Health Care for the Homeless Program Update

Board of Supervisors Health Committee

January 11, 2016
Presentation Objectives

• Explain the need for a change in governance structure for the Health Care for the Homeless Program
• Introduce the recommended solution
• Invite input to guide the development of a Plan of Correction, which will come back to the full Board for approval
Health Care for the Homeless
Funding Facts

• Total HCHP 2016 budget request - $11.39 million.
  – $3.11M from Section 330 HCH base grant
  – $8.28M from County, State Mental Health Services Act, program income and other funding

• Funds 9 sub-contracts with local organizations to provide services in the community

• Leverages ~$16M/year in Medi-Cal reimbursements, by enabling FQHC billing at AHS

• Enables discounted drug prices through the federal 340(b) program
Homeless Health Center Components

**2014 stats**
- 7,934 patients served in 32,936 encounters
- 24 FTE Alameda County staff, 52 FTE AHS and contractors
- 9 contracts for patient care services ($750K)

Scope defined by:
1. *Homeless* patients receiving
2. *Approved primary care services* at
3. *Approved sites*
Health Care for the Homeless at AHS

• AHS is a sub-recipient of the HCHP and must meet all Health Center program requirements
• AHS sees about 60% of visits
• Services provided by AHS via sub-recipient agreement include:
  – Medical homes at Wellness Centers
  – Mobile Health (van)
  – Same Day Clinic
  – Homeless Coordinating Office (inc. case management)
What is the issue?

• The typical 330 health center program is a private non-profit and the regulations reflect this
• However, some health centers are operated by public entities—these are referred to as “public centers”
• In 2014, HRSA published new requirements for the governance of public entity health centers
• In California, many counties, including Alameda, have 330 health centers as part of their public hospital and healthcare systems; all have been going through the process of meeting the new requirements
What is the issue?

• Public agencies must now meet specific governance requirements, or they may establish a “co-applicant governing board” to meet the requirements.

• Our situation has added complexity—we have two public entities—the County (the grantee), and Alameda Health System (the subrecipient).

• August 2015 HRSA Site Visit determined that neither the Board of Supervisors (BOS) nor the AHS Board of Trustees (BOT) meets the requirements.

• Failure to establish a Co-Applicant Board would result in the loss of the County’s 330 grant and related FQHC revenue totaling $19 million.
Homeless Health Center Components

Governance

Alameda Health System Board of Trustees

Sub-recipient agreement

Health Care Services Agency

Inpatient and other

Ambulatory care – Non-Homeless

Ambulatory Care – Homeless

Homeless Coordinating Office

Homeless Services

Risk loss of FQHC billing-16M/year

Alameda County Health Care Services Agency
What is the solution?

First step: Analysis and team problem-solving

• 2014-present, HCHP staff led convenings of affected Calif. Counties to share strategy and lessons
• 2015, experts were engaged to research, analyze and inform us about potential governance options
  – Interviewed national experts, as well as
  – Other California counties who are further on in the process
• In November, AHS & HCSA executive staff, Health Committee staff, and HCHP leadership met to review consultant recommendations, and agreed on a proposed solution:

  Joint Co-Applicant Board
Co-Applicant Board
HRSA Requirements

• Must be an independent self-perpetuating board that has the authority to appoint itself.
• Must be composed of a minimum of 9 and a maximum of 25 members.
• Normally, majority of members must be served by the 330 HCH Program—currently waived for HCHP as a homeless program
• Public agency boards (BOS, BOT) may retain responsibility for general fiscal and personnel issues.
How it would work

• HRSA considers the public agencies (County and AHS) and the Co-Applicant Board collectively as the health center.

• The Co-Applicant Board is separate from, and independent of, the public agency. It essentially mirrors a governing board of a non-profit FQHC.

• The Joint Co-Applicant Board will provide community board oversight to the HRSA-approved program scope—i.e., homeless services at both HCSA and AHS programs.

• Co-Applicant Agreement & Co-Applicant Board Bylaws define the respective roles and responsibilities.
Homeless Health Center Components

- AHS Board of Trustees
- Alameda Health System
- Inpt and other
- Ambulatory care – Non-Homeless
- Ambulatory Care – Homeless
- Homeless Coordinating Office
- Board of Supervisors
- Joint Co-App Board
- Sub-recipient agreement
- Health Care Services Agency
- Homeless Services

Co-Applicant agreement
<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan <em>(anticipated)</em></td>
<td>Receive Notice of Award (NOA) with conditions</td>
</tr>
<tr>
<td>Dec-Jan</td>
<td>Develop agreement on concept among BOS, BOT, and HRSA</td>
</tr>
<tr>
<td>Feb-Mar</td>
<td>Develop written plan of correction laying out steps for implementation</td>
</tr>
<tr>
<td>Mar</td>
<td>BOT vote on plan (not HRSA required)</td>
</tr>
<tr>
<td>Mar</td>
<td>BOS vote to approve plan of correction (HRSA required)</td>
</tr>
<tr>
<td>90 days after NOA <em>(est. late Mar)</em></td>
<td>Submit plan of correction to HRSA</td>
</tr>
<tr>
<td>120 days from HRSA Acceptance of Plan</td>
<td>Proof of implementation</td>
</tr>
<tr>
<td>Aug <em>(anticipated)</em></td>
<td>Competitive reapplication due</td>
</tr>
</tbody>
</table>
Take-away points

• We must address HRSA requirements – the stakes are high for all Alameda County residents served by AHS

• There are many details to be worked out, in the process of creating the bylaws and the Co-Applicant agreement—and the County is responsible for establishing the terms

• Ultimately, although the Co-Applicant Board will have a strong voice in the homeless program, the County holds the purse strings and employs the Director

• Success will require true collaboration
Alameda County and AHS Health Care for the Homeless
FQHC/330 Governance FAQs

What is the issue?
Many 330 health centers are operated by private non-profits (like La Clinica de la Raza and LifeLong Medical Care). However, some health centers are operated by public entities such as counties—these are referred to as “public centers”. In California, many counties have 330 health centers as part of their public hospital and healthcare systems.

The Health Resources Services Administration (HRSA) is the federal agency managing the Section 330 Health Center program. In 2014, HRSA published new requirements for the governance of public entity health centers. Alameda County’s Health Care for the Homeless Program (ACHCHP) has been actively working toward meeting these new requirements (see timeline). We need to submit a plan of correction to HRSA proposing our new governance structure. We estimate that this plan will be due to HRSA approximately in April 2016. This plan will need the approval of both the Board of Supervisors (BOS) and the AHS Board of Trustees (BOT).

1. Question: How does Alameda County qualify to be a Federally Qualified Health Center (FQHC)?
Answer: Alameda County’s Health Care for the Homeless Program (ACHCHP) receives, and has received since 1988, a grant from the federal governments under the Authorizing Legislation of the Health Center Program Section 330(h) of the Public Health Service Act (42 USCS § 254b).

2. Question: What are the benefits to Alameda County of the FQHC Program?
Answer: From 2011 to 2014, ACHCHP served 8,000-10,000 persons annually who were homeless (on the street or living in shelters and other housing) or at-risk for homelessness (doubling-up with friends/family) throughout Alameda County. The ACHCHP receives an annual Section 330 base grant of $3,113,811 to offset the cost of caring for uninsured homeless patients. Grants are on three-year renewal cycles and are not time limited. In addition, ACHCHP is eligible to have:
   - Additional grant funding from the Health Resources and Services Administration (HRSA) that is then added to the Section 330(h) grant.
   - Higher reimbursement from Medi-Cal and Medicare. This includes AHS as a sub-grantee.
   - Discounted drug prices through the federal 340(b) program.
   - Free tort protection (malpractice insurance).
   - Access to the National Health Service Corps providers and resources.
   - Access to federal Vaccines for Children (VFC) program.

3. Question: How does AHS benefit from the FHQC program?
Answer: Because AHS is a sub-recipient of the ACHCHP and voluntarily meets Health Center program requirements AHS is able to bill at a higher FQHC rate than if they were only billing at hospital-based clinic rates. AHS projected 2016 revenue exceeds $30 million from FQHC reimbursed healthcare delivered to homeless and non-homeless Medi-Cal and Medicare patients, representing 15%-20% of net AHS outpatient revenue. In addition, AHS receives grant funding (currently close to $300k) from the ACHCHP program to support their provision of primary care to persons experiencing homelessness.
4. **Question:** What are the requirements of the FQHC program?

- Located in or serve a high need community (specifically a designated Medically Underserved Area or Population).
- Governed by a community board composed of a majority (51% or more) of health center patients who represent the population served. A waiver may be requested by ACHCHP for this requirement. Homeless programs like ACHCHP qualify for this waiver.
- Provide comprehensive primary health care services as well as supportive services (education, translation and transportation, etc.) that promote access to health care.
- Provide services available to all with fees adjusted based on ability to pay.
- Meet other performance and accountability requirements regarding administrative, clinical, and financial operations.

5. **Question:** What are the governance requirements for FQHCs that ACHCHP must meet in order to continue to be an FHQC and to receive the program benefits?

**Answer:** The ACHCHP August 2015 HRSA Site Visit determined that neither the current County BOS nor the AHS BOT meet the following governance requirements:

- The governing board must be composed of at least 9 and no more than 25 individuals.
- A majority of members (at least 51%) must be served by the FQHC (may be waived for homeless programs, waived now for ACHCHP).
- Board must meet at least monthly, select the services to be delivered and hours of operation, approve the annual budget and grant application, engage in strategic planning, select and evaluate the health center director, and monitor organizational assets and performance.

Note that public entity boards (BOS, BOT) may retain responsibility for general fiscal and personnel issues.

6. **Question:** How can the ACHCHP meet these governance requirements?

**Answer:** To continue to qualify for the FHQC funding and related benefits, ACHCHP must meet the specific governance requirements of the health center program. Alameda County is unique in California in that we have two public entities comprising our Health Care for the Homeless section 330 program—the County (the grantee), and Alameda Health System (the sub-recipient), which is a public hospital authority. Neither public entity currently meets those requirements, and realistically can’t, given they have a large scope of authority and responsibility beyond the homeless program.

The solution recommended by HRSA and pursued by other California counties is to establish a “Co-Applicant Board”. This is the path that the leadership of HCSA and AHS, and the FQHC consultants, are recommending. In Alameda County, this would take the form of a **Joint Co-Applicant Board**, because we have two public entities.

Alameda County and AHS Executive staffs, along with FQHC consultants, have been working for several months to develop a recommendation that will enable both entities to meet the governance program requirements most effectively. Many options have been considered and it is the collective opinion that one Joint Co-Applicant Board will enable the ACHCHP to meet the intent of the Health Center Program Section 330(h) of the Public Health Service Act and the ever increasing needs of Alameda County’s persons experiencing homelessness, while having the least impact on the authority and operations of the BOS and the BOT.
7. **Question:** What is a co-applicant board?

**Answer:** The term “co-applicant” is used because the County does not qualify on its own as meeting all requirements of the Health Center Program grant, nor does AHS and the BOT on its own meet all the requirements of the Health Center Program sub-grantee. In public centers (like Alameda County and AHS) with a co-applicant governing board, HRSA considers both the public agency and the co-applicant collectively as the FQHC program. Together, Alameda County, AHS, and the proposed Joint Co-Applicant board would meet all Health Center Program requirements and comprise the health center program. Alameda County, AHS, and Joint Co-Applicant board would work collaboratively to implement the approved HRSA health center project.

As required by HRSA, once the original members are appointed, the Joint Co-Applicant Board would be self-sustaining and would appoint future members itself. It would essentially mirror a governing board of a private non-profit health center, both in terms of composition and authorities. It would include a representative majority of consumer/patient representatives (unless this requirement is waived by HRSA), it would meet monthly and it would fulfill all the required authorities of a Health Center governing board.

This Joint Co-Applicant Board would:
- Provide a clean delineation of responsibilities and authorities between the Co-Applicant Board and the BOT and BOS.
- Focus on the significant health center agenda items related to the operation of the homeless program (i.e. budget, sites, hours of operation, ED review, QI).
- Avoid the issue of HRSA questioning appointment of members of Board of Trustees from Board of Supervisors with no say from Co-Applicant Board.
- Start fresh with Board appointments for representation of the 330(h) program only.

This solution appears to be within the intent of HRSA guidelines and the Policy Information Notice (PIN), as it is a complete and separate patient-centered board.

8. **Question:** Why does AHS have to have a Co-Applicant Board since they are only a sub-recipient of the FQHC grant?

**Answer:** Sub-recipients are required to meet all Health Center program requirements just like the grantee and as such AHS and the BOT have to also develop a Co-Applicant Board to meet the governance requirements. They could each have their own Co-Applicant Board, but we are recommending that the BOS and BOT propose to develop a Joint Co-Applicant Board. HRSA would need to approve this arrangement.

9. **Question:** What authorities will the Joint Co-Applicant Board have over the ACHCHP program?

**Answer:** The Joint Co-Applicant Board will be required to meet monthly and maintain records/minutes that verify and document the Board’s functioning. In addition, the Board will have the following authorities over the ACHCHP:
- Approving applications related to the health center project, including grants/designation applications and other HRSA requests regarding scope of project.
- Approval of the annual ACHCHP budget and audit.
- Long-term strategic planning, which would include regular updating of the ACHCHP’s mission, goals, and plans, as appropriate.
- Evaluating ACHCHP’s progress in meeting its annual and long-term goals.
• Selecting services beyond those required in law to be provided by ACHCHP, as well as the location and mode of delivery of those services.
• Determining the hours during which services are provided at ACHCHP sites that are appropriate and responsive to the community’s needs.
• Approving the selection/dismissal and evaluating the performance of ACHCHP’s Program Director.
• Establishing general policies and procedures for ACHCHP that are consistent with HRSA Health Center Program and applicable grants management requirements.

10. Question: Alameda County and AHS are constrained by law in the delegation of certain government functions to private entities, and thus they will need to retain authority over general policies for the ACHCHP. Will this be possible?
Answer: Yes, Alameda County and AHS, with an approved co-applicant board arrangement, will retain authority for the establishment of the following types of general policy:

Fiscal Policies
• Internal control procedures to ensure sound financial management procedures.
• Purchasing policies and standards.

Personnel Policies
• Employee selection, performance review/evaluations and dismissal procedures.
• Employee compensation, including wage and salary scales and benefit packages.
• Position descriptions and classification.
• Employee grievance procedures.
• Equal opportunity practices.

11. Question: What would need to be developed in order to establish a Co-Applicant Board?
Answer: After approval of the plan by HRSA, staff from AHS, HCSA and ACHCHP would work together, along with County Counsel, to lay the groundwork for the Joint Co-Applicant Board through:

1. Development of a Co-Applicant Agreement that is a blueprint for how BOS, BOT, and joint board work together to oversee the ACHCHP.
2. Development of the Co-Applicant Board Bylaws that detailed board authority (e.g. budget, sites, hours of operation, evaluation, staff supervision).
3. Select joint co-applicant board members that include some representation from the homeless community.

12. Question: How will the Joint-Co-Applicant Board work?
Answer: The Board will provide community board oversight to both Alameda County’s ACHCHP, and AHS’ HCH grant program through an arranged agenda and approval process.

13. Question: What is the timeline for this decision and these changes?
Answer: We anticipate that the Plan of Correction will be due to HRSA in April 2016, and we will need to show evidence of implementation by July 2016.