APPLYING FOR NEW FUNDING STREAMS – MIGRANT VOUCHER PROGRAMS

WHO
WHY
WHEN
WHAT

George Ersek presentation on voucher progr.
cc: Josh

Everything should be made as simple as possible, but no simpler.

Resource ID # 6684

Applying For New Funding Streams-Migrant Voucher Programs

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WHO SHOULD APPLY

George's First Principle: Life is not fair, if it were, Elvis would be alive and all of the impersonators would be dead.

Any program that has experienced and can **document** a significant migrant and seasonal farmworker user increase over the last two years – think Expanded Medical Capacity
NOTE: The applicant will need UDS data for users and FTEs
NOTE #2: The applicant must indicate that the increase in users will meet the definition for a *significant* increase in users, which was defined in the 04 guidance as, a minimum increase in users of 10 percent of the current number of current users for the program reported in calendar year 2002 UDS or 1,000 new users. It is important to know that the base calculation for the user increase will be from the UDS report from **2 years prior to the year in which the application is being submitted.**
NOTE # 3: Expanded Medical Capacity is limited to those sites within the current Scope of Project as defined on Exhibit B of the Grant Application and, if submitted, an approved change in the scope of project. (Do not confuse scope of project with service area)

Any program that has identified and can **document** a migrant and seasonal farmworker population in the state or service area that is not able to access primary health care services – think New Access Point
Note: New access points must be outside of the currently approved Scope of Project

When it can be **documented** that oral health or mental health services are not accessible and/or not available to migrant and seasonal farmworkers in the service area – think Service Expansion. Note: Comprehensive Pharmacy Services, the 340B Drug Pricing Program may also be available, but the applicant must apply as a network which is defined as at least three separate health center grantees. Quality Care Management is another opportunity under Service Expansion, but the applicant should providing services directly.

WHY YOU SHOULD APPLY

George's Second Principle: Always pay attention to what's going on around you, for instance, if you see a bomb technician running past you, you should probably turn around and keep up with him.

The grantee has experienced increased users without additional funding resources. The applicant needs to be able to demonstrate that while it has experienced a user increase, it has attempted to but not been able to secure additional funding from other Federal, State and local programs to assure continued services.

A need for special services such as oral health, mental health and substance abuse has been identified, but the grantee has been unsuccessful in its attempts to obtain funding for these services.

Migrant and seasonal farmworkers in a distinct area of a state or service area has been identified as being unable to reasonably access primary health care services. Funding is needed to create a new access point for these individuals

Increases in users over the last several years have brought the ratio of grant funds to users considerably below $200 per user. Although the $200 per user is somewhat of an arbitrary figure, it is a guide to use in examining if the user increase experienced would justify applying for an expanded medical capacity award.

Corollary to George's Second Principle: By the time you make the ends meet, they move the ends.

WHEN SHOULD YOU APPLY

George's Third Principle: Time has a way of coming back at you. When you were 1 year old you had a party with a birthday cake you couldn't eat, people around you that you didn't know and you have forgotten the entire event, when you have your 90th birthday party you won't be able to eat the cake, you won't know who the people are in the room and you'll forget the whole event by that night

First, obtain a copy of the HRSA Preview to determine anticipated dates for the guidance's for the new funding streams to be released.

Second, obtain the guidance and note the due date(s) for application submission.

Now that you know the target dates there are several other factors that must be taken into account:

1) You are able to **document** the need that will justify your application for whichever new funding you are applying for
2) You have not received any funding increase over the last several years but are experiencing user increase or unmet service need
3) The governing or advisory board is aware of the need for additional funding and has gone on record as supporting an application
4) The State Primary Care Association will support your application
5) No officer or director of the center is currently under Federal, State or local criminal investigation or being indicted (just a little humor here)
6) The center is currently organizationally, operationally and fiscally stable. Keep in mind that adding staff or creating a new access site will create a burden on the existing program at the start. This is why it is important that the board be fully aware of both the need and implications for expansion.
7) This is actually a when not to apply. If the center has recently done major expansion, either through a Change In Scope or has received new funding for expanded sites or capacity, it should carefully consider its ability to absorb further operations. Remember, a general rule of thumb is that it will take at least two years for any major expansion to be fully operational and running at the anticipated capacity. The exception to this rule is when the center deliberately adds a site through a Change In Scope so that it may apply for funding under increased medical capacity, i.e. this was carefully preplanned and part of the design in becoming fully operational.

WHAT YOU NEED TO KNOW

George's Fourth Principle: Always think of the smart thing to do. Remember, if you are out hiking with friends and you come across an enraged, starving grizzly bear, you don't have to outrun the bear, you just have to outrun your friends.
Corollary to above: youth and skill are no match for experience and treachery.

Consistency, consistency, consistency, did I mention that it is critical that there is a consistent theme throughout the application as well as, consistency for numbers and what the goals are for the proposal.

First, everyone needs to understand that while the application will be subject to an "objective review process", that means that all applications will be reviewed according to the same criteria and through the same process. What that does not mean, is that the individual reviewers don't allow subjectivity to influence their scoring. It is important that by following the guidance instructions to the letter in terms of format and forms, you allow as little opportunity as possible for a reviewer to interpret what you mean. This is when subjective opinions will enter into the process. **Reality check time.** Never discount human nature, if a person gets frustrated they take it out on someone or something. Reviewers don't want to have to try and figure out what you want to do; they want you to clearly tell them.
George's fifth principle: If you think there is good in everybody, you obviously have not met everybody.

Here are some examples of following that reality check:

1) Follow the guidance in terms of section headings and what information is requested under each heading. Nothing reduces scores as easily as an application that does not adhere strictly to the required format. The guidance's are now designed to enable the applicant to explain in a logical sequence, what the problem is (need), how the problem will be dealt with (plan/response), how progress will be measured (evaluation), how the progress will impact on the people to be served and the center (impact), and what does the applicant have in terms of experience, skills, etc that will enable it to achieve the goals (resources/capabilities). The headings may vary in different guidance's, but the sequence is in that order.
2) Be specific as possible. For example, all of the health centers in BPHC are serving individuals that lack access to primary care services and as a result are

experiencing a higher than average number of acute and chronic conditions , in addition to a variety of health disparities. Simply stating that these conditions in general are present is not going to make your case above other applicants. Be specific, if you are going to identify diabetes as a problem, show how many of the individuals you are currently serving exhibit high glucose levels that require ongoing intervention. Specify how many individuals that should be tested are not being tested because current capacity is lacking. If cancer is a major health issue, indicate how many women receive PAP tests, how many were positive, how many more women need to have PAP tests. Being specific will also make it easier to achieve the consistency needed throughout the application since you will now have very specific topics which you must address in each of the sections of the application. **Reality check time.** Applications that do not attempt to solve all of the ills of the world but instead choose some key health care needs to address and do a great job in describing the needs specific to the target population for this application and what the specific goals and objectives are to address the needs always fare better than applications that try to generally address everything. The awards are simply not sufficient to deal with all of the health care needs of a special population like migrant and seasonal farmworkers. Reviewers know this and appreciate an application that is honest in what it is going to attempt to achieve.

3) Consistency!! If diabetes was identified as a specific health need, then in the plan/response portion of the application the applicant needs to target efforts to meet the need and specifically describe and link these goals and objectives to each of the specified needs. So, indicate how many and what kinds of staff are needed to do more screening and get more individuals in for screening. What will be the anticipated outcome(s) of the additional staff on the problem of diabetes, etc? The specific goals and objectives then can easily be added to the Health Care Plan and it should be easy to show how the new goals and objectives will be integrated into the existing Health Care Plan. The Business Plan will also be easy because now you indicate what the plan is to recruit and hire the individuals and how long that will take. The budget will incorporate these staff into the line item budget. With specific goals and objectives related to specific conditions, the plan for evaluating the outcomes will correlate directly to meeting the specified health needs. Meeting specific health care needs will flow directly into stating what the impact of the activities will be (including the evaluation activities, it is important to show how feedback will occur from the ongoing evaluation so corrections/enhancements can be made if necessary). Finally, with respect to dealing with diabetes,show how does the current mission, scope, experience and structure of the organization enable the organization to accomplish its goals with respect to meeting that health need.
4) While the narrative portion of the application is obviously critical, you need to pay attention to the forms that are required. In particular are the budget forms and I can't stress enough that reviewers will become frustrated (and you remember what happens with frustrated reviewers) if the numbers on the form SF424, the line item budget and narrative, the Staff Profile or Plan and the Income Analysis don't match. This happens with relative frequency and again with the competition

so intense, why lose points here when this is simply a matter of paying attention to detail. Also keep in mind that the reviewers will compare information from these forms to statements in the narrative. For example, if part of the application is hiring additional staff, they will look to see if these staff are on the Proposed Staff Profile and are accounted for in the budget. The Income Analysis will be compared to the Need section in determining if the breakdown of visits by payor category on the income analysis is consistent with the percentages of Medicaid, Medicare and uninsured provided in the discussion of the target population.

5) George's Principle Six: You can't tell which way the train went by looking at the tracks. Reviewers are going to look for hard evidence that the requested funds are needed and that the uninsured and underinsured are going to be targeted. As mentioned above, the Income Analysis Form has become a major tool in the reviewer's assessment of several parts of the application. **Reality Check time.** The grant awards are intended to enable health centers and programs meet the needs of the uninsured and underinsured.
Reviewers will now look to the Income Analysis and take into account the information in particular from the three lines for Self-pay and Column (a), Number of Visits and Column (d) Average Adjustment Per Visit. The nexus of Column (d) and the self-pay lines basically is the single most important factor in justifying the amount of grant funds being requested. The three self-pay lines represent the un and underinsured. The adjustments made to the charges represent what the financial burden is to the program for providing health care to these individuals. The number of visits indicates to the reviewers the extent to which the application intends to bring these individuals into the program.

George's final thought for the day, I have seen the truth and it makes no sense.

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FORM 3 - INCOME ANALYSIS FORMAT YEAR 1 ☐ YEAR 2 ☐ YEAR 3 ☐

PAYOR CATEGORY	NUMBER OF VISITS (a)	AVERAGE CHARGE PER VISIT (b)	TOTAL CHARGES (a * b) (c)	AVERAGE ADJUSTMENT PER VISIT (d)	AMOUNT BILLED [c-(a*d)] (e)	COLLECTION RATE (%) (f)	PROJECTED INCOME (e * f) (g)	ACTUAL ACCRUED INCOME (most recent 12 months) (h)
FEE FOR SERVICE								
Medicaid: Fee for Services								
Medicaid: EPSDT								
Medicaid: Capitated								
Subtotal: Medicaid								
Medicare: Fee for Services								
Medicare: Capitated								
Subtotal: Medicare								
Private Insurance								
Self-Pay: 100 percent								
Self-Pay: Sliding Fee Scale								
Self-Pay: Zero (0) percent								
Other: Capitation								
Other: Contracts								
SUB-TOTAL								
OTHER INCOME								
Contributions/Donations								
Fund Raising								
330 BPHC Grant								
Other Federal Grants								
State Grants								
Local Support								
Foundation Grants								
Other								
GRAND TOTAL								

SAMPLE SF424a

OMB Approval No. 0348-0044

BUDGET INFORMATION – Non-Construction Programs

SECTION A – BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Fed Domestic Assist No. (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal * (e)	Non-Federal (f)	Total (g)
1. **New Access Point Year 1**		$0	$0	$550,000	$7,473,934	$8,023,934
2. **New Access Point Year 2**		$0	$0	$439,699	$9,071,042	$9,510,741
3. **New Access Point Year 3**		$0	$0	$475,690	$9,582,506	$10,263,196
4.		$0	$0	$0	$0	$0
5. TOTALS						

SECTION B - BUDGET CATEGORIES

6. Object Class Category	Grant Program Function or Activity					Total
	(1) **Year 1**	(2) **Year 2**	(3) **Year 3**	(4)		(5)
a. Personnel	$4,587,223	$5,422,816	$5,500,000			
b. Fringe Benefits	$951,849	$1,125,234	$1,130,000			
c. Travel	$25,432	$35,010	$40,690			
d. Equipment	$118,000	$0	$0			
e. Supplies	$1,452,940	$1,952,300	$2,330,000			
f. Contractual	$326,020	$395,100	$425,000			
g. Construction – Alteration/Renovation	$32,000	$0	$0			
h. Other	$530,470	$580,281	$632,506			
i. Total Direct Charges (sum of 6a-6h)	$8,023,934	$9,510,741	$10,058,196			
j. Indirect Charges	$0	$0	$0			
k. TOTALS (sum of 6i and 6j)	$8,023,934	$9,510,741	$10,058,196			
7. Program Income	$5,770,180	$6,956,304	$7,537,506			

Standard Form 424A (7-97)

Prescribed by OMB Circular A-102

* Applicants are limited to the level of Federal funds identified in Program Guidance.

Sample Budget Narrative

This sample budget narrative is provided as a broad outline. Providing additional information and detail is recommended to fully describe your proposal. **Any significant changes in the costs of each object class from year 1 to year 2 and year 2 to year 3 should be fully explained and justified in the budget narratives for years 1, 2, and 3. The impact on the Federal request should be discussed.**

REVENUE: (From FORM 3 – Income Analysis)	Year 1	Year 2	Year 3
PATIENT SERVICE INCOME (including Pharmacy)	$5,770,180	$6,956,042	$7,537,506
LOCAL & STATE GRANTS (Break out by fund source)	$1,253,500	$1,565,000	$1,700,000
LOCAL FUNDING	$450,254	$550,000	$550,000
FEDERAL BPHC 330 GRANT	$550,000	$439,699	$475,690
OTHER FEDERAL FUNDING (Break out by fund source)	$0		
TOTAL: REVENUE	**$8,023,934**	**$9,510,741**	**$10,263,196**

EXPENSES:	Year 1	Year 2	Year 3
PERSONNEL: See Personnel by Position and BPHC Program	$4,587,223	$5,422,816	$5,500,000
FRINGE BENEFITS: Break out each portion of Fringe Benefits: FICA, Retirement, etc.	$951,849	$1,125,234	$1,130,000
TOTAL: PERSONNEL & FRINGE	**$5,539,072**	**$6,548,050**	**$6,730,000**
TRAVEL:			
Providers CME ($ per full-time equivalent (FTE))	$	$	$
Nursing CME ($ per FTE)	$	$	$
Other Professional CME ($ per FTE)	$	$	$
Travel to meetings ($ per attendees x # of trips) Executive Director (2 meetings) Board Chair (2 meetings)	$	$	$
Management & Board	$	$	$
State and National Meetings	$	$	$
Other Board/Management Travel	$	$	$
Local Travel (# of trips @ organization's mileage rate)	$	$	$
TOTAL: TRAVEL	**$ 25,432**	**$ 35,010**	**$ 45,690**
EQUIPMENT: See attached Equipment Listing			
TOTAL: EQUIPMENT	**$118,000**	**$ 0**	**$ 0**
SUPPLIES:			

FORM 2 - PROPOSED STAFF PROFILE

YEAR 1 ☐ YEAR 2 ☐ YEAR 3 ☐

PERSONNEL BY CATEGORY	TOTAL FTEs PROPOSED { a }		ANNUAL SALARY OF POSITION { b }	TOTAL SALARY { a * b }
	NEW STARTS (All sites included in Exhibit B-2)	SATELLITES (New site(s) ONLY)		
ADMINISTRATION				
Executive Director				
Finance Director				
Chief Operating Officer				
Administrative Support Staff				
MEDICAL STAFF				
Medical Director				
Family Practitioners				
General Practitioners				
Internists				
OB/GYNs				
Pediatricians				
Psychiatrists				
Other Specialty Physicians (attach list by type)				
Physician Assistants/Nurse Practitioners				
Certified Nurse Midwives				
Nurses (RNs)				
Pharmacist				
Other Medical Personnel (attach list by type)				
Laboratory Personnel				
X-ray Personnel				
Clinical Support Staff				
DENTAL STAFF				
Dentists				
Dental Hygienists				
Dental Assistants, Aides, Technicians				
MENTAL HEALTH STAFF				
Mental Health Specialists				
Substance Abuse Specialists				
Case Managers				
Other Professional Personnel				
OTHER STAFF				
Patient Education Specialist				
Homemaker/Aide				
Outreach				
Other Enabling				
Other staff				