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# The Spectrum of Federally Qualified Health Center Opportunities: From Designation to Collaboration

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- Well known for his expertise in federal grants, Medicaid and other government reimbursement systems, cost accounting and administrative issues, and his strategic handling of organizations facing crises, Ted has been selected again as a "Super Lawyer" for Health Care in Washington, D.C. in 2020.
- Ted has been counsel to numerous organizations, including health centers, community action agencies, Head Start programs, state and local governments and colleges and universities in the past 25+ years. During his time at the Firm, he has represented clients in front of federal and State courts, legislative bodies, administrative tribunals, Offices of Inspector General and federal agencies.
- He leads trainings for an equally diverse array of organizations including many state and national associations as well as individual entities and organizations.
- Ted has been Managing Partner of Feldesman Tucker since 2003 and has taught the first law school class in the country on federal grant programs at the George Washington University School of Law for the past several years.
- He is a member of the National Grants Management Association (NGMA) where he served on the Board for many years and as Chair for two terms as well as the National Association of College and University Attorneys (NACUA).

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- Provides guidance to health centers for purposes of identifying, evaluating, and implementing collaborative contractual relationships with other providers, in accordance with applicable health center program requirements





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## AGENDA

I. Summary of the Health Center Program

II. Key Benefits

III. Paths to FQHC Status

IV. Threshold Eligibility

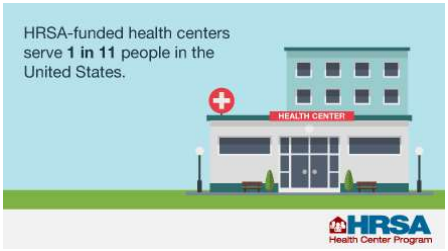
V. Top 4 Programmatic Requirements

VI. Spectrum of Collaboration

VII. Next Steps

HRSA Health Center Program

# I. Summary of the Health Center Program

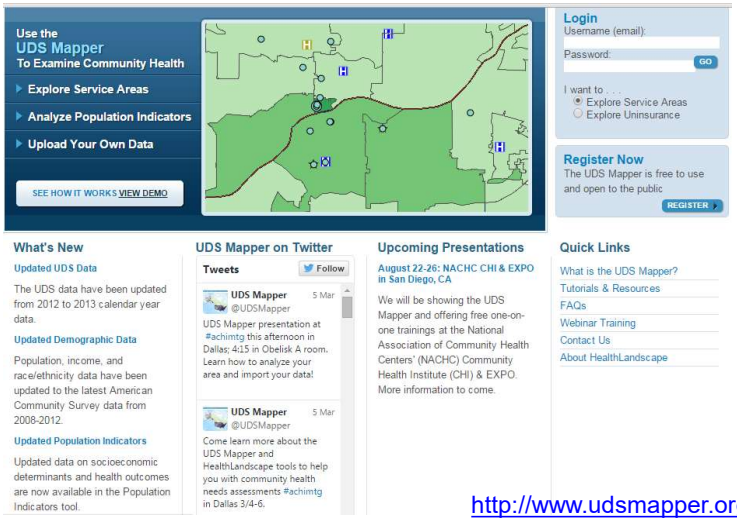





## 2019 HEALTH CENTER DATA

- Approximately 1,400 health centers with 12,000 delivery sites
- Total Patients: Over 29,000,000
- Patients at or below 100% of poverty: 68%
- Uninsured: 23%
- Medicaid/SCHIP: 49%
- Medicare: 10%
- Private Insurance: 18%

## UDS MAPPER




http://www.udsmapper.org/

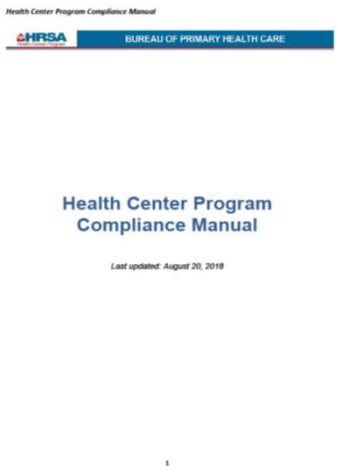




## BACKGROUND: LEGAL FRAMEWORK

- Awarding/Designating Body:
  - Bureau of Primary Health Care (BPHC) within the Health Resources Services Administration (HRSA)
- Statute:
  - 42 USC 254b
  - 42 USC 254b(r)(2)(A) permits DHHS to expend up to 5% of the annual Section 330 appropriation in support of "public centers"
- Regulations:
  - 42 CFR Part 51c
- Key HRSA Guidance:
  - HRSA Health Center Program Compliance Manual

## HRSA HEALTH CENTER COMPLIANCE MANUAL




1. Health Center Program Eligibility
2. Health Center Program Oversight
3. Needs Assessment
4. Required and Additional Health Services
5. Clinical Staffing
6. Accessible Locations and Hours of Operation
7. Coverage for Medical Emergencies During and After Hours
8. Continuity of Care and Hospital Admitting
9. Sliding Fee Discount Program
10. Quality Improvement/Assurance
11. Key Management Staff
12. Contracts and Subawards
13. Conflict of Interest
14. Collaborative Relationships
15. Financial Management and Accounting Systems
16. Billing and Collections
17. Budget
18. Program Monitoring and Data Reporting Systems
19. Board Authority
20. Board Composition
21. FTCA Deeming Requirements

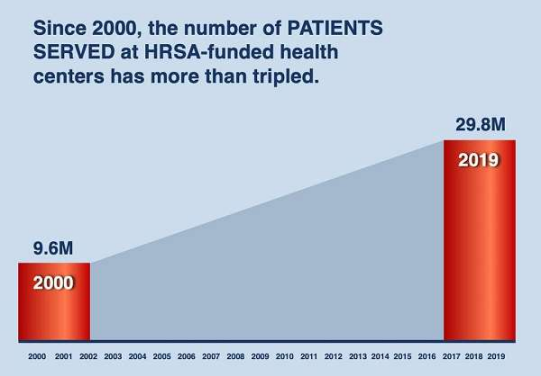




## OTHER SOURCES OF INFORMATION

- https://www.usaspending.gov/#/ (searchable database on grant awards)
- https://www.grants.gov/web/grants (search CFDA 93.224)
- Bureau of Primary Health Care: https://bphc.hrsa.gov/
- Federal Audit Clearinghouse: https://harvester.census.gov/facdissem/Main.aspx
- Guidestar: https://www.guidestar.org/

# II. Key Benefits








## BENEFITS AVAILABLE TO SECTION 330 GRANTEES AND LOOK-ALIKES

**Preferential payment under Sect. 1902(bb) of SSA (Medicaid)**

1. It's an individually determined "per visit rate" for "**FQHC Services" and "any other ambulatory services" provided for in the State Plan.** Other services, *e.g.* in-patient, should be paid at fee schedule.
2. The "Rate" is "equal to **100 percent** of the average of the costs of the center " in FY 1999 and 2000 which are reasonable and related to furnishing such services. That Rate is **"adjusted"** annually by:
   - Inflation using the Medicare economic index (MEI); and,
   - Increases or Decreases in the Scope of Services.
3. Wrap-around – a State must pay the difference, if any, between what an MCO pays an FQHC and what the State should have paid the FQHC at least every four months (increasingly an issue due to explosion of Medicaid Managed care).
4. Alternative Payment Methodology or "APM" – State can pay under an APM if FQHC agrees and APM pays no less than PPS (*i.e.*, PPS is a payment floor).

## ADDITIONAL BENEFITS AVAILABLE TO SECTION 330 GRANTEES AND LOOK-ALIKES

- Preferential Payments under Medicare (also PPS but not individually cost-based) $173.50/visit adjusted for GAF, preventive care, adjusted annually by FQHC inflation index (Sect. 1834(o) of SSA)
- Access to favorable drug pricing under Section 340B of the Public Health Service Act
- Access to providers through the National Health Service Corps





## BENEFITS AVAILABLE ONLY TO SECTION 330 GRANTEES AND SUB-RECIPIENTS

- Federal Grant funding pursuant to Section 330 including supplemental funding such as PPACA ($11B)
- Access to Federal Tort Claims Act (FTCA) coverage, in lieu of purchasing medical malpractice insurance

## COVID-19 FUNDING

- **Coronavirus Preparedness** and Response Supplemental Appropriations Act, (H8C): $100M
- **CARES ACT** - Coronavirus Aid, Relief, and Economic Security Act (H8D): $1.3B
- **Expanding Capacity** for Coronavirus Testing (ECT) (H8E): $583M
- **Provider Relief Fund**
  General Distribution 2% of 2018 Net Patient Revenue plus some Targeted Allocations (rural, uninsured testing)

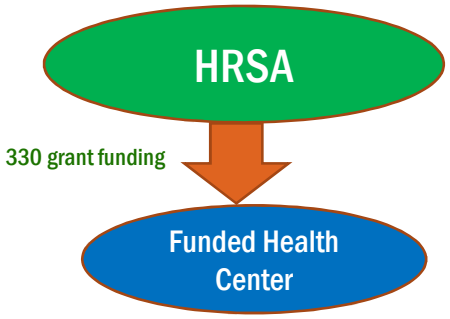





# III. Paths to FQHC Status

## PATHS TO FQHC STATUS: GRANTEE VS. LOOK-ALIKE

- Section 330 Grantee:
  - Entity receives (or is a subrecipient of) grant funding under Section 330 of the Public Health Service Act
  - New Access Point (NAP) grants are highly competitive

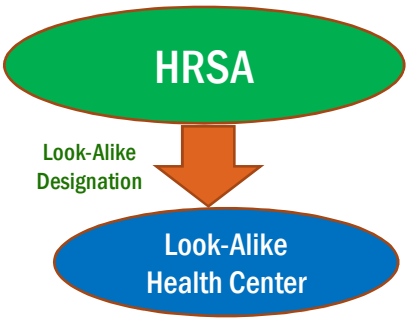







## PATHS TO FQHC STATUS: GRANTEE VS. LOOK-ALIKE

- FQHC Look-Alike:
  - Entity that is determined to meet requirements to receive funding but does not receive a Section 330 grant
  - Applicant must be fully compliant with all HRSA-related requirements upon application
  - HRSA's "Look-Alike Designation Application Instructions" (updated August 13, 2020)



## APPLYING FOR LOOK-ALIKE DESIGNATION

### Application Review Process: Approximate Timeframes

| Responsible Entity | Process | # of Days |
|---|---|---|
| Applicant | Development and submission of application once the application has been created in EHBs | 90 |
| HRSA | Preliminary review to assess eligibility and completeness of the application* | 30 |
| HRSA and Applicant | Site Visit Scheduling and Preparation | 60-75 |
| HRSA | Site visit compliance and eligibility review followed by communication of findings of noncompliance and/or ineligibility issues* | 45 |
| Applicant | Response if additional information is requested by HRSA | 30 |
| HRSA | Final determination of compliance and eligibility* | 45 |





## APPLYING FOR LOOK-ALIKE DESIGNATION

- FQHC Look-Alike: 4 Key Points
  1. Rolling non-competitive application process.
  2. Applicant must be fully compliant with all HRSA-related requirements upon application.
  3. FQHC look-alikes are well positioned to apply for Section 330 grant funds when a New Access Point grant becomes available.
  4. **New!** If 10 or more program requirements have non-compliance findings, HRSA may disapprove the application after the Operational Site Visit. Accordingly, having a thorough understanding of the common FQHC LAL application pitfalls and reviewing tips for success are essential to achieving designation.

# IV. Threshold Eligibility

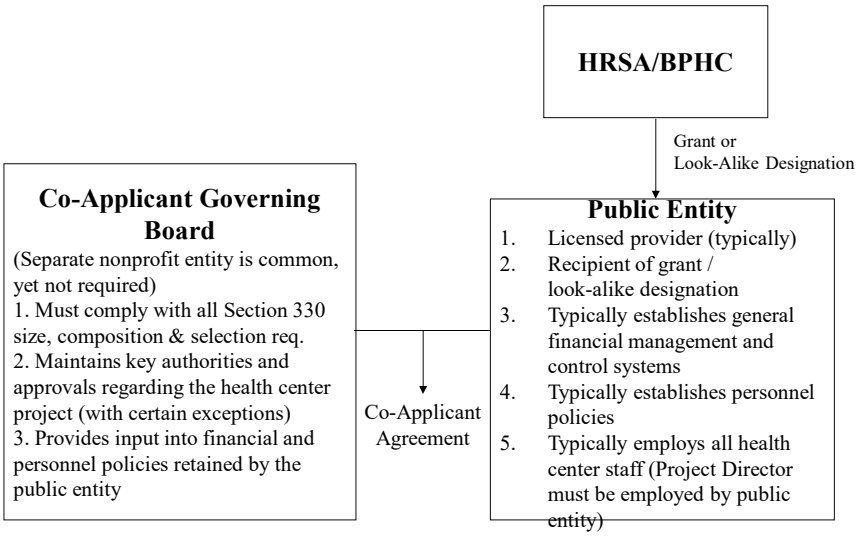




## PUBLIC CENTERS

- Nonprofit or Public Agency
  - Section 330(k)(3) defines a "public center" as a health center funded or to be funded through a grant to a public agency
- Documenting Public Agency Status:
  - Letter affirming the organization's status as a State, territorial, county, city, or municipal government; a health department organized at the State, territory, county, city or municipal level; or a subdivision or municipality of a US affiliated sovereign State formally associated with the U.S.;
  - A copy of the law that created the organization and that grants one or more sovereign powers (for example, the power to tax, eminent domain, police power) to the organization (for example, a public hospital district);
  - A ruling from the State AG affirming the legal status of an entity as either a political subdivision or instrumentality of the State (for example, a public university); or
  - A "letter ruling" which provides a positive written determination by the IRS of the organization's exempt status as an instrumentality under Internal Revenue Code section 115.

## PUBLIC ENTITY – CO-APPLICANT ARRANGEMENT








## AUTONOMY: LOOK-ALIKES

- Applicant entity must not be owned, controlled, or operated by another entity
- Applicant must own and control the organization's assets and liabilities (e.g., the organization does not have a sole corporate member, is not a subsidiary of another organization)

## MEDICALLY UNDERSERVED AREA / POPULATION

- Applicant entity must be located in or serve a designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP)
  - Organizational requirement (not individual site requirement)





# V. Top 4 Programmatic Requirements

## TOP 4 REQUIREMENTS

1. **Required Services**
2. **Sliding Fee Discount Program**
3. **Governing Board**
4. **Service Area**





## REQUIRED SERVICES: FORM 5A

**Clinical Services**
General primary medical care
Diagnostic laboratory and radiology
Screenings
Coverage for emergencies after hours
Voluntary family planning
Immunizations
Well child care
Gynecology and obstetrical care
Preventive dental
Pharmaceutical services

**Enabling Services**
Case management
Eligibility assistance
Health education
Outreach
Transportation services
Translation services
Other

## OPTIONAL ADDITIONAL SERVICES: FORM 5A

**Optional Additional Services**
Mental Health Services
Substance Use Disorder Services
Optometry
Recuperative Care Program
Occupational Therapy
Physical Therapy
Speech Therapy
Nutrition
Complementary and Alternative Medicine
Additional Enabling / Supportive Services





## CORE HEALTH CENTER REQUIREMENTS: SCOPE OF SERVICES

- In-Scope Services
  - Services must be provided directly, by contract, or by referral
  - Services must be reasonably available to full patient population

## FORM 5A: ADDITIONAL AND SPECIALTY SERVICES

- For look-alike applicants, specialty services may not be added to the scope of project at the time of initial designation submission.
  - However, specialty services may be requested for addition to the scope of project through the Change in Scope process after look-alike designation





## SERVICES

- Look-alike applicants must *currently* provide comprehensive primary medical care as its **main purpose**
- Provide current and projected number of patients/visits for:
  - Medical services
  - Dental services
  - Mental health services
  - Substance abuse services
  - Enabling services
- Number of current and projected medical patients must be greater than the number of current and projected patients within each of the other service types

## TOP 4 REQUIREMENTS

1. Required Services
2. **Sliding Fee Discount Program**
3. Governing Board
4. Service Area





## SLIDING FEE DISCOUNT PROGRAM

- Health center must have a schedule of charges that is designed to cover reasonable costs of operation and is consistent with locally prevailing rates
- Health center must have a corresponding schedule of discounts

| | |
|---|---|
| At/Below 100% FPL | • Full discounts or "nominal" charges |
| 101-200% FPL | • Discount adjusted based on ability to pay (at least 3 pay classes) |
| At/Above 201% FPL + | • No discounts |

## TOP 4 REQUIREMENTS

1. Required Services
2. Sliding Fee Discount Program
3. **Governing Board**
4. Service Area





## CORE HEALTH CENTER REQUIREMENTS: GOVERNING BOARD COMPOSITION

- Community-based governing board of 9 – 25 members
  - **Consumer members**: at least 51% must be patients of the health center project
    - As a group, must reasonably represent the populations served by the health center in terms of demographic factors such as race, ethnicity and gender
  - **Non-consumer members**: must represent the community served and, as a group, have broad range of skills and expertise (*e.g.*, finance and banking, legal affairs, business, health, social services, community affairs, *etc.)*
  - No Board member or immediate family member of a Board member may be a health center employee

## CORE HEALTH CENTER REQUIREMENTS: GOVERNING BOARD AUTHORITIES

- Board must hold monthly meetings and autonomously exercise certain authorities, including but not limited to:
  - Selecting/dismissing the Project Director.
  - Approving the annual budget.
  - Monitoring the financial status of the health center.
  - Conducting long-range/strategic planning.
  - Adopting, evaluating and updating the following policies:
    - Sliding Fee Discount Program
    - Quality Improvement/Assurance Program
    - Billing and Collections
    - Financial Management
    - Personnel





## CORE HEALTH CENTER REQUIREMENTS: GOVERNING BOARD AUTHORITIES

- Establish that:
  - No individual, entity, or committee (including, but not limited to, an executive committee authorized by the board) reserves or has approval/veto power over the board with regard to the required authorities and functions.
  - Collaboration or agreements with other entities do not restrict or infringe upon the board's required authorities and functions

## CORE HEALTH CENTER REQUIREMENTS: GOVERNING BOARD COMPOSITION

- Applying for Look-Alike Designation:
  - Bylaws must demonstrate compliance with Health Center Program governance requirements as detailed in Chapters 19: Board Authority and 20: Board Composition of the Compliance Manual.
  - Submit an org chart that demonstrates that the board retains ultimate authority and leadership of the health center.





## COMPLIANCE THOUGHTS ON GOVERNANCE

- CSBG Act has tripartite board
- Head Start Act has 3 required board members with very similar responsibilities
- Impossible to write out the perfect composition method in your by-laws (e.g., this member is designated a patient, this member is a politician, this member has expertise in ECE) so Board members can and probably do meet more than one requirement
- All fine but needs to be managed!

## TOP 4 REQUIREMENTS

1. Required Services
2. Sliding Fee Discount Program
3. Governing Board
4. **Service Area**





## SERVICE AREA

- "*The precise boundaries, as defined by the health center, of the geographic area to be served under the Health Center Program project.*"
  - Area in which the majority of the health center's patients reside (currently defined as 75%)

## SERVICE AREA

If proposed health center is within 5 miles of another Health Center Program award recipient or look-alike site

OR

If the proposed service area has a Health Center Program penetration level of the low-income population that is 75% or greater (per UDS Mapper),

AND

you do not sufficiently document both collaboration (e.g., letters of support from health centers that serve a significant number of patients in the area) and unmet need within the service area,

THEN

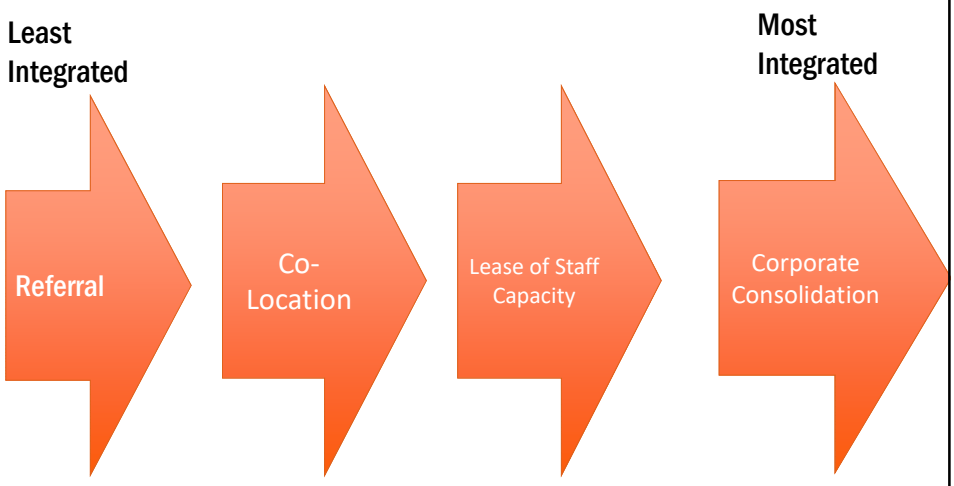
HRSA may opt not to approve your look-alike initial designation





# VI. Spectrum of Collaboration

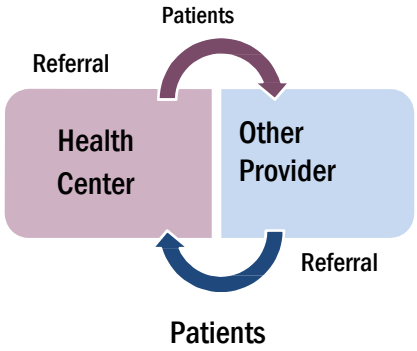
## RANGE OF COLLABORATION OPTIONS: LEAST TO MOST INTEGRATED





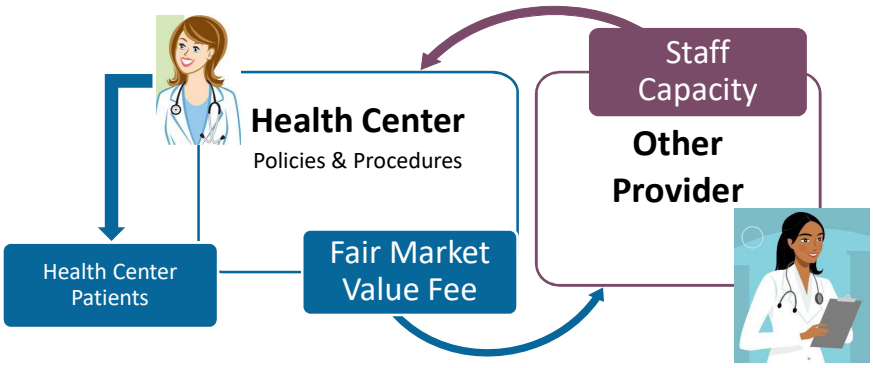



## REFERRAL RELATIONSHIPS




Each provider agrees to furnish services to individuals referred by the other.

## LEASE OF PERSONNEL




One provider contracts with the other provider to purchase clinical or administrative capacity.





## CORPORATE INTEGRATION MODELS

- Full corporate consolidation through merger
  - One corporation ceases to operate as an independent entity and one corporation is the "surviving entity"
- Partial corporate consolidation: two options
  - Both corporations continue in existence post-integration
  - Parent/subsidiary model

## CORPORATE INTEGRATION MODELS

- Key Legal Considerations:
  - Follow procedures mandated under the applicable state laws (*e.g.,* CON and/or licensure laws)
  - Transfer of employees
  - If practice acquisition, purchase price must align with fair market value
  - If consolidation would result in the transfer of a HHS grant, must obtain agency's prior approval through a "successor in interest" process





# VII. Next Steps

## IF YOU WANT TO BECOME A HEALTH CENTER…

1. Review the look-alike application and the Compliance Manual
2. Assess eligibility standards
   - Review the UDS mapper for need data and identify nearby health centers
3. Identify the "scope of project" and conduct financial analysis
4. Review key documents and identify necessary changes
   - Bylaws
   - Policies and Procedures
5. Modify Board composition and authorities, as necessary





## IF YOU WANT TO COLLABORATE A HEALTH CENTER…

1. Identify shared goals
2. Identify potential collaborative opportunities
3. Establish a Joint Steering Committee
4. Execute a Memorandum of Agreement that sets forth the planning process

## QUESTIONS??

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