Your Operational Site Visit Could be Next: Addressing HRSA's 19 Program Requirements & Grant Performance Risks

Presented to:

Community Health Institute

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Massachusetts League
of Community Health Centers

MA Community Health Centers

- ✓ 49 Community Health Center organizations (FQHC & hospital-licensed)
- ✓ ~300 sites reflect medical, dental, behavioral health, school-based and social services; provide patient-centered, culturally competent, high quality care
- ✓ **951,000 <u>total</u> patients (MA population: 6.7 million) = 1 in 7 residents**
- ✓ **4.5M <u>total</u> patient visits**

- Provide a broad range of primary & preventive care, including dental, eye and mental health/substance abuse care and other community-based services
- All 49 health centers have either purchased, implemented or are in the process of implementing a certified EHR; all preparing for Meaningful Use
  - ➢ 95% installed at all sites and used by all providers *(v. 92% nationally)*
  - ➢ 89% with PCMH recognition *(v. 65% nationally)*
  - ➢ 13.5% National Quality Leaders *(v. 4.8% nationally)*
  - ➢ 43.2% Health Center Quality Leaders *(30.4% nationally)*
- Transform communities by delivering quality care and addressing the factors that underpin and perpetuate poverty

Benefits of the "330" Designation

- Federal Section **"330"** funds come from Bureau of Primary Health Care, Health Resources & Services Administration, USDHHS
  - **NOTE**: In 2014, MA CHCs received $81M in "330" funds PLUS $9M in capital funds
- **Federal Tort Claims Act** (FTCA) malpractice insurance coverage
- Eligibility for **other federal funding opportunities** (programs / initiatives) based on FQHC status (ES, O/E, PCMH, QI, HIIP, OHSE, SA MAT, etc.)
  - **NOTE**: In addition to their base "330" funds, MA CHCs received an add'l $21M in 2015
- Eligibility for federal **National Health Service Corps** loan repayment (and possible scholarship) through automatic HPSA designation
- **340b Pharmacy**
- **Medicaid** Prospective Payment System
- Enhanced **Medicare** cost-based reimbursement

Responsibility of the "330" Designation

- HRSA's **e-Handbook (EHB) reporting** (SAC, BPR, O&E QPR, UDS, audit, etc.)
- **Uniform Data System (UDS) reporting** including patient demographics, visits, and clinical and financial performance measures
- Health center **regulations** (PINs, PALs, etc.)
- **HRSA's 19 Health Center Program Requirements → HRSA Operational Site Visit**
  - For **Summary**, see - http://www.bphc.hrsa.gov/about/requirements/index.html
  - For **OSV Guide**, see - http://www.bphc.hrsa.gov/administration/visitguidepdf.pdf

"330" Federal Oversight

- 19 Program Requirements are divided into 4 categories:
  - **Need** (1)
  - **Services** (2-8)
  - **Management and Finance** (9-16)
  - **Governance** (17-19)

- **Document, Document, Document!**
- **Minutes, Minutes, Minutes!**
- **Interviews, Interviews, Interviews!**

“330” Federal Oversight

United States Government Accountability Office

GAO

Report to Congressional Requesters

May 2012

HEALTH CENTER PROGRAM

Improved Oversight Needed to Ensure Grantee Compliance with Requirements

Published on *www.HealthCenterCompliance.com* (http://www.healthcentercompliance.com)

Home > HRSA to Increase its Oversight of the Health Center Program (Updated Link)

HRSA to Increase its Oversight of the Health Center Program (Updated Link)

August 13, 2012

On August 2, 2012, the Health Resources and Services Administration (HRSA) provided the U.S. Senate its Management Plan in response to two recent GAO reports regarding the health center program (GAO-12-504 and GAO-12-546). The GAO reports were highly critical of HRSA's overall oversight and monitoring of the Health Center program.

In answering these reports, HRSA highlights steps it is taking to increase its scrutiny of the health center program, including:

- new trainings for project officers and HRSA staff, with a focus on board composition, after-hours coverage, and key management staff program requirements;
- new procedures for placing conditions on notices of grant awards at any time during the year;
- improvements to ensure grantees address non-compliance in a timely matter; and
- operational site visits for each health center at least once in every five-year period.

HRSA already has increased its oversight activity by conducting site visits based on the Nineteen Program Requirements and Health Center Site Visit Guide published last year. HRSA's Management Plan is a reminder that grantees should expect increased scrutiny and oversight related to compliance with Section 330 requirements. The full Management Plan is available here [1].

Source URL: http://www.healthcentercompliance.com/hrsa-increase-its-oversight-health-center-program-updated-link

Links:
[1] http://www.cobum.senate.gov/public/index.cfm/2012/8/hrsa-responds-to-gao-findings-senators-request-for-plan-to-address-deficiencies-ineffective-management-at-hrsa

G A O

"330" Federal Oversight

- Health centers actively report to a HRSA Project Officer
- Within their **3 year project period**, each health center must (in addition to many other requirements):
  - Year 1: Submit Non-Competitive Budget Period Renewal application
  - Year 1½: **Have 3-Day Operational Site Visit** (review of 19 Program Requirements)
  - Year 2: Submit Non-Competitive Budget Period Renewal application
  - Year 3: **Submit Service Area Competition application**

Importance of Compliance with 19 PRs

- Operational Site Visit is designed to **perform a full organizational assessment** in all operational areas:
  1. Administration/Governance
  2. Fiscal
  3. Clinical
- There is a **great expectation** that health centers are in **full compliance** with all requirements
- Keeping up with the program requirements must be **continuous** (don't cram for the reviews)

Sanctions

- **'Mets' v. 'Not Mets' (*aka* out of compliance)**
  - **One year** of funding (means a SAC grant must be completed annually)
  - **Restricted draw downs** from HRSA
  - Could **hurt applying for additional funds** in the future if >X Not Mets
  - Possible **defunding** of grantee

- Also, can be put on restricted drawdown if most recent audit called into question whether the organization is able to continue as a **"going concern."**

Sanctions Example, per SAC FOA HRSA-16-003 p. 41-42

Project Period Length Criteria

The length of an awarded project period is determined by a comprehensive evaluation of compliance with program requirements by HRSA. Competing continuation applicants with one or more of the following characteristics will be awarded a one-year project period: [24]

- 10 or more Health Center Program requirement conditions.
- 3 or more unresolved conditions related to Health Center Program requirements in the 60-day phase of Progressive Action carried over into the new project period.
- 1 or more unresolved conditions related to Health Center Program requirements in the 30-day phase of Progressive Action carried over into the new project period.

If a competing continuation applicant has been awarded two consecutive one-year project periods in FY 2014 and FY 2015, and meets the criteria for a third consecutive one-year project period in FY 2016, the application will not be funded and the service area will be recompeted if no other fundable applications were received.

Any competing supplement applicant with 5 or more unresolved conditions related to Health Center Program requirements in the 60-day phase of Progressive Action or 1 or more unresolved conditions related to Health Center Program requirements in the 30-day phase of Progressive Action will not be funded and the service area will be recompeted if no other fundable applications were received.

Restricted Drawdown Determining Factors

HRSA will include a term for restricted drawdown on the NoA of any applicant selected for funding whose most recent audit called into question whether the organization is able to continue as a "going concern." When an award recipient is placed on restricted drawdown, all drawdown of federal funds requires approval from the Division of Grants Management Operations.

Sanctions Example, per OHSE HRSA-16-076 p. 26

Grant Status

Prior to the award date, HRSA will assess the status of all applicants. Applicants within the fundable range will **not** receive an Oral Health Service Expansion award if they have either of the following:

- Five or more 60-day Health Center Program requirement progressive action conditions; or
- One or more 30-day Health Center Program requirement progressive action conditions

When will you have your Site Visit?

1. If you have **not been reviewed** for quite some time
2. If you are a **new start**
3. If you are in the **middle** of your project period ←
4. If you've had any **significant operating issues**

- You should receive a notice from your Project Officer at least **6-8 weeks in advance** or longer

Who will be on your Site Visit?

- **3 HRSA reviewers** (Consultants) for **2½ days** (fiscal, clinical, administration/governance); 1 will be Team Leader
- Some are seasoned, some are new; mentoring process for new Consultants
- Each may have a **unique way** of looking at issues and holding discussions
- Your Project Officer may also attend, but typically does not conduct any part of the review

During Operational Site Visit – Board's Role

- **Make sure Board is PREPARED**

- Board members are invited (but not required) to attend the entrance and exit conferences

- There is a **separate closed door meeting with Board** (lunch on 2nd day?)
  - consider holding monthly Board meeting 2nd day or have Board ready for call via phone (if acceptable, per bylaws) to address and possibly rectify any policy issues → **RAPID RESOLUTION**

During Operational Site Visit – Board's Role

- As a component of the **19 Program Requirements**, Board members could be asked about the following:
  - ✓ **19 Program Requirements**
    - ✓ Status of the short-term and long-term **Strategic Plan**
    - ✓ Assessment of health center **operational** performance, information systems/informatics, overall management performance (CEO evaluation), patient satisfaction surveys, focus groups
    - ✓ Assessment of health center **financial** performance, reporting, nominal fee
    - ✓ Assessment of health center **clinical** performance, Quality Improvement Plan, no show rates
    - ✓ Board performance and **self evaluation**
    - ✓ **Etc.**
  - ✓ **REMINDER:**
    - ✓ **Oversight, leadership and monitoring is the responsibility of the Board (with your role in providing feedback as a patient leader, community leader and/or business leader)**
    - ✓ **Management of day-to-day operations is the responsibility of your CEO and their leadership team**

Keep in Mind…

- **DOCUMENT, DOCUMENT, DOCUMENT!**
- Ensure all **policies have been recently reviewed and approved by the Board**
  - ensure policies **adhere to recent BPHC PALs, PINs**
- If you are **out on any part of the requirement**, you are out on the entire requirement; absolutely **no partial credit** to remain in compliance
- Know what you are talking about **or** don't answer the question in the room
- **Respectfully challenge reviewers** if you believe you are correct – sometimes they are wrong; include Project Officer as HRSA (not Consultants) makes final decision

Trends - # of Not Mets

- From 2013-2014, the average # of Not Mets was **3.2**
- In 2015 (12 OSVs), the average # of Not Mets was **6.4 - *SIGNIFICANT INCREASE***
  - *So*…from 2013-2015, the average # of Not Mets has increased to **4.8**
  - 11 OSVs have been for CHCs ending their 5 year project period; 1 was completing their 2nd OSV
- In 2016 (8 OSVs), the average # of Not Mets is **2.5 - *SIGNIFICANT DECREASE***
  - So…from 2015-2016, the average # of Not Mets increased to **4.9**

Priority for Review - Highest Not Mets

Program Requirement	# of Not Mets	% of Not Mets
#2: Required & Additional Services	11	55%
#7: Sliding Fee Discounts	11	55%
#17: Board Authority	11	55%
#16: Scope of Project	10	50%
#3: Staffing Requirement	7	35%
#13: Billing & Collections	7	35%

- Source: League staff attended 12 OSVs in 2015 & 8 OSVs in 2016 (YTD)

Priority for Review - Highest Not Mets

Program Requirement	# of Not Mets	% of Not Mets
#6: Hospital Admitting Privileges & Continuum of Care	6	33%
#8: Quality Improvement / Assurance Plan	6	33%
#10: Contractual/Affiliations Agreements	6	33%
#12: Financial Management & Control Policies	4	20%
#18: Board Composition	5	28%

- **3 Not Mets** - #9: Key Management Staff, #14: Budget
- **2 Not Mets** - #1: Needs Assessment, #19: Conflict of Interest
- **1 Not Met** - #4: Accessible Hours of Operation/Locations, #5: After Hours Coverage, #15: Program Data Reporting Systems
- **0 Not Met** - #11: Collaborative Relationships

2. Required and Additional Services

Requirement:

- 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)

2. Required and Additional Services

- Ensures the health center is directly providing or has written arrangements and referrals in place to provide a comprehensive array of required and as necessary, additional **primary and preventive services that meet the needs of the populations it serves**.

- All services in the health center's scope of project must be **reasonably accessible** and available on a **sliding fee discount plan** to health center patients.

- 'In scope' (v. 'out of scope') referral arrangements must be formally documented in a written agreement (MOA, MOU, etc.) that at a minimum describes the manner by which the referral will be made and managed and the process for **referring patients back to the health center** for appropriate follow-up care.

- Documents and staff serve patients in **appropriate language(s)**.

- (e.g. Review official scope of project for services on *Form 5A: Services Provided* annually - through SAC or BPR – essential for FTCA malpractice coverage. Ensure Board has reviewed. Review clinical practice protocols. Written agreements should describe referral process.)

2. Required and Additional Services

REASONS WHY **NOT MET (11 of 20 CHCs)**:

- *Form 5A: Services Provided* not correct, per Consultant's interpretation → wrong column was checked
- MOUs/agreements that cover services missing 330 language, need to be more specific, not expired
- Tracking must occur in EMR
- Missing contract with hospital for Ob care
- Sliding Fee not captured in MOAs for Required Services, Column II (CHC pays) & III (CHC does not pay)

OMB No.: 0915-0285. Expiration Date: 9/30/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 5A: SERVICES PROVIDED (REQUIRED SERVICES)	FOR HRSA USE ONLY	
	Grant Number	Application Tracking #

Service Type	Service Delivery Methods		
	Direct (Health Center pays)	Formal Written Contract/ Agreement (Health Center pays)	Formal Written Referral Arrangement (Health Center DOES NOT pay)
General Primary Medical Care			
Diagnostic Laboratory			
Diagnostic Radiology			
Screenings			
Coverage for Emergencies During and After Hours			
Voluntary Family Planning			
Immunizations			
Well Child Services			
Gynecological Care			
Obstetrical Care			
• Prenatal Care			
• Intrapartum Care (Labor & Delivery)			
• Postpartum Care			
Preventive Dental			
Pharmaceutical Services			

Essential for FTCA Malpractice insurance

- For PAL 2014-06: Documenting **Scope of Project in Updated Forms 5A and 5B** (May 13, 2014), see - http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pal201406.pdf

2. Required and Additional Services

OMB No.: 0915-0285. Expiration Date: 9/30/2

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 5A: SERVICES PROVIDED (REQUIRED SERVICES)	FOR HRSA USE ONLY	
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Diagnostic Radiology			
Screenings			
Coverage for Emergencies During and After Hours			
Voluntary Family Planning			
Immunizations			
Well Child Services			
Gynecological Care			
Obstetrical Care			
• Prenatal Care			
• Intrapartum Care (Labor & Delivery)			
• Postpartum Care			
Preventive Dental			
Pharmaceutical Services			

3. Staffing Requirement

Requirement:

- Health center maintains a **core staff** as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals **(#2)**. Staff must be **appropriately licensed, credentialed and privileged**.

(Section 330(a)(1),(b)(1)-(2),(k)(3)(C), and (k)(3)(I) of the PHS Act)

3. Staffing Requirement

- Staff **composition and numbers must support the health center's Clinical Performance Goals** and ability to provide required and additional services.
- All health center providers are appropriately licensed, credentialed and privileged to perform the activities and procedures detailed within the health center's approved scope of project. Use **primary source documentation**. Verify licenses/certifications, DEA registration, etc. **Re-credential** every 24 months (**Board must approve**). **Peer review** must be part of re-credentialing.
- You must have **appeals process** for providers.
- Staffing should be **culturally and linguistically appropriate for the population** being served and **as noted in the health center's needs assessment (#1)**.
- (e.g. Ensure HR files, including contracts, are up-to-date and accurate. Review Staffing Profile. Review credentialing and privileging policies and/or procedures)

➢ For PIN 2002-22: Clarification of Bureau of Primary Health Care **Credentialing and Privileging** Policy (July 10, 2002), see - http://bphc.hrsa.gov/programrequirements/pdf/pin200222.pdf

3. Staffing Requirement

REASONS WHY **NOT MET (7 of 20 CHCs)**:

- Must present list of all licensed providers for credentialing and privileging approval (provider must be credentialed and approved by Board before they see patients)
- Privileges must match Services on *Form 5A: Services Provided*
- All providers (Column I, II, III) must be credentialed / privileged
- Privileges must match providers' new training (e.g. suturing)
- Policies and procedures must exist/match
- Providers at CHC >24 months must be re-credentialed, etc.

7. Sliding Fee Discounts

Requirement:

- 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))

7. Sliding Fee Discounts

- **New SFDP PIN 2014-02: Sliding Fee Discount and Related Billing and Collections Program Requirements (Sept. 22, 2014) released**, see - http://www.bphc.hrsa.gov/policiesregulations/policies/pdfs/pin201402.pdf
- Individuals **at or below 100% FPL must receive a full discount** on fees for services, however a nominal charge (**not fee**) may be charged.
- The fee schedule **must slide/provide at least 3 discount levels on charges** to individuals between 101% and 200% of the FPL ← ***new***
- There must be **no discount for patients above 200% FPL** using federal funds
- The fee schedule must be based on the most recent Federal Poverty Level/Guidelines, available at http://aspe.hhs.gov/poverty/ (released in Jan/Feb) and **must be updated and approved by the Board annually**
- Patients must be **notified/made aware of the availability** of the sliding fee discounts through multiple methods (posted signage in all waiting rooms, registration process) regardless of other factors (insurance status, population type)
- (e.g. Great 19-minute presentation available at: https://hrsa.connectsolutions.com/p8ed5chl03x/?launcher=false&fcsContent=true&pbMode=normal)

7. Sliding Fee Discounts

REASONS WHY **NOT MET (11 of 20 CHCs)**:

- Not following new PIN
- Fee schedule needs to be based on cost, not just market rates
- FPG not updated, not aligned within policy
- Didn't include all required and additional services on *Form 5A: Services Provided*
- Formal written agreements did not clearly state SFDP, or better
- Not Board approved

13. Billing and Collections

Requirement:

- Health center has **systems in place to maximize collections and reimbursement for its costs** in providing health services, including written billing, credit and collection policies and procedures.

(Section 330(k)(3)(F) and (G) of the PHS Act)

13. Billing and Collections

- Health centers must have **documented billing and collection policies and procedures** in place to maximize reimbursement.
- Health centers must **bill Medicare, Medicaid, CHIP, and other applicable public or private third party payors**.
- (e.g. Have a credit card policy, check signing policy)

13. Billing and Collections

REASONS WHY **NOT MET (7 of 20 CHCs)**:

- Missing documentation on waiving of fee, per SFPD
- School-based site missing Medicaid number
- Old policies / references
- Need policy on how to discharge patients

16. Scope of Project

Requirement:

- Health center **maintains its funded scope of project (#1, #2, #3, #4, etc.)** (sites, services, service area, target population, and providers), including any **increases based on recent grant awards**.

(45 CFR Part 74.25)

16. Scope of Project

2014 Health Center Data

Massachusetts Program Grantee Data

Total Number of Reporting Program Grantees: 37

Total Patients Served: 690,821

95% 85% 13.5% 43.2%

View Information by Criteria Reported Table 3A through 9E:

View Full 2014 State Report ▾ Go

Select a Different Reporting Year: 2013 ▾ Go

Download Massachusetts Aggregated Health Center Data

Find patient data by ZIP code using UDS Mapper **

View all Massachusetts Program Grantees

View National, State and Program Grantee Data

- Age and Race/Ethnicity
- Patient Characteristics
- Services
- Clinical Data
- Cost Data
- Footnotes

http://bphc.hrsa.gov/uds/datacenter.aspx?year=2014&state=MA

16. Scope of Project

- The "330" approved Scope of Project stipulates what the total grant-related project budget supports (including program income and other non-section "330" funds):
  - Five core elements: Services, Sites, Providers, Target Population, Service Area
  - **Changes in Scope may affect eligibility and coverage**
  - Significant Changes in Scope **must be approved by HRSA/BPHC**

- Health centers must **maintain their approved and funded scope of project in terms of number of patients served, visits, services available, providers, and/or sites**.

(e.g. Review all **Notice of Awards**: New Access Points, Expanded Medical Capacity, Behavioral Health Integration, Outreach & Enrollment, Quality Improvement Award)

(e.g. Review **annual UDS** trend reports; review UDS online profile)

(e.g. Review ***Form 5****A: Services Provided, 5B: Service Sites, 5C: Other Activities/Locations*)

- For additional resources, see - http://bphc.hrsa.gov/programrequirements/resourcecenter/managementandfinance/

16. Scope of Project

REASONS WHY **NOT MET (10 of 20 CHCs)**:

- *Form 5A: Services Provided* not completed accurately as services have changed (e.g. Transportation, Translation)
- Wrong columns are checked
- *Form 5B: Services Sites* (remove if not funded by "330") and *Form 5C: Other Activities/Locations* must be accurate

17. Board Authority

Requirement:

- 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)

17. Board Authority

- *For Public Center Grantees with Co-Applicant Arrangements ONLY—Public center (entity) grantee of record has a formal co-applicant agreement that stipulates*
  - *Roles, responsibilities, and the delegation of authorities.*
  - *Any shared/split responsibilities between the public center and co-applicant board.*

(Not applicable for MA CHCs)

17. Board Authority

- **New PIN 2014-01: Health Center Program Governance (Jan. 27, 2014) released**, see - http://bphc.hrsa.gov/policiesregulations/policies/pin201401.pdf

- Health center's board must:
  - **Meet monthly**. Not just 12 times a year.
  - **Review and approve** the annual health center (competitive and renewal) application and budget. Must be documented.
  - **Conduct an annual review** of the CEO's performance (with clear authority to select a new CEO and/or dismiss the current CEO, if needed). Note: **The CEO is the only staff person who must report directly to the Board.**

17. Board Authority

- Health center's board must:
  - **Review and approve the services** to be provided and the health center's **hours** of operation. Use patient surveys and review of UDS data annually.
  - **Measure and evaluate the health center's progress** in meeting annual and long term clinical and financial goals.
  - **Engage in strategic and/or long term planning** for the health center.

(e.g. Must have current strategic plan)

17. Board Authority

- Health center's board must:
  - **Review the health center's mission and bylaws** as necessary on a periodic basis.
  - Receive appropriate information that enables it to **evaluate health center patient satisfaction, organizational assets, and performance**.
  - **Establish the general policies** (not procedures) for the organization, which must **include, but are not limited** to:
    - Personnel
    - Health Care
    - Fiscal
    - Quality Assurance/Quality Improvement policies for the organization *(with the exception of fiscal and personnel policies in the case of a public agency grantee in a co-applicant arrangement)*

17. Board Authority

REASONS WHY **NOT MET (11 of 20 CHCs)**:

- Missed 1 Board meeting *(snow!)*
- Board did not approve budget prior to grant application submission
- Board did not approve Strategic Plan
- Board did not approve credentialing/privileging
- Bylaws missing process for recording and storing minutes
- Bylaws missing mission statement
- Bylaws missing language on creating ad-hoc committees
- Bylaws included standing committees that no longer exist
- Minutes do not reflect accuracy re: steps of Board (as minutes are legal documents of processes)
- More voting needs to occur, not just approval
- Need clarity on by-laws re: terms (e.g. 3 years on, 1 year off but can be asked to stay on)
- CEO evaluation not recently completed
- Board not receiving enough on clinical, financial, operational benchmarks and on strategic plan
- Bylaws missing dissolution of organization language

340b Audits for Participating Grantees

- Starting in FY15, BPHC began implementing the addition of a 340B Drug Discount Pricing Program Assessment Supplement to OSVs; see - http://www.hrsa.gov/opa/updates/october2014.html

- Primary focus of the OSV remains on the HRSA grant, although there will be an addition of some questions regarding 340B compliance

- Questions: Be prepared to share your organization's 340B policies, procedures, and other related documents in order to document they address the following:
  - **Patient Definition**
  - **Duplicate Discount**
  - **Contract Pharmacy**

- Use OPA tools and resources to learn about program compliance and audit readiness

Main Resources

- HRSA **19 Program Requirements Summary**, updated Feb. 2014
- HRSA 19 Program Requirements **OSV Site Guide**, updated Nov. 2014

- PAL 2014-08: Health Center **Program Requirements Oversight**
- PAL 2014-06: Documenting **Scope of Project in Updated Forms 5A and 5B**
- PIN 2014-02: **Sliding Fee Discount** and Related Billing and Collections Program Requirements
- PIN 2014-01: Health Center Program **Governance**
- PIN 2013-01: Health Center **Budgeting and Accounting Requirements** (Total Budget)
- PIN 2002-22: Clarification of Bureau of Primary Health Care **Credentialing and Privileging** Policy

Website Links

- HRSA **19 Program Requirements Summary**, updated Feb. 2014
  http://www.bphc.hrsa.gov/about/requirements/index.html
- HRSA 19 Program Requirements **OSV Site Guide**, updated Nov. 2014
  http://www.bphc.hrsa.gov/administration/visitguidepdf.pdf
- PAL 2014-08: Health Center **Program Requirements Oversight** (June 11, 2014)
  http://bphc.hrsa.gov/programopportunities/lookalike/pal201408.pdf
- PAL 2014-06: Documenting **Scope of Project in Updated Forms 5A and 5B** (May 13, 2014)
  http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pal201406.pdf
- PIN 2014-02: **Sliding Fee Discount and Related Billing and Collections Program Requirements** (Sept. 22, 2014)
  http://www.bphc.hrsa.gov/policiesregulations/policies/pdfs/pin201402.pdf
- PIN 2013-01: Health Center **Budgeting and Accounting Requirements** (Total Budget) (Mar. 18, 2014)
  http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin201301.pdf
- PIN 2014-01: Health Center Program **Governance** (Jan. 27, 2014)
  http://bphc.hrsa.gov/policiesregulations/policies/pin201401.pdf
- PIN 2002-22: Clarification of Bureau of Primary Health Care **Credentialing and Privileging** Policy (July 10, 2002)
  http://bphc.hrsa.gov/programrequirements/pdf/pin200222.pdf

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Massachusetts League
of Community Health Centers

Additional Program Requirements

Massachusetts League
of Community Health Centers

1. Needs Assessment

Requirement:

- 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)

1. Needs Assessment

- A needs assessment typically includes, but is not limited to, data on telling the story of your patient population:
  - Description of the service area, and inclusion of map(s) by zip &/or census tract
  - Population to provider ratios (e.g. # of primary care doctors)
    - Proximity to providers who accept Medicaid and/or uninsured patients
  - Demographic, socioeconomic, cultural, ethnic factors:
    - Income: Poor and Low-income population (e.g. 100% and 200% of FPL)
    - Uninsured population
    - Unemployment rates
  - Health disparities/quantitative health care needs
    - Health indicators (e.g., diabetes, hypertension, low birth weight, immunization rates)
  - Barriers to care
    - geographical/transportation, lack of insurance, literacy and language
  - Resources
  - Gaps in service
  - Any external factors affecting special populations
  - **Focus groups**
  - **Patient satisfaction surveys**

1. Needs Assessment

- Health center performs **ongoing and periodic needs assessments**.
- Assessments document the needs of its target population in order to **inform and improve its delivery of appropriate services**.
- (e.g. Complete at least 1 formal needs assessment within 3 year Project Period. Collaborate with local hospitals completing their required CHNA. Assure needs are incorporated into 3-year strategic planning. Review 'Needs' section of your SAC. Review service area map. Review neighborhood profiles, if applicable.)

- **NOTE: Use BPHC's UDSMapper.com to ensure consistency with UDS patient origin data**
- **NOTE: Use recent SAC's Need for Assistance worksheet scores**
- **NOTE: Can use this text/report for other grants**
- **NOTE: Health center's list of sites with service area zip codes (*Form 5B: Service Sites*)**

1. Needs Assessment

REASONS WHY **NOT MET (2 of 20 CHCs)**:

- Zip codes per UDS do not match zip codes per *Form 5B: Service Sites* (do you use UDS Mapper to review and share map with your Board?)

> 3) The applicant must propose to serve an announced service area and its patients identified in the SAAT .
>
> a) The total unduplicated patients projected to be served by December 31, 2017, entered on Form 1A, must be at least 75 percent of the Patient Target in the SAAT. See the Summary of Funding section above if the patient projection is less than the Patient Target in the SAAT.
> b) Zip codes entered in the Service Area Zip Codes field on Form 5B: Service Sites must be those where at least 75 percent of the current patients reside.[6] Refer to the SAAT to determine the zip codes where the majority of patients reside.

Per HRSA-16-171 SAC-AA FOA

- CHC did not complete updated needs assessment (however, they had participated in their local hospital's CHNA and completing SAC needs section but it was considered too old)

4. Accessible Hours of Operation/Locations

Requirement:

- Health center provides services at **times and locations that assure accessibility** and meet the needs of the population to be served **(#1)**.

(Section 330(k)(3)(A) of the PHS Act)

4. Accessible Hours of Operation/Locations

- The **times/hours** that services are provided are appropriate to ensure access for the health center's patient population.
  - For example, the health center should offer some appointments **after normal work hours based on input/feedback from patients (#1)**.

- The **locations** at which services are provided must be **accessible to the patient population**.
  - For example, sites are generally located in the areas where the health center's target population lives/works (**Uniform Data System zip codes table**).

4. Accessible Hours of Operation/Locations

- Appropriate consideration is taken into account in determining site/service locations and hours of operation for health centers **serving special populations**.
  - For example, services are offered at migrant camps by grantees targeting migrant and seasonal farmworkers.

- (e.g. Use periodic needs assessments and review of UDS zip codes to address hours/locations. Review *Form 5B: Services Sites* for accuracy. Ensure Board has reviewed patient satisfaction surveys for hours/locations. Post hours and locations clearly on website.)

4. Accessible Hours of Operation/Locations

REASONS WHY **NOT MET (1 of 20 CHCs)**:

- Unknown (homeless HC)

5. After Hours Coverage

Requirement:

- Health center provides **professional coverage for medical emergencies during hours** when the health center is closed.

(Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4))

5. After Hours Coverage

- After hours coverage includes the provision, **through clearly defined arrangements (#2),** for access of health center patients to professional coverage for medical emergencies **after the health center's regularly scheduled hours**.

- Specific arrangements for after-hours coverage (such as in a rural area) **may vary by community**. However, all health centers must have some type of clear arrangement(s) for after hours coverage.

5. After Hours Coverage

- The coverage system should **ensure telephone access to a covering clinician** (not necessarily a health center clinician) who can exercise independent professional judgment **(#3)** in assessing a health center patient's need for emergency medical care and who can refer patients to appropriate locations for such care, including emergency rooms, when warranted.

- (e.g. Periodically test after hours call-in, in languages of target population)

5. After Hours Coverage

REASONS WHY **NOT MET (1 of 20 CHCs)**:

- Unknown (homeless HC)

6. Hospital Admitting Privileges and Continuum of Care

Requirement:

- Health center physicians have **admitting privileges at one or more referral hospitals**, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly **establish arrangements for hospitalization, discharge planning, and patient tracking**.

(Section 330(k)(3)(L) of the PHS Act)

6. Hospital Admitting Privileges and Continuum of Care

- All health centers must either have admitting privileges for their physicians at one or more referral hospitals, or some other arrangements that ensure **continuity of care**.
- In cases where hospital admitting privileges and membership are not possible, the health center must have firmly established arrangements for patient hospitalization, discharge planning, and tracking.
- (e.g. If possible, add “Evergreen Clause” – automatic renewal - language)

6. Hospital Admitting Privileges and Continuum of Care

REASONS WHY **NOT MET (6 of 20 CHCs)**:

- Contract for 1 site missing re: inpatient care
- Expired contract re: pregnancy care
- Policy re: discharge planning must be documented / formalized
- Couldn't find documentation that hospital contract was in full compliance

8. Quality Improvement/Assurance Plan

Requirement:

- Health center has **an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management (#3)**, and that maintains the confidentiality of patient records. The QI/QA program must include:
  - **a clinical director** whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;*
  - **periodic assessment of the appropriateness of the utilization of services and the quality of services** provided or proposed to be provided to individuals served by the health center; and such assessments shall: *
    - be conducted by physicians or by other licensed health professionals under the supervision of physicians;*
    - be based on the systematic collection and evaluation of patient records;* and
    - identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.*

(Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2))

8. Quality Improvement/Assurance Plan

- QI/QA assessments must be conducted (e.g., assessments of the appropriateness of service utilization, quality of services delivered, the health status/outcomes of health center patients) on a regular basis.
- Types of items reviewed as part of quality management:
  - Incident reports
  - HRSA core measures
  - Safety procedures
  - Infection control
  - Patient complaints (and satisfaction)
  - Patient discharges
- The health center must have a clinical director, who may be full or part time staff, and should have appropriate training/background (MD, RN, MPH, etc.), as **determined by the needs/size** of the health center.

8. Quality Improvement/Assurance Plan

- The **clinical director must have clear responsibility**, along with other staff as appropriate, for conducting QI/QA assessments/activities.
- The plan includes methods for **measuring and evaluating patient satisfaction**.
- The health center must have clinical information systems in place for **tracking/analyzing/reporting key performance data** related to the organization's plan (e.g. Electronic Health Records, dashboards).
- The **findings of the QI/QA process are used to improve organizational performance**. Should be shared with Board periodically. Would recommend at least twice a year, at a minimum.
- Plan must be **Board-approved**. Would recommend annual approval. Would recommend having separate Board Quality Improvement Committee that should review HRSA measures prior to grant submission.

8. Quality Improvement/Assurance Plan

REASONS WHY **NOT MET (6 of 20 CHCs)**:

- Responsibility of QIP conflicts in policy v. CMO contract v. bylaws
- Discrepancy between what is in the policy and what is procedure
- Peer review is not spelled out and must be included in policy
- Policy written but peer review not fully implemented
- Policy must include who reports to the Board, how often and how Board subcommittee functions
- Supervision of QIP is not Board responsibility

9. Key Management Staff

Requirement:

- Health center maintains a **fully staffed health center management team** as appropriate for the size and needs of the center. **Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required**.

(Section 330(k)(3)(I) of the PHS Act, 42 CFR Part 51c.303(p) and 45 CFR Part 74.25(c)(2),(3))

9. Key Management Staff

- Health center has a **management team** that is the appropriate size and composition.
- Health center has a **Chief Executive Officer or Executive Director/Project Director**. If there has been a change in this leadership position, HRSA requires prior review and approval of this change. An 'interim' should be formally appointed.
- The management team (which may include a Clinical Director, Chief Operating Officer, Chief Financial Officer, Chief Information Officer, as appropriate for the size and complexity of the health center) is **fully staffed**.

9. Key Management Staff

REASONS WHY **NOT MET (3 of 20 CHCs)**:

- Need to add to current leadership expertise (rural or special pops grantees)

10. Contractual/Affiliation Agreements

Requirement:

- 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)) and Section 1861(aa)(4), Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a)(2))

10. Contractual/Affiliation Agreements

- The health center has the appropriate amount of oversight and the **ability to maintain its independence and compliance** for all contracted services and affiliation agreements.

- All contractual arrangements **must comply with Federal procurement standards** set forth in 45 CFR Part 74 (including conflict of interest standards) as well as state requirements.

  - For 45 CFR Part 74, see - http://www.hhs.gov/opa/grants-and-funding/grant-forms-and-references/45-cfr-74.html

10. Contractual/Affiliation Agreements

- Affiliation agreements or contracts must not:
  - Threaten the health center's **integrity**.
  - Compromise **compliance** with any other Program Requirements.
  - Limit the health center's **autonomy**.

- Health centers with sub-recipient arrangements must ensure that their **sub-recipient(s) comply with all statutory and regulatory requirements** applicable to "330" grantees.

10. Contractual/Affiliation Agreements

REASONS WHY **NOT MET (6 of 20 CHCs)**:

- Some agreements had only 1 signature
- Some agreements were extremely dated (2008) or have wrong name (if hospital system changed name); need to maintain master list of contracts
- Missing sliding fee language
- Failed to see consistent use of language/components (e.g. discrimination, disbarment uniformity)

11. Collaborative Relationships

Requirement:

- 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))

11. Collaborative Relationships

- The health center has collaborative relationships with other appropriate providers and organizations in the area, including other health centers (other "330" grantees).

- *Public Housing Primary Care grantees must show how residents are involved in the administration of the program.*

- In the SAC application, health centers must have letter(s) of support from service area health centers and are encouraged to have letters **from other community and health organizations**. If no letters are attached, the health center must have a written explanation of why letters are not available.

11. Collaborative Relationships

REASONS WHY **NOT MET (0 of 20 CHCs)**:

- None. ☺

12. Financial Management and Control Policies

Requirement:

- Health center **maintains accounting and internal control systems** appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and **separates functions** appropriate to organizational size to **safeguard assets** and **maintain financial stability**.
  - Health center assures an **annual independent financial audit** is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report.

(Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26)

12. Financial Management and Control Policies

- The health center has appropriate measures in place to protect its assets and adheres to Federal accounting requirements, including:
  - Accounting and internal control systems that are appropriate to the size and complexity of the organization and reflect Generally Accepted Accounting Principles (GAAP) or GASB, as applicable.
  - Policies and processes that safeguard the organization's assets.

12. Financial Management and Control Policies

- A complete audit submission which must include:
  - The auditor's report (including the auditor's opinion, financial statements, auditor's notes and required communications from the auditor).
  - Any management letter issued by the auditor, or a statement signed by an authorized representative of the health center that no management letter was issued.

Note: If any material weaknesses are identified in the audit, these must be addressed by the health center.

12. Financial Management and Control Policies

REASONS WHY **NOT MET (4 of 20 CHCs)**:

- "330" budget not done right within overall budget
- Salaries not done correctly
- Accounting manual must be approved by Board
- Policy (manual) must be appropriate for the size and complexity of the CHC
- Need policies within formal financial guidebook, not just memos
- Missing check signing policy

14. Budget

Requirement:

- Health center has **developed a budget** that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served.

(Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25)

14. Budget

- **New PIN 2013-01: Health Center Budgeting and Accounting Requirements (Total Budget) (Mar. 18, 2014) released**; see - http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin201301.pdf

- A **complete and clear budget based on solid numbers** should include: SF-424/budget justification, Staffing Profile (Form 2), and Income Analysis (Form 3).

- The budget should describe/reflect:
  - How total budget is aligned and **consistent with the service delivery plan** and patients to be served.
  - How **reimbursement will be maximized** from third party payors.
  - How the proportion of requested Federal grant funds is appropriate given other sources of income.

14. Budget

REASONS WHY **NOT MET (3 of 20 CHCs)**:

- Recent BPR Budget not approved by Board
- Budget only budgeted on # of visits → must include other factors (collection rate per payor, etc.)

15. Program Data Reporting Systems

Requirement:

- Health center has systems which **accurately collect and organize data for program reporting** and which **support management decision making**.

(Section 330(k)(3)(I)(ii) of the PHS Act)

15. Program Data Reporting Systems

- The health center has systems, including Management Information Systems (MIS) in place that can accurately **collect and produce data** to support health center oversight and direction **(#8)**.
- The health center submits **accurate and timely reports**, as required (e.g., UDS, FFR, HCQR) **(#8)**.
- The health center provides a **complete Clinical and Financial Performance Measures** Form with its annual application to demonstrate performance improvement **(#8)**.

15. Program Data Reporting Systems

REASONS WHY **NOT MET (1 of 20 CHCs)**:

- Program Income not included on UDS

18. Board Composition

Requirement:

- 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**.*

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

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).

18. Board Composition

- A majority (**at least 51%**) of the board members receive services (i.e., medical, dental or vision patients) at the health center.

- As a group, the "patient/consumer" board members must reasonably **represent the individuals who are served by the health center in terms of race, ethnicity, and sex**.
  (NOTE: There is **no established ratio** for board members to population served; however, board composition must be reasonably representative of the populations being (i.e., race, ethnicity, sex) served.)

- Board size must range between **9 and 25 members** - the **size of the board is appropriate for the complexity of the organization and the diversity of the community** served (e.g. Bylaws should not list size as 9-25).
  (NOTE: We recommend having no less than 10 members so you remain in compliance is someone resigns from Board.)

18. Board Composition

- *Health centers with approved waivers ONLY–appropriate strategies are in place to ensure consumer/patient participation and input from the target population (given board is not 51% consumers/patients) in the direction and ongoing governance of the organization.*

- *Health centers that receive <u>part</u> of their "330" funding to serve special populations and are not eligible for a waiver—the board includes representation from/for these special populations group(s), as appropriate (e.g., an advocate for the homeless, the director of a Migrant Head Start program, a formerly homeless individual).*

18. Board Composition

REASONS WHY **NOT MET (5 of 20 CHCs)**:

- Bylaws should not say 9-25; they should be more appropriate to the size and complexity of the CHC
- Adequate special pops person(s) missing from special pops grantee

19. Conflict of Interest Policy

Requirement:

- 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 may serve only as a **non-voting ex-officio** member of the board.*

(45 CFR Part 74.42 and 42 CFR Part 51c.304(b))

19. Conflict of Interest Policy

- The CEO/Program Director does not participate as a voting member of the board.
- Bylaws must list committees.
- The conflict of interest policy **must address** such issues as:
  - **disclosure of business and personal relationships**, including nepotism, that create an actual or potential conflict of interest;
  - **extent to which a board member can participate** in board decisions where the member has a personal or financial interest;
  - **using board members to provide services** to the health center;
  - board member **expense reimbursement policies**;
  - **acceptance of gifts and gratuities**;
  - **personal political activities** of board members; and
  - statement of **consequences for violating** the conflict policy.

19. Conflict of Interest Policy

- When **procuring supplies and other expendable property, equipment, real property,** and other services, the health center's policy must also address the following:
  - Health center must have **written standards of conduct** governing the performance **of its employees** engaged in the award & administration of contracts.
  - **No health center employee, board member, or agent may participate in the selection, award, or administration** of a contract supported by Federal funds **if a real or apparent conflict of interest** would be involved. Such a conflict would arise when a health center employee, board member or agent, or any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in the firm selected for an award.
  - The board members, employees, and agents of the health center grantee shall **neither solicit nor accept gratuities, favors,** or anything of monetary value from contractors, or parties to sub-agreements. However, recipients may set standards for situations in which the financial interest is **not substantial or the gift is an unsolicited item of nominal value**.
  - The standards of conduct must provide for **disciplinary actions** to be applied for violations of such standards by board members, employers, or agents of the health center grantee.

19. Conflict of Interest Policy

REASONS WHY **NOT MET (2 of 20 CHCs)**:

- Bylaws need to be improved; currently too minimally addressed
- Need staff conflict of interest approved by the Board
- CEO must be listed as a non-voting ex-officio member of Board