HRSA Health Center Program

BPR PROGRAM-SPECIFIC FORM INSTRUCTIONS

This document helps applicants complete the program-specific forms in the EHBs for the Budget Period Progress Report (BPR) Non-Competing Continuation (NCC).

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Form 1C: Documents On File

Instructions

This form lists selected items that support compliance with Health Center Program requirements, as outlined in the Health Center Program Compliance Manual. It does not include all documents, such as policies and procedures, protocols, or legal documents, that your health center must maintain on file.

Provide the date each document was last reviewed or revised. Select N/A if the item does not apply to your health center. **Note:** For the E.O. 14273 requirement, only select N/A if your health center does not participate in the 340B Drug Pricing Program.

Your health center board must evaluate your policies on Billing and Collections, Sliding Fee Discount Program, and Quality Improvement/Assurance at least once every 3 years as required in element d of Chapter 19: Board Authority in the Compliance Manual.

Do not submit listed documents with the application unless requested in the NOFO. If your application is funded, HRSA will review these documents as part of an Operational Site Visit or may request to review these post-award.

Note*:* Beyond Health Center Program requirements, other federal and state requirements may apply. You are encouraged to seek legal advice to ensure that organizational documents accurately reflect all applicable requirements.

Form 3: Income Analysis

Instructions

Form 3 collects the projected income from all sources other than this Health Center Program funding request for the **upcoming budget period**. Form 3 is divided into two parts: (1) Patient Service Revenue and (2) Other Income - Other Federal, State, Local, and Other Income.

Part 1: Patient Service Revenue

Patient service revenue is income directly tied to services provided **to health center patients within the scope of project**. This includes services reimbursed by health insurance plans, managed care organizations, federal and state based categorical grant programs (e.g., breast and cervical cancer screening), employers, patients' self-pay share, and health provider organizations. Reimbursements may be based upon visits, procedures, member months, enrollees, achievement of performance goals, or other service-related measures.

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations designed to make up the difference between the approved FQHC rate and the interim amounts received. It includes risk pool and other incentive income, as well as primary care case management fees. If you do not have an FQHC cost reimbursement rate from Medicaid and Medicare, contact your Primary Care Association (PCA) for help with your application.

The section groups patients and income into the same five payer groupings used in the UDS Manual. Each payer (lines 1-5) is described below. All patient service revenue is reported in this section of the form. Only include patient service revenue associated with sites and services proposed in your application.

Patients by Primary Medical Insurance - Column (a): Includes the projected number of unduplicated patients categorized by payer based on the patient's primary medical insurance (payer billed first) as of their last visit. Patients are categorized in the same way as in the UDS Manual, Table 4, lines 7 – 12.

For example:

- Categorize a patient with both Medicare and Medicaid coverage as a Medicare patient on line 2.
- Categorize a Medicaid patient with no dental coverage who is only seen for dental services as a Medicaid patient on line 1 and report the estimated income (columns b and c) and costs (column d) based on the dental service being a self-pay visit on line 5.

Non-Federal Income per Patient – Column (b): Includes all income associated with patient care including Fee for Service (FFS), capitated payments, Prospective Payment System (PPS) rate settlements, cost report settlements, incentive payments, and shared cost savings. These amounts are expressed as an average amount per patient. While many payments to FQHCs are transitioning to value-based care models, HRSA recognizes that many payments are still based on a per visit basis. In these situations, health centers may utilize an average number of visits per patient to calculate a payment per patient amount. [For example, for your health center, the average number of Medicaid patient visits is 5

visits per year and these visits are paid at $150 per visit. Thus, the calculated amount per patient for the year would be $750.]

Note: Do NOT include pharmacy-related revenue in calculating the Non-Federal Income per Patient. All pharmacy-related revenue (e.g., 340B, in-house retail pharmacy, etc.) is reported in Part 2: Other Income, Line 12.

Non-Federal Projected Income – Column (c): Calculated by multiplying the patient count in Column (a) by Income per patient in Column (b).

Total All Projected Costs – Column (d): Report the total of all project accrued costs associated with the delivery of services to the patients identified in Column (a)

- Report the portion of total estimated accrual-based budget costs for the Total All Projected Costs (d) column for each Payer Category on Lines 1 through 5. The costs by Payer Category should be determined utilizing standard cost accounting methods, including:
    - Identification of the direct costs for each service (e.g., medical, dental, mental health, substance use disorder, etc.) provided by the applicant within the proposed scope of project.
    - Allocation of indirect costs including central support, overhead, and other administrative costs to each service based on relevant statistics (e.g., number of patients, number of visits, square footage, number of FTEs, etc.) for each type of cost being allocated.
    - Consider the estimated visits by service for each Payer Category to derive the average cost per visit. The estimated visits for each service should consider patient utilization of the service for each Payer Category.
    - Total estimated visits by service by Payer Category multiplied by the average cost per visit for each service will derive the Total All Projected Costs (d) for each Payer Category.
- The value in the Total All Projected Costs (d) column for the Totals on Line 6 and Line 16 should equal the value of the total estimated budget costs on Form SF-424, 18.g (federal and non-federal total) and Form SF-424A, Section A – Budget Summary, Total (g) column, Line 5.

Note: Do not include costs associated with in-kind donations.

Difference between Projected Income and Costs – Column (e): Projected Income Column (c) less Projected Costs Column (d):

- The values for the Difference between Projected Income and Costs (e) column are expected to be negative values for each Payer Category, Lines 1 through 5, reflecting the need for other sources of support after applying Patient Services Revenues generated from the provision of services (Column c minus Column d).
- The value for the Total on Line 6 for the Difference between Projected Income and Costs (e) column should equal the value of the total estimated budget costs on Form SF-424, 18.g; less the value of Part 2: Other Income for Non-Federal Projected Income (c), Total on Line 15; less the value of the Health Center Program funding request.
- The value for the Total on Line 16 for the Difference between Projected Income and Costs (e) column should equal the value of the Health Center Program funding request for new applicants or continued funding amount.

Payer Categories (Lines 1 – 5): The five payer categories (Medicaid, Medicare, Other Public, Private, and Self-Pay) reflect the five payer groupings in UDS. The UDS Manual includes definitions for each payer category.

Patient Service Revenue is reported on the line of the primary payer (payer billed first). When a single visit involves more than one payer, assign each portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments that the patient pays, report that income on the self-pay line. If the co-payment is to be paid by another payer, report that income on the other payer's line. If you cannot accurately associate the income to secondary and subsequent sources, you may include that income on the primary payer line.

Ancillary Revenue Instructions: All service revenue is to be categorized by payer, including pharmacy and other ancillary service revenue. Ancillary services are supportive services that supplement primary care and are typically categorized as diagnostic services (e.g., lab, radiology, testing), therapeutic services (e.g., weight loss, improve well-being), or custodial services (e.g., home health). If you do not normally categorize the projected ancillary or other service revenue by payer, assign the projected income by payer group using a reasonable method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

Medicaid (Line 1): Income from all Medicaid payment sources including services paid directly by the State and from Medicaid managed care plans. This includes Early Periodic Screening, Diagnosis, and Treatment (EPSDT); Children's Health Insurance Program (CHIP); and other reimbursement arrangements administered either directly by the state Medicaid agency or by a fiscal intermediary. It includes all projected revenue from managed care capitation, settlements from FQHC cost reimbursement reconciliations, wrap-around payments, performance incentives, and primary care case management.

Medicare (Line 2): Income from all Medicare sources including services paid through a Medicare fiscal intermediary and from Medicare managed care plans (e.g., Medicare Advantage plans). It includes all projected income from managed care, settlements from the FQHC cost reimbursement reconciliations, risk pool distributions, performance incentives, and case management fee income.

Other Public (Line 3): Income not reported elsewhere from federal, state, or local government programs for providing services that is paid based upon delivery of service and patient meeting the plan's eligibility criteria. For example:

- Income from CHIP operated independently from Medicaid.
- Other Public income also includes income from categorical grant programs when the grant income is earned by providing services (e.g., Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program).

Private (Line 4): Income earned from private insurance plans, managed care plans, Marketplace Qualified Health Plans, self-insured employer plans, group contracts with unions and employers, service contracts with employers, Veterans Health Administration Community Care Network (CCN) agreements and other private contracts for services. Also categorize as private insurance: revenue from health benefit plans that are earned by government employees, veterans, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans.

Self-Pay (Line 5): Income from patients, including full-pay, self-pay, and sliding fee patients, as well as the portion of the visit income for which an insured patient is personally responsible.

Total (Line 6): Sum of lines 1-5.

Part 2: Other Income – Other Federal, State, Local, and Other Income

This section includes all income other than the patient service revenue shown in Part 1 that **supports the scope of project**. It includes other federal, state, local, and other income. It is revenue that is not directly tied to services, visits, procedures, or other specific services. It may only include income from non-health center patients in limited circumstances. For example, all pharmacy-related income that supports the scope of project would be included as part of in-house retail pharmacy sales to individuals who are not health center patients. Categorize income based on the source you receive it from and not the source it originates from.

Other Federal (Line 7): Income from direct federal funds, where your organization is the recipient of a notice of award (NOA) directly from a federal agency. It includes funds from federal sources such as the CDC, Housing and Urban Development (HUD), Centers for Medicare & Medicaid Services (CMS), Health Center Program capital awards, and others. The CMS EHR incentive program income is reported here to be consistent with the UDS Manual. Exclude this Health Center Program operational (H80) funding request.

State Government (Line 8): Income from state government funding, contracts, and programs, including uncompensated care funding; state indigent care income; emergency preparedness funding; mortgage assistance; capital improvement funding; school health funding; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); immunization funding; and similar awards.

Local Government (Line 9): Income from local government grants, contracts, and programs, including local indigent care income, community development block grants, capital improvement project funding, federal funding awarded through intermediaries, and similar awards. For example, include: (1) income earned under a contract with the local Department of Health to provide services to the Department's patients, and (2) grants that are awarded through municipalities.

Private Grants/Contracts (Line 10): Income from private sources, such as foundations, non-profits, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, if you operate a pharmacy in part for your own patients and in part as a contractor to another health center, report the pharmacy income for your own patients in Part 1 Line 12 and the income from the health center contract on this line.

Contributions (Line 11): Income from private entities and individual donors that may be the result of fundraising.

Pharmacy (Line 12): Income from pharmacy services including 340B pharmacy and in-house retail pharmacy sales.

Other (Line 13): Income not reported elsewhere, including items such as interest income, patient record fees, vending machine income, dues, and rental income. Do not include pharmacy revenue on line 13, all

pharmacy-related revenue is reported on Line 12. Applicants typically have at least some “other” income to report on Line 13.

Applicant (Retained Earnings) (Line 14): The amount of funds needed from your retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why this is necessary. Amounts from non-federal sources, combined with this Health Center Program funding request, should typically be able to cover operations.

Total Other (Line 15): The sum of lines 7 – 14.

Total Non-Federal (Line 16): The sum of Lines 6 and 15 (the total income aside from this Health Center Program funding request). The value for the Total on Line 16 for the Difference between Projected Income and Costs (e) column should equal the value of the Health Center Program funding request for new applicants or continued funding amount, although the value will be reported as a negative number on Form 3.

For example: If the Health Center Program funding request or continued funding amount is $1,000,000; the value on Form 3, Column e, Line 16 should be ($1,000,000) – a negative number.

Note: Do not include in-kind donations on Form 3. You may discuss in-kind donations in the SUPPORT REQUESTED section of the Project Narrative. You may also include in-kind donations on the SF-424A: Budget Information Form.