HRSA Compliance & CHC Board Oversight Responsibilities

CHC Board Meeting

May 28, 2020

HRSA Health Center Program Compliance Manual

- Applies to all health centers receiving 330 funds
- Designed to understand compliance
- Originally issued in August of 2017 and last updated in August of 2018
- Supersedes a number of PALs and PINs, including:
  - PIN 1994-07: Migrant Voucher Program Guidance
  - PINs 1997-27 and 1998-24: Affiliation Agreements of Community & Migrant Health Centers and Amendment to PIN 1997-27 Regarding Affiliation Agreements of Community and Migrant Health Centers
  - **PINs 2001-16 and 2002-22: Credentialing and Privileging of Health Center Practitioners and Clarification of BPHC Credentialing & Privileging Policy Outlined in PIN 2001-16**
  - PAL 2006-01: Dual Status-Health Centers that are both FQHC Look-Alikes and Section 330 Grantees
  - **PIN 2010-01: Confirming Public Agency Status under the Health Center Program and FQHC Look-Alike Program**
  - **PIN 2013-01: Health Center Program Budgeting and Accounting Requirements**
  - **PIN 2014-01: Health Center Program Governance**
  - **PIN 2014-02: Sliding Fee Discount and Related Billing and Collections Program Requirements**
  - **PAL 2014-08: Health Center Program Requirements Oversight**
  - PAL 2014-11: Applicability of PAL 2014-08: Health Center Program Requirements Oversight to Look-Alikes

Health Center Compliance Manual

- Chapters in the Compliance Manual are generally organized as follows:
  - **Authority:** Lists the applicable statutory and regulatory citations.
  - **Requirements:** States the statutory and regulatory requirements.
  - **Demonstrating Compliance:** Describes how health centers would demonstrate to HRSA their compliance with the **Requirements** by fulfilling all elements in this section.

***Health centers that fail to demonstrate compliance as described in the Compliance Manual will receive a condition of award/designation.**

Chapter 1 – Health Center Program Eligibility

- Eligibility Requirements/Documentation
  - Non-Profit Organizations
  - Public Agency Organizations
    - A current dated 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 United States (U.S.) affiliated sovereign State formally associated with the U.S. (for example, Republic of Palau);
    - 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 Attorney General 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 Internal Revenue Service of the organization's exempt status as an instrumentality under Internal Revenue Code section 115.
  - Tribal or Urban Indian Organizations

Chapter 2 – Health Center Program Oversight

- HRSA may impose specific award conditions if an applicant or recipient/designee:
  - Demonstrates undue risk in such areas as:
    - Financial stability;
    - Quality of management systems and ability to meet required management standards;
    - History of performance, specifically the applicant's record in managing previous Federal awards (timeliness of compliance with applicable reporting requirements and conformance to the terms and conditions of previous Federal awards);
    - Findings from reports and audits; and
    - Ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.
    - Has a history of failure to comply with the general or specific terms and conditions of a Federal award/designation;
    - Fails to meet expected performance goals [as prescribed in the terms or conditions of the Federal award or designation]
- Defines progressive action process and enforcement – Project period length is based on an assessment of a health center's compliance

Chapter 3 – Needs Assessment

- The HC to define and annually review service area, including size, boundaries, and barriers for accessibility to care
- The HC to assess unmet need for health services in the service area, including available resources, provider ratio by population, economic factors, and demographic factors.
- Demonstrate compliance by:
  - Review UDS report – Zip code and Form 5B – Do 75% of our patients reside in reported zip codes?
  - Annual Board Report
  - Needs assessment (strategic plan) at least every 3 years (access to care, causes of morbidity and mortality, and health disparities)

Chapter 4 – Required and Additional Health Services

- The HC must provide required primary health services :
  - Family medicine, internal medicine, pediatrics, obstetrics or gynecology
  - Diagnostic laboratory and radiologic services
  - Preventive health services (well-child, immunizations, prenatal, cancer screening, etc)
  - Emergency medical services
  - Pharmaceutical services
  - Case Management
  - Transportation
  - Culturally sensitive services (staff training)- translation and interpretation services
  - Patient and community education
  - Substance use services (required for HCH grant)
- Services to be provided directly, formal written contract/agreement or formal written referral agreement
- Form 5A – Services provided

Chapter 5 – Clinical Staffing

- The health center ensures that it has clinical staff and/or has contracts or formal referral arrangements in place with other providers or provider organizations to carry out all required and additional services included in the HRSA-approved scope of project.
- The health center has considered the size, demographics, and health needs (for example, large number of children served, high prevalence of diabetes) of its patient population in determining the number and mix of clinical staff necessary to ensure reasonable patient access to health center services. 
- Credentialing of Licensed Independent Practitioners – initial and every two years.

Chapter 6 – Accessible Locations and Hours of Operations

- The health center's service site(s) are accessible to the patient population relative to where this population lives or works (for example, in areas immediately accessible to public housing for health centers targeting public housing residents, or in shelters for health centers targeting individuals experiencing homelessness, or at migrant camps for health centers targeting agricultural workers). Specifically, the health center considers the following factors to ensure the accessibility of its sites:
  - Access barriers (for example, barriers resulting from the area's physical characteristics, residential patterns, or economic and social groupings); and
  - Distance and time taken for patients to travel to or between service sites in order to access the health center's full range of in-scope services.
- The health center's total number and scheduled hours of operation across its service sites are responsive to patient needs by facilitating the ability to schedule appointments and access the health center's full range of services within the HRSA-approved scope of project (for example, a health center service site might offer extended evening hours 3 days a week based on input or feedback from patients who cannot miss work for appointments during normal business hours).
- The health center accurately records the sites in its HRSA-approved scope of project on its Form 5B: Service Sites in HRSA's Electronic Handbooks (EHB).

Chapter 7 – Coverage for Medical Emergencies During After Hours

- To assure continuity of the required primary health services of the center, the health center must have:
  - Provisions for promptly responding to patient medical emergencies during the health center's regularly scheduled hours; and
  - Clearly defined arrangements for promptly responding to patient medical emergencies after the health center's regularly scheduled hours.
    - Coverage is provided via telephone or face-to-face by an individual with the qualification and training necessary to exercise professional judgment in assessing a health center patient's need for emergency medical care;
    - Coverage includes the ability to refer patients either to a licensed independent practitioner for further consultation or to locations such as emergency rooms or urgent care facilities for further assessment or immediate care as needed; and
    - Patients, including those with limited English proficiency, are informed of and are able to access after-hours coverage, based on receiving after-hours coverage information and instructions in the language(s), literacy levels, and formats appropriate to the health center's patient population needs.
    - The health center has documentation of after-hours calls and any necessary follow-up resulting from such calls for the purposes of continuity of care.

Chapter 8 – Continuity of Care and Hospital Admitting

- The health center must provide the required primary health services of the center promptly and in a manner which will assure continuity of service to patients within the center's service area.
- The health center must develop an ongoing referral relationship with one or more hospitals.
  - Receipt and recording of medical information related to the hospital or ED visit, such as discharge follow-up instructions and laboratory, radiology, or other results; and
  - Follow-up actions by health center staff, when appropriate.

Chapter 9- Sliding Fee Discount Program

- The health center must operate in a manner such that no patient shall be denied service due to an individual's inability to pay.
- The health center must prepare a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and must prepare a corresponding schedule of discounts [sliding fee discount schedule (SFDS)] to be applied to the payment of such fees or payments, by which discounts are adjusted on the basis of the patient's ability to pay.
- The health center must establish systems for [sliding fee] eligibility determination.
- The health center's schedule of discounts must provide for:
- A full discount to individuals and families with annual incomes at or below those set forth in the most recent Federal Poverty Guidelines (FPG) [100% of the FPG], except that nominal charges for service may be collected from such individuals and families where imposition of such fees is consistent with project goals; and
- No discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines [200% of the FPG].

The health center has board-approved policy(ies) for its sliding fee discount program that apply uniformly to all patients and address the following areas:

- Definitions of income and family;
- Assessment of all patients for sliding fee discount eligibility based only on income and family size, including methods for making such assessments;
- The manner in which the health center's sliding fee discount schedule(s) (SFDS(s)) will be structured in order to ensure that patient charges are adjusted based on ability to pay; and
- **Only applicable to health centers that choose to have a nominal charge for patients at or below 100% of the FPG: The setting of a flat nominal charge(s) at a level that would be nominal from the perspective of the patient (for example, based on input from patient board members, patient surveys, advisory committees, or a review of co-pay amount(s) associated with Medicare and Medicaid for patients with comparable incomes) and would not reflect the actual cost of the service being provided.**

Chapter 10 – Quality Improvement/Assurance

* The health center has a board-approved policy(ies) that establishes a QI/QA program. This QI/QA program addresses the following:
    - **The quality and utilization of health center services;**
    - **Patient satisfaction and patient grievance processes; and**
    - **Patient safety, including adverse events.**

* The health center designates an individual(s) to oversee the QI/QA program established by board-approved policy(ies). This individual's responsibilities would include, but would not be limited to, ensuring the implementation of QI/QA operating procedures and related assessments, monitoring QI/QA outcomes, and updating QI/QA operating procedures.

* The health center's physicians or other licensed health care professionals conduct QI/QA assessments on at least a quarterly basis, using data systematically collected from patient records, to ensure:
    - Provider adherence to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable; and
    - The identification of any patient safety and adverse events and the implementation of related follow-up actions, as necessary.

* The health center has operating procedures or processes that address all of the following:
    - Adhering to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable;
    - Identifying, analyzing, and addressing patient safety and adverse events and implementing follow-up actions, as necessary;
    - Assessing patient satisfaction;
    - Hearing and resolving patient grievances;
    - **Completing periodic QI/QA assessments on at least a quarterly basis to inform the modification of the provision of health center services, as appropriate; and**
    - **Producing and sharing reports on QI/QA to support decision-making and oversight by key management staff and by the governing board regarding the provision of health center services.**

The health center maintains a retrievable health record (for example, the health center has implemented a certified Electronic Health Record (EHR)) for each patient, the format and content of which is consistent with both Federal and state laws and requirements.

The health center has implemented systems (for example, certified EHRs and corresponding standard operating procedures) for protecting the confidentiality of patient information and safeguarding this information against loss, destruction, or unauthorized use, consistent with Federal and state requirements.

Chapter 11 – Key Management Staff

- The health center must have position descriptions for key personnel [also referred to as key management staff] that set forth training and experience qualifications necessary to carry out the activities of the health center.
- The health center must maintain sufficient key personnel [also referred to as key management staff] to carry out the activities of the health center.
- The health center must request prior approval from HRSA for a change in the key person specified in the Health Center Program award or Health Center Program look-alike designation.
- The health center's Project Director/CEO is directly employed by the health center, reports to the health center's governing board and is responsible for overseeing other key management staff in carrying out the day-to-day activities necessary to fulfill the HRSA-approved scope of project.
- The health center's governing board determines when a less than full time Project Director/CEO position is sufficient to oversee the day-to-day activities of the HRSA- approved scope of project.

Chapter 12 – Contracts and Subawards

- Contracts Procurement and Monitoring
  - Written Procedures that comply with Federal procurement standards
  - Documented records for procurement actions paid by Federal award (contractor selection or rejection)
  - Retention of contracts and related procurement records consistent with Federal document maintenance requirements
  - Monitors performance goals of contract
- Subawards: Monitoring and Management – N/A

Chapter 13 – Conflict of Interest

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

- The health center has and implements written standards of conduct that apply, at a minimum, to its procurements paid for in whole or in part by the Federal award. Such standards:

    - Apply to all health center employees, officers, board members, and agents involved in the selection, award, or administration of such contracts;
    - Require written disclosure of real or apparent conflicts of interest;
    - Prohibit individuals with real or apparent conflicts of interest with a given contract from participating in the selection, award, or administration of such contract;
    - Restrict health center employees, officers, board members, and agents involved in the selection, award, or administration of contracts from soliciting or accepting gratuities, favors, or anything of monetary value for private financial gain from such contractors or parties to sub-agreements (including subrecipients or affiliate organizations); and
    - Enforce disciplinary actions on health center employees, officers, board members, and agents for violating these standards.

Chapter 14 – Collaborative Relationships

- The health center documents its efforts to collaborate with other providers or programs in the service area, including local hospitals, specialty providers, and social service organizations (including those that serve special populations), to provide access to services not available through the health center in order to support
  - Reductions in the non-urgent use of hospital emergency departments;
  - Continuity of care across community providers; and
  - Access to other health or community services that impact the patient population.
- The health center documents its efforts to coordinate and integrate activities with other federally-funded, as well as State and local, health services delivery projects and programs serving similar patient populations in the service area (at a minimum, this would include establishing and maintaining relationships with other health centers in the service area).
- If the health center expands its HRSA-approved scope of project:
  - The health center obtains letters or other appropriate documents specific to the request or application that describe areas of coordination or collaboration with health care providers serving similar patient populations in the service area (health centers, rural health clinics, local hospitals including critical access hospitals, health departments, other providers including specialty providers, as applicable); or
  - If such letters or documents cannot be obtained from these providers, the health center documents its attempts to coordinate or collaborate with these health care providers (health centers, rural health clinics, local hospitals including critical access hospitals, health departments, other providers including specialty providers, as applicable) on the specific request or application proposal.

Chapter 15 – Financial Management and Accounting Systems

- The health center has and utilizes a financial management and internal control system that reflects Generally Accepted Accounting Principles (GAAP) for private non-profit health centers or Government Accounting Standards Board (GASB) principles for public agency health centers and that ensures at a minimum:
  - Health center expenditures are consistent with the HRSA-approved total budget and with any additional applicable HRSA approvals that have been requested and received;
  - Effective control over, and accountability for, all funds, property, and other assets associated with the Health Center Program project;
  - The safeguarding of all assets to assure they are used solely for authorized purposes in accordance with the terms and conditions of the Health Center Program award/designation;4 and
  - The capacity to track the financial performance of the health center, including identification of trends or conditions that may warrant action by the organization to maintain financial stability.
- The health center's financial management system is able to account for all Federal award(s) (including the Federal award made under the Health Center Program) in order to identify the source5 (receipt) and application (expenditure) of funds for federally-funded activities in whole or in part. Specifically, the health center's financial records contain information and related source documentation pertaining to authorizations, obligations, unobligated balances, assets, expenditures, income, and interest under the Federal award(s).
- The health center has written procedures for:
  - Drawing down Federal award funds in a manner that minimizes the time elapsing between the transfer of the Federal award funds from HRSA and the disbursement of these funds by the health center; and
  - Assuring that expenditures of Federal award funds are allowable in accordance with the terms and conditions of the Federal award and with the Federal Cost Principles6 in 45 CFR Part 75 Subpart E.
- If a health center expends $750,000 or more in award funds from all Federal sources during its fiscal year, the health center ensures a single or program-specific audit is conducted and submitted for that year in accordance with the provisions of 45 CFR Part 75, Subpart F: Audit Requirements and ensures that subsequent audits demonstrate corrective actions have been taken to address all findings, questioned costs, reportable conditions, and material weaknesses cited in the previous audit report, if applicable.
- The health center can document that any non-grant funds generated from Health Center Program project activities, in excess of what is necessary to support the HRSA-approved total Health Center Program project budget, were utilized to further the objectives of the project by benefiting the current or proposed patient population and were not utilized for purposes that are specifically prohibited by the Health Center Program.

Chapter 16 – Billing and Collections

- The health center has a fee schedule for services that are within the HRSA-approved scope of project and are typically billed for in the local health care market.
- The health center uses data on locally prevailing rates and actual health center costs to develop and update its fee schedule.
- The health center participates in Medicaid, CHIP, Medicare, and, as appropriate, other public or private assistance programs or health insurance.
- The health center has systems, which may include operating procedures, for billing and collections that address:
    - Educating patients on insurance and, if applicable, related third-party coverage options available to them;
    - Billing Medicare, Medicaid, CHIP, and other public and private assistance programs or insurance in a timely manner, as applicable; and
    - Requesting applicable payments from patients, while ensuring that no patient is denied service based on inability to pay.
- If a health center elects to offer additional billing options or payment methods (for example, payment plans, grace periods, prompt or cash payment incentives), the health center has operating procedures for implementing these options or methods and for ensuring they are accessible to all patients regardless of income level or sliding fee discount pay class.
- The health center has billing records that show claims are submitted in a timely and accurate manner to the third party payor sources with which it participates (Medicaid, CHIP, Medicare, and other public and private insurance) in order to collect reimbursement for its costs in providing health services consistent with the terms of such contracts and other arrangements.
- The health center has billing records or other forms of documentation that reflect that the health center:
    - Charges patients in accordance with its fee schedule and, if applicable, the sliding fee discount schedule; and
    - Makes reasonable efforts to collect such amounts owed from patients.
- The health center has and utilizes board-approved policies, as well as operating procedures, that include the specific circumstances when the health center will waive or reduce fees or payments required by the center due to any patient's inability to pay.
- If a health center provides supplies or equipment that are related to, but not included in, the service itself as part of prevailing standards of care4 (for example, eyeglasses, prescription drugs, dentures) and charges patients for these items, the health center informs patients of such charges ("out-of-pocket costs") prior to the time of service.
- If a health center elects to limit or deny services based on a patient's refusal to pay, the health center has a board-approved policy that distinguishes between refusal to pay and inability to pay and notifies patients of:
    - Amounts owed and the time permitted to make such payments;
    - Collection efforts that will be taken when these situations occur (for example, meeting with a financial counselor, establishing payment plans); and
    - How services will be limited or denied when it is determined that the patient has refused to pay.

Chapter 17 - Budget

- The health center must develop an annual budget that:
  - Identifies the projected costs of the Health Center Program project;
  - Identifies the projected costs to be supported by Health Center Program [award] funds, consistent with Federal Cost Principles1 and any other requirements or restrictions on the use of Federal funding; and
  - Includes all other non-Federal revenue sources that will support the Health Center Program project, including:
    - State, local, and other operational funding; and
    - Fees, premiums, and third-party reimbursements which the health center may reasonably be expected to receive for its operation of the Health Center Program project.
  - The health center must submit this budget annually by a date specified by HRSA for approval through the Federal award or designation process.

Chapter 18 – Program Monitoring & Data Reporting Systems

- The health center must establish systems for monitoring program performance to ensure:
  - Oversight of the operations of the Federal award [or designation]-supported activities in compliance with applicable Federal requirements;
  - Performance expectations [as described in the terms or conditions of the Federal award or designation] are being achieved; and
  - Areas for improvement in program outcomes and productivity [efficiency and effectiveness] are identified.
- The health center must compile and report data and other information as required by HRSA, relating to:
  - Costs of health center operations;
  - Patterns of health center service utilization;
  - Availability, accessibility, and acceptability of health center services; and
  - Other matters relating to operations of the Health Center Program project, as required.
- The health center must submit required data and information to HRSA in a timely manner and with such frequency as prescribed by HRSA.

Chapter 19 – Board Authority (Slide 1)

- The health center must establish a governing board that has specific responsibility for oversight of the Health Center Program project.
  - The health center's organizational structure, articles of incorporation, bylaws, and other relevant documents ensure the health center governing board maintains the authority for oversight of the Health Center Program
- The health center governing board must develop bylaws which specify the responsibilities of the board.
  - Holding monthly meetings (record in minutes board attendance, key actions, and decisions);
  - Approving the selection (and termination or dismissal, as appropriate) of the health center's Project Director/CEO;
  - Approving the annual Health Center Program project budget and applications;
  - Approving health center services and the location and hours of operation of health center sites;
  - Evaluating the performance of the health center;
  - Establishing or adopting policy related to the operations of the health center; and
  - Assuring the health center operates in compliance with applicable Federal, State, and local laws and regulations.

Chapter 19- Board Authority (Slide 2)

- The health center must develop its overall plan for the Health Center Program project under the direction of the governing board.
- The health center governing board must provide direction for long-range planning, including but not limited to identifying health center priorities and adopting a three-year plan for financial management and capital expenditures.
- The health center governing board must assess the achievement of project objectives through evaluation of health center activities, including service utilization patterns, productivity [efficiency and effectiveness] of the center, and patient satisfaction. – QI/QA Program
- The health center governing board must ensure that a process is developed for hearing and resolving patient grievances.

Chapter 19 – Board Authority (Slide 3)

Demonstrating Compliance -

- The health center's board minutes and other relevant documents confirm that the board exercises, without restriction, the following authorities and functions:
- Holding monthly meetings where a quorum is present to ensure the board has the ability to exercise its required authorities and functions;
- Approving the selection, evaluation and, if necessary, the dismissal or termination of the Project Director/CEO from the Health Center Program project;
- Approving applications related to the Health Center Program project, including approving the annual budget, which outlines the proposed uses of both Health Center Program award and non-Federal resources and revenue;
- Approving the Health Center Program project's sites, hours of operation and services, including decisions to subaward or contract for a substantial portion of the health center's services;
- Monitoring the financial status of the health center, including reviewing the results of the annual audit, and ensuring appropriate follow-up actions are taken;
- Conducting long-range/strategic planning at least once every three years, which at a minimum addresses financial management and capital expenditure needs; and
- Evaluating the performance of the health center based on quality assurance/quality improvement assessments and other information received from health center management, and ensuring appropriate follow-up actions are taken regarding:
    - Achievement of project objectives;
    - Service utilization patterns;
    - Quality of care;
    - Efficiency and effectiveness of the center; and
    - Patient satisfaction, including addressing any patient grievances.
- The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies in the following areas: Sliding Fee Discount Program, Quality Improvement/Assurance, and Billing and Collections.
- The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies that support financial management and accounting systems and personnel policies. However, in cases where a public agency is the recipient of the Health Center Program Federal award or designation and has established a co-applicant structure, the public agency may establish and retain the authority to adopt and approve policies that support financial management and accounting systems and personnel policies.

Chapter 20 – Board Composition

- The health center's governing board must consist of at least 9 and no more than 25 members.
- The majority [at least 51%] of the health center board members must be patients served by the health center. These health center patient board members must, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender.
- Non-patient health center board members must be representative of the community served by the health center and must be selected for their expertise in relevant subject areas, such as community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.
- Of the non-patient health center board members, no more than one-half may derive more than 10% of their annual income from the health care industry.
- A health center board member may not be an employee of the center, or spouse or child, parent, brother or sister by blood or marriage of such an employee. The project director [Chief Executive Officer (CEO)] may be a non-voting, ex-officio member of the board.
- The health center bylaws or other internal governing rules must prescribe the process for selection and removal of all governing board members. This selection process must ensure that the governing board is representative of the health center patient population. The selection process in the bylaws or other rules is subject to approval by HRSA.
- In cases where a health center receives an award/designation under section 330(g), 330(h) and/or 330(i) and does not receive an award/designation under section 330(e), the health center may request approval from HRSA for a waiver of the patient majority board composition governance requirement by showing good cause.

Chapter 21 – Federal Tort Claims Act (FTCA) Deeming Requirements

- This chapter does not apply to the County of Ventura Community Health Centers.
  - We currently do not employ providers, which is a requirement for the program.

Questions?

Link to full Health Center Compliance Manual

https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html