Keepin' It Compliant in Changing Times

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AGENDA

- Section 330 Amendments
- Operational Site Visits
- Financial Management Reviews
- Medicaid Payment Issues
- Immigration
- Mergers and Acquisitions

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Pressing Issues in Health Center Compliance

Bipartisan Budget Act of 2018's (Pub. L. No. 115-123) Amendments to Section 330

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"ONE-AND-DONE" RESTRICTION BIPARTISAN BUDGET ACT OF 2018

- Section 330(e)(1)(B): "The Secretary may make grants, for a period of not to exceed 1 year, for the costs of the operation of public and nonprofit private entities which provide health services to medically underserved populations but with respect to which the Secretary is unable to make each of the determinations required by subsection (k)(3). The Secretary shall not make a grant under this paragraph unless the applicant provides assurances to the Secretary that within 120 days of receiving grant funding for the operation of the health center, the applicant will submit, for approval by the Secretary, an implementation plan to meet the requirements of subsection (k)(3). The Secretary may extend such 120-day period for achieving compliance upon a demonstration of good cause by the health center."

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Operational Site Visits

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SITE VISIT PROTOCOL

- Site Visit Guide ("SVG") was replaced by a new Site Visit Protocol ("SVP"), which is fully aligned with the Health Center Program Compliance Manual.
- Unlike the SVG, the SVP details a more objective approach.
    - Set methodologies
    - Set documentation requests.
    - Greater level of focus on implementation / utilization of policies and operating procedures, which must include all required elements – compliance in practice as well as on paper – review of sample charts, files, records
- Still a 3-day onsite visit conducted by 3 reviewers (admin/governance, clinical, financial) who are consultants acting as "authorized representatives of HRSA"
    - Final reports should be issued by HRSA within 45 days of the site visit – report will include findings and final compliance determinations ***by element for each Chapter***
    - Non-compliance will result in new "standard" conditions that match up to each element

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OPERATIONAL SITE VISITS: TRICKS OF THE TRADE

- Start Preparing Early!
  - Start gathering documentation as soon as you receive notice of the OSV.
  - Do not wait until the review team is selected.
  - Review and revise policies and procedures as necessary.
- If there are unusual circumstances, communicate with your project officer.
  - E.g., if a center has special population funding and/or operates a public entity model, have your project officer ensure one of the reviewers is familiar with the nuances of special population funding and/or the public entity model.
- Have a pre-review call with the reviewers.
  - Are you allowed to have counsel?
  - How much subrecipient documentation will they review?
  - Will they sign a confidentiality agreement?

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OPERATIONAL SITE VISITS: TRICKS OF THE TRADE

- Actively participate in the review (i.e., talk to your reviewers!).
    - E.g., If the documentation the reviewers requested isn't sufficient to demonstrate compliance, ask the reviewers what alternative documentation they would accept.
- Fix any area of noncompliance while the reviewers are onsite.
- Conduct ongoing review of scope (Forms 5A-C in Electronic Handbook) – don't wait until right before an OSV or grant application!
    - More on this next!

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BASICS OF SCOPE

- The Compliance Manual eliminated "Scope of Project" as a separate requirement, opting to provide separate chapters for Form 5A (Chap. 4) and Form 5B (Chap. 6).
- Scope must reflect all services/activities health center is actually providing and where those services/ activities are provided.
- Scope sets the context for the Operational Site Visit – only in-scope activities, sites, etc. are included in the review
- What does "in-scope" mean?
  - Legal obligation to provide that service or activity, or to make available that site, etc. to everyone, regardless of ability to pay.
  - Commitment to provide continuity if you have to exit the service line.

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COMPLIANCE MANUAL: REQUIRED AND ADDITIONAL SERVICES [CH. 4]

- Not all in-scope services must be available at each site. However, every patient must have access to full complement of services offered by the health center as a whole.
- The service obligation under the Compliance Manual is the same as before, where all required services and in-scope additional/specialty services must be provided either directly or by established written contracts/referrals, but it expands contract and referral descriptions consistent with scope guidance on delivery methods.
- Direct services must be provided by employees or volunteers
  - Employee is an individual who receives a salary on a regular basis and a W-2, and health center withholds applicable taxes and benefit contributions
- Under the Site Visit Guide, contracts must include a statement of how health center's policies and procedures will apply to the contracted service. The Compliance Manual eliminates this statement, but requires:
  - Specific language regarding application of sliding fee discounts consistent with sliding fee requirements (See Chapter 9: Sliding Fee Discount Program)
  - Additional oversight and monitoring provisions (See Chapter 12: Contracts and Subawards).

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SCOPE OF SERVICES & OPERATIONAL SITE VISITS

- Centers should work to simplify their Form 5A.
  - Focus on the core requirements and services.
  - Even the most complex organizations can operate with a simplified Form 5A.
- If I receive separate funding to provide an enhanced service, do I need to include the enhanced service in my Form 5A?
  - No! You should only include the base service.
  - If you include the enhanced service on your Form 5A, the enhanced service must be made available to everyone.
  - E.g., Ryan White Part C provides funding for enhanced case management. Case management is already a Section 330 requirement. However, if you include "enhanced case management" rather than just "case management" in Form 5A the center must offer enhanced case management to everyone.
  - Also applies to state and private funding.
- During the OSV, you do not need to share information regarding out-of-scope services. Keep discussions focused on Form 5A.

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Financial Management Reviews

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FINANCIAL MANAGEMENT REVIEWS

- HRSA's Division of Financial Integrity ("DFI") is conducting Financial Management Reviews ("FMR") of entities receiving less than $750K in Federal grant funds (threshold for Single Audit Act audit) and larger entities above the threshold that did not have Section 330 project audited as a major program.

- If selected, DFI will ask for documentation to determine whether the health center has policies that adequately incorporate HHS's 12 legislative mandates found in HRSA Policy Bulletin 2018-04.

- Additional "yes" or "no" questions

- DFI's notice allows a health center to revise its existing policies to incorporate the necessary requirements prior to submission to HRSA.

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LEGISLATIVE MANDATES
HRSA POLICY BULLETIN 2018-04

- Salary Limitations
- Gun Control
- Anti-Lobbying
- Acknowledgement of Federal Funding
- Restriction on Abortion
- Exceptions to Restrictions on Abortion
- Ban on Funding Human Embryo Research
- Limitation on Use of Funds for Promotion of Legalization of Controlled Substances
- Restriction on Distribution of Sterile Needles
- Restriction on Pornography on Network Computers
- Restriction on Funding ACORN
- Confidentiality Agreements

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Medicaid Payments

PPS, wrap-around payments, risk arrangements and offsets.

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PROSPECTIVE PAYMENT SYSTEM

- The PPS rate is a per visit payment rate that reimburses FQHCS for 100 percent of their reasonable costs, as set in 1999 and 2000, for services within their scope of services. Payment rate is adjusted annually based on adjustments to a center's scope of services and inflation.
- MCOs and FQHCs – the wrap-around payment:
    - MCOs must pay FQHCs "not less than" what they would pay a non-FQHC. States then make up the difference between the center's PPS rate and the MCO's payment. E.g., PPS rate = $100; MCO payment = $60; Wrap payment = $40.
- States may also pay FQHCs through an alternative payment methodology ("APM") so long as the center agrees to the APM and the APM ensures the center is paid its PPS rate.

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PROSPECTIVE PAYMENT SYSTEM PAYMENT ISSUES

- Can a state Medicaid agency fully delegate its PPS obligation to an MCO, eliminating its wrap-around obligation?
  - CMS guidance says "generally no." If the State properly implements an APM, yes.
  - The Fifth Circuit, however, disagreed with CMS, stating that the Medicaid statute does not require an APM to delegate the wrap-around payment.
- Can a Medicaid MCO deny payment for out-of-network FQHC services?
  - **Depends.** State must specify in MCO contracts whether MCO is obligated to pay for certain out of network services.
- Is an FQHC entitled to PPS for out-of-network services?
  - **Yes**, in 2d and 3d Circuits (CT, NY, RI, VT; and, DE, MD, NJ, PA).
  - **No**, in 5th Circuit (LA, MS, TX).
- Can a state require a prior MCO payment as a prerequisite to its supplemental payment?
  - **No.** If MCO fails to pay its share of a legitimate visit, State's supplemental payment obligation is entire PPS rate, not nothing.

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PPS OFFSETS
CMS'S UNDERSTANDING OF INCENTIVE ARRANGEMENTS

Incentive Arrangements. CMS has long-standing policy that incentive amounts (both positive and negative) are separate from the MCO's payment for services and should not be included in Medicaid's calculation of supplemental payments.

According to CMS:

- Financial incentives provide the provider with an incentive to reduce unnecessary utilization of services or otherwise reduce patient costs.
- Incentive amounts should *not* be included in the State's calculation of supplemental (wraparound) payments.
- Inclusion of incentives in calculating wrap payments would negate financial impact incentives are designed to provide.
- State's wraparound payment obligation should be determined using the baseline payment under the contract for services being provided, without regard to the effects of financial incentives.

State Medicaid Directors Letter, "Policy Regarding FQHCs/RHCs " (September 27, 2000).
https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd092700.pdf

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CMS'S UNDERSTANDING OF INCENTIVE ARRANGMENTS

Incentive Payments. More recently, CMS affirmed that positive financial incentives paid by MCOs allow FQHCs to earn revenue over and above the amounts required under the PPS reimbursement methodology.

> "[. . .] FQHCs and RHCs are required by statute to be reimbursed according to methodologies approved under the State plan. In the event a particular financial incentive arrangement related to meeting specified performance metrics for these providers is part of the provider agreement with the managed care plan, **those financial incentives must be in addition to the required reimbursement levels specified in the State plan**."

CMS, Medicaid Managed Care Final Rule, Federal Register (Vol. 81), Friday, May 6, 2016, p. 27577.

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SHARED SAVINGS / SHARED RISK PROGRAMS

- Shared savings / shared risk programs create incentives for managing the total costs of care generally related to the reduction of non-primary care expenses (*e.g.*, hospital and specialist services).
- Payors use positive incentives to reward providers for savings ("**shared savings**") and positive and negative incentives ("**shared risk**") to reward and penalize providers for savings and losses related to a population of patients.
- MCOs typically establish baseline annual anticipated expenditures per enrollee; if average cost per patient is lower than the baseline, provider receives positive incentive payment; if average cost per patient is higher than baseline, provider owes money to the MCO.
- To ensure that incentives do not negatively impact care, shared savings/shared risk programs often are contingent on satisfying quality standards.

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SECTION 330 GRANT REQUIREMENTS

Health centers participating in value-based contracts must observe the following requirements relating to the use of grant funds and program income:

- **Permitted Use of Grant Funds.** Pursuant to Section 330's implementing regulations, grant funds "may be expended solely for carrying out the approved project in accordance with section 330 of the Act, the applicable regulations of this part, the terms and conditions of the award, and the applicable cost principles prescribed in 45 CFR part 75, subpart E." *42 C.F.R. § 51c.107(a).*
- **Capitation Payments.** Even when a health center renders services on a "prepaid capitation basis," the grant funds may only be used for the cost of delivering health services related to "project services," *i.e.*, services within the health center's scope of project. *Id. § 51c.107(b)(5).*

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SECTION 330 GRANT REQUIREMENTS

(continued)

- **Downside Financial Risk.** In general, FQHCs cannot accept down-side financial risk that may result in paying for services outside its scope of project with Section 330 grant funds.
  - "[I]f a health center is at financial risk for the costs of services beyond those covered under its scope, it must ensure that no Section 330 funds are used to offset the costs of these services. Since most health centers' approved scopes of project are limited to primary and preventive care, this means that Section 330 funds may not be used to offset the costs of specialty, hospitalization, and other types of care."

    BPHC, Letter to Health Center Director, February 22, 2011.

  - Federal law also restricts use of program income (*e.g.*, revenue generated from a grant-funded activity) to the health center's operational costs and to furthering the objectives of the health center's scope of project, where not otherwise prohibited by statute. *42 U.S.C. § 254b(e)(5)(C).*
    - Note: In certain circumstances, the assumption of a reasonable amount of down-side financial risk might further the purposes of an approved scope of project if the arrangement is designed to reduce avoidable hospital and specialty care for the health center's patients.

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Medicaid Payments

Work Requirements

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MEDICAID
WORK REQUIREMENTS

- Jan. 11, 2018 – CMS announced that it will approve 1115 waivers with work requirements.
- CMS approved such a waiver for Kentucky (now in litigation). Nine other states (AR, AZ, IN, KS, ME, MS, NH, UT and WI) have submitted waivers with work requirements.
- General requirements: Certain number of hours per week spent in employment, job search, job training, volunteer/community service.
- There is currently no clear link between work requirements and health outcomes.
- Anticipate as many as 14% to 24% of KY health center Medicaid patients will lose coverage in the first year

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Immigration

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IMMIGRATION

- In 2017, there was a sharp rise in federal activity involving immigration, including:
  - A significant expansion of U.S. Immigration and Customs Enforcement (ICE) enforcement actions
  - Issuance of three Executive Orders ("EOs"):
    - *Border Security and Immigration Enforcement Improvements* orders the construction of a wall on the U.S. southern border
    - *Protecting the Nation from Foreign Terrorist Entry into the US* originally suspended entry in the U.S. from seven countries for 120 days. Its second rendition barred travel from six predominantly Muslim countries for 90 days— removing Iraq
      - The Supreme Court let portions of the ban stay as applied to those who have no "credible claim of a bona fide relationship with a person or entity in the United States."

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IMMIGRATION

- Issuance of three Executive Orders ("EOs") (continued):
  - *Enhancing Public Safety in the Interior of the United States* provides for potential sanctions on "sanctuary jurisdictions," adds 10,000 immigration officers, gives state and local agencies the authority to perform the functions of immigration officers and expands whom the government considers a priority for deportation
    - Federal definition issued in memo Implementation of Executive Order 13769, May 22, 2017: "After consultation with the Secretary of Homeland Security, I have determined that, for purposes of enforcing the Executive Order, the term "sanctuary jurisdiction" will refer only to jurisdictions that "willfully refuse to comply with 8 U.S.C. 1373." A jurisdiction that does not willfully refuse to comply with section 1373 is not a "sanctuary jurisdiction" as that term is used in section 9(a)."
    - Enforcement only applies to Department of Justice funding to localities (e.g. Byrne Justice Assistance Grants) (but U.S. District Court for the Northern District of Illinois issued an injunction against imposition of Byrne JAG grant Sept. 15, 2017)
- The EOs do not directly impact immigrants' ability to receive care at health centers; however, news coverage has created a great deal of fear and apprehension among immigrant communities that may negatively impact immigrants' willingness to seek services

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IMMIGRATION

- Health centers are not required to verify the citizenship or immigration status of patients and can treat any person regardless of their immigration status .
- According to a 2011 Department of Homeland Security memo, immigration enforcement actions are generally not to occur in certain **"sensitive locations"** including medical treatment and health care facilities, such as doctors' offices, accredited health clinics, and emergent or urgent care facilities.
  - As of June 13, 2017, the "sensitive locations" policy remains in effect, but how it is implemented is determined by the Administration and it can be changed at any time without congressional approval or a public notice-and-comment process.
- With a valid court order, warrant, subpoena, or summons, any governmental entity, including ICE, can require a health center to provide protected health information:
  - If a health center maintains information regarding the immigration status of patients along with other PHI and receives a request for PHI that complies with HIPAA, the health center should supply its files as maintained in the normal course of business; or
  - In responding to law enforcement requests for PHI, health centers should comply with HIPAA's privacy rules as well as any state laws related to confidentiality and privacy.
    - For a valid court order signed by a judge, a health center should disclose only the information expressly described and requested.
    - If a subpoena is issued by someone other than a judge *(e.g.*, a court clerk or attorney) a health center may disclose PHI only if there is evidence of reasonable efforts to notify the person who is the subject of the information so that the person has an opportunity to object or seek a protect order.

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IMMIGRATION

- Health centers are permitted to educate patients about their rights; HOWEVER, we recommend health centers not use Section 330 grant funds for these purposes, unless such activities have been included in the health center's HRSA-approved scope of project (*e.g.*, a medical-legal partnership)
  - Permissible activities can include posting information about rights, distributing information about rights, and holding educational sessions about rights
  - The following "Know Your Rights" documents may be helpful in educating patients:
    - Wallet card from NILC - available in English, Spanish, simplified Chinese, Arabic, and Korean
    - Wallet Cards from Asian Americans Advancing Justice - available in Arabic, Bengali, Burmese, Chinese, Gujarati, Hindi, Karen, Khmer, Korean, Nepali, Punjabi, Urdu, and Vietnamese
    - Three page pdf handout in English from NILC (also available in Spanish, simplified Chinese, Arabic, and Korean)
    - 18-page pamphlet in English and Spanish on rights when interacting with law enforcement, from Catholic Legal Immigration Network, Inc. (CLINIC)
    - PowerPoint in English and Spanish from Catholic Legal Immigration Network, Inc. (CLINIC)
    - One-pager on "Know Your Rights" in various circumstances (*e.g.*, if stopped in your car, if police or immigration officials come to your home) from the ACLU

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IMMIGRATION

- **Reliable sources of legal information on immigration issues:**
  - **National resources**
    - The National Immigration Law Center (NILC) https://www.nilc.org/ continues to update resources on questions such as:
      - Is it safe for eligible immigrants to apply for health insurance?
      - What protections are currently in place for immigrants who seek care at a hospital or other health care provider?
      - If patients ask how they can prepare themselves for potential enforcement actions, what resources are available?
    - Immigration Legal Resource Center (ILRC) https://www.ilrc.org/
    - The American Civil Liberties Union (ACLU) https://www.aclu.org/issues/immigrants-rights
  - **State-specific information about immigration:**
    - The American Immigrant Council has state fact sheets highlighting key data about immigrant populations in each state: https://www.americanimmigrationcouncil.org/

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Mergers and Acquisitions

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MERGER OR ACQUISITIONS

- **Partial corporate consolidation:**
  - Both corporations continue in existence post-integration
    - One corporation "acquires" certain lines of business that are currently operated by the other corporation
    - Transferor may reorganize to assume related, often supportive functions

- **Full corporate consolidation through merger**
  - One corporation ceases to operate as an independent entity and one corporation is the "surviving entity"

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PARTIAL CORPORATE CONSOLIDATION

- Negotiate terms and conditions of agreement which would define, among other things:
  - Assets that will be purchased or leased (e.g., equipment, facility) and the assets excluded from the purchase or lease
  - Asset purchase or lease price, based on fair market value (or, under certain circumstances, less than FMV)
    - Note that acquisition or lease cost should not include a valuation of good will
  - Grants or contracts that will be transferred or assigned
  - Extent to which one corporation will assume the transferring corporation's liabilities, if at all
  - Workforce transfer understandings
  - Governance understandings

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FULL CORPORATE CONSOLIDATION: MERGER

- One corporation becomes part of the other corporation (the "surviving corporation") and legally dissolves (the "dissolving corporation")
- Surviving corporation would take title to all of the dissolving corporation's assets and would assume all of the dissolving corporation's liabilities
- Process for implementation
  - Follow procedures mandated under the applicable state nonprofit corporation law and other State laws (e.g. CON and/or licensure laws) and procedures in organizational documents
  - Contract HRSA (or other granting agency) early in process re: Successor in Interest arrangements

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FORMING A SEPARATE LEGAL ENTITY

- Shields each owner and/or director from liability for debts, obligations and other liabilities of the network and other owners and/or directors
- Shared control only extends to network's joint activities
- Each owner and/or director maintains its corporation's independence and autonomy
- Owners and/or directors can pool resources to make joint investments

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QUESTIONS?

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