NORTH CAROLINA
STATE DESIGNATED RURAL HEALTH CENTERS OPERATIONS GUIDANCE

Competitive Grant Program Administered by

North Carolina Department of Health and Human Services Office of Rural Health

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A. PURPOSE

The purpose of this manual is to provide an understanding of the State Designated Rural Health Centers Program in North Carolina, administered by the NC Department of Health and Human Services Office of Rural Health (ORH) through a competitive Request for Applications process. Additionally, this manual serves to standardize North Carolina State Designated Rural Health Center services and to describe strategies used by ORH to designate new rural health centers.

B. INTRODUCTION

Background:

Jim Bernstein, the founding director of ORH, contributed more than 35 years to North Carolina's rural and underserved communities to develop health services for low- income and vulnerable populations. In addition to developing a statewide network of Rural Health Centers, ORH works with the Division of Health Benefits (NC's Medicaid agency) and other agencies within the North Carolina Department of Health and Human Services to develop community-based approaches to improve care and care outcomes for underserved populations. These efforts include statewide and regional strategies to improve primary care, behavioral health, long-term care, and hospital and school health services.

Since its inception, the core belief guiding ORH is, "If improvement in [health] care or service is the goal, then those who are responsible for making it happen must have ownership of the improvement process." Distribution of primary care providers in North Carolina has historically been skewed toward cities and larger towns. Rural residents often find accessing primary care services difficult due to barriers such as transportation and lack of affordable resources.

North Carolina is fortunate to have three types of programs aimed at increasing access to primary care for uninsured and underserved residents in rural communities: Federally Qualified Health Centers (FQHCs), Centers for Medicare and Medicaid Certified Rural Health Clinics (CMS RHCs), and State Designated Rural Health Centers (SDRHCs). This manual will focus on SDRHCs; specifically, the process to become one, and the annual designation process.

C. STATE DESIGNATED RURAL HEALTH CENTER (SDRHC) PROGRAM

ORH assists underserved communities and populations with developing innovative strategies for improving access, quality, and cost-effectiveness of health care.

Through the establishment of State Designated Rural Health Centers (SDRHC), ORH partners with local communities to provide funding to serve underserved populations who would otherwise be unable to access needed primary care services due to geographic, economic, or other barriers. Thus, SDRHCs have become an integral part of the health care safety net for North Carolina's rural and underserved residents.

ORH defines an SDRHC as a health care safety net organization that is a 501(c)3 non-profit, community-owned organization with an active board or CMS Rural Health Clinic that has as its primary mission to provide primary health care services to those residing in its community. SDRHCs must be located within communities that are rural, in a health professional service area (HPSA), and have as its primary mission to deliver primary health care services. SDRHCs offer high quality primary health care services to all residents regardless of their ability to pay.

- Rural Health Centers are in rural communities that are medically underserved
- All Rural Health Centers accept Medicaid, Medicare, and private insurance

  The organization operating the Rural Health Center is a 501(c) 3 non-profit community owned organization or CMS Rural Health Clinic.

- The SDRHC administers ORH's Primary Care Access Plan/Behavioral Health Access Plan (PCAP/BHAP) to uninsured individuals in the service area who meet certain criteria.

The primary purpose of the state designation is to support new access points and stabilize current access at sites that do not already receive support through the Federally Qualified Health Center (FQHC) or designation.

SDRHC BENEFITS

- Technical Assistance (TA) provided by a Rural Health Operations Specialist
- Personalized Quality Improvement TA provided by a local Area Health Education Center (AHEC) Practice Support Coach
- Eligibility for State Loan Repayment Programs
- Eligibility for sliding fee scale support (PCAP/BHAP program)
- Eligibility for capital and special project funding
- Quarterly Training and Continuing Education opportunities

ELIGIBILITY

The following organizations are eligible for funding: non-profit or for-profit entities who have an active

board of directors and provide primary care services.

To determine SDRHC eligibility, the applicant organization must meet the following criteria:

A. **Rural determination** – Rural Determination can be found at: https://www.ruralhealthinfo.org/am-i-rural

ORH uses the criteria in RHIhub to determine whether a specific location/address is considered rural. Applicant may access the "Am I Rural" tool from the Rural Health Information HUB. *Previously funded sites may be grandfathered from rural determination provided there is justification to support continued need in the service area.*

Organizations can use RHI Hub's Am I Rural Tool to identify whether the location is eligible for the following:

a. Federal Office of Rural Health Policy (FORHP) grant programs
b. Health Professional Shortage Areas (HPSAs) rural classification
c. Medically Underserved Areas/Populations (MUAs/MUPs) rural classification
d. Centers for Medicare & Medicaid Services Rural Health Clinics status

B. **Health Professional Shortage Area determination** - HPSA scores can be found at: https://data.hrsa.gov/tools/shortage-area

SDRHCs are required to be in a rural underserved area. In addition, all facilities are to be in non-urbanized areas as defined by the Bureau of the Census or known as a Health Professional Shortage Area (HPSA)**.** Eligibility consideration will be based on locations with the highest HPSA score in the three disciplines: Primary Care, Dental Care, and Mental Health. Scores will reflect where there is a greater need and where there is a shortage of providers.

How to find your HPSA Score:
Organizations can access the HPSA Find link https://data.hrsa.gov/tools/shortage- area/hpsa-find to determine the HSPA score in their area.

Medically Underserved Area and Medically Underserved Population (MUA/P) can receive a score between 0-100. An area or population with an Index of Medical Underservice (IMU) of 62.0 or below qualifies for designation as a MUA/P.

How are scores determined:

The Health Resources Service Administration (HRSA) designates HPSAs. As part of HRSA's cooperative agreement with the State Primary Care Offices (PCOs), the PCOs conduct needs assessments in their states (North Carolina), then determine which areas are eligible for designations, and submit the designation application to HRSA for review and approval.

HRSA reviews the HPSA applications (*The State PCOs do not submit applications for Auto-HPSAs or Federal Correctional Facilities)* submitted by the State PCOs, and if the applications meet the statutory and regulatory designation eligibility criteria, then HRSA derives a HPSA score.

These shortages may be geographic, population, or facility-based:[9]

Geographic Area

A shortage of providers for the entire population within a defined geographic area.

Population Groups

A shortage of providers for a specific population group(s) within a defined geographic area (e.g., low income, migrant farm workers, and other groups).

Facility-based

Public or non-profit private medical facilities serving a population or geographic area designated as a HPSA with a shortage of health providers (Correctional Facility, State/County Mental Hospitals).

Demonstrated unmet need: County Distress Ranking – Tier 1 or 2 – County Distress Rankings can be found at: https://www.commerce.nc.gov/grants-incentives/county-distress-rankings-tiers

C. Demonstrate Unmet Need

ORH focuses on increasing access to primary care services using State appropriations. Organizations that receive Federal funds to support care within its service area are ineligible for this State funded program. Applicant organizations must meet the following criteria to be eligible for funding consideration:

Location in a Medically Underserved Area (MUA) that has a shortage of primary care health services for residents within a geographic area. MUAs may include a whole county, a group of neighboring counties, or ZIP codes.

If the population to be served already has access to an alternative safety net site within five (5) miles or a penetration level of the low-income population that is 75 percent or greater, the applicant organization must sufficiently document both collaboration and unmet need within the service area to be eligible.

Use the link below to determine whether your service area includes the identified zip codes.

Zip Codes with Unmet Need

County Distress Ranking

The North Carolina Department of Commerce annually ranks the state's 100 counties based on economic well-being and assigns each a tier designation ranking from Tier 1 (most distressed) to Tier 3 (least distressed). This tiered system is incorporated into various state programs to encourage economic activity in the less prosperous areas of the state.[12]

Use the link below to determine whether your organization is in one of the County's distressed Tier designations (Tier 1 or Tier 2 designation). Your location must be designated a Tier 1 or Tier 2 for consideration as an SDRHC. *Previously funded sites can be grandfathered from updated county ranking provided there is justification to support continued need in the service area.*

https://www.nccommerce.com/grants-incentives/county-distress-rankings-tiers

D. Proof that the organization is not owned, controlled, or operated by another entity and holds an active 501(c)(3) Status. (*Independent Rural Health Clinics, and Provider Based Clinics operated by Rural and Critical Access Hospitals are eligible to apply)*

The organization is not a subsidiary of another organization. At a minimum, the applicant organization must demonstrate that it maintains a Project Director/Chief Executive Officer (CEO) who will carry out independent, day-to-day oversight of activities solely on behalf of an active governing board of the 501(c)(3).

A corporation which is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code is called a "charitable or religious corporation" in the North Carolina Nonprofit Corporation Act. Determine whether your organization is established as a tax- exempt organization (nonprofit) under Internal Revenue Code Section 501(c)3.

This term also includes a corporation which is organized exclusively for one or more purposes specified in Section 501(c)(3) and which must distribute its assets upon its dissolution to another "charitable or religious corporation" or to the United States or another state.

Exempt Organization: Section 501(c)(3) is the portion of the US Internal Revenue Code that allows for federal tax exemption of nonprofit organizations, specifically those that are considered public charities, private foundations, or private operating foundations.[13]
https://www.irs.gov/charities-non-profits/charitable-organizations

E. Provider of primary health care services to all individuals in the defined service area regardless of ability to pay, including those who are ineligible for Medicaid and/or Employer Sponsored Health Insurance.

F. Enrolled or plan to enroll eligible providers in Medicare and Medicaid reimbursement programs

Organizations not currently billing Medicare and Medicaid will be given capacity funding for one year. Continuation of funding and SDRHC status is contingent upon completing the Medicare and Medicaid reimbursement process within one year of ORH funding.

G. Documentation demonstrating that at least 10% of patient payer mix are Medicaid beneficiaries **and that the provider is actively billing Medicaid for those services.**

Capacity Sites only: Enroll eligible providers in Medicaid reimbursement programs and achieve at least10% patient payer mix are Medicaid beneficiaries (End of Year 1)*

Tier Definitions - There are two tiers that exist within the SDRHC program.

*Tier 1- includes Capacity-Building sites that do not currently serve Medicaid patients, and/ or are unable to provide documentation demonstrating that at least 10% of patient payer mix are Medicaid beneficiaries. If awarded, Capacity-Building sites must enroll eligible providers in Medicaid reimbursement programs and must ensure at least 10% of the patient payer mix are Medicaid beneficiaries (End of Year 1). Tier 1 sites are eligible for Operating/ Infrastructure funds ONLY. Tier 1 sites are eligible for awards up to $100,000 per year, contingent upon meeting performance and financial goals as mutually agreed upon between ORH and the site.

Tier 2- includes State Designated Rural Health Centers that currently serve Medicaid and Medicare patients and meet the 10% of patient payer mix with Medicaid beneficiaries. Tier 2 sites are eligible for awards up to $250,500 and may receive funding in the following categories: PCAP, BHAP, Operating/ Infrastructure and Capital (Capital funding is available through a separate application process).

SDRHC TYPES OF FUNDING

Funding for active SDRHCs is allocated through a contractual agreement with ORH. The maximum total grant award is dependent upon demonstrated need and operating structure at each of the SDRHCs and is contingent upon funding availability. Future funding is contingent upon meeting performance and financial goals as mutually agreed upon between the division and the awardee.

Primary Care Access Plan Funds (PCAP)- Grant funds available for primary health care coverage to qualifying individuals. The visits are reimbursable at a rate of $115.00 per encounter to the SDRHC based on medically necessary on-site, face-to-face provider encounters, and may include on-site x-rays, in-house labs, surgical procedures, services performed by practice providers, prophylaxis, and telemedicine. Telemedicine encounters are defined as two-way, real-time, audio and visual interactions between a patient and a licensed provider.

Behavioral Health Access Plan Funds – Grant funds available for behavioral health and mental health counseling services for qualifying individuals. These services are integrated into the primary care setting. The visits are reimbursable at a rate of $80.00 per encounter to the SDRHC based on on-site, face-to-face behavioral health provider encounters. Behavioral health providers include licensed social workers, advanced practice registered nurses, psychologists, and psychiatrists and other licensed providers as determined by Medicaid.

Operating/Infrastructure Funds – An organization applying for funds in this category must demonstrate the ability to create systems and processes that promote sustainability of the organization being funded or how the funds will supplement the primary care services provided through PCAP/BHAP.

Funding should assist with one or more of the following operational or infrastructure priorities:

- Propose the creation and implementation of sustainable staff and infrastructure that enhances access to health care and improves quality
- Propose an efficient strategy that uses local resources and collaborates with other partners to respond to health care gaps in the community
- Propose a plan to blend behavioral health services fully or partially within the primary care practice

Capital Grant Funds – Capital funding allows SDRHCs to invest in healthcare infrastructure, including the construction, renovation, and expansion of healthcare facilities. Capital investments may also be made through the purchase and installation of major equipment and technology. Capital Grant funding does not support staff salaries or other operating/recurring

costs. Requests should not duplicate Community Health, Farmworker Health, or Rural Health Center operating projects. Capital Grant funding is requested through a separate application process.

- Rural Health Centers that are seeking Capital Funds must apply via an online application process for consideration and approval. Rural Health Centers must also submit a budget template with supporting documentation (two quotes from vendors). The total grant award is dependent upon documented and demonstrated need at the rural health center and is contingent upon funding availability.

PROGRAM OPERATIONS

- ORH Operations Team provides annual training in PCAP/BHAP, and Monthly Expense Reporting for new grantees and on an as-needed basis.
- ORH Operations Team provides updates and email correspondence to all grantees and community partners.
- ORH provides Monthly Expense Report (MER) template worksheets for PCAP/BHAP, Operating/Infrastructure Funds). Centers are required to complete and submit MERs by the 10th of each month with supporting documentation of expenses.
- MERs should include the signature of a person who is officially designated to sign legal documents on behalf of the rural health center, as well as signature of someone who can attest to the signature.

Desk Reviews and Site Visits

- The SDRHC Program requires quarterly desk reviews and/or site visits.
  A contract monitoring desk review and a contract monitoring site visit require the same supporting/back-up documentation. Supporting/back-up documentation is submitted to ORH prior to a desk review while documentation is reviewed on-site during a site visit.
- Rural Health Centers will receive an email notification for scheduling either a desk review or site visit by the contract monitor assigned to their grant. The ORH checklist will be created for each rural health center grantee that includes requirements for the selected month's information needed to proceed with the rural health center desk review or site visit. For instance, a list of PCAP/BHAP patients from the site electronic health report or practice management system and the selected monthly expense report with required supporting documentation.

Rural Health Center Practice Assessment

In accordance with the mission of the North Carolina Office of Rural Health to support equitable access to health in rural and underserved communities, a partnership was established with AHEC to provide practice support to SDRHCs. The assessment will enable the centers to optimize primary medical care service delivery at their practices based on eight (8) components: (1) Access, (2) Care Coordination, (3) Optimal Use of Health Information Technology, (4) Team Based Relationships, (5) Patient and Family Engagement, (6) Quality Improvement Culture and Evidence-Based Care, (7) Financial Health Leadership, and (8) Financial Health Management.

The practice assessment process occurs as needed to be determined by the Practice Coach, the

Practice, and the Operations Specialist. It is dependent on the organization's goals and objectives. Action plans should be completed annually and can be continued into the following year.

Clinical Performance Measurement - Quarterly Surveys

ORH works collaboratively with SDRHCs to assist with monitoring and evaluation of clinic performance measures and supportive programs. In addition to this technical supportive service, ORH's Data Team produces reports that inform internal and external partners about progress on the following quality measures: BMI Screening, Tobacco Cessation, Uncontrolled Diabetes and Controlled Hypertension, Screening for Depression and Follow-up Planning, and Early Entry into Prenatal Care. The nonclinical measures include: Total unduplicated patients served, number of PCAP/BHAP patients served, total encounters, and unduplicated patients by insurance status.

Data reports are requested quarterly. SDRHCs set baseline and target values prior to the onset of a new fiscal year. Baseline values represent the value reported by each SDRHC for the start of the contract period. The target values represent the value to be obtained at the end of the contract period. Each quarter, grantees report actual values representing actual calculated numbers for each area.

- Quarter One: July 1 through September 30
- Quarter Two: July 1 through December 31
- Quarter Three July 1 through March 31
- Quarter Four: July 1 through June 30