Orcas Island Health Care District

East Sound, Washington

Primary Care Service Analysis

Report Date: September 2019

DZA
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Certified Public Accountants

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Background

Orcas Island Health Care District (the District) was formed to support the provisions of primary and urgent care services on Orcas Island. The District does not operate primary care facilities but rather, supports two existing clinics on the island—Orcas Family Health Center and UW Medicine Orcas Island

Orcas Island is an island in the Puget Sound, Washington and primarily accessed by a public ferry. As such, medical emergencies require air transportation to hospitals on the main land or other islands. There are emergency medical services on the island run by Orcas Island Fire & Rescue.

The two clinics on the island have requested more financial support from the District than the District has in tax funds. The District is interested in exploring the various options for providing primary care and urgent care services on the island. Dingus, Zarecor, & Associates PLLC (DZA) has prepared this analysis.

Programs Analyzed

The District is interested in both primary and urgent care, including access to primary care after normal clinic hours. Generally, primary care services are those provided by physicians and their extenders (physicians' assistants or nurse practitioners)—clinic services. Clinic services can be provided by the following types of facilities:

- Physicians' clinic
- Rural health clinic (RHC)
- Federally qualified health center (FQHC)

Physicians' clinics and RHCs can be run independently "free-standing" or as a department of a hospital "provider-based." An FQHC can only be run independently (e.g. cannot be provider-based to a hospital).

This analysis provides analysis of the three clinic types.

The District could choose to join with one of hospitals near the island to become provider-based rural health clinics, or to start a critical access hospital of its own. Both of those, while options, exceed the scope of this analysis; estimating the feasibility or cost of a provider-based clinic requires analysis of the costs of the hospital. As such, we will instead discuss these as options in broad terms.

The clinic does not meet the requirement to be a provider-based location of a CAH hospital, except for provider-based RHC. It could be a provider-based location of a PPS hospital, but there is no reimbursement difference between that clinic type and free-standing clinic. Therefore, those options are both also excluded from this analysis.

A provider-based clinic is a clinic provider-based to a hospital CAH. A provider-based rural health clinic is a rural health clinic provider based to a hospital or CAH. The rules for those clinic types differ.

Requirements

Rural Health Clinics:

Intent — RHC is a designation made to a clinic by Medicare. The purpose of the special designation is to address "an inadequate supply of physicians services to Medicare beneficiaries in underserved rural areas, and to increase the utilization of nurse practitioners (NP) and physician assistants (PA) in these areas" *per the RHC manual*.

Location — To qualify, a clinic must be located in a rural area **and** in one of the following health professional shortage areas:

1. Geographic primary care HPSA
2. Population-group primary care HPSA
3. Medically underserved area (MUA) (excluding medically underserved populations (MUP))
4. Governor-designated and secretary-certified shortage areas (excluding a Governor's MUP)

Staffing — An RHC must employ a mid-level and have mid-levels (employed or contracted) available to see patients at least 50 percent of the time the clinic is open. An RHC on an island can contract all mid-levels (island RHCs are exempt from the requirement to *employ* a mid-level).

Laboratory Capabilities — The clinic must be able to provide the following six laboratory tests on site:

1. Urine analysis
2. Hemoglobin or hematocrit
3. Blood sugar
4. Examination of stool specimens for occult blood
5. Pregnancy tests
6. Primary culturing for transmittal to a laboratory

Ownership Structure — An RHC can be a public entity (government), not-for-profit entity, or for-profit entity (no restrictions).

Provider-based Considerations — A provider-based rural health clinic is an RHC either created or acquired by a main provider for the purpose of furnishing health care services under the ownership, administrative, and financial control of the main provider. Generally, the location must be within 35 miles of the CAH or hospital to be provider-based. However, in the case of a CAH or hospital with fewer than 50 beds, the location can be further than 35 miles if the hospital or CAH is located in a rural area.

Sliding Fee Schedule — A sliding fee schedule is not required. However, if one is provided, it must be provided to all patients in a uniform manner. If the clinic wishes to become a National Health Service corps approved site, a sliding fee schedule would then be required.

Governing Board — No requirement

Cost Reporting — Annual cost reports are required.

Federally Qualified Health Center — Look Alike:

Intent — FQHC is federal designation for entities meeting section 330 of the Public Service Act and generally receives Section 330 grants. An FQHC Look Alike is an entity meeting the federal definition of a "health center" that does not receive Section 330 grants. The purpose of the special designation is to provide comprehensive health services to the medically underserved, thereby reducing the patient load on emergency rooms.

Location — To qualify, the center can be located in either an urban or rural area, but must service a designated MUA or MUP.

Staffing — An FQHC must be have at least one physician on their health care staff. A mid-level is required to be able to furnish patient care services at all times the FQHC operates.

Laboratory Capabilities — No specific laboratory capabilities

Ownership Structure — An FQHC must be either a public entity (government) or not-for-profit entity.

Provider-based Considerations — Because of the governing board requirements discussed below, an FQHC cannot be provider-based.

Sliding Fee Schedule — A sliding fee schedule is required. The FQHC must "operate in a manner such that no patient shall be denied service due to an individual's inability to pay." A full discount of fees is required for individuals or families with annual incomes at or below the federal poverty guidelines.

Governing Board — A governing board is required and must be composed as such:

1. Between 9 and 25 members
2. At least 51 percent of the board members must be patients served by the health centers and must represent the individuals serviced by the health center in demographic terms.
3. Of the non-patient board members (i.e. those not satisfying number 2 above), no more than half may derive more than 10 percent of their annual income from the health care industry.
4. Board members cannot also be an employee of the center or have a direct relationship to employees of the center

Cost Reporting — Annual cost reports are required.

Free-standing Clinics:

Intent — Free-standing clinics are basic physician clinic offices. They can be owned by a hospital or physician and may be part of a group or may stand alone. UW Medicine Orcas Island is a free-standing clinic.

Location — No restrictions

Staffing — No restrictions, although to provide physician services, a physician is required.

Laboratory Capabilities — No requirements

Ownership Structure — A free-standing clinic can be a public entity (government), not-for-profit entity, or for-profit entity (no restrictions).

Sliding Fee Schedule — No requirements

Governing Board — No requirements

Cost Reporting — No requirement

Provider-based Clinics (not provider-based RHC):

Intent — Provider-based clinics are basic physician clinic offices that are a department of a main provider (usually a hospital or CAH). Because they are considered a department of the hospital, the technical component and the professional component of each service are billed separately. For an example, hospital emergency rooms are technically provider-based clinics (e.g. you get a bill for the hospital (or technical services), as well as a bill from the physician).

Location — To be provider-based to a CAH (not a provider-based RHC), the location of the clinic must be 35 or more miles from the next nearest hospital or CAH.

Staffing — No restrictions, although to provide physician services, a physician is required.

Laboratory Capabilities — No requirements

Ownership Structure — Owned and operated by a hospital or CAH.

Sliding Fee Schedule — No requirements

Governing Board — No requirements

Cost Reporting — This location would be reported as such on the main provider's cost report.

340B Discount Drug Program

The 340B discount drug program is a federal program allowing covered entities to purchase drugs at discounted prices. The intent of the program is to "enable covered entities to stretch scarce federal resources." Eligible drugs purchased under the program are used on outpatients. A 340B covered entity, therefore, can use the discounted rate to purchase drugs intended for use in the clinic.

The program also allows covered entities to contract with local pharmacies to fill scripts at the discounted rates. Because the price of the drug under 340B are so much lower than purchasing the drug under normal manufacturer pricing, both the pharmacy and the covered entity make money from the transaction. Covered entities who contract with their local pharmacies gain about $25 per encounter utilizing this program. With regards to the clinic types discussed in this paper, the following are covered entities:

1. FQHCs, including FQHC Look Alike
2. CAHs and any of the CAHs location meeting provider-based standards
3. PPS hospitals with disproportionate share rates at or above 11.75 percent
4. Sole community hospitals or rural referral centers with disproportionate share rates at or above 8 percent

The flow of a 340B contract pharmacy is as follows:

- Covered entity writes a prescription
- Contracted pharmacy fills the prescription
- Covered entity purchases replacement drug and sends to the contracted pharmacy

The flow of the money related to the contract pharmacy is as follows:

- Pharmacy
    - Receives fill fee from covered entity
- Covered entity
    - Receives revenue from patient or their insurance
    - Purchases drug at 340B cost
    - Pays pharmacy fill fee
    - Pays third-party administrator a fee

Rural Health Clinics:

Medicare

Rural health clinics are paid the lower of their cost per encounter or the established upper payment limit, subject to productivity standards. Most clinics have costs in excess of this upper payment limit. For 2019, the upper payment limit is $84.70 per encounter.

If an RHC is provider-based to a hospital with fewer than 50 beds, it is paid full cost, subject to productivity standards. The cost per encounter of a provider-based RHC can range anywhere from $100 per visit to over $300 per visit.

Washington Medicaid

RHCs are paid cost per encounter by Medicaid, subject to productivity standards. When a clinic first becomes an RHC in the state of Washington, it is paid a "like clinic" rate. Once it submits a finalized cost report to the state, the state will prospectively adjust the encounter rate to actual cost. Each year thereafter, that rate is inflated by the Medicare Economic Index (MEI) (about 1-2 percent a year). A clinic can request their rate be recalculated if it can show a change in scope of service and that their cost rate meets a percentage threshold from approved Medicaid rate. For 2019, the average cost per encounter for an RHC not associated with a hospital is approximately $150. That being said, Orcas Family Health Center's Medicaid rate is only $114 per encounter.

All-inclusive Rate — Rural health clinics are paid an all-inclusive rate meant to cover the cost of the physician and all services incident to that physicians service. Certain items, listed below, are not billed separately:

- Nurse visits
- Supplies and pharmaceuticals
- Covered vaccines, besides flu and pneumonia

Encounter — Encounters are defined as a medically necessary, face-to-face encounter between a physician or a mid level (practitioner). To count as an encounter, it must be medically necessary for the visit to be between the practitioner and the patient. In other words, a nurse encounter may be medically necessary, but it may not be medically necessary for that service to be provided by the practitioner.

Productivity Standards — Productivity is viewed in aggregate. A full time physician is expected to see 4,200 patients in a year; a mid-level is expected to see 2,100 patients in a year. The basis of cost per encounter reimbursement says costs will be divided by the greater of productivity visits or actual visits. For example: a clinic has 1.25 physician FTEs and .8 mid-levels FTE. Productivity visits are 6,930 (1.25*4,200 plus .8*2,100). If the physicians provided 4,000 encounters, and the mid-level 3,000, they would meet productivity standards in the aggregate.

Payment for Mid-levels — A mid-level and a physician receive the same encounter rate.

Vaccines — Vaccines cannot be billed to Medicare separately. Influenza and pneumococcal vaccines furnished to Medicare beneficiaries are paid through the Medicare cost report based on the cost of providing those injections. The costs of other vaccines are part of the RHC all-inclusive rate.

Diagnostic Services — Diagnostic services are outside of the all-inclusive rate. These are billed separately, with reimbursement based on established Medicare or Medicaid fee schedules.

Deductibles and Coinsurance — Medicare deductibles and coinsurance apply. However, in an RHC, these amounts are based on the gross charge. A patient will pay their deductible; once that is met, they are responsible for 20 percent of the standard charge.

Medicare Bad Debts — Unpaid Medicare deductibles or coinsurance may qualify to be reimbursed on the Medicare cost report. If they meet Medicare's criteria, they are reimbursed at 65 percent of the amount claimed.

Federally Qualified Health Center—Look Alike:

Medicare

FQHCs are paid a national prospective rate per encounter, adjusted for geographic differences in costs (GAF). For 2019, the FQHC payment rate for Washington (not King County) is $170.62 per encounter.

Due to governance requirements, FQHCs cannot be provider-based to a hospital or CAH.

Washington Medicaid

FQHCs are paid cost per encounter by Medicaid. When a clinic first becomes an FQHC in the state of Washington, it is paid a "like clinic" rate; once it submits a finalized cost report to the state, the state will prospectively adjust the encounter rate to actual cost. Each year thereafter, that rate is inflated by the MEI (about 1-2 percent a year). A clinic can request their rate be recalculated if able to show a change in scope of service and that the cost rate meets a percentage threshold of the approved Medicaid rate. For 2019, the average cost per encounter for an FQHC is approximately $250.

All-inclusive Rate — Federally qualified health centers are paid an all-inclusive rate meant to cover the cost of the physician and all services incident to that physicians service. Certain items, listed below, are not billed separately:

- Nurse visits
- Supplies and pharmaceuticals
- Covered vaccines, besides flu and pneumonia

Encounter — Encounters are defined as a medically necessary, face-to-face encounter between a physician or a mid-level (practitioner). To count as an encounter, it must be medically necessary for the visit to be between the practitioner and the patient. In other words, a nurse encounter may be medically necessary, but it may not be medically necessary for that service to be provided by the practitioner.

Productivity Standards — An FQHC is not subject to productivity standards.

Payment for Mid-levels — A mid-level and a physician receive the same encounter rate.

Vaccines — Vaccines cannot be billed to Medicare separately. Influenza and pneumococcal vaccines furnished to Medicare beneficiaries are paid through the Medicare cost report based on the cost of providing those injections. The costs of other vaccines are part of the FQHC all-inclusive rate.

Diagnostic Services — Diagnostic services are outside of the all-inclusive rate. These are billed separately, withreimbursement based on established Medicare or Medicaid fee schedules.

Deductibles and Coinsurance — There are no Medicare deductibles for FQHC covered services. Coinsurance is 20 percent of the lower of the FQHC charge or PPS payment amount.

Medicare Bad Debts — Unpaid Medicare coinsurance may qualify to be reimbursed on the Medicare cost report. If they meet Medicare's criteria, they are reimbursed at 65 percent of the amount claimed.

Free-standing Clinics:

Medicare

Free-standing clinics are paid the Medicare physician fees schedule, subject to increases or decreases depending on how a clinic fares in the Merit Based Incentive Payment System (MIPS) program.

Washington Medicaid

Free-standing clinics are paid the Medicaid physician fees schedule

All-inclusive Rate — Not applicable to free-standing clinics.

Encounter — Not applicable to free-standing clinics

Payment for Mid-levels — A mid-level is paid 85 percent of fee schedule amounts.

Vaccines — All covered vaccines are billed and paid based on established fee schedule amounts.

Diagnostic Services — Diagnostic services are billed separately, with reimbursement based on established Medicare or Medicaid fee schedules.

Deductibles and Coinsurance — Medicare deductibles and coinsurance apply. A patient will pay their deductible once that is met, they are responsible for 20 percent of the fee schedule amount.

Medicare Bad Debts — There is no payment for unpaid Medicare deductibles or coinsurance.

Provider-based Clinics (not a provider-based RHC):

Medicare

CAH — Provider-based clinics are paid 80 percent of Medicare physician fees schedule (also known as the facility portion) for professional services (practitioner), and cost for the technical portion (nurse and support costs).

PPS — Provider-based clinics not on the main campus of a PPS hospital are paid 80 percent of the Medicare physician fees schedule (also known as the facility portion) for professional services (practitioner), and 40 percent of the APC for the technical portion (nurse and support costs). Generally speaking, this payment is meant to be about the same as a free-standing clinic's payment.

Similar to what is received in an emergency room. the patient will get two bills with this type of clinic.

Washington Medicaid

Provider-based clinics are paid the Medicaid physician fees schedule

All-inclusive Rate — Not applicable

Encounter — Not applicable

Payment for Mid-levels — A mid-level is paid 85 percent of fee schedule amounts.

Vaccines — All covered vaccines are billed and paid based on established fee schedule amounts.

Diagnostic Services — Diagnostic services are billed separately, with reimbursement based on established Medicare or Medicaid fee schedules.

Deductibles and Coinsurance — Medicare deductibles and coinsurance apply. A patient will pay their deductible; once that is met, they are responsible for 20 percent of the fee schedule amount and 20 percent of the charge (in the case of a CAH) or 20 percent of the APC (in a PPS hospital).

Medicare Bad Debts — Unpaid deductibles or coinsurance related to the technical portion of the charges can be claimed on the Medicare cost report. If they meet Medicare's criteria, they are reimbursed at 65 percent of the amount claimed.

Pros and Cons

Rural Health Clinics

Pros	Cons
❖ Cost-based for Medicaid, including recruitment costs ❖ Physicians and mid-levels paid the same amount ❖ Can register site for loan repayment programs ❖ MIPS reporting not required ❖ If provider-based to a covered entity, can be registered for the 340B program	❖ Subject to productivity standards ❖ Yearly cost report requirement o part of the main provider's if provider-based ❖ Periodic surveys ❖ Cannot bill separately for high cost drugs or supplies ❖ Held to upper payment limit, which will likely be less than the cost of providing services (unless the clinic is provider-based to a hospital with fewer than 50 beds). ❖ Not paid separately for nurse visits ❖ Not a 340B covered entity; however, in the case of a provider-based RHC, the covered entity could be the main provider.

FQHC

Pros	Cons
❖ Cost-based for Medicaid, including recruitment costs ❖ Physicians and mid-levels paid the same amount ❖ Can register site for loan repayment programs ❖ MIPS reporting not required ❖ Medicare rate likely the highest ❖ Not subject to productivity standards ❖ 340B covered entity ❖ Potential for grant funding	❖ Yearly cost report requirement ❖ Periodic surveys ❖ Cannot bill separately for high costs drugs or supplies ❖ Not paid separately for nurse visits ❖ Governance requirements ❖ Highest level of compliance required

Free-standing

Pros	Cons
❖ Little to no compliance requirements ❖ Can bill separately for high costs drugs or supplies ❖ Can bill nurse visits separately	❖ Lowest Medicaid reimbursement ❖ MIPS reporting ❖ Not a 340B covered entity

Provider-based Clinic (not provider-based RHC)

Pros	Cons
❖ Does not have to be in a HPSA or rural area ❖ Can bill separately for high costs drugs or supplies ❖ Can bill nurse visits separately	❖ MIPS reporting ❖ Not a 340B covered entity, unless it is provider-based to a covered entity ❖ Must be 35 miles from the next nearest hospital or CAH

Analysis of the Orcas Island Health District

Location — Orcas Island Health Care District is rural. It has both a low-income population HPSA and a governor's exception MUP, therefore qualifying for both RHC and FQHC status.

There is more than one hospital within 35 miles of the hospital. While there is not clear guidance for the specific instance of an island, the location would not meet the provider-based (not provider-based RHC) requirements.

Staffing — Orcas Family Health Care has mid-levels meeting both the FQHC Look Alike and RHC requirements; UW Medicine Orcas Island does not. In order for these clinics to be RHC or FQHC, either UW would need to recruit mid-levels or the clinics must combine.

Laboratory Capabilities — Both Orcas Family Health Care and UW Medicine Orcas Island have the capabilities for the RHC laboratory requirements.

Ownership Structure — Since both organizations are currently not-for-profit, they meet the ownership requirements in their current form.

Sliding Fee Schedule — The clinics would need to adopt a sliding fee schedule to become FQHC. Although the RHC location does currently have a sliding fee schedule, it differs slightly from the FQHC requirements.

Governing Board — To be FQHC, the governing board would need to meet the FQHC requirements, which the current governance does not. It does, however, meet RHC standards.

Cost Reporting — A cost report for each location will need to be filed, which will cost between $2,000 to $5,000, depending on the clinic size and chosen preparer. Provider-based clinics (including provider-based RHC) will be reported on the main provider's cost report.

Provider-based — The following are potential hospitals with which the clinics could become provider-based:

1. Island Hospital in Anacortes.
2. Jefferson Health, Port Townsend, WA
3. Peace Health—Island, Friday Harbor, WA
4. Peace Health—United General, Sedro Woolley, WA
5. Whidbey General Hospital, Coupeville, WA

Hospitals 2-5 are all critical access hospitals and most have an RHC. Hospital 1 is not a CAH but has fewer than 50 beds. Hospital 3 is the smallest of the hospitals. The larger hospitals may be able to take the risk of a new location better than a smaller hospital.

These hospitals will want to provide services in their own manner and under their own governance.

There are two other hospitals generally close: Olympic Medical Center and Skagit Valley Hospital, with 78 and 137 beds, respectively. Requesting to be provider-based to those facilities will not, therefore, generate added Medicare reimbursement.

340B Considerations — Island Hospital in Anacortes does not have a high enough DSH percentage to qualify as a 340B covered entity. The CAHs are all covered entities.

Therefore, to take advantage of the 340B discount drug program, the District will want to choose either FQHC or provider-based RHC to one of the listed CAHs. Becoming provider based to Island Hospital in Anacortes, will not gain access to the 340B discount drug program.

Recommendation

The best reimbursement will be either FQHC Look Alike status or provider-based RHC, with the main provider being one of the CAHs listed above.

The cost of running a clinic can be minimized by consolidating locations and we recommend providing all clinic service in one location.

We also recommend changing coverage from the UW location only having physicians to the location instead having one physician with two mid-levels.

FQHC Look Alike — This clinic type likely is the best option for providing services on the island.

FQHC status comes with more compliance requirements and it may make sense to reach out to other community health centers or a company specifically equipped to assist with these requirements (we have a good one in mind).

Why FQHC? Medicare pays a prospective rate, which, if the clinic is run efficiently, could be higher than actual cost. Medicaid payments are based on cost from a base year; payment will either be greater or lower than actual cost.

An FQHC also qualifies as a 340B covered entity.

The purpose of an FQHC is to provide comprehensive health services to the medically underserved populations, falling closest in line with the intent of the District.

Provider-based RHC — An alternative choice is reaching out to the CAHs to see if there's interest in one of them running the clinics. We see this as the second best solution to providing primary care services on the island.

Most of the CAH listed currently have RHCs and therefore already have both the resources to get the clinics certified and the knowledge to ensure the conditions of participation are met.

Medicare's rate here will likely be the highest rate. However, the goal is to have a rate greater than cost, not a cost-based rate that is simply high.

Because it is provider-based to a CAH, this location could be registered as a 340B location.

Of the CAHs listed, we recommend starting discussion first with Jefferson Health and then Whidbey General Hospital. These two CAHs have RHCs, are currently registered as 340B entities, and have registered their additional locations for the 340B program (meaning it is likely they participate in the contract pharmacy portion of 340B). As such, these two would be able to ensure RHC compliance and assist in registering and contracting with the local pharmacy.

Island Hospital in Anacortes does not qualify for 340B; however, it does currently have RHCs. They would be a good option for simply helping get through the RHC process.

The two Peace Health CAHs are registered as covered entities. Neither, however, currently operate an RHC. Island has provider-based clinics (not provider-based RHCs), but has not registered separate locations for 340B. It is unknown if they are participating in the contract pharmacy portion of 340B, but we believe they currently are not. United General does not have qualifying clinics. More steps would be involved in working with these CAHs.

Free-standing Clinic or Free-standing RHC

There is not a significant difference in reimbursement between these two types, based on the current clinic levels at the UW Medicine Orcas Island site. This is due to the fact the UW Medicine Orcas Island site both codes at a slightly higher level than the current RHC and does not appear to meet productivity standards.

We understand the two clinics do not want to merge into one clinic, nor does UW Medicine Orcas Island want to become an RHC. The UW Medicine Orcas Island location would also need to recruit a mid-level to become an RHC.

Clinic Services

Both the FQHC and RHC programs are meant to leverage the physicians providing services by use of mid-levels. To keep costs at a reasonable level, mid-levels should be utilized to the greatest extent possible. While we recommend making a single clinic location, if the locations remain separate, each would need its own RHC or FQHC number.

Should the clinics choose to be a free-standing RHC and join locations, we simply need to file for a change in address and keep the existing clinic number. Any change should be investigated to see if it meets the definition and threshold for a change in scope with the state.

Timelines

Rural Health Clinic

Start by finding a partner. If the chosen partner currently has RHCs, the timeline should be closer to 6 months than a year; if not, we will need to "borrow" Orcas Family Health Centers RHC policies, etc., which will prolong the process.

This process starts by contacting Bonnie Burlingham at the State. The State will send you the necessary forms to fill out (expect to fill out many forms, both federal and state).

Before the clinic is certified, it will require a survey. The State farms out these surveys to the following two companies:

- https://thecomplianceteam.org/
- https://www.aaaasf.org/

The paperwork will likely take about 3 months and must be completed before you can schedule the survey. Surveys can be anywhere from 3-9 months. The date the clinic passes its survey will be the date RHC status begins.

To recap: the general timeline to become a provider-based RHC looks like:

- 3 months to find a partner
- 3 months—forms, gathering policies, etc.
- 3-9 months—scheduling and awaiting survey

Total time: 9 to 15 months

FQHC

This timeline is dependent upon whether you choose to partner with an existing community health center or to start an FQHC Look Alike on your own.

To be granted FQHC Look Alike status, a clinic must be operating as if it were an FQHC, including the governance requirements and sliding fee schedule policies. Anticipate needing a couple months to get yourselves in compliance with these criteria.

The clinic must operate as if it were an FQHC for 6 months before an application can be submitted.

For FQHCs, once the application process is started, it must be completed in 90 days.

To recap: the general timeline to become an FQHC looks like:

- 3 months to find a partner or qualified firm to help with the requirements
- 6 months providing services like an FQHC
- 3 months—application process

Total time: 9 to 12 months

Closing

We appreciate the opportunity to work with Orcas Island Health District. If you have questions or require additional information, please call me at 509.321.9485.

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Owner

Appendix A

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Orcas Island Health Care District	The District
Dingus, Zarecor & Associates PLLC	DZA
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Health Resources and Services Administration	HRSA
Medically underserved area	MUA
Medically underserved population	MUP
Medicare economic index	MEI
Merit based incentive payment system	MIPS
Nurse practitioner	NP
Physicians' assistant	PA
Prospective paid system	PPS
Rural health clinic	RHC
Section 330 of the Public Health Service Act	Section 330