Exhibit “A”

WSHD Treasurer's Report

Reporting Date: **Friday, October 29, 2021**

Pending Expenses	For	Amount
Brookshire Brothers	Indigent Care	$1,880.04
Wilcox Pharmacy	Indigent Care	$737.54
UTMB at Galveston	Indigent Care	$12,362.75
UTMB Faculty Group	Indigent Care	$4,995.64
Barrier Reef Emergency Physician	Indigent Care	$65.29
Indigent Healthcare Solutions	IC Inv #72582	$1,109.00
American Education Services	S Stern-Student Loan	$150.14
Penelope (Polly) Butler	Youth Counseling	$85.00
Kalos Counseling (Benjamin Odom)	Youth Counseling	$765.00
Gaidet Solutions	Youth-Irlen	$1,600.00
Chambers Cty PHD#1	IC Dental	$210.00
Chambers Cty PHD - ER	Indigent Care	392.33
$25 Optical	IC Special Program	$50.00
Benckenstein & Oxford	Inv #502332	$21,125.00
Hubert Oxford	Legal Retainer	$1,000.00
David Sticker	Inv #63	$1,843.75
Technology Solutions of Tx	Inv #1631	$75.00
Bonds & Ellis (Clay Taylor)	Inv #13139 (In re Abri)	$612.50
Function4	Inv892142	$114.25
Felipe Ojedia-Yard Service	Inv #1018	$300.00
Graciela Chavez-Office Cleaning	Inv #8018601	$100.00
The Hometown Press	Inv #3114	$600.00
Seabreeze Beacon	Inv #5451	$360.00
Anthem Accounts Payable	Refund for QY2A3	$2,501.61
QIPP Refund UnitedHealthcare	Refund for QY2A3	$399.69
Total Pending Expenses		**$53,434.53**

Paid during October 29, 2021 Regular

Funds Summary	Totals
Prosperity Operating (Unrestricted)	$856,580.77
First Financial (Restricted)	$8,615,879.82
First Financial (Unrestricted)	$5,704,503.34
TexStar	$690,459.00
Allegiance Bank LOC (Available)	$5,213,624.30
Cash Position (Less First Financial Restricted)	**$12,465,167.41**
Pending Expenses	$0.00
Ending Balance (Less expenses)	**$12,465,167.41**
Total Funds (Ending Balance+LOC Outstanding+QIPP Funds Outstanding)	**$13,266,399.16**
Last Month	
Prosperity Operating (Unrestricted) (9/17)	$552,526.76
First Financial (Restricted)	$10,154,654.39
First Financial (Unrestricted)	$3,872,877.79
Prosperity CD (Closed)	$0.00
TexStar	$690,441.52
Allegiance Bank DACA Accounts (Unrestricted)	$2,910,862.01
Allegiance Bank LOC (Available)	$1,530,285.69
Cash Position (Less First Financial Restricted)	**$9,556,993.77**
Pending Expenses	$190,683.52
Ending Balance (Less expenses)	**$9,366,310.25**
Total Funds (Ending Balance+LOC Outstanding+QIPP	**$13,445,320.30**

	Balances	Total Due	Balance Received	Balance Due	Due to District
FFB Balance Oct 28, 2021	$14,320,383.16				
	$14,320,383.16				
IGT 8, QIPP Year 4 (Public Only)					
Component 1-March (3rd Quarter)	$1,606,691.93	$1,606,691.93	$1,606,691.93	$0.00	$1,606,691.93
Component 1-April (3rd Quarter)	$1,655,613.71	$1,655,613.71	$1,655,613.71	$0.00	$1,655,613.71
Component 1-May (3rd Quarter)	$1,684,604.92	$1,684,604.92	$1,684,604.92	$0.00	$1,684,604.92
Component 1-June (4th Quarter)	$1,572,236.34	$1,572,236.34	$1,572,236.34	$0.00	$1,572,236.34
Component 1-July (4th Quarter)	$1,677,238.59	$1,677,238.59	$1,677,238.59	$0.00	$1,677,238.59
Component 1-August (4th Quarter)	$1,622,622.94	$1,622,622.94	$1,622,622.94	$0.00	$1,622,622.94
Total Component 1, IGT 8	**$9,819,008.43**	**$9,819,008.43**	**$9,819,008.43**	**$0.00**	**$9,819,008.43**
Loan 18 Set Aside (Salt Creek & Allegiance)					
Loan 18 Payment-March (3rd Quarter)	$1,606,691.93	$1,606,691.93	$1,606,691.93	$0.00	$1,606,691.93
Loan 18 Payment-April (3rd Quarter)	$1,655,613.71	$1,655,613.71	$1,655,613.71	$0.00	$1,655,613.71
Loan 18 Payment-May (3rd Quarter)	$1,684,604.92	$1,684,604.92	$1,684,604.92	$0.00	$1,684,604.92
Loan 18 Payment-June (4th Quarter)	$662,384.91	$1,572,236.34	$1,572,236.34	$0.00	$1,572,236.34
Loan 18 Payment-July (4th Quarter)	$0.00	$1,677,238.59	$1,677,238.59	$0.00	$1,677,238.59
Loan 18 Payment-August (4th Quarter)	$0.00	$1,622,622.94	$1,622,622.94	$0.00	$1,622,622.94
Total Loan 18 Set Aside	**$5,609,295.47**	**$9,819,008.43**	**$9,819,008.43**	**$0.00**	**$9,819,008.43**
IGT 9, QIPP Year 5 (Public Only)					
Component 1-Sept. (1st Half)	$957,730.66	$1,885,789.54	$957,730.66	$928,058.88	$1,606,691.93
Total Component 1, IGT 8	**$957,730.66**	**$1,885,789.54**	**$957,730.66**	**$928,058.88**	**$1,606,691.93**
Loan 9 Set Aside (Salt Creek & Allegiance)					
Loan 18 Payment-Sept. (1st Half)	$957,730.66	$1,885,789.54	$957,730.66	$928,058.88	$1,885,789.54
Total Loan 18 Set Aside	**$957,730.66**	**$1,885,789.54**	**$957,730.66**	**$928,058.88**	**$1,885,789.54**
Yr. 5 Component 2 (Public & Private)					
Y5/Q1-Comp. 2-Sept. due to MGRs.	$0.00	$0.00	$0.00	$0.00	$0.00
Total Component 2 due to MGRs.	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Yr. 4 Component 3 (Public & Private)					
Y4/Q4-Comp. 3-June, July, & Aug. due to MGRs.	$0.00	$1,919,722.55	$0.00	$1,919,722.55	$959,861.28
Total Component 3 due to MGRs	**$0.00**	**$1,919,722.55**	**$0.00**	**$1,919,722.55**	**$959,861.28**
Yr. 4 Component 4 & Lapse Funds (Public Only)					
Component Y4/Q4 due to MGRs (June-Aug. 2020)	$0.00	$3,133,367.93	$0.00	**$3,133,367.93**	$1,566,683.97
Total Component 4 due to MGRs	**$0.00**	**$3,133,367.93**	**$0.00**	**$3,133,367.93**	**$1,566,683.97**

Variance Payments (Deducted from Payments Received)					
Variance Payment	$0.00	($5,303.06)	$0.00	($5,303.06)	($2,651.53)
Total Variance Payment	**$0.00**	**($5,303.06)**	**$0.00**	**($5,303.06)**	**($2,651.53)**
Non-QIPP Funds due to NHs	**$0.00**				
Balance Owed on Line of Credit	**$808,255.88**				
Interest Reserves					
Reserve Ln 18	$78,530.14				
Reserve Ln 19 (Balance Due)	$1,155,043.54				
Allegiance Interest (October)	$7,024.13				
Total Reserves	**$1,240,597.81**				
Restricted	**$8,615,879.82**				
Unrestricted	**$5,704,503.34**				
Total Funds	**$14,320,383.16**	**$5,047,787.42**	**$0.00**	**$5,047,787.42**	**$2,523,893.72**

Unrestricted Funds Includes:

Loan 8-Repayment:	$5,609,295.47
Loan 9-Reserve:	$957,730.66
Balance owed on LOC:	$808,255.88
Interest Payments:	$1,240,597.81
Total:	**$8,615,879.82**

11 Month Outstanding Short Term Revenue Note-Loan 18 (Dec. 1, 2020-Nov. 1, 2020)
2nd Half of QIPP Year 4

Loan 18-Principle	$5,609,295.47	**Reserve**	$0.00
Interest	16.80%		

Amoritization Table

	Date	Balance	Interest	Principal Rcvd.	Payment
1	12/30/2020	$5,609,295.47	$78,530.14	$0.00	$78,530.14
2	1/31/2021	$5,609,295.47	$78,530.14	$0.00	$78,530.14
3	2/28/2021	$5,609,295.47	$78,530.14	$0.00	$78,530.14
4	3/31/2021	$5,609,295.47	$78,530.14	$0.00	$78,530.14
5-(Mar. 2021, Comp. 1)	4/30/2021	$5,609,295.47	$78,530.14	$1,606,691.93	$1,685,222.07
6-(Apr. 2021, Comp. 1)	5/31/2021	$5,609,295.47	$78,530.14	$1,655,613.71	$1,734,143.85
7-(May 2021, Comp. 1)	6/30/2021	$5,609,295.47	$78,530.14	$1,684,604.92	$1,763,135.06
8-(June 2021, Comp. 1)	7/31/2021	$5,609,295.47	$78,530.14	$662,384.91	$740,915.05
9 (July 2021, Comp. 1)	8/31/2021	$0.00	$78,530.14	*$0.00*	$78,530.14
10 (Aug. 2021, Comp. 1)	9/30/2021	$0.00	$78,530.14	*$0.00*	$78,530.14
11	10/31/2021	$0.00	$78,530.14	*$0.00*	$78,530.14
Amount Paid		$0.00	**$863,831.54**	**$5,609,295.47**	$6,473,127.01
Amount Due: October 31, 2021			**$863,831.54**	**$5,609,295.47**	**$6,473,127.01**
Amount Remaining				**$0.00**	**$0.00**

11 Month Outstanding Short Term Revenue Note-Loan 19 (June 1, 2021-Apr. 30, 2022)
1st Half of QIPP Year 5

Loan 19-Principle	$11,786,158.80	**Reserve**	$1,155,043.54
Interest	16.80%		

Amoritization Table

	Date	Balance	Interest	Principal Rcvd.	Payment
1	6/30/2021	$11,786,158.80	$165,006.22	$0.00	$165,006.22
2	7/31/2021	$11,786,158.80	$165,006.22	$0.00	$165,006.22
3	8/28/2021	$11,786,158.80	$165,006.22	$0.00	$165,006.22
4	9/30/2021	$11,786,158.80	$165,006.22	$0.00	$165,006.22
5-(Sept. 2021, Comp. 1)	10/31/2021	$11,786,158.80	$165,006.22	$1,885,789.54	$2,050,795.76
6-(Oct. 2021, Comp. 1)	11/30/2021	$11,786,158.80	$165,006.22	*$1,846,844.61*	*$2,011,850.83*
7-(Nov. 2021, Comp. 1)	12/31/2021	$11,786,158.80	$165,006.22	*$1,796,855.25*	*$1,961,861.47*
8-(Dec. 2021, Comp. 1)	1/31/2022	$11,786,158.80	$165,006.22	*$2,005,406.93*	*$2,170,413.15*
9 (Jan. 2021, Comp. 1)	2/28/2022	$0.00	$165,006.22	*$1,999,051.99*	*$2,164,058.21*
10 (Feb. 2021, Comp. 1)	3/31/2022	$0.00	$165,006.22	*$1,966,884.41*	*$2,131,890.63*
Reserve		$11,786,158.80	$0.00	*$285,326.07*	*$285,326.07*
11	4/30/2022	$0.00	$165,006.22	*$0.00*	*$165,006.22*
Amount Paid		$0.00	**$1,815,068.42**	**$11,786,158.80**	***$13,601,227.22***
Amount Due: October 31, 2021			**$1,815,068.42**	**$11,786,158.80**	**$13,601,227.22**
Amount Remaining			**$495,018.66**	**$0.00**	**$0.00**

Allegiance Bank Line of Credit

Principle (IGT 8)	$5,609,295.47	**Principle Balance Owed**	$801,231.75		
Interest Rate:	2.35%	**LOC Funds Available**	$5,213,624.30		
	Date	**Balance**	**Interest**	**Principal Rcvd.**	**Payment**
1	1/10/2021	Interest Payment	$12,803.16	$0.00	$12,803.16
2	2/10/2021	Interest Payment	$11,351.04	$0.00	$11,351.04
3	3/10/2021	Interest Payment	$10,252.54	$0.00	$10,252.54
4	4/10/2021	Interest Payment	$11,351.03	$0.00	$11,351.03
5-(Mar. 2021, Comp. 1)	5/10/2021	Interest Payment	$10,984.87	$0.00	$10,984.87
6-(Apr. 2021, Comp. 1)	6/10/2021	Interest Payment	$11,351.04	$0.00	$11,351.04
7-(May 2021, Comp. 1)	7/12/2021	Interest Payment	$10,984.87	$0.00	$10,984.87
8-(June 2020, Comp. 1)	8/6/2021	Principle Payment		$1,124,725.11	$1,124,725.11
9-(July. 2020, Comp. 1)	8/10/2021	Interest Payment	$11,351.03	$0.00	*$11,351.03*
10-(August 2021, Comp. 1	9/10/2021	Interest Payment	$8,781.35	$0.00	*$8,781.35*
	9/24/2021	Principle Payment	$0.00	$1,690,362.74	$1,690,362.74
	10/7/2021	Principle & Interest	$7,024.13	$1,992,975.87	$2,000,000.00
	10/31/2021	Principle & Interest			$0.00
Amount Paid	9/30/2020	$0.00	**$106,235.06**	**$4,808,063.72**	**$4,914,298.78**
Amount Remaining				**$801,231.75**	

District's Investments

	Amount	**Percentage**	**From**	**To**	**Interest**
***CD at Allegiance Bank C.D. #9503**	$6,014,856.05	0.35%	8/1/2021	8/31/2021	Paid Quarterly $5,301.58 Pd Aug 10
Texstar C.D. #1110	$690,459.00	0.0100%	9/1/2021	9/30/2021	Paid $5.70 Sept 2021

TO THE BEST OF MY KNOWLEDGE, THESE FIGURES IN THE WSDH TREASURER'S REPORT AND SUPPORTING DOCUMENTS CORRECT AND IN COMPLIANCE WITH THE DISTRICT'S INVESTMENT POLICY.

Edward Murrell,
President

Date

Robert "Bobby" Way
Treasurer/Investment Officer

Date

Italics are Estimated amounts

Exhibit “B”

WINNIE STOWELL HOSPITAL DISTRICT
WWW.WSHD-TX.ORG

FEDERALLY QUALIFIED HEALTH CENTER/RURAL HEALTH CLINIC FEASIBILITY STUDY

Determining the appropriate healthcare models to increase primary care access to the residents of East Chambers County Texas

October 25, 2021

Prepared by:

[THRIVE]

Creating Positive Healthcare and Social Service Outcomes

THRIVE
2156 Fairmont Lane
Naples, FL 34120
(239) 250-1202
bill.franz@thriveandachieve.com
www.thriveandachieve.com

Table of Contents

Executive Summary ..... **i**

I. Introduction **1**

A. The Winnie Stowell Hospital District 1

1. Legal Structure 1

2. Mission, Addressing Community Needs and Fiscal Responsibility 1

B. Engagement Purposes 2

C. THRIVE's Background and Experience 2

1. Bill Franz 2

2. Beth Little-Terry 3

3. Jeremy Wilson 3

4. Chuck Hutchings 3

D. Report Research 3

II. Comparing FQHC, FQHC Look-Alikes, and Rural Health Clinics **4**

A. Federally Qualified Health Centers 4

B. FQHC LAs 5

C. RHCs 6

D. Increased Reimbursement Rate Benefits of Health Centers Compared to Rural Health Clinics 8

1. Medicaid PPS Rate 8

2. Medicare PPS Rate 8

III. Health Centers – Nationally, Texas, and Nearby **8**

IV. Analysis of Demographics, Community Impact **9**

A. Demographics of the District 10

B. Demographics of Adjacent Zip Codes to Gain Patients for Economies of Scale 11

C. Current Medical Services Available to District Residents 12

1. Hospital 12

2. Other Medical Providers 13

3. Dental Services 13

4. Behavioral Health Services 14

5. Vision 15
6. Case Management 15
D. Impact on the Hospital 15
V. Financials and Location Recommendations 16
A. Costs and Staffing of the Health Center 16
B. Break Even Analysis 19
C. Costs to the Patient 20
D. Costs to the District 21
1. Operations Cost 21
2. Capital Cost 21
E. Location and Space Needs 22
VI. Applying For Look-Alike Status 23
A. Health Center Program Fundamentals 23
B. Health Center Models and The Hospital District's Role in the Health Center 24
1. Non-Profit 24
2. Public Agencies – Stand Alone 24
3. Public Agencies with Co-Applicant 24
4. Board Responsibilities 25
C. THRIVE's Recommendation on Health Center Model 27
D. Look-Alike Application 27
VII. Recommendations 28
A. SERVICES TO BE PROVIDED 28
1. Medical 28
2. Dental 28
3. Behavioral Healthcare 29
4. Labs 29
5. Imaging 29
6. Specialty and OB/GYN 29
7. Care Coordination 30
8. Optometry 30
B. Implementation Phases 30
Phase I – Establishing the Nonprofit (1-2 months) 30

Phase II – Readying the Clinic (2 months) 31
Phase III – Initial Clinic Operations (6 months) 31
Phase IV – Obtain FQHC LA Status (6 months) 32
Phase V – Continued Growth (Year 1) 32
VIII. Conclusion 33
Appendices 34
Appendix A – Advantages of an FQHC
Appendix B – Health Center Service Areas
Appendix B1 - Chambers Health (Chambers County Public Hospital District #1)
Appendix B2 - Coastal Health and Wellness
Appendix B3 – Gulf Coast Health Center, Inc
Appendix B4 – Health Center of Southeast Texas
Appendix B5 – Triangle Area Network, Inc.
Appendix C – Required Health Center Services
Appendix D –Health Center Program Requirements Categories
Appendix E –Required Annual Uniform Data System (UDS) Required Reporting
Appendix F –Application Review Process-Approximate Time Frame
Appendix G – District Program Enrollment and Funding
Appendix H – One Half Mile Radius of Hospital Medical Center
Appendix I – Select Acronyms

Executive Summary

THRIVE is pleased to have the opportunity to provide the Winnie Stowell Hospital District with its assessment of the healthcare delivery network within the area. At Thrive, we believe this is a unique opportunity to create a healthcare delivery network in the community that will be a shining example for other rural areas.

The following are the key takeaways from this report:

1. It is our opinion that a Federally Qualified Health Center ("FQHC") approved through the Health Resources and Services Administration ("HRSA") is feasible and will provide the best vehicle for residents of the area to receive comprehensive primary care services.
2. However, to establish the economies of scale, additional patients must be drawn from adjacent areas to the north and east.
3. Initially, a health clinic must be established that operates at least 40 hours a week for at least six months. After the six months, the District will qualify to pursue Health Center Look-Alike ("LA") status. Combined, FQHCs and LA models are referred to as "Health Centers".
4. We are recommending that the new Health Center be a completely separate nonprofit and not fall under the District directly. This will allow for complete separation of healthcare services from the District, much as its arrangement with Riceland Medical Center ("Hospital").
5. According to the feedback received from community leaders in anticipation of this report, we are happy to advise that there is significant opportunity to take advantage of the District's positive reputation in the community. This includes grants, naming of the clinic, co-sponsored community events, and named in-kind contributions.
6. The Hospital is a crucial component of the area's healthcare infrastructure. Historically, the Hospital's Rural Healthcare Clinic ("RHC") has been the source of primary care for many of the residents within the District. Fortunately, the Hospital has developed its services to provide more traditional healthcare associated with hospitals such as inpatient care and emergency room services and the Hospital has bolstered its ability to provide ancillary care (i.e., services that support direct healthcare such as labs, diagnostic imaging).
7. Most recently, the Hospital's response to COVID-19 has further bolstered its reputation in the community as a valuable healthcare resource. We feel that a Health Center and the Hospital can leverage this momentum by partnering to provide various service lines. This will assist the hospital in continuing to establish its place in the community as the preferred healthcare facility for inpatient services and ancillary care. This will also help the Hospital to maintain its financial sustainability.
8. The District's long-term goal should be to develop a modern, centrally located Federally Qualified Health Center ("FQHC") that is a prominent and integral part of the community,

which will provide primary care, dental, outpatient behavioral health, and social service offices. This will complement the Hospital's work and create a truly comprehensive healthcare network within the community.

9. It is our recommendation that the District should start the process of developing primary care operations in accordance with HRSA Health Center guidelines and apply for LA status after six months of operations. Commitment to any large-scale facility should be deferred until the following is realized:
    a. LA operations are established, and financial sustainability is achieved; and
    b. A determination is made on the quality of services delivered by the operation including patient satisfaction and willingness of the population to allow the Health Center to become their Patient Centered Medical Home ("PCMH").[1]
10. The initial operating start-up cost is expected to be $2,206,829 over the first two years. This includes 1) estimated grants to the Health Center of $1,249,329; and 2) estimated initial capital costs expected of $477,500.
11. Based on our research and analysis, we believe that opening a Health Center to service the primary healthcare needs of the residents of the District and surrounding areas is feasible with the help of the District to provide start up operating cost, initial capital cost, and possibly assistance with a permanent facility.
12. COVID-19 has created a disruption in all things related to healthcare. As such, this report:
    a. Does not anticipate any delays on equipment acquisition, facility licensure, or other steps. However, delays due to COVID may present themselves.
    b. Relies on 2019 data more heavily than 2020. It is the best base-year comparison for any medical operation and therefore we should rely on that information more comprehensively.
    c. Healthcare human resources are not as easily acquired. Salaries are estimated at the current market using a variety of sources, but changes in staffing costs may occur.

[1]The Patient-Centered Medical Home is a model of care, in which, patients are engaged in a direct relationship with a chosen provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the comprehensive integrated care provided to the patient, and advocates and arranges appropriate care with other qualified providers and community resources as needed. *See* https://pcmh.ahrq.gov/page/defining-pcmh.

I. Introduction

A. The Winnie Stowell Hospital District

1. Legal Structure

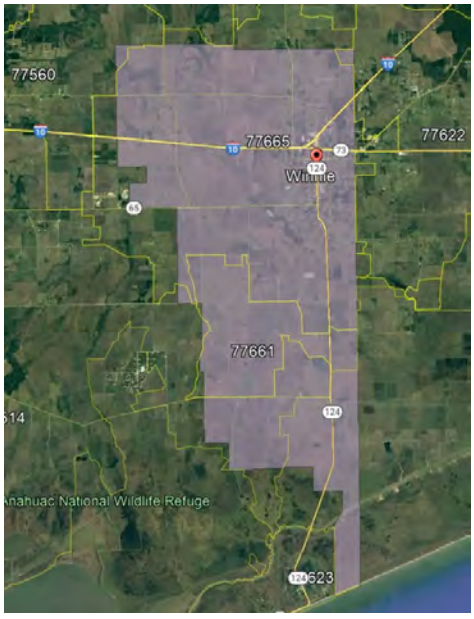
The Winnie Stowell Hospital District (District) is a political subdivision of the State of Texas organized pursuant to Tex. Const. Art. IX, § 9 (2014) and Chapter 286 of the Texas Health and Safety Code.

In 2004, the citizens of Winnie and Stowell voted to establish the District. The District generates revenue to provide healthcare services by way of a sales tax rate of $.007500 of the $.081250 in the sales tax collected within the District.

The District establishes rules and procedures that will identify any qualified client for the Indigent Care Assistance Program (ICAP). The District strives to assist the healthcare needs of the community.

The District's Board is made up of five elected officials who serve four-year staggered terms. The Board works together to: prepare plans for the future operations and viability of the District; promote cost effective operations and provisions of health care services; attain District objectives; ensure compliance with statutes and regulations; market its services; and provide leadership and management for the District.

2. Mission, Addressing Community Needs and Fiscal Responsibility



The Mission of the District is to *balance the healthcare needs of the community and its needy inhabitants with fiscal responsibility*. The District's boundaries mirror the East Chambers Independent School District and the East Chambers Emergency Services District #1. To the right is a Google Earth map of the District.

For the residents of the District, the District is the mandated payer of last resort for their healthcare needs. (*See* Tex. Health and Safety Code § 61.060). This means if a resident of the District has another public or private funding source available for services, those sources must be exhausted before the District will provide payment or direct services. In addition to the mandated services set forth in the Texas Health and Safety Code and the District's Indigent Care Assistance Programs (ICAP), the District also provides free youth counselling to all the residents of the District; assessments for Irlen's syndrome to all children in the District and free glasses, if needed; and provides healthcare assistance to all the children enrolled in the East Chambers Independent School District.

B. Engagement Purposes

In late August 2021, the District engaged Franz Strategic Solutions, LLC, which operates under the DBA of THRIVE, to assess the current community healthcare needs. Specifically, THRIVE was engaged to update a previous feasibility study to open a Federally Qualified Health Center ("FQHC") in the Winnie Stowell Hospital District service area. This included assessing the feasibility of creating and/or sustaining a FQHC Look-Alike ("LA") and/or Rural Health Clinic ("RHC"). Specifically, in this report, THRIVE attempts to provide a clear understanding and view of the:

1. Primary Care provider options;
2. Community demographics and needs;
3. Application Process and comparison of Health Center models;
4. Financial analysis, facility location and size, and impact on existing Hospital; and
5. Short term and long term paths forward.

Information within this report is a result of demographic and financial analysis, review of relevant rules and regulations, discussions with the District Board and community members, and other research. THRIVE's expertise in the area of FQHCs, LAs, and RHCs was utilized in creating the recommendations within this report.[2]

C. THRIVE's Background and Experience

For the Purpose of this engagement, THRIVE utilized a team of experts to develop the recommendations and conclusions stated within this report. These resources include:

1. Bill Franz

Bill is the Owner of THRIVE and has over 25 years facilitating and managing organizational improvement with a focus on strategy, operations, finance, and patient/client services. While consulting with Health Centers, healthcare systems, and public health departments, he has worked on several FQHC LA projects. Bill's consulting work includes the following: developing the strategy and action plan for spinning of a Public Agency Co-Applicant model FQHC to a stand-alone Nonprofit model; creating the financial modeling and operational strategies for several start-up FQHC LA projects; creating partnerships between Health Centers, hospital systems, and other social service entities; and creating the Health Center strategy for one of the largest healthcare systems in the Northeast. In addition to healthcare consulting, he has held the positions of Director of Systems and Patient Centered Transformation for a Health Center; Executive Vice President and Chief Financial Officer for the Community Foundation of Collier County; Project Manager for Northeast Health; and Financial Accounting Manager for the Research Foundation of the State University of New York.

[2] In addition to this report, Health Resources and Services Administration's ("HRSA") website is a great resource for all information related to Health Centers. We would encourage you to visit https://bphc.hrsa.gov/about/what-is-a-health-center/index.html to learn more.

2. Beth Little-Terry

Beth has vast experience in healthcare including Chief Executive Officer roles at several Federally Qualified Health Centers (FQHCs), including the CEO of a start-up Health Center in Rural Maryland; various positions focused on state Medicaid contracting; and coordinating services for the underserved. Beth's experience also includes work as a Grant Reviewer for the Health Resources and Services Administration ("HRSA").

3. Jeremy Wilson

Jeremy has worked as a Chief Financial Officer for a rapidly growing Health Center in rural Maryland. He has significant experience in Health Center strategy, financial management, compliance, and 340b contract pharmacy. He is also proficient in federal grant writing and management and has successfully written applications for HRSA Service Area Competitions and other funding opportunities.

4. Chuck Hutchings

Chuck has over 25 years' experience in management, consulting, and oversight of outpatient facilities including Health Center, physician practices and urgent care centers. Chuck has worked extensively on electronic medical record implementations; revenue cycle management; regulatory compliance, and quality initiatives.

D. Report Research

To prepare this report, THRIVE conducted interviews with all members of the District's Board as well as staff. We also performed several interview sessions with Mo Danishmund and Robert Jacobs from the Hospital. Additional interviewees included: Scott Campbell, East Chambers Independent School District Superintendent; Candice Moss, Chamber County Indigent Health; and Hubert Oxford IV, Winnie Stowell Hospital District Attorney.

There were many common comment threads in our conversations, which included:

1. There is a need for additional services in all areas of healthcare including medical, dental, behavioral health, and optometry are needed.
2. Two areas commonly discussed as issues in the community were the need for better behavioral health services and substance abuse.
3. The Hospital has improved its reputation over the past several years, but there is still room improvement.
4. Since the District has been able to increase annual revenues, the District has an obligation to put these resources to the best use.
5. If an additional healthcare facility is built, it should be in a prominent location and in close proximity to the hospital.

The themes and threads of these interviews were useful in creating our recommendations and are included throughout this report.

II. Comparing FQHC, FQHC Look-Alikes, and Rural Health Clinics

In order to decide whether or not to pursue a Health Center (i.e., FQHC or FQHC LA)[3] strategy or expand the existing RHC operated by the Hospital, we believe it is important to understand the difference in purpose and structure of each of these programs. In summary, the distinction between these facilities are as follows:

A. Federally Qualified Health Centers

An FQHC is a status designated under Section 330 of the Public Health Service Act ("Section 330"). *See* 42 U.S.C.S. § 254b (LexisNexis, Lexis Advance through Public Law 117-47, approved October 8, 2021). The program is administered under HRSA, a division of the Department of Health and Human Services (DHHS).

FQHCs provide primary care for the uninsured, as well as the economically and/or medically vulnerable populations ("Underserved Communities"). These Underserved Communities include all persons within a Medically Underserved Area (MUA)[4] or a Medically Underserved Population[5]. This program differs from the State of Texas County Indigent Care Program[6] as indigent care covers a much narrower defined population set forth in Chapter 61 of the Texas Health and Safety Code. The services provided by FQHCs help to reduce unnecessary hospital admissions and emergency department visits through the establishment of a Patient Centered Medical Home (PCMH). A PCMH is the primary care provider of healthcare services which improves patient care by providing preventative and comprehensive care, care coordination, chronic care management, and addressing social determinants of health. Not only does this improve patient outcomes, but it also reduces the overall cost of healthcare.

In addition, FQHCs benefit the community by:

1. Are more affordable for the resident than other healthcare delivery models such as an RHC[7];
2. Delivering high-quality integrated care including medical, dental, behavioral health and other health related services, regardless of the patient's immigration status;
3. Providing patient navigation to appropriate care;
4. Providing translation;
6. Opening access to affordable medications; and
7. Allowing for teaching hospital opportunities.

---

[3] Throughout this document, the term "**Health Center(s)"** refers to those entities who have either FQHC or FQHC LA status as both entity types fall under HRSA's Health Center Program.

[4] MUA: *See* Exhibit I for an explanation of this term and https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.

[5] MUP: *See* Exhibit I for an explanation of this term and https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.

[6] At a minimum, the Texas Indigent Care Program is available to anyone who: a) live in Texas; b) has income at or below 21% of the federal poverty guidelines; c) has resources less than $2,000; and d) isn't available for Medicaid. *See* https://www.hhs.texas.gov/services/health/county-indigent-health-care-program.

[7] Discussed in Section VI(A)(4) below.

Since FQHCs are afforded certain market advantages, they are able to provide enhanced services based on a sliding fee discount program[8] while remaining financially sustainable.[9]. In summary, FQHCs are able to achieve this by:

1. Receipt of Federal Grant Funding;
2. Enhanced Medicaid and Medicaid reimbursement in the form of Prospective Payments System (PPS) rates[10];
3. Access to 340B Federal Drug Pricing Program;
4. National Health Services Corps Student Loan Payment Program (because they are automatically designated as a Health Professional Shortage Area (HPSA));
5. Federal Torts Claims Act ("FTCA") coverage; and
6. FQHC Safe Harbor protections from anti-kickback provisions.

As discussed, in more detail below, typically, in order to become an FQHC, an organization initially applies for FQHC LA status and then applies for Federal funding opportunities. It is not until a FQHC LA receives Federal funding under Section 330 that an FQHC achieves full FQHC status.

B. FQHC LAs

FQHC LAs operate under the same statutory and regulatory policies of an FQHC, except that they do not qualify for Federal Funding, are not subject to Federal Torts Claims Act, and are subject to anti-kickback laws. They receive the same enhanced Medicaid and Medicare PPS rates as a FQHC and have access to 340B pharmacy benefits. Like an FQHC, their service area is automatically designated as a HPSA once they are granted FQHC LA status. Sometimes, LA applicants become fully funded FQHCs before they even receive their FQHC LA designation. A comparison of the benefits afforded to an FQHC and FQHC LA are set forth below:

{INTENTIONALLY LEFT BLANK}

[8] Sliding Fee Discounts are approved by the Health Center Board and must be in compliance with HRSA's requirements. *See* https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html#titletop.

[9] Also see Appendix A for more details of the advantages of operating an FQHC.

[10] PPS rate for FQHCs is a bundled payment that drives efficiency, not cost-based reimbursement. Rather than being paid fee-for-service, FQHCs receive a single, bundled rate for each qualifying patient visit. This single rate pays for all covered services and supplies provided during the visit. *See* http://www.nachc.org/wp-content/uploads/2017/03/PPS-One-Pager-noask.pdf.

Benefit	FQHC	FQHC LA
Operates under HRSA Regulations	√	√
National Health Services Corp Student Loan Forgiveness	√	√
Enhanced Medicaid / Medicare Reimbursement	√	√
340B Pharmacy Drug Pricing	√	√
Federal Grant Funding	√	
Federal Tort Claims Act Coverage	√	
FQHC Safe Harbor	√	

Because FQHC LAs do not fall under the FQHC Safe Harbor Provisions, it is important that all contractual relationships with the Hospital and other healthcare providers are at fair market value and adhere to all anti-kickback laws and regulations and Stark Laws[11].

C. RHCs

A RHC is a clinic located in a rural, underserved area with a shortage of primary care providers, personal health services, or both. Currently there are about 4,500 RHCs nationwide providing primary care and preventive health services in underserved rural areas.

RHCs must employ at least one Nurse Practitioner (NP) or Physician Assistant (PA) that works at least 50% of the time during operational hours. RHCs must also directly provide routine diagnostic and laboratory services, have an arrangement with a hospital to provide medically necessary services, and have drugs and biologicals available to treat emergencies.

A RHC operating under a Critical Access Hospital (i.e., the Hospital) receives several benefits which include:

1. Medicare reimbursement at 101% of cost;
2. Enhanced Medicaid reimbursement;
3. National Health Services Corps Student Loan Payment Program; and
4. Can claim a portion of bad debt on their cost report.

{INTENTIONALLY LEFT BLANK}

[11] *See* https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/.

A comparison of RHCs versus Health Centers are highlighted as follows:

Comparison of Rural Health Clinics (RHCs) and Federally Qualified Health Center (FQHCs)		
Characteristic	**RHC**	**FQHC**
Program Purpose	Increase the number of physicians and mid-level providers in rural areas	Address primary care shortages and health disparities
Location Requirements	Rural area that is defined by the Census as a Designated Medically Underserved Area ("MUA")[12], Health Professional Shortage Area ("HPSA")[13], or Governor Designated Shortage Area	Area designated as MUA or Medically Underserved Population ("MUP")[14]
Corporate Structure	Unincorporated, public entity nonprofit, or for profit	Tax-exempt nonprofit or governmental entity with nonprofit co-applicant
Board of Directors	Not required	Required with 51% patient representation
Services Provided	Basic primary care and routine diagnostic services	Comprehensive primary care (Medical, Dental, and Behavioral Health) and other required services as designated by HRSA
Staffing Requirements	At least 1 mid-level provider onsite at least 50% of the time the clinic is open	Flexible staffing model but must be able to provide services as proposed in HRSA grant application which must include services listed in Appendix F
Place of Service	RHC, patient's home, or accident scene	Approved healthcare delivery site
Medicare Reimbursement	All-inclusive rate system except where RHC is integral and subordinate part of a hospital of less than 50 beds – then reimbursement is actual cost	Prospective Payment System (PPS) rate with annual cost adjustment
Medicaid Reimbursement	Alternative PPS rate	Alternative PPS rate (new FQHCs based on estimated Year 1 cost with reconciliation to actual cost)
Federal Grant Funding	Some opportunities but there is no set funding program or schedule with one-time grants usually being available	Ongoing grants support with significant additional grant opportunities
340B Pharmacy	Generally, RHC not eligible	Automatically eligible for both FQHC and FQHC LA
FTCA Coverage	Not eligible	Eligible (FQHC LA programs not eligible)
Safe Harbor Provisions	No protection related to provision of goods or services, only physician recruitment[15]	Eligible pursuant to Health Center Safe Harbor Provisions[16]

{INTENTIONALLY LEFT BLANK}

[12] See Appendix I for definition.
[13] See Appendix I for definition.
[14] See Appendix I for definition
[15] *See* 42 CFR 1001.952(n).
[16] *See* 42 CFR 1001.952(w).

D. Increased Reimbursement Rate Benefits of Health Centers Compared to Rural Health Clinics

As stated previously, Health Centers are reimbursed using PPS Rates determined by the Centers for Medicare and Medicaid Services, for treatment of patients utilizing Medicaid and Medicare.

1. Medicaid PPS Rate

The average Medicaid PPS rate for a Health Center in Texas is currently $214.44 per patient visit compared to the average rate of $187.16 for Health Centers in Chambers, Liberty and Jefferson Counties. Chamber Health's current Medicaid PPS rate is $134.17 per visit.

2. Medicare PPS Rate

Medicare reimbursement is based on a national average cost with a geographic adjustment applied. Currently the Medicare PPS rate for Health Centers is Chambers County is $169.74 per routine visit with a rate of $227.72 for new patient, initial preventative physical exam, and annual wellness visits.

According to cost report filings and information from the Texas Department of Health and Human Services, the Rural Health Clinic at the Hospital receives $105.89 per Medicaid visit and $155.37 per Medicare visit.

When evaluating the feasibility of a Health Center, these rates are important because they provide the appropriate amount of revenue needed to cover the cost for comprehensive healthcare services to Medicaid and Medicare patients. Starting in 2001, Congress enacted the Health Center Medicaid[17] PPS rate to ensure Health Centers could continue to provide comprehensive healthcare to Medicaid patients and not be forced to divert Federal Section 330 grant funds, which are intended to cover the cost of care for the uninsured. In 2014, an enhanced Medicare PPS rate system with a similar intent was enacted.[18]

III. Health Centers – Nationally, Texas, and Nearby

Nationally, in 2020, there were 1,375 FQHCs serving 25.6 million patients and providing over 86.5 million medical visits. These FQHCs received total federal funding of over $4.7 billion. Meanwhile, there are 87 FQHC LAs across the country serving 679,000 patients.

Nationally FQHCs treat 13.4 million Medicaid patients, or 19% of Medicaid enrollees.

In the State of Texas, there are currently 72 FQHCs serving 1.6 million patients. There is only one FQHC LA in the State located in Odessa and it serves approximately 6,500 patients.[19] However, nationwide, in 2020, FQHC LAs served over 670,000 patients and provided over 2 million visits.

---

[17] *See* http://www.nachc.org/wp-content/uploads/2017/03/PPS-One-Pager-noask.pdf.

[18] See https://www.cms.gov/files/document/mm12046.pdf.

[19] While we have no way of knowing why there is only one (1) FQHC in Texas, we must assume it is because the other FQHC LA start-up was most likely converted to FQHCs.

With substantial Health Center funding opportunities from HRSA over the past several years, many FQHC LAs have achieved recognition of full FQHC status.

Regionally, FQHCs are heavily utilized by residents. In 2020, Chambers Health had 12,510 patients encounters while in Port Arthur, Gulf Coast Health Center reported 15,887 encounters.[20] Of the encounters seen at Chambers Health 19% were uninsured, 12% were Medicare, and 15% were Medicaid patients. The remaining patients had coverage through private insurance companies.

Cost and other information for National, State, and surrounding FQHCs can are as follows:[21]

FQHC	National	Texas	Chambers Health	Coastal Health and Wellness	Gulf Coast Health Center	Health Center of SE Texas	Triangle Area Network
Location			Anahuac	Corpus Christi	Port Author	Cleveland	Beaumont
Individual Patients - 2019	29,836,613	1,603,867	12,435	12,153	19,581	13,195	3,254
Individual Patients - 2020	25,590,897	1,612,141	12,510	7,985	15,887	12,279	2,969
Cost/Patient 2019	$1,044	$913	$460	$921	$569	$489	$1,180
Cost/Patient 2020	$1,157	$1,010	$557	$1,329	$665	$658	$1,515
HRSA Grants 2019	$4.9 billion	$269 million	$1.6 million	$3.6 million	$3.9 million	$2.8 million	$1.0 million
HRSA Grants 2020	$4.7 billion	$252 million	$2.0 million	$3.3 million	$4.2 million	$2.7 million	$1.2 million

IV. Analysis of Demographics, Community Impact

The demographics of the service area are useful to: 1) determine the community need; 2). Establish the necessity for a Health Center if a FQHC LA application is submitted; and 3) generating financial proformas to assess the sustainability of a FQHC LA.

Please note that the best publicly available data, and the data HRSA uses to make its determinations, are based on Zip Code Tabulation Areas (ZCTAs) as defined by the Census Bureau. The District's population is mainly within the U.S. Census Zip Code Tabulation Areas (ZCTA) of Winnie (77665) and Stowell (77661). These ZCTAs roughly align with post office zip codes, although there may be some slight deviations that would not have any material effect of the analysis. Demographic information in this section includes patients who reside outside of the

[20] Service Areas of these Health Centers can be found in Appendix B.

[21] *See* https://data.hrsa.gov/tools/data-reporting/program-data?type=AWARDEE.

District but within the ZCTAs.

A. Demographics of the District

In order to qualify for Health Center status, an organization has to serve a MUA or MUP.[22]

Standing alone, Chambers County, and therefore, the District is no longer deemed by HRSA to be a MUA or MUP. Consequently, the District is no longer considered by HRSA to be an MUA or MUP. Fortunately, to determine if any part of that area contains all or some of a MUA or MUP, HRSA looks at the Zip Code Tabulation Areas ("ZTCA").[23] In the case of the District, since the 77665 zip code includes portions of Jefferson County, the zip codes qualify as a MUP.

The following table and chart represent the current characteristics of these two ZTCAs:

Data Point	# of People
Total Population	6,823
Low Income Population	2,171
Total FQHC Patients	684
Population Not Served By FQHCs	6,139
Uninsured Not Served By FQHCs	1,100
Medicaid/Other Public Not Served By FQHCs	648
Medicare/Private Not Served By FQHCs	4,491
Population >= 65 Years Old	1,041
Population >= 18 and < 65 Years Old	4,224
Population < 18 Years Old	1,558

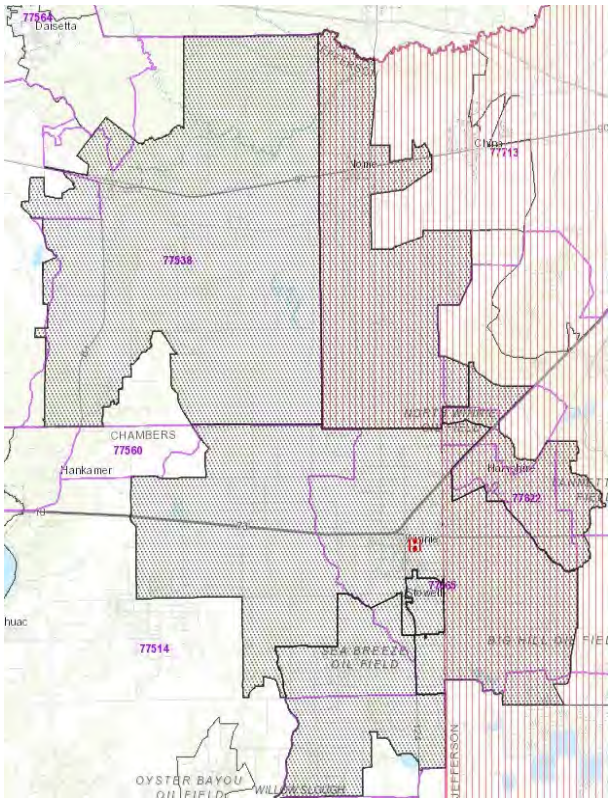
In comparison, the Hospital's RHC is located within the District and sees an estimated 2,500 unduplicated patients with a little over 8,000-10,000 total clinic visits annually.[24] Given this relatively high number of RHC patients compared to the total population, it is reasonable to assume that patients are travelling from outside the District to obtain primary care services.

{INTENTIONALLY LEFT BLANK}

[22] *See* Exhibit I.
[23] *See* Exhibit I.
[24] Based on the 2019 cost report and 2020 monthly report provided to the District.

B. Demographics of Adjacent Zip Codes to Gain Patients for Economies of Scale

Because of the relatively small size of the population within the District, it is important to note that serving a larger area than the District will create economies of scale that will come into play in running a Health Center. Most importantly, HRSA will want to see more patients served than just the two ZTCAs that are included in the District. Seeing that the Chambers County Public Hospital District #1 (CCPHD) has locations in Anahuac and West Chamber's County, the District should look to the north and east to expand the patient panel for its healthcare operations. In addition, expanding into these areas will provide coverage to a MUP as stated above, which will be required by HRSA for the FQHC LA application. The map to the right highlights these areas.



The ZTCAs include Winnie (77665), Stowell (77661), Devers (77538), Hampshire (77622), and Nome (77629).

Represents the ZTCAs inside the District

Represents the area designated as an MUP

Next, we compare the demographics of the target market to what was presented previously for those within the District's boundaries:

Data Point	# of Residents for District Zip Codes	# of People District Zip Codes and Target Zip Codes
Total Population	6,823	10,090
Low Income Population	2,171	2,879
Total FQHC Patients	684	893
Population Not Served By FQHCs	6,139	9,197
Uninsured Not Served By FQHCs	1,100	1,599
Medicaid/Other Public Not Served By FQHCs	648	991
Medicare/Private Not Served By FQHCs	4,491	6,766,
Population >= 65 Years Old	1,041	1,689
Population >= 18 and < 65 Years Old	4,224	6,110
Population < 18 Years Old	1,558	2,291

In addition, HRSA will look at a large number of community social and health statistics in making its determination in granting Health Center status. The following table represents a sample of relevant statistics reviewed by HRSA for these five zip codes as compared to the entire national Health Center patient panel:

Data Point	Target Zip Code Population	National Health Center Patients
% Of Population Living in Poverty	11%	13%
% Population – Racial/Ethnic Minority	20%	62%
% Population – Veterans	10%	1%
% Populations With A Disability	24%	13%
% Adults Who Delayed Treatment Due To Cost	17%	13%
% Adults Who Are Obese	39%	31%
% Adults Who Have Been Told They Have Diabetes	12%	11%
% Adults Who Are Binge Drinkers	17%	16%
% Adults With No Flu Vaccine	63%	*
% Adults Who Smoke	20%	16%

In the table above, the numbers that appear in red highlight are those statistics which HRSA will view as demonstrating need for additional services in the area.

C. Current Medical Services Available to District Residents

1. Hospital

The Hospital is a Critical Access Hospital (CAH) with an associated RHC. CAHs are a separate provider category under the Center for Medicare & Medicaid Services (CMS) and have their own Conditions of Participation and Payment Methods[25]

The Hospital is currently the only option in Winnie for complete medical care.[26] Fortunately for the community, it has comprehensive service capabilities including routine medical (RHC), behavioral health (currently paused with COVID emergency), emergency department, inpatient, swing-beds, laboratory, and diagnostic imaging.

The RHC sees approximately 8,500-10,000 patients per year and currently employs one physician and two physician assistants. The RHC provides basic medical clinic services including primary care.

[25] These regulations can be reviewed at https://www.ssa.gov/OP_Home/ssact/title18/1814.htm and https://www.ssa.gov/OP_Home/comp2/B-CFR-42.html.

[26] *See* Section IV(D) for a further discussion on the Hospital.

It is important that the District utilize the Hospital's capabilities in the most effective manner. If the Hospital were to become financially unviable, the community would lose its most valuable healthcare resource.

Patients needing a higher level of specialty care and OB/GYN services must travel outside the area to UTMB in Galveston, Beaumont, or Houston area. Furthermore, Chambers Health reports they saw approximately 8% of the District's population. [27] Most likely, the residents were seen at one of their FQHC Clinics, presumably in Anahuac.

2. Other Medical Providers

The District has an agreement with the University of Texas Medical branch (UTMB) – Galveston to provide advanced care for the District's indigent population when needed. These services are provided by UTMB at agreed upon rates.

Moreover, the District assists with providing health care funding for the children attending school at the East Chambers Independent School District (ECISD). This includes funding for school nurses, providing various testing, counseling and therapy, and accident insurance for all students. Beyond this, there are no other medical provider services in Winnie at this point in time.

3. Dental Services

Currently in Winnie, Dr. Michael Fahey is the only dentist. This practice participates in a wide range of insurance plans. His office is centrally located on 3rd Street and provides services Monday through Friday during normal business hours and is closed on weekends. There is little public information on Dr. Fahey, but stakeholder interviews indicate that he is a trusted provider in the community.

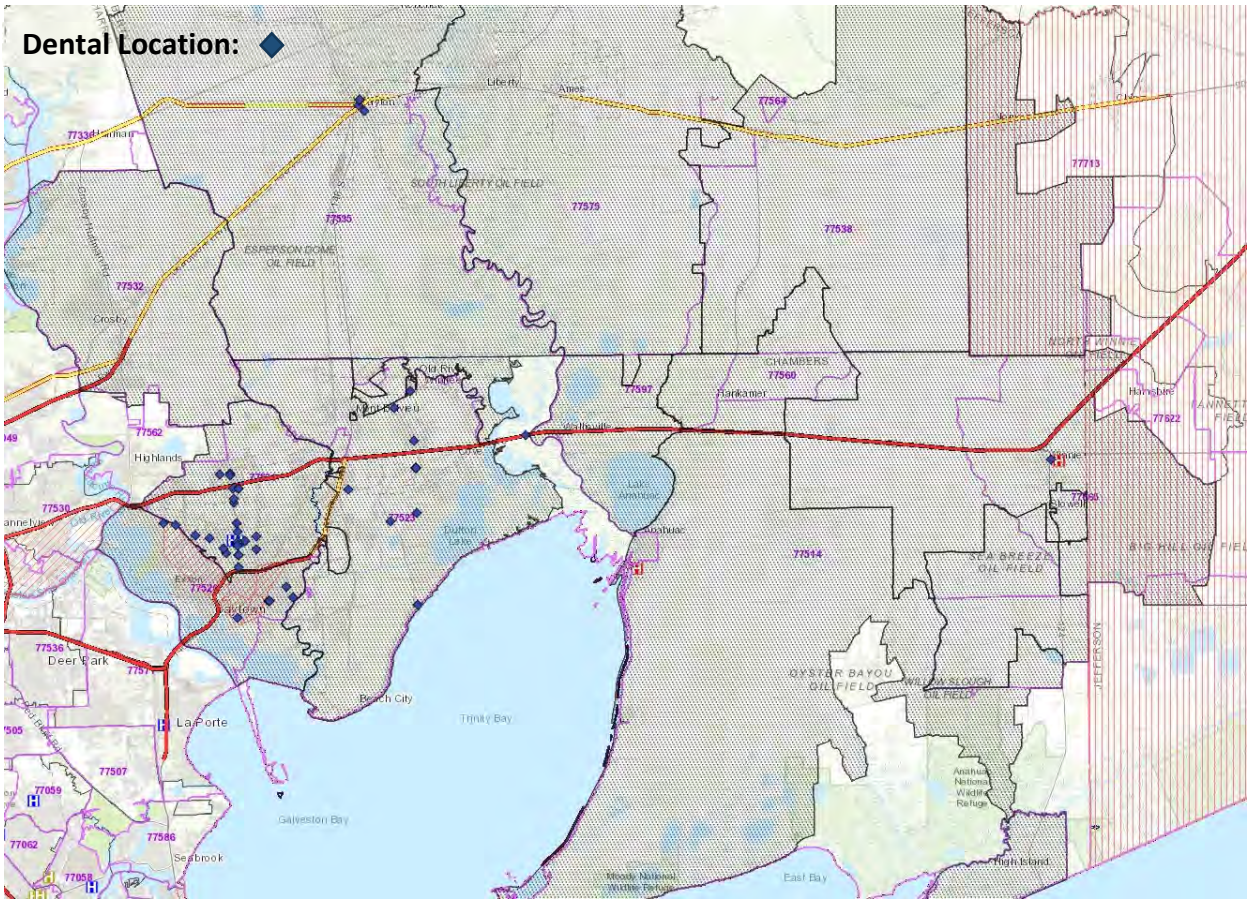
Currently, the District contracts with Chambers Health for dental services for its Indigent clients but only 8 indigent clients have utilized this service.

As you can see on the following map, dental services are not readily available in Eastern Chambers County.[28]

{INTENTIONALLY LEFT BLANK}

[27] See Appendix B and https://maps.udsmapper.org/map

[28] A list of these dentists and locations can be downloaded at: https://tsbde.texas.gov/resources/licensee-lists/



On average, a dentist patient panel is about 1,500 – 1,800 patients. Since the total targeted population is approximately 10,000 people, this leaves significant room for expanding dental services in the area, especially with children.

4. Behavioral Health Services

There are limited behavioral health services within the District and in its adjacent areas. With the assistance of the District, the Hospital did implement a behavioral health program which included Partial Hospitalization. This program started out fairly strong but eventually was suspended during the COVID pandemic.

In addition, the Hospital was performing "warm-handoffs" in their RHC. This is a practice where the medical provider identifies that a patient should seek behavioral health services and introduces the patient to a behavioral health provider, usually a licensed social worker, during the patient visit. This practice usually results in higher behavioral health referral compliance. However, in the case of the Hospital this did not increase the Behavioral Health volumes to any significant degree. The COVID pandemic has had a negative impact of the launching of this program also.

Meanwhile, the District provides indigent behavioral health services when the Hospital had a counselor or social worker available, but with the suspension of these programs due to COVID,

these services are no longer available.

The ECISD has strong behavioral health resources for its students. The District funds the ECISD's Youth Counselling Program and the Irlen Method Testing and Treatment Program (screening for learning disabilities).[29]

In addition, each school has a counselor and the District contracts with other licensed professionals as well. The gap in service with students is the inability to conduct family counselling sessions. This appears to be a relatively significant need.

Substance abuse in the area was raised as a concern during some discussions. Currently, the closest treatment facilities are in Beaumont. The community would benefit greatly from locally available outpatient services. This would benefit those not in need of full inpatient services and those who require access to treatment after discharge from an inpatient program.

Currently, the District refers indigent patients to Spindle Top in Beaumont for behavioral and substance abuse services but does not reimburse for those services.

5. Vision

There are currently no optometrists in close proximity to the District. Currently, the District refers patients to Dr. June Stansky in Baytown for services. Most residents of the District travel to Beaumont for vision services. However, District staff indicated that they were attempting to have an optometry group open a satellite in the area, but this has yet to come to fruition.

6. Case Management

The District currently provides case management services for the indigent enrolled in the ICAP program. As of July 2021, there were 57 individuals enrolled in this program. In August of this year, the District loosened the income limitation of the program from 150% to 200% of the Federal Poverty Level.[30]

The County has an indigent case management program for those who live outside the two hospital districts. However, the County's program rarely exceeds 10 cases on the active roll.

D. Impact on the Hospital

In order for a Health Center and the Hospital to both flourish, it is essential that the two entities work collaboratively. While we envision transitioning the RHC patients to the Health Center, the Health Center patients will need laboratory services, diagnostic imaging, and behavioral health[31]. We are recommending that these services be contracted to the Hospital at fair market value. Although the patient always has the choice on where to receive services, the hospitals resources

[29] *See* Appendix G for more information related to the District's programs.
[30] For more information please see: https://www.healthcare.gov/glossary/federal-poverty-level-fpl/
[31] See Appendix C for required services

are easily accessible. We are confident that this will result in additional net revenue for the hospital through volumes above and beyond which the Hospital is currently experiencing.

As stated earlier, we estimate that the Hospital currently treats 2,500 unduplicated patients, or between 8,000-10,000 occurrences at the clinic on an annual basis. In comparison, as stated in the Section V-Financials and Location Recommendation, because of the benefits associated with an FQHC and the larger targeted service area, we estimate that by the end of Year 1, the Health Center will provide primary care to over 3,471 patients, or 15,621 occurrences, and in Year 3, we hope to see these numbers increase to 5,517 patients, or 24,828 occurrences. If these estimates are correct, this would represent a significantly larger pool of patients that will need to be referred to the Hospital.

The Hospital did express concern that the RHC providers may take their existing patient panels and move them to a private practice if a Health Center were established. This is a legitimate concern, and the District and Hospital should work with these providers and *potentially* employ them if they meet the Health Centers credentialling criteria.

Lastly, the Hospital would like the Health Center's providers to have hospital privileges including admitting and rounding. We agree with this request.

V. Financials and Location Recommendations

A. Costs and Staffing of the Health Center

We have developed a proforma which shows our projected three year start up period income and expenses. Afterwards, the proforma trends revenues and costs an additional seven years into the future using an inflation multiplier of 1.03%. The additional seven years are not meant to be an exact predictor of Health Center financial returns. Instead, this period is intended to show continued operations without significant expansion. By trending this data, we can see that the Health Center should be viable.

{INTENTIONALLY LEFT BLANK}

Health Center P&L	Clinic Start-Up			Future Years Trended at 3% Increases per Year (1.03 *s Previous Year)						
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Net Outpatient Revenue	$ 70,301	$ 1,897,162	$ 3,127,136	$ 3,220,951	$ 3,317,579	$ 3,417,106	$ 3,519,620	$ 3,625,208	$ 3,733,964	$ 3,845,983
340B Revenue	71,335	463,896	737,316	759,435	782,218	805,685	829,855	854,751	880,394	906,805
HRSA Grant	-	-	650,000	650,000	650,000	650,000	650,000	650,000	650,000	650,000
Winnie Stowell Hospital District Grants	737,489	511,840	-	-	-	-	-	-	-	-
Total Revenue	**$ 879,125**	**$ 2,872,898**	**$ 4,514,452**	**$ 4,630,386**	**$ 4,749,797**	**$ 4,872,791**	**$ 4,999,475**	**$ 5,129,959**	**$ 5,264,358**	**$ 5,402,789**
Salary & Wages *(see FTE Table)*										
Providers	$ 201,425	$ 580,663	$ 991,942	$ 1,021,700	$ 1,052,351	$ 1,083,921	$ 1,116,439	$ 1,149,932	$ 1,184,430	$ 1,219,963
Clinical Support Staff	71,750	319,709	444,375	457,706	471,437	485,580	500,148	515,152	530,607	546,525
Patient Support Staff	55,500	175,750	266,770	274,773	283,016	291,507	300,252	309,260	318,537	328,093
Enabling and Outreach Staff	-	43,260	44,558	45,895	47,271	48,690	50,150	51,655	53,204	54,800
Leadership Team and Support	115,000	303,600	310,308	319,617	329,206	339,082	349,254	359,732	370,524	381,640
Finance and Billing	30,000	135,900	169,950	175,049	180,300	185,709	191,280	197,019	202,929	209,017
IT and Other Services	37,500	51,500	53,045	54,636	56,275	57,964	59,703	61,494	63,339	65,239
Total Salary and Wages	$ 511,175	$ 1,610,382	$ 2,280,947	$ 2,349,376	$ 2,419,857	$ 2,492,453	$ 2,567,226	$ 2,644,243	$ 2,723,570	$ 2,805,277
Benefits (20%)	$ 102,235	$ 322,076	$ 456,189	469,875	483,971	498,491	513,445	528,849	544,714	561,055
Total Salary, Wages and Benefits	**$ 613,410**	**$ 1,932,458**	**$ 2,737,137**	**$ 2,819,251**	**$ 2,903,828**	**$ 2,990,943**	**$ 3,080,671**	**$ 3,173,092**	**$ 3,268,284**	**$ 3,366,333**
Non_Salary Expense										
Dental, Behavioral Health & Optical Contracts	$ 81,250	$ 360,300	$ 444,000	457,320	471,040	485,171	499,726	514,718	530,159	546,064
Occupancy (4,000 sq. ft @ $22)	66,000	$ 89,980	$ 92,679	95,460	98,324	101,273	104,311	107,441	110,664	113,984
EHR Licensing (6.5% Net Revenue)	4,570	$ 123,316	$ 203,264	209,362	215,643	222,112	228,775	235,639	242,708	249,989
Pharmaceuticals ($5 avg. per medical visit)	7,750	$ 59,550	$ 101,400	104,442	107,575	110,803	114,127	117,550	121,077	124,709
Utilities	6,000	$ 8,180	$ 8,425	8,678	8,939	9,207	9,483	9,767	10,060	10,362
IT Outsourcing	15,000	$ 20,450	$ 21,064	21,695	22,346	23,017	23,707	24,418	25,151	25,905
Medical Supplies ($6 per medical visit)	9,300	$ 73,604	$ 129,090	132,963	136,952	141,060	145,292	149,651	154,141	158,765
Office Supplies, Comp. Expense ($4 per visit)	14,608	$ 64,359	$ 105,360	108,521	111,777	115,130	118,584	122,141	125,805	129,580
Malpactice (not needed once HRSA grant is awarded)	16,238	$ 63,750	$ -	-	-	-	-	-	-	-
Repairs and Maintenance	3,000	$ 4,090	$ 4,213	4,339	4,469	4,603	4,741	4,884	5,030	5,181
Audit and Legal	35,000	$ 46,427	$ 47,982	49,421	50,904	52,431	54,004	55,624	57,293	59,011
Travel, Conference and Meetings	4,500	$ 6,135	$ 6,319	6,509	6,704	6,905	7,112	7,326	7,545	7,772
Continuing Medical Education ($3,500/provider and $600/MA)	2,500	$ 5,300	$ 10,000	10,300	10,609	10,927	11,255	11,593	11,941	12,299
Dues and Subscriptions	-	$ 15,000	$ 15,000	15,450	15,914	16,391	16,883	17,389	17,911	18,448
Total Non-Salary Expense	**$ 265,715**	**$ 940,440**	**$ 1,188,796**	**$ 1,224,460**	**$ 1,261,194**	**$ 1,299,029**	**$ 1,338,000**	**$ 1,378,140**	**$ 1,419,485**	**$ 1,462,069**
Total Expenses	**$ 879,125**	**$ 2,872,898**	**$ 3,925,933**	**$ 4,043,711**	**$ 4,165,022**	**$ 4,289,972**	**$ 4,418,672**	**$ 4,551,232**	**$ 4,687,769**	**$ 4,828,402**
Contribution Margin	**$ -**	**$ -**	**$ 588,520**	**$ 586,675**	**$ 584,776**	**$ 582,819**	**$ 580,803**	**$ 578,727**	**$ 576,589**	**$ 574,387**
Patients Per Year	534	3,471	5,517	5,683	5,853	6,029	6,210	6,396	6,588	6,786
Total Visits Per Year	2,402	15,621	24,828	25,573	26,340	27,130	27,944	28,782	29,646	30,535
Federal Cost Per Patient	$ -	$ -	$ 117.81	$ 114.38	$ 111.05	$ 107.81	$ 104.67	$ 101.62	$ 98.66	$ 95.79
Total Cost Per Patient	$ 1,646.92	$ 827.61	$ 711.56	$ 711.56	$ 711.56	$ 711.56	$ 711.56	$ 711.56	$ 711.56	$ 711.56

Cost per Patient 2019	Total Cost
National	$ 1,044.00
Texas	$ 913.00
Chambers Health	$ 460.00
Coastal Health and Wellness	$ 921.00
Gulf Coast Health Center	$ 569.00
Health Center of Southeast Texas	$ 489.00
Triangle Area Network	$ 1,180.00

By Year 3, the Health Center should be fully staffed with the following positions.[32]

		Year 1				Year 2				Year 3			
Providers	Base Year Salary	Q1 FTEs	Q2 FTEs	Q3 FTEs	Q4 FTEs	Q1 FTEs	Q2 FTEs	Q3 FTEs	Q4 FTEs	Q1 FTEs	Q2 FTEs	Q3 FTEs	Q4 FTEs
Physicians Family (and CMO)	$ 190,000		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Pediatricians	$ 170,000									1.0	1.0	1.0	1.0
ARNPs Family	$ 115,000			1.0	1.0	3.0	3.0	3.0	4.0	5.0	5.0	5.0	5.0
Clinical Support Staff													
RNs (plus QA/QI)	$ 74,000				1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
LPNs	$ 51,000		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
MAs	$ 33,500		1.0	1.0	2.0	5.0	5.0	5.0	7.0	7.0	7.0	7.0	7.0
Patient Support Staff													
Patient Service Representatives	$ 37,000		2.0	2.0	2.0	4.0	4.0	4.0	7.0	7.0	7.0	7.0	7.0
Enabling and Outreach Staff													
Case Managers	$ 42,000					1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Leadership Team and Support													
Executive Director	$ 100,000		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Director of Operations	$ 80,000				1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Director of Finance	$ 80,000				1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Admin Assistant	$ 45,000					1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Finance and Billing													
Senior Accountant	$ 50,000					1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Accounting Clerks	$ 35,000					1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Billing Clerks	$ 40,000		1.0	1.0	1.0	1.0	1.0	1.0	2.0	2.0	2.0	2.0	2.0
IT and Other Services													
IT Specialists	$ 50,000		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Grand Totals		-	8.0	9.0	13.0	24.0	24.0	24.0	31.0	33.0	33.0	33.0	33.0

** FTE = Full Time Equivalent of Employment*

You can see from the above proforma that start-up operations for the Health Center will take some time, but the long-term returns will provide net income for future projects and services that can be funded by the Health Center itself.

The proforma is based on core Health Center operations. We anticipate that there will be other revenue opportunities that will present themselves and will provide the mutual benefits of better serving the community and increasing the bottom line without encroaching on the ancillary services provided by the Hospital[33]. These opportunities include non-face-to-face chronic care management for Medicare patients with two or more chronic conditions, health and wellness center, mobile units, dental chair in the medical clinic for pediatric sealants, telemedicine, private philanthropy, and many others. These items should be thoroughly explored while formally developing the Health Center's strategies.

Returning to Year 3, we believe that by this year, the Health Center will be able to obtain grant monies from HRSA and achieve full Health Center status. HRSA's Health Center program has bipartisan support in Congress and has for many years so the risk of the program contracting, or ceasing, is minimal. In addition, HRSA has offered many supplemental funding opportunities in

[32] All dental, behavioral health, and optometry services are outsourced via contract in the proforma, and therefore, there are no associated cost for Full Time Employees ("FTEs").

[33] HRSA requires a Health Center to provide ancillary services such as laboratory and diagnostic imaging to its patient. The Hospital will be able to provide these services via contract to these patients.

the past (in addition to COVID funding) which included technology, behavioral health, substance abuse, new access points, and more. We anticipate there will be similar opportunities in the future.

It is important to note that the Health Center grant program is a competitive process and there are Service Area Competitions (SAC) at least every three years for existing grantees. Chambers Health is the only Health Center in the area to serve the population within the District to any significant degree. If approved, the District should expect to see a HRSA Notice of Funding Opportunity (NOFO) in June 2024 for the area.

B. Break Even Analysis

In order to assess the risk associated with starting a Health Center, we must establish the break-even point of operations. There are both fixed and variable revenues and expenses that must be considered when assessing this break-even point.

The following table shows revenues and expenses for different patient levels of the Health Center. This assessment is based on Year 3 operations. It would initially appear that in order for the Health Center to sustain itself without assistance from the District, a panel of 4,400 patients, or 19,800 occurrences would be needed.

Break Even Analysis - Year 3 w/ No Fixed Expense Reduction from Proforma					
Patients	2,000	3,000	4,000	4,400	5,517
Visits	9,000	13,500	18,000	19,800	24,828
Total Revenue	$ 2,050,850	$ 2,751,275	$ 3,451,700	$ 3,731,870	$ 4,514,478
Total Expense	$ (3,299,191)	$ (3,477,378)	$ (3,655,564)	$ (3,726,839)	$ (3,925,933)
Net Income	**$ (1,248,341)**	**$ (726,103)**	**$ (203,864)**	**$ 5,031**	**$ 588,545**
Cost per Patient	$ 1,649.60	$ 1,159.13	$ 913.89	$ 847.01	$ 711.56
Cost per Visit	$ 366.58	$ 257.58	$ 203.09	$ 188.22	$ 158.13
				Break Even	**Per Proforma**

{INTENTIONALLY LEFT BLANK}

However, when we reduce salaries (we have added these costs back into net income) associated with reduced staffing levels, the patient panel needed for sustainability drops to 4,000, or 18,000 occurrences.[34] Please note that this assumes HRSA funding of $650,000.

Break Even Analysis - Year 3 w/ Adjustments to Staffing Levels					
Patients	2,000	3,000	4,000	4,400	5,517
Visits	9,000	13,500	18,000	19,800	24,828
Total Revenue	$ 2,050,850	$ 2,751,275	$ 3,451,700	$ 3,731,870	$ 4,514,478
Total Expense	$ (3,299,191)	$ (3,477,378)	$ (3,655,564)	$ (3,726,839)	$ (3,925,933)
Provider Expense Adjustments	$ 509,232	$ 362,828	$ 216,424	$ -	$ -
Support Staff Expense Adjustments	$ 261,414	$ 174,276	$ 128,544		
Net Income	**$ (477,695)**	**$ (188,999)**	**$ 12,560**	**$ 5,031**	**$ 588,545**
Cost per Patient	$ 1,264.27	$ 980.09	$ 827.65	$ 847.01	$ 711.56
Cost per Visit	$ 280.95	$ 217.80	$ 183.92	$ 188.22	$ 158.13
			Break Even		**Per Proforma**

C. Costs to the Patient

One of the major benefits of operating a Health Center is that the Health Center is responsible for taking care of all patients, regardless of their ability to pay. Therefore, they are required to provide a sliding fee scale ("SFS"). This SFS must be available to all patients whose income level is 200% or below the Federal Poverty Level. Here is an example of a Health Center sliding fee scale:

	Federal Poverty Guidelines					
Family Size	100% and Below **A**	101% - 125% **B**	126% - 150% **C**	151% - 175% **D**	176% - 200% **E**	Over 200% **Full Charge**
1	$0 - $12,880	$12,881 - $16,100	$16,101 - $19,320	$19,321 - $22,540	$22,541 - $25,760	$25,761
2	$0 - $17,420	$17,421 - $21,775	$21,776 - $26,130	$26,131 - $30,485	$30,486 - $34,840	$34,841
3	$0 - $21,960	$21,961 - $27,450	$27,451 - $32,940	$32,941 - $38,430	$38,431 - $43,920	$43,921
4	$0 - $26,500	$26,501 - $33,125	$33,126 - $39,750	$39,751 - $46,375	$46,376 - $53,000	$53,001
5	$0 - $31,040	$31,041 - $38,800	$38,801 - $46,560	$46,561 - $54,320	$54,321 - $62,080	$62,081
6	$0 - $35,580	$35,581 - $44,475	$44,476 - $53,370	$53,371 - $62,265	$62,266 - $71,160	$71,161
7	$0 - $40,120	$40,121 - $50,150	$50,151 - $60,180	$60,181 - $70,210	$70,211 - $80,240	$80,241
8	$0 - $44,660	$44,661 - $55,825	$55,826 - $66,990	$66,991 - $78,155	$78,156 - $89,320	$89,321
Per Each Additional Member	add $4,540	add $5,675	add $6,810	add $7,945	add $9,080	add $9,080

[34] Staffing reductions are as follows: 2,000 Patients – 1 Physician (DR), 2 Nurse Practitioners (NPs), 3 Medical Assistants (MAs), 3 Patient Service Representatives (PSRs); 3,000 Patients – 1 Dr, 1 NP, 2 MAs, 2 PSRs; 4,000 Patients – 1 Dr, 2 MAs, 1 PSR.

Based on eligibility, the patient is responsible for either the nominal fee or for the percentage listed of the total charge.
Example: A total charge of $90 for a dental exam with Slide B ($90 x 40% = $36 which is the total patient responsibility)

PAYMENTS MUST BE MADE AT TIME OF VISIT

Sliding Fee Level	Medical & Behavioral Health Services	Preventive** Dental Services	Additional*** Dental Services	Optometry, Rehabilitative Services (Physical Therapy, Chiropractic, Acupuncture, and Massage Therapy)
A*	$10.00	$15.00	$15.00	$15.00
B	$20.00	40%	50%	35%
C	$35.00	60%	65%	50%
D	$45.00	75%	80%	75%
E	$50.00	80%	90%	85%
Over 200%	Full Charge	Full Charge	Full Charge	Full Charge

Certain items provided within a visit(s) cannot be discounted. These include but are not limited to: Injected Medications, Durable Medical Equipment or Supplies, Physical Therapy Aids, Dentures, Crowns, Bridges, and Mouth Guards.

* **All patients below 100% of the Poverty Guidelines will be charged the nominal fee listed or less based on demonstrated ability to pay. Preventive and additional services performed in the same visit will result in only one nominal fee.**

** **Preventive Procedures:** exams, cleanings, x-rays, and sealants.

*** **Additional Procedures:** fillings such as with amalgam (silver) or composite (white), any gum treatments such as scaling and root planning (deep cleaning), and non-surgical simple extractions

As you can see, the fees for a medical visit in this example range from $10 to $50, depending on income level. When we compare this to the Hospital's RHC, there is a large difference. According to the Hospital's published rates, an existing self-pay patient is charged between $120 and $251 per patient visit while a new patient is charged between $190 and $379 per visit.

D. Costs to the District

1. Operations Cost

In addition to the start-up cost for Year 1 and 2 discussed above, additional start-up cost will most likely include legal counsel with Health Center expertise; physician recruitment; and consulting costs for practice start-up and HRSA operational compliance. If the district choses to utilize these external resources, it should be prepared to spend up to $480,000 for these services.

2. Capital Cost

It is our recommendation that the District own the healthcare facility and lease it to the Health Center. We estimate the Health Center will need at least 4,000 square feet by Year 3. This can be phased in with the purchase of two separate modular buildings. For the near future, it would be helpful if the building can be placed on the property already leased from the Hospital.

{INTENTIONALLY LEFT BLANK}

Capital Expense	Year 1	Year 2
Modular Buildings	$150,000	$150,000
Exam Room Set-up	$26,250	$26,250
Other Furnishings	$75,000	$50,000
Total Capital Expense	**$251,250**	**$226,250**
Non-Capital Expense		
Health Center Grant	$737,489	$511,840
Legal	$40,000	$10,000
Recruitment	$30,000	$25,000
Practice Start-Up	$75,000	
Look-Alike Application and HRSA Compliance	$250,000	$50,000
Total Non-Capital Costs	**$1,132,489**	**$596,840**
Total Expenditures	**$1,383,739**	**$823,090**

The District may choose to off-set these expenses by charging market value for the rental of the facility (included in the proforma) and issuing a loan instead of a grant to the Health Center (not included in the proforma). These revenues are as follows:

Revenue	Each Year
Rent	$92,679
Loan Repayment (if this option is chosen – begins Year 3 and ends after 8 years of payments)	$179,760
Total Potential Revenues	**$272,439**

E. Location and Space Needs

As far as determining the best location and pieces of property that may be for sale, we would defer to the Board and community leaders for their opinion. However, per our research, determining a specific location for the Health Center is somewhat of a challenge because of the limited commercial real estate that is available in Winnie.

Typically, the ideal facility space needed for a fully staffed site would be approximately 7,000 square feet. Additional space would be needed if the District decides to build an expanded Health Center facility with ancillary services, dental and behavioral health. However, starting with a smaller facility is certainly a viable option.

{INTENTIONALLY LEFT BLANK}

For THRIVE, we believe that the most important factors to consider are:

1. The location should be within close proximity of the hospital; and
2. The location should be visible from TX-124 if possible.[35]

When the District's Board decides how they would like to proceed, the average cost for a modular building can be constructed for as little as $100 per square foot with manufactured space even less. On the other hand, traditional medical construction can run between $150 to $200 per square foot for a very modest facility.

VI. Applying For Look-Alike Status

A. Health Center Program Fundamentals

There are six main fundamentals of HRSA's Health Center Program:

1. Serve High Needs Areas – Must serve a high need community or population
2. Comprehensive – Services must provide comprehensive primary care as well as enabling services (education, outreach, and transportation)
3. Collaborative – Collaboration with other community providers will maximize resources and efficiencies in service delivery
4. Patient Directed Governance – The Health Center must be established and operated as a: a) private nonprofit; b) or public agency; or c) a hybrid of the public agency model referred to as a "co-applicant arrangement", that involves a non-profit and a governmental entity; but no matter model chosen to operate the Health Center, the Health Center must be governed by a patient-majority community board
5. No One is Turned Away – Services are available to all, with fees adjusted based on one's ability to pay and using a sliding fee scale.
6. Accountable – Performance and accountability requirements regarding administrative, clinical, and financial operations must be met. [36]

The program fundamentals listed above demonstrate the amount of service, care, and oversight that a Health Center must provide. Fortunately, enhanced Medicaid and Medicare PPS rates, as well as the 340B pharmacy program, provide the financial resources Health Centers require in order to meet these needs. In addition, a fully funded FQHC also can rely on HRSA grant monies to carry out the program.

{INTENTIONALLY LEFT BLANK}

[35] For reference, Appendix H shows a map with a ½ mile radius of the hospital and two potential locations.

[36] *See* https://bphc.hrsa.gov/sites/default/files/bphc/programopportunities/lookalike/pdfs/lalidinstructionslides.pdf.

B. Health Center Models and The Hospital District's Role in the Health Center

As stated earlier, there are three (3) models for Health Centers. In this section, we will discuss the pros and cons for each model.

1. Non-Profit

This model is most common as it is more nimble, less bureaucratic and does not have the burden of two separate Boards providing oversight of healthcare delivery. The District can still assist the Non-profit in its oversight function because 1) the District is the landlord; 2) it may recommend multiple Board members to the non-profit as outlined by the non-profit's bylaws; 3) it is a continued source of funding. By having Board members on the Health Center Board, the District can ensure that its own fiscal and social responsibilities are being taken into consideration with Health Center decisions. Terms and conditions of District funding of the Health Center are still the independent decision of the District. For example, terms can be written into the lease agreement that require performance metrics or certain salary costs may need to be justified by the Health Center in order to access funding from the District.

2. Public Agencies – Stand Alone

Certain public agencies qualify to serve as FQHC's but because of the Board governance requirements, public agencies, often are not able to qualify alone.

3. Public Agencies with Co-Applicant

Since it is difficult for public agencies to qualify for an FQHC alone, public agencies often take advantage of the Co-Applicant model to establish Health Center status. In this model, public agencies may co-apply to own and operate Health Centers with a non-profit since it is easier to meet the board governance and composition requirements on their own. Therefore, as is the case at Chambers Public Hospital District #1, Chambers Health is the Public Agency and the "Co-Applicant" is the Chambers Community Health Center, a 501(c3). Because Chambers Health owns and operates a hospital, the FQHC's complement their hospital and most enable the system to capitalize on certain economies of scale such as staffing and purchases of supplies and equipment.

In the Co-Applicant model, the non-profit holds governance responsibility over the health center and is responsible for ensuring that HRSA program requirements are followed while the Public Agency is the licensed provider; facility owner; conduit for funding; responsible for general financial management and control systems; establish personnel policies; and can employ management team/ staff, including CEO. However, in this model the CEO still has reporting responsibility to the nonprofit Board.

The two entities work collaboratively and the roles and responsibilities for this model are delegated in a Co-Applicant Agreement that *"delegates the required authorities and functions to the co-applicant board and delineates the roles and responsibilities of the public agency and the co-applicant in carrying out the Health Center Program project"*. This means the Co-Applicant Board has the same governance and oversight responsibilities as a stand-alone Health Center as outlined below in Section 4. Board Responsibilities.

Overall, the Public Agency model, or the Co-Applicant model, represents the minority of health centers across the country. Out of the 1,375 Health Centers in the United States in 2020, only 97 were operating under the Public Agency model or the Co-Applicant Model.

4. Board Responsibilities

Again, all Health Centers must be governed by a Board where the majority of members are patients who are demographically representative of the center's patient panel. Of the remaining Board members, no more than one-half can derive more than 10% of their income from the healthcare industry[37]. Taking this into consideration, the following two tables outline Board responsibilities for both models outlined above:

Health Center Board Authority **Requirements of Both Non-Profit and Public Agency Models** *The health center must establish a governing board that has specific responsibility for oversite of the project* Section 330(k)(3)(H) of the PHS Act; 42 CFR 51c.303(i), 42 CFR 56.303(i), 42 CFR 51c.304(d), and 42 CFR 56.304(d); and 45 CFR 75.507(b)(2)	
Board Requirements – General Responsibilities	
Develop and maintain bylaws	Oversee and direct the development of the overall health center project plan
Assure compliance with Federal, State, and local laws	Provide long-range planning, including but not limited to identifying priorities
Conduct monthly meetings and maintain accurate minutes	Adopt a three year plan for financial management and capital expenditures
Hire and terminate the CEO	Assess achievement of project objectives through evaluation of activities, service utilization patterns, productivity, and patient satisfaction
Review and approve the annual health center program budget	Develop a process for hearing and resolving patient grievances

{INTENTIONALLY LEFT BLANK}

[37] *See* https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-20.html#titletop.

Board Requirements – Establish Policy with Emphasis on the Following	
Financial management practices	Health care policies including quality of care audit procedures
Systems to ensure accountability for health center resources (unless already established by the public agency who is the reward recipient)	Scope and availability of services
Review of the financial status of the health center	Decisions to subaward or contract for a substantial portion of services
Review the annual audit to ensure appropriate actions and follow-up	Service site locations
Eligibility for services	Hours of operation
Personnel policies (unless already established by public agency)	

In addition, the following table outlines the required Board composition of a Health Center:

Board Composition *The health center must establish a governing board that reflects the community it serves* *See Section 330(k)(3)(H) of the PHS Act; and 42 CFR 51c.304 and 42 CFR 56.304*	
At least 9 but no more than 25 members	A board member may not be employed by the health center (CEO can be an ex-officio/non-voting member)
51% of the members must be patients served by the health center, collectively representing the demographics of the patient panel	A board member may not be the spouse, child, parent, or brother or sister by blood or marriage to a health center employee
Non-patient members must be representative of the community and selected for their expertise	Bylaws, policies, and rules of the health center must prescribe process for selection and removal of members
Of the non-patient board members, no more than one-half can derive more than 10% of their income from healthcare	

Requirements for Board Governance and all other compliance items can be found in the HRSA Health Center Compliance Manual.[38]

{INTENTIONALLY LEFT BLANK}

[38] https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html

C. THRIVE's Recommendation on Health Center Model

We recognize the District's Board members are more familiar with the Co-applicant model utilized by Chambers Health and probably pre-disposed to go with a public agency model if for no reason other than to have more influence of the Health Center, but we would encourage the Board to consider the non-profit model as well. The reasons are as follows:

1. Non-profit models are often more nimble and more responsive to the healthcare needs because there is less bureaucracy or less "cooks in the kitchen".
2. By having an unencumbered non-profit Board, the non-profit Board would be less restricted by pre-conceived expectations.
3. Unlike Chambers Health, the District does not own or operate another Healthcare facility that would benefit from being a co-applicant with a non-profit to provide health services.
4. Safeguards can be put in place to protect the District's investment through involvement of District Board members on the non-profit Board; funding opportunities; and terms included in funding grants and/or lease agreements.
5. With the increased bureaucracy due to the public agency model, we have seen more disfunction in this model because the Public Agency and the Co-Applicant Board cannot agree on how to address community healthcare priorities.

Ultimately, this is a Board decision, but we would encourage you to keep an open mind and consider and discuss the options. Although the Public Agency model is an option for the District, we are recommending the traditional nonprofit model as we feel it best suits the project.

D. Look-Alike Application

In order to apply to become a FQHC LA, a clinic must:

1. Provide all required services;[39]
2. Already be operating in accordance with HRSA Health Center regulations, provide comprehensive primary care and be open at least 40 hours per week;
3. Comply with the program requirements for a 6-month period; and [40]
4. Have a functioning Board that is responsible for oversight and direction of the Health Center[41].

Once the application is submitted, HRSA will review the application. If the application is accepted, HRSA will schedule a site visit to audit program compliance. Once the FQHC LA

[39] *See* Appendix C for all required services.
[40] *See* Appendix D program requirements: https://bphc.hrsa.gov/programrequirements/compliancemanual
[41] *See* Board requirements and Composition: https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html

designation is achieved, the Health Center must be compliant with all program requirements throughout the initial three year designation period. Annually, the Health Center must submit an annual verification of compliance to HRSA as well as all Uniform Data System (UDS) requirements.[42] After the end of the three year designation period, a FQHC LA must submit a renewal of Designation to HRSA.

Upon the completion of clinic operations for the first six months, HRSA will be notified of the intent to apply via creation of the application template in their "Electronic Handbook", it takes approximately 6-8 months to receive final FQHC LA status determination.[43]

VII. Recommendations

THRIVE is making the following recommendations to the District. We believe that implementing these recommendations will take considerable effort but will also substantially increase access to primary care and create a more comprehensive healthcare delivery system within the area. The following five goals were considered in developing these recommendations:

1. A comprehensive healthcare system exists for the community;
2. The District's funding for healthcare produces the best community health outcomes; and
3. A financial hardship is not placed on the Hospital as it is a critical healthcare resource to the community.
4. The District should move forward with the establishment of an FQHC LA. Although this will take considerable time and resources, the comprehensive care delivered by the Health Center Model is optimal for the area.
5. In the future, the FQHC LA should monitor and apply for future HRSA grant funding in order to obtain full Health Center status. There also needs to be a significant partnership with the Hospital. The Hospital has many capabilities that can be leveraged to enable this partnership to flourish. A community partnership between the Health Center and the Hospital will bolster community support of both entities.

A. SERVICES TO BE PROVIDED

1. Medical

Over time, primary care services should move from the RHC at the Hospital to the new FQHC LA entity.

2. Dental

The District should reach out to the provider(s) in Winnie and the surrounding areas to establish a contract to see Dental patients. In Year 1, we would expect the dental visits to be relatively

[42] *See* Appendix E.
[43] *See* Appendix F.

low. At some point in the future, we would recommend the Health Center establish its own dental practice either by acquiring an existing practice or starting a practice from scratch.

3. Behavioral Healthcare

We recommend that the District contracts with the Hospital to provide integrated Behavioral Health (IBH) services in the clinic. This will allow the medical provider to perform a "warm-handoff" to an IBH provider. By having IBH providers in the clinic, compliance with referrals will be much more successful than a referral to the provider directly. The Health Center can bill for these visits at its contracted and enhanced rates. The Hospital can be reimbursed for their efforts on a fair market value basis (a fair market value assessment should be performed). In addition, with the Hospital's plans to reopen services such as Partial Hospitalization and Psychiatric Inpatient beds, there are referral opportunities for the partnership (please note that the patient always has the right to choose).

4. Labs

We recommend that the Health Center contract with the Hospital to perform lab work. Currently, the Hospital is in the process of updating their laboratory equipment which will be a tremendous benefit to the community. Their urine lab is established, they have in-house COVID testing, and soon they will have toxicology services. For the majority of lab services, the blood draw potentially could be performed at the Health Center and processed through the Hospital. The draws are included in the Health Center's rate and the labs are processed and billed separately. However, there must be a discount program for those who cannot afford the lab fees.

5. Imaging

We recommend that the Health Center contract with the Hospital to preform diagnostic imaging work. There is already the necessary equipment at the Hospital to perform Xray, ultrasound and CT scans. If more complex imaging is needed, the Hospital has additional equipment in Beaumont including a stand-up MRI.

6. Specialty and OB/GYN

The new Health Center should attempt to work with teaching hospitals in the State in order to provide specialty care to its patients. The closest teaching hospitals are UTMB – Galveston and Ben-Taub in Houston (1 ½ hours and 1 hours away respectively). Given that the District already has a relationship with UTMB, it makes sense to start with this teaching hospital.

The Health Center can become a center for which Graduate Medical Student and Residents provide services under the supervision of an attending physician. Teaching hospitals are generally open to these arrangements as it provides its residents with the opportunity to work with an underserved population, which is valuable experience. Health Centers sometimes can recruit from this pool as the National Health Services Corps Loan Repayment program can provide substantial incentive for new providers. In addition, HRSA has focused its Teaching Hospital

Graduate Medical Education (THGME) grant program to focus on community-based clinics.[44] These grants generally provide up to $160,000 per resident for an accredited residency program. This is a partnership opportunity to explore with UTMB or others (note: Teaching Hospitals cannot apply for these community-based grants).

The Health Center can contract with a provider group outside the area to provide services onsite a certain number of days per month. This is especially useful for OB/GYN and Podiatry.

7. Care Coordination

The District already has an indigent program coordinator operating under its programs, which would still operate under the District. The Health Center should enhance the care coordination by adding a case manager who would navigate patients to the services that are required.

8. Optometry

The Health Center should negotiate a contract with an Optometry practice from an adjacent area to perform screening and services.

B. Implementation Phases

Moving forward, the District must carefully consider if the establishment of a Health Center is feasible. This will include discussion of the size and scope of the facility, and what Health Center model to ultimately follow. On October 29th, THRIVE will participate in a Board Workshop to start this process.

If it is decided that the District will move forward, we recommend that the Health Center program be developed and implemented by phases. Please note that the activities are listed at a high level and the time frames are estimates. Flexibility will be needed to ensure the project proceeds efficiently. The District should work closely with the Health Center Board to carefully plan and monitor the progress each phase. The following is a summary and timeline of these phases:

Phase I – Establishing the Nonprofit (1-2 months)

It is crucial that the District quickly establish a nonprofit entity to apply for FQHC LA status. As stated above, the non-profit is required to oversee the Health Centers, regardless of the status. This includes establishing the Board and begin its work towards Health Center compliance. In Phase I the District will need to conduct the following activities:

1. Create the initial Board of Directors (start with a small board of 5-6 members which will quickly facilitate the expansion of the board to full compliance);
2. Conduct Board orientation;
3. Retain Health Center counsel;
4. Create bylaws;
5. Establish the nonprofit entity with the State and the IRS;

[44] *See* Appendix A.

6. Develop governance policies;
7. Create initial Executive Director job description;
8. Establish bank accounts;
9. Establish payroll vendor/inhouse;
10. Establish grant terms with non-profit for operations and capital cost;
11. Implement accounting system; and
12. Start compiling letters of support for FQHC LA application.

Phase II – Readying the Clinic (2 months)

The District will then need to perform the necessary tasks to prepare the clinic for operations. This includes starting the process of contracting with insurance companies. However, initially the clinic will see patients on a self-pay basis at the start of Phase III. In this phase the District should:

1. Hire Executive Director;
2. Conduct strategic planning;
3. Identify Electronic Medical Record (EMR) system;
4. Obtain group National Provider Identifier (NPI);
5. Procure initial equipment and furnishings;
6. Obtains Certificates of Occupancy;
7. Connect utilities;
8. Design logo and marketing images;
9. Develop patient materials;
10. Order medical supplies;
11. Hire and train small support staff;
12. Develop all Health Center Policies;
13. Contact with necessary services (linen, waste, janitorial, etc.)
14. Acquire and install technology;
15. Establish fee scales and CPT, ICD-10, and HCPCS coding references;
16. Establish billing company contract;
17. Recruit initial provider or provider service;
18. Establish insurance policies;
19. Establish fair market value for services and fee schedule;
20. Develop and approve sliding fee scale; and
21. Establish various Board committees.

Phase III – Initial Clinic Operations (6 months)

The clinic will establish operations in this phase. The first patients will be indigent or self-pay. The goal will be to establish a presence as the primary care provider of choice in the community. The following activities will take place in this phase:

1. Initiate operations;
2. Negotiate insurance contracts;
3. Create community awareness;
4. Procure additional equipment;

5. Seek additional provider;
6. Seek additional staff;
7. Initiate contracts for diagnostic imaging, labs, behavioral health and dental;
8. Identify and retain audit firm;
9. Register in HRSA systems and compile FQHC LA application;
10. Begin Patient Centered Medical Home (PCMH) certification; and
11. Conduct "mock" HRSA site visit review.

Phase IV – Obtain FQHC LA Status (6 months)

In this phase, the District will need to focus on submitting the FQHC LA application to HRSA and achieving FQHC LA status. In addition, we will prepare for expansion. Activities include:

1. On board new staff;
2. Provide ongoing Board and staff HRSA training;
3. Apply for 340B Pharmacy status;
4. Submit PCMH certification;
5. Follow up to HRSA application response;
6. HRSA site visit scheduling; and
7. Obtain FQHC LA designation.

Phase V – Continued Growth (Year 1)

Next, the District will continue to foster our community relationships as well as prepare for a true community-based health center.

1. Add additional provider;
2. Add additional staff;
3. Acquire additional equipment;
4. Identify dental practice options (continue to contract, purchase practice, or start in-house);
5. Identify permanent location;
6. Initiate new construction or renovations of permanent location;
7. Acquire final equipment; and
8. Open operations in permanent facility.

{INTENTIONALLY LEFT BLANK}

VIII. Conclusion

The District is well positioned to start a Health Center. This will provide a comprehensive and coordinated set of healthcare services to the community that do not currently exist. It is also important to acknowledge the continued role of the District's current programs including but not limited to: youth counselling, Irlen's Screening, student insurance, and case management. These services compliment the work of a Health Center as well as the school system.

The Hospital is positioned to enhance its services within the community by reaching a broader base of patients and providing them with the necessary laboratory work, diagnostic imaging, and much needed behavioral health programs. We feel that this will only strengthen the impact of the Hospital and contribute to its financial sustainability.

We appreciate the opportunity to provide this report to the District and look forward to our working session on October 29th.

Appendices

Appendix A – Advantages of an FQHC

Federal Grant Funding - Section 330 of the Public Health Service Act created the health center program. This program allows HRSA to provide grants to FQHCs through two funding streams - an annual appropriation and the Community Health Center Fund. As of 2018, annual funding for this program exceeded $4.7 billion and served thehealthcare needs of over 28 million patients.

Enhanced Medicaid Reimbursement - With bipartisan support, Congress created the FQHC Prospective Payment System, a specific payment methodology that recognizes the critical role that FQHCs play in caring forMedicaid patients and within state programs. These rates are derived from the cost of providing comprehensive services to each FQHC patient. Services include (but are not limited to) medical, dental, behavioral health and vision care. These rates ensure FQHCs are not forced to divert their Federal Grant Funding to subsidize traditionally low Medicaid payments.

Enhanced Medicare Reimbursement - Under the Affordable Care Act, Congress established a new payment system for the costs of FQHC services under Medicare Part B. Under this system, a national FQHC rate was established with an annual increase each year based on the Medical Economic Index or the "Market Basket" of FQHC goods and services. In addition, certain regions' rates are adjusted by the FQHC Geographic AdjustmentFactor.

340B Federal Drug Pricing Program - The 340B Drug Pricing Program allows health centers to stretch increasingly scarce federal resources and reinvest in patient care. Manufacturers who participate in Medicaid agreeto provide outpatient drugs to eligible providers at reduced prices.

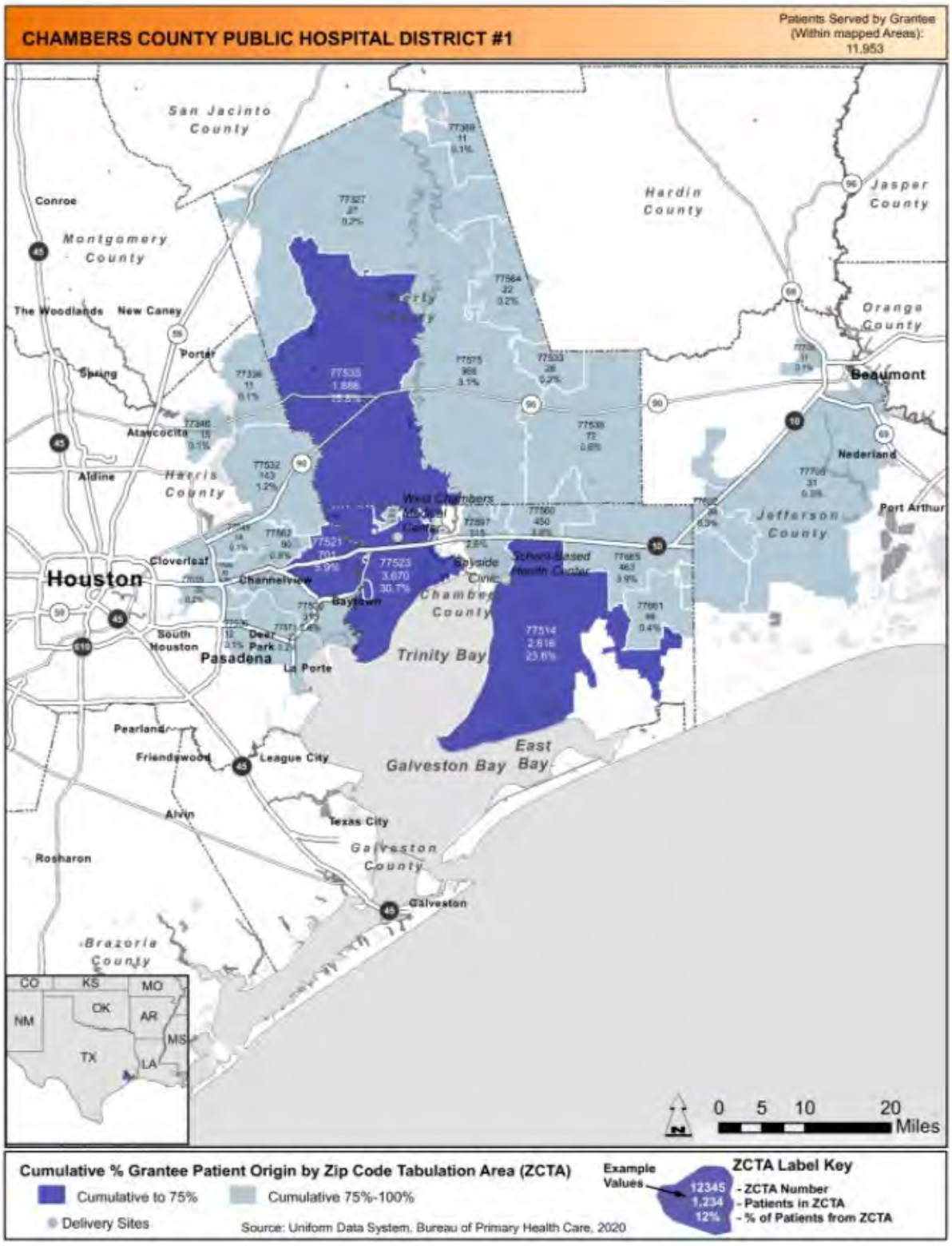
National Health Services Corp Student Loan Repayments Program - This program allows varying degrees of student loan repayment for both full-time and part-time medical providers after two years of service within a Health Professional Shortage Area (HPSA). After two years, providers can re-apply for subsequent loan forgiveness.

Federal Torts Claims Act Coverage - The Federally Supported Health Center Act of 1992 and 1995 granted medical malpractice liability protection through the Federal Tort Claims Act to HRSA-supported health centers.Under this act, health centers are considered federal employees and are immune from lawsuits, with the federal government acting as the primary insured.

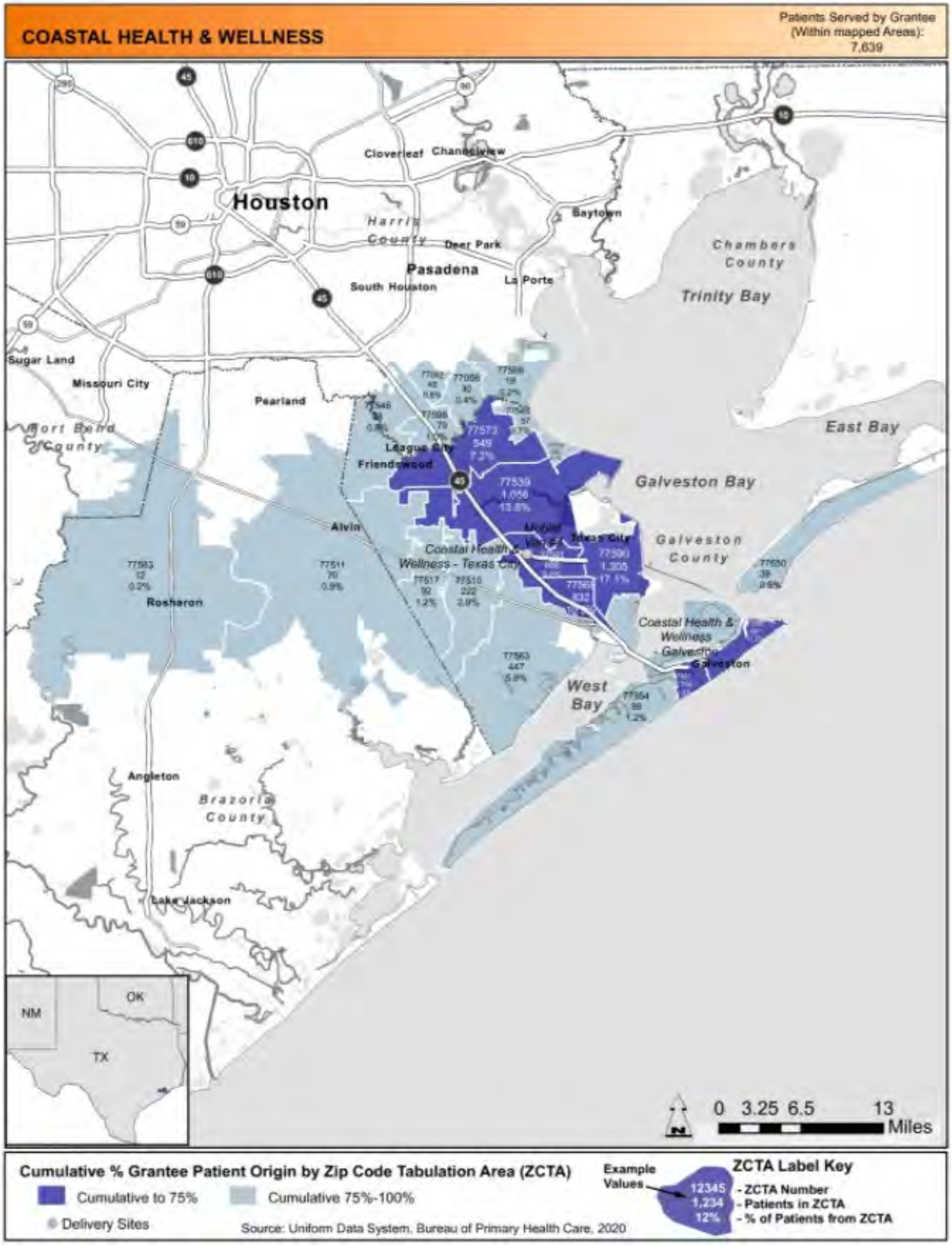
FQHC Safe Harbor Protections - In its final rule under 42 CFR Part 1001, the Inspector General (IG) approved the Safe Harbor Arrangements Under the Anti-Kickback Statute. In this ruling, the IG set forth rules to protect arrangements involving goods, items, services, donations, and loans provided by individuals and entities in order to protect an FQHC's from anti-kickback laws. Therefore, FQHCs are able to receive grants, provide below fair market value services, and other donations from health care providers in your community can be an essential and effective means to preserve the health center’s limited financial resources and support the availability of in-scope services.

Appendix B – Health Center Service Areas

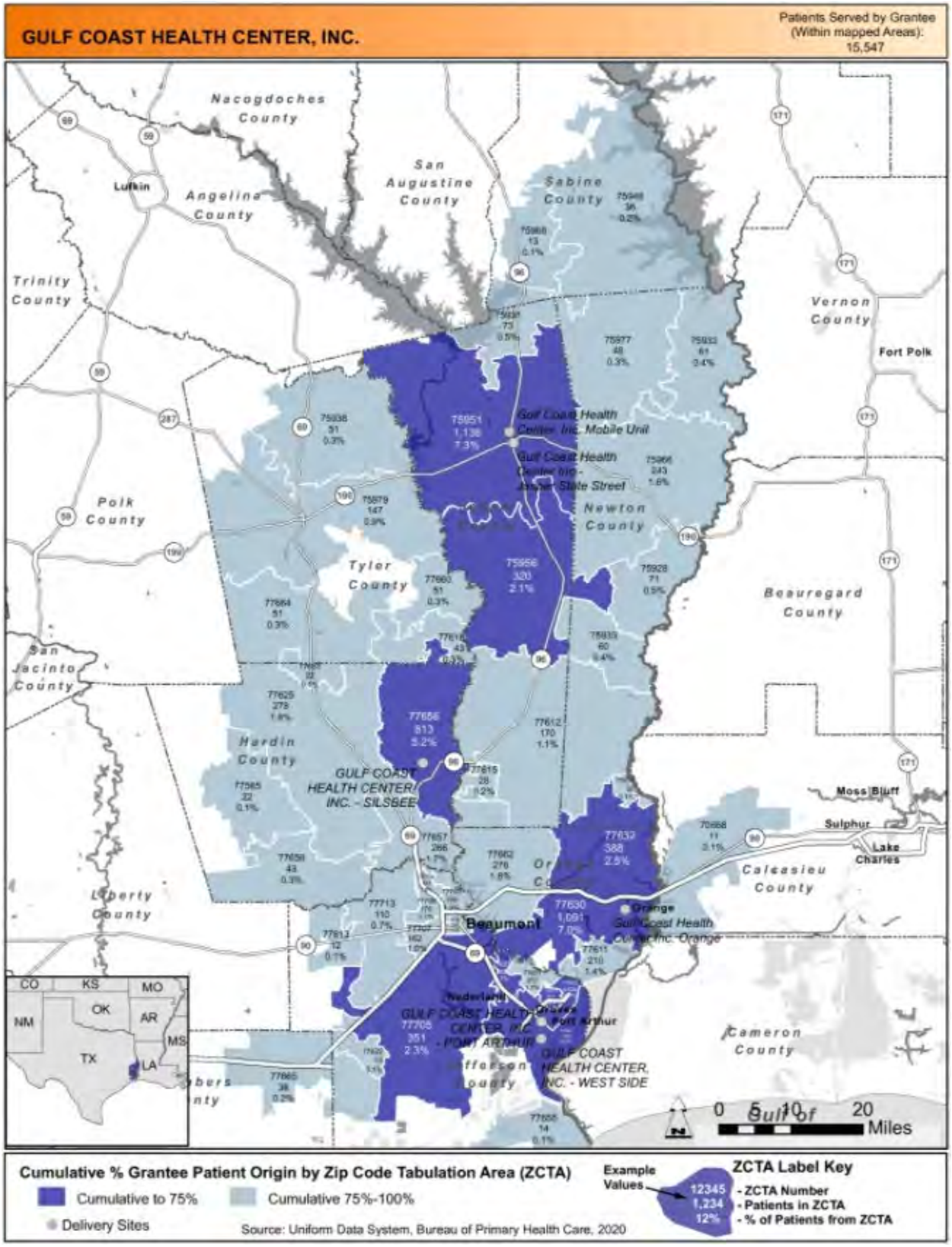
Appendix B1 - Chambers Health (Chambers County Public Hospital District #1)



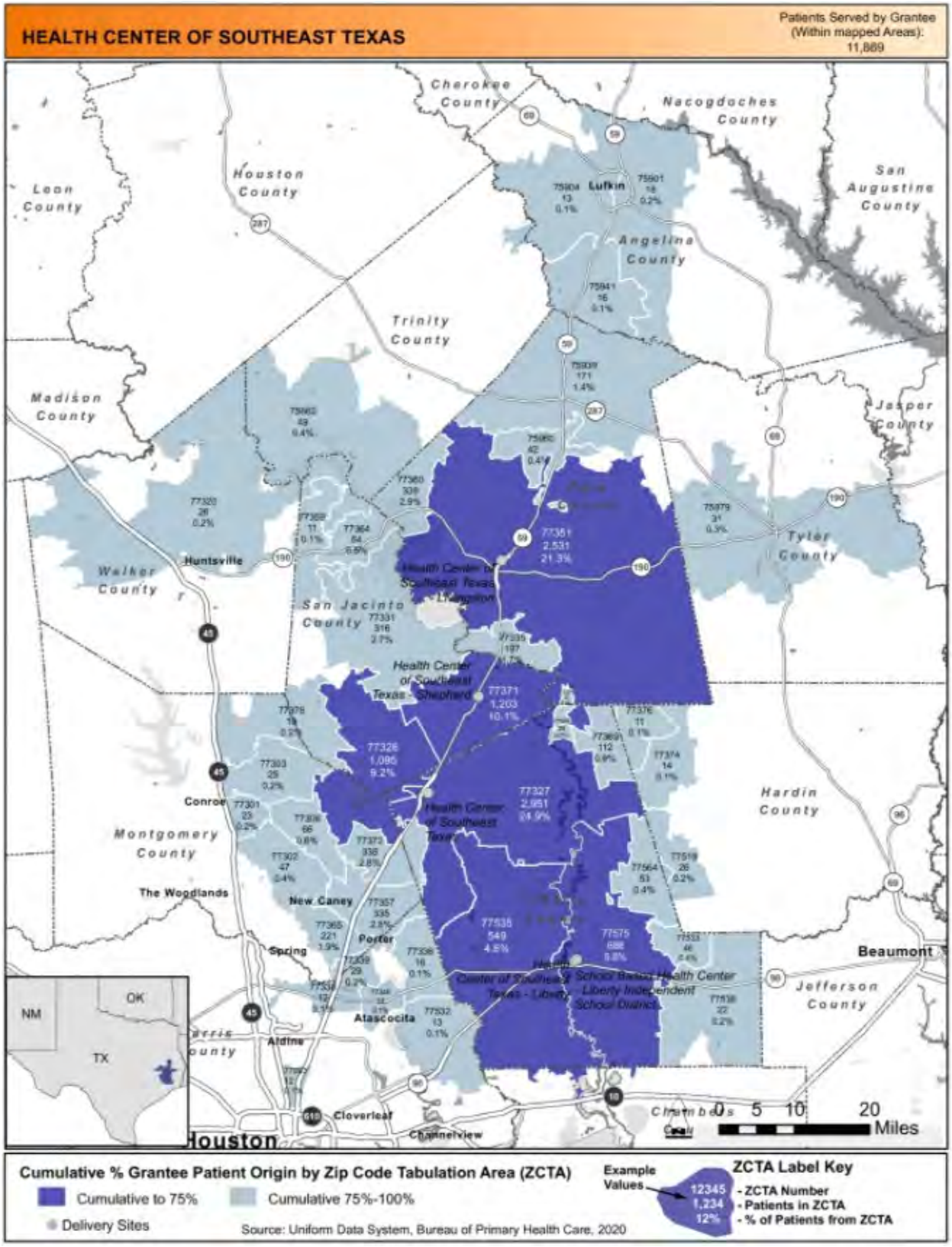
Appendix B2 - Coastal Health and Wellness

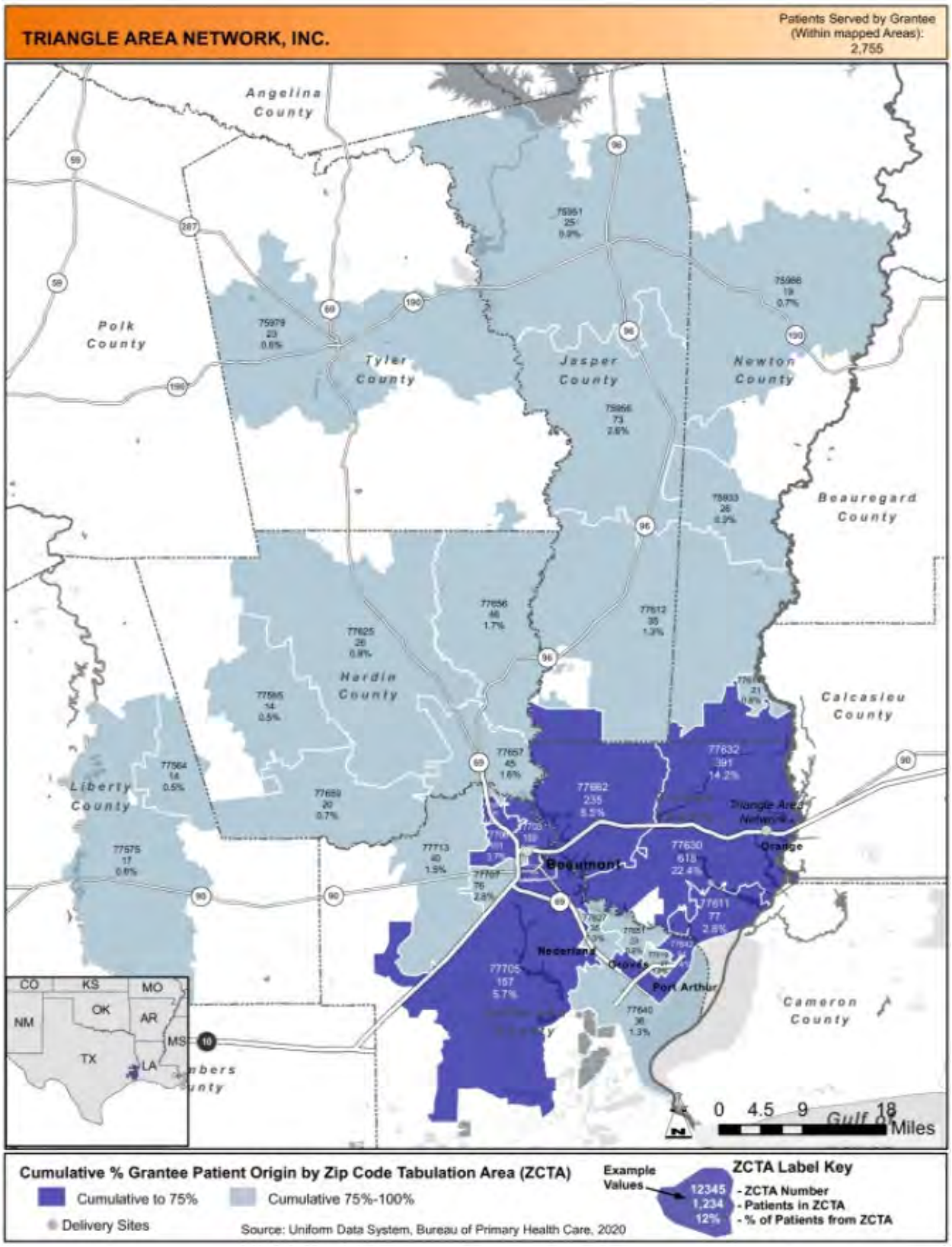


Appendix B3 – Gulf Coast Health Center, Inc.



Appendix B4 – Health Center of Southeast Texas




TRIANGLE AREA NETWORK, INC.
Patients Served by Grantee (Within mapped Areas): 2,755
Angelina County
Polk County
Tyler County
Jasper County
Newton County
Beauregard County
Hardin County
Liberty County
Calcasieu County
Cameron County
Beaumont
Orange
Nederland
Port Arthur
Gulf of
0 4.5 9 18 Miles
CO KS MO NM OK AR MS TX LA
Cumulative % Grantee Patient Origin by Zip Code Tabulation Area (ZCTA)
Cumulative to 75%
Cumulative 75%-100%
Delivery Sites
Source: Uniform Data System, Bureau of Primary Health Care, 2020
Example Values
12345 - ZCTA Number
1,234 - Patients in ZCTA
12% - % of Patients from ZCTA
ZCTA Label Key

Appendix C – Required Health Center Services[45]

The following services are required for a Health Center Program *Services must be provided directly or via contract with a qualified party*	
Clinical Services	**Enabling Services**
General Medical Primary Care	Case Management
Diagnostic Laboratory and Radiology	Eligibility Assistance
Screening	Health Education
Coverage for Emergencies After Hours	Outreach
Voluntary Family Planning	Transportation Services
Immunizations	Translation Services
Well Child Care	Other Services (As Needed)
Gynecology and Obstetrical Care	
Preventive Dental	
Pharmaceutical Services	

Appendix D –Health Center Program Requirements Categories

The following categories highlight the requirement areas of a Health Center *The complete compliance manual can be found at:* https://bphc.hrsa.gov/programrequirements/compliancemanual	
Needs Assessment	Contracts and Sub Awards
Required and Additional Health Services	Conflict of Interest
Clinical Staffing	Collaborative Relationships
Accessible Locations and Hours of Operations	Financial Management and Accounting Systems
Coverage for Medical Emergencies During and After Hours (after hours coverage may include referral to an emergency room)	Billing and Collections
Continuity of Care and Hospital Admitting	Budget
Sliding Fee Discount Program	Program Monitoring and Data Reporting Systems
Quality Improvement/Assurance	Board Authority
Key Management Staff	Board Composition

[45] *See* page 30
https://bphc.hrsa.gov/sites/default/files/bphc/programopportunities/lookalike/pdfs/lalidinstructionslides.pdf

Appendix E –Required Annual Uniform Data System (UDS) Required Reporting

The following is a list of tables required by all Health Centers as part of their annual UDS reporting	
Table 1: Patients by Zip Code	Table 7: Financial Costs
Table 3A: Patients by Age and Sex Assigned at Birth	Table 8A: Financial Costs
Table 3B: Demographic Characteristics	Table 9D: Patient Service Revenue
Table 4: Selected Patient Characteristics	Table 9E: Other Revenues
Table 5: Staffing and Utilization	Appendix D: Health Center Health Information Technology Capabilities
Table 5 (continued): Selected Service Detail Addendum	Appendix E: Other Data Elements
Table 6A: Selected Diagnoses and Services Rendered	Appendix F: Workforce
Table 6b: Quality of Care Measures	

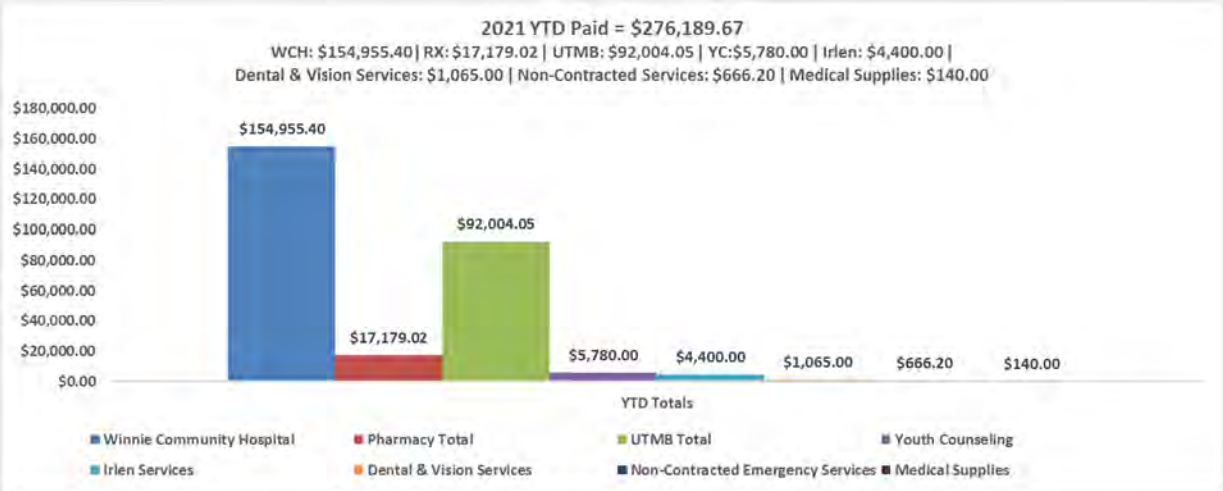
Appendix F –Application Review Process-Approximate Time Frame[46]

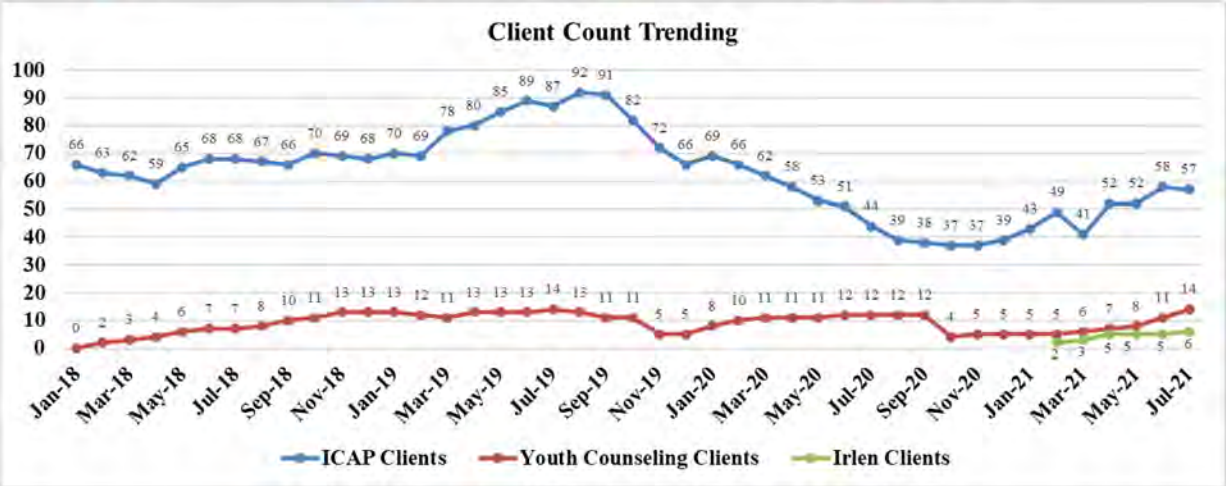
Responsible Entity	Process	# Of Days
Applicant	Development and submission of application once the application has been created in Electronic Handbook	90
HRSA	Preliminary review to assess eligibility and completeness of the application	30
HRSA and Applicant	Site Visit Scheduling and Preparation	60-75
HRSA	Site visit compliance and eligibility review followed by communication of findings of noncompliance and/or ineligibility issues	45
Applicant	Response if additional information is requested by HRSA	30
HRSA	Final determination of compliance and eligibility	45

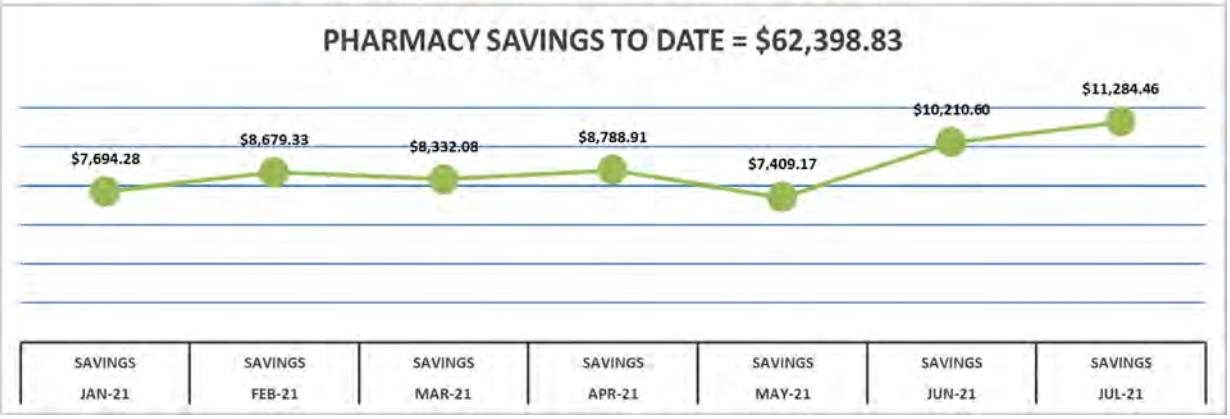
[46] See page 18 of the HRSA FQHC LA Webinar Slides: https://bphc.hrsa.gov/sites/default/files/bphc/programopportunities/lookalike/pdfs/lalidinstructionslides.pdf

Appendix G – District Program Enrollment and Funding

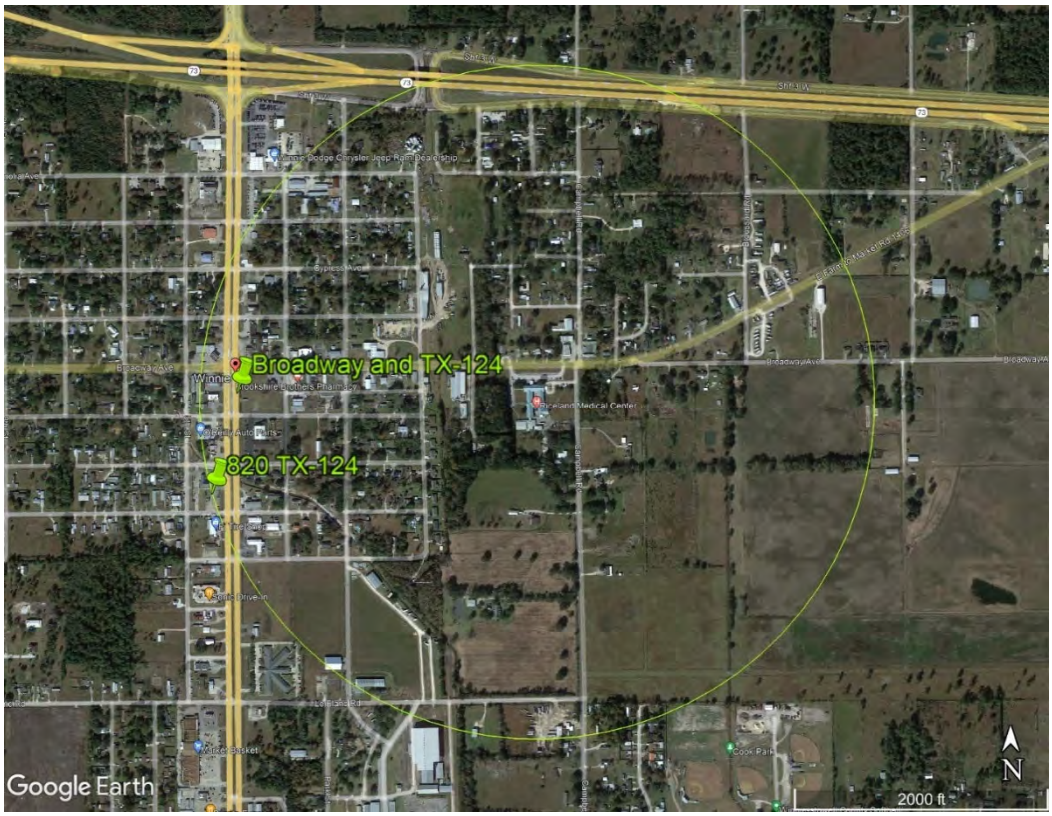
As of July 2021, the District has provided the following statistics on its programs:







Appendix H – One Half Mile Radius of Hospital Medical Center



Appendix I – Select Acronyms

Acronym	Meaning	Description
FQHC	Federally Qualified Health Centers	A Health Center that receives Federal funding from HRSA.
FQHC LA	Federally Qualified Health Center Look-Alike	A Health Center that has not received Federal funding from HRSA but operates under the Health Center program rules and guidance.
HPSA	Health Professional Shortage Area	A geographic area, population, or facility that has a shortage of primary, dental, or mental health care providers.
HRSA	Health Resources and Services Administration	The administrative component of the Department of Health and Human Services responsible for overseeing the Health Center Program.
MUA	Medically Underserved Area	Areas designated by HRSA as having too few primary care providers.
MUP	Medically Underserved Population	Populations designated by HRSA as not having adequate access to healthcare. Examples include minority populations, homeless, migrant workers, and low-income.
SFS	Sliding Fee Scale	The HRSA compliant schedule of discounts that Health Centers are required to offer anyone at or below 200% of the Federal Poverty Level.
ZCTA	Zip Code Tabulation Area	Geographically defined areas used by the Census Bureau in its tabulation of information. ZTCAs follow or approximate zip code boundaries.