Promising Practices #9
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Community Health Center Incubator Programs: Providing State Support to Leverage Federal Dollars

The unprecedented federal investment in community health centers made in health reform legislation passed by Congress this year brings equally unprecedented challenges and opportunities for health center expansion. While all federally qualified health centers (FQHCs) receive base grants through the Section 330 annual federal appropriation, they will need to compete for increased federal funding under health reform. In addition, federal dollars will be available for the establishment of new health centers and those FQHCs without a federal grant and other non-FQHC organizations wishing to receive a federal grant who are best prepared, will get funded. Federal funding is only 18% of health center revenues, and in most states health centers receive state funding for various purposes including operations, uncompensated care, and service expansions. These funds are an essential supplement to their federal grants. Despite that fact, many states have had to make tough budget cuts to essential programs, including health centers due to the continuing state fiscal crisis. However, given the availability of increased federal funding, now is a critical time for states to maintain and even increase their investment in health centers in order to leverage additional federal dollars. One way that states can maximize this opportunity is to invest in health center incubator programs. Incubator programs can strengthen existing health centers to compete once new federal money becomes available and provide a pathway for non-grantees to acquire the FQHC designation and also the federal grant money that goes along with it.

The structure of incubator programs varies greatly state to state, but all begin with a similar concept: to provide state funding for the development of new and expanded FQHCs. In most cases, this includes funding for operations, expanded services, community development and sometimes capital. One common piece of advice that the states with incubator programs expressed was the importance of establishing a strong working relationship with the state health department. This is the department that generally administers the incubator program for the State, and by working effectively with them, health centers and Primary Care Associations (PCAs) can create successful programs that leverage significant federal dollars.

This paper explores health center incubator programs in four states and important lessons learned by the states' PCAs.

Texas FQHC Incubator: Providing Seed Money for Development and Expansion

Overview

During the first year of President George W. Bush's initiative to expand the federal Health Centers program, Texas was unsuccessful in securing funding for many of its New Access Points (NAPs). The Texas Association

of Community Health Centers (TACHC) concluded that with some start-up money from the state for organizational and community development, the health centers could develop successful applications for the next federal grant cycle. They took this idea to the state legislature and made the case for state funding to start the FQHC Incubator Program.

State Legislation

In 2003, the Texas Legislature passed Senate Bill 610 (see Appendix A), which established the FQHC Incubator Program and directed the Department of State Health Services to make grants to establish new or expand existing facilities that could qualify as FQHCs. The intent of the Incubator Program was to provide funding that enhanced eligibility of designated FQHCs for upcoming federal expansion grants and to promote and support new organizations to begin the FQHC development process. The state originally authorized $10 million in discretionary funding to the FQHC Incubator program. This funding was not mandatory and TACHC continues to fight for it each year. In 2010, Texas, like many other states, is making cuts across the board and the Incubator Program is subject to a 50% state wide reduction in spending.

Types of Grants Available

Within the Department of State Health Services, the Texas Primary Care Office currently administers the FQHC Incubator Program and offers open enrollment to any organization which meets the guidelines for funding. There are several different types of funding available for activities related to becoming an FQHC.

- Training and Technical Assistance - funds are awarded for education of board members and staff regarding development and operations of a FQHC.
- Development - funds are awarded for various activities related to assisting organizations in meeting FQHC requirements, ex: health needs assessment and feasibility studies.
- Capital - funds are awarded for renovation/remodeling and equipment, but may *not* be used for new construction.
- Salary - funds are awarded to support the hiring of key administrative staff like CEO, CFO, CMO (if not in place) and the hiring of clinical providers who will increase services and expand access to new patients (these providers must be eligible to bill Medicaid/Medicare).

Requirements

In order to receive the Capital and Salary grant funds, organizations are required to have a consumer board (made up of at least 51% patients) in place at the time of application. Each organization that applies for funds must meet a deliverable that is set forth at the beginning of the grant period and produce documents showing their progress toward such deliverable (e.g.: contract with construction company for renovation of a building; offer letter to hire new clinician). Organizations are expected to demonstrate that they are working towards FQHC status and when the next funding opportunity is available through Health Resources and Services Administration (HRSA) they must apply.

Outcomes

The Incubator Program allowed the number of health center patients served by FQHCs to grow to more than 770,000 Texans in 2007 – a 41% increase since 2003. It also brought more than $40 million a year in renewable, ongoing federal funds to Texas. This expansion would not have been possible without the state-provided seed dollars critical to making new and existing FQHCs more competitive in the grant awards process.

Lessons Learned

- Every state should be working with their Primary Care Office to look at the success rate of FQHC applicants in their state. If this number is low then they have a compelling argument to take to the legislature that start-up funds are essential and will raise the competitiveness of the applications.
- States thinking of developing incubator programs should consider providing resources to the PCA which can provide support and technical assistance to health centers for community development work.
- PCAs should work with the state to establish standard regulations and policies for the incubator program. They may want to consider issuing guidelines on things like a standard application process, reporting requirements, timeframe of contract, and caps on awards.
- PCAs should make sure they have policies in place for how to deal with service-area overlaps, when a new organization is looking to expand into an existing health center's service area.

For more information on Texas FQHC Incubator Program:

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Vermont Health Center Improvement and Development Funds: Growing Both FQHCs and Look-alikes

Overview

After a failed attempt in 2006 to bring a single-payer health care system to the state, the Vermont legislature turned to FQHCs as a way to fortify the state's health care system and the Bi-State Primary Care Association (Bi-State) proposed some initial ideas on how to move forward. Bi-State noted that many look-alikes in Vermont had insufficient data gathering tools which made it difficult to put together competitive 330 grant applications. Recognizing the need, the legislature established a fund for these look-alikes which finances service expansions and improvements for both FQHCs and look-alikes.

State Legislation

House Bill 516 (see Appendix B) was enacted during Vermont's 2005-2006 legislative year, appropriating a pool of approximately $200,000 to be distributed though the Vermont Department of Health (DOH) to look-alikes for "initial capitalization and to establish income sensitized sliding scale fee schedule[s] for patients of these organizations." Because of these development funds, by 2009 all of the state's look-alikes had been able to convert to FQHCs. Unfortunately, as the state no longer had look-alikes, the legislature sought to cut the funding pool down from $110,000 to $10,000. Bi-State responded by documenting the need that still existed for FQHCs and future look-alike development. They also advocated for a broadening of the legislative language, so funds could be distributed not just to establish new health centers, but to establish new programs and service expansions within existing FQHCs. Through its data gathering and advocacy efforts, Bi-State was

able to keep $100,000 in this fund for "federally qualified health center (FQHC) development, service expansion, and uncompensated care."

Requirements

In the original program, look-alikes were required to submit proposals to the DOH detailing the amount of uncompensated care they delivered at their centers as well as a development plan for their center. Funds were granted through a two tiered system, with look-alikes qualifying for the first tier if they could adequately demonstrate completion of a "needs assessment" including stakeholder interest and broad community involvement in their center. Tier 1 allotments were usually around $10,000 per program to get them off the ground. Second tier funds were subsequently distributed to centers that could show documentation of progress on their overall plan, particularly that Tier 1 funds were appropriately expended. These funds were usually distributed in greater amounts, intended for the actual implementation of outlined programs. Currently, under the expanded legislative language, funds are distributed to FQHCs for new projects at the discretion of the DOH's Office of Rural Health and Primary Care.

Outcomes

All look-alikes successfully secured federal funding and are now FQHCs.

Lessons Learned

- Investment in new programs is akin to venture capital. There is a risk involved in that one can never be certain what the exact direction or outcome of the project will be. For this reason, the program has benefitted from distributing funds in its two-tier system, holding centers accountable for their work before distributing substantial funds under the second tier of the program.
- It is important to be aware that progress for upcoming centers can be slow as they rely on the work of volunteers and often experience high rates of turnover. This is something that should be accounted for in developing guidelines for funding these programs
- Knowledge and documentation of the needs of look-alikes and FQHCs and communicating that need to the state legislature are keys to accessing, securing, and retaining health center funds.

For more information on Vermont's Initiative:

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<u>Indiana State Funded Health Centers: Growing the FQHC Model</u>

Overview

In 1995, the Indiana Primary Health Care Association (IPHCA) approached the General Assembly and State Department of Health to grow Community Health Centers in the state. Together they created a state-funded

health center model, similar to the FQHC model. At the time, there were only four FQHCs in the state and they wanted to grow their capacity as well as foster the creation of new health centers.

State Legislation

The Assembly appropriated $2 million for the biennium ($1 million per year) to the State Department of Health (DOH) as a line item in their annual budget for state-funded health centers. Beginning in 1995, this fund grew each year and received a significant boost in 2000 when the State of Indiana received their Tobacco Settlement money which was used to increase the program allotment to $20 million. Unfortunately, this year the program was reduced to $15 million and is subject to review by the General Assembly who will be making budget cuts across the board. DOH works closely with IPHCA to develop a funding strategy; however, the amount that each center receives is left to the discretion of DOH and there is no formula currently in place.

Requirements

To be eligible to receive these funds the center must: be a non-profit or government entity; have a board or advisory committee; demonstrate need in the community; have the ability to bill Medicaid and Medicare; have a Nurse Practitioner or Physician who works at least 32 hours per week. To expand the program across the state, DOH adjusted the board requirement, so that state funded health centers must only have a 30% patient board and there is flexibility for communities to use a hospital board or similar advisory committees to count for this requirement. Also, state funded health centers do not have to be located in Medically Underserved Areas (MUAs).

Outcomes

There was significant growth between 1997- 2000 of state funded health centers, mostly in urban areas. There are now 19 FQHCs in the state and 28 state funded health centers.

Lessons Learned

- It is necessary to develop a formula for distributing funds to the health centers. Currently in Indiana the state uses a rough estimate based on the number of patients and number of uninsured at each center as the basis for distribution, however the PCA would like to see a more standardized method so that each center receives their fair share.
- It is important to build good relationships with state legislators and have a close working partnership with DOH. The IPHCA had difficulty with administrative turn-over in the state government, which requires constant education of new staff regarding the value of health centers and the history and importance of the funding provided by the state.

For more information on Indiana's state funded health centers:

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Iowa Incubator Grants: Supporting New Access Points

Overview

The Iowa/Nebraska Primary Care Association (IA/NEPCA) along with the Iowa Department of Public Health was involved in the creation of the Iowa Community Health Center Incubator Program in 2005. During President George W. Bush's initiative to expand Health Centers program, IA/NEPCA began to look at HRSA application data in the state of Iowa and realized that existing health centers had a better chance of getting funded. They thought if funding was available for health centers to become FQHC look-alikes this would increase their chance of submitting a successful application.

State Legislation

State Senator Jack Hatch from Des Moines, Iowa led the legislative effort, as he had previously worked for INConcertCare (a health center controlled network in Iowa/Nebraska) and understood the value of community health centers. With his strong leadership, the Iowa State Legislature passed HF 825 (see Appendix C) in 2005 appropriating $650,000 to the Iowa Department of Public Health for an "incubation grant program to community health centers." Grants were for a period of two years during which time the health center must apply for FQHC look-alike status. In 2009 with the state facing budget problems, nearly all programs in the state received a cut, including the Incubator program, which was reduced to $500,000. Unfortunately in 2010, even deeper budget cuts were necessary and, the state was forced to eliminate funding for the Incubator program; however, IA/NEPCA is hopeful that the budget situation will improve and the program will be funded again next year.

Requirements

Eligible communities must have submitted a NAP application in the most recent competition from HRSA and received a score of 85 or more on their application. It was designed this way so that the community would be able to demonstrate their readiness to support a health center. In addition, the community had to provide a local match of 25% of the incubator grant. This local contribution ensured the community's willingness to support the health center and many communities obtained this funding through businesses, hospitals, private donors or fundraisers.

If there was more than one eligible applicant applying for incubator grants, then the funds were awarded on a competitive basis: however, to date, there has only been one eligible applicant each year so there was no need for a competitive process. Once the health center receives a NAP award, incubator funding ceases.

Outcomes

Two organizations have received incubator funding since 2005 and one was awarded a NAP grant in 2006. IA/NEPCA was successful in securing the second organization an additional, third year of funding, which was necessary because there had been no opportunities to apply for NAPs since 2007.

Lessons Learned

- It is important to consider sustainability from a community perspective. The two year funding limit put centers at a disadvantage when they were not successful in securing a NAP award during that time

period. Nothing guarantees that a community will get a NAP award so the state must consider how they will support the centers until they are funded.

For more information on Iowa's Incubator Grants:

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***NACHC Mission**:*
To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations

***NACHC Description**:*
Established in 1971, the National Association of Community Health Centers (NACHC) serves as the national voice for America's Health Centers and as an advocate for heath care access for the medically underserved and uninsured.

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Appendix A

S.B. No.610

AN ACT, relating to grants for federally qualified health centers.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1.Chapter 31, Health and Safety Code, is amended by adding Section 31.017 to read as follows:

Sec 31.017. FEDERALLY QUALIFIED HEALTH CENTERS.

(a)The department may make grants to establish new or expand existing facilities that can qualify as federally qualified health centers, as defined by 42 U.S.C. Section 1396d(l)(2)(B), in this state, including:

(1) planning grants;

(2) development grants;

(3)capital improvement grants; and

(4)grants for transitional operating support.

(b)This section expires September 1, 2009.

SECTION 2.This Act takes effect September 1, 2003.

Appendix B

FY 2005-2006 Biennium

Section 277(f) describes the legislative policy intent for the appropriation:

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) LOOK-ALIKES; CAPITALIZATION GRANTS

(a) Funds appropriated in Sec. 263(e)(4) of this act to the department of health shall be expended for the purpose of providing to federally qualified health center (FQHC) look-alikes funds for initial capitalization and to establish an income‗sensitized sliding scale fee schedule for patients of these organizations. In distributing the grants, the department shall consider ensuring the geographic distribution of health centers around the state as well as criteria under federal law. Initial priority shall be given to health centers in Lamoille, Washington, and Windsor/Windham counties, and other counties that demonstrate readiness to achieve look-alike status. The goal shall be to ensure there are FQHC look-alikes in each county in Vermont.

AS PASSED BY HOUSE AND SENATE H.441

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VT LEG 247887.1

(d) Of these Global Commitment funds, $750,000 shall be used to support the Vermont coalition of clinics for the uninsured health care and dental services provided by clinics for uninsured individuals and families and for federally qualified health center (FQHC) development, service expansion, and uncompensated care.

Appendix C

HF825

332 b. For an incubation grant program to community
333 health centers that receive a total score of 85 based
334 on the evaluation criteria of the health resources and
335 services administration of the United States
336 department of health and human services
337 ………………………………………….$ 650,000
3 38 The Iowa department of public health shall select
3 39 qualified applicants eligible under this lettered
3 40 paragraph, and shall approve grants in prorated
3 41 amounts to all such selected qualified applicants
3 42 based on the total amount of funding appropriated. A
3 43 grantee shall meet all federal requirements for a
3 44 federally qualified health center, including
3 45 demonstrating a commitment to serve all populations in
3 46 the grantee's respective medically under served
3 47 community and satisfying the administrative,
3 48 management, governance, service-related, utilization
3 49 of funding, and audit requirements unique to federally
3 50 qualified health centers as provided under section 330
4 1 of the federal Public Health Service Act, as amended,
4 2 and as codified at 42 U.S.C. } 254(b). A grant may be
4 3 approved for a two=year period. However, if a grantee
4 4 is approved as a federally qualified health center
4 5 during the grant period, the grant and accompanying
4 6 funding shall be terminated for the remainder of the
4 7 grant period. If a grantee is not approved as a
4 8 federally qualified health center during the grant
4 9 period, the grantee may apply for a subsequent grant
4 10 under this lettered paragraph on a competitive basis.
4 11 A recipient of a grant under this lettered paragraph
4 12 shall provide a local match of 25 percent of the grant
4 13 funds received.