll give you a minute to select your responses.

Give you a couple more seconds to answer the question here. Okay, we see the results up on the screen. The answer is D, the FQHCs are not required to maintain a collaborative relationship with their local Medicaid department, although it's preferable that they have a good relationship, really the requirement is just that they're billing for Medicaid. They are required to have an independent financial audit performed, so that is a requirement of an FQHC.

All right, let's move onto another health center requirements around governance. Governance refers to the structures and processes that are used to steer an organization. For FQHCs specifically, governance relates to the organization's board of directors.

The health center must have a board that develops plans for the long range viability of the organization by engaging in strategic plannings, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction and monitoring organizational assets and performance.

On this slide you'll see the requirement responsibilities. It's to meet monthly to approve grant applications in their budget, to select and dismiss and perform an evaluation of the CEO, to select the services that they're providing and the hours that they're providing those services, to measure and evaluate the progress of meeting their long term program and financial goals, and to establish the general policies of the health center.

The hallmark of the health center program is its consumer directed board. A majority of members of the board, or at least 51%, must be individuals who are served by the health center. Patient board members must be a current registered patient of the health center and must have accessed the health center in the past 24 months to receive at least one or more services that are in scope with their grant to generate a visit at the health center.

As a group the patient members of the board must represent the individuals who are served by the health center, so this is in terms of race, ethnicity, and sex. Non-consumer members of the board should have expertise in one of the following areas: community affairs, local government, finance and banking, legal affairs, trade unions, or other commercial and industrial concerns, or social service agencies within the community. The board has to have at least nine, but no more than 25 members, as appropriate for the complexity of the organization.

Conflict of interest is prohibited by health center requirements and health centers must have a policy in place and written in their bylaws that prohibit conflicts of interest. No board member shall be an employee of the health center or an immediate family member, and the CEO of the health center can only serve as a non-voting member of the board.

How did APICHA do it? APICHA was able to meet all of the governance requirements, although it was a 10 year process. In an interview with APICHA staff they said that there were some key expertise they had to consider in their board membership including an administrator in another health related field. Also the medical director is key. In the beginning he or she can volunteer their time as a board member or in another way.

To recap there are many benefits to achieving the FQHC designation, including the grant funding and the enhanced reimbursement. However, there are 19 sometimes quite complex requirements that must be in place to become an FQHC. As you've heard the process to ensure that all these requirements are in place can take a long time. We've briefly described each of them but there's a lot more information about all these requirements available online on HRSA's website. The next step is to think about, "What does this mean for your organization?"

On the screen you'll see some of the questions to help you consider what are your next steps and for your organization to think about. For example, is becoming an FQHC aligned with your mission? What steps do you need to take to meet these 19 health center requirements? What requirements do you already have in place and what would you need to do to maintain the remaining ones? What do you need to do to successfully apply? Be aware that once you're awarded you'll have 120 days to make sure that you have implemented and met all aspects of the 19 health center requirements.

Thank you for joining us today. That's the end of our presentation but we are going to open it up for questions and you can ask the questions to the chat. What we're asking is that if you also want to add your email if there's any questions that we're not able to get to we're more than happy to follow up with you directly to answer your questions. Right now if you have any questions about the presentation or any additional information on becoming a health center please enter that into the chat now.

Laura: Okay, so we received our first question and I'm going to put the question to Stacey. The question is: do organizations usually receive the full amount, which in the earlier slide you saw was $650,000, when they apply?

Stacey: Yes, organizations can receive up to that $650,000 amount annually for the grant award. They'll need to have that included in their budget that that's what they're asking for. There have been times when grantees ask for less than that because their budget doesn't need that much, but they can receive up to that amount and for the most part most do.

Laura: Great, thank you. We have another question that just came in and the question is: how competitive is the application process?

Stacey: This is a great question. It is a competitive process but most of that is built upon the appropriation. Because the New Access Point, or NAP applications, when that federal opportunity announcement, as Laura had explained that the FOA has released it comes with a certain amount. That means that's the amount of money that congress has budgeted for new access points. Depending on that size of the dollar amount that's appropriated then equals how many health centers that HRSA thinks they can grant new access point status to. In years where there's a smaller amount of appropriations it can be more competitive, or if there's a larger amount it may be a little less competitive. Overall these are very typically competitive processes because applicants are applying

from all over the country in states and territories in the United States. Not only are clinics who are not 330 funded sites applying, but also health centers that already have 330 status can also apply for a new service site. They're also in that same application pool leading to more competition.

Laura: Great. Thank you, Stacey. We have another question and that is: is the FQHC lookalike subject to the same 19 requirements as FQHCs?

Stacey: That's another great question. Yes, the lookalikes are subject to all of the 19 health center requirements but it's very different from the new application point process. Lookalikes must be compliant with the 19 health center requirements before the receive lookalike status. To become a lookalike is a very different process and I do recommend that you look at the HRSA website and the lookalike portion of their web page on that, because it provides more detail on it. It's a longer process to become a lookalike and that's because lookalikes need to be compliant with the 19 health center requirements before they get the status, and they need to prove to HRSA that they are compliant with those beforehand, whereas the new access points, it's different. You apply for the funding for the new access points through that federal opportunity ... Through the FOA.

Then you have 120 days to become compliant. They're very different in terms of when it's expected that the site be compliant with the 19 requirements, but in both circumstances, lookalike or a funded 330 site for the new application process, all health centers must be compliant with the 19 requirements.

Laura: Great, thank you. Another question that came in ... How long does it typically take to become an FQHC? We mentioned 20 years would be a long time and that's what APICHA experienced. How long does it typically take?

Stacey: I don't know if I have a typical amount of time. I think it varies by where the clinic or the center is at the time that they apply. We have seen some clinics that weren't a health center yet who have a majority of the health center requirements in place or nearly in place and so the process to apply and then meet the 100 day requirement was a little easier for them, they didn't have to spend a lot of time before their application getting things in place. For a clinic that may be a little further away from those 19 health center requirements there may be pieces that they want to get in place, or at least have a plan for how they're going to get those in place before they apply.

In their application for new access point they require what's called an implementation plan so you'll have to document how you're going to get those health center requirements met in 120 days. The short answer is I don't think there is a typical timeframe, it depends on the clinic and how far along they are in the 19 health center requirements.

The second factor that's going to come into play is actually when there is an FOA, so when there is funding and an application available. Sometimes those happen every year or two and sometimes there's further gaps in between when there's that appropriation, when there's that grant opportunity to apply for a new access point.

Laura: Great. Another question, can lookalikes apply for 330 funding after they achieve the lookalike status?

Stacey: Yes, absolutely. A lookalike can definitely apply for 330 funding. In the past at least one, maybe two, new access point applications we've seen that health centers with lookalike status get additional what we call priority points when they apply. Certainly they can and sometimes they get a few extra points on their application for being a lookalike when they're applying for full health center status.

Laura: Great, thanks. Another question is: is it easier for rural or urban areas to receive funding for FQHCs?

Stacey: Another great question, full of great questions today. For each funding opportunity announcement, or FOA, there's ... I don't want to say emphasis. Different priority points or ways that certain applicants can get more points in their applications. We have seen times when rural applicants, because of their rural status, frontier or rural, or because of the lack of primary care services in their area, are able to get additional points towards their application. Yes, not that the application process is any easier. The application process is the same whether you're rural, urban, or frontier. Sometimes rural organizations or rural entities will get additional points on their grant. It all depends on what the actual grant is prioritizing at that time.

Laura: Great, well thank you Stacey. It looks like we don't have any additional questions so I'll just give another minute here to see if anyone wants to type in some additional questions.

Stacey: There was another question that came up asking if FOAs can be found on the HRSA website. Once they're released, yes, they can be found on the HRSA website but they won't be up until they're actually released. There needs to be an appropriation for new access points, and then HRSA creates a funding opportunity, and then they'll release that. Once those are released they do provide a lot of guidance on how to submit an application. They have a webinar, they have a lot of technical assistance available on their website. There currently is not a new access point FOA out. We don't have any time length for when the next one will be out, it all depends on the federal budget.

I would recommend on that HRSA website, you can sign up to get their updates on funding announcements. If you sign up for that when there is one released, and it will be called a new access point, you can get the alert that that's coming out or has been released.

Laura: All right, thank you Stacey. Again, we'll just give another minute to see if anyone has any additional questions. Okay, well it looks like we don't have any additional questions. Thank you to everyone who participated in today's webinar. We hope you found it helpful. There will be an evaluation popup in a few seconds, and if you could please take a minute to fill out the evaluation. Also, if you think of any questions that you didn't ask you can see that both my email, Laura Gerard, and Stacey's email are up on the slide right now so feel free to email either of us with any questions that you may think of. Thank you again for your participation today.

Looks like we had one last question that somebody asked us, the slides will be available and they will be available and the recording will be available and those will be emailed out to all of you who participated today.