

COLLABORATING WITH A COMMUNITY HEALTH CENTER

TO PROVIDE COMPONENTS OF A COLLEGE HEALTH PROGRAM

The missions of Community Health Centers and colleges and universities have much in common. Community Health Centers are focused on providing high quality, accessible, patient-centered care regardless of cultural background, social barriers, or ability to pay. Similarly, many colleges are devoted to increasing access for low-income students and other populations that have been historically disenfranchised from higher education. Thus, there are inherent opportunities for colleges and Community Health Centers to work together.

By Stephen L. Beckley, CEBS
Ann C. Deinhardt, MSW
Valerie A. Lyon, MHA
Anna Mayme Wainwright, MHA



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*Healthcare Management and Benefit Consultants
Specializing in Higher Education*

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Photos of various Community Health Centers, with website links, are provided in this paper. They were selected because they provide examples of the broad scope of services and capabilities of Community Health Centers, they have a clinic location on a college campus, or they are located in a geographic area with a nearby large public college campus with student demographics and other factors that might warrant consideration of a partnership with a Community Health Center.



*Pueblo Community Health Clinic on
the campus of Pueblo Community College*

Inquiries should be submitted to: Stephen L. Beckley, CEBS
Hodgkins Beckley Consulting, LLC
www.HBC-SLBA.com
Email: Beckley@HBC-SLBA.com
Tel: 866-981-5898, ext. 1



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Review of Appendix, Keywords, and Abbreviations

As a precursor to understanding this paper, readers are encouraged to review [Appendix A](#), [Appendix B](#), and the [Sliding Fee Discount Program \(SFDP\)](#) section for this paper. The following are abbreviations used in this paper:

- ACA: Patient Protection and Affordable Care Act
- ACHA: American College Health Association (www.ACHA.org)
- CHP(s): College Health Programsⁱ
- FPL: Federal Poverty Level¹
- HRSA: Health Resources and Services Administration, US Department of Health and Human Services (<https://www.HRSA.gov/>)
- Institutions of Higher Education,ⁱⁱ referred to in this paper as “colleges and universities” or collectively as “colleges”
- MUA/MUP: Medical Underserved Area or Medically Underserved Population
- NACHC: National Association of Community Health Centers (www.NACHC.org)
- SAHF^{iv}: Student Administrative Health Fees

Abstract

The missions of Community Health Centers and colleges and universities have much in common. Community Health Centers are focused on providing high quality, accessible, patient-centered care regardless of cultural background, social barriers, or ability to pay. Similarly, many colleges are devoted to increasing access for low-income students and other populations that have been historically disenfranchised from higher education. Thus, there are inherent opportunities for colleges and Community Health Centers to work together.

Community Health Centers routinely serve a broad cross section of the local population, including 19 percent of patients covered by commercial insurance.² Many students qualify for Medicaid in states that have expanded eligibility under the Affordable Care Act, and Medicaid reimbursements could apply to a substantial portion of the care students receive from College Health Programs. Relative to the qualification for Medicaid (income below 138 percent of Federal Poverty Level [FPL]³), 40 percent of undergraduates are Pell Grant recipients and 31 percent of all students have income at or below FPL.⁴

ⁱThe American College Health Association has 1,100 institutional members, composed mostly of College Health Programs that serve students enrolled at four-year and graduate/professional colleges and universities, employing more than 3,000 health and wellness professionals (source: www.ACHA.org/about). Forty-two percent of community college campuses provided some form of student health service in 2016 ([Burkhart and Moreno](#)), and 73 percent of community colleges provided mental health counseling in 2019 ([Chen](#)).

ⁱⁱFor fall 2018, 3,928 colleges and universities (1,626 public, 1,635 private non-profit, and 667 for-profit) served 19.6 million students. There were 13.1 million students enrolled at four-year year and graduate/professional colleges and universities, and 6.5 million students were enrolled at two-year and associate degree granting institutions. Source: 2020-2021 Almanac, The Chronicle of Higher Education.

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This paper explains some of the possibilities and considerations for colleges and universities to collaborate with Community Health Centers to provide selected CHP services. Higher education leaders are encouraged to ask three questions.

- 1) What are the best options to ensure that tuition and fee funding ([SAHF^{iv}](#)) and/or other institutional allocations for CHP services do not unnecessarily duplicate the insurance coverage students may have through Medicaid or commercial insurance?
- 2) Do student demographics, such as the percentage of low-income students or the proportion of students coming from the local community, suggest a Community Health Center might be interested in expanding its service capability to better serve students (refer to [Key Considerations for Collaborating with a Community Health Center](#))?
- 3) Could quality of care and operational stability be improved by providing health care services to students through a Community Health Center?

Boards of directors for Community Health Centers are similarly encouraged to consider whether there are opportunities to better serve potential patients, to expand services, and to increase public and community leader support for their organizations.

This partnering concept is not new. There are numerous existing collaborations as shown in the section entitled [Collaborations Between Colleges and Community Health Centers](#). A 2010 paper published by the Association of Academic Health Centers recognized the potential for partnerships with Community Health Centers:

“Academic health centers play an essential role in advancing health and well-being, not only in the treatment of patients, through innovative research, and with the education of the future health workforce, but also in long-standing community partnerships. Through community outreach and local partnerships, academic health centers are expanding the realm in which they educate, research, and provide care. A significant, but often overlooked, component of academic health center community involvement is the collaborative relationship with community health centers. These relationships have enhanced the academic health center role as healthcare provider and community health leader.”⁵

Typically, collaboration with a Community Health Center will be most viable for CHPs that (1) have limited administrative capability to bill insurance and participate with Medicaid and commercial insurance and (2) are located in states that do not allow for CHP funding arrangements (i.e., [SAHF^{iv}](#)) to pay for either remaining balance medical expenses not covered by students’ personal insurance or medical expenses incurred by uninsured students. Even when these two conditions exist, a college with a large student population may still find that partnering with a Community Health Center is advantageous. In addition to being able to fully participate with Medicaid, a Community Health Center may be able to provide primary care services and insurance billing with much lower costs. It can also provide services within a student health facility, operate a pharmacy or urgent care clinic on a campus, and/or provide other ancillary services such as laboratory, radiology, and physical therapy. The college could continue to provide specialty care

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(e.g., psychiatry), mental health counseling services, health promotion and wellness programs, and other services that may not be readily available from a Community Health Center. A key factor in determining which services should be funded and provided by a CHP often hinges on whether the services can be reimbursed by students' insurance and/or there are other equitability concerns suggesting the services should be provided to all students, regardless of their insurance status.

The option to create a new Community Health Center is discussed in the section of this paper, [Possible Alternatives to Collaboration for Public Colleges and Universities](#). Generally, the option for converting a CHP to a Community Health Center structure or creating a new Community Health Center is most viable for large public universities committed to enhancing health care access for the entire community. This may be most applicable to public universities with academic health centers or other academic divisions that have a broad interest in improving community health care access.

Also addressed in this paper are [FERPA](#) and [HIPAA Compliance Considerations](#) and other regulatory and environmental factors for collaborating with a Community Health Center to provide CHP services.

Overview of Community Health Centers

Community Health Centers are regulated, and are often funded, by the Health Resources and Services Administration ([HRSA](#)) of the US Department of Health and Human Services and its Bureau of Primary Health Care ([HRSA/BPHC](#)).ⁱⁱⁱ [Appendix A](#) includes the following description of the required scope of services (see page 1):

“In general, health centers are required by Statute to provide primary and preventive health care to medically underserved populations. In addition to medical care, health centers must provide or arrange for preventive dental care, certain basic behavioral health services, and “enabling” services – wraparound care, like case management, interpretation and transportation – that help patients get the care they need. Some health centers also provide additional specialty medical dental and behavioral health services. Health centers focus not only on the health of individual patients, but also on the health of the entire community. Needs assessment, program development, evaluation and the very definition of “community” are all framed in terms of each community’s unique assets and needs.”

For some parents, students, and other stakeholders, Community Health Centers may be inaccurately perceived as being “free clinics” that are staffed by volunteers and are working with severely limited resources. This is not a valid perception, as they are highly regulated and professionally staffed, and many have [NCQA accreditation](#) as [Patient Centered Medical Homes](#) and/or are accredited by the Accreditation Association for Ambulatory Health Care ([AAAHC](#)) or [The Joint Commission](#). Readers of this paper may find local Community Health Centers by using the [search tool](#) on the HRSA website. The [National Association](#)

ⁱⁱⁱ Community Health Centers operate under Section 330 of the U.S. Public Health Service Act, and may be awarded Section 330 federal grant funding, as well as several other benefits, including enhanced Centers for Medicare and Medicaid Services reimbursement and pricing through the 340B Federal Drug Pricing Program. To receive these benefits, Community Health Centers must meet the requirements detailed in the HRSA’s Compliance Manual. The required scope of services and 21 Chapters of the Compliance Manual for operation of a Community Health Center are discussed in [Appendix A](#).

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of Community Health Centers and state associations (e.g., Pennsylvania Association of Community Health Centers) are important resources for understanding the capabilities and functioning of Community Health Centers.

Community Health Centers ensure quality and cost effectiveness through stringent oversight by HRSA. The following are listed as [Health Center Program Fundamentals](#) at the HRSA website.

- Deliver high quality, culturally competent, comprehensive primary care, as well as supportive services such as health education, translation, and transportation that promote access to health care.
- Provide services regardless of patients' ability to pay and charge for services on a sliding fee scale.
- Operate under the direction of patient-majority governing boards of autonomous community-based organizations. These include public and private non-profit organizations and tribal and faith-based organizations.
- Develop systems of patient-centered and **integrated care** [emphasis added] that respond to the unique needs of diverse medically underserved areas and populations ([MUA/MUP](#)).
- Meet [requirements](#) regarding administrative, clinical, and financial operations.

Community Health Centers are widely recognized for their vital role in responding to the COVID-19 pandemic. This is an excerpt from an article in Forbes magazine on August 12, 2020:⁶

“... Nearly 30 million Americans rely on 1,400 community health centers to provide services at more than 12,000 sites across the country. This population includes 1 in 9 children, 1 in 5 rural residents, and 1 in 3 living [in] poverty. Vulnerable populations served include veterans, agricultural workers, and individuals living in public housing. Most health centers provide a wide range of medical, dental, and behavioral health services. Importantly, they do so regardless of a patient's ability to pay; in fact, almost one-quarter of health center patients are uninsured and nearly half are covered by Medicaid.

Health centers have risen to the occasion during the Covid-19 pandemic having conducted over 2.6 million tests to date, many through walk up or drive-up testing. More than half of all people tested and of confirmed cases have been from communities of color. Health centers have also continued to serve their communities by conducting clinical visits virtually.”

As shown in [Appendix C](#), Community Health Centers employ more than 236,000 full-time health care providers and staff, and the number of patients served tripled from 9.6 million in 2000 to 30 million in 2018. While Community Health Centers are focused on providing access to care for medically underserved populations, they also serve the entire community by providing outstanding services and participating with commercial insurance plans. Accordingly, Community Health Centers often serve a broad cross-section of the local population, with 19 percent of all patients, nationally, having commercial insurance coverage.⁷

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Table 1 shows the increasing trends for patients with Medicaid and private health insurance using Community Health Centers from 2010 to 2018, differentiated by states that expanded Medicaid eligibility under the ACA.

	Non- Expansion			Medicaid Eligibility Expanded		
	2010	2018	% Change 2010 - 2018	2010	2018	% Change 2010 - 2018
Uninsured	2,629,896	2,817,139	7%	4,549,649	3,506,377	-23%
Medicaid	1,777,335	2,584,435	45%	5,508,918	10,874,303	97%
Private Insurance	783,818	1,731,239	121%	1,856,535	3,416,994	84%
Medicare	477,062	821,317	72%	950,528	1,873,470	97%
Other Public insurance	109,647	94,276	-14%	385,461	170,591	-56%
Total Patients	5,777,758	8,048,406	39%	13,251,091	19,841,735	50%
Total Visits	20,942,224	29,021,697	39%	54,260,002	84,876,080	56%

Table 1

College or University Characteristics Suggesting Collaboration Advantages

Although collaborating with a Community Health Center could be advantageous in many situations, colleges and universities with one or more of the following characteristics are likely to find this option warrants consideration.

- One-third or more of undergraduate students are Pell Grant recipients.
- A significant graduate student population exists, having personal income that is less than 200 percent of federal poverty level ([FPL](#)), with most not covered by commercial insurance plans.ⁱ
- The college is focused on serving Black, Indigenous, and People of Color (BIPOC) communities or has other characteristics that align with students who are likely to have an existing patient relationship with a Community Health Center located near the college. Many Community Health Centers focus on providing access to care for underserved populations. This includes the LGBTQIAP+ community.
- The college does not realistically have full capability within its CHP to (1) bill insurance and serve as an in-network participating provider with students' personal health insurance; (2) provide state-of-the-art services (e.g., accreditation, evidence-based medicine, and integrated care); or (3) develop new or sufficient resources to achieve either objectives one or two.
- The college wants to (1) leverage such a partnership to expand access to culturally sensitive and competent services; and (2) work with an existing Community Health Center that is already excelling in providing cost-effective patient/client care.

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Collaborating with a Community Health Center could positively impact students due to the similar income eligibility thresholds for Medicaid and Pell Grants (adjusted gross family income of \$26,000 or less),⁸ and the ability to offer a Sliding Fee Discount Program (**SFDP**) for low-income students who are not covered by Medicaid. Accordingly, providing services through a Community Health Center could significantly reduce tuition/fees and other institutional funding allocations normally devoted to providing CHP services without jeopardizing students' access to care. This is because of the following two advantages of Community Health Centers:

- 1) capability to participate with Medicaid and bill commercial insurance/health plans with low administrative overhead costs compared to many **CHPs**; and
- 2) enhanced reimbursement for Medicaid,⁹ and other cost advantages (e.g., 340B pharmacy as explained in [Appendix A](#)) and economies of scale for many administrative and billing functions.

Absent collaboration with a Community Health Center, for a CHP to optimally bill insurance and ensure students' access to care, the college usually needs to be in a state jurisdiction that allows designated health fees or other institutional funding to pay for costs not reimbursed by students' personal health insurance (refer to [Insurance Billing and Ensuring Students' Access to Care](#)). Otherwise, students can be inadvertently disenfranchised from access to care if the state regulatory environment for insurance billing is not carefully considered, the insurance status of students is not fully assessed, and/or a requirement does not exist for students to have health insurance as specified in *Standards for Student Health Insurance/Benefit Coverage* endorsed by the American College Health Association.¹⁰ The Community Health Center option, however, eliminates or reduces these concerns, especially if the college is located in state that has expanded Medicaid eligibility.

Key Considerations for Collaborating with a Community Health Center

Ability to Provide Services on a College's Campus with Varying Funding Arrangements

A Community Health Center site could be located on a college's campus and/or the college could arrange transportation to an existing site in the community (refer to [Collaborations Between Colleges and Community Health Centers](#)). For on-campus services, a college could have a blend of internally operated services (e.g., counseling and psychiatry, disability, physical therapy, or sports medicine) with primary care, pharmacy, dental, and vision services provided in the same facility by a Community Health Center.

A college can pre-fund access to care at a Community Health Center for all students, regardless of income. For example, at the [University of Houston – Victoria](#), students have a pre-funded benefit at a Community Health Center. The student is responsible for a \$25 payment per visit. Other options include having employees of the college work at a Community Health Center site (refer to [Fitchburg State University's](#) recent collaboration with Community Health Connections and to [Status of College Health Program Employees](#)).

Insurance Billing and Ensuring Students' Access to Care

A key question posed in this paper is whether some portion of the funding for CHPs unnecessarily duplicates students' personal insurance coverage. This is true for colleges with large low-income student populations in states where Medicaid eligibility has been expanded under the ACA, as 100 percent coverage is provided by Medicaid for most of the primary care services offered by CHPs. Insurance billing is complex, requires extensive resources, and is highly variable based on differing regulation by state jurisdictions. Refer to [Appendix E](#) for a more complete discussion of insurance billing for CHPs. The summary of eight best practices in Appendix E, as well as the section entitled "A Safety and Welfare of Patient Exception for College Health Programs" provides information on the ability to not bill insurance when there is a concern for the student.



*Philadelphia Community Health
and Literacy Center*

In 11 states, CHPs are using tuition/fees and other institutional funding sources, defined collectively in federal regulations as Student Administrative Health Fees ([SAHF^{iv}](#)), to fund either remaining balances for medical expenses not covered by students' personal insurance (e.g., copayments, coinsurance, deductibles) or medical expenses incurred by uninsured students. Refer to [Appendix E](#) for an explanation of this funding model and the use of SAHF as a secondary payer in coordination of benefits with students' insurance as the primary payer.

CHPs may have difficulty both participating with Medicaid and having a SAHF secondary payer arrangement due to potential conflict with the requirement that Medicaid be a payer of last resort.¹¹ Alternatively, several Community Health Centers have concluded that a conflict does not exist for participating with Medicaid while accepting SAHF funding to either cover remaining balances from students' personal insurance or to fund charges for students who are uninsured. From the perspective of these Community Health Centers, the agreement with a college to accept SAHF funds simply constitutes billing to another insuring or grant funding entity.

Students covered by either managed care Medicaid plans or by certain commercial insurance plans may have an existing primary care provider (PCP) designation and will be required to change their PCP to the Community Health Center. The process for making a PCP change may be as simple as a phone call to the insurer, or as complex as a several-months process with the state's regional Medicaid office. In some states (e.g., Massachusetts), the change of PCP can be done relatively easily and within one to two business days.

^{iv} **Student Administrative Health Fees (SAHF)**

(1) Definition. A student administrative health fee is a fee charged by the institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage. Source: Federal Register, March 12, 2012. [CMS-9981-F](#), Student Health Insurance Coverage. p. 16468.

Sliding Fee Discount Program (SFDP)

The goal of the SFDP is to minimize financial barriers for low-income patients, while monetarily investing patients in their care, based on their ability to pay.¹² Given the prevalence of Pell Grant recipients, other low income students, and financially independent students on many campuses, the SFDP can reduce the financial to health care many students face.

Community Health Centers must establish a schedule of discounts based on individual and family income and size relative to the Federal Poverty Level (**FPL**). Patients at or below 100 percent of the FPL receive a full discount, those greater than 100 percent but less than 200 percent receive a partial discount, and those greater than or equal to 200 percent receive no discount. Community Health Centers may choose to have a nominal fee for those at or below 100 percent of the FPL. Refer to [Appendix F](#) for an example SFDP. The nominal fee is based on input from patient board members, patient surveys, advisory committees, or reviews of copay amount(s) associated with Medicare and Medicaid for patients with comparable incomes. The nominal fee is not reflective of the actual cost of the service being provided.¹³ Therefore, Community Health Centers would assume responsibility for most of the cost of care for students at or below 100 percent of the FPL. The cost to students who have family income greater than the FPL would be variable, depending on the student's insurance carrier and plan details (high deductible plan, copayment structure, etc.). Students with individual or family income greater than 100 percent of FPL, but less than 200 percent, will receive care at a discount based on a schedule. Students with income greater than or equal to 200 percent of FPL would receive care at similar cost to private sector primary care community locations.

The SFDP also determines patient responsibility if there is an outstanding balance after a claim has been submitted to the insurance company. Footnote 9 of Chapter 9 of HRSA's Health Center Program Compliance Manual, Sliding Fee Discount Program, gives this example of application of the SFDP:

“... an insured patient receives a health center service for which the health center has established a fee of \$80, per its fee schedule. Based on the patient’s insurance plan, the co-pay would be \$60 for this service. The health center also has determined, through an assessment of income and family size, that the patient’s income is 150% of the FPG and thus qualifies for the health center’s SFDS. Under the SFDS, a patient with an income at 150% of the FPG would receive a 50% discount of the \$80 fee, resulting in a charge of \$40 for this service. Rather than the \$60 co-pay, the health center would charge the patient no more than \$40 out-of-pocket, consistent with its SFDP, as long as this is not precluded or prohibited by the applicable insurance contract.”¹⁴

Community Health Centers are responsible for preparing and maintaining the fee schedule, as well as board-approved policies for applying these fees uniformly to patients. Income eligibility must be reviewed prior to receiving care and it must be periodically reassessed. Given that students' financial information (required for the student's family if they are a dependent of a parent/guardian) must be vetted for the SFDP before the time of service, this may be perceived by students as a significant administrative burden and could ultimately be an access barrier. One possible solution is for the agreement with the Community Health Center to include acceptance of the college's report of family income status for the SFDP, thereby eliminating the need for other commonly required documentation of family income.¹⁵

FERPA and HIPAA Compliance Considerations

The Department of Education and the Department of Health and Human Services issued updated joint guidance in December 2019 for the applicability of the Family Educational Right and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) to student health records.¹⁶ It may be important to establish that a collaboration with a Community Health Center does not structurally constitute the ongoing operation of a student health service and/or counseling service. This would appear to resolve any question as to whether students' medical records at the Community Health Center are governed by HIPAA rather than FERPA.

There should be no significant barriers to a college or university entering into a service agreement with a Community Health Center for immunization compliance. In some instances, the student may have to authorize transfer of their immunization history to the college for compliance reporting. Community Health Centers have a long-standing history of assisting elementary and secondary schools with immunization records and this process can be replicated for higher education colleges. The HITECH Act amended HIPAA, permitting providers to send proof of immunization directly to schools if oral or written consent is received from the student or parent. Additionally, Community Health Centers are accustomed to collaborating with public health departments during health or safety emergencies.

It is important to recognize and to fully comply with confidentiality requirements that are specified in state laws or regulations for licensed health professionals. These requirements may supersede either FERPA or HIPAA because they are more restrictive. A complete discussion of student health records regulation is beyond the scope of this paper. Readers are encouraged to consult with their legal counsel for compliance concerns relating to CHPs.

Status of College Health Program Employees

A consideration in the decision to collaborate with a Community Health Center may include whether current CHP professional and support staff could maintain employment with the college. While each arrangement with a Community Health Center is likely to have unique features, as seen with the integration of academic health centers and Community Health Centers,¹⁷ there is an opportunity for staff to maintain employment with the college under a Community Health Center collaboration agreement. The Community Health Center may contract with the college to provide staffing in its clinics through, for example, an employee leasing agreement. The contract would typically include a schedule of compensation to the college when there is an insurance reimbursement for medical care provided by the college's employees. As noted in the collaboration for [Fitchburg State University](#), a commitment was made to have a university-employed provider work at the Community Health Connections site near campus.

In evaluating whether to provide continued employment with the college for CHP professional staff, it is important to consider differences in the compensation systems used by the college and the Community Health Center. Most Community Health Centers have some form of performance-based compensation for professional staff that are seeing patients/clients, whereas most CHPs do not link compensation to productivity or other performance factors related to organizational objectives and mission.

Responsibility to Continue Providing Effective College Health Programs

Collaborating with a Community Health Center does not relieve a college of its responsibility to continue to effectively provide the myriad services and benefits that constitute a CHP (refer to [Appendix B](#)), especially, for example, counseling services. Many Community Health Centers provide extensive behavioral health services; however, they are only required to provide referrals to counseling and psychological or substance use disorder services.

Adopting a Community Health Center structure does not eliminate the need for a college to provide an effective student health insurance/benefit program and comply with [ACHA's Standards for Student Health Insurance/Benefit Coverage](#).¹⁸ For example, having an institutional requirement for health insurance as a condition of enrollment (Standard I), even in states that have expanded Medicaid, remains important to ensure students have access to appropriate, cost-effective health insurance.

Funding for Community Health Centers

Table 2 shows the distribution of Community Health Center revenue by payer source for 2018 (data is also available by state).¹⁹

Location	Medicaid	Medicare	Private Insurance	Self-pay	Federal Section 330 Grants	Other Grants and Contracts
United States	45%	8%	11%	4%	17%	12%

Table 2

As noted in [Table 1](#) in the [Overview of Community Health Centers](#), many Community Health Centers provide a significant portion of their care for privately insured persons who do not qualify for a Sliding Fee Discount Program ([SFDP](#)). This reflects increase acknowledgement, especially in the media, of the value and quality of care provided.

Medicaid

Medicaid eligibility expansion under the ACA had a positive effect on the sustainability of Community Health Centers. A 2018 Commonwealth Fund national survey found that Community Health Centers in states that expanded Medicaid were more likely to be financially stable, provide affordable care to patients, and coordinate patient care with social services in the community.²⁰

Medicaid reimburses Community Health Centers under the prospective payment system (PPS). PPS rates are per-visit rates, specific to each Community Health Center, based on the historical costs of providing care, resulting in rates more closely reflecting the actual cost of care. In these cases, Medicaid reimburses at a higher rate than other payers (e.g., Medicaid paid 79 percent of charges versus 56 percent for private insurance in 2017).²¹ These enhanced rates also support services not traditionally reimbursed by Medicaid, including case management, translation, transportation, etc., helping Community Health Centers manage costs while expanding access to these services for patients. The PPS is beneficial to Community Health

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Centers, especially considering Medicaid comprises 45 percent of their revenue (refer to [Table 1](#)). Given that 40 percent of undergraduates are Pell Grant recipients and 31 percent of all students are at or below the federal poverty level,²² Medicaid reimbursements apply to a substantial portion of the care students would typically receive if they attend a college in a state that has expanded Medicaid eligibility.

Commercial Insurance

Community Health Centers also participate with commercial health insurance organizations/plans as in-network providers, and the income from privately insured patients is key to their financial viability. Although the reimbursement rates vary widely based on geographic area, commercial insurance plans pay significantly more for physician services than Medicare. The Kaiser Family Foundation reported in April 2020 that “For physician services, private insurance paid 143 percent of Medicare rates, on average, ranging from 118% to 179% of Medicare rates across studies.”²³

Governance for Community Health Centers and Operating Integrity

As explained in [Appendix A](#), Community Health Centers are subject to many governance requirements. The operating integrity of Community Health Centers (e.g., maintaining quality care, financial stability and integrity, and adherence to the tenet of operating solely for the benefit of its patients), is primarily ensured through mandated oversight by an independent board of directors and the numerous, highly specific requirements in the HRSA Health Center Program Compliance Manual.

One notable requirement is that at least 51 percent of the board of directors must be composed of the Community Health Center’s patients. The board’s authorities are set forth by Chapter 19 of HRSA’s Health Center Program Compliance Manual.²⁴ Similar to the traditional function of a board of directors for a non-profit entity, this board is the policymaking body of the Community Health Center, responsible for carrying out the mission of the health center through a strategic plan. Except for obligations to governmental agencies and funding sources, the board’s authority is absolute and therefore cannot be limited, restricted, voting blocked, veto-powered, etc., including agreements or collaborations with other organizations.

Collaborations Between Colleges and Community Health Centers

There are several four-year colleges and universities that have noteworthy collaborative partnerships with area Community Health Centers.

University of Houston-Victoria

The University of Houston-Victoria has a [collaborative partnership](#) with Community Health Centers of South Central Texas, which has a clinic located near the campus. The clinic provides primary care, behavioral health services, and dental care. Table 3 shows the University pre-funds visits by students, whether or not they have health insurance, subject to a \$25 copayment.



*Community Health Center in
Burlington, Vermont*

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Students who live on campus or within 50 miles of the Victoria campus are eligible to use the Community Health Centers of South Central Texas located less than two (2) miles from UHV. Insurance is not required but may be used.

The co-pay will be no more than \$25 each visit. When you attend your first appointment, you will need to bring:

- A Texas State issued ID or a UHV Student ID card to show eligibility
- Proof of address (can print from myUHV)
- Proof of financial eligibility (FAFSA print-out, available on myUHV)

Table 3

Michigan Technological University



Upper Great Lakes Family Health Center's clinic on the campus of Michigan Technical University

Michigan Technological University in Houghton, Michigan has a [collaboration](#) with the Upper Great Lakes Family Health Center (UGL). UGL operates a location on the University's campus, where only students have walk-in access for primary care. Students are referred to nearby UGL locations for specialty and dental services. Students may also use any of the other nine UGL locations within Michigan.

Fitchburg State University

Fitchburg State University in Massachusetts developed a [partnership](#) with [Community Health Connections](#) in August 2020, to provide care for its students (refer to [Appendix G](#) for the rationale to discontinue operating its Student Health Services). Students use their own health insurance and must change their primary care provider, if required by Medicaid or their insurance carrier, when they seek care at Community Health Connections. In Massachusetts, this is easily done by placing a call to MassHealth, and the change in primary care provider is usually implemented within 24 hours. Students covered by Fitchburg's student health insurance plan have a maximum copay of \$15, and students covered by other personal insurance pay the cost sharing amounts specified by their insurance (with possible reduction if the student is eligible for the sliding fee discount).

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Students have priority for same-day appointments. Fitchburg State University employs a physician assistant to work at the Community Health Connections clinic located near the campus. A reimbursement schedule specifies payment to the University when the physician assistant sees a patient with Medicaid or commercial insurance.

Eastern New Mexico University

Eastern New Mexico University has a clinic on its campus operated by La Casa Family Health Services. The name of the facility is La Casa ENMU Student Health Services.

Private Colleges In West Virginia and Pennsylvania

Two private colleges in West Virginia and one in Pennsylvania have clinics on their campuses operated by Community Health Centers:

- The [AB Wellness Center](#) at Alderson Broaddus University is provided by Barbour Community Health Association.
- A [clinic](#) on the campus of West Virginia Wesleyan College is provided by Community Care of West Virginia
- Scranton [Primary Health Care Center](#) provides Student Health Services on the campus of Lackawanna College.

Community Colleges

The following community colleges have clinic locations on their campuses operated by Community Health Centers:

- [Arkansas State University Three Rivers](#), Malvern, AR
- [Compton College](#), Compton, CA
- [Delgado Community College](#), New Orleans, LA
- [Jefferson College](#), Watertown, NY
- [Lamar Community College](#), Lamar, CO
- [McLennan Community College](#), Waco, TX
- [Onondaga Community College](#), Syracuse, NY
- [Pueblo Community College](#), Pueblo, CO
- [San Diego City College](#), San Diego CA
- [Santa Rosa Junior College](#), Petaluma, CA
- [Wenatchee Valley College](#), Wenatchee, WA

An updated list of relationships between colleges and universities and Community Health Centers is maintained in the FAQ for this paper at the [document repository](#) shown in the Table of Contents.

Possible Alternatives to Collaboration for Public Colleges and Universities

Students, administrators, and other stakeholders at public colleges and universities may ask about the potential for converting an existing CHP to operate as a Community Health Center. Some public colleges (known in federal regulations as “public entities”) can apply to become a Federally Qualified Health Center if the university works with and shares authority for the Community Health Center with a board of directors that meets the governance requirements in HRSA’s Health Center Program Compliance Manual.

Assuming that the need for a new Community Health Center can be established (as described below), there would be a significant front-end cost for the college, both direct and indirect, before the long-term objective of having Section 330 grant funding can be achieved. The common initial step for establishing a new Community Health Center is to operate with a “Look-Alike” designation from HRSA as explained in Section 1 of [Appendix A](#), Options for Becoming a Health Center. Look-Alikes do not receive Section 330 grant funding.

As noted in the [Abstract](#), the option for converting a CHP to a Community Health Center structure or creating a new Community Health Center is likely to be most viable for large public universities that want to make a commitment to improving health care access for the medically underserved population in the community. Serving the needs of students would be a component of this mission. This circumstance may be most applicable to public universities with academic health centers or other academic divisions that have a broad interest in community health care access. This does not mean, however, that a specific clinic location is precluded from providing preferred access for students.

HRSA is concerned with avoiding overlap among Community Health Centers. Colleges located in or serving an area ([MUA](#) or [MUP](#)) with an existing Community Health Center must demonstrate that there is a need for an additional location (i.e., that current locations do not fully meet the primary care service needs of the community) and that the applying college is working with the existing health centers. Thus, a college would need to establish that a significant population of students and staff are medically underserved because existing Community Health Center clinic locations are not readily accessible due to distance, availability of services, or other barriers. Fully assessing the need for a Community Health Center location on or near campus may be difficult, as the [American Community Survey](#) and other demographic data may not accurately show the number of low-income students since many students have distant permanent residences. Some colleges may be able to demonstrate that a location on or near the campus will better serve low-income students and is unlikely to disrupt, or draw patients away from, an existing Community Health Center.

Most importantly, as discussed in [Governance for Community Health Centers and Operating Integrity](#), the operating independence of the Community Health Center must be ensured. Some colleges may view this unfavorably due to losing full organizational control of a key student service. Other stakeholders may see the advantage of increased operating and funding stability and accountability for their students’ health care. More specifically, many current [CHPs](#) do not have special standing and must vie for their share of the limited

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resources that fund the wide range of other services that typically compose student services or student affairs divisions (e.g., housing, food services, recreation centers, career centers, student centers/unions, etc.). One advantage of working under a Community Health Center structure would be funding that is separate from institutional budget constraints. There would also be greater oversight and compliance guarantees for quality of care and integrity of fiscal operations.

Conclusion

This paper addresses the potential mission compatibility between Community Health Centers and many colleges and universities. Regardless of whether there is a robust economic recovery following the end of the COVID-19 pandemic, stakeholders will continue to expect that higher education leaders will reconsider all methods of operation. This includes ensuring that available resources are fully leveraged to provide optimal services at the most advantageous cost. Reassessing the operation of College Health Programs (**CHPs**) should be informed by the ongoing expansion of Medicaid eligibility for low-income adults in the 38 states, plus the District of Columbia, under the Affordable Care Act²⁵ and the significant increase in the use of Community Health Centers.



Community Health Connections' clinic near the campus of Fitchburg State University in Fitchburg, Massachusetts

The concept of collaborating with a Community Health Center to provide primary care and selected other health care services for college students is not new. [Existing example collaborations](#) demonstrate the viability of this concept, including the ability to:

- ensure that institutional funding for CHPs (**SAHF**) does not unnecessarily duplicate benefits students already have through Medicaid or commercial health insurance/benefit plans;
- provide higher quality, more cost-effective care;
- provide care that emphasizes cultural competency and sensitivity; and
- provide care that is fully integrated with community access points to best ensure seamless availability of care for students in the local area and/or periods when they do not have student status.

The collaboration advantages are not one-sided. By partnering with colleges, Community Health Centers may be able to better meet the needs of existing and/or new patients and expand services capabilities. For both colleges and Community Health Centers, effective partnering can increase support from state and local governmental leaders and community businesses and service organizations. This should resonate in

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communities where a college is already committed to increasing access for low-income students and other populations that have been historically disenfranchised from higher education.

Many emerging key questions and trends for health care (e.g., increased use of telehealth) are beyond the scope of this paper. Readers are encouraged to review the FAQ at the [document repository](#) shown in the Table of Contents for an ongoing discussion for a variety of topics.

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Chris Brownson, Ph.D.

Associate Vice President for Student Affairs
Director, Counseling and Mental Health Center
Clinical Associate Professor, Department of Educational Psychology
The University of Texas at Austin

Mike Eyster

Board Member
Lane Community College
Eugene, Oregon

Shannon Millington, PT

Director of Ancillary Services
University Health Services
University of Oregon

Joy Stewart-James, Ed.D.

Associate Vice President
Student Health & Counseling Services
Sacramento State University

Gordon Taylor

Interim Executive Director, Student Health & Counseling
University of Texas at San Antonio

About the Authors



Stephen L. Beckley, CEBS

Stephen is a senior partner with Hodgkins Beckley Consulting. He has more than 30 years of experience conducting program reviews for college health programs.



Ann C. Deinhardt, MSW

Ann provides consulting services for Federally Qualified Health Centers. She has helped many Community Health Centers across the country, mostly nurseled, to implement HRSA requirements and develop proposals for Look Alike and FQHC designation and funding.



Valerie A. Lyon, MHA

Valerie has over 30 years of experience in health care administration including hospital, medical group practice management, and college health programs. She became a partner with Hodgkins Beckley Consulting in 2017.



Anna Mayme Wainwright, MHA

Anna is an early careerist with a passion for college health. She received a Master's in Health Administration from the Sloan Program at Cornell University in May 2020 and currently works within college health on strategic support and planning.



*North Country Family Health Center at Jefferson
Community College in Watertown, New York*

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APPENDIX A

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS
“SO YOU WANT TO START A HEALTH CENTER?”



COLLABORATING WITH A COMMUNITY HEALTH CENTER
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Foreword

This publication is a guide for health care providers and organizations, public agencies, or community-based organizations and individuals interested in becoming part of the Health Center Program.

This guide outlines the many considerations and recommended steps a community must consider for assessing readiness to apply to become a community health center. This guide provides links to resources and toolkits that support each step of the process.

There is no single way to start a community health center.¹ There is no one-size-fits-all model.

The decision to embark on the long path of becoming a community health center is not an individual or organizational decision. It is a community decision. The very essence of a health center is that it grows from, responds to, and is governed by the community it serves.

Pursuing a health center and choosing the right option depends on many things:

- Community needs (health status, barriers to health care access, special populations, etc.)
- Qualifying health professional shortage designations
- Community support and participation in building, sustaining, and utilizing the health center
- Ability to create and sustain consumer-majority governance
- Current or potential collaborative partnerships

In addition to these conditions, every health center must meet the statutory, regulatory, and policy requirements set forth in Section 330 of the Public Health Service Act (42 U.S.C 254b) – the authorizing statute of the Health Center Program – and the requirements set forth in the Health Resources & Services Administration’s (HRSA) Health Center Program Compliance Manual.² The requirements set forth in the Compliance Manual apply to all health centers that apply for and/or receive Federal Health Center Program award funds as well as subrecipient organizations and Health Center Program look-alikes (which do not receive Federal funding under section 330).

1 Throughout this document, the term “health center” is used to denote community health centers, migrant health centers, healthcare for the homeless health centers, public housing primary care centers, and health center Look-Alikes, and is used interchangeably, unless noted otherwise.

2 Throughout this document, HRSA’s Health Center Program Compliance Manual will be referred to as “Compliance Manual.” <https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html>

Section 1

Background & Overview

Health centers are a vital part of health care delivery in the United States today.

In 2018, nearly 1,400 health center organizations delivered care to over 28 million people at over 11,000 sites in every state, territory, and the District of Columbia.³ Health centers serve one in twelve people in the United States, including one in three people living in poverty, one in five people in rural areas, one in six Medicaid beneficiaries, and one in nine children.⁴ Over 90% of health center patients are low-income, over 80% are uninsured or publicly insured (i.e. Medicaid, Medicare, CHIP, etc.), nearly 1.4 million patients served by health centers are homeless, and more than 385,000 patients are veterans.⁵

By mission and statute, the health center model requires that health centers locate in areas of greatest need, provide services regardless of patients' ability to pay, and are led by representatives of the population they serve. Despite addressing higher levels of need and patient complexity, health centers consistently demonstrate quality health outcomes at costs well below national averages.

Health centers are estimated to save the entire health care system more than \$24 billion annually.⁶ Every \$1.00 of federal Health Center Program funding is estimated to generate \$5.73 of economic activity for low-income and underserved communities.⁷ In total health centers generate an estimated \$54.6 billion in economic activity.⁸

Section 330 of the Public Health Service Act (42 U.S.C 254b)

The authorizing Statute for the Health Center Program is Section 330 of the Public Health Service Act (42 U.S.C 254b).

Section 330 funding is subject to Congressional appropriation and may or may not be available every year. Historically, support for health centers has been high and bipartisan. However, budget constraints at the federal level can affect availability of funds for new organizations.

In general, health centers are required by Statute to provide of primary and preventive health care to medically underserved populations. In addition to medical care, health centers must provide or arrange for preventive dental care, certain basic behavioral health services, and "enabling" services – wraparound care, like case management, interpretation and transportation – that help patients get the care they need.

Some health centers also provide additional specialty medical dental and behavioral health services. Health centers focus not only on the health of individual patients, but also on the health of the entire community. Needs assessment, program development, evaluation and the very definition of "community" are all framed in terms of each community's unique assets and needs.

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Health Center Program Compliance Manual

The Health Resources and Services Administration (HRSA) / Bureau of Primary Health Care (BPHC) monitors and helps support a health center's compliance with all requirements outlined in the [Health Center Program Compliance Manual](#), which was released in 2017.

HRSA updated the Compliance Manual in 2018 to reflect amendments to Section 330 that resulted from the Bipartisan Budget Act of 2018. The Compliance Manual outlines the Health Center Program Requirements – which form the foundation of the Health Center Program – and describes how health centers demonstrate compliance with these requirements.

Health Center Program Site Visit Protocol

One of the mechanisms by which HRSA assesses compliance with the Health Center Program requirements is through conducting Operational Site Visits (OSV).

During the OSV, a team of three independent consultants utilizes the [Health Center Program Site Visit Protocol](#) (SVP), which is HRSA's tool for assessing compliance. Nearly all the elements within the Health Center Program Compliance Manual are assessed during an OSV, and the SVP serves as an "open-book" test for health centers and reviewers.

Health centers – current awardees and look-alikes – in addition to applicants applying to receive initial look-alike designation must review methodologies and questions in the SVP. In circumstances where HRSA has determined that a health center has failed to demonstrate compliance with one or more of the Health Center Program requirements, a condition(s) will be placed on the award/designation, which will follow the Progressive Action policy and process. A condition placed on the award/designation may mean the following:

- Requiring payments as reimbursements rather than advance payments;
- Withholding authority to proceed to the next phase of the project until receipt of evidence of acceptable performance within a given period of performance; or
- Requiring additional, more detailed financial reports.

If it is determined that noncompliance cannot be remedied by imposing such additional conditions, one or more of the following actions may be taken as appropriate in the circumstances:

- Temporarily withhold cash payments pending further action;
- Disallow all or part of the cost of the activity or action not in compliance;
- Wholly or partly suspend award activities or terminate the Federal award
- Initiate suspension or debarment proceedings
- Withhold further Federal awards for the project or program; or
- Take other remedies that may be legally available.

More information is available in "[Chapter 2: Health Center Program Oversight](#)," of the Compliance Manual.

Options for Becoming a Health Center

Applying for Health Center Program Funding

Eligible organizations may apply for Health Center Program funding by applying in response to a competitive open funding opportunity announcement.

HRSA's two most common competitive funding opportunity types are 1) New Access Point (NAP) funding; and 2) Service Area Competition (SAC) funding. HRSA maintains a list of open and previously funded opportunities on their website (see [HRSA Program Funding Opportunities](#)).

New Access Point (NAP) Funding

- HRSA releases a notice of funding opportunity (NOFO) when Congress appropriate funds for new access points (NAPs). These funds may not be available every year.
- Recent NAP NOFOs have required that proposals be submitted by 1) new organizations (new applicants) not currently directly receiving Health Center Program funding or 2) health centers currently receiving Health Center Program operational funding (satellite applicants).
- New applicants include Health Center Program look-alikes, an organization that is operational at the time of application, or an organization that proposes to become operational within 120 days of the Notice of Award.
- NAP applications must include a proposal for at least one full-time, permanent service delivery site for the provision of comprehensive primary health care services to underserved populations. Applicants may propose multiple access points in a single NAP application with the understanding that all proposed sites must be open and operational within 120 days of the Notice of Award.
- All applications are scored through an objective review process. HRSA uses this score and other factors to make the final funding determinations.
- Selected applicants receive a Notice of Award (NOA), which is the legal document issued to notify the recipient of the award.
- In the 2019 NAP funding competition, the maximum amount of the award was \$650,000 total costs (includes both direct and indirect costs) per year. Up to \$150,000 of those funds were able to be used in Year 1 for one-time only minor capital costs for equipment and/or minor alteration/renovation.

Service Area Competition (SAC) Funding

Service Area Competition (SAC) funding ensures continued access to affordable, quality primary health care services for communities and vulnerable populations currently served by the Health Center Program award recipients.

Organizations that have historically been eligible to compete for SAC funds include domestic public or nonprofit private entities, such as tribal, faith-based, or community-based organizations, that propose to serve an announced service area and its associated population(s) to ensure continued access to affordable, quality primary health care services.

HRSA maintains a Service Area Announcement Table (SAAT) on its website which lists all services areas currently announced for competition through the SAC NOFO. The table includes the patient target for each service area (see [HRSA's Service Area Competition Technical Assistance webpage](#)).

Applying for Look-Alike Designation

Look-Alikes are organizations that do not receive a Health Center Program Federal award but are designated by HRSA as meeting all Health Center Program requirements. (Section 1861(aa)(4)(B) and section 1905(l)(2)(B) of the

SSA.)⁹ Look-Alikes were created to maximize access to care for medically underserved populations and communities by allowing organizations that don't receive 330-funding to be a part of the Health Center Program.¹⁰

Applying for Look-Alike status is an option for organizations seeking to become part of the Health Center Program. Applying for Look-Alike status is an option even when there are no funding opportunities for new access points. HRSA accepts applications for Look-Alike (LAL) initial designation from private, non-profit entities or public agencies on an ongoing basis.

Organizations seeking LAL-status must meet the additional requirements:

1. Deliver comprehensive primary health care services to patients within the proposed service area;
2. Operates the Health Center Program project and that it owns and controls its assets and liabilities; and
3. Not currently receiving funding as a Health Center Program Federal award recipient.

For more information on becoming a Look-Alike, refer to [HRSA's Look-Alike Initial Designation Technical Assistance webpage](#).

Health Center Program Benefits

Health centers participating in the Health Center Program that demonstrate compliance with program requirements are eligible for multiple benefits. The benefits below are specifically for health center that receive 330-funding:

- **Section 330-Funding Awards:** In 2017, 1,367 health centers received funding to provide comprehensive primary care services to underserved populations and communities.
- **Health Center Federal Tort Claims Act (FTCA) Medical Malpractice Program Coverage:** Through the Federal Tort Claims Act (FTCA), eligible HRSA-supported health centers may be granted medical malpractice liability protection. To obtain deemed status, health centers that receive funding under section 330 of the PHS Act must submit an initial deem application to HRSA/BPHC and meet certain statutory deem requirements. Renewal applications for redeeming must be submitted on an annual basis.

Health centers receiving 330-funds and health centers that do not receive funding (i.e. Look-Alikes) are eligible for a range of program benefits:

- **340B Drug Pricing Program:** Ability to Participate in Public Health Service Act (PHS) 340B drug pricing program to purchase prescription drugs at discount, subject to application and approval.
<http://www.hrsa.gov/opa>
- **National Health Service Corps (NHSC):** Health Center Program awardees and designees have access to NHSC providers and resources.
<http://nhsc.hrsa.gov>
- **Medicaid and Medicare Prospective Payment Systems (PPS):** A Prospective Payment System (PPS) is a method of reimbursement in which Medicare and Medicaid payment is made on a predetermined, fixed amount. Health centers designated by CMS as a Federally Qualified Health Center (FQHC) are eligible for the FQHC PPS rate of reimbursement for services to Medicare and Medicaid beneficiaries.¹¹
- **Vaccine for Children (VFC) Program:** This program through the Centers for Disease Control & Prevention (CDC) provides free vaccines for uninsured and underinsured children.
<https://www.cdc.gov/vaccines/programs/vfc/index.html>
- **Access to other potential federal, regional, and state funding programs**

⁹ "Health Center Program Compliance Manual," *Health Resources & Services Administration*, August 18, 2018.

¹⁰ "Health Center Program Look-Alikes," *Health Resources & Services Administration*, May 29, 2019.

¹¹ "Federally Qualified Health Center," *Centers for Medicare and Medicaid Services*, January 2018.

Health Center Program Eligibility

Decisions will need to be made about the type of organization the health center will be. Establishing a new corporate entity, filing with the Internal Revenue Service and state officials, and establishing a board and staff can be major undertakings. Likewise, to convert an existing corporation to a health center will almost certainly require changes to the board and by-laws, and maybe even articles of incorporation. Review with legal counsel to help determine the best path.

Three models will be discussed here, as they represent the most common models for starting new health centers: non-profit models, public entity models, and tribal or urban Indian organizations. More detailed information is included in HRSA's Health Center Program Compliance Manual.

- Non-profit Organization
- Public Agency Organization/Public Entity Models
- Tribal or Urban Indian Organization

Non-profit Organization

Non-profit entities are eligible to apply to be health centers. For-profit entities are not eligible to be health centers.

If there is an existing non-profit organization in the community that could serve as the corporate vehicle (or for conversion of a community provider, like a community action program or free clinic), it can save a lot of effort. Otherwise, the health center could form a new non-profit organization.

This approach requires forming a nonprofit corporate entity under State law and filing for tax-exempt status under the US Internal Revenue Code, both of which can be completed with the help of legal counsel.

- A designated 501(c)(3) tax-exempt organization does not pay income tax on net revenue or donations. Donations given to the entity are tax deductible by the donor. These organizations have limitations on lobbying and must have an appropriate tax-exempt purpose (providing health care services to the underserved is one of them).
- A designated 501(c)(4) tax-exempt organization is primarily an education-based organization and can conduct unlimited lobbying. Donations are not tax deductible to the donor.

The organization will need to meet compliance requirements for health centers as outlined in the Health Center Program Compliance Manual. To do this, health centers must establish a governing board that has specific responsibility for oversight of the Health Center Program project.

Health center governance is one of the most fundamental and important parts of the Health Center Program's success (see [Section 6: Developing Community Governance](#)). Unlike other non-profits or health care providers, health center boards must be composed of a majority (at least 51%) of patients served by the health center and the patients must represent the individuals who are served by the health center. The health center's governing board must consist of at least 9 and no more than 25 members. For non-profits seeking health center status, they might have to replace existing board members or limit the size of their board. For more information on the governance requirements for health centers, the Compliance Manual contains two chapters specifically on governance: [Chapter 19: Board Authority](#); and [Chapter 20: Board Composition](#).

To become a health center, the types of programs or services may need to be modified. For instance, an independent women's health center providing mostly family planning would need to broaden its services to include comprehensive primary and preventive care and to accept males, children and the elderly, or at the very least make arrangements for their care following HRSA/BPHC program requirements, which can be stringent. For example, under Chapter 9 of the Compliance Manual, no patient shall be denied service due to an inability to pay. As a result, all health centers must prepare a fee schedule or payments for the provision of its services "consistent with locally prevailing rate or charges."

ernance structure for the purposes of meeting Health Center Program governance

§ may be structured in one of two ways to meet the program requirements: 1) the public agency meets all the Health Center Program governance requirements based on the existing ties of the public agency's governing board; or 2) together, the public agency and the Health Center Program requirements. Public agencies with a co-applicant board must have the authority to delegate the required authorities and functions to the co-applicant board and define the responsibilities of the public agency and the co-applicant in carrying out the Health Center Program.

public agency health centers (including the definition of public agencies eligible to apply for the Health Center Program) and are subject to the same Health Center Program Compliance Manual and are subject to the same Health Center Program requirements. NACHC has a free publication on public centers, "Public Agency Centers: A Discussion

n Organization

izations, including those defined under the Indian Self-Determination Act or the Indian Health Care Improvement Act, are eligible to apply for Health Center Program funding or designation.¹³ These organizations meet the necessary criteria for demonstrating that they are either non-profits or public

Support Health Centers

(PCA) are nonprofit associations representing health centers and other primary care providers at the state and regional levels. PCAs provide a wide array of services to their members and to the public. Some services include centralized clinician recruitment support, technical assistance, advocacy, and governance matters, training, conferences, and more. PCAs are actively involved at the state and national levels as well. PCAs vary in the services they provide. HRSA has a [n webpage](#) where you can find your state PCA.

PCOs are usually part of state government (often housed in the State Health Department). PCOs work in partnership with PCAs in areas including analyzing and monitoring primary care services, submitting requests for MUA, MUP and HPSA designations, helping health centers and other clinicians in the state, and advocating for health centers within the State. You can find your state PCO at the [Primary Care Office webpage](#).

National Association of Community Health Centers (NACHC) is the primary national, nonprofit, professional membership organization that represents health centers. NACHC promotes the provision of high quality, accessible, coordinated, culturally and linguistically appropriate and community-based health services.

¹³Health Center Program Compliance Manual, p.75, HRSA, August 2018.

¹⁴"National Health Center Program Compliance Manual," *Health Resources & Services Administration*, August 18, 2018.

directed for all underserved populations. In addition to advocacy on issues that affect the delivery of health care for the medically underserved and uninsured, NACHC:

- Provides education, training and technical assistance to community-based health care providers and patient-majority boards of directors in support of their missions and responsibilities;
- Develops and implements programs that stimulate public and private sector investment in the delivery of quality health care;
- Provides benefits and services to those centers that participate in NACHC as members, sometimes in conjunction with affiliated PCAs.

For additional training and technical assistance regarding starting a health center, refer to **Section 10: Additional Resources**.

Section 2

Defining Community

The core concept of a community health center is that it serves the community in which it is located.

As previously discussed, the requirements of health center status also preserve the community focus, by requiring the governance of the organization to reflect the community, as well as be made up of a majority of actual, active patients of the health center. In addition, a new health center will want to serve a broad spectrum of community members with a variety of payment sources (commercial insurance, Medicare, Medicaid, etc.) to ensure a stable and predictable revenue stream while providing care regardless of ability to pay, insurance status, immigration status, or any other reason.

Health centers also respond to their community by keeping abreast of changing demographics, emerging health trends, and population shifts – and then planning and executing strategies to serve all. This would include providing care in languages other than English, monitoring disease hotspots (like influenza outbreaks or sexually transmitted infection spikes) and working in conjunction with other local providers, local social service organizations, and the faith community so the health center can be an integral part of a whole community's service offerings – in a way that makes care affordable and accessible.

In addition to these market conditions, health centers are required to provide services in areas of the greatest needs. HRSA defines these communities in specific ways, which are highlighted below.

Medically Underserved Area/Medically Underserved Population

Each health center must serve at least one Medically Underserved Area (MUA) or Medically Underserved Population (MUP). MUAs and MUPs are designations used by the federal government to designate areas and populations with a shortage of primary care services. Later in this guide there will be information about how to apply for such designation, but a background on MUAs/MUPs is relevant now.

MUAs have a shortage of primary care health services for residents within a geographic area, such as a whole county, a group of neighboring counties, a group of urban census tracts, or a group of civil divisions. MUPs are specific sub-groups of people living in a defined geographic area with a shortage of primary care health services.

MUA and MUP designations are based on the Index of Medical Underservice (IMU). The IMU is calculated based on four criteria:¹⁴

1. The population-to-provider ratio
2. The percent of the population living below the federal poverty level
3. The percent of the population over age 65
4. The infant mortality rate

While MUAs are designated for geographic areas, MUPs are designated for population subsets within a geographic area, for instance low-income individuals. This designation option recognizes that some groups within the broader service area may experience exceptional difficulty accessing health care or have extraordinary health status challenges, even though the broader population within a geographic area may not.

¹⁴ "Medically Underserved Areas and Populations (MUA/Ps), HRSA Health Workforce, May 30, 2019.

It is important to note that the health center must serve individuals who live in an MUA or are part of an MUP, but the center doesn't have to be physically located in the MUA. Moreover, this is an organizational requirement, not a site-based one: only one site of a multi-site health center must serve an MUA/MUP.

Each state has a Primary Care Office (PCO) that assists with MUA/MUP designation, along with four PCOs that serve U.S. territories, and state PCAs, and HRSA/BPHC also can provide assistance. Your target community or population may already have a designation. Current designations, and updates on designation criteria can be seen at <https://bhw.hrsa.gov/shortage-designation/muap>. If there is no MUA/MUP designated for the health center to serve, one will need to be applied for, and the state PCA and PCO can assist with that process.

Health Professional Shortage Areas

A Health Professional Shortage Area (HPSA) is a federal designation that refers to a geographic area, population, or facility with a shortage of primary care, dental, or mental health providers and services.

HPSA designations are used to allocate resources for several federal programs, including programs for health care professionals who receive educational loan repayment or scholarships through the National Health Service Corps (NHSC), in return for working in underserved communities at eligible organizations (see **Section 8: Human Resources** for more information). PCOs submit designation applications to HRSA, which then evaluates applications based on established criteria. If a submitted application meets the criteria, HRSA designates the area, population, or facility in question as a HPSA.

HPSAs are designated in three health disciplines:

- Primary Care – indicating few primary care clinicians available to population
- Dental Health – indicating a shortage of primary care dentists
- Mental Health – indicating a lack of psychiatrists and/or core mental health providers

These shortages may be:

- Geographically-based: There is a shortage of providers for an entire population within a defined geographic area.
- Population-based: There is a shortage of providers for a specific population group within a defined geographic area (i.e. low income, migrant farmworkers, Native Americans, non-English speaking population, etc.).
- Facility-based: HPSA-designation automatically applies to some types of facilities such as 330-funded FQHCs, FQHC Look-Alikes, Indian Health Facilities, and Rural Health Clinics that meet NHSC site requirements. Other facilities which are not automatically designated by statute, such as correctional facilities and state mental hospitals, may also be designated if qualifying applications are submitted to HRSA.

For more information, refer to HRSA's "[Shortage Designation Application and Review Process](#)" webpage. To see if your community is already designated as a HPSA, visit: <http://hpsafind.hrsa.gov>.

Special Populations

Many health centers choose to focus on special populations or certain subsets of the community at large.

Three of these populations have specific funding streams within Section 330 of the Public Health Service Act to support care to them (HRSA defines each population in detail in the Compliance Manual glossary)¹⁵:

¹⁵ "Glossary," Health Center Program Compliance Manual, p.89, HRSA, August 2018.

- 330(g) Migratory and Seasonal Agricultural Worker (MSAW)
- 330(h) Homeless Populations
- 330(i) Residents of Public Housing

Health centers should consider working closely with one of these populations if there is significant need in your community, as these individuals typically experience some of the greatest barriers to access to health care anywhere. There are other underserved populations in communities that can experience barriers – communities of color, the LGBTQ+¹⁶ population, Asian/ Pacific Islanders, and veterans, to name a few. HRSA/BPHC has awarded funding through National Cooperative Agreements (NCAs) to organizations that can provide technical assistance on reaching certain populations. A list of current NCA partners and their target populations is available on the Health Center Resource Clearinghouse (which is a project of the 20-NCAs): <https://www.healthcenterinfo.org/our-partners/>

Defining Services Area

Now that the federal definitions of MUAs, MUPs, HPSAs, and special populations have been explained, it's important to consider what your health center will propose for its service area.

Because of the unique traits of health centers – especially community responsiveness – the health center must propose to serve a geographic area (sometimes called a “service” area). There must be at least one MUA or MUP contained within the service area of the health center and targeted by the health center for care. A health center should be available to serve other patients as well. If a health center chooses to target care to migrant, homeless, and public housing programs the health center should be physically located so as to be convenient, and the health center should expect to target a significant portion of its resources and efforts to serving them.

Currently, as part of Service Area Competition NOFOs, HRSA requires that at least 75% of the health center's patients come from the service area as defined by the health center. Beyond the requirements, however, the service area should be a rational and logical geographic area for the delivery of services, taking into consideration, among other factors, the ability to ensure the health center's services are available and accessible to all residents of the area and the elimination of barriers to care. This can vary based on the population and the nature of the geography. Some programs serving migrant or seasonal agricultural workers, for instance, serve the entire state, while an urban program in a major city may be made up of just a few census tracts, ZIP codes, or even city blocks. In general, a service area is defined by:

- Minor civil division
- Census county division
- Census tract (in metropolitan areas)
- A group of the above that constitute a “natural neighborhood”

A service area can also be defined by:

- A lack of transportation (particularly public transportation)
- Geographic barriers, such as a river, mountain range or highway
- Location in relationship to other service providers
- Travel time to other providers
- Cultural, ethnic or linguistic variables

¹⁶ LGBTQ is defined as Lesbian, Gay, Bisexual, Transgendered and Queer+

Section 3

Developing a Needs Assessment

Successful program planning requires an excellent needs assessment. HRSA requires every health center to conduct a comprehensive needs assessment for the current or proposed patient population utilizing the most recent available data for the service area (and any special populations within the area). More information is provided at Chapter: Needs Assessment in the HRSA Compliance Manual.

The needs assessment must address, at a minimum:

- Factors associated with access to care and service utilization;
- Significant causes of morbidity, mortality, as well as any associated health disparities (per Compliance Manual); and
- Other unique health care needs or characteristics that impact health status, access and/or utilization.

The manner by which the needs assessment is completed and the extent to which additional indicators or a focus on specific population subset(s) are included, however, is within the discretion of each health center to decide. In the 2019 NAP NOFO, HRSA awarded additional priority points to applicants that proposed “NAP full-time service sites” that were located in “hot spot zip codes” – HRSA provided a list of hot spots – in addition to “NAP service sites” operating at least 20 hours a week.”

State and Community Planning Efforts

Certain states and communities undertake robust health planning efforts. Many state PCAs have significant needs assessment data already compiled for a community planning effort and may also be able to dedicate resources to your effort. These efforts may also link the potential health center with existing operational resources, like statewide information technology networks, that can inform the planning process.

Similarly, some major urban areas also maintain priority lists of communities that need primary care resources. If your area has a large public hospital or health department, for instance, those institutions would be well aware of areas that need primary care resources. Indeed, presently, every non-profit hospital is required to complete a community needs assessment, and usually will make those findings available to other community groups. Information on these needs assessments can be found on the Centers for Disease Control and Prevention’s website: <http://www.cdc.gov/chinav/index.html>

Another key tool to leverage in planning efforts is the UDS mapper. UDS, short for Uniform Data Systems, is the report that all health centers must file annually with HRSA/BPHC. One key data point of this report is patient origin data by ZIP code, which the UDS mapper aggregates into map form. The UDS Mapper is a tool will help you pinpoint the estimated number of individuals at or below 200% of the federal poverty level and tie those individuals to existing health centers that serve them. It will also provide information on geographic reach, penetration rate, and growth of Section 330-funded and look alike health centers, so you can have an idea where the residents of your community are seeking care today. Visit www.udsmapper.org to register (free of charge) and gain access to the wealth of information at that site.

Setting Priorities and Planning

Setting priorities is the first step in needs assessment planning. It is important to remember that it is unlikely that a new health center will be able to address all of the unmet need for primary care in any community, so available resources and programmatic aims will need to be prioritized. The quantitative data is the start, and qualitative feedback from the group about what the health care priorities are will help target resources and interventions. Perceptions about these priorities will likely differ among respondents, but that does not make any perception “wrong.” Diversity of opinion among community leaders and planning group members make the process strong. Likewise, members of the planning group will need to compromise on their areas of focus to develop a good health center.

Community Analysis

Understanding the assets and needs of a community is the basis for establishing support for a health center. This is more than just a quantifiable analysis of demographics, health status and care utilization. It is a broader analysis that paints a picture of how the community is structured and where facilitators and barriers to community health care are likely to emerge.

Here are some steps for conducting this analysis:

- Identify the sectors of a community. These can include business, labor, government, faith community, health care, civic organization, educational institutions as well as others.
- Identify the key populations, subpopulations, and key constituencies that make the community unique (i.e. immigrant populations, elderly community, children and youth, etc.).
- List the organizations that represent the identified sectors and populations/constituencies in the community.
- Identify the influencers of that sector – the key individuals as well as the key trends.
- Identify potential organizations/individuals that may pose barriers to starting a health center.

Remember that in the case of individuals, today's naysayer may be tomorrow's cheerleader, so remember to think of them as opportunities rather than brick walls.

Community Participation

Once you have a list of influencers – individuals, organizations, and sectors – from the community analysis, the next step is to start bringing people together to involve them in the effort. **Tip:** One of the great keys to doing community-based work is that people like to be asked to participate and provide their opinion.

There are three main components to this process: getting the word out, holding public forums, and keeping people involved and motivated to do the work.

1. Getting the word out. Use contacts, social media and people already familiar with the planning of a health center to speak to key individuals across sectors of the community. Decide who is going to speak to whom, and have a process for feedback and evaluation.
 - Train those who are going to speak about the health center project on not only the details of the project, but also tips on public speaking, and how to report questions back, especially if the question is a new one.
 - It's always a good idea to use an approved presentation template – so that the audiences are getting the same message every time no matter who is giving the presentation.
2. Holding public forums. Personal invitations to public meetings are always better than relying on posters or other kinds of communication. Tips for a public forum include:

- Be sure the sponsor is a trusted member of the community.
 - Hold the meeting at an accessible and convenient time and location.
 - Invite the media, if appropriate.
 - Offer assistance in attending the meeting: transportation, child- care, translation, etc.
 - Document attendance with a sign-in sheet that includes follow up contact information.
3. Keeping people involved and motivated. Helping people know their efforts are worthwhile and making a difference is important.
- Assign clear and manageable roles and tasks.
 - Build on success to maintain momentum.
 - Build a feedback loop into every action or task. People must see that there are outcomes to their efforts.
 - Use technology to maintain connection and to drive additional interest – platforms like LinkedIn, Facebook, Twitter and Instagram, as well as traditional telephone, email and text messaging techniques (i.e. WhatsApp) – can be valuable communication tools.

Thinking About Partnerships

The support of the health care provider community is very important when starting a health center.

Perhaps the first step of involving the health care community is to get a full picture of other health centers in the area. The *HRSA Data Warehouse* has a “[Find a Health Center](#)” function on their website.¹⁷ Enter in the potential site location or community to get a list of nearby health centers. Contact these health centers and enlist their help. It will be vital that you demonstrate that there is not a potential service area overlap and that the need is great enough in your service area to justify new health centers or sites.

Initial reactions to the effort can range from full support to opposition – some providers will see the effort as creating competition. Aside from other health centers, hospital systems are increasingly building referral networks, purchasing and establishing practices in their communities both to ensure a steady flow of patients for diagnostic and surgical procedures and to establish systems for referral to prevent readmissions after hospitalization.

Support from local providers will help the health center’s effort in the eyes of the public at large and could be a good recruitment strategy for board members. Although the number of non-patient health care professionals on the board is limited by federal statute, they can serve on committees and serve as liaisons to other professionals in the community. Contact other local health care providers, medical and dental societies, health departments, hospitals and private primary care providers to enlist their help.

As a health center expands into a community or is already established, community relationships are important. Co-ordination and integration of activities are key factors in starting a health center. An organization must think about collaborating with other providers or programs in the service area, including local hospitals specialty providers, and social service organizations to provide access to services not available through the health center in order to support:

- Reductions in the non-urgent use of hospital emergency department;
- Continuity of care across community providers; and
- Access to other health or community services that impact the patient.

¹⁷ “Find A Health Center,” *HRSA Data Warehouse*. May 30, 2019. <https://findahealthcenter.hrsa.gov/>

As you start to think about these areas, make a list of agencies, organizations, or individual health care providers (or non-health care providers) that could help serve your population. Once you've made a list, think in a broader sense, and ask:

- Are there any other community health centers I can partner with?
- What other state agencies can I work with?
- Are there any federal programs that can help me take care of the population we are serving?

Your health center is just one component of your patient's, and your community's, well-being. Strong partnerships with other providers, community-based organizations, public agencies, and social institutions isn't something that's just nice-to-have, it's a critical ingredient for your long-term success.

Section 4

Physical Space Considerations

A health center must consider both the size and location of their health in order to provide access to its community and to help attract and retain patients.

Access and Location

In practice, the health center must be easy to reach and convenient for the patients the health center wishes to serve. Depending on the target population, it may make sense to locate near where people live, where they work, or where they access social networks, like churches, community centers, and the like. Usually, a major street, located among other businesses that serve the population, is a good idea. Public transportation access and parking are major considerations. A beautiful facility that is several blocks away from public transit routes or that has no available parking may not be easily accessible to patients. The HRSA Compliance Manual, [Chapter 6: Accessible Locations and Hours of Operations](#)¹⁸ outlines the requirements associated with ensuring that locations and hours of operations do not pose a barrier to care.

Space or Building Considerations

When looking for space, plan for growth as successful start-up operations may outgrow their space quickly. While services can be provided directly, through contract or referral arrangements, a health center may need to plan for expansion of:

- Provider offices, exam and treatment rooms, dental suites, and private spaces for behavioral health counseling
- Areas devoted to other health services, like reception, patient waiting and counseling, social work, laboratory and x-ray services, and pharmacy
- Administrative and clinical and information systems functions

Because each new health center will have its own circumstances related to physical space (including cost and availability), there is no one standard approach that all new health centers should adopt. Most health centers do plan for the following:

- Two to three exam rooms per medical provider (physician, nurse practitioner, physician assistant, nurse mid-wife). This should allow for sufficient patient flow. Being on the ground floor (or in a building with adequate, and redundant, elevator service) is usually a good idea for those with mobility challenges
- Two to three dental suites for each dental care team (which may consist of a dentist, dental hygienist, and/or dental assistant)
- One private space for each behavioral health provider, and a room for group sessions (if this is in your plan)

It may make long-term sense to secure professional assistance from functional space planners to identify space and equipment required by health center operations and local licensing (if applicable). Space planners help both ensure adequate space is available and prevent overbuilding.

¹⁸ Chapter 6: Accessible Locations and Hours of Operations can be found at <https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-6.html#titletop>

One resource to help with space considerations is Capital Link (www.caplink.org), which is an NCA funded by HRSA/ BPHC to help health centers in accessing capital financing for buildings and equipment. They can also provide extensive technical assistance with financial and market analyses, business plans, and proposal development for capital projects, space design, project planning, debt financing, and fundraising. Many of their services are free of charge to health centers.

Section 5

Business Planning

The health center planning group has considered community, service area, target population, locations, and matters of organizational governance. Now it turns to business planning to determine the viability of a health center organization. This business plan will be the critical tool in determining a health center's future. To make a business plan, it is necessary to translate services into volume, revenues and expenses, and plan for financial viability.

Note that business planning is more than just making a budget. This kind of planning, which projects volumes and utilization, as well as forecasts revenues and costs, is really a must for any organization considering health center development. Much of the information needed for the business plan should have been obtained during the needs assessment phase, though it may need to be supplemented at this point. Please refer to **Section 3: Developing a Needs Assessment** for additional information.

Market Share

Perhaps the most important estimate that will be made during business planning is just how many people will seek services at the center. During the planning phase it can be easy to assume a “build it and they will come” mentality – but does the planning group really understand the competitive environment in which it plans to operate? A potential health center would undertake primary market research – surveying people and organizations within the target service area (and population) to ensure the validity of key assumptions that influence later components of the plan. The potential volumes will drive financial projections that will determine whether the health center is a viable entity.

This research seeks information about the location, range of services, charges and best communication methods to drive utilization of the health center. It is also important to understand how this potential health center can distinguish itself from the competition – what would cause a potential patient to disrupt her existing provider relationship and choose this center? This is an inexact science but err on the side of conservatism – if it seems that 10,000 people will choose to use the health center, work from an assumption that 5,000 or 6,000 actually will do so.

This estimate becomes the health center’s “market share.” Tools for calculating market share are in the business planning section of the appendix.

Business Strategy

Once the potential market share is understood, the business planner turns next to how patients will be served. This is where the planning group documents how the health center will differentiate itself from its competition. This differentiation discussion should be completed before a physical location is chosen – because often times, location is the single most important differentiator possible.

This is also where qualitative research comes into play. In learning about the community’s needs and wants in a health care provider, the planning group possibly heard commentary about availability during non-traditional hours, care in other languages, and other kinds of suggestions. This is where the planning group would cement their decisions about what kind of health center the organization will be at least initially. Remember that it will be the responsibility of the board to understand changes in the community, so that in the future, these assumptions may change. That kind of change is good – it is a sign that the health center organization is healthy and truly responsive to the community it serves.

Collaborations should also be determined during this phase. Deciding to collaborate for certain services – like dental care, for instance – will have a major impact on the rest of the planning process.

Management and Organization of the Health Center

During the business planning phase of health center development, it will be time to make some decisions about who is going to govern the health center, who will operate the health center, and the need for external assistance or support for getting started. While all the decisions may not be ready to be made, knowing what decisions will be on the horizon will be helpful for the health center's first board of directors.

The following tips will help with planning:

1. Members of the board of directors: These should be identified by name, with care taken to make sure that the patient majority requirement as well as other board requirements will be met. It may also be helpful to determine who will serve in positions of board leadership at the outset. Guidance for HRSA compliance of program requirements should be taken from the HRSA Compliance Manual, [**Chapter 20: Board Composition**](#).
2. The Proposed Management Team: Who will serve as the CEO, or will a search need to be conducted? A Chief Medical Officer (CMO) and Chief Financial Officer (CFO)¹⁹ should also be identified, as both will be critical staffing positions necessary to get operations going quickly. If these individuals are unknown, the planning group should craft job descriptions, or at a minimum, a statement of desired characteristics to guide selection. This is also an opportunity to propose an organizational structure for inside the health center, including an organizational chart. [**Chapter 11: Key Management Staff**](#) from the HRSA Compliance Manual is an excellent place to start ensuring compliance with Program Requirements.
3. Need for Outside Assistance: It is common for a newly formed health center to need consulting services to help get started, or even to help design parts of the program for approval. While not a HRSA requirement, it is not uncommon for health centers to expend 2% or more of their initial funding on external consultants to help create policies and procedures, think through operational plans, or just to complete start up tasks that the staff does not have time to do. There are many consultants that have experiencing operating and assisting new and established health centers, health centers with special population-funding, and health centers with unique operational models (i.e. public agency health centers).

¹⁹ While CMO and CFO is used, Medical Director and Finance Director can be used interchangeably

Section 6

Developing Community Governance

One of the most important and distinguishing features of the health center model is the community-based, patient-majority governance structure, which is mandated by federal Statute.

Health Center Program Requirements, referenced extensively earlier in this document, spell out the standards health centers must meet. In particular, in the Compliance Manual, Chapters 19 and 20 – on Board Authority and Board Composition respectively – include a comprehensive review of governance requirements regarding size, composition and authorities.²⁰

The board of a health center is the ultimate authority and cannot be limited in exercising its authorities. “The organizational structure and documents do not allow for any other individual, entity or committee (including, but not limited to, an executive committee authorized by the board) to reserve approval authority or have veto power over the health center board with regard to the required authorities and functions.” And/or the health center board exercises, without restriction, its required authorities and functions.

To ensure appropriate board composition, the HRSA Compliance Manual, [**Chapter 20: Board Composition**](#) outlines not only requirements needed within board approved health center bylaws but composition requirements for board members. The number of board members must be specified in the bylaws of the organization. This can be either a specific number or a limited range. HRSA Program Requirements require that boards have between nine (9) and twenty-five (25) members who are representative of the population served. The size should relate to the complexity of the organization and the diversity of the community served. Please note, as a best practice, while not a program requirement, it is encouraged that the bylaws stipulate a range of members so that additions and deletions do not require bylaw changes and be sure to compare the desired range with any state law applicable to board membership ranges. Another best practice, while not a program requirement, it is best to have more than nine members so that if one person has to drop off the health center does not fall out of compliance with the HRSA Program Requirements in [**Chapter 20: Board Composition**](#).

In addition, the Health Center board must meet the following requirements:

- A majority (at least 51%) of the board members must be individuals who use the health center as their regular source of health care. The Health Center Program Compliance Manual defines “patient” for board representation purposes as an individual who has received at least one service in the past 24 months that generated a health center visit, where both the service and the site at which the service was provided are included within the HRSA-approved scope of project.
- A parent, foster parent, court appointed guardian or caretaker of a dependent child or adult, a legal sponsor of a legal immigrant who is a patient or a person with legal authority to make health care decisions on behalf of a patient also may qualify as a patient board member.
- No more than one half of the non-patient board members may be individuals who derive more than 10% of their annual income from the health care industry. It is in the discretion of the health center and its board to define the term “health care industry,” provided that it is applied uniformly.

²⁰ The governing board of a health center 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 is exempt from the specific board authority requirements discussed in this chapter. Section 330(k)(3)(H) of the PHS Act.

public relations, or other areas of expertise relevant to the health center.

It is important to note that no board member may be an employee of the health center²¹ or the spouse, child, parent, brother or sister of a health center employee by blood, marriage, or adoption. By including marriage, this includes in-laws, and extends to same- and opposite-sex marriages.

Organizations that serve exclusively migrant or seasonal agricultural workers, persons experiencing homelessness, or public housing residents may be able to apply for a waiver of the patient majority governance requirement, that waiver may not supplant the intent that patients of the health center's services guide and direct the care is offered. Health centers integrate into the communities they serve and processes to monitor the needs of a community must be woven into any request for waiver from governance requirements.

and Responsibilities of the Board

The Board of Directors (or Governing Board) is the principal policymaking body of the health center. The Board of Directors is required to hold monthly meetings. It is autonomous, bound only by its legal responsibilities under its charter and bylaws, and state and federal statutes. The Board of Directors of a health center is charged with the responsibility of assuring that the mission of the center is carried out through its strategic plan and services. This is a implied and extremely important obligation to the broader community in which the health center is located – an obligation to accomplish the objectives of the health center.

The health center's policymaking body, the Board of Directors (board) should distinguish its policymaking authority and responsibility from the authority and responsibility of the health center's executive director and staff. The executive director and staff implement and execute the policies set by the board. The board delegates the day-to-operational responsibilities to the Executive Director/CEO. This means that the board must observe, question, monitor the operational functions of the health center, but it should refrain as much as possible from direct participation in those functions or risk becoming micro-managers.

There are various primary areas in which a board has responsibilities:²²

Finance

The board adopts financial management practices including a system to ensure accountability for health center assets and resources; approves the annual budget (including the use of grant and non-grant funds and resources); monitors the financial status of the health center; selects the independent auditor, accepts the annual audit, and ensures that appropriate follow-up actions are taken; approves payment and eligibility for services including the Sliding Fee Discount Program for individuals with incomes at or below 200% of the federal poverty level, the fee schedule, adopts billing and collection policies related to waiver / reduction of fees and limiting/denying services due to an unwillingness to pay;

Legal

The board ensures that the health center is operated in compliance with applicable federal, state and local laws and regulations. The board protects the corporation from unnecessary liability and ensures compliance in accordance with the priority areas of the Office of Inspector General of the Department of Health and Human Services. The board also approves the applications related to the Health Center Program project, including approving the annual budget, which outlines the proposed uses of both Health Center Program award and non-Federal resources and revenue. For more information on the board's oversight role, see [Health Center Program Site Visit Protocol: Board Authority](#). For information on the Office of Inspector General, visit <https://oig.hhs.gov>.

²¹Executive director or CEO may be considered an ex-officio member of the board, though does not count in determining patient majority or in any other requirement of governance.

²²Authorities and responsibilities are outlined in the HRSA Compliance Manual, Chapter 19-Board Authority, Element C, D,E, F.

3. Human Resources

The board establishes general personnel policies including CEO selection/hiring and periodic CEO evaluation, compensation of the CEO and wage and benefit schedules for other personnel, continuing education, employee grievance policies, equal employment opportunity practices and Department of Labor requirements (Federal and State), as well as any local hiring requirements. The board's responsibility is to establish policy, not to engage in implementing these policies.

4. Evaluation

The board evaluates the performance of the health center and ensures appropriate follow-up actions are taken regarding quality of care, service utilization patterns, and productivity (efficiency and effectiveness).

5. Planning

The board engages in strategic planning at least once every three years, which at a minimum addresses financial management and capital expenditure needs. The board also approves the health center's purpose, mission, vision, and values.

6. Resource Development

The board is responsible for fundraising and approving programmatic improvements through grants from federal, state, foundation and other sources.

The goal of this involvement is to make sure the board of directors is active and abreast of developments and challenges the organization is facing and is prepared to make policy recommendations to ensure the mission of the organization – providing health care services to target populations – is achieved.

Organization of the Board's Work

While not a HRSA program requirement, as a best practice, most health centers find it valuable to organize themselves into certain committees, so that a subset of board members becomes intimately familiar with certain areas of operation, sharing their in-depth review with the full board. These committees may be standing committees – they are always constituted and have specific areas of focus identified in the bylaws, or can be ad hoc committees, charged with undertaking a specific, time-limited task (like bi-annual strategic planning). A health center may also have advisory committees, composed of other community members, or non-governing board member patients, to provide additional insight into health center operations.

Legal Issues

One of the major responsibilities, briefly mentioned above, is compliance. Corporate compliance should start with the adoption of a resolution establishing a formal Corporate Compliance Program. Focus areas covered by the Corporate Compliance Program may include:

- Written Policies, Procedures, and Practice Standards
- Designation of a Compliance Officer
- Staff Education and Training
- Communication
- Internal Auditing and Monitoring
- Discipline and Enforcement
- Corrective Action Planning

Furthermore, as part of the Corporate Compliance Program, the health center should demonstrate the board's approval of a Program's framework which recognizes that board members have specific obligations in dedicating

resources to assure compliance. Regularly, the board must monitor the implementation and operation of the compliance program to ensure its effectiveness.

Nonprofit organizations usually can indemnify their board members against losses incurred as a result of service as a board member. This means that the organization will bear any cost associated with defending a legal action against a board member, including judgment or settlement. The circumstances in which a board member can be indemnified are a matter of state law and are usually specified in the by-laws. Legal counsel should be consulted on this matter.

Section 7

Planning to Meet Health Care Standards

A health center must provide high quality care to the patients and communities it serves. The planning process is the right time to start considering standards of care that the health center will meet. Fortunately, there are many sources to help with this planning. One of the best resources a planning group will have is a clinical leader who is well versed in evidence-based medicine. This individual will be able to help interpret health care standards to the planning group in a way that makes them easy to adopt and implement.

Health centers focus on primary health care services and outcomes. That means focusing on periodic physician care, chronic disease care, and wellness care. These are reflected in the listings of required services available in Program Requirements, found in [**Chapter 4: Required and Additional Health Services**](#) and can always be expanded upon with approval.

HRSA requires health centers to establish and maintain ongoing quality improvement and quality assurance programs and systems that include both clinical services and clinical management. The specific requirements for such programs area addressed in [**Chapter 10: Quality Improvement and Assurance**](#) of the Health Center Program Compliance Manual.

The Primary Care Medical Home (PCMH) standards are an excellent basis for the kinds of care a health center will provide. Included in these standards are recommendations for care coordination, regular reminders and follow up plans for patients, and ideas for how to ensure patients receive all the care they need.

In addition to the Program Requirements and PCMH standards, the following are some guidelines a new health center may wish to consider in planning its care:

- Medicaid Health Plan Employer Data and Information Set (HEDIS) are a standardized set of measures to assess the performance of Medicaid managed care plans (and are often also used by commercial plans). They were developed by the National Committee for Quality Assurance (NCQA), and can be found here: <https://www.ncqa.org/hedis/>
- Quality Family Planning (QFP) Guideline were issued by the Centers for Disease Control and Prevention (CDC) in 2014. These recommendations for family planning apply to both women and men. For more information, visit <https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>
- The Joint Commission's ambulatory care accreditation is a process that can promote high quality and improve both patient safety and healthcare outcomes for your community health center. Successful community health centers embark on and complete the accreditation journey as a team. For more information, visit: https://www.jointcommission.org/accreditation/ambulatory_healthcare.aspx
- Prenatal care standards are available from the Office of Women's Health within the U.S. Department of Health and Human Services: <https://www.womenshealth.gov/pregnancy/youre-pregnant-now-what/prenatal-care-and-tests>
- Pediatric care standards, following the American Academy of Pediatrics Bright Futures guidelines are available at: <https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx>

While this list is not exhaustive, it can provide a starting point for some of the most common health care standards a new health center will want to follow.

Section 8

Human Resources

Earlier in this document the specific role of the board of directors as related to human resources was discussed. That role is but the beginning of the human resources function of a health center. In most other organizations, aside from selecting a CEO, human resources functions are completely delegated to management.

Every health center is required to have a CEO and strongly recommended to have a CMO and CFO. As health centers grow, they may have chief operations officers, human resources directors, a chief information officer, a head of quality improvement, and other leaders. Under [Chapter 11: Key Management Staff](#), only the CEO must be directly employed by and reports to the board.

Staffing Needs and Clinician Recruitment and Retention

Each health center will have its own staffing needs. HRSA recognizes the need for this flexibility in [Chapter 5: Clinical Staffing](#) of the Health Center Program Compliance Manual, which requires health centers to have sufficient staff to ensure that services are available and accessible promptly, as appropriate and in a manner to ensure continuity of care, taking into consideration the size, demographics and health needs of the patients.

While health centers rely on licensed independent practitioners (LIPs²³) in order to provide patient care, the rest of the staffing model of the health center will be up to the project plan the health center creates. The types of practitioners that a new health center plans to employ will depend on the quantity and specific service needs of the population to serve.

In any event, the new health center should plan for appropriate clinical support staff (nurses, medical assistants, registration/check in, referral processing staff, dental assistants, behavioral health intake clerks, clinic secretary, health educators, to name a few) in order to deliver the care the community wants and needs.

When hiring new providers, health centers can refer to the National Practitioner Data Bank (NPDB). NPDB was established by Congress in 1986 and is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers. This tool was designed to prevent practitioners from moving state to state without disclosure or discovery of previous damaging performance. The NPDB contains more than 1.4 million reports and interacts with more than 23,000 entities. For more information, refer to <https://www.npdb.hrsa.gov/index.jsp>.

Recruiting and retaining clinicians is as much art as science. The first step is understanding where help is available. One of the best sources for clinical recruitment and retention for a health center is the National Health Service Corps (NHSC). NHSC can be a significant help in recruiting providers and helping in placing primary, dental, and mental health clinicians and repaying professional education loans. There are stringent eligibility rules for both providers and health center. It is recommended that health centers interested in NHSC recruitment contact the National Health Service Corps (www.nhsc.hrsa.gov) as well as their state PCA.

The PCA can help with more than just connection to the NHSC. Many state PCAs maintain databases of vacancies in their states and can help health centers create recruitment plans.

²³ Licensed independent practitioners (physicians – both MD and DO, Advance Practice Nurses, Dentists, Clinical Psychologists, and sometimes Physician Assistants, Dental Hygienists and Clinical Social Workers, depending on the state) are individuals who because of their licensure may exercise independent clinical judgment and provide health care services without supervision.

Another area not to overlook for clinician recruitment is the local hospital community and medical schools and residency programs, dental schools and schools of psychology. Hospitals may be seeking outpatient practice opportunities for clinicians they wish to recruit to the community, and training programs are always looking for rotation sites or shadowing locations for students, residents and interns. If there is a medical or dental residency program in your area, linking with that program right away can help the health center form a long-term pipeline for candidates.

In addition, some National Cooperative Agreement partners (some mentioned earlier in this document with links to their sites) assist in clinician recruitment. Visit the Health Center Resource Clearinghouse for more information on NCA partner resources: www.healthcenterinfo.org.

Staffing Ramp Up

Another area that health centers need to consider is the ramp up, or phase in period. Looking at the business plan, the health center will undoubtedly have a period of time over the first few years of operation that patient volumes are growing. The health center should have a ramp up plan that takes this growth into account. Do not overcommit the resources of the health center by staffing for full production at day one.

Recruitment of provider staff is a key area that a planning group should consider.

- Will the health center be located in an area that is easy to attract providers to?
- Or will recruitment and retention be an ongoing challenge?

In the ramp up plan, the health center should think about employing a slight excess of provider staff if recruitment is expected to be challenging. The clinician recruitment cycle follows the academic cycle in many cases, so expect that clinicians seeking a position directly from training will start their searches around September or October, with an expectation of executing contracts around April or May of the following year, and then starting a position in July or August.

Adequate provider staffing is a key area of focus for new health centers (and for existing centers). Some health center experts recommend staffing for about 115% of expected provider productivity (as it relates to patient volume). Additional provider and provider support staffing (i.e medical assistants) should be planned for when the health center is consistently outperforming volume expectations by 10% (e.g. every week for six weeks).

Creating a Competitive Staffing Environment

For clinicians, as well as for all positions in the health center, offering a competitive employment package is no longer a luxury. It is essential in the marketplace if the new center wishes to attract and retain a high caliber workforce. Here are some tips for recruitment and retention of the entire staff of the health center:

- **Market competitive wage/salary:** The successful health center will study local prevailing rates and propose to the board of directors a salary band that allows recruitment of the best candidates.²⁴ In the past some have maintained that health centers cannot and should not attempt to meet prevailing rates, but in today's competitive environment, this is no longer a viable strategy.
- **Market the health center:** A newly forming health center can offer lots of advantages to staff members. The opportunity to be in "on the ground floor" of setting up the practices and growing along with the patient population can be most satisfying. Developing recruitment materials can help a whole team of health center supporters be recruitment advocates.

²⁴ The board of directors must approve salary bands, but the CEO (or designate) determines the actual rate within the band.

- **Act fast when identifying a candidate for a position:** Assuming the health center can afford the addition and the position is necessary for the operation and growth of the enterprise, do not hesitate. In a world of instant communication, the organization that contacts a candidate first, consistently and effectively will win the candidate.
- **Fit is everything** Candidates must share the values of the organization and have a commitment to serving the underserved. It is far preferable to have a vacancy in a position than it is to have a poor hire. Plus, the rest of the team will appreciate the commitment to the mission. One way to do so is to have teams of health center staff interview potential candidates, so they can get a sense of what it would mean to work with them each day.
- **Credentialing and Privileging:** All health center staff must meet the Credentialing and Privileging Requirements as described in [Chapter 5: Clinical Staffing](#).

All employees and contractors of the health center must be checked against the OIG's exclusions list: Any health care entity that receives reimbursement under Medicare and Medicaid must ensure they are not employing or contracting with anyone on the exclusions database, or risk heavy sanction. Indeed, this verification occurs not only at the point of hire or contract but must be reviewed periodically as well. Some organizations review the database monthly. The database is available at <http://exclusions.oig.hhs.gov>.

Retention is a major factor for health centers as well, not only for clinicians but for all staff. Health centers must consider carefully their competitive environment. Note that salary level is but one factor – though the lower the wage or salary, the bigger a factor it is. Benefits, retirement savings vehicles and staff bonus programs, as well as a voice in the workplace are all key factors that can help good employees stay.

Section 9

Information Technology

The health center's information technology system (IT) serves many purposes – from patient appointment scheduling and billing to ongoing needs assessments and quality improvement and performance improvement. IT systems are increasingly complex, and there are several systems that are specialized for health center operations.

IT systems are generally categorized into two areas: operations functions and management functions.

Operations functions are those aspects of data and information processing that allow health center staff to work efficiently every day. This includes patient registration and scheduling, visit documentation, billing systems, and telephone systems.

Management functions include reporting of data and outcomes that allow the health center leadership (board and staff) to evaluate the health center's activities and make any changes necessary. Patient utilization information, health status outcomes on an aggregated basis and provider productivity are examples of management functions.

Electronic Health Records

Data warehouses and centralized software sharing systems (sometimes known as an ASP model – ASP standing for “application service provider”) are becoming the norm. HRSA/BPHC supports Health Center Controlled Networks (HCCN), many of which offer shared IT system support. An HCCN serving your area may be able to help plan for IT development.

It likely goes without saying that a newly forming health center should plan to launch an electronic health record (EHR) from the very beginning. Avoiding a conversion to electronic systems later will save a major organizational transformation. What's more, in planning for space needs, starting out with an electronic health record means not building space for traditional paper medical records, and means dedicating adequate resources to computer equipment, cabling, wireless capacity, and low voltage service throughout the health center.

HRSA requires health centers to establish systems for monitoring program performance. However, HRSA stops short of requiring formal IT systems. Regardless of the type of system a health center establishes, it must ensure 1) Oversight of operations of the Federal award-supported activities; 2) Performance expectations (as described in the Notice of Award); and 3) Areas of improvement in program outcome and activity. See [Chapter 18: Program Monitoring and Data Reporting Systems](#) for more information.

When selecting an IT system for the new health center, make sure the system can collect and organize all the required data elements that a health center need. Most importantly among these is the UDS Report – Uniform Data System – that all health centers file annually with HRSA/BPHC. It is recommended when considering an IT system that a health center interview many customers about their experiences with the system, and specifically ask about UDS preparation. If the IT system is not configured properly, completing this voluminous report will be a herculean effort.

Remember as well to consider future scalability of an IT system. The small physician practice system that is very simple for providers to use may not be able to keep pace with planned growth in the health center, nor produce the detailed reports required under PCMH, UDS and other funder programs.

For tips on selecting an IT system, contact the PCA, NACHC, and visit www.healthit.gov, specifically the page dedicated to selecting the right IT vendor, <https://www.healthit.gov/faq/how-do-i-select-vendor>.

Other IT Systems in the Health Center

There's more to IT systems than EHRs and telephone systems, of course. A health center will need standard office processing suites (word processing, spreadsheet and perhaps statistical modeling programs), finance systems and perhaps HR systems. This document will not consider standard office suites but will touch on finance systems and HR IT systems.

Finance Systems

A new health center will need to establish good financial controls, and one of the ways this is accomplished is through the general ledger and accounting system. It is recommended that a new health center contact other health center chief financial officers for advice on selecting a finance system that works, all the while considering integration with the EHR system for patient accounting.

A financial system will need to have accounting, treasury and inventory control functions, and be able to be adjustable in terms of the chart of accounts. Additional information on the requirements for financial management systems can be found in 45 C.F.R. Part 75, which is applicable to all federal grantees receiving funds from HHS, as well as the Health Center Program Compliance Manual.

HR Systems

A robust HR system may be an excellent investment for a new health center. These systems can help with time-keeping, salary history, tracking of benefit time, and eligibility to work in the United States. Some payroll vendors offer ASP model HR systems that can be easily configured and come at low cost, compared with implementing a full-scale system.

Section 10

Additional Resources

Many resources have been listed and presented throughout this document.

HRSA/BPHC maintains many free sources of technical assistance for health centers and organizations that wish to become health centers. Below is additional information about key HRSA-funded resources:

- **Primary Care Associations (PCAs):** PCAs are nonprofit associations representing health centers and other primary care safety net providers at state and regional levels. PCAs provide a wide array of services to their members and to the primary care community. Some services include centralized clinician recruitment support, technical assistance on clinical, management, finance and governance matters, training, conferences, and more. PCAs are actively involved in health policy at the state and national levels as well. PCAs vary in the services they provide. Your state and regional PCA can be found at: <https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/associations.html>
- **Primary Care Offices (PCOs):** PCOs are usually part of state government (often housed in the State or Territorial Health Department). They receive funding through the Bureau of Health Workforce (BHW) to improve primary care service delivery, conduct health provider needs assessments, manage health professional shortage designation, and address workforce availability in the various states and/or territories to meet the needs of underserved populations. PCOs work in partnership with PCAs in areas including analyzing and prioritizing need for primary care services, submitting requests for MUA, MUP and HPSA designations, helping recruit and retain physicians and other clinicians in the state, and advocating for health centers within the State Government. Find your PCO here: <https://bhw.hrsa.gov/shortage-designation/hpsa/primary-care-offices>
- **National Cooperative Agreements (NCAs):** As of 2019, twenty (20) organizations have a national cooperative agreement (NCA) with HRSA to provide free training and technical assistance (T/TA) to support existing and potential health center awardees and FQHC look-alikes. The NCA partners possess subject matter expertise in functional areas, and support health center's ability to maintain fiscal and operational excellence, engage in effective workforce development activities, utilize cutting-edge health information technology and structure health care services in a manner culturally and linguistically appropriate to the patient population served. These organizations are funded to provide T/TA to health centers in a manner that increases patient safety and health outcomes, effectively serves diverse special, vulnerable, and underserved rural, frontier, and urban populations. This T/TA often takes the form of learning collaboratives, state/regional/national trainings, webinars, newsletters, toolkits, and fact sheets. A list of organizations can be found at: <https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/natlagreement.html>
- **Health Center Resource Clearinghouse:** In 2018, the twenty NCAs – collaborating through the National Resource Center on Training and Technical Assistance – launch the National Health Center Resource Clearinghouse: <https://www.healthcenterinfo.org/>. As of 2019, over 500 resources on diabetes, social determinants of health, workforce, finance, emergency management, special and vulnerable populations, quality improvement, capital development, and other topics, are available for free in the Clearinghouse.

Conclusion

This guide has offered advice and insight on key considerations for starting a health center.

As stated in the beginning – there is no one right way to complete this task. Every community is different, and every person has different priorities. The goal in a health center planning process is to design a community-based health care intervention that will address the needs of the population. A well-functioning planning group will succeed in this effort.

As discussed throughout this guidance, the [Health Center Program Compliance Manual](#) can be particularly helpful in understanding the federal requirements for many of the areas addressed in this guide. The HRSA Compliance Manual is the principal resource to assist health centers in understanding and demonstrating compliance with Health Center Program Requirements. Before deciding to begin the effort to establish a health center, you must understand the federal requirements on health center governance, clinical operations, quality of care, services provided, and management and finance systems. The Health Center Resource Clearinghouse – www.healthcenterinfo.org – contains hundreds of training and technical resources for Health Centers and organizations seeking Health Center status.

Some final advice: Do not be afraid to ask for help.

- Tap the network of more than 1,400 health center organizations around the country that have gone down the path of becoming a health center.
- Contact your state PCA.
- Contact your state PCO.
- Contact NCA-organizations for technical assistance.
- Contact HRSA/BPHC for guidance.

And most importantly, make your presence active and known within your community. Your community partners are the keys to your success.

Good luck!

APPENDIX B

LOOKOUT MOUNTAIN GROUP,
DEFINITION FOR COLLEGE HEALTH PROGRAMS



COLLABORATING WITH A COMMUNITY HEALTH CENTER
TO PROVIDE COMPONENTS OF A COLLEGE HEALTH PROGRAM



www.lookoutmountaingroup.net

Definition for College Health Programs

Updated: April 2019

Page 1 of 2

The Lookout Mountain Group is updating its definition for College Health Programs from the organization's 2009 and 2017 reports. Both reports are available at our website.

A College Health Program describes the constellation of services, strategies, policies, and facilities an institution of higher education assembles to advance the health of its students. While some College Health Programs are also intended to provide extensive services for faculty and staff, most of the components are dedicated to providing services for eligible students.

On many campuses, College Health Programs are wholly focused on the provision of health care in the form of medical and mental/behavioral health care services and may include a variety of health care related services such as sports medicine services for intercollegiate athletes, student health insurance/benefit programs, crisis intervention, and public safety.

On many campuses clinical health care services are partnered with health promotion, which includes developing campus public health policy, creating a campus environment that supports healthy behaviors, community advocacy for healthy lifestyles, developing personal skills for better health and wellness, and encouraging clinical health care services to emphasize prevention along with curative services.

Components of a College Health Program

These service components may be provided by college or university entities, contracted entities, or collaboratively with governmental/community services.

- **Public Health** – Public health is the health of the population as a whole, especially as monitored, regulated, and promoted by the state. It is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention, and detection and control of infectious diseases. Overall, public health is concerned with protecting the health of entire populations. By definition, public health aims to provide the maximum benefit for the largest number of people. This may involve crisis response, health communications, threat assessment, immunization compliance policies, emergency preparedness, and surveillance for both communicable disease and health risk behaviors.
- **Health Care** – Health care is the efforts made to maintain or restore physical health by trained and licensed professionals or the maintenance and improvement of mental/behavioral health, especially through the provision of medical services.
- **Medical Services** – These involve, at a minimum, arrangements for individual primary and urgent care medical services that facilitate appropriate student access. Therapeutic and ancillary services for immunization, radiology, laboratory, pharmacy, sports medicine/physical therapy, and other services are routinely available.
- **Mental or Behavioral Health Services** – These involve crisis and short-term intervention services to address mental/behavioral concerns and diseases through the use of various types of therapies, which typically include individual and group psychotherapy, psychiatric services, and assessment for mental or



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Definition for College Health Programs

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behavioral health and substance use disorder conditions. Long-term care needs are identified and are generally referred to community providers (integration of community providers with SHIBP benefits is increasingly important). Many services include consultation to assist faculty and staff in identifying and assisting distressed students, outreach to the campus community members to destigmatize accessing services, psycho-educational, and other prevention services, including increasing students' resilience to commonly and appropriately occurring life challenges.

- **Student Health Insurance/Benefits Programs (SHIBPs)** – Most colleges and universities offer a SHIBP that provides coverage for medical and mental/behavioral health care not provided through on-campus services. Colleges are experiencing increasing need for SHIBPs due to cost shifting in employer-sponsored health insurance, both reduction of benefits and increased cost to employees for dependent coverage. Requiring health insurance as a condition of enrollment is often a key component to assure students have access to health care services beyond the scope and capabilities for on-campus services. Many campuses also have substantial charges for on-campus services and their SHIBPs are usually designed to cover these charges.

- **Health Promotion** – Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete medical, mental/behavioral, and social well-being (e.g., resilience building), an individual or group must be able to identify and realize aspirations, satisfy needs, and change or cope with the environment. Health Promotion initiatives include: creating supportive environments, building healthy public policy, strengthening community actions, developing personal skills, and reorienting health services toward prevention.

Additional Components – Other health-related services that are often included within a College Health Program include: services for students with disability, services for students with housing and/or food insecurity, services for sexual assault and misconduct survivors, special services for international students and students traveling abroad, dedicated clinics for care of children, collegiate recovery programs , supervision of campus-based emergency medical services, and occupational health services for specialized student populations such as students in the performing arts and health professionals students.

APPENDIX C

HRSA, COMMUNITY HEALTH CENTER FACT SHEET



COLLABORATING WITH A COMMUNITY HEALTH CENTER
TO PROVIDE COMPONENTS OF A COLLEGE HEALTH PROGRAM



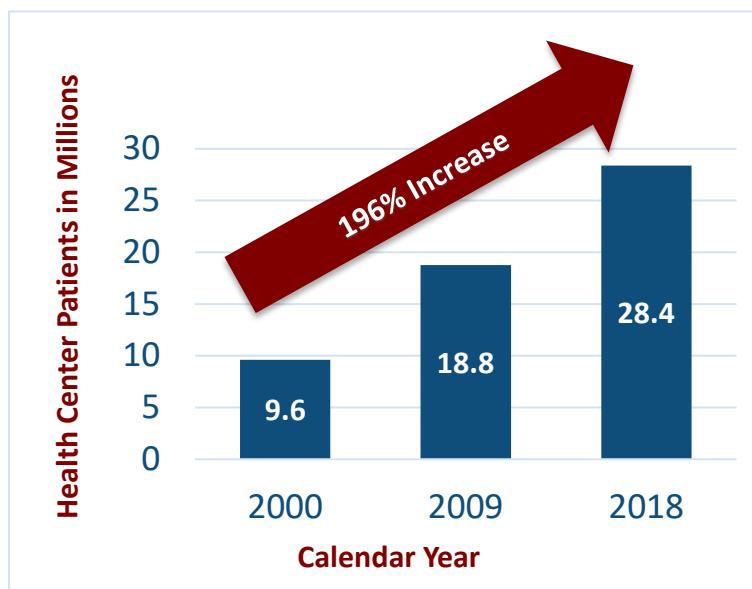
HRSA Health Center Program

Health Center Overview

For more than 50 years, health centers have delivered affordable, accessible, quality, and value-based primary health care to millions of people regardless of their ability to pay. Not only are health centers serving 1 in 12 people across the country, the Health Center Program is leading the nation in driving quality improvement and reducing health care costs for America's taxpayers. Because health centers provide high quality primary care services across the country, the health center network is also called upon to support public health priorities such as the opioid crisis and the White House initiative, *Ending the HIV Epidemic: A Plan for America*.

Providing Value-Based Care to Millions Across the Nation

HRSA's investments have advanced the nation's health by ensuring more patients and communities each year have access to high quality, comprehensive primary care. Today, HRSA funds nearly 1,400 health centers operating approximately 12,000 service delivery sites in every U.S. state, U.S. territory, and the District of Columbia. In 2018, there were more than 236,000 full-time health center providers and staff serving nearly 28.4 million patients. In fact, health centers have almost tripled the number of patients served in 2000 when the program served approximately 9.6 million patients.



Driving Quality Improvement

The number of staff and patients is just one piece of the story. HRSA's quality improvement investments advance a model of coordinated, comprehensive, and patient-centered care, integrating medical, dental, behavioral health, substance use disorder, and patient services.

These investments have positioned 1,045 health centers (77 percent) to achieve Patient-Centered Medical Home (PCMH) recognition. The PCMH model of care enables health centers to sustain strong patient outcomes at lower costs despite treating a sicker and poorer population than other health care settings.

This is most evident in patient outcomes:

- 67 percent of health center patients with diabetes controlled their blood sugar levels ($\text{HbA1c} \leq 9$ percent), exceeding the national average of 60 percent.¹
- 63 percent of health center patients with hypertension controlled their blood pressure, exceeding the national average of 57 percent.²

In addition to better patient outcomes, the health center model of care is associated with reductions in the use of more costly care options, such as emergency departments and hospitals.³ Health center patients also had 24 percent lower spending as compared to non-health center patients across all services.⁴



Addressing Emergent Public Health Needs

HRSA-funded health centers are well-positioned to meet the nation's most pressing health care needs, as well as emerging health priorities. Health centers are the first line of care in combatting the nation's opioid crisis. In 2018, health centers screened and identified nearly 1.1 million people for substance use disorder and ultimately provided medication-assisted treatment to nearly 95,000 patients nationwide an increase of 143% since 2017. Overall, 93 percent of health centers provided mental health counseling and treatment and 67 percent of health centers provided substance use disorder services.

HRSA-funded health centers are a key component in the *Ending the HIV Epidemic Initiative* by serving as a key point of entry for detection and diagnosis of people living with HIV. In 2018, health centers provided over 2.4 million HIV tests to more than 2 million patients and treated 1 in 6 patients diagnosed with HIV nationally.

Resources

- For more information on the HRSA Health Center Program, visit: bphc.hrsa.gov
- To locate a HRSA-funded health center, visit: findahealthcenter.hrsa.gov

¹ National Committee for Quality Assurance, The State of Health Care Quality. Diabetes Care (2017)

² National Committee for Quality Assurance, The State of Health Care Quality. Controlling for High Blood Pressure (2017)

³ Laiteerapong, Neda et al. "Health Care Utilization and Receipt of Preventive Care for Patients Seen at Federally Funded Health Centers Compared to Other Sites of Primary Care." *Health Services Research* 49.5 (2014): 1498-1518.

⁴ Nocon, Robert S. et al. "Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings." *American Journal of Public Health* 106.11 (Nov 2016): 1981-1989.



APPENDIX D

RURAL HEALTH INFORMATION HUB, FAQS
AND THE HEALTH CENTER PROGRAM



COLLABORATING WITH A COMMUNITY HEALTH CENTER
TO PROVIDE COMPONENTS OF A COLLEGE HEALTH PROGRAM



Federally Qualified Health Centers (FQHCs) and the Health Center Program

If you are looking for a Federally Qualified Health Center in a rural area, you can search by address, state, county, and/or ZIP code at [Find a Health Center](http://findahealthcenter.hrsa.gov/) (<http://findahealthcenter.hrsa.gov/>).

Federally Qualified Health Centers are important safety net providers in rural areas. FQHCs are outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid. They include federally-designated Health Center Program awardees, federally-designated Health Center Program look-alikes, and certain outpatient clinics associated with tribal organizations.

Approximately 1 in 5 rural residents are served by the Health Center Program, according to the Health Resources and Services Administration (HRSA) [Bureau of Primary Health Care](https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf) (<https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf>). (BPHC). Health centers provide a comprehensive set of health services including primary care; behavioral health; chronic disease management; preventive care; and other specialty, enabling, and ancillary services, which may include radiology, laboratory, dental, transportation, translation, and social services. To be a qualified entity in the federal Health Center Program, an organization must:

- Offer services to all, regardless of the person's ability to pay
- Establish a sliding fee discount program
- Be a nonprofit or public organization
- Be community-based, with the majority of its governing board of directors composed of patients
- Serve a Medically Underserved Area or Population
- Provide comprehensive primary care services
- Have an ongoing quality assurance program

HRSA's Bureau of Primary Health Care (BPHC) [Health Center Program Compliance Manual](https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html) (<https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html>) provides additional information on health center requirements.

There are several distinctions that should be understood related to health centers:

- **Health Center Program**
 - **Health Center Program Awardee** – Health centers that receive award funding from the HRSA Bureau of Primary Health Care under the Health Center Program, as authorized by Section 330 of the Public Health Service (PHS) Act. Most awards provide support to contribute to serving an entire underserved community (or service area), while others fund specific underserved populations as mandated in the Section 330 authorization, such as migratory and seasonal agricultural workers, persons experiencing or at risk for homelessness, and residents of public housing.
 - **Health Center Program Look-Alikes** – Look-alikes are health centers that have been designated by HRSA as meeting all the Health Center Program requirements, but do not receive award funding under the Health Center Program.
- **Federally Qualified Health Center (FQHC)**

FQHCs are outpatient clinics that qualify for specific reimbursement under Medicare and Medicaid. FQHCs include Health Center Program awardees and look-alikes as well as certain outpatient clinics associated with tribal organizations. Note that different rules may apply to outpatient clinics associated with tribal organizations who enroll in Medicare or Medicaid as FQHCs.
- **Health Center**

A non-specific term that does not identify whether a health facility is a Health Center Program awardee, a health center look-alike, or an FQHC.

For the remainder of this guide, the term "health centers" will be used to refer to Health Center Program awardees, look-alikes, and FQHCs.

If you are interested in becoming a health center, see [How to Become a Health Center](https://bphc.hrsa.gov/programopportunities/howtoapply/index.html) (<https://bphc.hrsa.gov/programopportunities/howtoapply/index.html>) and [So You Want to Start a Health Center...? A Practical Guide for Starting a Federally Qualified Health Center](https://cdn1.digitellinc.com/uploads/nachc/articles/09550126eb1edd85b1b7267a3e3b0145.pdf) (<https://cdn1.digitellinc.com/uploads/nachc/articles/09550126eb1edd85b1b7267a3e3b0145.pdf>).

Frequently Asked Questions

- [What are the benefits of FQHC status?](#)
- [What are the benefits for Health Center Program awardees and look-alikes?](#)
- [What is the Health Center Program?](#)
- [How does a health center become certified as an FQHC?](#)
- [Where can I find statistics on health centers?](#)
- [How do I apply for a Health Center Program grant?](#)
- [Are Health Center Program awards granted on a competitive basis?](#)
- [Which special populations can be served by healthcare organizations applying for funding through Section 330 of the Public Health Service Act?](#)
- [What are school-based health centers and how would I set one up?](#)
- [Can a for-profit clinic be a health center?](#)
- [Is a board of directors required?](#)
- [Are there location requirements for health centers?](#)
- [Are there specific staffing requirements for health centers?](#)
- [What types of services do health centers provide?](#)
- [Are there minimum hours that a health center must be open?](#)
- [Is a sliding fee scale required?](#)
- [Must health centers accept all patients, regardless of their ability to pay?](#)
- [Are there special programs to assist health centers in attracting and retaining healthcare providers to their organization?](#)
- [What strategies have rural health centers used to provide behavioral health and dental health services to meet the needs of their patient population?](#)
- [What are the Medicare Administrative Contractors \(MACs\), and what is their role in administering Medicare Part A and Part B for health centers?](#)
- [Can another healthcare organization, such as a Critical Access Hospital, operate an FQHC?](#)
- [Are there funding opportunities available for the expansion, renovation, purchase of major equipment, or new construction of health centers?](#)
- [Who can I contact for additional information about health centers?](#)

What are the benefits of FQHC status?

Once certified by the Centers for Medicare and Medicaid (CMS) as an FQHC, health centers are eligible for several benefits including:

- Medicare reimbursement under a Prospective Payment System (PPS), in which Medicare payment is made based on a national rate which is adjusted based on the location of where the services are furnished. CMS provides a brief overview of the [FQHC PPS](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS) (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS>).
- Medicaid reimbursement under the Prospective Payment System (PPS) or other state-approved Alternative Payment Methodology (APM) for services provided under Medicaid. A 2017 Medicaid and CHIP Payment and Access Commission (MACPAC) issue brief, [Medicaid Payment Policy for Federally Qualified Health Centers](https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf) (<https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf>), provides an overview of Medicaid reimbursement for FQHCs.

What are the benefits for Health Center Program awardees and look-alikes?

Health Center Program awardee and look-alike designation from the Health Resources and Services Administration offers health centers:

- Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost

through the [340B Drug Pricing Program](#) (/funding/369).

- Access to the [Vaccines for Children Program](#) (<https://www.cdc.gov/vaccines/programs/vfc/index.html>).
- Automatic designation as a Health Professional Shortage Area (HPSA), which provides eligibility to apply to receive National Health Service Corps (NHSC) personnel and eligibility to be a site where a J-1 Visa physician can serve. Health centers must still review and sign the NHSC site agreement. Learn more about requirements for health centers to become [approved NHSC sites](#) (<https://nhsc.hrsa.gov/sites/auto-approved-sites.html>).

Additional benefits are available for Health Center Program awardees, including:

- **Federal award funding** under Section 330 of the Public Health Service (PHS) Act
- **Medical malpractice coverage** may be granted for the health center organization, their employees, and eligible contractors under the Federal Tort Claims Act (FTCA). To receive coverage, awardees must submit an application to the HRSA Bureau of Primary Health Care and meet the requirements to attain deemed status. See HRSA's [Health Center Program Federal Tort Claims Act \(FTCA\)](#) (<https://bphc.hrsa.gov/FTCA/>) for additional information. Note that FTCA coverage is available only to Health Center Program awardees, not Health Center Program look-alikes.

What is the Health Center Program?

Section 330 of the Public Health Service (PHS) Act defines the Health Center Program as a funding opportunity for organizations to provide healthcare services to underserved populations. Benefits to health centers participating in this program include funding to help with the costs of uncompensated care as well as malpractice coverage under the Federal Tort Claims Act.

HRSA's Bureau of Primary Health Care offers funding opportunities for new and continued Health Center Program funding:

- **New Access Point (NAP) funding opportunities** are intended to provide operational support for new service delivery sites under the Health Center Program to improve the health of the nation's underserved communities and vulnerable populations by expanding access to affordable, accessible, quality, and cost-effective primary healthcare services. The NAP notice of funding opportunity (NOFO) is posted on the [Funding and Opportunities section](#) (/topics/federally-qualified-health-centers/funding) of this guide and on [Grants.gov](#) (<https://www.grants.gov/>), when accepting applications. [Health Center Program New Access Points Technical Assistance](#) (<https://bphc.hrsa.gov/program-opportunities/new-access-points>) provides specific information about NAP funding.
- **Service Area Competition (SAC) funding opportunities** are for maintaining accessible and affordable quality healthcare services in areas of need that are currently served by the Health Center Program. Healthcare organizations meeting the Section 330 program requirements are eligible for SAC funding. The SAC program is also posted on the [Funding and Opportunities section](#) (/topics/federally-qualified-health-centers/funding) of this guide and on [Grants.gov](#) (<https://www.grants.gov/>). [Service Area Competition Technical Assistance](#) (<https://bphc.hrsa.gov/program-opportunities/sac>) provides specific information about the program, including the service area announcement table, application resources, and frequently asked questions.

Types of organizations that may apply are public and private nonprofit organizations that meet the Health Center Program Requirements. Once they receive the awards, they become responsible for serving the general community, and/or statutorily mandated special medically underserved populations of migratory and seasonal agricultural workers, homeless individuals, or residents of public housing.

View full-text of [Title 42 of the U.S. Code, Chapter 6A, Public Health Service Act, and section 254b](#) (<https://uscode.house.gov/view.xhtml?hl=false&edition=prelim&req=granuleid%3AUSC-prelim-title42-section254b>). (the equivalent of Section 330).

For more information on the health center look-alike program, requirements, and application procedures, see HRSA's [Health Center Program Look-Alikes](#) (<https://bphc.hrsa.gov/programopportunities/lookalike/>). Detailed application instructions and links to technical assistance resources can be found on HRSA's [Look-Alike Initial Designation Technical Assistance](#) (/funding/3980).

How does a health center become certified as an FQHC?

With the exception of tribal organizations, which may apply to CMS directly to become an FQHC, organizations must first become a Health Center Program awardee or Health Center Program look-alike in order to become certified as an FQHC. After receiving Health Center Program awardee or look-alike designation, health centers may apply to CMS for Medicare FQHC certification, and to their state Medicaid office for Medicaid FQHC certification. Each health center site must separately enroll to receive FQHC certification and Medicare FQHC reimbursement. Prospective FQHC enrollees can review [Information on Medicare Participation, Federally Qualified Health Center](#) (<https://www.cms.gov/Regulations-and-Guidance>)

[/Guidance/Manuals/Downloads/som107_exhibit_179.pdf](#) for details.

More information on certification can be found in the [State Operations Manual Chapter 2](#) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf>), section 2826. Additional information on Medicare enrollment for FQHCs can be found in the [Medicare Program Integrity Manual Chapter 15](#) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf#page=46>), under 15.4.1.4 – Federally Qualified Health Centers.

Where can I find statistics on health centers?

HRSA's [Health Center Data & Reporting](#) (<https://bphc.hrsa.gov/dataprofiling/index.html>) provides a wide range of options from the Uniform Data System (UDS), which health centers are required to report data to annually:

- [National Health Center Data](#) (<https://data.hrsa.gov/tools/data-reporting/program-data/national>) offers national-level data on health center awardee quality measures, health outcomes, patient characteristics, staffing, and more.
- [Health Center Program Awardee Data](#) (<https://data.hrsa.gov/tools/data-reporting/program-data?type=AWARDEE>) and [Health Center Look-Alike Data](#) (<https://data.hrsa.gov/tools/data-reporting/program-data?type=LOOK-ALIKE>) allow you to drill down to a specific location and see data on services provided, medical conditions, patient characteristics, and costs.
- [Health Center Data Comparisons](#) (<https://data.hrsa.gov/tools/data-reporting/data-comparisons>) lets you compare either state data to national data or states to one another for patients served, services provided, and patient characteristics.
- [Uniform Data System \(UDS\) Mapper](#) (<https://www.udsmapper.org/index.cfm>) is free, but requires registration to use. It provides additional details on health center service areas, high need and services available related to the opioid epidemic, and more.

The HRSA Data Warehouse offers additional resources:

- [Health Sites](#) (<https://data.hrsa.gov/data/dashboards/sites>) provides data on health center location.
- [Data Explorer](#) (<https://data.hrsa.gov/tools/data-explorer>) includes additional details on operating hours, rural status, and awardee status.

The National Association of Community Health Centers provides these data sources:

- [Community Health Center State Level Data and Maps](#) (<https://www.nachc.org/state-level-data-maps/>) offers state-level data on health center patients, staff, patient visits, and the number of awardees and delivery sites.
- [Community Health Center Chartbook, 2019](#) (<http://www.nachc.org/wp-content/uploads/2019/01/Community-Health-Center-Chartbook-FINAL-1.28.19.pdf>) includes statistics on telehealth services, financial health, workforce status, and many of the data points mentioned above in chart format.

You can also look at the [resources](#) ([/resources/topics/federally-qualified-health-centers](#)) we have listed on Federally Qualified Health Centers (FQHCs) and limit by the topic "Statistics and Data" and other topics of interest for data from other organizations.

How do I apply for a Health Center Program award?

Applying for health center funding requires significant planning and grant writing resources as the application process can be complex. For those working through the process, it may be helpful to separate the steps of development into manageable tasks. The key aspects of developing a grant proposal for a Section 330 PHS Act Health Center Program can be found in [So You Want to Start a Health Center...? A Practical Guide for Starting a Federally Qualified Health Center](#) (<https://cdn1.digitellinc.com/uploads/nachc/articles/09550126eb1edd85b1b7267a3e3b0145.pdf>) and include the following:

- Determine you can meet the compliance requirements within the specified time period for newly funded organizations. See the [Health Center Program Compliance Manual](#) (<https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/hc-compliance-manual.pdf>).
- Confirm your location or the population to be served is an eligible Medically Underserved Area (MUA) or Medically Underserved Population (MUP). See the [MUA Find tool](#) (<https://data.hrsa.gov/tools/shortage-area/mua-find>).
- Assess the need for health services in the catchment area. See page 11 of [So You Want to Start a Health Center, Needs Assessment and Planning](#) (<https://cdn1.digitellinc.com/uploads/nachc/articles/09550126eb1edd85b1b7267a3e3b0145.pdf#page=15>).
- Establish and maintain community support by engaging citizens, healthcare providers and other

stakeholders in the local planning and implementation process.

- Find a suitable location for your health center. See page 16 of So You Want to Start a Health Center, [Physical Space Considerations](https://cdn1.digitellinc.com/uploads/nachc/articles/09550126eb1edd85b1b7267a3e3b0145.pdf#page=20) (<https://cdn1.digitellinc.com/uploads/nachc/articles/09550126eb1edd85b1b7267a3e3b0145.pdf#page=20>).
- Select a patient-majority governing board that meets federal requirements.
- Identify staffing needs and policies for employment practices, including the recruitment and retention of provider staff.
- Develop a business plan identifying the population groups to be served, management and organizational structure, projected demand for services, and expected expenses and revenue.

It may be helpful to contact training and technical assistance organizations such as [National Cooperative Agreement \(NCA\) holders](#) (<https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/national-training>), [Health Center Controlled Networks \(HCCN\)](#) (<https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/hccn.html>), and/or [your state's Primary Care Association \(PCA\)](#) (<https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/associations.html>). These entities are funded by HRSA to provide training and technical assistance to health centers, and they have the resources to assist in the growth of health centers within their state or geographic area.

Specific information regarding Section 330 award application procedures can be accessed from the technical assistance sites for [New Access Points](#) (<https://bphc.hrsa.gov/program-opportunities/new-access-points>) or [Service Area Competition](#) (<https://bphc.hrsa.gov/programopportunities/fundingopportunities/SAC/index.html>).

Keep in mind you can only apply at a time that HRSA is accepting applications for New Access Points or for Service Area Competition (Section 330 federal awards).

Are Health Center Program awards granted on a competitive basis?

Yes. Based upon federal appropriations, HRSA announces if they have funding available for New Access Points (NAPs) competition, which support new sites that are either the satellite site of an existing Section 330 health center, or a new health center organization, including Health Center Program look-alikes. In addition, once every 3 years (and more often if necessary), existing Health Center Program award recipients have their service areas re-competed. If the existing awardee would like to continue receiving the award, they must re-apply for it, but it is possible another organization could be granted the Health Center Program award for that service area as SAC is a competitive award opportunity.

Which special populations can be served by healthcare organizations applying for funding through Section 330 of the Public Health Service Act?

Healthcare organizations can apply for awards under Section 330 of the Public Health Service Act to specifically serve statutorily defined special populations.

Migratory and Seasonal Agricultural Worker Health Centers provide comprehensive and culturally competent primary health services to migratory and seasonal agricultural workers and their families. Additional services of this program include disease prevention and occupational health and safety.

The **Healthcare for the Homeless Program** serves patients who are at risk for homelessness, are homeless, or live in shelters or temporary housing. They provide comprehensive healthcare services that include substance abuse and mental health services.

Public Housing Primary Care Health Centers provide residents of public housing access to comprehensive primary care services. Often these services are provided on the public housing premises or within easy access to residents.

What are school-based health centers and how would I set one up?

School-based health centers (SBHCs) provide primary care and other services in or near schools, reducing scheduling and transportation barriers for students, and are often located in communities with higher rates of free or reduced lunches. SBHCs in rural areas are more likely to serve other populations in addition to students, according to the [2013-14 Digital Census Report](http://censusreport.sbh4all.org/) (<http://censusreport.sbh4all.org/>) from the School-Based Health Alliance. [School-Based Health Centers in an Era of Health Care Reform: Building on History](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3770486/) (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3770486/>) found that common services include chronic

illness management, immunizations, reproductive health services, oral health, substance abuse and mental health treatment.

SBHCs at minimum have a primary care provider on staff and a majority of them also have a behavioral health professional. They may also have dental providers, health educators, dietitians, outreach coordinators, and vision care providers, according to the [2016-17 National School-Based Health Care Census Report](https://www.sbh4all.org/wp-content/uploads/2019/05/2016-17-Census-Report-Final.pdf) (<https://www.sbh4all.org/wp-content/uploads/2019/05/2016-17-Census-Report-Final.pdf>) from the School-Based Health Alliance.

While SBHCs are most commonly operated by a health center, they may also be sponsored by another type of organization, such as a local health department or hospital. [Twenty Years of School-Based Health Care Growth and Expansion](https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05472) (<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05472>) reported that there were 2,584 SBHCs in the United States: 1,181 operated by an FQHC and 823 in rural areas, and about 20% of SBHCs used telehealth as of the 2016-17 school year. [The Evidence on School-Based Health Centers: A Review](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6381423/) (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6381423/>) also found that SBHCs may be well-suited to reach American Indian and Alaskan Native communities.

A number of organizations offer planning guides and tools for starting SBHCs. General tips provided include:

- **Involve the community in the planning process.** This could include establishment of a School Health Advisory Committee, which often includes school leadership, the school nurse, students, parents, and others.
- **Conduct a needs assessment.** Who is your target audience and what are their primary unmet needs?
- **Determine the SBHC's organization.** What services will you provide? Where? With what staff? How will the SBHC interact with the school? [School-Based Health Centers: A Funder's View of Effective Grant Making](https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1234) (<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1234>) recommends at minimum a primary care provider and front-office staff member for staffing, and to provide space for a small waiting room, two exam rooms, a bathroom, and an office, as well as internal and external doors to allow for flexible hours. The school nurse and/or school counselor most often facilitates regular communication between school staff and the SBHC.
- **Plan funding sources.** The [School-Based Health Center Capital Program](https://bphc.hrsa.gov/programopportunities/fundingopportunities/shbcc/index.html) (<https://bphc.hrsa.gov/programopportunities/fundingopportunities/shbcc/index.html>) or foundation grants may provide funding for start-up costs. Medicaid/Children's Health Insurance Program billing is common for ongoing costs; Section 330 health center funding, Title X of the Public Health Service Act, and state funding are additional options. Strategizing how to get parent/guardian consent forms for student enrollment was also identified as an important step.

Resources include:

- [SBHC 101: Making an Informed Decision about Starting a School-Based Health Center](https://www.sbh4all.org/events/sbhc-101-making-an-informed-decision-about-starting-a-school-based-health-center/) (<https://www.sbh4all.org/events/sbhc-101-making-an-informed-decision-about-starting-a-school-based-health-center/>) – webinar recording and slides from the School-Based Health Alliance.
- [Going Where The Kids Are: Starting, Growing and Expanding School Based Health Centers](https://vimeo.com/345494409) (<https://vimeo.com/345494409>) – webinar recording from Community Health Center, Inc. about the benefits and challenges of health centers adopting SBHCs, as well as strategies for integrating behavioral and oral health.
- A set of modules (<https://www.cashbc.org/opening-an-sbhc-tools-and-resources>) from the Colorado Association for School-Based Health Care on starting a SBHC.
- [Opening a School-Based Health Center: A How-To Guide for West Virginia](https://livewell.marshall.edu/mutac/wp-content/uploads/2011/08/OpenSBHC2ndEd.pdf) (<https://livewell.marshall.edu/mutac/wp-content/uploads/2011/08/OpenSBHC2ndEd.pdf>) and [start-up tools](https://livewell.marshall.edu/mutac/school-health-centers/tools-resources/administrative-toolkits/) (<https://livewell.marshall.edu/mutac/school-health-centers/tools-resources/administrative-toolkits/>) – while specific to West Virginia, it provides updates from an earlier New Mexico resource.
- [Sustainability Tools](https://www.sbh4all.org/resources/sbhc-sustainability/) (<https://www.sbh4all.org/resources/sbhc-sustainability/>) from the School-Based Health Alliance.

See “[What types of healthcare services can be provided in rural schools? \(/topics/schools#services\)](#)” for additional information, including how SBHCs collaborate with school nurses.

Can a for-profit clinic be a health center?

No. A health center must be a public entity or a private nonprofit organization.

Is a board of directors required?

Yes, a health center must be governed by a board of directors. The board must include a majority (at least

51%) of patients of the health center who are representative of the populations served by the center. The governing board ensures that the center is community-based and responsive to the community's healthcare needs. Health centers under the management of American Indian tribes, organizations, or tribal groups are exempt from specific board composition requirements. For detailed information about board development and management, see [Chapter 20: Board Composition](https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-20.html#titletop) (<https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-20.html#titletop>) of the Health Center Program Compliance Manual. The [Health Center Resource Clearinghouse](https://www.healthcenterinfo.org/results/?Combined&ResourceTopic=Governance) (<https://www.healthcenterinfo.org/results/?Combined&ResourceTopic=Governance>) also offers resources related to health center governance.

Are there location requirements for health centers?

Each health center that receives Health Center Program award funding must meet the service area location requirements outlined in the notice of funding opportunity. Health centers must be located in or serve a designated Medically Underserved Area (MUA) or serve a designated Medically Underserved Population (MUP). Migrant and Seasonal Agricultural Worker Health Centers, Health Care for the Homeless, and Public Housing Primary Care Programs do not need to meet the MUA/MUP restriction. Health centers may be located in rural or urban areas.

Are there specific staffing requirements for health centers?

No, there are no specific requirements for staffing mix at a health center. Health centers must maintain a core staff that is able to carry out the required and additional health services of the health center. This may vary based on the needs of the community. Additional information about clinical staffing and demonstrating compliance is available in [Chapter 5: Clinical Staffing](https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-5.html#titletop) (<https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-5.html#titletop>) of the Health Center Program Compliance Manual.

What types of services do health centers provide?

Health centers must provide comprehensive primary care and preventative health services for all age groups. Examples of types of services that must be provided directly by a health center or by formal arrangement with another provider include:

- Preventive dental services
- Screenings
- Immunizations
- Well child visits
- Referrals to specialty care providers
- Pharmaceutical services as appropriate
- Patient case management to establish eligibility for health and related services
- Transportation services necessary for adequate patient care
- Translation services for limited English speaking patients
- Health education of patients and the general population

For more information, please see HRSA's [Health Center Program Compliance Manual](https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/hc-compliance-manual.pdf) (<https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/hc-compliance-manual.pdf>).

Are there minimum hours that a health center must be open?

While there are no specific requirements on hours, health centers are required, on an organizational level, to provide services at times and locations that assure accessibility and meet the needs of the population served, and to record their hours of operation in the current scope of project (as described on [Form 5B](https://bphc.hrsa.gov/sites/default/files/bphc/programopportunities/lookalike/pdfs/id/form5b.pdf) (<https://bphc.hrsa.gov/sites/default/files/bphc/programopportunities/lookalike/pdfs/id/form5b.pdf>)).

However, health centers may be subject to minimum hour requirements to receive certain benefits. For example:

- Minimum hours are required in order for providers to receive Federal Tort Claims Act (FTCA) coverage, which is discussed in HRSA's [Federal Tort Claims Act Health Center Policy Manual](https://bphc.hrsa.gov/sites/default/files/bphc/ftca/pdf/ftcahcpolicymanualpdf.pdf#page=6) (<https://bphc.hrsa.gov/sites/default/files/bphc/ftca/pdf/ftcahcpolicymanualpdf.pdf#page=6>).
- [Minimum patient-care hours are required](https://nhsc.hrsa.gov/sites/current-sites/maintain-site-) (<https://nhsc.hrsa.gov/sites/current-sites/maintain-site->

[status.html](#)) for National Health Service Corp (NHSC) providers.

Additionally, individual state Medicaid agencies, CMS, and private third party insurers may have their own policies regarding operational hours and schedules. Each health center is responsible for ensuring that it complies with the requirements of the benefit/third-party payer programs it participates in.

Is a sliding fee scale required?

Yes, health centers are required to have a sliding fee discount program. Health centers may offer a full discount or elect to have a nominal charge for individuals and families whose incomes are at or below 100% of the Federal Poverty Guidelines (FPG). For individuals with incomes above 100% and at or below 200% FPG, partial discounts are provided using a sliding fee scale with discounts based solely on the patient's family size and income. No sliding fee program discounts are provided to individuals and families with annual incomes above 200% of the current FPG. For more information about sliding fee scales and nominal charges, see [Chapter 9: Sliding Fee Discount Program \(<https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html#titletop>\)](#) of the Health Center Program Compliance Manual.

Must health centers accept all patients, regardless of their ability to pay?

Yes. This is a key requirement of the Health Center Program.

Are there special programs to assist health centers in attracting and retaining healthcare providers to their organization?

Health centers are eligible for a variety of federal programs that can be used to attract and retain healthcare providers within their organization, including:

- [National Health Service Corps Recruitment and Retention Assistance \(/funding/839\)](#) – A scholarship and loan repayment program that exchanges financial support for years of service at eligible healthcare facilities recruiting and retaining qualified clinicians.
- [J-1 Visa Waiver \(/topics/j-1-visa-waiver\)](#) – Allows international medical graduates who have completed residency and fellowship training to remain in the U.S. and practice in a federally-designated Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA).
- [Teaching Health Center Graduate Medical Education Program \(/funding/2512\)](#) – Funds medical education expenses for training residents in community-based primary care residency programs that include health centers.

What strategies have rural health centers used to provide behavioral health and dental health services to meet the needs of their patient population?

Many strategies have been developed related to the provision of behavioral health services and dental health services. The most common strategies include:

- **Using the National Health Service Corps to recruit and retain dental and behavioral healthcare professionals**
Health Center Program awardees and look-alikes are eligible to participate in the [National Health Service Corps \(NHSC\) programs \(<https://nhsc.hrsa.gov/>\)](#). The NHSC loan repayment program is not limited to primary care providers; they also accept and recruit licensed dental and mental/behavioral healthcare providers to NHSC approved sites, which include health centers. The NHSC scholarship program will pay for a variety of school expenses for students in fully-accredited training programs for physicians, dentists, nurse practitioners, certified nurse midwives, and physician assistants.
- **Contractual agreements with local dental service providers**
Health centers are eligible to contract with private dentists for dental services provided within their own dental facilities. [Increasing Access to Dental Care Through Public Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers \(<https://www.cdhp.org/resources/243-fqhc-handbook-increasing-access-to-dental-care-through-public-private-partnerships>\)](#) provides detailed information regarding the implementation of a contract with dentists to provide oral health services for underserved populations. This manual includes statutory information on contracting, how award money from the Health Center Program can be used, setting rates for contracted services, and the scope of services that can be contracted. [Case Studies of 8 Federally Qualified Health Centers: Strategies to Integrate Oral Health with Primary Care \(<http://nyachnyc.org>](#)

</wp-content/uploads/2015/10/CHWS-Oral-and-Primary-Care.pdf>) includes examples of contracted oral health services integrated with primary care.

- **Implementation of telemental health services**

Telemental health, or telebehavioral health, may be implemented in an FQHC to expand their behavioral health services. [Increasing Access to Behavioral Health Care Through Technology \(https://www.hrsa.gov/sites/default/files/publichealth/guidelines/BehavioralHealth/behavioralhealthcareaccess.pdf\)](https://www.hrsa.gov/sites/default/files/publichealth/guidelines/BehavioralHealth/behavioralhealthcareaccess.pdf) discusses how to plan, implement, and further develop a telebehavioral health program. According to a 2018 NACHC publication, [The Health Center Program is Increasing Access to Care through Telehealth \(http://www.nachc.org/wp-content/uploads/2018/02/Telehealth_Snapshot_FINAL_2.22.18.pdf\)](http://www.nachc.org/wp-content/uploads/2018/02/Telehealth_Snapshot_FINAL_2.22.18.pdf), nearly half of rural health centers use telehealth technologies, and 56% of those provide telemental health services.

- **Expansion of dental services to offsite locations**

Mobile units and school-based programs are some examples of how health centers have expanded their dental services. The [Oral Health Infrastructure Toolkit \(https://www.nnoha.org/ohi-toolkit/download-full-toolkit/\)](https://www.nnoha.org/ohi-toolkit/download-full-toolkit/) provides additional tools and information on how to establish these programs.

- **Integration and co-location of behavioral health services**

Most health centers integrate behavioral health (mental health and substance abuse) services within their facility (co-location) and use staff employed by the center to provide onsite behavioral health services. However, health centers may use outsourced staff from another facility, or a combination of staff who are outsourced and employed staff. Most health centers provide these services onsite, integrated with primary care services. For examples of health centers that integrated behavioral health, see [Case Studies of 6 Safety Net Organizations that Integrate Oral and Mental/Behavioral Health with Primary Care Services \(http://www.chwsny.org/wp-content/uploads/2019/02/OHWRC_Case_Studies_Oral_and_Behavioral_Health_Integration_With_Primary_Care_2019.pdf\)](http://www.chwsny.org/wp-content/uploads/2019/02/OHWRC_Case_Studies_Oral_and_Behavioral_Health_Integration_With_Primary_Care_2019.pdf).

For additional resources, see the Health Center Resource Clearinghouse priority topic, [Behavioral Health \(https://www.healthcenterinfo.org/priority-topics/behavioral-health/\)](https://www.healthcenterinfo.org/priority-topics/behavioral-health/).

What are the Medicare Administrative Contractors (MACs), and what is their role in administering Medicare Part A and Part B for health centers?

Medicare Administrative Contractors (MACs) are selected by the Centers for Medicare & Medicaid Services (CMS) to administer and process Medicare Part A and Medicare Part B claims. MACs serve as the primary contact between the Medicare Fee-For-Service program and healthcare providers enrolled in the Medicare program, including healthcare providers affiliated with FQHCs. MACs also support and work with FQHCs by enrolling providers in the Medicare program, educating providers on Medicare billing requirements, handling provider reimbursement and auditing institutional provider cost reports, managing the initial claims appeals process, and establishing local coverage determinations (LCDs). Organizations can also use the online Provider Enrollment, Chain and Ownership System (PECOS) to enroll as an FQHC in Medicare. For more information, please see the CMS overview of [Medicare Administrative Contractors \(https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors\)](https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors). To access a CMS Medicare Administrative Contractor within your state, see the [CMS Review Contractor Directory - Interactive Map \(https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map\)](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map).

Can another healthcare organization, such as a Critical Access Hospital, operate an FQHC?

In general, no. However, a city- or county-owned public hospital or a 501(c)(3) Critical Access Hospital (CAH) can operate an FQHC if the CAH's governing body or board of directors is developed to meet the Health Center Program Requirements.

Are there funding opportunities available for the expansion, renovation, purchase of major equipment, or new construction of health centers?

The Health Resources and Services Administration has offered grants to support expansion, renovation, purchase of major equipment, or new construction. These grants are posted on HRSA's Capital Development Grant Technical Assistance (<https://bphc.hrsa.gov/programopportunities/fundingopportunities/capdev.html>) website. Other funders may support capital projects and can be found listed on the [Funding and Opportunities section \(/topics/federally-qualified-health-centers/funding\)](#) of this guide and the [Capital Funding for Rural Healthcare guide \(/topics/capital-funding\)](#).

Who can I contact for additional information about health centers?

For additional information about health centers and related programs contact one or more of the following:

- For award questions:
[Bureau of Primary Health Care](https://bphc.hrsa.gov/) (<https://bphc.hrsa.gov/>).
Health Resources and Services Administration
Health Center Program Support or call 877.464.4772
7:00 am to 8:00 pm ET, Monday through Friday (except Federal holidays)
- For technical, policy, and operational assistance for new and established health centers including CMS regulations:
[CMS Regional Office Rural Health Coordinators](https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf) (<https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf>).
- For training, technical assistance, research papers, policy, and advocacy issues:
[National Association of Community Health Centers](https://www.nachc.org/) (<https://www.nachc.org/>) (NACHC)
Telephone: 301.347.0400
- For assistance in the establishment of geographic eligibility and the development of a health center:
[State and Regional Primary Care Associations](https://www.nachc.org/about-nachc/state-affiliates/state-regional-pca-listing/) (<https://www.nachc.org/about-nachc/state-affiliates/state-regional-pca-listing/>).

More on this Topic

- [Resources](#) ([/topics/federally-qualified-health-centers/resources](#))
- [Organizations](#) ([/topics/federally-qualified-health-centers/organizations](#))
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APPENDIX E

HODGKINS BECKLEY CONSULTING,
CONSIDERING INSURANCE BILLING FOR
COLLEGE HEALTH PROGRAMS
(EXCERPTED WITHOUT APPENDICES)



CONSIDERING INSURANCE BILLING FOR COLLEGE HEALTH PROGRAMS

By Stephen L. Beckley, Valerie A. Lyon, and Marc M. Tract

JANUARY 2019



CONSIDERING INSURANCE BILLING FOR COLLEGE HEALTH PROGRAMS

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ABSTRACT

The advantages for successful insurance billing for College Health Programs can be compelling. It can result in reduced tuition/fee costs, lower out-of-pocket costs for health care services, and increased awareness of the availability services provided by the College Health Programs. Conversely, adopting insurance billing when the circumstances are not favorable can result in increased administrative burdens with nominal improvements in revenue. In the worst-case outcomes, students experience a severe loss of access to care.

Colleges continue to receive information about insurance billing that is likely to constitute impermissible practices in most state jurisdictions. Adopting insurance billing without fully understanding the regulatory environment and compliance requirements can result in liability for possible violation of insurance fraud statutes, and/or for noncompliance with insurance participating provider agreements. Given the variability of insurance billing regulation by state jurisdiction, it is essential to consult with legal counsel with expertise in insurance regulatory law for the state in which the College Health Program is located.

**CONSIDERING INSURANCE BILLING
FOR COLLEGE HEALTH PROGRAMS**

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- B. Mayo Clinic Charity Care Policy
- C. National Association of Insurance Commissioners, Model Statute for Coordination of Benefits
- D. Do You Have MassHealth Coverage? January 2017
- E. Credentials for Authors

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CONSIDERING INSURANCE BILLING FOR COLLEGE HEALTH PROGRAMS

KEYWORDS:

- Affordable Care Act (ACA)
 - Bridge Plans
 - College Health Programs
 - Coordination of Benefits (COB)
 - Primary and Secondary Payor
 - Student Administrative Health Fees (SAHF)
 - Student Health Insurance/Benefit Programs (SHIBPs).
-

STEPHEN L. BECKLEY, CEBS

Fort Collins, CO
Valerie A Lyon, MHA
Ithaca, NY
Hodgkins Beckley Consulting, LLC
877-559-9800
www.HBC-SLBA.com

MARC M. TRACT, ESQ.

Katten Muchin Rosenman, LLP
New York, NY
212-940-8800
www.kattenlaw.com

CONSIDERING INSURANCE BILLING FOR COLLEGE HEALTH PROGRAMS

UPDATED PUBLICATION FROM 2013

This document provides an update for our publication on insurance billing from January 2013. An important first change is to the title. Since 2013 we note the creation of new leadership positions and departments to oversee the major components of services related to the health and well-being of students, such as the Associate Vice President for Student Health and Wellbeing at the University of Alabama,^{1,2} as well as increased adoption of integrated and highly collaborative health and counseling services.³ Because the previous

title could be construed to infer that there is a common separation between health and counseling services, we chose to use the term “College Health Programs” for the title as used by the Lookout Mountain Group in its recent publication, “An Eight-Year Update for the Lookout Mountain Group’s Review of College Health Programs.”

As a precursor to reading this publication it will be important for recipients to review Appendix

A to understand key concepts for coordination of benefits (COB) and the secondary payor concept

for student administrative health fees (SAHF). This Appendix explains how COB works when a person is covered by more than one health insurance plan, and how SAHF can be used in certain state jurisdictions to fund all or some of the charges not covered by students’ personal health insurance.

We do not include an update for the continued trend for public university College Health Programs to move away from traditional prepaid funding sources toward insurance billing. Nor do we discuss the viability of SHIBPs, which was an important topic at the time of our 2013 publication. Results for the American College Health Association’s (ACHA) 2017 survey, presented at the ACHA annual meeting in Washington, DC, on June 8, 2018,⁵ and other readily available articles and presentations, provide information on these subjects from 2013 to present. Similarly, a discussion of the trend for increased utilization for College Health Programs is not included since this information is also readily available from other sources. Finally, we do not include analysis or recommendations for maximizing insurance revenue for College Health Programs due to the highly technical and complex nature of medical coding and ever-changing regulatory environment.

“A College Health Program describes the constellation of services, strategies, policies, and facilities an institution of higher education assembles to advance the health of its students. While some College Health Programs are also intended to provide extensive services for faculty and staff, most of the components are intended to provide services exclusively for eligible students. On many campuses, College Health Programs are wholly focused on the provision of health care in the form of medical and psychological services and may include a variety of health care related services including sports medicine services for intercollegiate athletes, student health insurance/benefit programs, crisis intervention and public safety services.”⁴

— *Lookout Mountain Group*

VARIABILITY OF FINANCIAL RESULTS FOR INSURANCE BILLING

While many colleges have achieved long-term success funding a substantial portion of health services operations through insurance billing revenue, the overall results remain highly variable. The reason for the variability of success mainly stems from environmental factors associated with College Health Programs. Some of the major environmental elements for optimal results for insurance billing include the following.

- The college is located in a state jurisdiction that allows SAHF to take an always-secondary payor position in COB with students' personal health insurance (refer to "[Mitigating the Impact of Cost Sharing Provisions on Students' Access to Care](#)").
- The college has an effective insurance requirement as a condition of enrollment in compliance with ACHA's insurance standards (i.e., a "restrictive waiver" insurance requirement results in relatively few students without access to care).^{6 7}
- There are few completely uninsured students who are eligible to use the health service (e.g., part-time students).
- Billing for Affordable Care Act (ACA) preventive care services is a priority for the health service, and the insurance status of students and reimbursement policies of commercial insurers are favorable.
- The SHIBP provides comprehensive benefits (including full coverage for health service charges or only has nominal copayments), has a favorable cost, and is effectively marketed, often resulting in 40 percent or more of eligible students being covered.
- The health service is a participating provider with almost all students' personal health insurance plans and/or it offers a successful [bridge plan](#) (e.g., the plan provides meaningful benefits and is a good insurance value from a cost-benefit perspective) that provides access to care for students who are insured by HMOs or other provider networks that will not contract with the health service as a participating provider.
- In-network provider reimbursement rates for primary care visits and other services are favorable (e.g., at 120 percent of Medicare or higher).
- The college is in a geographic area where employer-sponsored health plans have relatively low copayments for primary care visits for illness or injury (even if there is a high deductible health plan).

Viewed collectively, the above list is daunting relative to the probability of achieving optimal results from insurance billing. When all of the above variables do exist, the expected high range for insurance reimbursements from third party payors often equates to 30 to 45 percent of the operating cost of a health service (not including pharmacy and other major ancillary services). While this is significantly

CONSIDERING INSURANCE BILLING FOR COLLEGE HEALTH PROGRAMS

less than what would otherwise be required for profitability for a primary care practice, it is important to recognize that most college health services will continue to require significant SAHF subsidization after insurance billing has been successfully implemented. This is because College Health Programs have circumstances that are more economically disadvantageous than is common for community primary care practices. These include the requirements to be open for extended periods when there are relatively few patients either on the campus and/or wanting to access services, employee benefits costs that are higher than common for community providers, and relatively low levels of provider productivity compared to community providers.

It is noteworthy that profitability is also highly variable among community physician practices. Hospital-owned primary care physician practices are generally not profitable. A Medical Group Management Association (MGMA) study, reported in *Harvard Business Review*, shows that the loss was \$196,000 per employed physician in 2016.⁸ Urgent care clinics, however, are more likely to be profitable, but they also operate on a different model than most primary care practices and college health services.⁹

It is a certainty there will continue to be significant changes in primary care reimbursements. There will be movement to outcomes-based compensation, as well as changes for provider reimbursements for telemedicine, required increased data reporting, and other payment-related modifications that will increase the complexity of insurance billing.¹⁰ In short, College Health Programs that have adopted insurance billing are likely to experience increasing complexity for both contracting and delivery of care, as well as the probability of increased volatility for costs and revenue. From a positive perspective, insurance billing may result in earlier adoption of best practices in the delivery of health care services to students.

To be economically viable, insurance billing for most College Health Programs usually requires that new revenue exceeds 15 percent of billed charges. If this threshold is not met, then administrative and staffing costs are likely to exceed new revenue. When insurance billing fails, the most severe outcome is that a significant number of students are effectively disenfranchised from care. In these situations, it is not uncommon to find that insurance billing results in the health service primarily providing care to the students covered by the SHIBP. This is because the SHIBP may be the only insurance plan that has extensive first-dollar benefits for charges at the health service and/or large numbers of students are underinsured or uninsured (or other factors exist that are listed above).

For many students not covered by the SHIBP, losing access to the on-campus health service, because there are now significant charges following the adoption of insurance billing, is not resolved by obtaining services from community health care providers. There are often transportation and accessibility barriers (e.g., lengthy wait times), in addition to cost, with community health care providers that makes access to College Health Program services essential for many students.

BILLING FOR ACA PREVENTIVE CARE SERVICES

Students and parents/guardians, like many consumers, are becoming increasingly aware of the broad spectrum of ACA preventive care services that all ACA-governed health insurance plans must provide without any patient cost sharing (i.e., copayments, deductibles, and coinsurance).¹¹ If a College Health Program does not bill insurance, it is likely that routinely provided preventive care services* funded from tuition/fees will be unnecessarily duplicated by many students' personal health insurance. The circumstances for ACA preventive care services being a major factor for insurance billing revenue are variable, but still well worth considering in evaluating whether insurance billing is appropriate for a College Health Program.

Many college health administrators would contend that preventive care services account for a small percentage of current health services expenditures, and, therefore, any duplication of private insurance is nominal. This view may, however, be incomplete as the revenue opportunity for preventive care services from students' insurance can be significant, and entirely appropriate given the focus of the ACA on providing preventive care services to consumers (discussion of the long-term medical effectiveness and economic return for providing preventive care services is beyond the scope of this publication).¹²

* Examples of ACA preventive care services for adults that would commonly be provided to college students include the following.

These services are free only when delivered by a doctor or other provider in your plan's network.

- Alcohol misuse screening and counseling
- Depression screening
- Diet counseling
- HIV screening
- Immunization vaccines
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling
- Syphilis screening
- Tobacco use screening¹³

CONSIDERING INSURANCE BILLING FOR COLLEGE HEALTH PROGRAMS

ACA preventive care services that are commonly provided in college health services for women also include contraception, cervical cancer screening, chlamydia infection screening, and well-woman visits.¹⁴

In addition to billing for stand-alone visits for ACA preventive care services, in some locations it is common for commercial insurers to reimburse health care providers for billing ACA preventive services using current procedural terminology (CPT) code modifier 25 as an addition to an evaluation and management (E&M) office visit charge for care for an illness or injury. For example, a nurse practitioner seeing a student for a recurring upper respiratory condition ultimately concludes that sleep deprivation and other behaviors are contributing factors. Under this scenario, the medical office visit for the upper respiratory infection could be extended to provide the student with ACA preventive care services for alcohol misuse screening and counseling, depression screening, or other elements of a wellness exam. With appropriate documentation in the medical record and applicable coding, the students' insurance plan may reimburse this portion of the visit's cost at 100 percent under ACA preventive care benefits.

While the ACA mandates preventive care benefits, commercial insurers have discretion as to how they cover them.¹⁵ Also, as noted in the quote from the HHS website, ACA preventive care services are only required to be provided for in-network participating providers (e.g., an HMO is not required to provide ACA preventive care benefits at a college health service that is not an in-network participating provider).

There are wide variances in the revenue reported from insurance billing from providing ACA preventive care services among college health services that have a long history of insurance billing. There are undoubtedly multiple causes for these variances, including the likelihood that some health services are serving a significant number of students who have personal health insurance, with which they cannot pragmatically become in-network participating providers (e.g., Medicaid, Medicare, or group model HMOs). There can also be resistance among staff toward completing the additional documentation and coding that is required for providing preventive care services. These problems are not unique to college health services that are self-operated. In several instances, we have also observed health services that have been outsourced or have community partner arrangements whereby billing for ACA preventive care services does not account for a significant portion of insurance billing revenue, despite the insurance status of students and local commercial insurer reimbursement policies appearing favorable.

FEDERAL RECOGNITION FOR THE EXISTENCE OF COLLEGE HEALTH PROGRAMS

Student administrative health fees (SAHF) were first recognized in federal regulations issued in March 2012 by the US Department of Health and Human Services (HHS) for the operation of student health insurance programs (CMS-9981-F).¹⁶ In these regulations, prefunding arrangements for College Health Programs (i.e., either designated health fees or general funding allocations from tuition, fees, or other funding sources) were defined as follows.

“Student administrative health fees are those that are charged to all students enrolled at a college or university, regardless of whether a student enrolls in student health coverage or utilizes any services offered by the clinic, which gives all students access to a student health clinic’s services and supports a number of services and activities that foster a healthier campus community.”

“(c) Student administrative health fees. (1) Definition. A student administrative health fee is a fee charged by the institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage.”¹⁷

There was no explanation provided in the regulations for how the term SAHF was chosen. To our knowledge, the term had not been used prior to the March 2012 issuance of the regulation by HHS or any other federal or state regulatory agency. While the federal recognition of SAHF was important, because it concluded such prefunding arrangements for college health and counseling services do not constitute a form of health insurance, the definition is somewhat problematic as it does not fully recognize the broad spectrum of services that compose a College Health Program.

Several state insurance departments have recognized SAHF in considering insurance billing for College Health Programs and other matters pertaining to the operation of College Health Programs (e.g., Pennsylvania).¹⁸ The definition of SAHF is also recognized by entities, such as Cornell University’s Legal Information Institute,¹⁹ and formal SAHF plan documents have recently been adopted by several major public universities and private colleges and universities that are engaged in insurance billing (refer to “[Eight Best Practices for Insurance Billing for College Health Programs](#)”).

MITIGATING THE IMPACT OF COST SHARING PROVISIONS ON STUDENT's ACCESS TO CARE

As explained in 2013 (refer to [Appendix A](#)), a secondary payor status for SAHF allows a health service to first bill a student's insurance, and SAHF funds may then cover some or all of the remaining charges, depending upon the benefits specified for SAHF, not paid by the student's personal insurance. This use of SAHF is further explained and updated in the section entitled "[State Regulation for Insurance Billing](#)." In states where it is permissible, designating SAHF funding as a secondary payor when College Health Programs bill students' insurance has resulted in cost savings for students via reduced tuition/fees without losing access to care because of cost sharing provisions (i.e., copayments, deductibles, and coinsurance) in students' personal insurance.

Unfortunately, there continues to be presentations and informal communications among college health administrators promoting insurance billing practices that would be impermissible in many state jurisdictions. In some presentations for insurance billing, there are appropriately accurate reviews for state jurisdictions obtaining a secondary payor status in COB for SAHF. An example of a balanced and cautionary presentation to this complex subject was provided by Diane Norris, Director of Health Services at Georgia Southern University, at ACHA's 2017 annual meeting "Is Third Party Billing the Answer?"²⁰ Refer also to "[Permissibility of Separate Fee Schedules for Uninsured Students, Cash Discounts, and Other Mechanisms to Reduce Patient Cost Sharing](#)."

In some of the presentations referenced above, it was suggested there were ways to waive patient cost sharing responsibility that, in our view, were likely to be impermissible billing practices in most state jurisdictions and/or noncompliant with most participating provider agreements. Inappropriate waiving of patient cost sharing responsibility is not unique to College Health Programs. These practices continue to be the subject of litigation for community health care providers. In reviewing regulatory agency advisories/notices, journal articles, and other publications over the past few years, there are consistent and common points of advice for physician practices that can be broadly applied to many state jurisdictions (refer to recommendation for "[Have a consistently applied and formally written charity care/ability-to-pay-allowance determination](#)"). Since the previous publication in 2013, a review of the case law suggests commercial insurers and health plans will continue to litigate the effect of health care providers inappropriately waiving patients' financial responsibility for cost sharing provisions contractually specified in health insurance benefit schedules. Numerous courts have found such waivers of patient financial responsibility objectionable.²¹

There is another major consideration for SAHF being used to fund charges, on a secondary payor basis, not covered by students' personal health insurance. Due to the long-term trend for employers to adopt high deductible health plans and/or have limited provider networks, equity concerns can be raised when students received significantly different financial benefits from SAHF (especially when there is a designated health fee). For example, a student with personal health insurance that only has a \$20 copayment for a primary care visit will receive a much lower benefit from SAHF than a student who is

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covered by insurance that has a \$1,000 deductible. In response to scenarios like this, some stakeholders have suggested that SAHF should only cover 50 percent of the charges incurred at the health service for students who are covered by high deductible health plans or for students who are covered by health plans that will not allow the health service to become a participating provider. Another option would be to require students under these situations to enroll in a bridge plan. Equity concerns for SAHF can present challenging questions that are inextricably related to the decision process for considering insurance billing.

STATE REGULATION FOR INSURANCE BILLING

It is important to reiterate from our 2013 publication that regulation of insurance billing often includes state specific statutes and/or regulations. For example, New Jersey passed legislation this year establishing clear penalties for health care providers who waive patient liabilities. The Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act specifies the following.

"Section 15 – WAIVER OF PATIENT RESPONSIBILITIES

- a. It shall be a violation of this act if an out-of-network health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider. As the commissioner shall prescribe by regulation, a pattern of waiving, rebating, giving or paying all or part of the deductible, copayment or coinsurance by a provider shall be considered an inducement.
- b. This section shall not apply to any waiver, rebate, gift, payment, or offer that falls within a safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing, including, but not limited to, anti-kickback, self-referral, false claims, and civil monetary penalties, including any advisory opinions issued by the Centers for Medicare and Medicaid Services or the Office of Inspector General pertaining to those laws."²²

As discussed below, there is widespread agreement that health care providers that are billing Medicare and Medicaid and/or are engaged as in-network participating providers with commercial insurers cannot simply waive charges for uninsured persons without completing a formally documented ability-to-pay allowance determination (an example charity care policy from the Mayo Clinic is provided in [Appendix B](#)). Again, the specificity of state regulation is important to emphasize. At least one state (Texas), includes this provision in its Insurance Code.

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“§ 552.001 – APPLICABILITY OF CHAPTER

- (a) This chapter does not apply to the provision of a health care services to a:
 - (1) Medicaid or Medicare patient who is covered by a federal, state, or local government-sponsored indigent health care program;
 - (2) financially or medically indigent person who qualifies for indigent care health services based on (A) a sliding fee scale; or (B) a written charity care policy established by a health care provider; or
 - (3) person who is not covered by a health insurance policy or other health benefits plan that provides benefits for the services and qualifies for services for the uninsured based on a written policy established by a health care provider.”²³

Finally, the number of state jurisdictions that are allowing SAHF for College Health Programs to take an always-secondary payor position has increased since 2013 (refer to [Appendix A](#)). Interestingly, this has occurred in some states that have adopted, verbatim, the National Association of Insurance Commissioners model statute for coordination of benefits (COB). In at least two instances, the federal definition of SAHF appears to have swayed state insurance regulatory agencies to view funding arrangements for College Health Programs as falling outside the definition of an insurance “Plan” for their respective COB statutes/regulations and, therefore, to allow SAHFs to take an always-secondary payor position (refer to, Definitions, pages 4–5, of [Appendix C](#)).

The importance of having legal counsel with expertise in insurance regulatory law for the state jurisdiction in which the College Health Program is located cannot be overstated, given the variability of regulation of insurance billing practices by state jurisdiction.

PERMISSIBILITY OF SEPARATE FEE SCHEDULES FOR UNINSURED STUDENTS, CASH DISCOUNTS, AND OTHER MECHANISMS TO REDUCE PATIENT COST SHARING

It is sometimes alleged informally by college health professionals and others that HHS has broadly ruled that any health care provider can choose to write-off some or all of the cost of a service or supply simply by determining that the patient does not have health insurance coverage. Such allegations are not supported by any of the articles, position papers, or regulatory guidance reviewed for this update ([note limited exception for the State of Texas](#)).

Guidance from the law firm, Holland & Hart, provides a succinct explanation for both impermissible and permissible gifts, rewards, and free or discounted services.

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"The federal Anti-Kickback Statute ('AKS') and Civil Monetary Penalties Law ('CMPL') generally prohibit offering anything of value to induce patients to order or receive services payable by federal healthcare programs unless the arrangement fits a regulatory safe harbor. Violations may result in criminal, civil and administrative penalties. Common marketing programs that may implicate the laws include but are not limited to:

- 'Patient appreciation' gifts or gift cards.
- Free supplies (e.g., free diapers, free formula, etc.).
- Free or discounted items or services as loss leaders to encourage other business.
- Free screening programs.
- Referral reward programs.
- Drawings for prizes.
- 'Insurance only' billing or waiving copays and deductibles.
- Free transportation programs.
- Rebates.

The AKS contains exceptions for certain discounts and transportation programs if regulatory conditions are satisfied. The CMPL also contains several potentially relevant exceptions, including:

- Providing an item of or service of low value, which the Office of Inspector General ('OIG') interprets as each item or service is less than \$15, and all such gifts total no more than \$75 per patient per year.
- Providing free or discounted items or waiving copays and deductibles after a good faith determination of financial need or unsuccessful collection efforts so long as the discount or waiver is not part of any advertisement or solicitation and is not routine.
- Incentives that promote certain types of preventative care, or that promote access to care and poses a low risk of harm to patients and government programs.

Providers should also check their state laws for similar prohibitions. Even if allowed under federal or state law, waiving copays or deductibles or offering inducements for services may violate commercial payer contracts."²⁴

A SAFETY AND WELFARE OF PATIENT EXCEPTION FOR COLLEGE HEALTH PROGRAMS

In addition to the common exceptions for providing services without charge that are noted above, it is our opinion that most state insurance departments and commercial insurers would be inclined to grant a special exception for SAHF to not bill insurance when there is concern for the safety or welfare of the student. This exception is warranted due to the communal living circumstances for residential colleges, the unique health care service role for College Health Programs and the common interplay of parental health insurance, and the widespread, highly publicized concerns for access to mental health care services and primary care services for college students. The following provision was adopted by a public university in its SAHF plan (SAHFP) document.

"The SAHFP Sponsor reserves the right to use Student Administrative Health Fee funds and/or other available funds to cover charges incurred at UHS [**University Health Service**] by a student when the SAHFP Administrator or their delegate determines that it is in the best interests of either the student or the University. Considerations for such a determination may include, but are not limited to, highly sensitive care situations where a student's wellbeing could be in jeopardy if charges were submitted to the student's personal health insurance and/or the student was required to pay for the service or supply. Such best-interest determinations will be made solely by the SAHFP Administrator or their delegate on a case-by-case basis."²⁵

We provide the foregoing text for illustrative purposes only. Any similar exception proposed for adoption by another university's College Health Program should be reviewed under applicable state law, and by commercial insurers for which a College Health Program is acting as an in-network participating provider.

CONFIDENTIALITY CONCERN FOR INSURANCE BILLING

The confidentiality of students' medical information and/or use of health and counseling services is often cited as a prominent concern for College Health Programs participating with commercial insurers and engaging in insurance billing. This matter is appropriate for including in a college's evaluation or formal insurance billing feasibility study for its College Health Program. The following section on "[Billing for Medical Visits and Not Psychological Counseling](#)" also addresses whether there should be special concerns for confidentiality relating to mental health care services. While there are noteworthy exceptions (we were recently informed that a president at a public university dismissed any discussion of insurance billing due to confidentiality concerns), most colleges considering insurance billing ultimately conclude that confidentiality concerns can be addressed or abated with appropriate information for students and parents/guardians, and with careful enactment of policy and administrative safeguards.

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For colleges that adopt insurance billing, the confidentiality concern will usually be addressed by reaching three conclusions. First, regulatory research confirms the permissibility of the “safety and welfare exception” that allows the College Health Program to not bill a student’s insurance plan whenever there is a concern for the welfare of the student (including a concern for confidentiality). Second, the college’s requirement for health insurance as a condition of enrollment includes a recommendation for remaining enrolled in the SHIBP to best assure access to care relative to concerns for confidentiality and independence of the student. A likely third conclusion to support insurance billing will be a finding that peer institutions have adopted it without experiencing significant harm to students.

Many college health professionals have emphasized the need to educate students and parents/guardians about the option to restrict access to explanation of benefit (EOB) information for students’ claims information. Federal law requires that EOB forms, providing information about adjudication of medical claims, must be provided to the primary insured person (usually a parent/guardian) for employer-sponsored health plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA).²⁶ An increasing number of states have passed laws due to recognized problems with the limits of federal protections, as explained in this excerpt from a 2016 article published by *National Public Radio*.

“Federal law does offer some protections, but they are incomplete, privacy advocates say. The Health Insurance Portability and Accountability Act of 1996 is a key federal privacy law that established rules for when insurers, doctors, hospitals and others may disclose individuals’ personal health information. HIPAA contains a privacy rule that allows people to request that their providers or health plan restrict the disclosure of information about their health or treatment. People can ask that their insurer not send to their parents the ubiquitous ‘explanation of benefits’ form describing care received or denied, for example. But an insurer isn’t obligated to honor that request.”²⁷

State laws, which are only applicable to commercial health insurance plans that are not governed by ERISA, allowing dependents to restrict parents/guardians access to health insurance claims information, are undoubtedly well intended. Such laws, however, may not provide meaningful confidentiality protections for students. A parent/guardian, who routinely manages medical billing, payments to health care providers, taxes, and other personal finances for all family members would readily see that online access to health insurance claims information is no longer available for the college student family member. It is not hard to imagine a student having difficulty declining a request from a parent/guardian to restore access to online insurance claims information.

BILLING FOR MEDICAL VISITS AND NOT PSYCHOLOGICAL COUNSELING

A 2015–16 survey of by the Association for University and College Counseling Center Directors (AUCCCD) showed that only about 4 percent (20 of 517 respondents) of college counseling centers billed third parties for services.²⁸ Thus, insurance billing for college counseling services is much less common than billing for medical services provided by College Health Programs. The factual basis for this disparity in billing is questionable, depending upon the specific circumstances of the college.

It is generally understandable that insurance billing for psychological counseling is low among community mental health care providers, given that participation by them as in-network for insurance remains a major problem in most parts of the country. National media reporting suggests 30 percent of clinical psychologists do not participate with insurance plans.²⁹ In California, a 2016 survey of family therapists found that half did not take insurance.³⁰ Despite the passage of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA),³¹ a 2017 study by Milliman, a risk management and health care consulting company, found that behavioral health care was four to six times more likely to be provided out-of-network than medical or surgical care; and that insurers paid primary care providers 20 percent more for the same type of care than they paid mental health specialists. Simply put, the MHPAEA has failed to significantly improve access to mental health care benefits. Even though insurers and health plans have dropped annual limits for therapy visits, and higher copays and separate mental health deductibles have become less of a problem, there are more subtle access challenges, such as medical necessity reviews (whereby length and type of treatment must be reviewed and approved).³²

The low level of insurance billing for psychological counseling in College Health Programs may also be due to misunderstandings, and/or inaccurate assertions, about the confidentiality of medical information that is part of the claims administrative systems of commercial health insurers, health plans, and third-party claims administrators. These concerns are periodically expressed on list serve discussions and in previously referenced College Health Program meetings devoted to considering insurance billing. Unfortunately, there is a common inaccurate assertion that there is an insurance industry database of medical claims that employers, governmental agencies, and other organizations can use to access students' medical claims. This is usually based on a misunderstanding of the function and capability of the Medical Information Bureau.³³ Inaccurate or misleading information undoubtedly contributes to excluding psychological counseling from insurance billing for a College Health Program. There may be a rational basis for not billing psychological counseling, as explained above, but communicating to students and parents/guardians that caution is being taken to assure confidentiality of counseling records by not billing insurance may be a long-term disservice to students. For example, such communication could infer to students they should be concerned about use of an employee benefits plan for mental health care services after they graduate from college.

It is appropriate to consider confidentiality of students' use of College Health Program services and/or medical claims information as part of the overall decision process for considering insurance billing (refer to "[Confidentiality Concerns for Insurance Billing](#)"). Generally, there is not a rational basis for having any greater concerns for the confidentiality of psychological counseling records than the highly confidential and sensitive records for services that are routinely provided in primary care, psychiatry, pharmacy, and other components of College Health Programs.

BRIDGE PLANS AND OTHER PREPAID FUNDING ARRANGEMENTS

Among College Health Program administrators, the term “bridge plan” has become common to describe an additional prepaid benefit or discount program that students can purchase to augment SAHF benefits and services. They have also been referred to as optional health fees or complementary care plans.

Although bridge plans exist at both public and private colleges, they are primarily found at public universities (e.g., for 2018-19, University of California Los Angeles, Arizona State University, Colorado State University, and University of Louisville). As noted above, they are often viewed to best meet the needs for students who have health insurance that covers catastrophic illness or injury, but does not cover routine charges at the College Health Program because of a limited provider network, a high deductible, or other cost sharing feature. For example, a student with a high deductible health plan is allowed to waive enrollment in the SHIBP but is required to then complete a negative check-off to decline enrollment in the bridge plan to prefund care on-campus and provide benefits for urgent care and emergency room services at the hospital near campus.

A key question, particularly for private colleges, is how bridge plans can exist from a regulatory perspective. If a state were to conclude that bridge plans are a form of SAHF, then the programs might be required to be provided on a negative check-off basis (i.e., the fee is charged to all students and they must proactively waive the fee). This concern may be less important in state jurisdictions that have explicitly recognized College Health Programs in statute or regulation (e.g., Massachusetts)³⁴ or by general exemption for regulation of insurance under programs operated by the state or any of its political subdivisions (thereby exempting public colleges, e.g., North Carolina).³⁵ Colleges should consult with their state insurance departments for the operation of a bridge plan prior to implementation. For example, in one instance, a state insurance department informally asked that the name of the bridge plan not refer to “supplemental coverage,” as the state had reserved this terminology for Medicare supplemental policies. A second concern is whether SAHF can include benefits for services provided off campus, and at what point have the benefits become so significant they should be regulated as a form of insurance.

A final question for the operation of bridge plans is whether they should be viewed as being subject to ACHA insurance standards.³⁶ In our view, colleges should operate bridge plans under the same basis as SHIBPs relative to ACHA’s standards. For example, this would mean they should be operated in the best interest of covered students rather than being operated primarily to meet the revenue needs of a College Health Program. More specifically, a bridge plan should first and foremost be a good insurance value, reflecting a fair cost for the reasonable likelihood of incurring medical expenses covered by the plan. Having a consistent claims-to-premiums loss ratio of less than 80 percent might raise questions about whether the program is a good insurance value, and/or the cost of the program is simply excessive. Likewise, fear tactics or other marketing techniques that would otherwise be impermissible for insurance products in a given state jurisdiction should be carefully avoided (refer to your state’s insurance advertising code).³⁷

INSURANCE BILLING OFTEN REQUIRES CONSIDERATION OF OUTSOURCING/COMMUNITY PARTNERING

Because of the complexity of contracting with commercial insurance plans, compliance concerns, and ongoing administrative costs, outsourcing or some level of community partnering is often an integral part of the decision to evaluate insurance billing for a College Health Program. This is particularly true for colleges with enrollment of less than 15,000 students. In 2017 ACHA formed an Outsourcing Task Force with the following charges.

- “Explore the state of outsourced health and mental health services in higher education including reasons cited for outsourcing operations.”
- Examine the pros and cons of outsourcing in terms of service to the campus community, internal and external collaboration, and operational and fiscal efficiency.
- Identify best practices for outsourced health and mental health services using case examples.”³⁸

While it is beyond the scope of this paper, it is important to note there are numerous permutations for outsourcing, including partnering, joint ventures, and other collaborative arrangements with community and external resources. It is not surprising that outsourcing and community partnering would become a trend for College Health Programs, since it has become increasingly challenging for community health care physicians to maintain independent practices. A *US News & World Report* article summarizes several studies that confirm the widespread increase in the number of physicians opting to leave private practice. In summary, the article notes the following.

“ . . . a growing number of doctors are opting out of owning their own practices, especially in light of the fact that many will be able to make more money and have better support if they join a larger practice or hospital. This has led to health care experiencing a massive shift toward a ‘big-box’ approach – independent doctors joining larger group-, corporate- or hospital-owned practices.”³⁹

Low reimbursement rates from commercial insurers, administrative and technology burdens (many as a result of the ACA), burnout among providers, nonclinical paperwork, third party authorizations that detract from providing quality of care, and concerns for the future of the medical profession are all cited as key findings in a survey by The Physicians Foundation.⁴⁰

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Outsourcing and community partnering has produced both highly positive and negative results for colleges. A recent positive example is Franklin & Marshall College, a private college located in Lancaster, Pennsylvania, that partnered with a local hospital to move to insurance billing for both health and counseling services, obtain funding for a state-of-the-art new facility, and significantly increase resources for wellness programs. This was accomplished through an employee leasing arrangement that allowed existing employees to maintain the college's benefits and compensation.

Concerns for outsourcing now include the potential instability of both large and small health care organizations. For example, two large health care organizations in Boston, which had historically provided outstanding services for the operation of College Health Programs, announced in 2017 they would no longer be able to continue these relationships with local colleges and universities. In other words, the continued trend toward mergers with large health care organizations can create uncertainty for the long-term stability of outsourcing arrangements for College Health Programs.⁴¹

If the college is in a state where eligibility for Medicaid has been expanded, then the desire for a College Health Program to be a Medicaid participating provider can be a contributing factor for the need to assess outsourcing. For example, as of the date of this report, two College Health Programs operated by public universities in Kentucky, Western Kentucky University and Murray State University, have outsourced health services that participate with Medicaid. These two programs have been outsourced to community clinics that have the resources and capabilities to meet the administrative and care requirements for participating with Medicaid.

MEDICAID PREMIUM ASSISTANCE FOR SHIBPS

Medicaid funds have been used to pay for the cost of SHIBPs for many years in Minnesota and Montana. Based on this experience, ACHA developed a position paper in 2013,⁴² following the expansion of Medicaid eligibility in numerous states under the ACA. Beginning in fall 2017, the Medicaid program in Massachusetts, MassHealth, began providing premium assistance to pay for the cost of SHIBPs at public colleges and universities. The program was subsequently expanded to private colleges. A flyer for the MassHealth program is included in [Appendix D](#) that explains the program to students. With technical assistance and support provided by UMass Medical School, in the 2017–18 plan year MassHealth enrolled just over 31,000 eligible college students into its student health plan premium assistance program, for a savings to the Commonwealth of approximately \$24 million.⁴³

A student health plan premium assistance pilot program adopted at Cornell University in 2014 is now in its fifth year of operation with over 400 students enrolled.⁴⁴ Efforts are underway to expand the program to other New York colleges and universities.

In addition to often providing much greater access to health care providers and reducing costs for the state, obtaining premium assistance for SHIBPs eliminates the need for College Health Programs to become Medicaid participating providers. This is important, as it has proven to be administratively impossible for most College Health Programs, which are not outsourced to large community health care providers that are already participating with Medicaid and Medicare, to meet the reporting and compliance requirements for Medicaid, including many commercial Medicaid programs.

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EIGHT BEST PRACTICES FOR INSURANCE BILLING FOR COLLEGE HEALTH PROGRAMS

With the possibility of a “[safety and welfare of patient exception](#)” that may be unique to College Health Programs, the general best practices for insurance billing for College Health Programs are the same as those that would apply to all health care providers. In our literature review, we found the following points of advice would apply to College Health Programs.

1. Carefully adhere to all requirements in commercial insurer participating provider agreements.

Retain internal staff and/or external consultants and billing services to assure all requirements for each of the participating provider agreements are fully understood and complied with by your College Health Program. Creating and following a voluntary compliance plan (refer to the “Office of Inspector General Compliance Program for Individual and Small Group Physician Practices”)⁴⁵ is also important if the College Health Program will be billing Medicare or Medicaid.

In entering into participating provider agreements, it is important to fully disclose any requirements that will be unique to your College Health Program. For example, it may be necessary to note that students’ medical records must be maintained by the College Health Program under the Family Education Rights and Privacy Act, yet all the technical requirements for the Health Insurance Portability and Accountability Act will still be fulfilled.

If the College Health Program is in a state jurisdiction where an always-secondary payor position is allowed for SAHF, it is our view that including notice of intent to use this arrangement should be documented in the negotiations for commercial participating provider agreements, and/or included as a notation in the agreements. As noted below, a formal plan document for SAHF is also required.

2. Retain billing consultants and legal counsel to assess and understand the regulatory environment.

Fully comprehending both federal and state regulatory environments for insurance billing is a best practice. Having access to billing consultants and legal counsel with expertise in insurance regulatory law, and the specific requirements for the state jurisdiction in which the College Health Program is located, is essential.

3. Have the same fee schedule for all patients.

An “OIG Advisory Opinion” from January 2008 fully shows the complexity for determining the permissibility of a prompt pay discount.⁴⁶ A cash discount or other form of “dual fee” schedule is probably not worth the trouble, since the amount of the discount probably cannot be greater than the fair market value of the administrative cost for billing and the time value of money for immediate payment. One billing consultant succinctly advises the following.

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“. . . strike the word ‘cash discount’ from your vocabulary. You do not have two fees – one for cash and one for insurance. You may, however, offer a TOS [time of service] discount for prompt payments for services rendered that day . . . the question of how much discount is too much is the subject of much rumor and fuzzy logic.”⁴⁷

If a College Health Program offers a service without any cost (e.g., flu shots), it should not also bill insurance for that service to other students (e.g., billing a service to students covered by a SHIBP for a service that is free to all other students, even though it might be covered by the plan).

As previously noted, we are only aware of one state ([Texas](#)) that specifically allows health care providers to offer a free or discounted service to uninsured individuals without having to complete an ability-to-pay or charity care documentation process.

4. Make sure charges from the College Health Program to the SHIBP for services, supplies, or administrative costs are not in excess of fair market value.

Since students covered by the SHIBP will often have either benefit incentives and/or referral requirements for seeking care at the College Health Program, it is arguable that SHIBP covered students should have the lowest cost of care (i.e., lowest cost fee schedule) compared to students covered by other commercial insurers with which the College Health Program is an in-network participating provider. In no event should the charges to the SHIBP be greater than the average reimbursement levels of major commercial insurers. This is likely to be what a regulatory agency or court would use to determine what constitutes fair market value in assessing the fee schedule for the SHIBP.⁴⁸

This standard for SHIBP charges not exceeding fair market value becomes particularly important when (1) funding for SHIBP claims at the College Health Program is based on a capitation that is solely determined by the college (i.e., the portion of the cost of the SHIBP is retained by the college and not remitted to the insurance carrier); (2) the college dictates a fee schedule to commercial insurers for reimbursement of claims for its College Health Program as part of a request for proposal process or other contract negotiation; or (3) the claims liability for the College Health Program is self-funded or directly contracted to a health care provider, and the college can solely determine the cost of the claims liability.

From the broadest perspective, it is a best practice for a College Health Program to comply with the standards for health insurance endorsed by the ACHA, which, regarding this specific recommendation, would focus on compliance with Standards III and IV respectively.

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"Standard III: The institution acknowledges it has a fiduciary responsibility to manage student health insurance programs in the best interest of students covered by the programs.

Standard IV: The student health insurance program is annually reviewed to assure it is in full compliance with all applicable federal and state statutes and regulations."⁴⁹

When a College Health Program adopts insurance billing, the fiduciary responsibility requirement in ACHA's insurance standards would also suggest that careful consideration be given to self-funding (assuming it is permissible in the state jurisdiction for the College Health Program) or capitation funding, along with other advanced plan management practices, to mitigate as much of the cost impact as possible for students covered by the SHIBP. More specifically, engaging in insurance billing for just health service medical visits could easily increase the cost of annual per student claims by \$125 to \$250 (assuming 100 percent coverage of health service charges), depending upon the level of utilization (e.g., two visits per year to the health service per student covered by the SHIBP) and the negotiated fee schedule for SHIBP charges.

If adopting insurance billing were to increase SHIBP claim charges by 25 percent under a fully insured program, it might be advisable to consider self-funding for the entire program. After appropriate capitalization for reserves and other costs, it would not be uncommon for self-funding to result in at least a 10 percent cost reduction for the SHIBP. Thus, reducing the cost impact of insurance billing to the SHIBP to a 15 percent cost increase. Another advanced management practice that could help mitigate the cost of insurance billing for the SHIBP includes direct contracting with local health care facilities and providers to eliminate provider network access fees and obtain optimum fee schedules.

5. Ensure accurate coding and maintain updated and proper documentation.

The following is advised from Hofstra University's Master's in Health Law and Policy "Best Practices for Health Care Providers to Avoid Fraud."

"Ensure Accurate Billing

Because insurers and patients place great trust in care providers, Congress mandates severe punishment for false claims. The government exercises broad power in auditing and investigating suspected fraud. To avoid inadvertent fraud, care providers must maintain accurate billing practices to avoid inaccuracies such as overcharges or claims for undocumented or undelivered services.

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Maintain Updated and Proper Documentation

Care providers should maintain accurate records to ensure that future treatments produce the best possible patient outcomes. Accurate records also assist care providers in defending themselves against malpractice suits.

Viewed from the Centers for Medicare and Medicaid Service's perspective, if a practitioner does not document rendered services, the treatment did not take place. Duly, care providers should maintain proper documentation for all delivered services.”⁵⁰

Having accreditation through The Joint Commission or the Accreditation Association for Ambulatory Health Care can be an integral component of a compliance program. Commercial insurer participating provider agreements will also specify compliance with quality assurance measures, such as conformance with standards required under the health plan accreditation of the National Committee for Quality Assurance (NCQA).⁵¹ A College Health Program achieving recognition as a Patient-Centered Medical Home may also be advantageous for obtaining optimal reimbursement rates from payors and assure conformance with participating provider policies.⁵²

6. Have a consistently applied and formally written charity care/ability-to-pay-allowance determination.

For many reasons, a College Health Program may conclude that it is beyond its capabilities to administer an ability-to-pay-allowance determination to reduce charges not covered by students' personal health insurance. Absent the ability to have a secondary payor status for its SAHF, the complexity and burdens of this process may be reason enough for a College Health Program to not engage in insurance billing. This is a particularly important determination, since many students remain dependents of their parents/guardians for tax purposes, and the financial information required would probably necessitate obtaining complete data for income, assets, and expenses from parents/guardians.

An example charity care policy, used by the Mayo Clinic, is provided in [Appendix B](#) for those College Health Programs administrators that may want to implement a charity care/ability-to-pay-allowance policy. The policy should be included as an appendix to a formal plan document for SAHF.

Some medical societies, such as the Medical Association of the State of Alabama, have recently provided cautions for waiving cost sharing charges and have provided recommendations for documenting charity care, noting that the HHS “Roadmap for New Physicians” states the following.

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“The kickback prohibition [Anti-Kickback Statute, 42 U.S.C. § 1320a-7b (b)] applies to all sources of referrals, even patients. For example, where the Medicare and Medicaid programs require patients to pay copays for services, you are generally required to collect that money from your patients. Routinely waiving these copays could implicate the AKS and you may not advertise that you will forgive copayments. However, you are free to waive a copayment if you make an individual determination that the patient cannot afford to pay or if your reasonable collection efforts fail.”⁵³

7. Regardless of whether there is a designated health fee, develop and publish a formal plan document for SAHF.

Especially if a secondary payor position is being taken for SAHF, in our view, a formal plan document is required for coordination of benefits with students’ personal health insurance. As of the date of this report, several public universities and private colleges and universities have adopted formal SAHF plan documents (refer to the [document repository](#) for example SAHF plan documents). It is also important for SAHF to include a complete explanation of the circumstances when a patient may not be billed for a service or supply due to concern for the safety and welfare of the patient (refer to “[A Safety and Welfare of Patient Exception for College Health Programs](#)”).

Even when a secondary payor arrangement is not implemented, or when there is no insurance billing, a plan document for SAHF is recommended to establish the highly important nature of the service the college provides for its students. It is one thing to discontinue or change access to a program in a career center, recreation center, dining service, residence hall, or other student services program. It is far more serious to discontinue or change access to medical or psychological services that are highly regulated under state and federal licenses, and closely linked to the safety and well-being of students. In other words, a plan document for SAHF can be used to reinforce, for all stakeholders, the unique and special requirements that come with providing a College Health Program.

8. Use care in developing program descriptions and terminology.

It is important to not use terms such as “waiving charges,” “discounting charges,” or “free care,” when a College Health Program is engaged in insurance billing. Beyond the simple fact there is no such thing as “free care,” (i.e., there must be a funding source such as tuition and fees, grant funding, or other funding to provide a service), there could be either regulatory concerns and/or compliance concerns with commercial participating provider agreements, if correct and accurate billing language is not used. An example occurred when an insurance department informally asked a private college to not refer to its college health service bridge plan as a “supplemental coverage,” since that term was reserved, exclusively, for Medicare supplemental health insurance plans in that state jurisdiction.

It is provided only to highlight major points that would apply in most state jurisdictions. For example, for audit purposes it may be important to document a fund transfer from a SHIBP under a capitation funding system to a College Health Program for on-campus services. Such detailed and specific requirements are beyond the scope of this paper.

SUMMARY

The following are highlights for this updated publication on insurance billing for College Health Programs.

- The advantages for successful insurance billing for College Health Programs can be compelling. It can result in reduced tuition/fee costs, lower out-of-pocket costs for health care services, and increased awareness of the availability services provided by the College Health Programs. Conversely adopting insurance billing when the circumstances are not favorable can result in increased administrative burdens with nominal improvements in revenue. In the worst-case outcomes, students experience a severe loss of access to care.
- Colleges continue to receive information about insurance billing that likely constitute impermissible practices in most state jurisdictions. Adopting insurance billing without fully understanding the regulatory environment and compliance requirements can result in liability for possible violation of insurance fraud statutes, and/or for noncompliance with insurance participating provider agreements. Given the variability of insurance billing regulation by state jurisdiction, it is essential to consult with legal counsel with expertise in insurance regulatory law specific to the state in which the College Health Program is located.
- While many colleges have achieved long-term success funding a substantial portion of health services operations through insurance billing revenue, the overall results remain highly variable due to numerous and complex environmental factors. Challenges for insurance billing are also common for community health care providers and are a major driver in the trends for consolidation of physician practices and hospital-owned physician groups.
- Federal recognition for the existence of funding systems for College Health Programs as being student administrative health fees (SAHF) may be a contributing factor in more states permitting health fees and general tuition/fees to fund all or some of the charges not covered by students' personal health insurance. Designating SAHF funding as a secondary payor when College Health Program's bill students' insurance has resulted in cost savings for students via reduced tuition/fees without losing access to care because of cost sharing provisions (i.e., copayments, deductibles, and coinsurance) in students' personal insurance. Equity concerns for SAHF can present challenging questions (e.g., extent of coverage for students with high deductible health plans) that are inextricably related to the decision process for considering insurance billing.

CONSIDERING INSURANCE BILLING FOR COLLEGE HEALTH PROGRAMS

- Eight best practices for insurance billing for College Health Programs are identified and explained.
 1. Carefully adhere to all requirements in commercial insurer participating provider agreements.
 2. Retain billing consultants and legal counsel to assess and understand the regulatory environment.
 3. Have the same fee schedule for all patients.
 4. Make sure charges from the College Health Program to the SHIBP for services, supplies, or administrative costs are not in excess of fair market value.
 5. Ensure accurate coding and maintain updated and proper documentation.
 6. Have a consistently applied and formally written charity care/ability-to-pay-allowance determination.
 7. Regardless of whether there is a designated health fee, develop and publish a formal plan document for the student administrative health fee (SAHF).
 8. Use care in developing program descriptions and terminology.

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APPENDIX F

EXAMPLE COMMUNITY HEALTH CENTER SLIDING FEE DISCOUNT PROGRAM



COLLABORATING WITH A COMMUNITY HEALTH CENTER
TO PROVIDE COMPONENTS OF A COLLEGE HEALTH PROGRAM

HRSA Policy 2014-02

Policy Information Notice (PIN) 2014-02 clarifies HRSA's policy regarding the sliding fee discount program (SFDP) at Federally Qualified Health Centers. The purpose of this document is to highlight specific areas from the PIN that have unique implications for special populations. "Special populations" include migrant and seasonal farmworkers, persons experiencing homelessness and residents of public housing. These populations face unique challenges to accessing needed services and warrant special attention when developing the health center's sliding fee discount policies "...so as not to overlook or create additional barriers to care."

HRSA is clear that health centers have the ability to exercise discretion to ensure services remain accessible, stating that "The unique characteristics of target populations (e.g., individuals experiencing homelessness) and service areas (e.g., areas with high cost of living) must be considered in developing policies and supporting operating procedures to ensure that these elements do not become a barrier to care. The PIN states, "Health centers retain flexibility in establishing the related operating procedures to minimize barriers to care."

Policies must be the same for all patients, regardless of population and there can be no discounts based on anything other than income and family size. Yet it remains important when developing these policies to consider some of the unique circumstances faced by special populations.

Verification of Income

Many agricultural workers and homeless individuals get paid in cash and therefore lack documentation such as pay stubs, tax returns, public benefit letters and bank statements. This makes it difficult to prove their income and qualify for discounted services. To overcome this, many health centers allow alternative documentation such as a letter from an employer or written self-attestation statement.

In cases where documentation such as a check stub is provided, consideration should be given to the fact that agricultural workers are generally not employed year round due to growing seasons, weather and other variables beyond their control. Health centers should make every attempt to determine the real annual income based on these factors, rather than automatically multiplying by twelve months the current amount being earned, which would likely disqualify many from receiving the discounts. It is up to the center to define what documentation is required and how it is annualized for income determination.

Definition of "Family"

Because of the mobile nature of their work and lifestyle, which is tied to crops and seasons, the living arrangements of many farmworkers don't fall within the typical definition of "family." For example, crews of men may travel and live together while their wives and families remain at home. Or multiple families may travel and live together under one roof. Or extended families may live and travel together, including grandparents, aunts, uncles and cousins, etc. Health centers should consider whether the definition they are using of "Family" adequately reflects the reality of their patient's living arrangements.

The PIN states, "It is important that the eligibility determination process be conducted in an efficient, respectful, and culturally appropriate manner to assure that administrative operating procedures for such determinations do not themselves present a barrier to care." In the Q&A posted on HRSA's web site after the release of the PIN, it states health centers "Can include as part of "family size" persons who are not living with the patient but who are largely dependent on the patient's income."

Eligibility Re-Determination

The PIN states, "Health centers may establish and implement streamlined SFDS patient eligibility renewal/review procedures that are separate from the initial sliding fee discount screening." This is particularly important for special populations for whom producing paperwork one time can be a challenge they may not be able repeat annually or more often.

Nominal Fees

Health centers must provide a full discount for individuals and families with annual incomes at or below 100 percent of the federal poverty line. The majority of patients that belong to special populations will fall into this category. Health centers can adopt a nominal charge for these patients as long as it does not impede access to their services due to inability to pay. The PIN states that, "nominal charges must be considered nominal from the perspective of the patient," in a footnote, suggesting health centers seek input from patient board members, survey, advisory committees and or copays associated with Medicare and Medicaid to assist in determining what patients would consider nominal.

In October 2014, The National Healthcare for the Homeless Council (NHCHC) issued a policy advisory discouraging health centers from charging patients below 100% of poverty a nominal fee so as not to create a disincentive to accessing needed services. It cites "severe disparities in morbidity and mortality that merit additional efforts to increase the frequency and intensity of services," going on to say that, "in a survey of homeless persons conducted by the National Consumer Advisory Board, those directly experiencing homelessness identified not being able to pay for health services as the largest barrier to obtaining health care." Furthermore, the advisory suggests that "attempts to collect nominal fees are likely to be cost ineffective for provider agencies."

Waiving Fees

The NHCHC advisory quotes The Code of Medical Ethics of the American Medical Association, which states that, "when a copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment." If health centers opt to charge patients at or below poverty a nominal fee, policies should outline under what circumstances those fees will be waived.

Collections

PIN 2014-02 states, "The Health Center Program statute requires health centers to make every reasonable effort to secure from patients payment for services in accordance with such schedules. In balancing the statutory requirement of maximizing revenue with ensuring that no patient is denied

services based on inability to pay, the applicable definition of “reasonable” effort may vary depending on elements unique to the individual health center, such as the target population.” It is up to the board to define what is “reasonable” for their particular target population and when it’s acceptable to write off charges.

Board Authority

Responsibility for reviewing and approving policies around the sliding fee discount schedule annually rests with the health center board of directors. Board members need to take this responsibility very seriously since it can determine whether or not members of special populations and others below the poverty line are able to afford their services and maintain access to badly needed care. Vigilance around this issue is required in order to ensure that all policies around the sliding fee discount program are “Effective in addressing financial barriers to care.”

For all these reasons it’s important that health centers, especially those receiving special populations funding, have adequate representation from those populations on their board to ensure policies that are culturally appropriate and sensitive to the unique barriers they face.

The following pages provide examples of alternative forms used by community health centers to determine patient income.

APPLICATION FOR DISCOUNT SERVICES SLIDING FEE SCHEDULE

PATIENT NAME _____ HOME/_____
 CELL NUMBER _____

I have been given the opportunity to apply for the BRCHS discount services sliding fee schedule, and I DO NOT WISH TO APPLY FOR THE BRCHS DISCOUNT SERVICES SLIDING FEE PROGRAM AT THIS TIME.

Patient Signature _____ Date _____

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical, behavioral health, and/or dental needs. This information will not be used to withhold or deny services to you.

- | | |
|--|--|
| 1. Are you covered under Medicaid, Medicare and/or any other insurance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. If you have private insurance, what is your annual deductible, per family member? | \$ _____ |
| 3. Have you or your dependents ever applied for or been denied for Medicaid or Medicare? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Would you like to apply or re-apply for Medicaid today? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Are you unemployed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Are you too sick to work or are you disabled? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please include yourself, your spouse/partner and all dependents living in the home below:

Name	Date of Birth	Relationship to Head of House	Insurance or Medicaid?
		Head of Household	Yes or No
			Yes or No

INCOME VERIFICATION

Please enter your **gross income** (the \$ amount received before taxes are taken out). Household income includes **everyone** in the home. Proof of income includes: most recent tax return, check stubs, bank verification, a letter from the employer stating wages earned or proof of unemployment.

If there is no income to report, or if you do not want to comply with documentation requirements, you must complete the reverse side of this application.

HOW ARE YOU PAID? AMOUNT? CIRCLE ONE?

Work Wages	S	Weekly /Bi weekly /Other	Office Use Only Staff Signature: _____ Verifies Wages are calculated in PM System Date: _____
Cash Wages	S	Weekly /Bi weekly /Other	
Disability	S	Weekly /Bi weekly /Other	
Social Security	S	Weekly /Bi weekly /Other	
Unemployment	S	Weekly /Bi weekly /Other	
Worker's Comp	S	Weekly /Bi weekly /Other	
Child Support	S	Weekly /Bi weekly /Other	
Other Income	S	Weekly /Bi weekly /Other	

PLEASE REFER TO THE CURRENT BRCHS SLIDING FEE DISCOUNT SLIDE SCHEDULE

PATIENT ACKNOWLEDGEMENT STATEMENT

I certify that the information provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance coverage, I will contact/notify the facility. I understand that I will be financially responsible for all or a portion of my care and that I will be asked to submit payment at the time of service. I authorize the release of any information necessary to establish my family's eligibility for discounted services and I give my consent to release my information to Pharmaceutical Companies for auditing purposes only for any Bulk Medication Patient Assistance Programs of which I may enrolled.

Patient Signature _____ Date _____

Declination Statement (for Patient's Who Do Not Want to Comply with Sliding Scale Requirements)

Because you do not wish to apply or comply with the requirements to apply for our sliding scale discount, you are choosing to be a self pay patient. This means that you will pay **\$75.00** up front at the time of service and you will be responsible for any and all balances due after the provider's charges for your visit are entered. You will also be responsible for any lab and/or x-ray charges for today's visit. Any discount for office charges or lab charges are not applicable and you will not be allowed to receive a discount for these charges in the event that a future sliding scale application is completed.

Patient Signature _____ Date _____

COMPLETE BELOW FOR Self-Declaration of Income

Please complete the information below only ***if you have no other way to document your income***. All of the boxes below must be checked and all the questions answered. Failure to complete this information will result in denial of your application for a sliding scale discount.

- I get paid in cash.
- I do not get pay checks.
- I do not get pay stubs.
- I cannot get a letter from my employer. Explain why: _____

My cash income is \$ _____ How often?: Weekly, Bi-Weekly, Monthly,

Other: _____

Current Employer: _____

Patient Certification Statement

I certify that I have no other way to document my income and that all of the above information is accurate. I understand that this information is to be used to determine eligibility for the BRCHS Sliding Fee Discount Schedule. I understand that BRCHS officials may verify information on this form.

Patient Signature _____ Date _____

Employee Certification Statement

I certify that I asked the applicant/recipient about all the sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me.

Employee Signature _____ Date _____

SLIDING FEE SCALE PROGRAM

SELF DECLARATION OF INCOME

I, _____ certify that I am self-employed or have worked odd jobs for cash, for the last _____ months/years.

My average monthly income is \$_____. I have no records nor have I filed Income Taxes.

Generally, the type of work I do is _____. If you need to verify this information you may contact the following person for a reference:

Name: _____

Address: _____

City: _____

Phone Number: _____

I certify that the information listed above is true and correct to the best of my knowledge, I understand that in accordance with SECT.817.50, of the Florida State Statute, providing false information to defraud a health care provider for the purpose of obtaining goods or services is a MISDEMEANOR in the second degree.

Applicant's Signature

Date

Self-Declaration of Income-English

ATTESTATION/SELF DECLARATION FORM

Parent/Legal Guardian or Patient Name: _____ MR # _____

First

Middle

Last

Address _____
Street _____ City _____

State _____ Zip _____

Gender _____ M _____ F _____

DOB _____

Please place a check mark under the amount of your annual household income range.

\$0 -	\$11,491	\$15,511	\$19,531	\$23,550	\$27,571	\$31,591	\$35,611	\$39,631	\$43,651	\$47,671	\$51,691
\$11,490	\$15,510	\$19,530	\$23,550	\$27,570	\$31,590	\$35,610	\$39,630	\$43,650	\$47,670	\$51,690	over

Number of people in your household: _____

Sliding Fee Schedule One Time Program Eligibility, please check what applies:

I am not interested in disclosing my financial information, therefore I acknowledge my family and I are not eligible for the sliding fee discount program.

I presently do not have any documentation to verify my income; the reasons are (mark all that apply):

I get paid in cash

I do not get paychecks or pay stubs

I did not file a tax return last year

I cannot get a letter from my employer

Other, Please explain _____

I certify that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for the _____ Community Health Center's sliding fee discount program. I understand that the Health Center may verify information on this form and on my next visit I need to bring in valid documentation to substantiate the above information. I also understand that if I intentionally misrepresent my family's income, I will not be eligible to receive services at a discounted rate in the future.

Signature of Patient/Parent/Legal Guardian _____ Date _____

For Office Use ONLY:

Qualifies for _____ % Discount Does not qualify because _____

Date of Determination _____ Employee Signature _____

SUPPORT FORM

Instructions: Please check the box(es) that apply and fill in name(s) and date(s), then sign form and give back to applicant.

To Whom It May Concern:

I, the undersigned, verify that I [give loan] money to _____
(check one) _____ (name of applicant)
to help with living expenses each month. In the month of _____, 20____ I [gave loaned]
(check one) _____
the amount of \$_____.

Check all that apply:

- I [gave loaned] this money directly to the named applicant to help pay household expenses.
(check one)
- I pay this money directly to the company(ies) to cover expenses for the named applicant's household.
- I will continue to do this each month.
- I will not continue to do this. I am only helping temporarily or until _____.

Name of Person Helping Household (**PLEASE PRINT**)

Signature of Person Helping Household

Date

Address: _____
Number & Street/PO Box _____ City _____ State _____ Zip _____

Contact Number: (_____) _____ - _____

VERIFICATION OF EARNINGS FORM

Dear Employer:

An employee of your company has applied for the Access Assistance (Discount Program) at Access Family Health Services, Inc. Please complete this form and return it to the employee. Thank you for your cooperation.

Name of Employee: _____

Address: _____
Number & Street/PO Box _____ City _____ State _____ Zip _____

Social Security Number: _____ - _____ - _____

It is hereby certified that the individual named above is employed by the undersigned, and that the following wages and hours represent a normal rate of this individual.

Number of hours worked per week (average) _____

Average Gross Weekly Income \$ _____

Signature of Employer Representative _____

Name of Employer: _____

Address: _____
Number & Street/PO Box _____ City _____ State _____ Zip _____

Telephone Number: (_____) _____ - _____

Does employee have health insurance coverage? Yes No

PERMISSION TO RELEASE WAGE/INSURANCE INFORMATION:

Signature

Date

APPLICATION FOR DISCOUNT SERVICES SLIDING FEE SCHEDULE

PATIENT NAME _____ HOME/_____
 CELL NUMBER _____

I have been given the opportunity to apply for the BRCHS discount services sliding fee schedule, and I DO NOT WISH TO APPLY FOR THE BRCHS DISCOUNT SERVICES SLIDING FEE PROGRAM AT THIS TIME.

Patient Signature _____ Date _____

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical, behavioral health, and/or dental needs. This information will not be used to withhold or deny services to you.

- | | |
|--|--|
| 1. Are you covered under Medicaid, Medicare and/or any other insurance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. If you have private insurance, what is your annual deductible, per family member? | \$ _____ |
| 3. Have you or your dependents ever applied for or been denied for Medicaid or Medicare? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Would you like to apply or re-apply for Medicaid today? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Are you unemployed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Are you too sick to work or are you disabled? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please include yourself, your spouse/partner and all dependents living in the home below:

Name	Date of Birth	Relationship to Head of House	Insurance or Medicaid?
		Head of Household	Yes or No
			Yes or No

INCOME VERIFICATION

Please enter your **gross income** (the \$ amount received before taxes are taken out). Household income includes **everyone** in the home. Proof of income includes: most recent tax return, check stubs, bank verification, a letter from the employer stating wages earned or proof of unemployment.

If there is no income to report, or if you do not want to comply with documentation requirements, you must complete the reverse side of this application.

HOW ARE YOU PAID? AMOUNT? CIRCLE ONE?

Work Wages	S	Weekly /Bi weekly /Other	Office Use Only Staff Signature: _____ Verifies Wages are calculated in PM System Date: _____
Cash Wages	S	Weekly /Bi weekly /Other	
Disability	S	Weekly /Bi weekly /Other	
Social Security	S	Weekly /Bi weekly /Other	
Unemployment	S	Weekly /Bi weekly /Other	
Worker's Comp	S	Weekly /Bi weekly /Other	
Child Support	S	Weekly /Bi weekly /Other	
Other Income	S	Weekly /Bi weekly /Other	

Patient Advised of Discount Rate: _____ Initials _____

Audit Stamp: _____

PLEASE REFER TO THE CURRENT BRCHS SLIDING FEE DISCOUNT SLIDE SCHEDULE

PATIENT ACKNOWLEDGEMENT STATEMENT

I certify that the information provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance coverage, I will contact/notify the facility. I understand that I will be financially responsible for all or a portion of my care and that I will be asked to submit payment at the time of service. I authorize the release of any information necessary to establish my family's eligibility for discounted services and I give my consent to release my information to Pharmaceutical Companies for auditing purposes only for any Bulk Medication Patient Assistance Programs of which I may enrolled.

Patient Signature _____ Date _____

Declination Statement (for Patient's Who Do Not Want to Comply with Sliding Scale Requirements)

Because you do not wish to apply or comply with the requirements to apply for our sliding scale discount, you are choosing to be a self pay patient. This means that you will pay **\$75.00** up front at the time of service and you will be responsible for any and all balances due after the provider's charges for your visit are entered. You will also be responsible for any lab and/or x-ray charges for today's visit. Any discount for office charges or lab charges are not applicable and you will not be allowed to receive a discount for these charges in the event that a future sliding scale application is completed.

Patient Signature _____ Date _____

COMPLETE BELOW FOR Self-Declaration of Income

Please complete the information below only ***if you have no other way to document your income***. All of the boxes below must be checked and all the questions answered. Failure to complete this information will result in denial of your application for a sliding scale discount.

- I get paid in cash.
- I do not get pay checks.
- I do not get pay stubs.
- I cannot get a letter from my employer. Explain why: _____

My cash income is \$ _____ How often?: Weekly, Bi-Weekly, Monthly,

Other: _____

Current Employer: _____

Patient Certification Statement

I certify that I have no other way to document my income and that all of the above information is accurate. I understand that this information is to be used to determine eligibility for the BRCHS Sliding Fee Discount Schedule. I understand that BRCHS officials may verify information on this form.

Patient Signature _____ Date _____

Employee Certification Statement

I certify that I asked the applicant/recipient about all the sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me.

Employee Signature _____ Date _____

APPENDIX G

FAQ FOR FITCHBURG STATE UNIVERSITY
PARTNERSHIP WITH COMMUNITY HEALTH CONNECTIONS



COLLABORATING WITH A COMMUNITY HEALTH CENTER
TO PROVIDE COMPONENTS OF A COLLEGE HEALTH PROGRAM

Questions and Answers about Health Services Transition

[EXPAND ALL](#) | [COLLAPSE ALL](#)

- Why is Fitchburg State University transitioning to a partnership with Community Health Connections?

Today, driven by a better understanding of health and its impact on successful learning, many institutions of higher education feel the need to provide increased health services. Demands on health services are more complex than ever and increasing numbers of students are arriving on campus with health needs.

Given this reality, the university over the last couple of years has been exploring how to best strengthen its services for the benefit of our students. Expanded services, of course, are costly. To provide more services, health centers need more staff with a wider range of expertise as well as more space to provide care. Unfortunately, the university has neither the resources nor the space to expand its health services.

With our mission grounded in student access and affordability, we felt that partnering with an already established and conveniently located health provider would provide the greatest overall value to our student body.

As we have considered how to provide the best comprehensive medical health care for our students, we consulted with national experts. This process led us to develop a partnership with a highly respected, federally qualified health center that has two locations very close to our campus, Community Health Connections. Many of our students and employees already use one of their four locations in our area.

- Why would this change happen now, when we are in the middle of a global pandemic?

We have been thinking about how to expand our array of health services for a few years. Due to increasing demand for a broader array of services and because of the seen and unforeseen challenges posed by the current pandemic, the university's options were to partner with a strong health care provider like CHC or to initiate third-party billing so that we could expand services. The analysis of the two choices, and the experiences of many of our sister institutions, demonstrated that creating a partnership with CHC was the best option for our students, our community, and the institution.

Making the move at this time was prompted by the retirement of two of the four staff in Health Services early this summer. When we received news of the impending retirement of the director, in particular, we knew we needed to act swiftly to ensure that Fitchburg State students have access to excellent medical care.

Some advantages of CHC:

- CHC's mission is about access to health care, and they are particularly adept at providing low income, underinsured, or uninsured people with health care.
- They provide not only medical care, but also dentistry, optometry, behavioral health, and even podiatry.
- CHC offers evening and weekend hours that we were not able to provide.
- Two sites are conveniently located adjacent to campus.



[FAQ](#) as of January 26, 2021

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— Why Community Health Connections?

Community Health Connections (CHC) is a federally qualified health care center that is as passionate about access to health care as we are about access to education. Their mission is to provide quality comprehensive care to underinsured and uninsured people. The ACTION Center, located in the Market Basket shopping center on Water Street, is within walking distance. There, students will have access to medical, dental, and behavioral health (including mental health providers who can prescribe medication). The Nichols Road location is about a mile from campus, and includes the services mentioned above, along with optometry and podiatry.

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— But what about having to use insurance?

It is true that students will have to use their student health insurance or other insurance to access care.

Student Health Insurance is mandated by the state, and none of those monies have ever gone to Fitchburg State University. It goes to Blue Cross Blue Shield to pay for the care at providers such as Community Health Connections.

For our students who are underinsured, connecting with CHC is a strong benefit. They have staff dedicated to providing **enrollment assistance** to help find the right health insurance plan that fits your needs. In addition, Community Health Connections is committed to providing services regardless of the patient's ability to pay. Access to the **Sliding Fee Discount Program** will allow for out of pocket costs to be as low as \$15 for a primary care visit. If you have questions about your insurance coverage for CHC services, call 978-878-8100. CHC's Certified Application Counselors are happy to help you and your family with your health insurance needs.

For all students: if we had continued offering campus-based health services, we would have moved to using third-party billing (accessing insurance to help pay for and expand services), similarly to many institutions in the State University System and outside of it.

— Has anything changed about how we will be responding to medical emergencies?

No. We will continue to use University Police as the point of contact, and engage with the local 911 system.

— Why do I have to switch my primary care physician to access medical care?

Unlike an urgent care center or walk-in clinics, CHC is a Family Practice, which offers the benefit of coordinated health care. In order to access the services at CHC and benefit from the family practitioners, those accessing medical care must declare their primary care physician at CHC. Luckily, in Massachusetts, this is a very easy process. See below.

Do note that switching the PCP only applies to medical care. The other areas (dentistry, optometry, etc.) do not require a switch.

How to Change Your PCP to a CHC Provider

- Call the customer service number on the back of your insurance card and ask about transferring to CHC.
 - You can switch back during the summer, if you prefer. Some plans also make special arrangements to transfer care when students are away from their service area.
 - Review your insurance plan; if there are limitations, you may want to consider enrolling in the school-sponsored **Student Health Insurance Plan**.
-

— How will I access my Fitchburg State medical record?

You will access your medical record in the same way. See this **web page** for more information.

Existing medical records will be stored in a secured location and accessed only by designated staff. Confidentiality of these records will be maintained.

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— Will student athletes continue to receive medical care?

Yes, the team doctor and trainers are not associated with Student Health Services.

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— Will we still have a flu clinic on campus?

Yes! And we are under discussion about other types of clinics to bring to campus.

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— Will Pet Therapy continue?

— How do I get to the CHC locations in Fitchburg if I don't have a car?

There are several ways to travel to the CHC locations.

- Take the Shuttle to the MART/T Station and walk a couple of blocks across the Water Street bridge to the ACTION Center
- The ACTION Center is accessible by the #5 bus (free with your student ID)
- The Nichols Road location is accessible by the #6 bus (free with your student ID)

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— Can I get a COVID test at Community Health Connections if I am symptomatic?

Yes. The ACTION Center next to the Market Basket on Water Street has daily COVID testing Monday-Friday, 9 am - 4 pm. No referral necessary. Follow the signs for testing. Please bring your photo ID and your insurance card. Contact 978-878-8100 for more information.

All students have been offered an initial COVID test, and the university will continue with surveillance testing throughout the Fall semester. We do not offer symptomatic testing.

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