

To: FQHC/RHC Adult Day Health Care Centers
Those concerned about continued availability of services for elderly and disabled populations

From: Andie Martinez, Associate Director for Special Populations

Date: April 21, 2009

Re: Policy Brief: The Special Contribution of FQHC/RHC operated Adult Day Health Care Centers to the Elderly and Disabled of California

MEMORANDUM

Executive Summary

The Schwarzenegger Administration is proposing to dramatically reduce reimbursement rates to Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Adult Day Health Care (ADHC) centers. FQHC/RHC ADHCs are now subject to a rate reduction from an average Prospective Payment System (PPS) rate of \$160.58 to a flat FFS Medi-Cal rate of \$76.22.

FQHC/RHC ADHCs are reimbursed at enhanced PPS rates to more accurately reflect the cost of providing a medical home for medically complex, low-income individuals, including disabled adults 18 years of age and older, the elderly, and the uninsured. The FQHC/RHC ADHCs PPS reimbursement rates also reflect the higher level of required services resulting in a PPS cost range between \$106 - \$227 per visit, with the average rate for all twelve sites being \$160.58.¹ Currently, stand-alone ADHCs are reimbursed at the FFS Medi-Cal rate of \$76.22 per visit,² which is an arbitrarily constructed rate. However, SB 1755 (Chesbro), passed in 2006, requires the establishment of a cost-based rate for ADHCs and the cost analysis is currently underway.

There are over 650 ADHCs in California; five FQHC ADHC providers operate eleven of the sites and one site is operated by an RHC. Combined, the FQHC/RHC ADHCs serve approximately 1,600 participants.

The Administration projects that all of the FQHC/RHC ADHCs will remain open and the savings generated from reducing their rates will be approximately \$2.5 million annually. However, contrary to the Administration's assertion, the proposal to dramatically reduce reimbursement rates to FQHC/RHC ADHCs will result in many of these facilities ceasing operations. The comprehensive, high quality, and integrated care provided at these health

¹ Figure based on weighted average using clinics average daily attendance.

² An ADHC visit constitutes a minimum of 4 hours per day.

centers cannot be furnished at the reduced rate. The closure of these facilities will result in approximately 240 FQHC/RHC ADHC participants moving into Skilled Nursing Facilities (SNF) within three months. This move will cost the State an estimated \$6.5 million (\$13.4 million³ with the federal match) in the first year, a sum far greater than the anticipated \$2.5 million (\$5 million with the federal match) in cost savings estimated from aligning all ADHC rates.

The PPS reimbursement that FQHC/RHC ADHCs currently receive is warranted because they provide a comprehensive service to complex patients. Participants at FQHC/RHC ADHCs tend to be referred to the ADHC by the FQHC/RHC primary care provider because of the intricate nature of their case, which often times includes dementia, obesity, and other complicated medical conditions that require more one on one care. Furthermore, by federal mandate, FQHC/RHCs operate in the most underserved areas and serve the most underserved patients of the State. The comprehensive and preventive nature of their services results in significant government savings in overall medical and long term care costs.

In May 2001, the Davis Administration advanced a similar proposal as a cost containment measure. The proposal was later withdrawn. While no one can be certain why the proposal was withdrawn, at the time AltaMed Health Services Corporation, the largest FQHC ADHC in the state, had published an analysis of the different levels of services required of a FQHC ADHC as opposed to an ADHC and the analysis provided objective information as to the different level of services the two are required to offer, in turn explaining the different rate structures.

Impact to FQHC/RHC ADHCs

The impact of aligning the reimbursement rates will be financially devastating to FQHC/RHC ADHC providers and participants. The cost of providing care to the medically complex participants who attend FQHC/RHC ADHCs far exceeds the State's proposed reimbursement. According to a CPCA-conducted survey in February 2009, seven of the twelve sites will close if the rate is reduced. They will not be able to sustain operations due to the increasing transportation, staff, facility, and supply costs. In some counties, if the FQHC ADHC closes there are no other ADHC options in the county.

Transportation costs are identified by the FQHC ADHCs in less urban areas as one of the main financial barriers to remaining open. In these areas there is no reliable, safe public transit. For Marin Adult Day Health Care, for example, transportation can total \$80 per day per participant, and with the reduced rate, continuing operation of the ADHC will be financially unsustainable. Adding to the cost is the requirement that participants not be in transit for more than sixty minutes, which limits the number of participants that can be transported at one time. If the ADHC in Marin closes, Marin County will not have an ADHC option for needy participants.

The FQHC ADHCs in Sonoma and Santa Cruz Counties, in addition to Marin, are the only ADHCs in the county. The ADHCs in Sonoma (Southwest Adult Day Services) and Santa Cruz (Elderday) anticipate closing if the rates are reduced. Their closure will result in 160

³ Figure based on the 2007-08 California nursing home reimbursement rate of \$152.48 /day.

participants losing access to care. For example, if Southwest Adult Day Services closes the next closest ADHC is 50 miles away. The participants that will be turned away will be left with costly options for care, including nursing homes, skilled nursing facilities or emergency rooms. The State has not included these new high costs in their savings estimate.

For the five FQHC ADHCs that are able to remain open staffing will be drastically reduced, resulting in their inability to care for the most medically challenging patients. The participants at these centers require significant amounts of one on one attention from skilled nurses and social workers. In addition to the required skilled nursing services, the FQHC ADHCs are also able to provide more intensive nursing services to ensure the participants remain relatively independent and out of the emergency room because of the enhanced reimbursement rate.

For example, skilled nurses at Lifelong Medical Care provide extensive, and much needed, medication management given that the average FQHC ADHC participant has five different medical or mental health diagnoses and requires seven to eight medications to function.⁴ Consequently, the medication management must be significant to avoid emergency room visits or worse. This management function includes supervising the patient filling his/her mediset, medication reminders, communicating with physicians regarding medication and dose management, calling in new prescriptions and refills on behalf of the participant, training patients in self-administration, educating the participant and the family about medications, arranging for special medication packaging at pharmacies, and reconciling the participant/caregiver medication lists with the physicians medication lists. All of these services are associated with the relatively simple and quick task of taking a medication. Were it not for these expanded services, the health of many of LifeLong's participants with life-threatening conditions such as congestive heart failure, diabetes, and hypertension would become much less stable, resulting in poor health outcomes, emergency room visits, and hospitalizations. With a reduced rate, Lifelong will be forced to cut back the number of skilled nursing staff and will not be able to accept the most medically complicated participants due to the lack of staffing resources required to provide the appropriate care.

As the example above highlights, the enhanced Medi-Cal reimbursement rates that FQHC/RHC ADHCs receive reflect the actual cost of delivering care. Moreover, the comprehensive preventive nature of the care is saving long term medical costs for the State. Evidence shows that FQHC patients have lower overall medical costs,^{5,6} fewer emergency visits and fewer inpatient days than non-FQHC patients.^{7, 8} Additionally, the average participant at an FQHC/RHC ADHC visits the center three days a week, thus the average cost

4 CPCA FQHC ADHC Survey, February 4, 2009

5 National Association of Community Health Centers, The Robert Graham Centers, and Capital Link. "Access Granted: the Primary Care Payoff," 2007, available at www.cq.com/flatfiles/editorialFiles/healthBeat/reference/NACHCReport.pdf [accessed February 2, 2009].

6 Proser, M. *Quality and Cost Effective Care at Community Health Centers*. National Conference of State Legislators, 2004 Health Care Series. February 11, 2004.

7 Falik, et al., "Comparative Effectiveness of Health Centers as Regular Source of Care." (2006) *Journal of Ambulatory Care Management*. 29(1): 24-35.

8 Duggar BC, Et Al. *Utilization of Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers*. Center for Health Policy Studies, 1994.

per participant during the month is between \$1279 and \$2734.⁹ Were these same participants to attend SNFs, the average cost of their care would escalate to \$4,574 per month.¹⁰ The FQHC/RHC ADHC monthly visits are half the cost of a nursing home stay. FQHC/RHC ADHC staff estimate that if they were to lose their PPS rate and subsequently close 123 participants would be forced to seek care in a SNF immediately, and 118 would move into a SNF in the following three months.¹¹ If 241 participants were to be placed in SNFs this year it would result in an approximately \$6.7 million cost to the State (\$13.4 million with the federal match). Thus, the projected \$2.5 million savings (\$5 million with the federal match) would be decimated by the placement of a mere 241 of the 1,600 FQHC ADHC participants in SNFs.

This figure does not even account for those participants who would refrain from seeking care in another ADHC (if there is one within their transportation range), and who would eventually turn to the emergency room for what could have been prevented at the FQHC ADHC. The participants that would be placed in SNFs immediately or in the short term are the same participants that could continue to lead satisfying lives in their communities if they are given the opportunity. FQHC/RHC ADHCs provide this opportunity because of the direct linkage to primary care.

Strengths of FQHC/RHC ADHCs

FQHC/RHC ADHCs are entitled to the PPS reimbursement for their work. The work they do is unique and qualitatively different from stand-alone ADHCs, and their reimbursement rate is reflective of the additional challenges FQHC/RHC ADHCs accept.

1. Rigorous Federal Application/Review Process. FQHC/RHC ADHCs must meet a strict set of requirements and be approved by the federal government in addition to meeting state licensing standards.¹² Non-FQHC/RHC ADHCs are not required to meet the same level of rigorous standards. While all ADHCs must provide therapeutic activities, personal assistance, meals, social services, health-related services, medication management, transportation, personal care services, and rehabilitation therapy, FQHC ADHCs must provide these services in addition to meeting a number of other requirements. For FQHC ADHCs, additional requirements include serving the uninsured, offering a sliding fee scale, providing 24 hour call and after hour coverage, operating as a nonprofit with a Board of Directors comprised of 51 percent consumers, providing primary and preventive health care services, including enabling services such as language translation. FQHC ADHCs are well-equipped to meet the needs of their diverse patient population. FQHC /RHC ADHCs report that over 64 percent of staff are multilingual, and all centers reported that they *always* are able to meet the language needs of the participants with full or part-time staff.¹³ Another enabling service required of FQHC ADHCs is providing directly or arranging dental, mental health and other specialty care. This service is facilitated by the direct connection to primary health care at the FQHC.

⁹ Figures calculated using the range of PPS rates for FQHC/RHC ADHCs.

¹⁰ Figure based on the 2007-08 California nursing home reimbursement rate of \$152.48 /day.

¹¹ CPCA FQHC ADHC Survey, February 4, 2009

¹² See Attachment 1

¹³ CPCA FQHC ADHC Survey, February 4, 2009

Perhaps most importantly, FQHC ADHCs must be located in a Medically Underserved Area (MUA), Health Professional Shortage Area (HPSA), or in a location where they are serving a Medically Underserved Population (MUP). RHC ADHCs must be located in a MUA, HPSA, or Governor Designated Shortage Area. FQHC/RHC ADHCs are located in areas of the state with the greatest unmet need. If these centers close because of the dramatic reduction in reimbursement rates, there will be limited, if any, care options for the participants.

2. Complex Patient Population. FQHC/RHC ADHCs serve a complex patient population. While all ADHCs serve adults who on average are 75 years of age and disabled,¹⁴ FQHC/RHC ADHCs serve a clientele who are more likely to have multiple chronic health and mental health conditions. According to the CPCA survey, of the 1,600 participants attending FQHC/RHC ADHCs, 16 percent are clinically obese, 51 percent have diabetes, and 63 percent have hypertension. The average participant has five different medical or mental health diagnoses and requires seven to eight medications to function.¹⁵ Research shows that three or more activity of daily living (ADL) limitations is a strong predictor of nursing home placement.¹⁶ Participants at the FQHC/RHC ADHCs on average have four ADL limitations. And lastly, participants are more likely to have psychiatric problems or varying degrees of dementia. In California's FQHC/RHC ADHCs, 15 percent have some form of dementia.¹⁷

Physical restrictions and health limitations are not the only obstacles FQHC/RHC ADHC participants must contend with. According to CPCA's survey, over 74 percent of participants live below 200 percent of the Federal Poverty Level, and a third are below 100 percent. These severe financial limitations impact the housing, nutrition, and general living options of the participants. Also, language barriers pose a major obstacle for the FQHC/RHC ADHC participant population, but FQHC/RHC ADHCs work to compensate for this barrier because staff report that nearly 45 percent of all participants are non-English speaking. According to a 2004 report by the National Health Law Program and The Access Project, non-English-speaking patients are less likely to use primary and preventive care services and more likely to use emergency rooms in part because of the language barrier.¹⁸ Similarly, participants are unlikely to avoid this barrier at stand-alone ADHCs if their FQHC/RHC ADHC closes. In turn, they may delay their care until they have no option but to go to the emergency room, which will result in emergency room visits and related increased costs to the State.

While FQHC/RHC ADHCs serve the most complicated of ADHC eligible participants, the model the centers operate, coupling primary care with intensive staff attention, leads to positive health outcomes for the participants, thus translating to overall cost savings for the

14 National Adult Day Service Association (NADSA), "Census of Adult Day Service Programs: 1997-1998," for the National Council on the Aging, Inc., Washington, D.C., 1998; Reifler, B. et al., "Adult Day Services in America," Prepared for Partners in Caregiving: The Dementia Service Program, Winston-Salem, N.C., 1995; Weaver, J., "Adult Day Services: State Regulatory and Reimbursement Structure," 1996; Weissert, W. et al., "Effects and costs of Day Care Services for the Chronically Ill: A Randomized Experiment," *Medical Care*, 1980, 18(6), 567-584.

15 CPCA FQHC ADHC Survey, February 4, 2009.

16 Miller, EA; Weissert, WG. Predicting elderly people's risk for nursing home placement, hospitalization, functional impairment, and mortality: a synthesis. *Med Care Res Rev.* 2000;57:259-97.

17 CPCA FQHC ADHC Survey, February 4, 2009.

18 NHeLP and the Access Project. (2004) Language Services Action Kit.

State. The interaction between primary care and the ADHC often begins with the participant's core provider. Many of the referrals received by the FQHC/RHC ADHCs come from the physicians in the health center. FQHC/RHC physicians relay that they send their most complicated patients to their affiliated ADHC because of the comprehensive care delivery model; a model not found in a stand-alone ADHC. Secondly, FQHC/RHC ADHCs can provide the necessary staffing ratios that allow close monitoring and assistance, often one to one, for complex cases with cognitive and psychiatric disabilities and sensory losses. As determined by the CPCA survey, FQHC/RHC ADHCs exceed the hour and staff requirements in Title 22 in a number of categories, including therapy hours, nurses on staff, skilled nursing services, and medical social workers. AltaMed Health Services ADHCs provide these additional services on a daily basis to a wide variety of clients who would otherwise be in institutional care- at far greater cost to the State. One of the numerous complex cases that highlights the intensive work the staff provide at one of AltaMed's six ADHCs is exemplified in the following account:

A 65-year old female with multiple diagnoses of schizophrenia, obsessive-compulsive disorder, diabetes mellitus, obesity and hypertension. The participant underwent medically indicated gastric by-pass surgery and lost over 100 lbs. She requires ongoing psychological support to avert periodic binges and nursing monitoring to intervene with fluctuating glucose levels. With encouragement from ADHC staff, the participant has had increased attendance and socialization patterns as reported by family members. She has had decreased hallucinations and both staff and family report a decrease in napping. Her compliance with attendance to the center has increased and is noted as engaging in more coherent speech. Family support has been provided by social work staff with coordination of needed monthly medical supplies and referral services.

The complexity of this case requires skill, expert intervention and knowledge of resources and AltaMed's ADHC staff provides it in a community setting with family and physician partnerships. This level of intervention and associated cost is unmatched by institutional placement.

Additionally, many ADHCs do not accept morbidly obese patients over 250 lbs, a particularly difficult population to serve. Without care and assistance these patients frequently seek help at a hospital, a costly alternative to an FQHC/RHC ADHC. Lifelong Medical Care, an FQHC ADHC in Oakland, serves a number of participants weighing between 300 and 400 lbs and is able to do so only because of their skilled staff and equipment, which is made possible with their enhanced reimbursement rate. One case study represents the high level of care these participants require:

A 52-year old African American female, who weighed 400 lbs when she first began visiting Lifelong. She was also diagnosed with diabetes, hypertension, severe osteoarthritis, and asthma. She had fallen when getting out of bed one day, and had not left her bed thereafter for six months for fear of falling again. She was using newspapers and a waste basket for her toileting needs. Lifelong obtained toileting support supplies immediately, but when the registered nurse sought physical therapy and rehab options for the participant NONE would take her; no out-patient physical therapy provider or any of the 22 SNF's she contacted. The only remaining option for the participant became in-patient hospitalization, then a 1 month stay at a rehab hospital, and later in-home physical therapy. After 8 weeks, the participant became

strong enough to leave her house via para-transit and began coming to Lifelong's ADHC. Her strength has continued to improve, her medical condition is totally stabilized, and she has remained in her own home. The participant credits ADHC efforts as "life saving."

Without the expertise and dedication of Lifelong's skilled staff, morbidly obese patients would be a tremendous cost burden to the State. Lifelong alone saves the State of California thousands of dollars a month by providing care to this vulnerable population.

3. Connection to a Medical Home. FQHC/RHCs improve the health status and outcomes of their patients by assuring a medical home - usual source of care. Stand-alone ADHCs cannot offer this same level of care because they are not affiliated with a primary care facility. FQHC/RHCs offer a comprehensive, coordinated system of care that includes access to essential services on-site or by referral including oral health, behavioral health, substance abuse, and specialty care. These services are supplemented by a broad range of enhanced services that together assure access to care including outreach, patient education, translation and interpretation, transportation vouchers, assistance finding (and keeping) housing, help establishing home and community-based disability care, and assistance applying for health insurance coverage. These services provided at the FQHC/RHC are linked to the services at their ADHCs because staff at the ADHC are in close and frequent communication with their fellow clinic staff on behalf of their participants. ADHCs that are affiliated with an FQHC/RHC provide an incalculable benefit to the participants by integrating all aspects of care.

Staff at the FQHC/RHC ADHCs report that providing the same level of quality care to participants would not be possible without the partnership with the primary care health center. Staff are able to communicate changes in the behavior and health of their participants to the primary care provider on a daily basis. At Lifelong Medical Care in Oakland, a physician can run downstairs to check in with a patient if a medical emergency takes place. The ability to triage between ADHC and FQHC staff on an immediate basis helps to stave off potential emergency room encounters. Emergencies that require triage occur every day for a third of the FQHC/RHC ADHCs, and between two to three times a week for five of the sites.¹⁹ The connection to the FQHC/RHC prevents over ten emergency room visits a week. This type of care is not feasible at a stand-alone ADHC.

Numerous studies show that the comprehensive primary care provided at a community health center is cost effective, ultimately saving millions in Medicaid resources. The Federal Office of Management and Budget has ranked health centers one of the ten most effective federal programs. By focusing on prevention, health centers save substantial dollars in avoided emergency room visits, medical treatment, and hospitalization. Patients with chronic health issues have better health outcomes when they are connected to primary care,²⁰ and improved health outcomes reduces long term costs. FQHC/RHC ADHCs are designed to connect the primary care received at the FQHC/RHC to the daily complicated life of the ADHC participant, and thereby decrease the likelihood that the participant's chronic

¹⁹ CPCA FQHC ADHC Survey, February 4, 2009.

²⁰ Huang, E.S., et al. (2005). "The Cost-Effectiveness of Improving Diabetes Care in U.S. Federally Qualified Community Health Centers." Health Services Research.

health issues will burden society with expensive emergency room and in-patient hospital costs.

Conclusion

FQHC/RHC ADHCs distinguish themselves by providing ADHC as part of an integrated patient-centered medical home for the disabled and elderly, providing comprehensive care to more medical and psychiatric complex patients than can be served by stand-alone ADHCs, and by securing federal approval to serve the most Medically Underserved Areas of the State. The State's proposal will result in the loss of these benefits and increase overall cost to the State within weeks. From a quality of life perspective, it is likely to result in incalculable harm to the lives of already medically compromised elderly and disabled Medical patients.

ATTACHMENT 1

The Health Center Program: Requirements

Health centers, both Federally Qualified Health Centers, which receive Federal funding, and Federally Qualified Health Center Look-Alikes, which do not, must meet a strict set of requirements; the following list provides a summary. For additional information on these requirements, please review:

- Health Center Program Statute: section 330 of the Public Health Service Act (42 U.S.C. §254b)
- Program Regulations (42 CFR Part 51c and 42 CFR Parts 56.201-56.604 for Community and Migrant Health Centers)
- Grants Regulations (45 CFR Part 74)

Need

1. Needs Assessment: Demonstrate and document the needs of the target population, including updating their service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)

2. Medically Underserved Area (MUA)/Medically Underserved Population (MUP) Designation: Serve, in whole or in part, a designated MUA/MUP. (Section 330(a) of the PHS Act) (Requested, not required for HCH, PHPC, or MHC applicants)

Services

3. Required and Additional Services: Provide all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals per program requirements. (Section 330(a) of the PHS Act) Note: Applicants requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services. (Section 330(h)(2) of the PHS Act)

4. Staffing Requirement: Maintain a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. (Section 330(a)(1) and (b)(1), (2) of the PHS Act)

5. Accessible Hours of Operation/Locations: Provide services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)

6. After Hours Coverage: Provide professional coverage during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act)

7. Hospital Admitting Privileges and Continuum of Care: Physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, applicant must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)

8. Sliding Fee Discounts: A system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. This system must provide a full discount to individuals and families with annual incomes at or below the poverty guidelines (only nominal fees may be charged) and for those with incomes between 100 percent and 200 percent of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income. No discounts may be provided to patients with incomes over 200 percent of the Federal poverty level. (Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f))

9. Quality Improvement/Assurance Plan: Ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management and maintains the confidentiality of patient records; the QI/QA program must include:

- A focus of responsibility to support the quality improvement/assurance program and the provision of high quality patient care;
- Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the applicant; and
- Such assessments shall: be conducted by physicians or by other licensed health professionals under the supervision of physicians; be based on the systematic collection and evaluation of patient records; and identify and document the necessity for change in the provision of services by the applicant and result in the institution of such change, where indicated. (Section 330(k)(3)(C) of the PHS Act and 42 CFR 51c.303(c)(1-2))

Management and Finance

10. Collaborative Relationships: Establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. Interested section 330 applicants must secure a letter of support from the existing health center(s) in the service area or provides an explanation for why such a letter of support cannot be obtained. (Section 330(k)(3)(B) of the PHS Act)

11. Affiliation Agreements: Appropriate oversight and authority over all contracted services. Section 330(k)(3)(I)(ii) and 42 CFR Part 51c.303(n), (t)

12. Key Management Staff: Maintain a fully staffed health center management team as appropriate for the size and needs of the center. Prior review of final candidates for Project Director/Executive Director/CEO position is required. (Section 330(k)(3)(H)(ii) of the PHS Act and 45 CFR Part 74.25 (c)(2), (3))

13. Financial Management and Control Policies: Accounting and internal control systems are appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets. Assures that an annual independent financial audit is performed in accordance with Federal audit requirements, addressing all reportable/material weaknesses in the Audit Report. (Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Part 74.21)

14. Program Data Reporting Systems: Systems which accurately collect and organize data for program reporting and which support management decision making. (Section 330(k)(3)(l)(ii) of the PHS Act)

15. Billing and Collections: Systems in place to maximize collections and reimbursement for costs related to providing health services, including written billing, credit, and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)

16. Budget: Reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan. (Section 330(k)(3)(D), Section 330(k)(3)(l)(i), and 45 CFR Part 74.25)

17. Service Level: Maintain funded scope of project (i.e., projected number of patients to be served, including any increases based on recent New Access Point/Expanded Medical Capacity awards). (45 CFR Part 74.25)

Governance

18. Board Authority: Governing board maintains appropriate authority to oversee the operations of the center, including:

- holding monthly meetings (May be waived for eligible applicants. See Form 6- B),
- approval of the health center's grant application and budget,
- selection/dismissal and performance evaluation of the health center CEO,
- selection of services to be provided and the health center's hours of operations,
- establishment of general policies for the health center. Note: Some fiscal and personnel policies may be retained in the case of public centers (also referred to as "public entities"). (Section 330(k)(3)(H) of the PHS Act)

19. Conflict of Interest Policy: Bylaws or written corporate board-approved policy include provisions that prohibit conflict of interest or the appearance of conflict of interest by board members, employees, consultants, and those who furnish goods or services to the health center. No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive Officer may serve only as an ex-officio member of the board. (45 CFR Part 74.42 and 42 CFR Part 51c.304(b), when applicable)

20. Board Composition (May be waived for eligible section 330 applicants. See Form 6- B): Governing board must be composed of individuals, a majority of whom are being served by the center and, who as a group, represent the individuals being served by the center.

Interested section 330 applicants that receive/request targeted funding to serve migrant and seasonal farmworkers, individuals experiencing homelessness, and/or residents of public housing, must have appropriate representation on the board from these populations. (Section 330(k)(3)(H) of the PHS Act)

21. Waiver of Board Requirements (Applicants requesting targeted funding under sections 330(g), 330 (h), and/or 330(i) but not requesting 330(e) funds): Upon a showing of good cause the Secretary shall waive, for the length of the project period, all or part of the requirements of this subparagraph in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). Such eligible applicants may request a waiver of the Board Composition and/or Monthly Meeting requirement(s). (Section 330(k)(3)(H) of the PHS Act)

22. Board Size (for CHC and MHC): Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization. (42 CFR Part 51c.304)

23. Board Expertise (for CHC and MHC): Remaining members of the board shall be representative of the community in which the center's catchment area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community. (42 CFR Part 51c.304)

24. Non-Consumer Board Member Income (for CHC and MHC): No more than one-half (50%) of the non-consumer board members may derive more than 10 percent of their annual income from the health care industry. (42 CFR Part 51c.304)

ATTACHMENT 2

The List of FQHC/RHC ADHCs in California

<u>Name of FQHC/RHC ADHC</u>	<u>FQHC Corporation</u>	<u>County/Counties</u>
AltaMed Downey Adult Day Health Care Center	AltaMed	Los Angeles
AltaMed El Monte Adult Day Health Care Center	AltaMed	Los Angeles
AltaMed Golden Age Adult Day Health Care Center	AltaMed	Los Angeles
AltaMed Pico Rivera Adult Day Health Care	AltaMed	Los Angeles
AltaMed East Los Angeles Adult Day Health Care Center	AltaMed	Los Angeles
AltaMed Grand Plaza ADHC	AltaMed	Los Angeles
Berkeley Adult Day Health Center	West Oakland Health Council	Alameda
LifeLong Medical Care Adult Day Health Care	Lifelong Medical Care	Alameda
Marin Adult Day Health Care	Lifelong Medical Care	Marin
Southwest Adult Day Services	Southwest Health Center	Sonoma
Salud Para La Gente: Elderday	Salud Para La Gente	Santa Cruz
Day Break ADHC	Castle Family Health	Merced