U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

HEALTH CENTER PROGRAM UPDATE

DATE: February 8, 2013

DOCUMENT TITLE: Look-Alike Initial Designation Application Instructions 2013

TO: Health Center Program Look-Alikes
Health Center Program Grantees
Primary Care Associations
Primary Care Organizations
National Cooperative Agreements

The Health Resources and Services Administration (HRSA) is committed to improving the health of underserved communities and vulnerable populations. Health Center Program look-alikes maintain a critical role in supporting the delivery of comprehensive, culturally competent, quality primary health care services to low-income, underserved, and special populations.

Enclosed are the revised initial designation application instructions for 2013. This document supersedes all previous initial designation instructions. Annual certification and renewal of designation application instructions for existing look-alikes will be released separately.

Changes for 2013 initial designation applications. The revised initial designation instructions include several changes, including but not limited to:

- Increased emphasis on and clarification of documentation required to demonstrate that organizations are operational and compliant with all Health Center Program requirements at the time of application.
- Clarification of documentation required to demonstrate that the primary purpose of applicant organizations is to provide primary medical care.
- Revised review processes that reflect the ability of HRSA to issue look-alike designations independent from the Centers for Medicare and Medicaid Services.

Application Submission Process: All look-alike applications must be submitted electronically via HRSA's Electronic Handbooks (EHB).

Effective Date: All applications begun in the HRSA EHB on or after February 8, 2013 are required to comply with the application instructions contained herein.

Technical Assistance: HRSA encourages organizations to contact their State Primary Care Association (PCA) and/or Primary Care Office (PCO) for assistance in developing an application. Contact information

for the State PCAs and PCOs are available on HRSA's Web site at http://bphc.hrsa.gov/technicalassistance/.

Organizations requiring technical assistance in preparing an initial designation application may also submit questions to HRSA's Bureau of Primary Health Care, Office of Policy and Program Development at lookalike@hrsa.gov or 301-594-4300.

James Macrae
Associate Administrator for Primary Health Care

Attachments

U.S. Department of Health and Human Services
Health Resources and Services Administration

Bureau of Primary Health Care

Health Center Program

Look-Alike Initial Designation Application Instructions

2013

Release Date: 02/08/2013

All applications started in the HRSA Electronic Handbook (EHB) on or after the release date must adhere to the instructions contained herein.

Office of Policy and Program Development
Lookalike@hrsa.gov
301-594-4300
http://bphc.hrsa.gov/about/lookalike/index.html

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

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LOOK-ALIKE INITIAL DESIGNATION PURPOSE AND BACKGROUND

Purpose

The Health Resources and Services Administration (HRSA) administers the Health Center Program.[1] Health centers, which include both grantees and look-alikes, improve the health of the Nation's underserved communities and vulnerable populations by ensuring access to comprehensive, culturally competent, quality primary health care services. Individually, each health center plays an important role in ensuring access to services, and when combined, they have had a critical impact on the health care status of medically underserved and vulnerable populations throughout the United States and its territories.

This document provides information about Health Center Program look-alikes, including an overview of program requirements and instructions for submitting applications for look-alike initial designation. For the purposes of this document, the term "health center" refers to both Health Center Program look-alikes and grantees.

Summary of Changes

Applicants should note the following significant changes compared to the 2011-2012 Initial Designation Application Instructions:

- Applicants must serve a currently designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP).
- Applicants must propose look-alike designation for at least one existing, full-time, permanent site that operates at least 40 hours per week.
- Applicants must provide comprehensive primary medical care as their primary purpose. Primary medical care current and projected patient visits must be equal to or greater than the combined visits for all other services provided (e.g., dental, behavioral health, etc.).
- Applicants must provide documentation of current Medicare and Medicaid primary care provider numbers.
- Clarification of requirements to demonstrate that the organization is operational and compliant with all Health Center Program requirements, including:
    - Applicants must provide a minimum of six months of financial statements if not operational for a sufficient time period to provide an annual independent financial audit;
    - Applicants must provide a minimum of six months of governing board meeting minutes demonstrating the board is exercising its authority over an operational and compliant organization;

[1] Authorized by section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b).

- Requirement to represent the proposed service area using a map and associated data generated by UDS Mapper, among other data as appropriate; and
- Additional detail required in the summary of contracts, affiliation agreements, and formal referral arrangements.

Other

- Removal of the role of the Centers for Medicare and Medicaid Services (CMS) in the look-alike designation process; and
- Initial designation, annual certification, and renewal of designation look-alike instructions will be released separately rather than combined in a single document.

Background

Look-alikes were established to maximize access to care for the underserved populations and communities by allowing for entities that do not receive Health Center Program funding to operate and provide services consistent with those health centers funded under the Health Center Program. Both Health Center Program grantees and look-alikes must provide a comprehensive system of care that is responsive to the community's identified health care needs, provide services to all persons residing in the health center's service area regardless of ability to pay, and meet all Health Center Program statutory, regulatory, and policy requirements.

Terminology

Historically, look-alikes have been referred to as Federally Qualified Health Center (FQHC) Look-Alikes. This document uses the term "look-alikes" to underscore: (1) that Health Center Program look-alikes are health centers that "look like" Health Center Program grantees that do not receive a grant under section 330 of the PHS Act; and (2) that look-alikes are eligible, as are Health Center Program grantees, to apply to CMS for reimbursement under Medicare and Medicaid FQHC payment methodologies.

Legislative Authority

An amendment to the Omnibus Budget Reconciliation Acts[2] created and defined a category of facilities under Medicare and Medicaid known as FQHCs. One of the definitions of an FQHC as set forth[3] is an entity determined by the delegated Department of Health and Human Services (HHS) authority to meet the requirements of the grant program authorized by section 330 of the PHS Act (the Health Center Program, 42 U.S.C. 254b), but does not receive a Health Center Program grant. This category of health centers has been labeled, "look-alikes."

The Balanced Budget Act of 1997[4] modified the look-alike definition under section 1905 of the SSA by adding the requirement that the "entity may not be owned, controlled or operated by another entity."

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[2]Omnibus Budget Reconciliation Acts (OBRA) of 1989, 1990, and 1993, amended section 1905 of the Social Security Act (SSA).
[3] Section 1861(aa)(4)(B) and section 1905(l)(2)(B) of the SSA.
[4] Public Law 105-33.

HRSA, in collaboration with the CMS, issued Policy Information Notice (PIN) 1999-09, Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities, issued April 20, 1999, and PIN 1999-10, Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Nonprofit Entities, issued April 20, 1999, to implement the BBA requirements for public agencies and private nonprofit organizations. These documents describe the statutory limits on the involvement of another entity in the ownership, control, and/or operation of a public or private nonprofit look-alike. Applicants should work closely with HRSA if there are questions about the application of these policies before submitting an initial designation application.

Benefits of Look-Alike Designation, Scope of Project, and Other Lines of Business

Look-alikes are eligible to receive a number of benefits including:

- Purchase of discounted drugs under the section 340B Federal Drug Pricing Program;
- FQHC payment methodologies for services provided under Medicare;
- FQHC payment methodologies for services provided under Medicaid[5] under the Prospective Payment System or other State-approved Alternative Payment Methodology; and
- Automatic Health Professional Shortage Area designation and access to National Health Service Corps providers.

The benefits of look-alike designation apply only to activities that are included in the approved scope of project which defines five core elements of the Health Center Program:

- Sites;
- Services;
- Providers;
- Service area(s); and
- Target population.[6]

All activities in the scope of project must comply with Health Center Program requirements. Services that are within the approved scope of project but are not covered as a FQHC service by Medicaid or Medicare are not eligible for FQHC payment methodologies, but must remain compliant with Health Center Program requirements.

Look-alikes may engage in other lines of business outside their scope of project (e.g., a day care center), but these activities are not eligible for look-alike benefits.

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[5] See HRSA Program Assistance Letter (PAL) 2001-09 and section 1902(bb) of the SSA.
[6] Refer to PIN 2008-01, Defining Scope of Project and Policy for Requesting Changes available at http://www.bphc.hrsa.gov/policiesregulations/policies/pin200801.html.

Health Center Program Requirements

Look-alikes must demonstrate compliance with the applicable requirements of section 330 of the PHS Act, 42 Code of Federal Regulations (CFR) Part 51c (Grants for Community Health Centers)[7], and 42 CFR Part 56 (Grants for Migrant Health Services and Migrant Health Centers)[8], referred to also as Health Center Program requirements, as applicable. HRSA encourages applicants to review the Health Center Program requirements and applicable statutes, regulations, and policies prior to developing an application. These are available on HRSA's website at http://www.bphc.hrsa.gov/about/requirements/index.html.

Applicants may be designated to serve the general medically underserved population and/or a special population authorized under section 330 of the PHS Act[9] (i.e., migratory and seasonal agricultural workers, homeless populations, and residents of public housing).

Applicants that serve the general population *and* a special population (i.e., migratory and seasonal agricultural workers, homeless populations, and/or residents of public housing) must satisfy all Health Center Program general population program requirements and the Health Center Program requirements of the specific special population.

Applicants requesting designation to *exclusively* serve a special population(s) may not have more than 25 percent of patients from the general underserved population.[10] All health centers must ensure the availability and accessibility of required primary health care, as well as preventive, and enabling services, including oral health, mental health, and substance abuse services, regardless of an individual's ability to pay.

General Community Health Center (CHC) Requirements

Applicants that request look-alike designation to serve the general medically underserved population must demonstrate compliance with section 330(e)(Community Health Center) statutory and regulatory program requirements and applicable policies. Applicants must make services available to all residents of the service area (including migratory and seasonal agricultural workers, persons experiencing homelessness, and residents of public housing), to the extent possible using available resources.[11] Requirements include:

- Compliance with general community Health Center Program requirements; and

[7] 42 CFR Part 51c does not apply to look-alikes exclusively serving homeless individuals or residents of public housing.
[8] 42 CFR Part 56 only applies to look-alikes exclusively serving migratory and seasonal farmworkers.
[9] The types of health centers authorized under section 330 of the PHS Act are: Community Health Center (CHC) (section 330(e)), Migrant Health Center (MHC)(section 330(g)), Health Care for the Homeless (HCH)(section 330(h)), and Public Housing Primary Care (PHPC)(section 330(i)).
[10] Refer to PIN 2009-05, Policy for Special Populations-Only Grantees Requesting as Change in Scope to Add a New Target Population, located at http://bphc.hrsa.gov/policiesregulations/policies/pin200905specialpops.html for HRSA's policy on target populations.
[11] Section 330(a)(1)(B) of the PHS Act.

- A plan that ensures the availability and accessibility of required primary and preventive health care services, including oral health, mental health, and substance abuse services, to all individuals in the service area.

Special Populations Requirements

Applicants that exclusively serve a special population(s) are not subject to the requirement to provide access to care for all residents of the service area; however, all health centers must address the acute care needs of all who present for service regardless of residence and/or ability to pay. Applicants serving only a special population(s) may request a "good cause" exemption to waive the requirement that the center provide all required primary health services.[12] HRSA will only consider waivers of the 51 percent consumer/patient majority governance requirement and the monthly meetings governance requirement.

Migrant Health Center Requirements

- Compliance with migrant health center and, as applicable, general community program requirements;[13] and
- A plan that ensures: (1) the availability and accessibility of required primary and preventive health services, including oral health, mental health and substance abuse services, to migratory and seasonal agricultural workers and their families in the area to be served; (2) how adjustments will be made for service delivery during peak and off-season cycles; and (3) how the special environmental and occupational health concerns will be addressed.

Health Care for the Homeless Requirements

- Compliance with health care for the homeless and, as applicable, general community program requirements;[14]
- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health, and substance abuse services, to people experiencing homelessness in the area to be served; and
- A mechanism for delivering comprehensive substance abuse services to homeless patients (i.e., detoxification, risk reduction, outpatient treatment, residential treatment, and rehabilitation for substance abuse provided in settings other than hospitals).

Public Housing Primary Care Requirements

- Compliance with public housing primary care and, as applicable, general community program requirements;[15]

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[12] Section 330(k)(3)(H)(iii) of the PHS Act.
[13] PHS Act section 330(g) and 330(e) and program regulations.
[14] PHS Act section 330(h) and 330(e) and program regulations.
[15] PHS Act section 330(i) and 330(e) and program regulations.

- A plan that ensures the availability and accessibility of required primary and preventive health services, including oral health, mental health, and substance abuse services, to residents of public housing primary care in the area to be served; and
- A mechanism for involving residents in the preparation of the application and in the ongoing planning and administration of the program.

HRSA will not grant waivers for organizations that serve the general population or the general population in conjunction with a special population.

ELIGIBILITY

Applicants must demonstrate that they meet the following eligibility requirements at the time the initial designation application is submitted to HRSA:

- Be a public or private, nonprofit entity, including tribal, faith-based, and community-based organization.

- Serve a defined geographic area that is currently federally designated, in whole or in part, as a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP). [16, 17, 18]

  NOTE: Applicants requesting designation only for special populations are not required to have an MUA/MUP designation for the proposed service area and/or target population.

- Be independently owned, controlled, and operated[19] per section 1905(l)(2)(B) of the SSA.

  Additional policy clarification regarding health center affiliations is available in PIN 1997-27, Affiliation Agreements of Community and Migrant Health Centers located at http://bphc.hrsa.gov/policiesregulations/policies/pin199727.html and Amendment to PIN 1998-24, Regarding Affiliation Agreements of Community and Migrant Health Centers located at http://bphc.hrsa.gov/policiesregulations/policies/pin199824.html. In addition, HRSA's interpretation of the statutory limits on the involvement of another entity in the ownership, control and/or operation of a public entity or private nonprofit entity is located in PINs 1999-09

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[16] Look-alike applicants do not have to be located in a MUA but must serve in whole or in part either an MUA or MUP.
[17] Requested, not required for look-alikes exclusively serving migratory and seasonal farmworkers, homeless individuals, or residents of public housing.
[18] The list of MUAs and MUPs is available at http://bhpr.hrsa.gov/shortage/.
[19] See PIN 1999-09, Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities (dated April 20, 1999) at http://www.bphc.hrsa.gov/policiesregulations/policies/pin199909.html, PIN 1999-10, Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Non-Profit Entities (dated April 20, 1999) at http://www.bphc.hrsa.gov/policiesregulations/policies/pin199910.html.

and 1999-10, Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities and for Private Nonprofit Entities, respectively, provide additional information. These PINS are located at http://bphc.hrsa.gov/policiesregulations/policies/index.html.

NOTE: Applicants proposing a corporate integration model may be subject to a review by the Department's Office of the General Counsel against State law reserved authorities.

- Be operational and compliant with all Health Center Program requirements. The applicant must be operational and compliant with all Health Center Program requirements, providing all required services under the authority of a compliant governing board for at least six months before submitting an initial designation application. Applicants must document their operational status by submitting:
    a. Primary care Medicaid and Medicare provider numbers and associated documentation;
    b. An annual financial audit in accordance with generally accepted accounting principles or, if in operation less than one year, a minimum of six months of monthly financial statements; and
    c. A minimum of six months of governing board meeting minutes demonstrating how the board is exercising its authority over an operational organization in compliance with Health Center Program requirements, including:
        i. Holding monthly meetings;
        ii. Approving look-alike applications and budget;
        iii. Selecting/dismissal and performance evaluation of the health center CEO;
        iv. Selection of services to be provided and the health center hours of operations;
        v. Measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance; and
        vi. Establishing general policies for the health center.[20]

- Provide comprehensive primary medical care as its primary purpose. Applicants may propose additional services, e.g., behavioral health or oral health care, as needed. All required services must be provided at the time of application, with contracts and written formal referral arrangements in place for any services not provided directly by the applicant. Primary medical care current and projected patient visits must be equal to or greater than the combined visits for all other services provided (e.g., dental, behavioral health, etc.).

- Request initial designation for at least one full-time, permanent service delivery site that provides access to all required comprehensive primary, preventive, enabling, and additional health care services including oral health care, mental health care, and substance abuse services, either directly on-site or through established written arrangements without regard to

[20] Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304.

ability to pay.[21] Full-time is defined as being operational a minimum of 40 hours per week. An applicant may not propose to provide only a single service, such as dental, mental health, or prenatal services. An applicant may also propose sites that are mobile, seasonal, or intermittent in addition to the permanent site(s).

- Serve all individuals in the targeted service area or population to the extent possible using available resources. Applicants cannot propose to exclusively serve a single age group (e.g., children) or health issue/disease category (e.g., HIV/AIDS, chronically mentally ill). If an applicant proposes to target a sub-population within the service area or population (e.g., children in schools or adults with chronic mental illness), the applicant must demonstrate how all required health care services will be made available to those and other persons in need of care who may seek services at the proposed site(s).

Public Entities[22]

Public entities applying for look-alike designation must comply with all Health Center Program requirements. Public entities that are not able to independently meet all health center requirements due to operational and/or legal constraints may comply with these requirements through a "co-applicant" arrangement. In co-applicant arrangements, the public entity receives the look-alike designation and the co-applicant's board serves as the health center's governing board. The public entity and the co-applicant are collectively referred to as the "health center."

In the co-applicant arrangement, the public entity is responsible for maintaining and demonstrating compliance with all program requirements under the oversight of the co-applicant governing board. The public entity may retain the responsibility for establishing fiscal and personnel policies. The co-applicant governing board must meet all the size and composition requirements and perform and maintain all governance authorities,[23] including:

- Holding monthly meetings;
- Approving look-alike applications and budget;
- Selecting/dismissal and performance evaluation of the health center CEO;
- Selection of services to be provided and the health center hours of operations;
- Measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance; and

[21] Migrant Health Center applicants may be seasonally operated.
[22] Please refer to http://www.bphc.hrsa.gov/policiesregulations/policies/pin201001.html for information on public entities and co-applicant arrangements.
[23] Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304.

- Establishing general policies for the health center.

HRSA recommends that the co-applicant governing board be formally incorporated to ensure maximum accountability.

The public entity and the co-applicant entity must have a co-applicant agreement that describes the delegation of authority and defines each party's role, responsibilities, and authorities. The co-applicant agreement, governing board bylaws, and articles of incorporation must assure that the co-applicant governing board retains its full authorities, responsibilities, and functions, aside from those prescribed general policies that may be retained by the public entity.

Not all organizations that serve public interests by providing health care and other essential services to the underserved in their communities can be classified as public entities eligible for public entity status under the Health Center Program. HRSA will use documentation of one or more of the following to assess whether an organization will qualify as a public entity for purposes of look-alike designation:

1. Internal Revenue Service (IRS) determination that the entity is a subdivision, municipality, or instrumentality of government that is exempt under Internal Revenue Code section 115 and the public entity has obtained a "letter ruling" (i.e., a positive written determination by the IRS of this status) by following the procedures specified in Revenue Procedure 2009-1 or its successor, as applicable. Evidence to support this determination may include an affirmation letter from the IRS or similar documentation;

2. Public entity demonstration through supporting documentation that it meets the IRS standards that would determine that the public entity is a subdivision, municipality, or instrumentality of government that is exempt under Internal Revenue Code section 115;

3. Formal documentation from a sovereign State's taxing authority equivalent to the IRS or authority granting the entity one or more governmental powers.

More information on confirming public entity is available in PIN 2010-01, Confirming Public Agency Status under the Health Center Program and FQHC Look-Alike Program located at http://bphc.hrsa.gov/policiesregulations/policies/pin201001.html.

Need and Collaboration

HRSA is committed to increasing access to health care services to vulnerable and underserved populations, including expanding and adding new sites and services in communities with high unmet health care needs. Applicants must demonstrate the need for health care services in the area to support the designation of a new look-alike. HRSA strongly recommends that applicants applying to serve the same, or a contiguous, area served by a current Health Center Program grantee or look-alike conduct a thorough analysis of the level of unmet need before submitting an initial designation application. Likewise, HRSA will conduct an analysis of all submitted applications to determine the level of unmet need in the area to determine the need for an additional health center. HRSA's policy and process for determining service area overlap is identified in PIN 2007-09, Service Area Overlap: Policy and Process, located at http://bphc.hrsa.gov/policiesregulations/policies/pin200709.html. Applicants should review this PIN and must submit all required documentation to facilitate the HRSA review process. The UDS

Mapper, located at http://www.udsmapper.org/, is one means to assess unmet need and to identify other safety net providers in and near the proposed service area; a UDS Mapper-generated map and its associated data is a required attachment. Detailed instructions to develop and submit a UDS Mapper-generated service area map (a required submission) are located in Appendix C: Required Attachments Instructions.

In addition, applicants must demonstrate collaboration and coordination of health care services with other area health care providers including existing Health Center Program grantees and look-alikes, hospitals, rural health clinics and health departments through letters of support, memorandums of agreement/understanding, and/or other formal documentation. For more guidance, see Program Assistance Letter 2011-02, Health Center Collaboration, available at http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html.

APPLICATION REQUIREMENTS

HRSA strongly encourages applicants to work with the appropriate Primary Care Associations, Primary Care Offices, and/or National Cooperative Agreements in determining their readiness to develop a look-alike initial designation application and throughout the application process. Refer to http://www.bphc.hrsa.gov/technicalassistance/ for a complete listing of these organizations.

Initial designation applications must:

1. Provide all required evidence that the applicant is operational and providing all required services in the community/population in compliance with Health Center Program requirements at the time of application.[24]

2. Demonstrate a high level of primary health care need in the community/population;

3. Present a sound proposal to meet this primary health care need, demonstrate that the applicant is already providing comprehensive health care services in the service area under Health Center Program requirements, display responsiveness to the health care environment of the service area, and demonstrate collaborative and coordinated delivery systems for the provision of primary health care to the underserved;

4. Demonstrate that the proposed look-alike is currently providing and will continue to provide access to comprehensive, culturally competent, quality primary health care services as its primary purpose to improve the health status of underserved and vulnerable populations in the proposed service area.

5. Provide evidence that the proposed look-alike site(s) will serve populations in high need areas. Applicants must submit a completed Form 9—Need for Assistance (NFA) Worksheet to demonstrate the relative need for additional primary health care services.

[24] Program requirements are available at http://www.bphc.hrsa.gov/about/requirements/index.html.

6. Provide evidence of how the proposed project will maintain or increase access to primary health care services, improve health outcomes and reduce health disparities in the community/population to be served.

7. Provide evidence that all persons in the target population will have ready access to the full range of required primary, preventive, enabling and supplemental health care services, either directly on-site or through established arrangements without regard to ability to pay.

8. Demonstrate responsiveness to the health care environment and the underserved in their community by documenting the organization's collaborative and coordinated health care delivery systems. Applicants must demonstrate partnerships and collaborative activities with Health Center Program look-alikes and grantees, rural health clinics, hospitals, State and local health departments, and/or health services delivery projects and other programs serving the same population(s).

9. Provide a sound and complete plan that reflects appropriate short- and long-term strategic planning and coordination with other providers of care, organizational capability to manage the proposed scope of project, and cost-effectiveness in addressing the health care needs of the target population.

10. Provide a reasonable and accurate budget (Form 3A–Look-Alike Budget) based on the scope of project proposed in the application.

Application Requirements for Community Health Center and Special Population Designations

Applicants requesting designation for one or more types of health centers (i.e., Community Health Center, Migrant Health Center, Health Care for the Homeless, and Public Housing Primary Care) must indicate the type of designation requested on Form 1A—General Information Worksheet. As noted above, special population(s) designations are intended for organizations that serve that population exclusively. Applicants whose patient populations are simply comprised of a high proportion of one or more special populations, e.g., persons experiencing homelessness and residents of public housing, can serve those populations as a general community health center and do not have to seek a special population designation.

School-Based Health Centers

Applicants that propose a school-based health center service delivery site that does not independently provide all required services and/or is not accessible to the general population of the service area must demonstrate how the broader look-alike system of care (e.g., other look-alike service delivery sites) will ensure that the entire underserved population in the service area (including the area served by the school-based health center) has access to all required services.

Mobile Medical Vans

A mobile medical van cannot be the only site in the look-alike's scope of project. Mobile medical vans are an approved method for the delivery of primary care services if the applicant is also proposing at

least one full time, permanent site in its scope of project. To be eligible as a service delivery method, the mobile medical van must be fully equipped and staffed by health center clinicians providing direct primary care services (e.g., primary medical services) at various locations.

Mobile medical vans do not need to provide services on a regularly scheduled basis, although regularly scheduled services facilitate continuity and access to care for the target population. Mobile medical vans that are not equipped or utilized for direct patient care are not considered service sites and therefore are not eligible to be included as part of a look-alike's scope of project.

PROGRAM ABSTRACT

The program abstract should be single-spaced and limited to two pages. It will be uploaded to the Electronic Handbooks (EHB). The abstract should be clear, accurate, concise, and without reference to other parts of the application. It must summarize the:

1. History of the organization;
2. Length of time the organization has been operational in compliance with Health Center Program requirements;
3. Community and population group(s) served;
4. Target population(s);
5. Major health care needs and barriers to care in the service area;
6. Organizational structure;
7. Current number of providers, service delivery locations, services currently being provided, and total number of primary health care patients and primary health care visits while operational as a primary health care provider compliant with Health Center Program requirements; and
8. Any other relevant information.

PROGRAM NARRATIVE REQUIREMENTS

The Program Narrative provides a comprehensive description of the proposed look-alike. It should provide a detailed picture of the community/target population served, the organizational structure, and how the organization is addressing the identified primary health care needs of the community.

Applicants must fully address all requirements within the narrative component of the application. All documents (i.e., Program Narrative, forms, documents, and attachments) are evaluated individually and collectively for consistency. The Program Narrative should be succinct, self-explanatory, and well-organized. Applicants must respond to all criteria and submit all applicable forms and attachments to demonstrate compliance with program requirements located at

http://www.bphc.hrsa.gov/about/requirements/index.html. HRSA may disapprove applications that do not include all required information.

The Program Narrative should be organized using the following framework and section headers. Applicants must ensure that all of the specific elements in the Program Narrative are completely addressed.

Applicants should label each section of the Program Narrative (Need, Response, Collaboration, Evaluative Measures) and label each sub-section (e.g., "Target Population") as outlined below.

Need

Information provided on need should serve as the basis for, and align with, the activities and goals described in the Clinical and Financial Performance Measures Forms and throughout the application.

1. **Target Population**. Describe the unique characteristics of the target population, including characteristics that impact access to primary health care, health care utilization, and/or health status. Describe additional aspects of need that are not captured by quantitative data. Reference Attachment 1: Patient Origin Study, Form 4—Community Characteristics and Form 9—Need for Assistance.

2. **Existing Services**. Describe existing health care services (including mental health/substance abuse and oral health) currently available in the applicant's service area, including any gaps in services (e.g., provider shortages) and the role and location of any other providers who currently serve the target population. Reference data from the UDS Mapper and Attachment 2—Service Area Map.

3. **Health Care Environment**. Describe the health care environment and any significant changes that have affected the community's ability to provide services and/or have affected the applicant's fiscal stability, if applicable. Reference Form 3—Income Analysis Form, Form 3A—Look-Alike Budget Information and Attachment 15—Most Recent Independent Financial Audit, as applicable.

4. **Special Populations**. For applicants requesting designation to serve migratory and seasonal agricultural workers, people experiencing homelessness, and/or residents of public housing, describe the specific health care needs and access issues of the proposed special population(s).

Response

1. **Service Delivery Model**. Describe the service delivery model(s) to serve the health care needs identified in the Need section, including service delivery models to meet the specific needs of special populations if seeking special population designation. The applicant must clearly demonstrate how the primary purpose of the organization is the provision of primary medical care. All sites and activities described should be consistent with those listed in Forms 5B—Service Sites and 5C—Other Activities/Locations, including locations of sites, hours, and after-hours care. Applicants transitioning from a specialty orientation (e.g., HIV, dental or behavioral health) may describe how the transition to the provision of comprehensive primary health care services has

been accomplished and will be sustained. The service delivery model must be supported by information provided in Form 1A—General Information Worksheet, Form 2—Staffing Profile, Form 5A—Services Provided and Attachment 13—Resumes for Key Personnel.

NOTE: Only Public Housing Primary Care applicants must demonstrate that the service site(s) is (are) immediately accessible to the public housing community being targeted.

2. **Primary Health Care Services**. Describe how the primary health care services are appropriate for the needs of the target population and are available and accessible to all life cycles without regard to ability to pay. Describe the hours of operation, including any evening and/or weekend hours. Services discussed should be consistent with those listed in Form 5A—Services Provided, and applicants should reference the form as applicable.

   NOTE: Required primary health care services must be provided directly by the health center or through an established written arrangement, such as through a contract/formal agreement or through a formal written referral arrangement. In addition, required services provided directly by the proposed look-alike or by formal agreements or formal written referral arrangements must be offered on a sliding fee scale and available equally to all patients regardless of ability to pay. Informal referral arrangements are not acceptable for the provision of a required service.

   NOTE: Only Health Care for the Homeless applicants must demonstrate that substance abuse services will be made available as part of the required services.

3. **Enabling Services**. Describe how the service delivery model(s) ensures the integration of enabling services (e.g., outreach, transportation).

4. **Continuity of Care**. Describe how the organization ensures continuity of care (e.g., admitting privileges), access to a continuum of care, and access to special care services (e.g., referral relationships).

5. **Contracts/Formal Written Agreements**.

   a. **Contracts for a Substantial Scope of Project**. Discuss the appropriateness of all current contracts for a substantial portion of the operation of the health center. Contracts for a substantial portion of the proposed scope of project include any of the following:
      i. Core primary care providers (consistent with Health Center Program requirements);[25]
      ii. Non-provider health center staff;
      iii. Chief medical officer (CMO);
      iv. Chief financial officer (CFO); and/or

[25] Health Center Staffing Requirement: Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed, and privileged. (Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act).

v. A memorandum of understanding (MOU) or memorandum of agreement (MOA) for a substantial portion of the proposed scope of project.

Contracts for a substantial portion of the operation of the health center must be included on Form 8—Health Center Agreements and attached in full according to the instructions provided in Form 8.

NOTE: All applicants must complete Form 8–Health Center Agreements and reference it throughout the Response section as applicable. In addition, CHC and/or MHC applicants that respond "no" to any question in the Governance checklist section of Form 8 must clearly discuss the specific situation(s).

b. **Other contracts**. Discuss the appropriateness of other contracts/formal written agreements. All contracts/formal written agreements (including those constituting a substantial scope of project) and formal written referral arrangements (see below) must be summarized in Attachment 7—Affiliation, Contract, and/or Referral Agreements.

6. **Clinical Staffing**.

a. **Current Clinical Staffing List**. List all clinical staff currently employed or under contract,[26] each individual's position, credential, category FTE and whether the clinician is employed by the applicant. Applicants may insert a table such as the example below.

Current Clinical Staffing List *EXAMPLE*					
Name	**Position**	**Credential**	**Category (Medical / Dental / Behavioral Health)**	**FTE**	**Employed or contracted by applicant?**
John Smith	Pediatrician	MD	Medical	.75	Employed
Sally Jones	CMO	MD	Medical	.55	Employed
Greg Johnson	Nurse	NP	Medical	1.0	Contracted
Shelley Ricks	Dentist	DD	Dental	.3	Employed
Barbara Miller	Psychiatrist	MD	Behavioral Health	.2	Contracted

If any clinical positions are staffed by volunteers, provide the name of the individual providing the service, type of service being provided, reason for volunteer providing the service, any form of compensation received by the volunteer, and validity of license

[26] HRSA utilizes Internal Revenue Service (IRS) definition to differentiate employees and contractors. To be considered as an employee by the IRS, the individual must receive a salary from the covered entity on a regular basis with applicable taxes and benefits deducted along with coverage for unemployment compensation in most cases. The covered entity should issue a W-2 form for an employee to be a covered individual, and a Form 1099 to an individual who is a contractor.

and/or certification of the volunteer at the time of service provision in accordance with applicable law.

b. **Current Clinical Staffing Description.** Describe how clinical staff (those employed directly and those under contract) currently provide the required, preventive, enabling, and additional health services as appropriate and necessary either directly or through established written contracts/arrangements.

   For each contracted provider, describe how contracting is appropriate and how the organization provides oversight of the contracted provider. This must align with the Current Clinical Staffing List outlined in 4.a. above.

c. **Projected Designation Period Staffing Description.** Describe the clinical team staffing plan for the first year of designation, the current number of patients, the number of patients projected by the end of the first year, and how the organization will continue to provide the required, preventive, enabling, and additional health services as appropriate and necessary either directly or through established written arrangements and referrals. This staffing plan (including both current and projected providers) must align with Form 2—Staffing Profile for directly employed (not contracted) providers only.

   If the clinical team staffing currently includes, or in the first year of designation will include contracted providers, describe how contracting for providers is appropriate and how the organization does and/or will provide oversight of the contracted providers.

   NOTE: The applicant must include a summary of all current or proposed contracts in Attachment 7—Affiliation, Contract, and/or Referral Agreements and copies of contracts in Attachment 8—Health Center Agreements for contracts that constitute a substantial scope of project, i.e., core primary care providers.

d. **Formal Written Referral Arrangements**. Under a formal written referral arrangement, the applicant maintains responsibility for the patient's treatment plan and will be providing and/or paying/billing for appropriate follow-up care based on the outcome of the referral.

   Describe how formal written referral arrangements are utilized to provide required, preventive, enabling, and additional health services as appropriate and necessary. Discuss how visits will be documented in the patient record, how follow-up care will be ensured, and how services will be provided on a sliding fee discount scale compliant with Health Center Program requirements.
   These arrangements must align with services indicated in Form 5A—Services Provided, Column III and must be summarized in Attachment 7—Affiliation, Contract, and/or Referral Agreements.

   NOTE: Informal referral arrangements are not acceptable for the provision of required services.

7. **Patient Discounts**. Describe the system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay and demonstrate how the established schedule of charges is consistent with locally prevailing rates or charges. In addition, describe how the corresponding schedule of discounts/sliding fee scale ensures that no patient will be denied services due to their inability to pay. Reference the schedule of discounts/sliding fee scale in Attachment 14—Schedule of Discounts in the response.

   NOTE: Additional clarification on the Sliding Fee Discount Program requirements is available on HRSA's website at http://bphc.hrsa.gov/policiesregulations/policies/draftslidingfee.pdf.

   NOTE: Ability to pay is determined by a patient's annual income and family size according to the most recent Federal Poverty Guidelines for the contiguous 48 states, Alaska and Hawaii. Additional information is available on HHS' website at http://aspe.hhs.gov/poverty/).

8. **Quality Improvement/Quality Assurance (QI/QA)**. Describe the organization's quality improvement/quality assurance (QI/QA) and risk management plan(s) including:

   a. Accountability and communication throughout the organization for systematically improving the provision of quality health care, including a clinical director whose responsibilities clearly include oversight of the QI/QA program.
   b. The process and parties responsible for developing, getting board approval and updating policies and procedures that support the QI/QA and risk management plan(s).
   c. The process and parties responsible for provider licensure, credentials, and privileges – ensuring that all providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform proposed services (consistent with Form 5A) at proposed sites/locations (consistent with Forms 5B and 5C).
   d. Risk management procedures, including those related to patient grievance procedures and incident reporting and management.
   e. Monitoring the impact of the provision and efficiency of clinical services on the assessed health needs of the target population (e.g., clinical and financial performance measures).
   f. Maintenance of confidentiality of patient records throughout the continuum of care.
   g. Periodic assessment of appropriateness of service utilization, quality of services delivered, and patient outcomes, conducted by physicians or other licensed health professionals under the supervision of physician, including peer review and systematic evaluation of patient records to identify areas for improvement in documentation of services provided either directly or through referral.
   h. Utilization of appropriate information systems for tracking, analyzing, and reporting key performance data, including data necessary for 1) required performance measures (e.g., electronic health records, payment management systems) and 2) tracking of diagnostic tests and other services provided to health center patients to ensure appropriate follow up and documentation in patient record.
   i. Utilization of QI results to improve performance.

Note: *Clinical directors may be full or part-time staff and should have appropriate credentials (e.g., MD, NP, PA, MPH) to support the QI/QA plan as determined by needs and size of the health center.*

9. **Eligibility and Enrollment.** Describe how the organization will assist individuals in determining their eligibility for, and enrollment in, health insurance options that will be available starting in January 2014 as a result of the Affordable Care Act (e.g., Medicaid coverage for individual up to 133% of the Federal poverty guidelines in states choosing to provide this coverage; the ability to purchase insurance through an Exchange; the availability of Advanced Premium Tax Credits for insurance purchased through and Exchange for individuals with incomes up to 400% FPG; and the availability of cost-sharing reductions for insurance purchase through an Exchange for persons up to 250% of the Federal poverty guidelines). Specifically describe how potentially-eligible individuals will be identified and informed of the new options; what type of assistance will be provided for determining eligibility; and what type of assistance will be provided for completion of the relevant enrollment process.

Collaboration

1. **Other Health Centers in Service Area**. List all other Health Center Program grantees and look-alikes in or adjacent to the proposed service area (see HRSA's UDS Mapper, located at http://www.udsmapper.org/). Describe formal and informal collaboration and coordination of services[27] with each of these entities. Indicate for each whether a letter of support was requested and, if not, why. If requested letters could not be obtained, explain here and provide documentation of efforts made to obtain the letters in Attachment 16—Letters of Support.

2. **Other Safety Net Providers in Service Area**. Describe formal and informal collaboration and coordination of services[28] with other health care providers in the proposed service area, including rural health clinics, hospitals, State and local health departments and/or health care delivery projects, private providers and programs serving the same population(s). Include letters of support from these entities in Attachment 16—Letters of Support.

3. **Special Populations Applicants**. Migrant Health Center, Health Care for the Homeless, and/or Public Housing Primary Care applicants must discuss formal agreements with other organizations that provide services or support to the special population(s) for which designation is sought.

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[27] Review PAL 2011-02, Health Center Collaboration available at http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html for information on maximizing opportunities to collaborate with other health care safety net providers.

[28] Review PAL 2011-02, Health Center Collaboration available at http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html for information on maximizing opportunities to collaborate with other health care safety net providers.

NOTE: Formal collaboration (contracts, agreements, and/or arrangements) should also be summarized in Attachment 7—Affiliation, Contract, and/or Referral Agreements.

NOTE: *Applicants MUST document support for the look-alike designation through current dated letters of support from all Health Center Program grantees and look-alikes, health departments, rural health clinics, and/or hospitals in the service area. If such letters cannot be obtained, include documentation of efforts made to obtain the letters along with an explanation including documentation of efforts made to obtain the letter. All letters of support should be merged into one document, included in Attachment 16, and referenced in the application as appropriate.*

Evaluative Measures

Information provided on need should serve as the basis for, and align with, the activities and goals described in the clinical and financial performance measures and throughout the application. The applicant must demonstrate that its program data reporting systems accurately collect and organize data for reporting and support management decision-making.

1. **Clinical Performance Measures**. Outline within the Clinical Performance Measures Form, current baselines and time-framed and realistic goals that are responsive to the health needs identified in the application. See detailed instructions in Appendix B: Clinical and Financial Performance Measures Instructions.

2. **Financial Performance Measures**. Outline within the Financial Performance Measures Form, current baselines and time-framed and realistic goals that are responsive to the strategic planning needs identified in the application. See detailed instructions in Appendix B: Clinical and Financial Performance Measures Instructions.

3. **Additional Measures**. Provide a brief description of any additional evaluation activities planned to assess progress throughout the designation period, including tools used to collect and analyze relevant data.

Resources/Capabilities

1. **Organizational Structure**. Describe how the organizational structure is appropriate for the operational needs of the project, including how lines of authority are maintained from the governing board to the chief executive officer (CEO)/executive director down through the management structure and are in accordance with Health Center Program requirements. Reference Attachment 4—Governing Board Bylaws, Attachment 11—Organizational Chart, and, as applicable: Attachment 6—Co-Applicant Agreement for Public Centers (for Public Centers that have a co-applicant board),[29] and Attachment 7—Affiliation, Contract, and/or Referral Agreements.

[29] In cases where a public center has a co-applicant board, the public center and co-applicant board must have a formal co-applicant agreement that stipulates: roles, responsibilities and the delegation of authorities; and any shared roles and responsibilities of each party in carrying out the governance functions.

2. **Oversight of Contracted Services**. Describe how the organization maintains appropriate oversight and authority over all contracted services, including any affiliation arrangement(s) (as referenced in Program Specific Form 8—Health Center Agreements), in accordance with Health Center Program requirements.[30] Applicants must summarize all applicable current or proposed contracts and/or other agreements in Attachment 7—Affiliation, Contract, and/or Referral Agreements. If applicant has contracts for a substantial scope of project, the applicant must reference Form 8—Health Center Agreements throughout the response.

   NOTE: BPHC is concerned about health centers that delegate a substantial portion of the scope of the project to another entity or entities, particularly those agreements and contracts that diminish the health center's role in carrying out the its activities and which may be perceived as the health center serving as a conduit to another party for financial benefit.[31]

3. **Management Team**. Describe how the organization maintains a fully staffed management team (chief executive officer (CEO), chief clinical officer (CCO)/chief medical officer (CMO), chief financial officer (CFO), chief information officer (CIO), and chief operating officer (COO) as applicable), that is appropriate and adequate for the size, operational and oversight needs, and scope of the proposed project and is in accordance with Health Center Program requirements. Explain any management positions that are combined and/or part time (e.g., CFO and COO roles are shared). Describe the organizational and management structure and lines of authority, referencing Attachment 11—Organizational Chart, as applicable. Provide position descriptions that include the associated roles, responsibilities, and qualifications and resumes for the CEO, CCO/CMO, CFO, CIO, and COO, referencing Attachment 12—Position Descriptions for Key Personnel, and Attachment 13—Resumes for Key Personnel, as applicable.

4. **Recruitment Plan**. Describe the plan for recruiting and retaining key management staff and health care providers as appropriate within the first 2-year designation period and discuss any key management staff changes in the last year, as applicable.

5. **Service Delivery Sites**. Describe how the service site(s) within the scope of project are appropriate for implementing the service delivery plan and reasonable for the current number of patients and for the projected number of patients at full capacity. All facilities described must be currently owned or under a lease agreement and must be listed on Form 5B—Service Sites. Describe how access to facilities and on-site space is assured in Attachment 7—Affiliation, Contract, and/or Referral Agreements. Attach floor plans and lease documents for all facilities in Attachment 17—Floor Plans.

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[30] As stated in PIN 1997-27, Affiliation Agreements of Community and Migrant Health Centers and/or PIN 1998-24, Amendment to PIN 1997-27, Regarding Affiliation Agreements of Community and Migrant Health Centers. Applicants are encouraged to review http://bphc.hrsa.gov/about/requirements.html for additional information on program requirements and expectations.

[31] PIN 1999-10, Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Nonprofit Entities available at http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin199910.pdf.

6. **Expertise with Target Population**. Describe expertise in working with the target population, including experience developing and implementing systems and services appropriate for addressing the target population's identified primary health care needs.

   NOTE: Public Housing Primary Care (PHPC) applicants must specifically describe how residents were involved in the development of the application and will be involved in administration of the proposed project.

7. **Strategic Planning**. Describe the organization's strategic planning process and how the target population's health care needs and the related program evaluation objectives and data measures have been and will continue to be incorporated into ongoing strategic planning.

8. **Electronic Health Records (EHR).** Describe any current or planned acquisition/development and implementation of certified EHR technology systems used for tracking patient and clinical data to achieve meaningful use. Meaningful use encourages the use of EHR to improve the patient's experience of care and provider care coordination, reduce per capita health care costs, and increase population health. More information about meaningful use is available at http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp.

9. **Financial Information Systems**. Describe financial information systems that are in place for collecting, organizing, and tracking key performance data for program reporting on the organization's financial status (e.g., revenue generation by source, aged accounts receivable by income source, debt to equity ratio, net assets to expenses, working capital to expenses, visits by payor category) and that support management decision making.

10. **Collections and Reimbursement**. Describe systems that are in place to maximize collections and reimbursement for costs in providing health services, including written procedures for determining eligibility, as well as billing, credit, and collection policies and procedures.

11. **Financial Management**. Describe financial management capability, accounting and control systems, and policies and procedures appropriate for the size and complexity of the organization, and which reflect Generally Accepted Accounting Principles (GAAP). Describe how the organization maintains and separates functions appropriate to the organization's size to safeguard assets, maintain financial stability, and maintain a distinct scope of project for the look-alike designation and any other lines of business.

12. **Financial Audits**. Describe the organization's annual independent auditing process performed in accordance with Federal audit requirements. Provide the most recent financial audit (performed in accordance with Federal audit requirements), and the management letter in Attachment 15. Organizations that have been in compliance with Health Center Program requirements for less than one year and do not have an audit may submit monthly financial statements for the most recent 6-month period and specify when an independent financial audit will be completed. Specific guidance for the submission of financial statements is in Appendix C: Required Attachments Instructions.

13. **Emergency Preparedness**. Discuss the status of emergency preparedness planning and development of emergency management plans, including participation or efforts to participate

with State and local emergency planners. In addition, explain any "No" responses on Form 10–Annual Emergency Preparedness Report.[32]

14. **Budget**. Describe how the budget is aligned and consistent with the proposed service delivery plan and number of patients to be served.

15. **State Health Care Delivery Plan**. Describe current or proposed efforts to integrate with the state health care delivery plan for ensuring access to health care including outreach, enrollment, and delivery system reform.

Governance

NOTE: Applicants who are operated by Indian tribes or tribal, Indian or urban Indian groups should respond to ONLY Item 5 below[33] and should select N/A on Form 6B—Request for Waiver of Governance Requirements.

1. **Board Authority**. Discuss how the signed bylaws and/or other relevant documents demonstrate compliance with the Health Center Program requirements.[34] Specifically, describe how Attachment 4—Governing Board Bylaws , Attachment 8—Articles of Incorporation, and/or Attachment 6—C o-Applicant Agreement[35] document that the organization has an independent governing board that meets the following criteria:

    a. Meets at least once a month (this requirement may be waived for eligible applicants; see Form 6B—Request for Waiver of Governance Requirements);

    b. Ensures that minutes are captured for all meetings;

    c. Selects the services to be provided;

    d. Determines the hours during which services will be provided;

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[32] Review PIN 2007-15, Health Center Emergency Management Program Expectations, available at http://bphc.hrsa.gov/policiesregulations/policies/pin200715expectations.html.

[33] Per section 330(k)(3)(H) of the PHS Act Health Center Program governance requirements do not apply to health centers operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or urban Indian organizations under the Indian Health Care Improvement Act.

[34] Section 330(k)(3)(H) of the PHS Act and regulations at 42 CFR Part 51c304 or 42 CFR Part 56.304, as applicable.

[35] Public center applicants whose board cannot directly meet health center governance requirements are permitted to establish a separate co-applicant health center governing board that meets all the section 330 governance requirements.

- In the co-applicant arrangement, the public center receives the section 330 grant and the co-applicant board serves as the health center board.
- Together, the two are collectively referred to as the health center.

The public center and health center board must have a formal co-applicant agreement that stipulates roles, responsibilities, and the delegation of authorities, including and any shared roles and responsibilities of each party in carrying out the governance functions for the health center.

e. Measures and evaluates the organization's progress in meeting its annual and long-term programmatic and financial goals and develops a plan for long-range viability;

f. Approves the health center's annual budget;

g. Approves the health center's look-alike applications;

h. Approves the selection/dismissal and conducts the annual performance evaluation of the organization's Executive Director/CEO;

i. Establishes general policies for the organization (only a public center may retain responsibility for establishing general fiscal and personnel policies); and

j. Establishes policies that include provisions that prohibit conflict of interest.

2. **Board Composition.** Document that the structure of the board (co-applicant board for a public center) is appropriate in terms of size (i.e., number of board members), composition, and expertise (e.g., board members have a broad range of skills and perspectives in such areas as finance, legal affairs, business, health, social services). More specifically, document that:

   a. The board is comprised of at least 51 percent of individuals who currently receive their primary health care from the organization (this requirement may be waived for eligible applicants; see Form 6B—Request for Waiver of Governance Requirements);

   b. As a group, board members represent the individuals served by the organization in terms of race, ethnicity, and gender. Reference Form 4—Community Characteristics, and Form 6A—Current Board Member Characteristics;[36]

   c. Non-patient members are representative of the community in which the applicant's proposed service area is located and are selected for their expertise;

   d. Board has a minimum of nine but no more than 25 members, as appropriate for the complexity of the organization;

   e. No more than half (50 percent) of the non-patient members derive more than 10 percent of their annual income from the health care industry; and

   f. No board member is an employee of the health center or an immediate family member of an employee (only the CEO may serve as a non-voting, ex-officio board member).

   NOTE: An applicant requesting designation to serve general community and special populations (Health Care for the Homeless, Migrant Health Center, and/or Public Housing Primary Care) must have appropriate board representation from both the general community and special

[36] Eligible applicants requesting a waiver of the 51 percent patient majority board composition requirement must list the applicant's board members on Form 6A–Current Board Member Characteristics and NOT the members of any advisory council.

populations. At minimum, there must be at least one representative from each of the special population groups for which designation is requested. Special population representatives should be individuals that can clearly communicate the needs/concerns of the target populations to the board (e.g., current resident of public housing, a formerly homeless individual, an advocate for migrant or seasonal farm workers).

3. **Board Operations**. Demonstrate the effectiveness of the governing board by describing how the board:

   NOTE: At a minimum, applicants must demonstrate that the governing board is properly executing its authorities over the organization's operations. Six months of operation, including six months of board meeting minutes and six months of financial statements must be provided for HRSA's review. Regardless of the number of months of operation, an organization that is not compliant with any Health Center Program requirement(s) cannot be approved.

   a. Operates, including the organization and responsibilities of board committees.

   b. Monitors and evaluates its (the board's) performance.

   c. Provides board training, development, and orientation for new members to ensure that they have sufficient knowledge to make informed decisions.

   NOTE: Only an applicant requesting to serve special populations (MHC, HCH, and/or PHPC) may request a waiver of the monthly meeting or 51 percent patient majority requirement. An approved waiver does not relieve the governing board from fulfilling all other board authorities and responsibilities required by statute.

4. **Governance Waivers**. Applicants requesting a waiver for one or both of the governance requirements must indicate such request on Form 6B—Request for Waiver of Governance Requirements and explain:

   a. Why the project cannot meet this requirement and describe in Form 6B the alternative mechanism(s) for gathering and utilizing patient input; and/or

   b. Why the project cannot meet the monthly meeting requirement and describe in Form 6B the alternative meeting schedule and how it will assure that the board will maintain appropriate oversight of the project.

   c. Indian Tribes or Tribal, Indian, or Urban Indian Groups Only: Describe the governance structure and how it will assure adequate: (1) input from the community/target population on health center priorities; and (2) fiscal and programmatic oversight of the project.

REQUIRED FORMS, DOCUMENTS, AND ATTACHMENTS

HRSA may disapprove applications that do not include all required forms, documents and attachments in accordance with the detailed instructions provided in Appendices A, B, and C.

Required Forms and Documents

Applicants must complete forms online using HRSA's EHB. Forms do not need to be downloaded or uploaded. Applicants create documents (e.g., Program Abstract and Program Narrative) and then upload them into the EHB system.

For detailed instructions for all forms, see Appendix A: Required Forms Instructions, Appendix B: Clinical and Financial Performance Measures Instructions and instructions as noted below. MS Word versions of all forms are available at http://bphc.hrsa.gov/about/lookalike/index.html.

REQUIRED FORMS OVERVIEW			
Required Documentation	**Type**	**Description**	**Instructions**
Cover Page	Form	Provides a summary of information related to the program at the time of application submission.	Appendix A
Form 1A—General Information Worksheet	Form	Provides a summary of information related to the applicant, proposed service area, target population, provider information, and patient visits by service type.	Appendix A
Program Abstract	Document	Provides a brief summary of the project.	Application Requirements, Program Abstract section (above)
Program Narrative	Document	Provides a comprehensive description of the proposed project, including a detailed picture of the community/target population served, the organizational structure, and how the organization is addressing the identified primary health care needs of the community.	Application Requirements, Program Narrative section (above)
Clinical Performance Measures	Form	Provides time-framed and realistic goals and related clinical performance measures with baselines that are responsive to the identified primary health care needs of the community served and the strategic needs of the overall organization.	Appendix B
Financial Performance Measures	Form	Provides time-framed and realistic goals and related financial performance measures with baselines that are responsive to the identified financial needs of the community served and the strategic needs of the overall organization.	Appendix B
Form 2—Staffing Profile	Form	Reports personnel salaries supported by the total budget for the first year of the designation period. Current clinical staff must be described within the Program Narrative (6.a.).	Appendix A
Form 3—Income Analysis Form	Document	Projects program income, by source, for the first 2-year designation period.	Appendix A

REQUIRED FORMS OVERVIEW			
Required Documentation	**Type**	**Description**	**Instructions**
Form 3A—Look-Alike Budget Information	Form	Reports program budget by function and activity for the first year of the designation period.	Appendix A
Form 4—Community Characteristics	Form	Reports service area and target population data for the entire scope of the project for the most recent period for which data are available.	Appendix A
Form 5A—Services Provided	Form	Identifies what services are available and how these services are currently provided. *If the application is approved, HRSA will use the information presented on Form 5A to determine the services included in the Scope of Project for the look-alike. Any services that are described or detailed in other portions of the application (e.g., narratives, attachments) will not be included in the organization's Scope of Project.*	Appendix A
Form 5B—Service Sites	Form	Identifies details of each proposed service delivery site. Applicants must complete Form 5B for each site proposed as a look-alike site. *If the application is approved, HRSA will use the information presented on Form 5B to be the sites included in the Scope of Project for the look-alike. Any sites that are described or detailed in other portions of the application (e.g., narratives, attachments) will not be included in the approved Scope of Project.*	Appendix A
Form 5C—Other Activities/Locations (if applicable)	Form	Provides information about activities/locations that: 1) do not meet the definition of a service site; 2) are conducted on an irregular timeframe/schedule; and/or 3) offer a limited activity from within the full complement of health center activities included within the Scope of Project.	Appendix A
Form 6A—Current Board Member Characteristics	Form	Provides information about governing board members, including areas of expertise and whether the member is a patient of the health center and/or a resident of the service area.	Appendix A
Form 6B—Request for Waiver of Governance Requirements	Form	Provides justification for and type of waiver requested. *Only organizations that request designation exclusively to serve a special population(s) authorized under section 330 of the PHS Act are eligible for a waiver of certain governance requirements.*	Appendix A
Form 8—Health Center Agreements	Form	Provides information about contracts and other agreements that constitute a substantial portion of the scope of project. *Form 8 is approved for the length of the designation period.*	Appendix A

REQUIRED FORMS OVERVIEW			
Required Documentation	**Type**	**Description**	**Instructions**
Form 9—Need for Assistance	Form	Provides information about the need in the community specific to core barriers to primary care access, core health indicators, and other health indicators.	Appendix A
Form 10—Annual Emergency Preparedness and Management Report	Form	Provides information about the organization's emergency preparedness planning and progress toward implementing an emergency management plan.	Appendix A
Form 12—Contact Information	Form	Identifies organizational contacts for ongoing communication with HRSA.	Appendix A

Required Attachments

Below is a brief overview of required attachments. Attachments are created by the applicant and are then uploaded to the EHB. ***For detailed instructions and requirements for Attachments, see Appendix C.***

Required Attachment	Description
Attachment 1—Patient Origin Study	Identifies the number of patients residing in each zip code served by the organization.
Attachment 2—Service Area Map	Provides a map that clearly identifies the areas served by the organization, all service delivery sites, the designated MUA/MUP areas, census tracts, ZIP codes, and the location of other primary care provider sites (e.g., Health Center Program grantees, look-alikes, hospitals, free-clinics, etc.).
Attachment 3—Current or Requested MUA/MUP Designation	Provides documentation of the organization's medically underserved area or population designation.
Attachment 4—Governing Board Bylaws	Describes the authorities and responsibilities of the governing board.
Attachment 5—Governing Board Meeting Minutes	Documents meetings of the governing board, how they exercise their authorities and provide oversight to the health center.
Attachment 6—Co-Applicant Agreement for Public Centers (if applicable)	Signed agreement between the public entity and co-applicant that describes how the two organizations will work together in support of the health center.
Attachment 7—Affiliation, Contract, and/or Referral Agreements (if applicable)	Provides a brief summary of current contracts and agreements (e.g., contracted provider and/or staff, management services contracts, formal referral arrangements, etc.).
Attachment 8—Articles of Incorporation	Provides official articles of incorporation, including seal page, documenting the State acceptance for the applicant of record.
Attachment 9—Evidence of Non-Profit or Public Agency Status	Provides official documentation of public entity or non-profit status.
Attachment 10—Medicare and Medicaid Provider Documentation	Provides evidence that the applicant is currently a primary health care Medicaid and Medicare provider.
Attachment 11—Organizational Chart	Provides a graphic depiction of the organizational and management structure and lines of authority, key employee position titles, names, and full-time equivalents.
Attachment 12—Position Descriptions for Key Personnel	Provides detailed information about each key personnel position.
Attachment 13—Resumes for Key Personnel	Provides resumes for all key personnel identified in the organizational chart.
Attachment 14—Schedule of Discounts/Sliding Fee Scale	Documents the organization's sliding fee scale for patients under 200% of the most recent Federal poverty guidelines.
Attachment 15—Most Recent Independent Financial Audit	Provides the organization's most recent independent financial audit and management letter, if applicable or a minimum of 6 months of financial statements for organizations in operation less than one year.

Required Attachment	Description
Attachment 16—Letters of Support	Provides documentation of support for the organization's look-alike designation from the other primary care providers in the area, including other Health Center Program grantees and look-alikes, rural health clinics, hospitals, state and local health departments, and other programs serving the same population(s).
Attachment 17—Floor Plans	Provides the organization's floor plans.
Attachment 18—Other Information	Provides any additional information to support the application.

APPLICATION REVIEW

HRSA reviews initial designation applications first for eligibility and completeness. HRSA will disapprove all ineligible or incomplete applications and notify the applicant of the reason for the disapproval. If determined to be eligible and complete, HRSA will review applications for compliance based on the applicable requirements, statutes, and policies. Application review will result in one of the following outcomes:

1. **APPROVE**. HRSA determines that the applicant is eligible and compliant with all program requirements and issues a Notice of Look-Alike Designation (NLD). This can occur without HRSA interaction with the applicant but more often occurs after a request for more information.

2. **REQUEST FOR MORE INFORMATION**. The applicant meets the eligibility criteria and the application is complete, but does not demonstrate full compliance with one or more program requirements. HRSA will provide feedback on the areas of non-compliance and how those areas of non-compliance must be addressed in writing through the EHB. HRSA will also provide phone consultation by request. The organization will have a period of up to 30 days to submit additional information as necessary to demonstrate compliance. If the organization does not respond to identified areas of non-compliance within the specified time period, remains non-compliant with program requirements after submitting requested materials, or the response to HRSA's request is otherwise incomplete, then HRSA will discontinue the review and disapprove the application. If the organization's response is within the defined timeframe and meets all requirements, HRSA will approve the application.

3. **DISAPPROVE.** The applicant does not meet the eligibility criteria and/or the application is incomplete, or there are several areas of significant non-compliance with one or more program requirements. HRSA will provide written feedback on the areas of non-compliance and how those areas of non-compliance may be addressed in a future. HRSA will also provide phone consultation by request.

Applicants can re-apply for initial designation after an application is disapproved.

Review Time Frames

HRSA will review applications in the order in which they are received. The following table identifies the days allotted for the steps in the development and review of an initial designation application. HRSA time frames are approximate and may vary due to extenuating issues.

Responsible Entity	Steps in Process	Approximate Time
Applicant	Time allotted for the submission of application once the application process has been initiated in the EHB. NOTE: **HRSA cannot extend this 90-day period**. Applicants whose applications expire in the EHB can begin a new application, with a new 90-day timeframe, the following day.	90 days
HRSA	Approximate time allotted for HRSA's initial review of the application once received in EHB, and HRSA's request for additional information.	90 days
Applicant	Time allotted for applicant response to any follow-up information requested by HRSA.	5-30 days
HRSA	Approximate time allotted for HRSA review of applicant submission of additional information.	45 days
HRSA	Designation Process	15 days

SUBMITTING THE APPLICATION

Applications must be submitted electronically through the HRSA Electronic Handbooks (EHBs). Refer to HRSA's *Electronic Submission User Guide*, available online at http://bphc.hrsa.gov/about/lookalike/index.html for detailed application and submission instructions.

Initial designation applications are accepted on a rolling basis throughout the year. Applicants have 90 days to complete an application in EHB. Because HRSA cannot extend this 90-day period, we encourage applicants to prepare as much of the application outside the EHB system as is feasible. Applicants can view Microsoft Word versions of all EHB forms at http://bphc.hrsa.gov/about/lookalike/index.html.

Applications will be considered submitted when they are successfully transmitted electronically by the applicant's Authorizing Official (AO) through HRSA's EHB within 90 calendar days of the date of initiation of the application process in the HRSA EHB.

Applicants must ensure that the AO is available to submit the application before the 90-day application period has ended. HRSA will not accept submission or re-submission of incomplete, rejected or otherwise delayed applications after the 90-day application period.

Registering in the HRSA EHB

In order to submit the initial designation application in the EHB, the AO and any other application preparers must register in the HRSA EHB.

The purpose of the EHB registration process is to collect consistent information from all users, avoid collection of redundant information, and allow for the unique identification of each system user.

Registration within the HRSA EHB is required only once for each user. HRSA's EHB allows a user to associate his/her single username with more than one organization.

STEP 1: Identify roles for all individuals who will be involved in the application process and who will need access to the application within the EHB. HRSA's EHB offers the following three functional roles for individuals from applicant organizations:

1. Authorizing Official (AO)
2. Business Official (BO)
3. Other Employee (for project directors, assistant staff, AO designees, and others)

STEP 2: Each person creates an individual system account.

STEP 3: Each person associates their account with the applicant organization.

STEP 4: Once the registration is complete, all users will be prompted to go through an additional step to gain access to the application in the HRSA EHB.

ADDITIONAL INFORMATION AND TECHNICAL ASSISTANCE

Program Requirements and Application Questions

For additional information related to **program issues and/or technical assistance (not related to EHB)**:

Office of Policy and Program Development
HRSA, Bureau of Primary Health Care
5600 Fishers Lane, Room 17C-26
Rockville, MD 20857
Telephone: 301-594-4300
Fax: 301-594-4997
Email: lookalike@hrsa.gov
Technical Assistance Resources: http://bphc.hrsa.gov/about/lookalike/index.html

EHB Accounts, Passwords, Roles, and Privileges

For help **establishing an EHB account, password assistance, or setting up the roles and privileges** associated with your EHB account and to access EHB tutorials, contact:

HRSA Call Center
Phone: 877-Go4-HRSA or 877-464-4772 [TTY: 877-897-9910]
Fax: 301-998-7377
Email: CallCenter@hrsa.gov
Hours of Operation: Monday – Friday, 9:00 a.m. to 5:30 p.m. ET

Navigating and Completing Applications in the EHB

For assistance with **navigating and completing BPHC applications in the EHB**, contact:

HRSA Bureau of Primary Health Care (BPHC) Helpline
Phone: 877-974-2742
Email: bphchelpline@hrsa.gov
Hours of Operation: Monday – Friday, 8:30 a.m. to 5:30 p.m. ET

Appendix A: Required Forms Instructions

The BPHC Program Specific forms must be completed electronically in the HRSA EHB. To preview the forms, visit http://bphc.hrsa.gov/about/lookalike/index.html. Portions of the forms that are grayed out are not relevant to the application and do not need to be completed.

FORM 1A – General Information Worksheet (Required)

Form 1A provides a summary of information related to the proposed look-alike project.

1. APPLICANT INFORMATION

- Complete all relevant information that is not pre-populated.
- Applicants may check only one category in the Business Entity section. If an applicant is a Tribal or Urban Indian entity and also meets the definition for a public or private entity, then the Applicant should select the Tribal or Urban Indian category.
- Applicants may select more than one category for the Organization Type section.

2. PROPOSED SERVICE AREA

2a. Target Population and Service Area Designation

- Applicants seeking section 330(e) look-alike designation for Community Health Centers (CHC) MUST provide Medically Underserved Area (MUA) and/or Medically Underserved Population (MUP) designation information. Select the MUA and/or MUP designations that best describe the proposed service area. For inquiries regarding MUAs or MUPs, call 1-888-275-4772 (option 2) or contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816. For additional information, visit the Shortage Designation website at http://bhpr.hrsa.gov/shortage.
- Select the type of designation requested (i.e., section 330(e), section 330(g), section 330(h), and/or section 330(i)). Refer to definitions of the MHC, HCH, and PHPC populations.

2b. Service Area Type

- Classify the proposed target population type as Urban, Rural, or Sparsely Populated. To be determined sparsely populated, the entire proposed service area must have seven or fewer people per square mile.

2c. Target Population Information:

- Applicants with more than one proposed site should report aggregate data for all of the sites included in the look-alike initial designation application.
- Provide the number of individuals currently composing the service area and target populations.

When providing the count of patients and visits, note the following guidelines (see the 2012 UDS Manual available at http://bphc.hrsa.gov/healthcenterdatastatistics/reporting for detailed information):

- A visit is a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit,

services must be documented in the patient's record. Such contacts provided by contractors and paid for by the grantee are considered to be visits.
- A patient is an individual who had at least one visit in the previous year.
- Since a patient must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits. Do not report patients and visits for services outside the organization's proposed scope of project. Specifically, the scope of project defines the service sites, services, providers, service area, and target population for which look-alike designation may be applicable. For more information, see PIN 2008-01 available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html.
- Do not report patients and visits for vision services.

Patients and Visits by Service Type:
- Project the number of patients and visits anticipated within each service type category across all proposed look-alike sites by the end of the 2-year designation period. Within each service type category (medical, dental, behavioral health, substance abuse, and enabling services), an individual can only be counted once as a patient. An individual who receives multiple types of services should be counted once for each service type (e.g., once for medical and once for dental).

Unduplicated Patients and Visits by Population Type:
- Project the number of patients and visits anticipated within each population type category across all proposed look-alike sites by the end of the 2-year designation period.
- Data reported for patients and visits should not be duplicated within or across the four target population categories (i.e., General Community, Migrant and Seasonal Farm Workers, Public Housing Residents, Homeless Persons).

> *NOTE: The Population Type in this table refers to the population being served, not the Funding Type (i.e., section 330(g), section 330(h), section 330(i)).*

FORM 2 – Staffing Profile (Required)

The Staffing Profile reports personnel salaries supported by the total budget for the first year of the proposed project. Include all staff directly employed by the health center (i.e., Form W-2, Wage and Tax Statement, issued by the health center).[37] Anticipated staff changes within the proposed designation period must be addressed in the Resources/Capabilities section of the Program Narrative.

[37] HRSA utilizes Internal Revenue Service (IRS) definition to differentiate employees and contractors. To be considered as an employee by the IRS, the individual must receive a salary from the covered entity on a regular basis with applicable taxes and benefits deducted along with coverage for unemployment compensation in most cases. The covered entity should issue a W-2 form for an employee to be a covered individual, and a Form 1099 to an individual who is a contractor.

- Salaries in categories representing multiple positions (e.g., LPN, RN) must be averaged. To calculate the average annual salary, sum the salaries within the category and divide that amount by the total number of FTEs.
- Report ONLY portions of salaries that support activities within the proposed look-alike scope of project.
- Do not include contracted (to include individual and organization level contracts) or volunteer staff on this form.

The Staffing Profile should be consistent with the personnel costs included in the budget justification.

FORM 3 – Income Analysis (Required)

Project the program income, by source, for each year of the proposed look-alike designation period by presenting the estimated revenues for the first 2-year designation period (Year 1 and Year 2). Anticipated changes within the proposed designation period must be addressed in the budget justification. Entries that require additional explanation (e.g., projections that include reimbursement for billable events that UDS does not count as visits) must be discussed in the Comments/Explanatory Notes box and, if necessary, detailed in the budget justification. Form 3 must be based ONLY on the proposed look-alike project.

The two major classifications of revenues are as follows:

- **Program Income (Part 1)** includes fees, premiums, third party reimbursements, and payments generated from the projected delivery of services. Program income is divided into Fee for Service and Capitated Managed Care. Program Income reported must be consistent with information reported on Form 3A—Look-Alike Budget Information. **All service-related income must be reported in this section of the form.**
- **Other Income (Part 2)** includes state, local, other Federal grants or contracts (e.g., Ryan White, HUD, Head Start), and local or private support that is not generated from charges for services delivered.

If the categories in the worksheet do not describe all possible categories of Program Income or Other Income (e.g., laboratory, imaging, pharmacy, other professional services), applicants may add lines for additional income sources. Explanations for such additions must be noted in the Comments/Explanatory Notes box.

NOTE: Not all visits reported on this form are reported in UDS, and similarly, not all visits reported in UDS are included on this form. This form reports only visits that are billable to first or third parties, including individuals who, after the sliding fee discount schedule has been applied, may pay little or none of the actual charge. (See Column (a) instructions below for additional details.)

Applicants may contact their State/Regional Primary Care Association to inquire about FQHC rates for service delivery programs that are similar in size. For contact listings, refer to http://bphc.hrsa.gov/technicalassistance/partnerlinks/.

PART 1: PROGRAM INCOME

All service-related income must be reported in this section of the form.

Projected Fee for Service Income

Lines 1a.-1e. and 2a.-2b. (Medicaid and Medicare): Show income from Medicaid and Medicare *regardless of whether there is another intermediary involved*. For example, if the applicant has a Blue Cross fee-for-service managed Medicaid contract, the information would be included on lines 1a.-1e., not on lines 3a.-3d. If CHIP is paid through Medicaid, it must be included in the appropriate category on lines 1a-1e. In addition, if the applicant receives Medicaid reimbursement via a Primary Care Case Management (PCCM) model, this income must be included on line 1e.—Medicaid: Other Fee for Service.

Line 5 (Other Public): Include CHIP **not** paid through Medicaid as well as any other state or local programs that pay for visits (e.g., Title X family planning visits, CDC's Breast and Cervical Cancer Early Detection Program, Title I and II Ryan White visits).

Column (a): Enter the number of billable visits that will be covered by each category and payment source: Medicaid, Medicare, other third-party payors, and uninsured self-pay patients. **Do not calculate visits for laboratory, imaging, pharmacy, or other professional services.**

Column (b): Enter the average charge per visit by payor category. An analysis of charges will generally reveal different average charges (e.g., average Medicare charges may be higher than average Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) charges). If this level of detail is not available, calculate averages on a more general level (i.e., at the payor, service type, or agency level).

Column (c): Enter Gross Charges before any discount or allowance for each payment category calculated as [columns (a)*(b)].

Column (d): Enter the adjustment rate (percentage) to the average charge per visit listed in column (b). In actual operation, adjustments may be taken either before or after the bill is submitted to a first or third party. Adjustments reported here do NOT include adjustments for bad debts which are shown in columns (f) and (g). Adjustments in column (d) include those related to:

1. Projected contractual allowances or discounts to the average charge per visit.
2. Sliding discounts given to self-pay patients (with incomes 0-200% of the Federal poverty guidelines).
3. Adjustments to bring the average charge/reimbursement up or down to the:
    a. Negotiated Federally Qualified Health Center (FQHC) reimbursement rate
    b. Established Prospective Payment System reimbursement rate
    c. Cost based reimbursement expected <u>after</u> completion of a cost reimbursement report
4. Any other applicable adjustments. These must be discussed in the Comments/Explanatory Notes box.

NOTE: An adjustment rate that has the effect of increasing charges is expressed as a negative.

Column (e): Enter the total Net Charges by payment source calculated as [column (c)*(100 - column (d))]. Net charges are gross charges less adjustments described in column (d).

Column (f): Enter the estimated collection rate by payor category. The collection rate is the amount projected to be collected divided by the net charges. As a rule, collection rates will not exceed 100%, and may be less than 100% due to factors such as bad debts (especially for self pay), billing errors, or denied claims not re-billable to another source. Explain any rate greater than 100% using the Comments/Explanatory Notes box.

NOTE: Do not show sliding discount percentages here; they are included in column (d). Show the collection rate for actual direct patient billings.

Column (g): Enter Projected Income for each payor category calculated as [columns (e)*(f)].

Projected Capitated Managed Care Income

This section applies only to capitated programs. Visits provided under a fee-for-service managed care contract are included in the fee-for-service section of this form.

Lines 7a.-7d. (Type of Payor): Group all capitated managed care income types of service by payor on a single line. Thus, capitated Medicaid dental visits and capitated Medicaid medical visits are added together and reported on line 7a.

Number of Member Months (Column a): The number of member months for which payment is received. One person enrolled for one month is one member month; a family of five enrolled for six months is 30 member months. A member month may cover just medical services, or medical and dental, or a unique mix of services. Unusual service mixes that provide for unusually high or low per member per month (PMPM) payments must be described in the Comments/Explanatory Notes box.

Rate per Member Month (Column b): Also referred to as PMPM rate, this is the average payment across all managed care contracts for one member. PMPM rates may be based on multiple age/gender specific rates or on service specific plans, but all these must be averaged together for a "blended rate" for the provider type.

Risk Pool and Other Adjustments (Column c): This is an *estimate* of the *total* amount that will be earned from risk or performance pools, including any payment made by a Health Maintenance Organization (HMO) to the applicant for effectively and efficiently managing the health care of enrolled members. The estimate is usually for a prior period, but must be accounted for in the period it is received. Describe risk pools and other adjustments in the Comments/Explanatory Notes box. Risk pools may be estimated using the average risk pool receipt PMPM over an appropriate prior period selected by the applicant.

FQHC Cost Settlement and Wrap Adjustments (Column d): This is the *total* amount of payments made to the applicant to cover the difference between the PMPM amount paid for Medicaid or Medicare managed care visits and the applicant's PPS/FQHC rate.

Projected Gross Income (Column e): Calculate this for each line as [columns (a)*(b)] + [columns (c)+(d)] = column (e).

PART 2: OTHER INCOME

This section includes **all income not entered elsewhere** on this form. It includes grants for services, construction, equipment, or other activities that support the project, where the revenue is **not**

generated from services provided or visit charges. It also includes income generated from fundraising and contributions.

Line 10: Enter the amount of funds applied from the applicant's retained earnings, reserves, and/or assets needed to achieve a breakeven budget. Please explain the reason for and source of amounts entered on this line in the Comments/Explanatory Notes box.

NOTE: DO NOT include in-kind donations on the Income Analysis form. Applicants may discuss in-kind contributions in the Project Narrative.

FORM 3A – Look-Alike Budget Information (Required)

Part 1: Expenses: includes personnel, fringe benefits, travel, equipment, supplies, contractual, construction, and other. Indirect charges may also be included.

For each of the expense categories enter the projected first year expenses for each of the applicable Programs, Functions, or Activities. If the categories in the form do not describe all possible expenses, organizations may enter expenses in the "Other" category. The total fields are calculated automatically as you move through the form.

Part 2: Revenue: includes funds supplied by the applicant and/or Federal, State, local, other sources. For each of the revenue categories, enter the projected first year revenue from each of the applicable Programs, Functions, or Activities. If revenue is collected from sources other than the listed sources, indicate those in the "Other" category. The total fields are calculated automatically as you move through the form.

FORM 4 – Community Characteristics (Required)

Report service area and target population data for the entire scope of the project for which data are available (i.e., all proposed look-alike sites). Race and ethnicity information will be used only to ensure compliance with statutory and regulatory governing board requirements.

Service area data must be specific to the proposed project and include the total number of persons for each characteristic (percentages will automatically calculate in EHB). If information for the service area is not available, extrapolate data from the U.S. Census Bureau, local planning agencies, health departments, and other local, state, and national data sources. Estimates are acceptable.

Target population data is most often a subset of service area data. Report the number of persons for each characteristic (percentages will automatically calculate in EHB). ***Patient data should not be used to report target population data since patients are typically a subset of all individuals targeted for service.*** Estimates are acceptable.

If the target population includes a large number of transient individuals (e.g., the county has an influx of migrant and seasonal farm workers during the summer months) that are not included in the dataset used for service area data (e.g., census data), the applicant should adjust the service area numbers accordingly to ensure that the target population numbers are always less than or equal to the service area numbers.

NOTE: The total numbers for the first four sections of this form (i.e., Race, Hispanic or Latino Identity, Income as a Percent of Poverty Level, and Primary Third Party Payment Source) ***must match****. These total numbers will also be consistent with the service area and target population totals reported on Form 1A.*

Guidelines for Reporting Race

All individuals must be classified in one of the racial categories, including individuals who also consider themselves Hispanic or Latino. If the data source does not separately classify Hispanic or Latino individuals by race, report them as Unreported/Declined to Report. Utilize the following race definitions:

- Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
- Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, Palau, Chuuk, Yap, or other Pacific Islands in Micronesia, Melanesia, or Polynesia.
- Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- American Indian/Alaska Native – Persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- More Than One Race – Persons who identify with 2 or more races.

Guidelines for Reporting Hispanic or Latino Identity

- If ethnicity is unknown, report individuals as Unreported/Declined to Report.
- Utilize the following ethnicity definition: Hispanic or Latino – Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

NOTE: Applicants compiling data from multiple data sources may find that the total numbers vary across sources. Such applicants should make adjustments as needed to ensure that the total numbers for the first four sections of this form match.

Guidelines for Reporting Special Populations

The Special Populations section of Form 4 does not have a row for total numbers; individuals that represent multiple special population categories should be counted in all applicable categories.

FORM 5A – Services Provided (Required)

Identify the services that will be available through the proposed look-alike and how the services will be provided (i.e., Direct by Applicant, Formal Written Contract/Agreement, Formal Written Referral Arrangement/Agreement).

Information presented on Form 5A will be used by HRSA to determine the scope of project for the look-alike project. Only the services included on Form 5A will be considered to be in the approved scope of project. Services described or detailed in other portions of the application (e.g., narratives, attachments) are not considered to be included in the approved scope of project if the application is designated.

NOTE: Specialty services and other services may not be included in an applicant's proposed scope of services at the time of initial designation application submission. However, specialty services may be

added to the scope of project through the Change in Scope process after a look-alike has been designated. Refer to PIN 2009-02,Specialty Services and Health Centers' Scope of Project available at http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin200902.pdf for more information.

FORM 5B – Service Sites (Required)

Identify the look-alike site(s). Provide the required data for each proposed new access point that meets the definition of a service site. Refer to PIN 2008-01, Defining Scope of Project and Policy for Requesting Changes available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html for more information on defining service sites and for special instructions for recording mobile, intermittent, or other site types. Information presented on Form 5B will be used by HRSA to determine the scope of project for the look-alike. Only the service sites included on Form 5B will be considered to be in the approved scope of project. Service sites described or detailed in other portions of the application (e.g., narratives, attachments) are not considered to be included in the approved scope of project if the application is designated. Applicants should include on each Form 5B, the zip codes for the area served by the site. The applicant's entire service area as demonstrated on Form 4, should be represented by the consolidation of all zip codes across all proposed service sites (all 5B forms).

NOTE: At least one proposed service site must be a full-time (operational 40 hours or more per week), permanent service delivery site (with the exception of proposed look-alike projects serving only migrant and seasonal farm workers, which may propose a full-time seasonal service delivery site). Subsequent service sites may be administrative, part-time, seasonal, etc. In addition, a mobile van may only be included if it is proposed in addition to a permanent or seasonal service delivery site.

NOTE: In HRSA EHB, applicants will have to state if the proposed site is a Domestic Violence site (e.g., emergency shelter). If so, applicants will not provide a street address to protect the confidentiality of the precise location.

FORM 5C – Other Activities/Location (As applicable)

Provide requested data for other activities/locations (e.g., home visits, health fairs). List only the activities/locations that: 1) do not meet the definition of a service site; 2) are conducted on an irregular timeframe/schedule; and/or 3) offer a limited activity from within the full complement of health center activities included within the scope of project. Look-alike service site(s) should not be listed. Refer to PIN 2008-01, Defining Scope of Project and Policy for Requesting Changes (available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html) for more details.

Information presented on Form 5C will be used by HRSA to determine the scope of project for the look-alike. However, regardless of what information is included on Form 5C, only the services included on Form 5A and the service sites included on Form 5B will be considered part of the approved scope of project. Any additional activities/locations described or detailed in other portions of the application (e.g., narratives, attachments) that are not listed on Form 5B are not considered to be included in the approved scope of project, even if the look-alike is designated.

FORM 6A – Current Board Member Characteristics (Required)

List all current board members and provide the requested details.

- Public entities with co-applicant health center governing boards must list the co-applicant board members.

- Applicants requesting a waiver of the 51 percent patient majority requirement must list the health center's board members, not the members of any advisory councils.
- List the current board office held for each board member, if applicable (e.g., Chair, Treasurer).
- List each board member's area of expertise (e.g., finance, teacher, nursing).
- Indicate if each board member is a health center patient.
- Indicate if each board member lives and/or works in the service area.
- List how long each individual has been on the board.
- Indicate if each board member is a representative of a special population (i.e., homeless, migrant, public housing).

NOTE: Indian tribes or tribal, Indian, or urban Indian organizations are not required to complete this form. When Tribal is selected as the business entity on Form 1A, Form 6A will automatically display as complete. However, such applicants may include information on this form as desired.

FORM 6B – Request for Waiver of Governance Requirements (As applicable)

Only applicants requesting funding to ***ONLY*** serve migrant and seasonal farm workers (section 330(g)), people experiencing homelessness (section 330 (h)) and/or residents of public housing (section 330(i)) are eligible to request a waiver.

- An applicant that currently receives or is applying to receive CHC (section 330(e)) designation is not eligible for a waiver. Form 6B will automatically show as complete and the applicant will not be able to enter information on this form.
- Indian tribes or tribal, Indian, or urban Indian groups are not required to complete this form. Form 6B will not permit the applicant to enter information on this form.
- Current health center program grantees with an existing waiver must reapply for governance waiver approval as part of the look-alike initial designation application.

In completing Form 6B, applicants requesting a waiver must justify why the applicant cannot meet the statutory requirements requested to be waived and describe the appropriate alternative strategies detailing how the applicant intends to assure consumer/patient participation/input (if board is not 51 percent consumer/patients) and/or regular oversight in the direction and ongoing governance of the organization (if no monthly meetings).

FORM 8 – Health Center Agreements (Required)

Complete Part I, indicating whether current or proposed agreements constitute a substantial portion of the proposed scope of project. If the applicant has a contract for core primary care providers, non-provider health center staff, chief medical officer (CMO) or chief financial officer (CFO), if a proposed site is operated by a contractor, which must also be identified in Form 5B—Service Sites, or if the applicant otherwise has an agreement to provide a substantial portion of the scope of project, the answer must be "**Yes**." If "**Yes**," indicate the number of each type in the appropriate field. If "**No**," skip to the Governance Checklist in Part II.

Complete the Governance Checklist. If the response to any of the Governance Checklist items is **No**, the response to the question regarding agreements/arrangements affecting the governing board's composition, authorities, functions, or responsibilities must be "**Yes**," and the number of such

agreements/arrangements must be indicated. Additionally, "**No"** responses for the Governance Checklist must be explained in the Resources/Capabilities section of the Program Narrative.

Part III should be completed only by applicants that responded "**Yes"** to Part I.1 or Part II.2. In Part III, use the Organization Agreement Details section to provide the contact information for each organization (up to 10) with which an agreement/arrangement either (1) constitutes a substantial portion of the proposed scope of project (as described in Part I) or (2) impacts the governing board's composition, authorities, functions, or responsibilities (as described in Part II). **Upload each agreement/arrangement** (up to 5) in full. Agreements/arrangements that exceed these limits should be included in Attachment 18—Other Information.

NOTE: Attachment 7—Affiliation, Contract and/or Referral Agreements must include a comprehensive list and summary of each arrangement, contract, and affiliation agreement, including those which are also discussed and attached in full as part of Form 8—Health Center Agreements.

FORM 9 – Need for Assistance Worksheet (NFA) (Required)

The worksheet is presented in three sections: Core Barriers, Core Health Indicators, and Other Health

1. **GENERAL INSTRUCTIONS FOR COMPLETING FORM 9**
   All applicants must submit a completed NFA Worksheet (Form 9) as part of the application. Applicants must present data on the NFA Worksheet based on ***the target population to be served within the proposed service area***, as appropriate. Only one NFA Worksheet will be submitted regardless of the number of look-alike sites proposed in the application.

   - Applicants are expected to complete the NFA Worksheet based on the entire proposed scope of their project.
   - If an applicant proposes to serve **multiple sites, populations and/or service areas**, the NFA Worksheet responses should represent the total targeted population within the proposed service area. **No more than one response should be submitted for any barrier or health indicator.**

   Guidelines for Completing the NFA Worksheet:

   - Responses cannot be expressed as ranges (e.g., 31-35).
   - Responses must be expressed in the **same format/unit of analysis** identified in each barrier or health indicator (e.g., a mortality ratio cannot be used to provide a response to "age-adjusted death rate"). The following table provides examples of the unit and format of responses:

Format/Unit of Analysis	Example
Percent	25% (25 percent of target population is uninsured)
Prevalence (expressed as percent or rate)	8.5% (8.5 percent of population has asthma) **or** 85 per 1,000 (85 asthma cases per 1,000 population)
Proportion	0.25 (25 out of 100 people, or 25% of all persons, are obese)
Rate	50 per 100,000 (50 hospital admissions for hypertension per 100,000 population)
Ratio	3000:1 (3000 people per every 1 primary care physician)

2. POPULATION TO BE SERVED

All responses must be based on data for the total target population within the proposed service area, as appropriate, per the following criteria:

(a) Applicants requesting designation to serve the medically underserved population of a service area **(under section 330(e) ONLY)** must provide responses that reflect the primary health care needs of the target population for the application. When the service area is a sub-county area (made up of groups of census tracts, other county divisions or zip codes), but data for a particular Barrier or Health indicator are not available at sub-county levels, applicants may use an extrapolation technique to appropriately modify the available county-level or other level (including if necessary, national) data to reflect the service area population.

(b) Applicants requesting designation to serve **ONLY a homeless population (under section 330 (h)), a migrant/seasonal farmworkers population (under section 330(g)) or residents of public housing (under section 330(i)), or any combination of these special populations**, may use an extrapolation technique to appropriately modify available data for these special populations to reflect their specific population(s) within the proposed service area.

(c) Applicants requesting designation to **serve a homeless population (under section 330 (h)), a migrant/seasonal farmworker population (under section 330(g)) or residents of public housing (under section 330(i)) IN COMBINATION WITH the medically underserved, general population of a service area (under section 330(e))**, must present responses that reflect the total population to be served. In calculating the response, applicants may use extrapolation techniques to appropriately modify available data to reflect the homeless, migrant/seasonal farmworker and/or public housing population within the service area (as in (b) above), then combine this with data about the general population within the defined the service area. As above, where sub-county data are not available, applicants may use an extrapolation technique to modify available county-level or other level data to reflect the service area population.

3. DATA

Please use the following guidelines when reporting data:

(a) All data must be from a reliable and independent source, such as a State or local government agency, professional body, foundation or other well-known organization using recognized, scientifically accepted data collection and/or analysis methods; and

(b) Applicants must provide the following information for all data sources:
- Name of data source;
- The year to which the data apply;
- Description of the methodology utilized (e.g., extrapolation); and
- Any additional information of relevance.

4. NFA WORKSHEET

SECTION 1: CORE BARRIERS

A response is required for **three (3) out of the four (4)** Core Barriers listed:
- Ratio of Population to One FTE Primary Care Physician
- Percent of Population at or Below 200 Percent of Poverty
- Percent of Population Uninsured

- Distance (miles) OR Travel Time (minutes) to Nearest Primary Care Provider Accepting New Medicaid Patients and/or Uninsured Patients

SECTION 2: CORE HEALTH INDICATORS

Applicant should provide a response to **one (1)** core health indicator **from within each of the six (6) categories**: Diabetes, Cardiovascular Disease, Cancer, Prenatal and Perinatal Health, Child Health, and Behavioral and Oral Health.

If an applicant believes that none of the specified indicators represent the applicant's target population within the proposed service area, the applicant may propose to use an "Other" alternative for that core health indicator category. In such a case, the applicant must specify the indicator's definition, data source used, and rationale for using this alternative indicator.

CORE HEALTH INDICATOR CATEGORIES	Format/Unit of Analysis
1. Diabetes	
1(a) Diabetes Short-term Complication Hospital Admission Rate	Number per 100,000
1(b) Diabetes Long-term Complication Hospital Admission Rate	Number per 100,000
1(c) Uncontrolled Diabetes Hospital Admission Rate	Number per 100,000
1(d) Rate of Lower-extremity Amputation Among Patients with Diabetes	Number per 100,000
1(e) Age Adjusted Diabetes Prevalence	Percent
1(f) Adult Obesity Prevalence	Percent
1(g) Diabetes Mortality Rate[38]	Number per 100,000
1(h) Other	Provided by Applicant
2. Cardiovascular Disease	
2(a) Hypertension Hospital Admission Rate	Number per 100,000
2(b) Congestive Heart Failure Hospital Admission Rate	Number per 100,000
2(c) Angina without Procedure Hospital Admission Rate	Number per 100,000
2(d) Mortality from Diseases of the Heart[39]	Number per 100,000
2(e) Proportion of Adults reporting diagnosis of high blood pressure	Percent
2(f) Other	Provided by Applicant
3. Cancer	
3(a) Cancer Screening – Percent of women 18 and older with No Pap test in past 3 years	Percent
3(b) Cancer Screening – Percent of women 40 and older with No Mammogram in past 3 years	Percent
3(c) Cancer Screening – Percent of adult 50 and older with No Fecal Occult Blood Test within the past 2 years	Percent
3(d) Other	Provided by Applicant

[38] Number of deaths per 100,000 reported as due to diabetes as the underlying cause or as one of multiple causes of death (ICD-9 Code 250).

[39] Total number of deaths per 100,000 reported as due to heart disease (includes ICD-9 Codes I00-I09, I11, I13, and I20-I51).

CORE HEALTH INDICATOR CATEGORIES	Format/Unit of Analysis
4. Prenatal and Perinatal Health	
4(a) Low Birth Weight Rate (5 year average)	Percent
4(b) Infant Mortality Rate (5 year average)	Number per 1000 births
4(c) Births to Teenage Mothers (ages 15-19; Percent of all births)	Percent
4(d) Late entry into prenatal care (entry after first trimester; Percent of all births)	Percent
4(e) Cigarette use during pregnancy (Percent of all pregnancies)	Percent
4(f) Other	Provided by Applicant
5. Child Health	
5(a) Pediatric Asthma Hospital Admission Rate	Number per 100,000
5(b) Percent of Children tested for elevated blood lead levels by 36 months of age	Percent
5(c) Percent of children not receiving recommended immunizations: 4-3-1-3-3[40]	Percent
5(d) Other	Provided by Applicant
6. Behavioral and Oral Health	
6(a) Depression Prevalence	Percent
6(b) Suicide Rate	Number per 100,000
6(c) Youth Suicide attempts requiring medical attention (Percent of all Youths)	Percent
6(d) Percent of Adults with Mental disorders not receiving treatment	Percent
6(e) Any Illicit Drug Use in the Past Month (Percent of all Adults)	Percent
6(f) Heavy alcohol use (Percent among population 12 and over)	Percent
6(g) Homeless with severe mental illness (Percent of all homeless)	Percent
6(h) Oral Health (Percent without dental visit in last year)	Percent
6(i) Other	Provided by Applicant

SECTION 3: OTHER HEALTH INDICATORS

Applicants must provide responses to two (2) out of the twelve (12) Other Health Indicators listed below. Alternatively, applicants can propose up to two (2) of the identified indicators using an "Other" indicator. For each "Other" indicator (up to two (2)), applicants must specify the indicator's definition, data source used, and rationale for using this indicator in place of one of those specified.

OTHER HEALTH INDICATORS	Format/Unit of Analysis
(a) Age-Adjusted Death Rate	Number per 100,000
(b) HIV Infection Prevalence	Percent
(c) Percent Elderly (65 and older)	Percent
(d) Adult Asthma Hospital Admission Rate	Number per 100,000
(e) Chronic Obstructive Pulmonary Disease Hospital Admission Rate	Number per 100,000
(f) Bacterial Pneumonia Hospital Admission Rate	Number per 100,000
(g) Three Year Average Pneumonia Death Rate[41]	Number per 100,000
(h) Adult Current Asthma Prevalence	Percent

[40] 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B.

[41] Three year average number of deaths per 100,000 due to pneumonia (includes ICD-9 Codes 480-486).

OTHER HEALTH INDICATORS	Format/Unit of Analysis
(i) Adult Ever Told Had Asthma (Percent of all adults)	Percent
(j) Unintentional Injury Deaths	Number per 100,000
(k) Percent of population linguistically isolated (percent of people 5 years and over who speak a language other than English at home)	Percent
(l) Waiting time for public housing where public housing exists	Months
(m) Other	Provided by Applicant
(n) Other	Provided by Applicant

Form 10 – Annual Emergency Preparedness Report (Required)

Select the appropriate responses regarding emergency preparedness. If any answer is no, explain the response in the Resources/Capabilities section of the Program Narrative. This form will be used to assess the status of emergency preparedness planning and progress towards developing and implementing an emergency management plan.

Form 12 – Organizational Contacts (Required)

Provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the application.

Appendix B: Clinical and Financial Performance Measures Instructions

The clinical and financial performance measures serve as ongoing monitoring and evaluation tools for look-alikes and HRSA. The performance measures should include time-framed and realistic goals for related performance measures (as referenced below) with baselines that are responsive to the identified primary health care needs of the community served and the strategic needs of the overall organization, including multiple sites and/or various activities at multiple sites. If baselines are not yet available, identify when the data will be available. If designated, look-alikes must report on the progress of achieving the goals and baselines during each annual certification application, as well as develop new goals and baselines for each renewal of designation application.

Performance Measures

Applicants must respond to the health center performance measures within each Need/Focus Area identified below, as appropriate. The health center performance measures are accessible on HRSA's website at http://bphc.hrsa.gov/policiesregulations/performancemeasures/. Additional information on the Clinical Performance Measures can be found in the annual Uniform Data System Reporting Manual available at http://bphc.hrsa.gov/uds/. Additional technical assistance related to the clinical and financial performance measures is available through HRSA and the State PCA.

- Only applicants that provide or assume primary responsibility for some or all of a patient's prenatal care services, whether or not the applicant does the delivery, are required to include prenatal performance measures, including the required measures: Percentage of pregnant women beginning prenatal care in the first trimester and Percentage of births less than 2,500 grams to health center patients.

- If the applicant is applying for look-alike designation to target special populations (e.g., migrant/seasonal farmworkers, residents of public housing, homeless persons), they are encouraged to include additional goals and related performance measures that address the unique health care needs of these populations, as appropriate.

- If the applicant has identified other unique populations, life-cycles, health issues, risk management efforts, etc., in the narrative Need section, they are encouraged to include additional goals and related performance measures as appropriate.

- Any additional narrative regarding the clinical and financial performance measures should be included in the Evaluative Measures section of the Program Narrative, as appropriate.

Applicants must address the performance measures provided by HRSA, as applicable. All applicants must also include one Behavioral Health (e.g., Mental Health or Substance Abuse) and one Oral Health performance measure of their choice in the clinical performance measures.

Applicants may also wish to consider utilizing Healthy People 2020 goals and performance measures when developing their clinical and financial performance measures. Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The program consists of 41 focus areas and more than 1,400 objectives. Further information on Healthy People 2020 goals may be downloaded at http://www.healthypeople.gov/document/.

Initial Designation applicants should include current baseline measures and goals that can be achieved in a 2-year period, starting January 1 and ending December 31. Use the sample Initial Designation application clinical and financial performance measures formats provided below.

Need Addressed/Focus Area

This is a concise categorization of the major need or focus area to be addressed by the applicant for their service area, target population, and/or organization (Diabetes; Cardiovascular; Costs, Productivity; etc.). Applicants are expected to address each required performance measurement area as well as any other key needs of their target population or organization as identified in the application narrative.

Designation Period Goal(s) with Baseline

Goals relating to the Need/Focus Area should be listed in this section. Applicants should provide goals for the required performance measures listed above as well as other goals, which can be accomplished by the end of the 2-year designation period. The goals should be reasonable, measurable, and reflect an anticipated impact upon the specified need or focus area. The applicant must also provide baseline data to indicate their status at or prior to the beginning of the designation period. Baseline data provides a basis for quantifying the amount of progress/improvement to be accomplished in the designation period. If applicants choose to establish a baseline for any of the new clinical performance measures, they are encouraged to utilize current data. Applicants are expected to track performance against these goals throughout the entire approved designation period and to report interim progress achieved on the goal in subsequent Annual Certification applications.

Performance Measure(s)

Applicants must make use of the required performance measures listed above when setting goals in the Designation Period Goal(s) with Baseline section (also noted in the sample performance measures). Applicants may also include additional performance measures. Additional measures chosen by the applicant should also define the numerator and denominator that will be used to determine the level of progress/improvement achieved on each goal (e.g., Numerator: One or more screenings for colorectal cancer. Denominator: All patients age 51-80 years during the measurement year).

Data Source & Methodology

The source of performance measure data, method of collection and analysis (e.g., electronic health records, disease registries, chart audits/sampling) should be noted by the applicant. Data should be valid and reliable and derived from currently established management information systems, where possible.

Key Factors

This is a brief description of the key factors (up to 3) that may impact (positively or negatively) the applicant's progress on each of the clinical and financial performance measures.

Major Planned Actions

This is a brief description of the major planned actions (up to 2) to be completed in response to the key factors identified in the Key Factors section impacting performance on the clinical and financial performance measures.

Comments/Notes

Supplementary information, notes, context for related entries in the plan may be provided, as applicable.

SAMPLE MEASURES

<table>
<tr><td colspan="2" rowspan="4">DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

SAMPLE CLINICAL PERFORMANCE MEASURE</td><td colspan="4">FOR HRSA USE ONLY</td></tr>
<tr><td>Organization Name</td><td colspan="3">Application Tracking Number</td></tr>
<tr><td>XYZ Health Center</td><td colspan="3">00000</td></tr>
<tr><td>Designation Period Date</td><td colspan="3">01/01/2013 -

12/31/2015</td></tr>
<tr><td colspan="6">Focus Area: Diabetes</td></tr>
<tr><td colspan="6">Performance Measure: Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent</td></tr>
<tr><td colspan="2">Is this Performance Measure Applicable to your Organization?</td><td colspan="4">Yes</td></tr>
<tr><td colspan="2">Target Goal Description</td><td colspan="4">By the end of the Designation Period, increase the % of adult patients with type 1 or 2 diabetes whose most recent hemoglobin A1c (HbA1c) is ≤ 9% (under control) up to 65%</td></tr>
<tr><td colspan="2">Numerator Description</td><td colspan="4">Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.</td></tr>
<tr><td colspan="2">Denominator Description</td><td colspan="4">Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria</td></tr>
<tr><td colspan="2">Baseline Data</td><td colspan="2">Baseline Year: 2011

Measure Type: Percentage

Numerator: 2200

Denominator: 4000</td><td>Projected Data (by End of Designation Period)</td><td>65%</td></tr>
<tr><td colspan="2">Data Source & Methodology</td><td colspan="4">Representative sample of patient records. (Data run on 1/10/2010)</td></tr>
</table>

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ Health Center	00000
	Designation Period Date	01/01/2013 - 12/31/2015

Key Factor and Major Planned Action #1	**Key Factor Type:** [x] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** XYZ offers a variety of pharmaceutical assistance programs, including the provision of free, discounted, or generic medications as well as medications through its 340B Federal Drug Pricing arrangement. At least 70% of diabetic patients are on 3 to 8 medications because of co-morbidity complications that occur. **Major Planned Action Description:** Increase education and outreach efforts to diabetic patients on the importance of daily testing and the availability of free/discounted glucometers and test strips available through XYZ.
Key Factor and Major Planned Action #2	**Key Factor Type:** [x] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** XYZ has an agency-wide, multidisciplinary team that includes physicians, nurses, medical assistants, a quality management coordinator and a data specialist. The team works with each site to analyze and improve the internal processes to achieve effective diabetes care delivery. **Major Planned Action Description:** At each site, XYZ will identify a physician champion who will be allotted administrative time to work with fellow staff to test and implement changes. The agency-wide and site-specific teams will form a collaborative infrastructure that provides diabetic patients with the necessary tools and support to successfully manage their disease.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE CLINICAL PERFORMANCE MEASURE	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ Health Center	00000
	Designation Period Date	01/01/2013 - 12/31/2015

Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [x] Restricting [_] Not Applicable **Key Factor Description:** Time management becomes problematic when XYZ staff juggles regular work with Diabetes Collaborative tasks. The agency-wide team would like to meet more frequently, but providers are pressed for administrative time given their full clinical schedules. Any type of backlog or deficiency adds system stress to a provider or staff member's work schedule that negatively affects patient care management. **Major Planned Action Description:** Hire an additional clinical staff person to provide additional "non-clinical" review time for the agency-wide team members.
Comments	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE FINANCIAL PERFORMANCE MEASURE	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ	00001
	Designation Period Date	01/01/2013 - 12/31/2015

Focus Area: Costs			
Performance Measure: Medical Cost per Medical Visit			
Is this Performance Measure Applicable to your Organization?	Yes		
Target Goal Description	By the end of the Designation Period, maintain rate of increase not exceeding 5% per year, such that medical cost per medical visit is less than or equal to 164.83.		
Numerator Description	Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray costs)		
Denominator Description	Non-nursing medical visits (excludes nursing (RN) and psychiatrist visits)		
Baseline Data	**Baseline Year:** 2011 **Measure Type:** Ratio **Numerator:** 492000 **Denominator:** 4000	Projected Data (by End of Designation Period)	164.83
Data Source & Methodology	UDS		
Key Factor and Major Planned Action #1	**Key Factor Type:** [x] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** Recent addition of nurse practitioner providers increased XYZ encounters. **Major Planned Action Description:** Continue assessing current patient/provider mix to best utilize resources.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration SAMPLE FINANCIAL PERFORMANCE MEASURE	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ	00001
	Designation Period Date	01/01/2013 - 12/31/2015

Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [X] Restricting [_] Not Applicable **Key Factor Description:** Recently lost our pediatrician to a local competitor, therefore child visits are down. **Major Planned Action Description:** We are beginning efforts to recruit a NHSC loan repayor to address the shortage.
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**
Comments	

Appendix C: Required Attachments Instructions

To ensure that attachments are organized and printed in a consistent manner, follow the order provided below.

- Number the electronic attachment pages sequentially, resetting the numbering for each attachment (i.e., start at page 1 for each attachment).
- Merge similar documents (e.g., Letters of Support) into a single document. Add a table of contents page specific to the attachment.
- Limit file names for attachments to 100 characters or less. Attachments will be rejected by EHB if file names exceed 100 characters.
- If the attachments marked "required for completeness" are not uploaded, the application will be considered incomplete and non-responsive, thereby making it ineligible.

Attachment 1—Patient Origin Study (Required)

Identify the number of patients residing in each zip code served by the organization (e.g., ZIP Code 29999 = 48 patients; ZIP Code 29994 = 134 patients). Submit this information in a table format starting with the zip code with the greatest number of patients served.

Attachment 2—Service Area Map (Required)

Produce and upload a PDF version of a UDS Mapper-produced map of the service area for the project. See HRSA's UDS Mapper for assistance in creating a service area map located at http://www.udsmapper.org/tutorials.cfm. Specific instructions on how to create a map are located at http://www.udsmapper.org/docs/ServiceAreaMapInstructions.pdf. The service area map must clearly identify:

1. The areas (e.g., zip codes or census tracts) served by the organization.
2. Each service delivery site listed in Form 5B--Service Sites.
3. Designated medically underserved areas (MUAs) and/or medically underserved populations (MUPs).
4. All Health Center Program grantees in the proposed service area.
5. All Health Center Program look-alikes in the proposed service area.
6. Other health care providers serving the same population(s), e.g., free clinics, rural health centers, etc.
7. The UDS data that complements the information provided in the map.

Attachment 3— Current MUA/MUP Designation (Required)

Provide a dated copy of the current MUA/MUP designation. For inquiries regarding MUA/MUP, call 1-888-275-4772 (press option 1, then option 2); contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816; or obtain additional information at http://bhpr.hrsa.gov/shortage/. Applicants may submit as documentation of the MUA/MUP designation a confirmation page from HRSA's "Find Shortage Areas" website.

Attachment 4—Governing Board Bylaws (Required)

Provide a signed and dated copy of the governing board bylaws. The bylaws must demonstrate compliance with the board authority, composition, conflict of interest and all other requirements of section 330 of the PHS Act, 42 CFR 51c, and 42 CFR 56 (as applicable).

Attachment 5—Governing Board Meeting Minutes (Required)

Submit a copy of at least six consecutive months of signed and dated governing board meeting minutes that demonstrate how the board exercises all required authorities over the operations of the organization, including the board's involvement in the development and approval of the look-alike application.

Attachment 6—Co-Applicant Agreement for Public Centers (As applicable)

Public centers (also referred to as public entities or public agencies) with a co-applicant arrangement must provide a signed and dated copy of the written agreement between the two parties. The co-applicant agreement must identify the roles and responsibilities of both the public center and co-applicant, the delegation of authorities of both parties, and any shared roles and responsibilities in carrying out the governance functions.

Attachment 7—Affiliation, Contract, and/or Referral Agreements (As applicable)

Provide one document that includes a summary of each affiliation, contract or agreement (e.g., contracted providers, staff, management services, and formal referral arrangements).

Attachment 7—Affiliation, Contract and/or Referral Agreements must include a comprehensive list and summary of each arrangement, contract, and affiliation agreement, including those which are also discussed and attached in full as part of Form 8—Health Center Agreements. Indicate with an asterisk (*) agreements in Attachment 7 that are also attached in full as part of Form 8.

Applicants that do not have contractual agreements with another entity should clearly indicate so in the narrative. As a reminder, contracts must be in compliance with section 330 of the PHS Act and 42 CFR Part 51c.

Organize each summary by the following categories:

Formal Written Contracts/Agreements for Services Provided

Summaries of formal written contracts/agreements for required services (i.e., services indicated in Form 5A—Services Provided, Column II) must include:

1. Name and contact information for each provider or provider group.

2. Brief description of the purpose and scope of each contract, including the type of services to be provided, how and where services will be provided, how the service will be documented in the patient record; how the applicant will pay and/or bill for the service; and how the applicant's policies and procedures, including the applicability of a sliding fee scale, will apply.
3. Timeframe for each agreement/contract.

Formal Written Referral Arrangements/Agreements for Services Provided

Summaries of formal written referral arrangements/agreements (i.e., services indicated in Form 5A—Services Provided, Column III) must include:

1. Name and contact information for each affiliated agency or provider.
2. Brief description of the purpose and scope of each arrangement/agreement, including, type of services to be provided, the manner by which the referral will be made and managed, how and where services will be provided.
3. How services will be provided on a sliding fee scale compliant with Health Center Program requirements.
4. How the referred visit will be documented in the patient record.
5. How continuity of care for the referred patients will be assured, to include a description of the process for referring patients back to the applicant for appropriate follow-up care.

Other Contracts and Affiliation Agreements

Summaries of other contracts (i.e., contracts or affiliations for management and other services not included on Form 5A—Services Provided) must include:

1. Name and contact information for each affiliated agency or provider.
2. Brief description of the purpose and scope of each contract/affiliation, including the type of services to be provided, how and where services will be provided, and how the health center will reimburse costs.
3. Timeframe for each contract/affiliation.

NOTE: All affiliation, contract, and referral agreements must be available for submission to HRSA by request.

NOTE: In Form 8—Health Center Agreements, applicants must note and attach in full all contracts that make up a substantial scope of project, e.g., contracting for core primary care providers, non-provider health center staff, chief medical officer (CMO) or chief financial officer (CFO), if a proposed site is operated by a contractor, or if the applicant has an agreement that otherwise constitutes a substantial portion of the scope of project. These agreements must also be summarized in Attachment 7—Affiliation, Contract and/or Referral Agreements.

Attachment 8—Articles of Incorporation (Required)

Private, non-profit organizations must provide a copy of the Articles of Incorporation filed with the State or other evidence of non-profit status (e.g., a letter from the State or the Federal government or

evidence that an application for non-profit status has been submitted). Include the seal page documenting the State acceptance of the articles.

Attachment 9—Evidence of Non-Profit or Public Agency Status (Required)

Private Nonprofit: A private, nonprofit organization must submit any one of the following as evidence of its nonprofit status:

- A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- A statement from a state taxing body, state Attorney General, or other appropriate state official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- Any of the above proof for a state or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

Public Center: Consistent with PIN 2010-10 (http://bphc.hrsa.gov/policiesregulations/policies/pin201001.html), applicants must provide documentation demonstrating that the organization qualifies as a public entity (e.g., health department, university health system) for the purposes of section 330 of the PHS Act, as amended. Any of the following is acceptable:

1. Affirm Instrumentality Letter (4076C) from the IRS or a letter of authority from the Federal, state, or local government granting the entity one or more sovereign powers.
2. A determination letter issued by the IRS providing evidence of a past positive ruling by the IRS or other documentation demonstrating that the organization is an instrumentality of government, such as documentation of the law that created the organization or documentation showing that the state or a political subdivision of the state controls the organization.

Formal documentation from a sovereign state's taxing authority equivalent to the IRS granting the entity one or more governmental powers. Public entity applicants can refer to PIN 2010-01, Confirming Public Agency Status under the Health Center Program and FQHC Look-Alike Program, located at http://bphc.hrsa.gov/policiesregulations/policies/pin201001.html.

Attachment 10—Medicare and Medicaid Provider Documentation (Required)

Submit a copy of CMS notification that documents the organization is an approved primary care Medicare and Medicaid provider and the provider numbers.

Attachment 11—Organizational Chart (Required)

Provide an organizational chart showing the organizational and management structure, and lines of authority. The chart must include:

- Key employee position titles;
- Names; and
- Full-time equivalents (FTEs) of each individual. Provide a justification for any part-time or split positions in the Program Narrative.

Clearly identify each individual with the following responsibilities:

- CEO/Executive Director
- Chief Medical Officer (CMO)/Clinical Director;
- Chief Financial Officer (CFO)/Financial Manager; and
- Other key management staff, e.g., Chief Operations Officer (COO).

The chart should demonstrate that the governing board retains ultimate authority and leadership of the organization.

Public entities with co-applicant arrangements should demonstrate the relationship between the two co-applicants and the co-applicants' relationships to the health center.

Attachment 12—Position Descriptions for Key Personnel (Required)

Submit a copy of position descriptions for all key management positions. Indicate if key management positions are combined and/or part-time (e.g., chief financial officer (CFO) and chief operation officer (COO) roles are shared). At minimum, position descriptions should include:

- Position title
- Description of duties and responsibilities
- Position qualifications, supervisory relationships
- Skills, knowledge and experience requirements
- Travel requirements
- Salary range
- Hours worked

Attachment 13—Resumes for Key Personnel (Required)

Provide resumes of key personnel for the organization. If a resume is included for an identified individual who is not yet hired, include a letter of commitment from that person along with the resume.

Attachment 14—Schedule of Discounts/Sliding Fee Scale (Required)

Provide a schedule of charges with a corresponding schedule of discounts for which charges are adjusted on the basis of the patient's ability to pay. Applicants must show sliding fee scale discounts for persons with incomes between 200% and 100% of the most current annual Federal poverty guidelines (see the most current annual poverty guidelines at http://aspe.hhs.gov/poverty/). Patients with incomes below 100 percent of the Federal poverty guidelines may not be charged for services (nominal fees are acceptable if they are not barriers to obtaining services). No discounts may be given to patients with incomes over 200% of the Federal poverty guidelines.

Attachment 15—Most Recent Independent Financial Audit (Required)

Applicants in operation for more than one year

Submit a complete copy of the organization's most recent annual audit, including the auditor's opinion statement (i.e., management letter). Audit information must include the balance sheet, profit and loss statement, audit findings, and any noted exceptions. The audit must comply with generally accepted accounting principles (GAAP).

Applicants in operation less than one year

Submit monthly financial statements for the period of time the organization has been operational as a provider of comprehensive primary health care services, at minimum the most recent six-month period. Six months of financial statements must include a statement of financial position (balance sheet), statement of financial activities and changes in net assets, statement of cash flows, and any notes to financial statements, as appropriate.

Attachment 16—Letters of Support (Required)

Submit current and dated letters of support addressed to the appropriate organization contact (e.g., board, CEO) to document commitment to the request for look-alike designation from the other primary care providers in or adjacent to the service area, including FQHCs (i.e., each Health Center Program grantee and look-alike), rural health clinics, hospitals, local health departments, and other programs serving the same population(s). If one or more letters from other local providers serving the same population are not provided, provide an explanation in the Program Narrative and upload evidence of requesting such support in Attachment 16 as appropriate. See the Collaboration section of the Project Narrative for more details on required collaboration.

Attachment 17—Floor Plans (Required)

Submit floor plans for all operational look-alike sites.

Attachment 18—Other Information (As applicable)

Include other relevant documents to support the proposed project plan.

Appendix D: Acronyms

AC – Annual Certification
APM – Alternative Payment Methodology
BBA – Balanced Budget Act
BHPR – Bureau of Health Professions
BPHC – Bureau of Primary Health Care
CCN – CMS Certification Number
CCO – Chief Clinical Officer
CEO – Chief Executive Officer
CFO – Chief Financial Officer
CFR – Code of Federal Regulations
CIO – Chief Information Officer
CIS – Change in Scope
CMO – Chief Medical Officer
CMS – Centers for Medicare and Medicaid Services
COO – Chief Operating Officer
DTP/DTaP – Diphtheria, Tetanus, and Pertussis
EHB – Electronic Handbooks
FQHC – Federally Qualified Health Center
FPG – Federal Poverty Guidelines
FTCA – Federal Tort Claims Act
FTE – Full-Time Equivalent
FY – Fiscal Year
GAAP – Generally Accepted Accounting Principles
HHS – Health and Human Services
Hib – Haemophilus Influenzae Type B
HPSA – Health Professional Shortage Area
HRSA – Health Resources and Services Administration
ID – Initial Designation
IPV – Inactive Polio Vaccine
IRS – Internal Revenue Service
LOI – Letter of Interest
LAL – Look-Alike
MMR – Measles, Mumps and Rubella
MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MSAW – Migratory and Seasonal Agricultural Workers
MUA – Medically Underserved Area
MUP – Medically Underserved Population
NAP – New Access Point
NHSC – National Health Service Corps
NLD – Notice of Look-Alike Designation
OBRA – Omnibus Budget Reconciliation Act
OMB – Office of Management and Budget

OPPD – Office of Policy and Program Development
PAL – Program Assistance Letter
PCA – Primary Care Association
PCO – Primary Care Office
PHS – Public Health Service
PIN – Policy Information Notice
PPS – Prospective Payment System
QI/QA – Quality Improvement/Quality Assurance
RD – Renewal of Designation
RO – Regional Office of CMS
SAO – Service Area Overlap
SCHIP – State Children's Health Insurance Plan
SSA – Social Security Act
TBD – To Be Determined
UDS – Uniform Data System
USC – United States Code

Appendix E: Benefits of Look-Alike Designation

Reimbursement under Medicare and Medicaid

Medicare FQHC Reimbursement Methodology

FQHCs that have received a CMS Certification Number (CCN) and participation date from CMS are eligible to be reimbursed by Medicare under the FQHC payment methodology.

Medicare reimburses health centers enrolled as FQHCs based on an all-inclusive rate for each visit by a Medicare beneficiary. Medicare fiscal intermediaries set the all-inclusive rate based on each FQHC's estimate of allowable cost to be incurred during the reporting period divided by the number visits expected to be furnished during the reporting period. At the beginning of the FQHC's fiscal year, the Fiscal Intermediary or A/B Medicare Administrative Contractor (MAC) calculates an interim all-inclusive visit rate based on either estimated allowable costs and visits from the FQHC (if it is new to the FQHC Program) or on actual costs and visits from the previous cost reporting period (for existing FQHCs). The FQHC's interim all-inclusive visit rate is reconciled to actual reasonable costs at the end of the cost reporting period.

Congress mandated the use of a national upper payment limit in OBRA of 1990, specifying payment for FQHC services under the authority of sections 1833(a)(3) and 1861(v)(1) of the SSA. There are two FQHC payment limits: one limit applies to entities located in urban areas and one limit applies to entities located in rural areas. These rates are adjusted annually by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care physician's services. The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wage levels. The MEI includes a bundle of inputs used in furnishing physicians' services such as physician's own time, non-physician employees' compensation, rents, medical equipment, etc. The MEI measures year-to-year changes in prices for these various inputs based on appropriate price proxies. Providers may view the list of current Medicare Administrative Contractors (MACs) for each jurisdiction on the CMS website (A/B MAC Jurisdictions) at http://www.cms.hhs.gov/MedicareContractingReform.

FQHC's are responsible for submitting materials necessary to obtain a CCN and participation date (CMS 855A form and supporting documentation) with its CMS fiscal intermediary/MAC; it is also their responsibility to monitor its progress through the review and approval process. Any services provided to Medicare patients prior to the FQHC's participation date will be reimbursed at the standard Medicare rate only.

The CMS Medicare Enrollment Application for Institutional Providers (Form CMS-855A) is available at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf.

The Medicare FQHC Fact Sheet provides important information including the FQHC Prospective Payment System (PPS) scheduled to be implemented in 2014, as mandated by the Affordable Care Act, and other resources. The Fact Sheet is available at http://www.cms.hhs.gov/MLNProducts/downloads/fqhcfactsheet.pdf.

Contact the Medicare office at 800-633-4227. Visit the CMS website at http://www.cms.hhs.gov/.

Medicaid FQHC Reimbursement Methodology

Currently, State Medicaid Agencies reimburse FQHCs under a prospective payment system (PPS) or an equivalent alternative payment methodology (APM), as specified in section 1902(bb) of the SSA. The payment methodology should be described in the approved State plan. In 2014, under the provisions of the Affordable Care Act, Medicaid will be expanded to cover all individuals up to 133 percent of FPL (up to 138 percent of Federal poverty guidelines, when including the 5 percent disregard) in many states.

Prospective Payment System: Under PPS, States pay FQHCs participating prior to fiscal year 2000 the average of the reasonable costs of providing Medicaid-covered services during two base years, adjusted for inflation or a change in the scope of services. The PPS baseline rate was calculated using 100 percent of the reasonable costs incurred during fiscal year 1999 and fiscal year 2000. This calculation should have included all Medicaid covered services payable as FQHC services under 1905(a)(2)(C) of the Act. For FQHCs initially participating in years after fiscal year 2000, the initial PPS rate is based on the rates established during that year for other such centers or clinics in the same or adjacent area with a similar case load (or based on the actual costs determined in accordance with Medicare payment principles). The initial PPS rate is subject to adjustment, as discussed below.

Alternative Payment Methodology: A State may, in reimbursing an FQHC for services furnished to Medicaid beneficiaries, use an APM, but only if the following statutory requirements are met. First, the APM must be agreed to by the State and by each individual FQHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is at least equal to the amount to which it is entitled under the Medicaid PPS.

In order to become eligible for FQHC reimbursement from Medicaid, FQHCs must enroll in their State Medicaid as an FQHC provider. Each state has its own Medicaid provider enrollment process. FQHCs are required to work directly with their State Medicaid office. The initial reimbursement payments for newly designated FQHCs is determined based on the rates of surrounding FQHCs, or in the absence of other FQHCs in the area, by cost reporting methods. After the initial year, payment is set by using the MEI factor used for other FQHCs.

Adjustments: In FY 2002 and for each FY thereafter, each FQHC is entitled to a PPS payment amount (on a per visit basis) after its initial year of the PPS amount to which the health center was entitled in the previous FY, increased by the percentage increase in the MEI for primary care services. The per visit rate may also be adjusted to take into account any increase (or decrease) in the scope of Medicaid covered services furnished by the FQHC during that FY.

NOTE: A change in scope of project for an FQHC is NOT THE SAME as a change in scope of service for increased/decreased Medicaid reimbursement. Some States may require proof of the HRSA's approval of the change in scope of service to process a Medicaid rate change. FQHCs should refer to their State's Medicaid policies and procedures when requesting payment adjustments due to a change in scope of services.

Supplemental Payment: Section 1902(bb)(5) of the SSA requires States to make supplemental payment to FQHCs that subcontract (directly or indirectly) with Managed Care Entities (MCEs). Under section 1903(m)(2)(A)(ix), the MCE must pay the FQHC no less than it would make if the services were furnished by another provider. The State supplemental payment represents the difference, if any, between the

payment received by the FQHC for treating the MCE enrollees and the payment to which the FQHC would be entitled for these visits under the Medicaid PPS provision of BIPA.

Contracted Services: Health centers may be eligible for Medicare and Medicaid FQHC reimbursement for the cost of contracted services that are furnished to patients of the FQHC as part of an FQHC visit; however, they are not eligible to receive reimbursement for referred services not paid for by the health center, or not provided to the individual as a patient of the FQHC.

Note: Additional information about the provisions of the Affordable Care Act related to Medicaid and CHIP by State is available at http://www.medicaid.gov/AffordableCareAct/Provisions/Provisions.html.

340B Drug Pricing Program

Organizations designated as look-alikes are eligible to purchase prescription and non-prescription medications for their outpatients at a reduced cost through the 340B Drug Pricing Program.

Look-alikes may apply for participation in the 340B Drug Pricing Program without operating or owning a pharmacy and can contract with a local pharmacy to meet the needs of their patient base. The look-alike must order and pay for the drugs, which are delivered to the local pharmacy for distribution to patients at discounted prices that comply with the sliding fee scale requirements in section 330 of the PHS Act. It is important that the contract state that the look-alike is billed and receives the invoice, NOT the pharmacy paying for the drugs. For additional information about the 340B Program and enrollment requirements, contact the HRSA Office of Pharmacy Affairs, Pharmacy Services Support Center at 1-800-628-6297 or http://www.hrsa.gov/opa/index/html.

Health Professional Shortage Area Designation and National Health Service Corps Recruitment and Retention Assistance

All look-alikes are eligible to receive recruitment and retention assistance available through the National Health Service Corps (NHSC).

A Health Professional Shortage Area (HPSA) means any of the following which the Secretary of the HHS determines has a shortage of health professional(s): (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; (3) a public or nonprofit private medical facility; or (4) an entity eligible for automatic HPSA status, including look-alikes.

Benefits of the HPSA Designation: The HPSA status aids health centers in their efforts to recruit and retain health professionals. The HPSA designation confers: (1) basic eligibility to apply to receive NHSC personnel (scholars, loan repayors, or Ready Responders); and (2) eligibility to be a site where a J-1 visa physician can serve [upon recommendation from a State or an interested U.S. government agency such as the Appalachian Regional Commission (ARC), or Department of Health and Human Services (DHHS)].

NHSC Clinical Vacancy List: For successful recruitment of health professionals, it is important to: (1) develop and maintain an accurate list of current clinical vacancies; and (2) make the list widely available to providers seeking positions at health centers or other facilities serving the underserved. An excellent source for accomplishing these goals is the NHSC Opportunities List (List), an on-line list of opportunities in HPSAs. All look-alike vacancies are eligible to be included on the list, which is available at http://nhscjobs.hrsa.gov/. NHSC personnel must serve at a vacancy on the list; with the NHSC giving priority to the placement of its personnel in HPSAs of greatest shortage. A guide to HPSAs and disciplines, designations and future NHSC service sites is available at http://nhsc.hrsa.gov/currentmembers/scholars/fromtrainingtopractice/disciplinesdesignfuture.pdf. In addition, physicians on J-1 visas often use the list to identify vacancies in HPSAs where they can serve in return for a waiver of their return home requirement. States participating in the State Loan Repayment Program and available clinicians with no service obligation, who are looking for a job where they can serve the underserved, may also use this list.

Application Requirement: A look-alike's vacancies must be on the list before the health center can receive NHSC personnel. The health center must apply to the NHSC by completing the NHSC Recruitment and Retention Assistance Application available at http://nhsc.hrsa.gov/sites/becomenhscapprovedsite/index.html. Once an organization files the NHSC Recruitment and Retention Assistance Application and the NHSC approves the application, its vacancy(ies) will be included on the list. Inclusion of a look-alike vacancy on the list does not assure that the health center will receive NHSC providers or physicians on J-1 visas.

Site Profile, Website Links: Look-alikes may also complete the Site Profile form. This site-specific information can be linked to its site on the List, allowing interested individuals an opportunity to learn more about the site. If the site or organization has an existing website, it can provide its Uniform Resource Locator (i.e., URL) for additional information.

HPSA Score: The NHSC is required to give priority to the placement of its providers in HPSAs of greatest need. A HPSA score, which measures HPSA need, has been automatically computed for every designated FQHC. HPSA scores and a discussion about how they were developed are available at the Shortage Designation website located at http://bhpr.hrsa.gov/shortage/. If a look-alike is located in a geographic or population group HPSA, the score for that HPSA can be used instead of the automatic score. Generally, the NHSC Scholarship, Ready Responder, and DHHS J-1 Programs have cut off scores below which FQHCs will not be eligible to participate. For the NHSC Loan Repayment Program, the HPSA score influences the order in which qualified organizations are approved to participate in the program. HPSA scores are not a factor for the—Conrad State and ARC J-1 Programs. Please contact your State PCO for assistance in improving a HPSA score. The PCO has the background and expertise in the designation process.

For Further Information: For questions about the NHSC Recruitment and Retention Assistance Application, NHSC Opportunities List, or other related matters, contact the NHSC Recruitment Training and Support Center at 800-221-9393. For additional questions about the HPSA designation process, please contact the HRSA, Bureau of Health Professions (BPHr), Office of Shortage Designation at 301-594-0816. Facilities are added to the HPSA database on an on-going basis, and are included in the HPSA Database Web Look-Up found on the BHPr website located at http://bhpr.hrsa.gov/shortage.

Appendix F: Glossary

340B Federal Drug Pricing Program: The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the PHS Act. Section 340B limits the cost of covered outpatient drugs to certain Federal grantees, look-alikes and qualified Disproportionate Share Hospitals. Significant savings on pharmaceuticals may be seen by those entities that participate in this program. The terms PHS Pricing, 340B Pricing, and—602 Pricing reference the same program and the same discount. The terms ceiling price and discount price are considered the same. For additional information about the 340B Federal Drug Pricing Program, please contact HRSA's Office of Pharmacy Affairs at http://www.hrsa.gov/opa/ or 800-628-6297.

Active Patient: A patient is an individual who has at least one visit during the year within the organization's approved scope of project. A patient does not include an individual who only has visits such as outreach, community education services, and other types of community-based services not documented on an individual basis. Also, a person who only receives services from large-scale efforts such as mass immunization programs, screening programs, and health fairs is not a patient. A person whose only contact with the look-alike is to receive Women, Infants, and Children (WIC) counseling and vouchers is not a patient and the contact does not generate a visit.

Actual accrued income: Accrued income is income which has been accumulated or accrued irrespective of actual receipt, which means event incurred but the cash has not yet been received. The applicant must report accrued income for the most recent 12-month period, for which data is available.

Additional Services: Services that are not included as required primary health services and that are appropriate to meet the health needs of the population served by the health center. Additional health services are appropriate when necessary for the adequate support of primary health services (section 330(b)(2) of the PHS Act).

Census Tracts: Small, relatively permanent statistical subdivisions of a county designed to be relatively homogeneous units with respect to population characteristics, economic status, and living conditions, census tracts average about 4,000 inhabitants. Tracts are delineated by a local committee of census data users for the purpose of presenting data. Census tract boundaries normally follow visible features, but may follow governmental unit boundaries and other non-visible features in some instances; they always nest within counties. Information to determine the census tracts with a given service area is available online at http://www.census.gov/geo/www/tractez.html.

Cultural Competency: HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care published by the U.S. Department of Health and Human Services. This document is available online at http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf. Additional resource information can be found on the HRSA cultural competence web page, located at http://www.hrsa.gov/culturalcompetence.

Enabling Services: Per section 330(b)(1)(A)(iv) of the PHS Act, enabling services are non-clinical services that enable individuals to access health care services and improve health outcomes. Enabling services include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction (e.g., educational materials, nicotine gum/patches), and outreach.

Federal Tort Claims Act (FTCA): The Federally Supported Health Centers Assistance Act of 1992 and 1995 (the Act) granted medical malpractice liability protection through the FTCA to health centers receiving grant funds under section 330 of the PHS Act. Under the Act, Health Center Program grantees, their employees, and eligible contractors are considered Federal employees immune from suit with the Federal government acting as their primary insurer. Look-alikes are not eligible for FTCA coverage.

Federally Qualified Health Center (FQHC): A category of facilities under Medicare and Medicaid as identified in the OBRA of 1989, 1990, and 1993. The three types of FQHCs are: organizations receiving grants under section 330 of the PHS Act, certain tribal organizations, and look-alikes (authorized under section 1861(aa)(4)(B) and section 1905(l)(2)(B) of the SSA). Requirements for tribal organizations designated as FQHCs differ from organizations that receive grants under section 330 of the PHS Act and look-alikes.

Full-Time Equivalent (FTE) Employee: A FTE of 1.0 means that the person worked full-time for one year. Each agency defines the number of hours for full-time work. For example, if a physician is hired full-time and works 36 hours per week as is specified in her contract, she is a 1.0 FTE. The FTE is based on employment contracts for clinicians and exempt employees; FTE is calculated based on paid hours for nonexempt employees. FTEs are adjusted for part-time work or for part-year employment. In an organization that has a 40 hour work week (2080 hours/year), a person who works 20 hours per week (i.e., 50% time) is reported as—0.5 FTE. In some organizations different positions have different time expectations. Positions with different time expectations, especially clinicians, should be calculated on whatever they have as a base for that position. Thus, if physicians work 36 hours per week, this would be considered 1.0 FTE, and an 18 hour per week physician would be considered as 0.5 FTE, regardless of whether other employees work 40 hours weeks. FTE is also based on the number of months the employee works. An employee who works full time for four months out of the year would be reported as 0.33 FTE (4 months/12 months).

Staff may provide services on behalf of the look-alike under many different arrangements including, but not limited to: salaried full-time, salaried part-time, hourly wages, NHSC assignment, under contract, or donated time. Individuals who are paid by the look-alike on a fee-for-service basis only and do not have specific assigned hours, are not counted in the calculation of FTEs since there is no basis for determining their hours.

Health Professional Shortage Areas (HPSAs): Federally-designated areas that have shortages of primary medical care, dental or mental health providers and may be urban or rural areas, population groups or medical or other public facilities. A list of HPSA designations is available on HRSA's website at http://bhpr.hrsa.gov/shortage/shortageareas/index.html.

Homeless: Per section 330(h)(5)(A) of the PHS Act, the term homeless individual means an individual who lacks housing (without regard to whether the individual is a member of a family), including an

individual whose primary residence during the night that is a supervised public or private facility that provides temporary accommodations and an individual who is a resident in transitional housing.

Medically Underserved Area (MUA)/Medically Underserved Population (MUP): Health Center Program grantees and look-alikes are required under the statute to serve, in whole or in part, areas or populations designated by the Secretary of Health and Human Services as medically underserved. (*NOTE: This is not required for organizations only serving special populations*.) Guidelines for use in applying the established criteria for designation of MUAs and MUPs are based on the Index of Medical Underservice (IMU), published in the Federal Register on October 15, 1976. Guidelines for use in submitting requests for exceptional MUP designations are based on the provisions of Public Law 99-280 enacted in 1986. The three methods for designation of MUAs and MUPs can be found at http://bhpr.hrsa.gov/shortage/muaps/index.html.

Migratory and Seasonal Agricultural Workers: Per section 330(g)(3)(A) of the PHS Act, the term migratory agricultural worker means an individual whose principal employment is in agriculture, who has so been employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode. Per section 330(g)(3)(B) of the PHS Act, the term—seasonal agricultural worker means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker.

For both categories of workers, agriculture is defined as farming of the land in all its branches, including cultivation, tillage, growing, harvesting, preparation, and *on-site* processing for market or storage. NOTE: Persons employed in *aqua*culture, lumbering, poultry processing, cattle ranching, tourism, and all other non-farm-related seasonal work are not included.

New Access Point: A new access point is a new delivery site for the provision of comprehensive primary and preventive health care services. Every competitive new access point demonstrates compliance with the applicable requirements of section 330 of the PHS Act, the 42 CFR Part 51c, and HRSA policies. To be competitive, new access point applications must:

(a) Demonstrate that all persons will have ready access to the full range of required primary, preventive, enabling (see definition above) and supplemental health services, including oral health care, mental health care and substance abuse services, either directly on-site or through established arrangements without regard to ability to pay;

(b) Demonstrate compliance at the time of application (or a plan for compliance within 120 days of a grant award) with the requirements of section 330, and its implementing regulations;

(c) Demonstrate how section 330 funds will expand services and increase the number of people served through the establishment of a new service delivery site(s) and/or at an existing site(s) not currently within a HRSA funded scope of project;

(d) Demonstrate that the site(s) will be operational and services will be initiated within 120 days of a grant award; and

(e) Demonstrate how section 330 funds will augment already available funds and in-kind resources to expand existing primary health care service capacity to currently underserved populations.

Required Primary Care Services: Section 330(b)(1)(A) of the PHS Act, available on HRSAs website at http://bphc.hrsa.gov/policiesregulations/legislation/index.html defines the term—required primary health services as:

(i) Basic health services which, for the purposes of this section, shall consist of -

(I) Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives;

(II) Diagnostic laboratory and radiologic services;

(III) Preventive health services, including—

(aa) Prenatal and perinatal services;

(bb) Appropriate cancer screening;

(cc) Well-child services;

(dd) Immunizations against vaccine-preventable diseases;

(ee) Screenings for elevated blood lead levels, communicable diseases, and cholesterol;

(ff) Pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;

(gg) Voluntary family planning services; and

(hh) Preventive dental services;

(IV) Emergency medical services; and

(V) Pharmaceutical services as may be appropriate for particular centers;

(ii) Referrals to providers of medical services (including specialty referral when medically indicated) and other health-related services (including substance abuse and mental health services);

(iii) Patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services;

(iv) Services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals); and

(v) Education of patients and the general population served by the health center regarding the availability and proper use of health services.

Risk Management: Risk management is the process of making and carrying out decisions that will assist in preventing adverse consequences and minimizing adverse effects of accidental losses upon an organization. Also, a systematic and scientific approach in the empirical order to identify, evaluate, reduce or eliminate the possibility of an unfavorable deviation from expectation and, thus, to prevent the loss of financial assets resulting from injury to patients, visitors, employees, independent medical staff, or from damage, theft, or loss of property belonging to the health care entity or persons mentioned. Risk management also encompasses the evaluation and monitoring of clinical practice to recognize and prevent patient injury. Additional information on Risk Management is available on HRSAs website at http://bphc.hrsa.gov/ftca/riskmanagement/index.html.

School-Based Health Center: A health center located on or near school grounds, including pre-school, kindergarten, and primary through secondary schools, that provides on-site comprehensive preventive and primary health services. Additional information on School Based Health Centers is available on HRSAs website at http://www.hrsa.gov/ourstories/schoolhealthcenters/.

Scope of Project: Defines the activities that the total approved grant-related project budget or look-alike designation supports. Specifically, the scope of project defines the service sites, services, providers, service area(s) and target population for which section 330 grant funds and look-alike designation benefits may be used. For more information please see PIN 2008-01 available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html.

Section 1115 Demonstration and Waiver Projects: Section 1115 of the SSA provides the Secretary of Health and Human Services broad authority to waive provisions under SSA, and approve experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow States to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some States expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

There are two types of Medicaid authority that may be requested under section 1115:

Section 1115(a)(1) – allows the Secretary to waive provisions of section 1902 to operate demonstration programs, and

Section 1115(a)(2) – allows the Secretary to provide Federal financial participation for costs that otherwise cannot be matched under Section 1903.

Projects are generally approved to operate for a 5-year period and states may submit renewal of designation requests to continue the program for additional periods of time. Demonstrations must be budget neutral over the life of the project, meaning they cannot be expected to cost the Federal government more than it would cost without the waiver.

Service Area: The concept of a service area has been part of the Health Center Program since its beginning. In general, the service area is the area in which the majority of the organization's patients reside. The section 330 authorizing statute requires that each grantee/look-alike periodically review its catchment area to:

(i) Ensure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate;

(ii) Ensure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and

(iii) Ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation. (Section 330(k)(3)(J) of the PHS Act.)

The service area should, to the extent practicable, be identifiable by census tracts. Describing service areas by census tracts is necessary to enable analysis of service area demographics. Service areas may also be described by other political or geographic subdivisions (e.g., county, township, zip codes as appropriate). The service area must be designated in full or in part as a MUA or contain a designated MUP. While organizations may serve patients from outside their service area, they must provide access to services for all residents of the service area regardless of ability to pay. Health Center Program grantees and look-alikes designated to serve exclusively a section 330 authorized special population (i.e., section 330 (g), (h), and/or (i)) are not subject to the requirement to serve all residents of the service area. Please see PIN 2007-09, Service Area Overlap: Policy and Process, for more information.[42]

Service Site: Service sites include any location where a health center, either directly or through a subrecipient, provides primary health care services to a defined service area or target population. Service sites are defined as locations where all of the following conditions are met. For more information see PIN 2008-01, Defining Scope of Project and Policy for Requesting Changes, located at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html.

Health Center Visits: Health center visits are generated by documenting in the patients' records face-to-face contacts between patients and providers; providers exercise independent judgment in the provision of services to the patient; services are provided directly by or on behalf of the health center, whose governing board retains control and authority over the provision of the services at the location; and services are provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every

[42] See PIN 2007-09, Service Area Overlap: Policy and Process, available at http://bphc.hrsa.gov/policiesregulations/policies/pin200709.html.

month). However, there is no minimum number of hours per week that services must be available at an individual site.[43]

NOTE: The statutory requirement in section 330(k)(3) of the PHS Act states that—primary health services of the center will be available and accessible in the catchment area of the center promptly, as appropriate, and in a manner which assures continuity. [44]

NOTE ALSO: the regulatory requirement in 42 CFR Part 51c.303(m) that health centers—must be operated in a manner calculated to preserve human dignity and to maximize acceptability and effective utilization of services.[45]

Sliding Fee Discount: Discounts (also referred to as a sliding fee scale or schedule of discounts) must be provided to patients at or below 200% of the FPG (available at http://aspe.hhs.gov/poverty/) based on their ability to pay. Those at or below 100% of the poverty guidelines must receive a 100% (full) discount (they may pay a nominal fee if consistent with program goals and as long as such as a fee does not result in the denial of health care services due to an individual's inability to pay). Health centers must establish their own schedule of discounts based on income and family size as it relates to the FPG with the discount applied to the charge for services—sliding down from 0% (no discount-full charge for those individuals with incomes over 200% of the FPG) to 100% (full discount). The number of distinct categories of discounts is chosen by the health center. Additional information on Sliding Fee Schedules is available on HRSAs Technical Assistance website at http://bphc.hrsa.gov/policiesregulations/policies/index.html.

Specialty Service: Specialty services are considered 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.[46] For additional information on specialty services please refer to PIN 2009-02, Specialty Services and Health Centers' Scope of Project located at http://bphc.hrsa.gov/policiesregulations/policies/pin200902purpose.html.

Target Population: The target population is the medically underserved population served by the health center. It is usually a subset of the entire service area population, but in some cases, may include all residents of the service area. Health Center Program grantees and look-alikes are required to serve all residents of the center's service area, regardless of the individual's ability to pay, including MSAWs, homeless populations and residents of public housing. Although they may also extend services to those residing outside the service area, HRSA recognizes that health centers must operate in a manner consistent with sound business practices.

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[43] See PIN 2008-01, Defining Scope of Project and Policy for Requesting Changes available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801defining.html.
[44] Section 330(k)(3) of the PHS Act: http://bphc.hrsa.gov/policiesregulations/legislation/index.html.
[45] 42 CFR Part 51c.303(m) http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=626179edffee25c5ec82659521cc6f36&rgn=div5&view=text&node=42:1.0.1.4.26&idno=42#42:1.0.1.4.26.3.21.3.
[46] PHS Act section 330(a)(1)(B) and section 330(b)(2).

Health Center Program grantees and look-alikes designated to serve exclusively a section 330 authorized special population(s) (i.e., section 330(g), (h), and/or (i)) must support care for the specific population(s) and, as such, are not subject to the requirement to serve all residents of the service area). However, all Health Center Program grantees and look-alikes should address the acute care needs of all who present for service, regardless of residence. In the case of Health Center Program grantees and look-alikes, individuals who are not members of the special population group(s) served by the health center may be seen initially and then referred to more appropriate settings for their non-acute health care needs. Those grantees and look-alikes serving a special population may not have more than 25 percent of patients from the general population. Please refer to PIN 2009-05, Policy for Special Population-Only Grantees Requesting a Change in Scope to Add a New Target Populationhttp://bphc.hrsa.gov/policiesregulations/policies/pin200905specialpops.html for additional information.

Uniform Data System (UDS): The UDS is a reporting requirement for look-alikes and grantees that includes the core set of information appropriate for monitoring and evaluating health center performance and reporting on trends. UDS collects basic demographic information on populations served, such as race/ethnicity and insurance status of patients. The data helps to identify trends over time, enabling HRSA to establish or expand targeted programs and identify effective services and interventions to improve access to primary health care for vulnerable populations. UDS data is also compared with national data to look at differences between the U.S. population at large and those individuals and families who rely on the health care safety net for primary care. Additional information on UDS reporting requirements is located at http://bphc.hrsa.gov/healthcenterdatastatistics/index.html.

Visit: Visits are a documented, face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be documented.