

FELDESMAN+TUCKER+LEIFER+FIDELL

# **Federally Qualified Health Centers 101**

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Associate

# AGENDA: PART I

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- I. Establishing the Framework:  
An Overview of the Health  
Center Program
- II. Health Center Program Core  
Requirements



# DISCLAIMER

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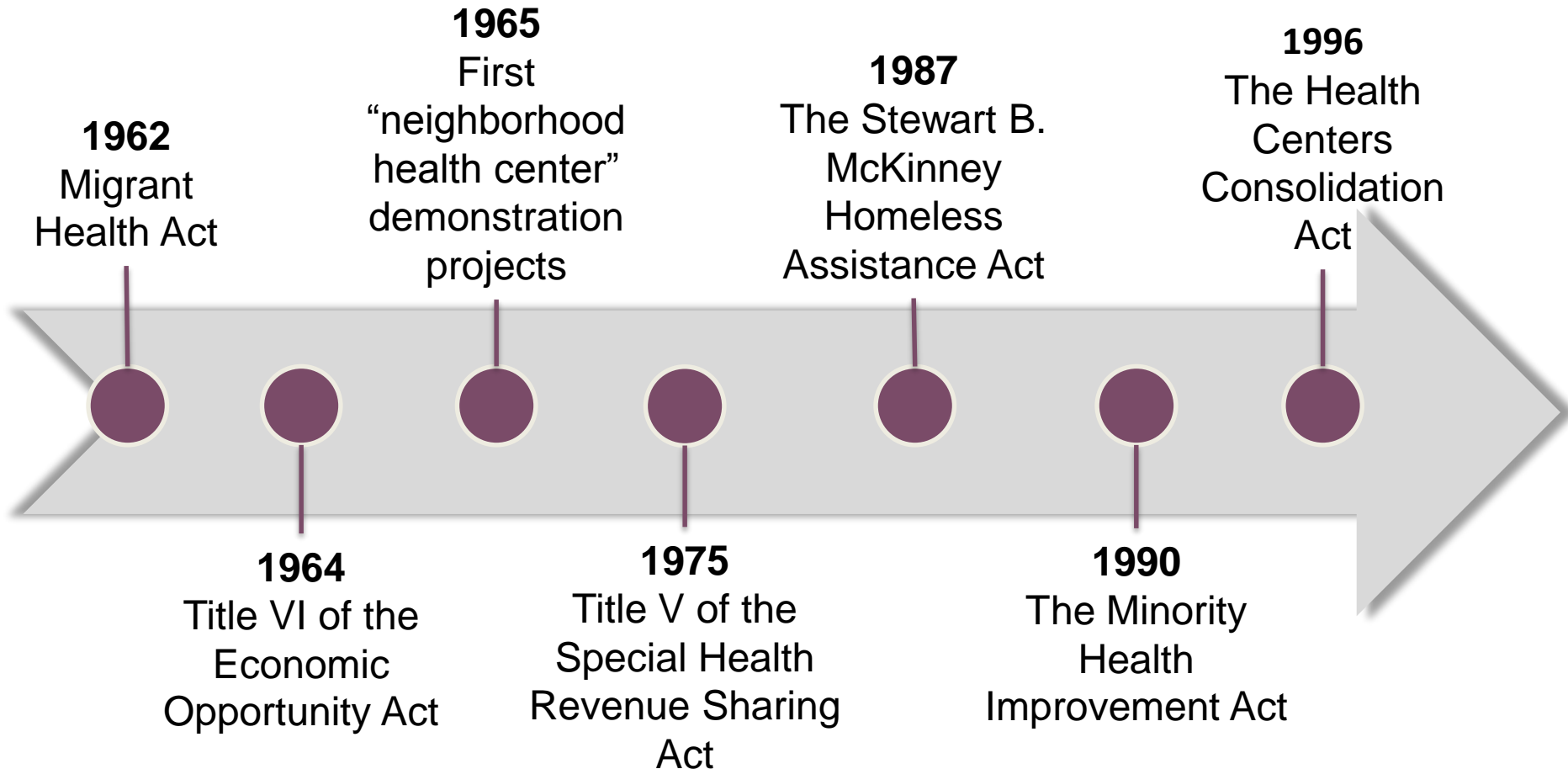
- Presentation is intended as general information only, not as specific legal advice
- Consult qualified legal counsel for specific advice

# I. Establishing the Framework

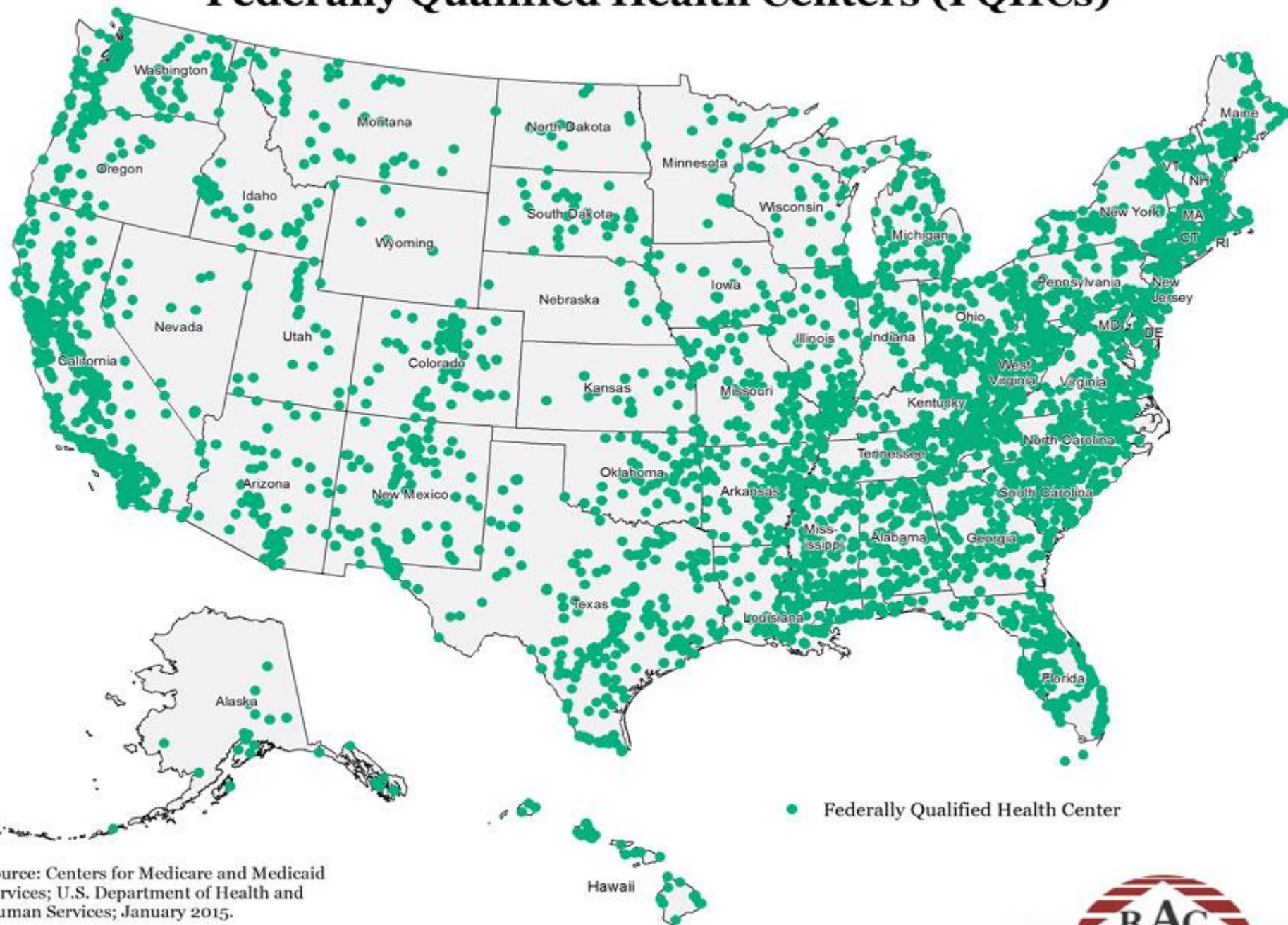
## An Overview of the Health Center Program



# HEALTH CENTER TIMELINE



# Federally Qualified Health Centers (FQHCs)



Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; January 2015.

Note: Alaska and Hawaii not shown to scale

# WHAT IS A HEALTH CENTER?

## Grantee

Nonprofit, tax-exempt organization

Meets all HRSA requirements

Receives Section 330 Grant

## Sub-Recipient

Nonprofit, tax-exempt organization

Meets all HRSA requirements

Receives a portion of a Grantee's Section 330 Grant

## “Look-alike”

Nonprofit, tax-exempt organization

Meets all HRSA requirements

Does not receive Section 330 Grant

# HEALTH CENTER BENEFITS

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- Medicaid/Medicare fair payment via prospective payment system methodology
- Access to favorable drug pricing under Section 340B
- Access to providers through the National Health Service Corps (NHSC)
- Access to the federal Vaccines For Children program



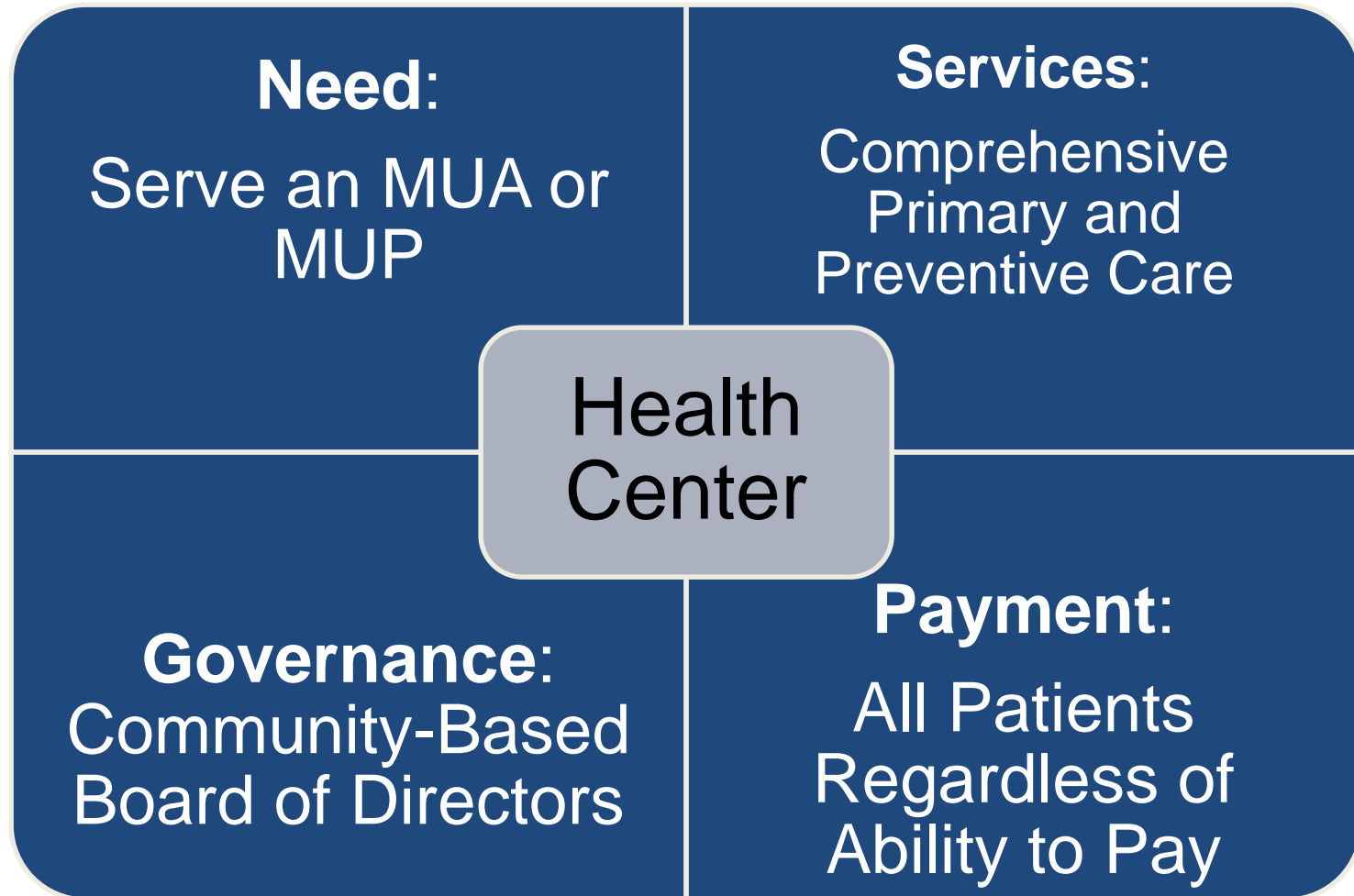


# BENEFITS FOR GRANTEES ONLY

- Access to Federal Tort Claims Act (FTCA) coverage, in lieu of purchasing malpractice insurance, for eligible “persons”
- Safe Harbor under the federal anti-kickback statute for certain arrangements with other providers or suppliers of goods, services, donations, loans, *etc.*, which benefit the medically underserved population served by the grantee



# FOUR HEALTH CENTER “PILLARS”

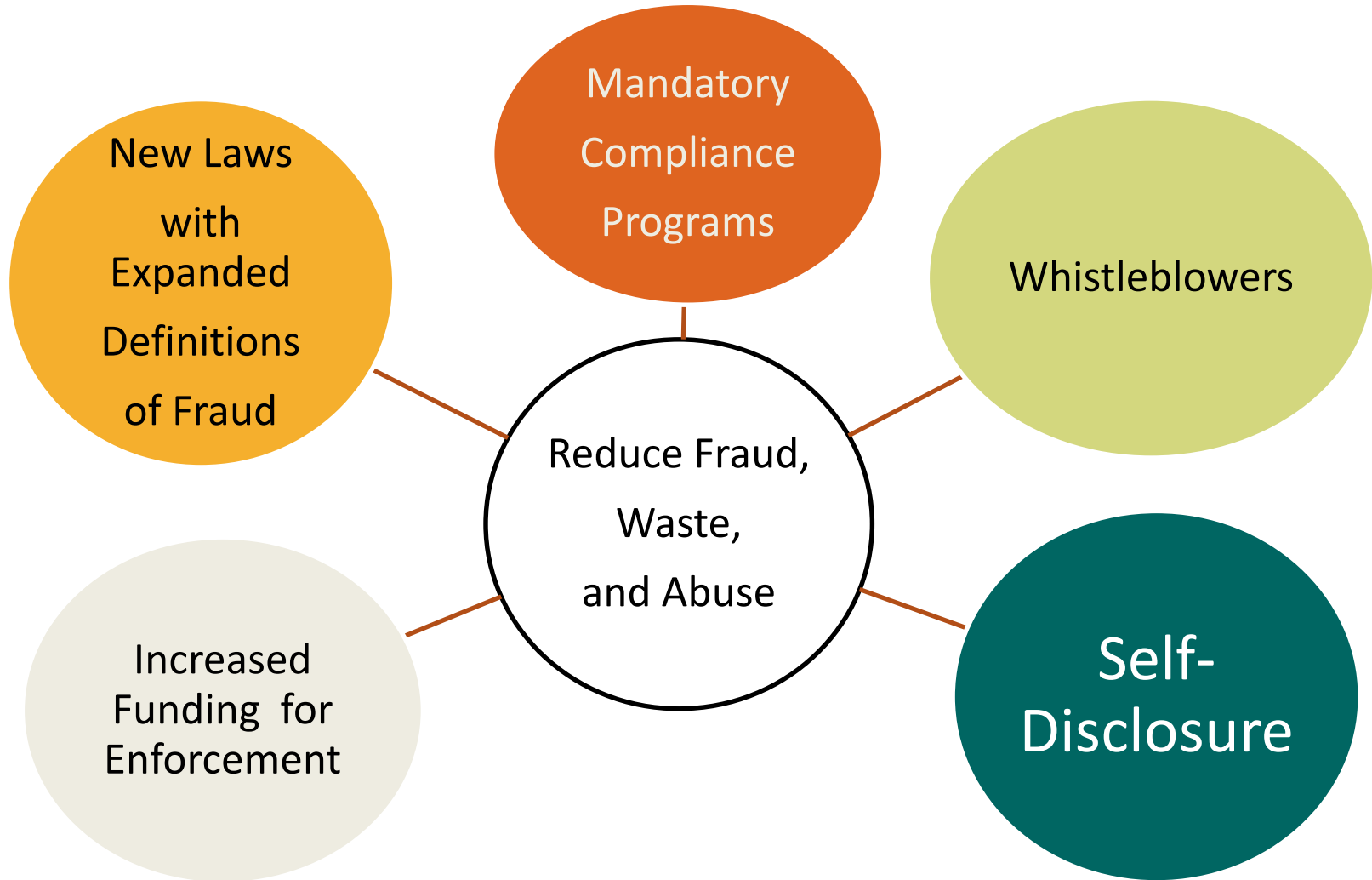


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## II. Health Center Program Core Requirements



# CLIMATE OF ACCOUNTABILITY, TRANSPARENCY, & ENFORCEMENT



# STATUTORY AND REGULATORY AUTHORITIES

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- Requirements are based on the following legal authorities:
  - Section 330 of the Public Health Service Act (42 U.S.C. § 254b)
  - Health Center program regulations (42 C.F.R. Part 51c)
  - Interpretative Material (see next slide): PINs, PALs, letters, memos, directives
    - Program Information Notices (PINs)
    - Program Assistance Letters (PALs)
  - Specific Award Conditions

# KEY PINS/PALS

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- **Scope of Project**
  - PINs: 2008-01, 2009-02, 2009-03, 2009-05
  - PALS: 2011-07, 2012-06, 2013-03, 2014-05, 2014-06, 2014-10
- **Service Area Overlap:** PIN 2007-09
- **Sliding Fee Discount Program:** 2014-02
- **Affiliations:** PINs 97-27, 98-24; PAL 2011-02
- **Federal Tort Claims Act Manual:** PIN 2011-01
- **Budgeting and Accounting Requirements:** PIN 2013-01
- **Governance:** PIN 2014-01

Find all of these and more resources at:

<http://www.bphc.hrsa.gov/programrequirements/policies/index.html>

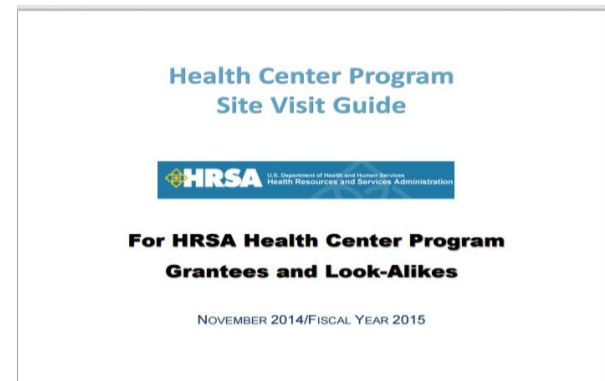
# HEALTH CENTER PROGRAM REQUIREMENTS

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- Bureau of Primary Health Care established “19” Program Requirements
  - Legal standards mandated by health center statute and regulations
  - Grouped into four categories:
    - Need
    - Services
    - Management & finance
    - Governance

# EVALUATING COMPLIANCE WITH THE PROGRAM REQUIREMENTS

- Every health center will be evaluated through an “Operational Site Visit” or OSV once every project period
- HRSA’s main review instrument is the “Site Visit Guide”
  - Designed to be objective
  - Standardized questions designed to be answered with a simple “yes” or “no”
  - Available at:  
<http://bphc.hrsa.gov/administration/visitguidepdf.pdf>



NOTE: Site Visit Guide may soon be replaced by the Program Requirements Compliance Manual



# HRSA'S 19 PROGRAM REQUIREMENTS



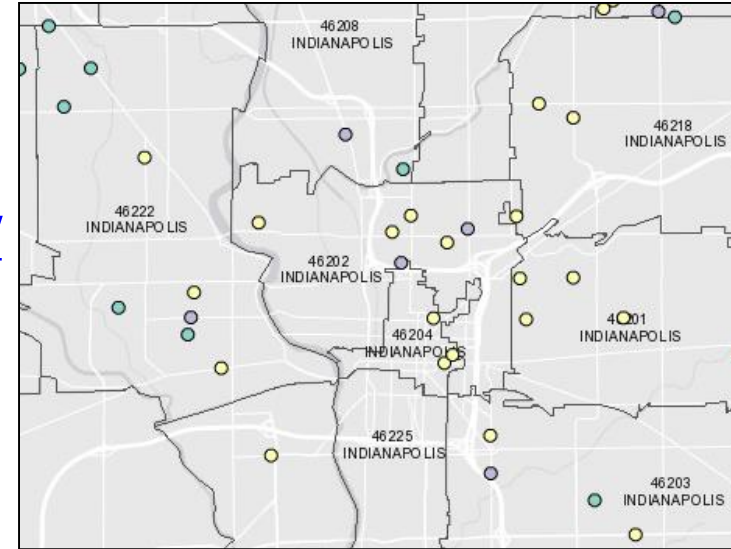
# #1: NEEDS ASSESSMENT

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**Needs Assessment:** Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)

# NEEDS ASSESSMENT

- What's a Service Area?
  - Must serve an Medically Underserved Area (MUA) or a Medically Underserved Population (MUP): <http://muafind.hrsa.gov/>
  - Identifying the target population(s) and assessing unmet need
- Avoid Service Area Overlap with other health centers by checking UDS Mapper [www.udsmapper.org](http://www.udsmapper.org)
  - PIN 2007-09
- Resources
  - State Primary Care Association: <http://www.indianapca.org/>
  - National Association of Community Health Centers: <http://www.nachc.com/>
  - Bureau of Primary Health Care: <http://bphc.hrsa.gov/>



## #2: REQUIRED & ADDITIONAL SERVICES

**Required and Additional Services:** Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) of the PHS Act)

**Note:** Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services. (Section 330(h)(2) of the PHS Act)

# SCOPE OF SERVICES

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- Must provide, or arrange for the provision of, all required services including:
  - **Basic preventive and primary care services:** diagnostic lab and x-ray, prenatal and post-natal care, well-child care, immunizations, screenings, voluntary family planning, preventive dental services, and pharmacy (as appropriate)
  - **Enabling services** such as outreach, transportation, and translation
  - **Education** regarding the availability and proper use of health services
  - **Case management services** (counseling, referral, and follow-up) and other services designed to assist patients in establishing eligibility for financial assistance programs

# SCOPE OF SERVICES CONT'D

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- Services can be provided directly or by established written arrangement (*i.e.*, contract or referral)
- Required services must be available and *reasonably accessible* to all patients
- May provide additional services appropriate to meet the needs of the target population
- Expected to establish collaborative arrangements with other community-based health and social service providers

## #4 : HOURS OF OPERATION REQUIREMENT

### #5: AFTER HOURS COVERAGE

#### **Accessible Hours of Operation/Locations:**

Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)

**After Hours Coverage:** Health center provides professional coverage for medical emergencies during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4))

# #7: SLIDING FEE DISCOUNTS

**Sliding Fee Discounts:** Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay.

- This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.\*
- No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines.\*
- No patient will be denied health care services due to an individual's inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived.  
(Section 330(k)(3)(G) of the PHS Act, 42 CFR Part 51c.303(f)), and 42 CFR Part 51c.303(u))



# HEALTH CENTER CHARGES AND DISCOUNTS

- Health centers must have a **schedule of charges** designed to cover reasonable costs of operation and consistent with locally prevailing (community) rates
  - **Schedule of discounts** corresponds to patient income and family size
  - No patient can be denied services due to an individual's inability to pay
  - **PIN 2014-02**
- |                     |  |
|---------------------|--|
| At/Below 100% FPL   | • Full discounts or “nominal” charges                                |
| 101-200% FPL        | • Discount adjusted based on ability to pay (at least 3 pay classes) |
| At/Above 201% FPL + | • No discounts   |

# SLIDING FEE DISCOUNT PROGRAM

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- Nominal fee
  - Not a requirement, health center discretion
  - Nominal from the perspective of the *patient*
  - Fixed flat fee that does not reflect the trust cost or value of the service provided
  - Not more than the fee paid by a patient in the first SFDS payment class above 100%
  - Not a payment threshold or a minimum payment
- Discounts must apply to:
  - All patients who qualify
  - All services within the scope of project (required or additional, regardless of the type of service or mode of delivery)
  - In-scope referral providers (or health center may pay the difference)
- Communicated to patients in a manner appropriate for languages and literacy levels of the target population

# SLIDING FEE DISCOUNT PROGRAM

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- Policies approved, reviewed, and updated by the governing board
  - Update annually per Federal Poverty Guidelines
  - Develop income verification system to assess patients for eligibility
  - Required documentation may not create a barrier to care
  - Include policies to waive or reduce payments based on individual determinations
- Multiple sliding fee scales
  - May develop more than one schedule of discounts for distinct services or modes of delivery (must comply with PIN 2014-02 and not be a barrier)
- “Supplies and equipment”
  - Related to a service (eyeglasses or dentures) may be charged on a different discount structure less than prevailing costs, but more than normal discount
  - Included in a service (casting materials and bandages) may not be charged separately or on a different discount schedule
- May provide discounts above 200% only from non-330 funding sources

# #10: AFFILIATIONS & #11: COLLABORATIONS

**Contractual/Affiliation Agreements:** Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements. (Section 330(k)(3)(I)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a) (2))

**Collaborative Relationships:** Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (section 330 grantees and FQHC Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. (Section 330(k)(3)(B) of the PHS Act and 42 CFR Part 51c.303(n))

# AFFILIATIONS & COLLABORATIONS

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- Health centers must make efforts to collaborate with other local providers
  - May include providers serving the same underserved community(ies) or population(s)
  - May coordinate with non-health care agencies, networks and programs serving / supporting the same population
  - Document all linkages, partnerships, and collaborative arrangements/activities

# AFFILIATIONS & COLLABORATIONS

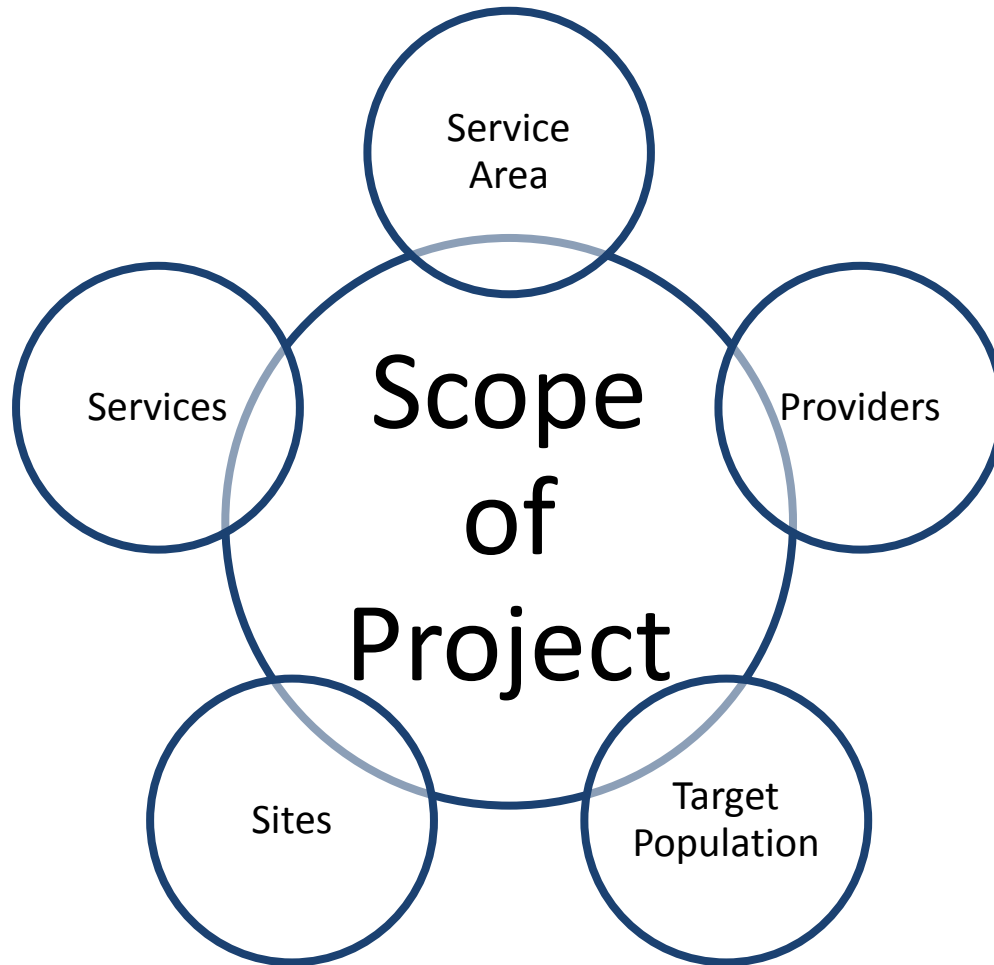
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- In any affiliation, a health center must maintain:
  - Independence and compliance with all core requirements
  - Appropriate oversight and authority over all contracted services provided to its patients
- Affiliation or contracted agreements
  - Must comply with HRSA affiliation policies limiting third party involvement in health center's structure, governance, and operation
  - A third party may not:
    - Select a majority of the board or non-user members
    - Have overriding approval or veto authority
    - Select or dismiss the Executive Director/CEO
    - Control the health center's relationships with other entities unless there is no impact on compliance to collaborate/coordinate care with local providers

## #16: SCOPE OF PROJECT

**Scope of Project:** Health center maintains its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards. (45 CFR Part 74.25)

# WHAT IS SCOPE OF PROJECT?



- The who, what, where, and how of providing access to care in the community
- Must request *prior* approval from HRSA to add or delete sites and services
- Impacts grant funds and eligibility for health center benefits
- Changes made through the Electronic Handbook or “EHB”
- **PIN 2008-01**



# #18: BOARD COMPOSITION

**Board Composition:** The health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically:

- Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.\*
- The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.\*
- No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.\*
- **Note:** Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p).  
(Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)

# COMMUNITY-BASED BOARD OF DIRECTORS

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- Health centers are required to have community-based governance: at least 51% of board members must be consumers of health center services
  - **Consumer:** A current registered patient of the health center who has accessed the health center in the past 24 months to receive at least one or more in-scope service(s) that generated a health center visit
    - May be a legal guardian of a patient who is a dependent child or adult, or a legal sponsor of an immigrant
  - **Visit:** A documented, face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the patient
- PIN 2014-01

# COMMUNITY-BASED BOARD OF DIRECTORS

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- Non-consumer members of the Board:
  - Representative of the community in which the health center's service area is located
  - Selected for expertise in areas such as community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community
- No more than 50% of the non-consumer board members may derive more than 10% of their annual income from the health care industry

# #17: BOARD AUTHORITY

**Board Authority:** Health center governing board maintains appropriate authority to oversee the operations of the center, including:

- Holding monthly meetings;
- Approval of the health center grant application and budget;
- Selection/dismissal and performance evaluation of the health center CEO;
- Selection of services to be provided and the health center hours of operations;
- Measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;\* and
- Establishment of general policies for the health center.

(Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)

**Note:** In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center. (Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv))

# RESPONSIBILITIES OF THE BOARD

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- Meet monthly (no exceptions)
- Hire, annually evaluate, and, as necessary, fire the CEO
- Determine scope, location, and availability of services
- Development, adoption, and periodic updating of general policies and procedures of the health center:
  - Financial management practices: annual operating and capital budgets, schedule of charges and discounts, and collections policies
  - Personnel policies: selection and dismissal procedures, salary and benefit scale, and employee grievance procedures
  - Establish quality of care audit policies and quality assurance/improvement plan
  - Compliance program policies and procedures
- Approve the annual health center budget and audit

# RESPONSIBILITIES OF THE BOARD CONT'D

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- Review and approve applications related to the Section 330 grant
- Evaluate Board procedures and performance periodically for efficiency and effectiveness
- Evaluate health center activities including services utilization patterns, productivity, patient satisfaction, achievement of the project objectives
- Conduct long-term strategic planning, including regular updating of the health center's mission, goals, and plans,
- Evaluate the health center's progress in meeting its annual and long-term goals
- Represent the Health Center in the community
- Document, document, **DOCUMENT EVERYTHING!**
- PIN 2014-01

# DISTINGUISHING BOARD ROLES FROM MANAGEMENT ROLES

## Board of Directors

Determines mission and vision, goals and strategy

Chooses direction, sets priorities, and makes policy

Selects and oversees CEO

Engages in strategic planning

Establishes measures of accountability

Evaluates health center performance

Supports the CEO

## Management

Determines how to *accomplish* goals and strategy

Implements procedures and necessary operational processes

Selects and oversees health center employees

Oversees and monitors daily operations

Collects data regarding health center services and patients

Provides Board with information and requests guidance

# #19: CONFLICT OF INTEREST POLICY

**Conflict of Interest Policy:** Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants, and those who furnish goods or services to the health center.

No board member shall be an employee of the health center or an immediate family member of an employee.

The Chief Executive Officer may serve only as a non-voting ex-officio member of the board. (5 CFR Part 74.42 and 42 CFR Part 51c.304(b))

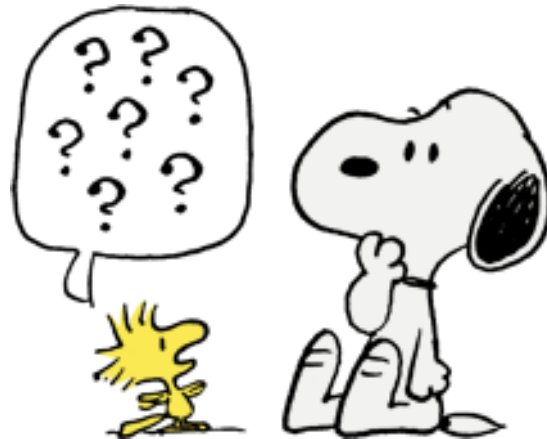


# CONFLICT OF INTEREST POLICY

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- Approve and annually update a comprehensive COI Policy (or “Standards of Conduct”):
  - Applicable to Board members, employees, contractors and other agents of the health center
  - Define “conflict of interest” and establish other prohibitions regarding: gifts and gratuities, nepotism, and bribery
  - Establish procedures to disclose and manage potential or actual conflicts of interest
  - Address consequences for violating the policies
  - Specifically consider the following risks:
    - Board members or immediate family members providing services to the health center
    - Board member expense reimbursement policies
    - Confidentiality

# Questions on Part I?



# AGENDA: PART II

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## **I. Pathways to Becoming a Health Center**

## **II. Spectrum of Integration: Ways to Collaborate with Health Centers**



# I. Pathways



# “TYPES” OF HEALTH CENTERS

## Grantee

Receives  
Section  
330 Grant

## Sub-Recipient

Receives a  
portion of a  
Grantee's  
Section 330  
Grant

## “Look-alike”

Does not  
receive  
Section  
330  
Grant

# GRANTEE MODEL

## Compete for New Access Point (NAP) Grant

- Maximum annual grant request = \$650,000
- Only 1 application per organization
- Must propose to establish a new service delivery site:
  - New Starts: Organization that does not currently receive any funding under section 330 may expand existing sites or establish new sites
  - Satellites: Organization that currently receives funding under any of the section 330 programs proposing to establish a new delivery site(s)
- Must propose to provide comprehensive primary care services
- Must propose to serve a federally designated MUA/MUP unless requesting **only** special population funding (migrant, homeless, and/or public housing) (*new starts only*)
- Must be operational within 120 days of grant award

# GRANT APPLICATION PROCESS

- Funding opportunities are announced on
  - HRSA's web site:  
<http://www.hrsa.gov/grants/index.html>
  - Grants.gov: <http://grants.gov/>
- To apply:
  - Register & Get Ready
    - 1) DUNS, 2) SAM & 3) Grants.gov
  - Find & Submit
  - Write a Strong Application



# SUB-RECIPIENT MODEL

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- Prime grantee awards a portion of its grant to another entity (sub-recipient) and the sub-recipient provides certain services on behalf of the prime grantee
  - Sub-recipient retains its autonomous corporate identity and must qualify as an FQHC independently
  - Prime Grantee ensures sub-recipient compliance through oversight and monitoring
- Relationship is governed by written contract and the two entities remain independent
- Health centers may have and be sub-recipients of other grantees

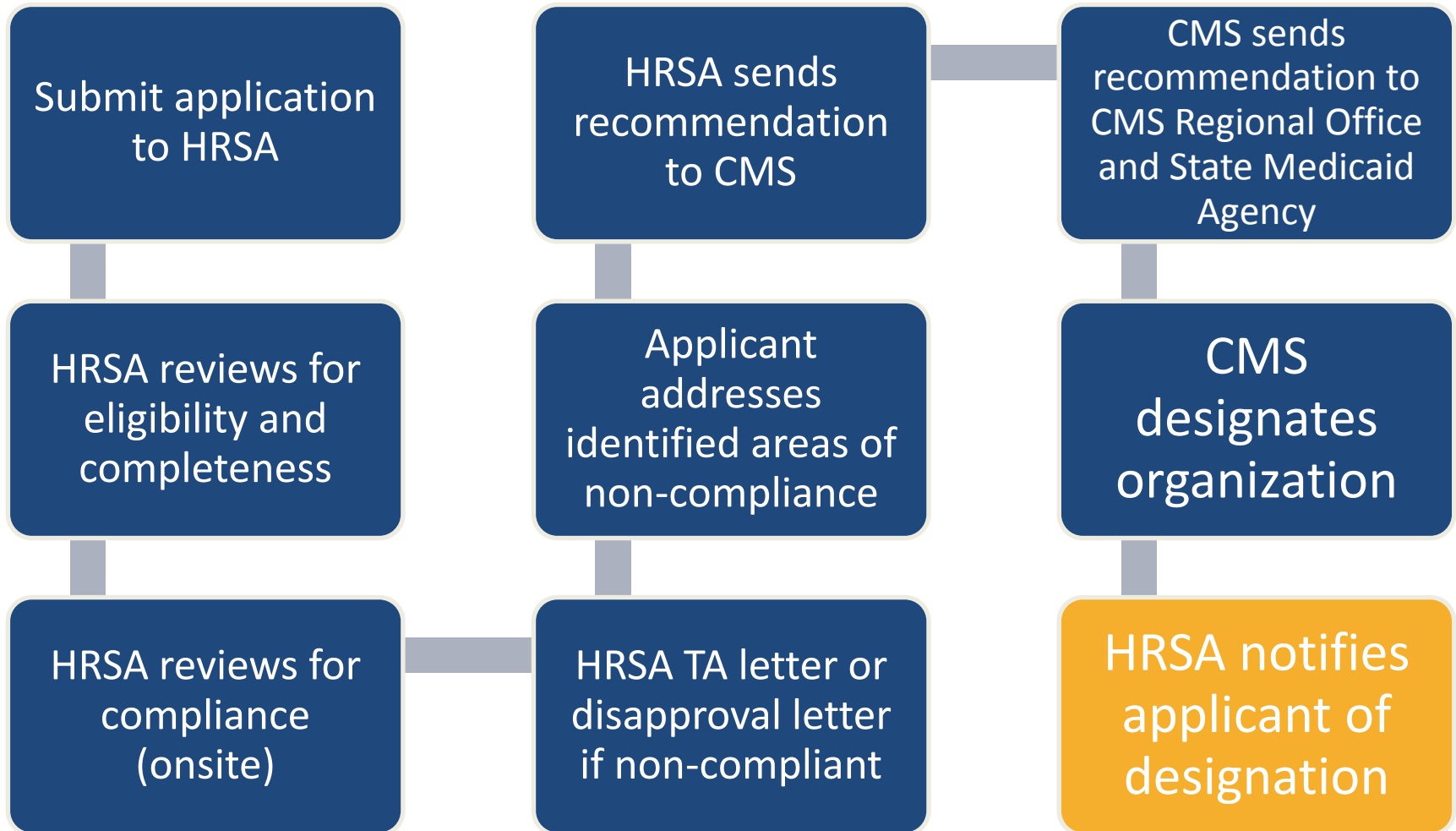


# LOOK-ALIKE MODEL

- Noncompetitive rolling application
- Must be operational for six months when you apply
- The FQHC Look-Alike Program is operated under an intra-agency agreement between HRSA and Centers for Medicare and Medicaid Services (CMS)
- HRSA is responsible for: (a) Assuring compliance with requirements under Section 330; and (b) Making a recommendation to CMS for designation as an FQHC Look-Alike
- CMS has final authority to designate applicants as an FQHC Look-Alike



# FQHC LOOK-ALIKE DESIGNATION PROCESS



## II. Approaches to Health Center Collaboration



# SPECTRUM OF INTEGRATION

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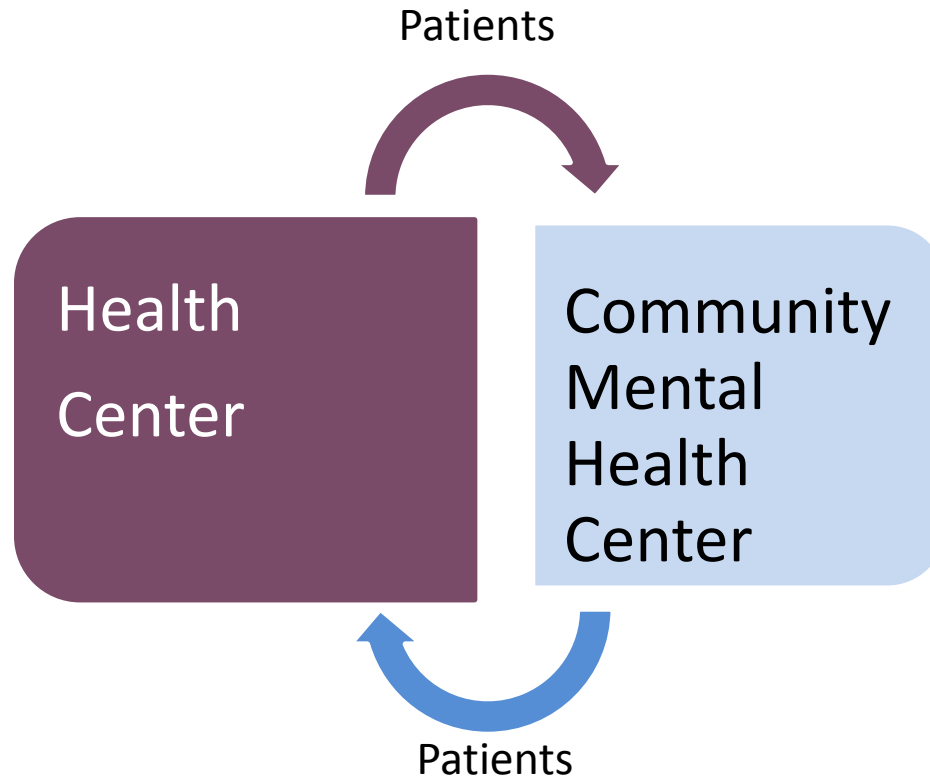
- Referral arrangements
- Co-located referral arrangements
- Lease of personnel / services
- Transfer of outpatient practice site(s)

*Mix & match of the above options as necessary to implement identified initiatives*

- Corporate integration: partial consolidation or total integration

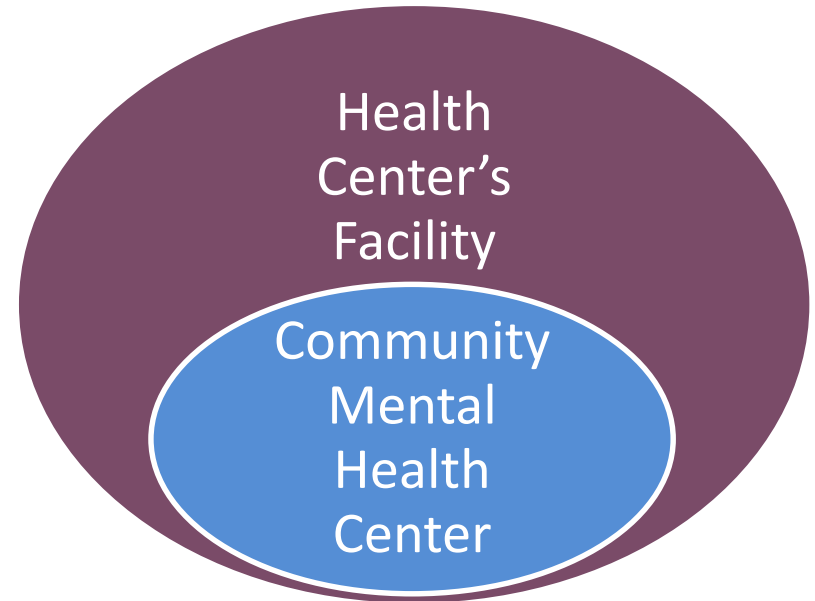
**NOTE:** Health center benefits do not “pass through” to a collaboration partner; however, if the partnership is structured properly, some benefits may apply to the arrangement and the patients who are thereby served

# FORMAL WRITTEN REFERRALS



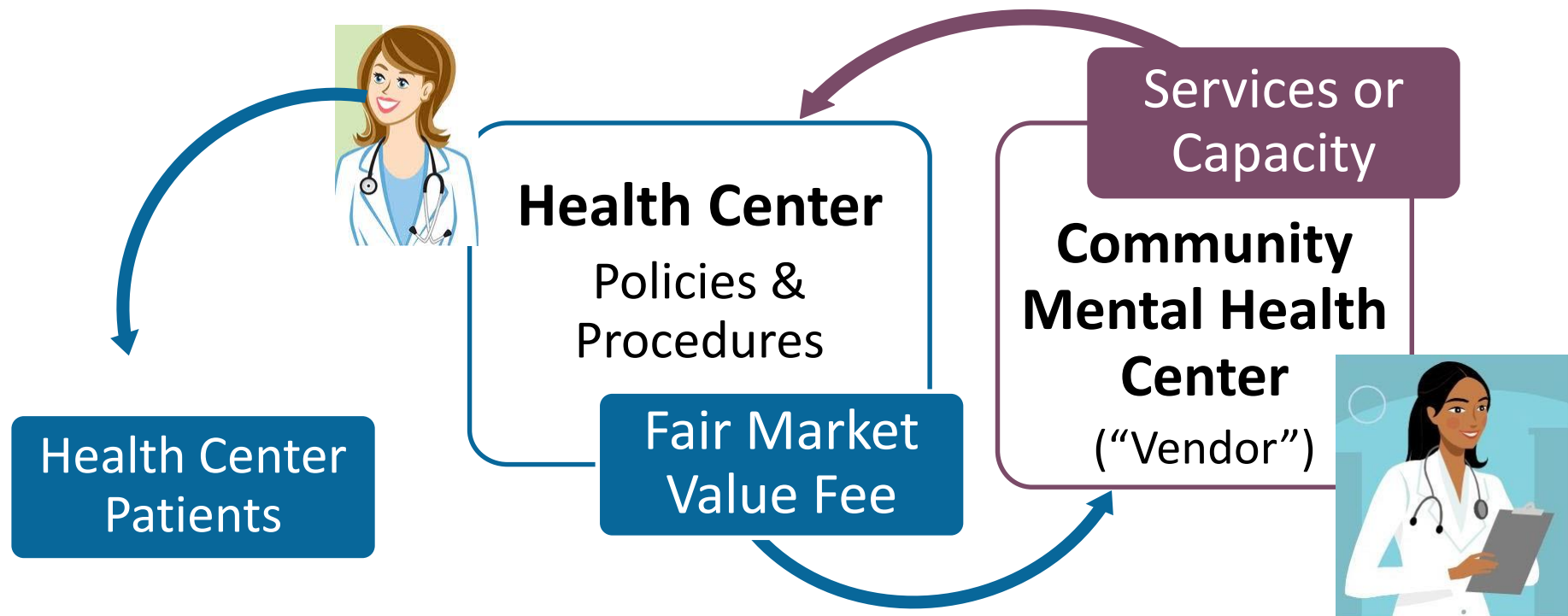
Each provider agrees to furnish services to individuals referred by the other entity - each provider is financially, clinically, and legally responsible and is solely liable for claims related to services it directly provides

# CO-LOCATED FORMAL REFERRALS



Similar to referral relationship, but co-located provider is physically located in and provides services to its own patients (including individuals referred to it by the other provider) at the other provider's facility, subject to applicable state law

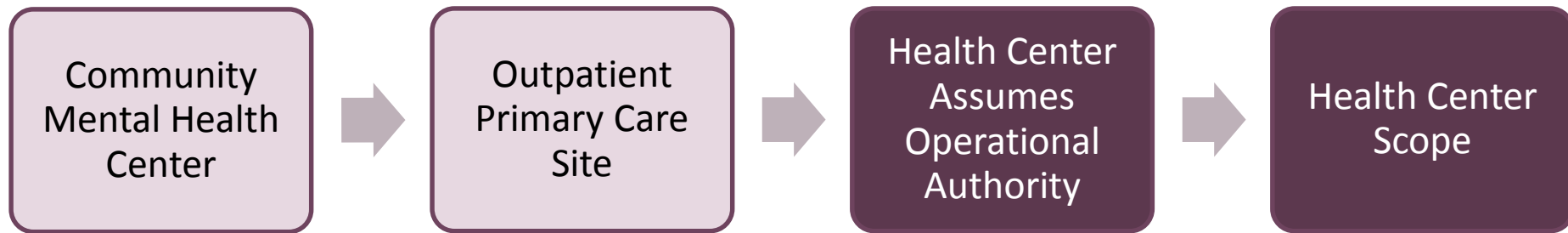
# LEASE OF PERSONNEL / SERVICES



Health center contracts with Community Mental Health Center to furnish clinical and/or administrative services to or on behalf of the health center - health center is financially, clinically, and legally responsible for provision of the leased services

# TRANSFER OF CLINICAL SITES

## Transfer of Operational Authority



### Caution:

- Health center must obtain HRSA's approval to add transferred or new site to health center's scope of project
- Consider grant transfer implications



# CORPORATE CONSOLIDATION TRENDS

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- Safety net providers seeking to consolidate with health centers to reduce duplication of services, increase coordination of care, and address financial challenges
- Health center will be the “surviving” corporation to preserve the Section 330 grant
- HRSA considerations:
  - Impact on scope of project (e.g., new sites or services)
  - Service area overlap
  - Potential change in CEO and other key management positions
  - Board composition and authorities
  - Aligning project periods
  - **Transfer of grant**

# UNDER ALL OPTIONS ALONG SPECTRUM OF INTEGRATION

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- Health centers must maintain independence and compliance with all core requirements
  - Operations must be integrated into the health center's scope of project (*i.e.*, must have access to full scope of services, regardless of ability to pay)
  - Affiliations must actually expand access
  - Collaborations must be structured to comply with HRSA affiliation policies that limit third party involvement in the structure, governance, and operation of the health center
  - Health centers can own (but not be owned by) a third party
- PIN 97-27; PIN 98-24

# NEXT STEPS: WHERE DO YOU START?

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- Identify the health center(s) in your community
- Familiarize the identified health center(s) with your organization's scope of services and quality achievements
- Schedule informal meetings to become more familiar with one another's operations
- Identify collaboration options

# QUESTIONS?

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