HRSA Operational Site Visits

Tuesday, May 10, 2016

2016 Annual Health Center Board Member Training

Michigan Primary Care Association
www.m pca.net
Overview

- Health Centers and Look-Alikes
- Michigan’s Health Centers
- Operational Site Visits
- Program Requirements
- Most Common Conditions for Michigan Health Centers
- Process for Addressing Conditions
- MPCA Training and Technical Assistance
FQHC & Look Alike Health Centers

- Located in or serve a medically underserved areas or populations
- Governed by a community board composed of 51 percent or more of Health Center patients who represent the population served
- Provide comprehensive primary health care services as well as support services (e.g. education, translation, transportation)
- Charge uninsured patients for services on a sliding-fee scale based on their family size and income.
Michigan’s Health Centers

- 39 Health Center organizations
- 36 Health Center Program Grantees
- 1 FQHC Look-Alike
- 2 are Health Center Program Grantees & FQHC Look-Alike
- 250+ service sites
- Over 615,000 patients served annually
# FQHC and FQHC Look-Alike

<table>
<thead>
<tr>
<th>Requirement/Benefit</th>
<th>FQHC</th>
<th>FQHC Look-Alike</th>
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<tbody>
<tr>
<td>Meet all FQHC requirements, including governance</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Provide care to Federally designated Medically Underserved Area/Population</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Enhanced Medicaid Payment</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Access to favorable drug pricing under section 340B of the PHSA</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Access to providers through the National Health Service Corps</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Receive Grant Money</td>
<td>X</td>
<td></td>
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<tr>
<td>Federal Tort Claims Act Coverage</td>
<td>X</td>
<td></td>
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<tr>
<td>Federal Loan Guarantee Program</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Eligible to apply for additional grant funds</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Application</td>
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<td>Competitive</td>
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Types of Health Centers

- Community Health Centers
- Migrant Health Centers
- Health Care for the Homeless Health Centers
- Public Housing Health Centers
- Federally Qualified Health Center Look-Alikes
- Indian Health Service
- Ryan White Program, Part C
OPERATIONAL SITE VISITS
What is an Operational Site Visit?

- Origin of the process
- Current process for compliance
Operational Assessment 101

- Compliance with all 19 Health Center program requirements
- Occurs once during every project period
- Standard review instrument: Health Center Site Visit Guide
- Team of 3 HRSA consultants + Project Officer
- The team will request documents for review in advance of their visit and on-site
- The site visit typically lasts three days
- Will share any and all findings during the exit interview
- Final written report will be sent at a later date
Site Visit Agenda

- Entrance Conference
- Tours
- Board Meeting
- Working / Review Time
- Staff Meetings
- CEO Debriefings
- Exit Conference

DAY 1:
9:00 AM – 11 AM
Entrance Conference
Introduce Consultant Team/Purpose of the Site Visit
Health Center Overview - Sr. Management Team/Board Leadership

11:00 AM - 11:00 AM
Tour representative sites (Timing and sites to be determined)

1:00 – 2:00 PM
Lunch

2:00 PM - 4:30 PM
Individual Interviews. Information gathering/document review

4:30 PM – 5:00 PM
Update the Chief Executive Officer

DAY 2:
8:30 AM - 12:00 PM
Continue Meeting with Senior Management Team and Health Center Staff. Information gathering/document review

12:00 PM – 1:00 PM
Working Lunch with Board of Directors (Or, if preferred, we can arrange an evening meeting with the Board to facilitate attendance.)

1:00 PM - 4:30 PM
Continue Meeting with Senior Management Team and Health Center Staff. Continue information gathering/document review

4:30 PM – 5:00 PM
Update the Chief Executive Officer

DAY 3:
8:30 AM - 12:00 AM
Continue Meeting with Senior Management Team and Health Center Staff. Continue information gathering/document

12:00 AM – 1:00 PM
Lunch

1:00 PM - 3:00 PM
Continue Meeting with Senior Management Team and Health Center Staff. Continue information gathering/document review, review and finalize Technical Assistance recommendations

3:00 PM
Exit Interview with Senior Management Team/Board leadership. Consultants summarize findings.

4:30 PM
Team departs
Program Requirements

Section 1 Need
• Program Requirement 1

Section 2 Services
• Program Requirements 2-8

Section 3 Management and Finances
• Program Requirements 9-16

Section 4 Governance
• Program Requirements 17-19

1. Needs Assessment
2. Required and Additional Services
3. Staffing
4. Accessible Hours/Locations
5. After Hours Coverage
6. Hospital Privileges and Continuum of Care
7. Sliding Fee Discounts
8. QI/Assurance Plan
9. Key Management Staff
10. Contractual/Affiliation Agreements
11. Collaborative Relationships
12. Financial Management and Control
13. Billing and Collections
14. Budget
15. Program Data Reporting Systems
16. Scope of Project
17. Board Authority
18. Board Composition
19. Conflict of Interest

http://bphc.hrsa.gov/about/requirements/index.html
Section 1: Need

1) Needs Assessment
   - Needs of target population
   - Updated service area consistent with patient origin data in UDS
Section II: Services

2) Required and Additional Services
   ◦ Primary medical services
   ◦ Optional services: urgent, dental, behavioral health, etc.
   ◦ Pharmacy services
   ◦ Referral system for specialists

- Official scope of project for services (Form 5A)
- Clinical practice protocols and/or related policies and/or procedures that support delivery of health center services
- Contracts, MOAs, MOUs, etc. for services via formal written agreements and/or formal written referral arrangements
Section II: Services

3) Staffing

- Staffing profile
- Provider contracts, agreements, arrangements related to staffing
- Credentialing and privileging policies and procedures
- Documentation of provider licensure/certification for licensed/certified health practitioners
Section II: Services

4) Accessible Hours of Operation/Location
   • Scope of project: Form 5B- Service Sites
   • Services provided at times that assure accessibility and meet the needs of the population to be served
   • Locations that assure accessibility and meet the needs of the populations to be served
   • Signage posted in English and other languages as based on patient population
Section II: Services

5) After Hours Coverage

- Policies and procedures for after hours coverage
- Agreements, systems, and/or contracts to support coverage
- Form 5A: Services provided
Section II: Services

6) Hospital Admitting Privileges and Continuum of Care

- Hospital admitting privileges agreements/documentation
  - Hospitalization, discharge planning, patient tracking

- Form 5C: Activities/locations (if applicable, hospitals where health center providers have admitting privileges should be noted on this form)
Section II: Services

7) Sliding Fee Discounts
   - Schedule of fees/charges for all services in scope
   - Sliding fee scale (schedule of discounts)
     ◦ Board approved
   - Operating procedures supporting the discount program
   - Signage and notification methods
   - Documentation/forms to determine eligibility
   - Documents to support evaluation and basis for nominal charges set
     ◦ Determination of eligibility: rates for At or below 100% FPL, 100-200% FPL, above 200% FPL
Section II: Services

8) Quality Improvement/Assurance Plan

- QI/QA plan and related supporting policies and procedures
  - Plan approved by board
  - Addresses all operational areas of the health center
- Clinical director’s job description
- HIPAA-compliant patient confidentiality and medical records policies and procedures
  - Assessments: systematic collection and evaluation of patient records
- Clinical care policies and procedures
- Clinical information tracking policies and procedures
Section III: Management and Finances

9) Key Management Staff

- Health center organizational chart
- Key management staff appropriate to meet the needs of the health center
- Health Center’s official scope of project for services and sites
Section III: Management and Finances

10) Contractual/Affiliation Agreements
- Contracts/sub-awards for substantial portion of Health Center project
  - All must meet the program requirements
- MOA/MOU for substantial portion of Health Center project
- Contracts with another organization for core primary care providers and/or contracted key management staff
- Any other key affiliation agreements if applicable
Section III: Management and Finances

11) Collaborative Relationships

- Letters of support
  - Other FQHCs
  - Hospitals
  - Health departments
  - Private providers
  - Elected officials
  - Community stakeholders

- MOA/MOU

- Other relevant documentation of collaborative relationships
Section III: Management and Finances

12) Financial Management and Control Policies

- Independent financial audit and management letter (including corrective action plans if applicable)
- Most recent single audit
- Financial performance measures and monthly financial reports, budgets, adequate cash, disbursements, chart of accounts, accounting procedures (income analysis)
Section III: Management and Finances

13) Billing and Collections
- Policies and procedures for billing and collections
  - Maximize collections and reimbursements
- Encounter forms
- Medicare and Medicaid cost reports
- Income analysis
- Managed care or any other third party payer contracts
- Financial performance measures
Section III: Management and Finances

14) Budget
   • Annual budget
   • Budget and business plan must be approved by the board

15) Program Data Reporting Systems
   • Health Center trend report (UDS)
   • Clinical and financial information systems
     ◦ EHR, practice management systems, billing systems
   • Support Management decision making
Section III: Management and Finances

16) Scope of Project

- Grant awards over the past 5 years
- Project growth
- Current capacity
- Planned expansions
  - Staff
  - Funding resources
Section IV: Governance

17) Board Authority
- Organizational bylaws (established by the board)
- Minutes of recent board meetings
  - Monthly meetings
  - Approval of grant application and budget
  - Selection/evaluation/dismissal of CEO
  - Selection of required/additional services
  - Strategic planning (short and long-term goals)
- Health center policies and procedures
- Board annual meeting schedule
- Co-applicant agreement (if applicable)
- List of board committees
Section IV: Governance

18) Board Composition

- 51% (majority) of board members are served by the health center
  - Received one/more in-scope services in the past 24 months (face-to-face contact between patient and provider)
  - Patient board members, as a group, reasonably represent individuals who are served by the health center in terms of race, ethnicity, and sex
- 9-25 members
- Bylaws define specific number or range of board members
- Non-patient members represent the community currently served by the health center and have a broad range of skills, expertise, and experiences (finances, legal affairs, business, health, managed care, social services, labor relations, and government)
- No more than half of the non-consumer board members may derive more than 10% of their income from the health care industry
Section IV: Governance

19) Conflict of Interest Policy

- Prohibition of conflict of interest by board, staff, and consultants and those who furnish goods/services to the health center
- No board member shall be an employee of the health center or an immediate family member of an employee
- CEO: non-voting ex-officio member of board
- Annual conflict of interest statements required to be signed by board members
SITE VISIT AND FINDINGS
Site Visit Findings

- Site visit team will deliver findings in several ways:
  - “Met” or “Not Met” for each program requirement
  - Discussion on what needs to be altered or improved to meet requirements
  - Documenting “best practices” in areas where the Health Center has exemplary performance
National Health Center Findings

Nationally, grant conditions are most commonly related to the following program requirements:

- PR 18: Board Composition
- PR 15: Program Data Reporting Systems
- PR 14: Budget
- PR 2: Required and Additional Services
Michigan Health Center Findings

In Michigan, grant conditions are most commonly related to the following program requirements:

- PR 7: Sliding Fee Discounts
- PR 12: Financial Management & Control Policies
- PR 13: Billing & Collections
- PR 17: Board Authority
- PR 8: Quality Improvement/Assurance Plan
- PR 2: Required & Additional Services
- PR 6: Hospital Admitting Privileges & Continuum of Care
Health Center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient’s ability to pay.

System must provide full discount to individuals and families with annual incomes at/below 100% FPL.

For those between 100-200% FPL, fees must be charged in accordance with a sliding discount policy based on family size and income.
Financial Management & Control Policies

- Health Center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles and separates functions appropriate to organizational size to safeguard assets and maintain financial stability.
Billing & Collections

• 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
Health center governing board maintains appropriate authority to oversee the operations of the center
Quality Improvement/Assurance Plan

- Health Center has an ongoing Quality Improvement/Assurance Program that includes clinical services and management, and that maintains the confidentiality of patient records.

- The program must include:
  - Clinical director
  - Periodic assessment of appropriateness of utilization of services and quality of services provided or proposed to be provided to individuals served by the Health Center.
Required & Additional Services

- Health Center provides all required primary, preventative, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals.
Hospital Admitting Privileges & Continuum of Care

- Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care.
Grant Condition Process

- Condition placed
- 90 days to respond
  - 60 days added if there is no response (restrictions are placed and include block funding and draw-down restrictions)
  - In the last 30 days, there is a likelihood of being defunded
  - Service area competition will allow for funding to continue
- 30 days for HRSA review
- 120 days to implement
- Condition removed if you are able to respond in a timely manner
MPCA TECHNICAL ASSISTANCE FOR HRSA SITE VISITS
Questions?

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