

**State of Nevada  
Department of Health and Human Services**

**Federally Qualified Health Center Incubator Project**

**Request for Information**

**PURPOSE AND OVERVIEW**

Nevada has made significant advances in reducing the rate of medically uninsured residents; however, there are good reasons to believe that many Nevadans have difficulties in accessing health care. A recent study places Nevada 48<sup>th</sup> in the nation with regard to the ratio of health care providers to population.

One solution to expand access to health care is through the promotion of Federally Qualified Health Centers (FQHCs), which are chartered to serve underserved areas or populations. The State's experience with FQHCs demonstrates that FQHCs primarily serve the most vulnerable Nevadans; nearly three quarters of their patients are uninsured or on Medicaid, and more than 95 percent live below 200 percent of the Federal poverty level. Because of this, FQHCs qualify for enhanced reimbursement from Medicare and Medicaid. They must offer a sliding fee scale; provide comprehensive services; have an ongoing quality assurance program; and have a governing board of directors, the majority of whom must be patients of the FQHC.

FQHCs are also a valuable tool for the State to leverage federal funding to increase health care access. Compared to states with similar population size, Nevada receives a small fraction of health center program dollars.

The purpose of this Project is to:

- Increase access to health care for low-income Nevadans;
- Provide funding for increased services that enhance the growth of FQHCs and FQHC Look-Alikes;
- Promote and support public and nonprofit entities to further the FQHC development process; and
- Increase prospects for upcoming federal expansion grants in the State of Nevada.

**OBJECTIVE OF THIS REQUEST FOR INFORMATION (RFI)**

The objective of this RFI is to identify not less than two (2) qualified applicants who can meet the outlined criteria. This RFI does not obligate the State to award a contract or complete the project, and the State reserves the right to cancel solicitation if it is considered to be in its best interest. All costs incurred in responding to this RFI will be borne by the applicant(s). In the event no qualified applicants are identified as a result of this RFI, the State reserves the right to perform alternate measures to identify potential applicants.

## **PROGRAM FUNDING**

The FQHC Incubator Project has \$500,000 in State funds to award annually to nonprofit or public entities that meet program goals. Funding of up to \$250,000 in each year of a two-year funding cycle will be awarded competitively to the two eligible applicants who obtain the highest scores by demonstrating effective project capacity. A Request for Applications (RFA) is expected to be released on July 1, 2017.

Program funds may support technical assistance, organizational development, minor capital improvements, and provider and/or administration salary support. DHHS will make the final determination of an applicant's abilities and intent to comply with the required program expectations.

## **ELIGIBLE ORGANIZATIONS**

Category 1: Current FQHC

Category 2: FQHC Look-Alike

Category 3: Organizations that are not FQHCs or FQHC Look-Alikes, but comply with Chapter 20 Board Governance in HRSA's Draft Health Center Program Compliance Manual requirements concerning mission statement, board of directors composition, and bylaws. Category 3 applicants must be serving patients at the time of application and commit to application for Look-Alike status and New Access Point designation during the funding period.

## **LICENSES AND CERTIFICATIONS**

The Applicant, its employees and agents must comply with all Federal, State and local statutes, regulations, codes, ordinances, certifications and/or licensures applicable to an operational organization as defined by Category 1, 2, and 3.

## **PROGRAM LIMITATIONS**

- Applicants must be a public entity in Nevada or a Nevada nonprofit organization with a tax-exempt determination under Section 501(c)(3) of the Internal Revenue Code. If currently debarred, suspended or otherwise excluded or ineligible for participation in federal or state assistance programs, the applicant is ineligible to apply for funds.
- Applicants must agree to link their Electronic Health Record (EHR) system with the Nevada Tobacco Quit Line administered by National Jewish Health for the purposes of tobacco cessation data collection.
- If the applicant has not met performance measures of previous DHHS contracts, DHHS reserves the right to not award additional contracts.
- All applicants must provide all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. [Section 330(a) of the PHS Act]

- Funds are awarded for the purposes specifically defined in this document and shall not be used for any other purpose.
- Funds must only be used to open a new primary health care clinic through expansion and/or meet all the program expectations necessary as defined in PIN 98-23 Revised to become a FQHC or FQHC Look-Alike, and/or FQHCs must only use funds to provide or expand services that qualify the applicant for additional federal grants.
- Applicants awarded funds shall leverage FQHC Incubator Project funds with other resources if the actual cost of the deliverable exceeds the allowable and contracted amount.
- DHHS reserves the right during the contract period to renegotiate or change deliverables in order to: expand services; reduce funding when deliverables are not satisfactorily attained.

## **FUNDING CATEGORIES**

### *Capital Improvement*

Allowable funds for:

- Clinical Renovations for Medical, Dental and Behavioral Health
- Equipment

Describe proposed renovations or capital improvements to the new expansion site. State whether the site is leased or owned. If leased, a copy of the lease must be submitted to DHHS. Identify the site address and current or proposed hours of operations.

If Capital Improvement costs exceed the amount requested, briefly describe other funding sources.

### *Salary Support*

Allowable funds for:

- Eligible providers as defined in Section 605 of the Division of Health Care Financing and Policy Medicaid Services Manual
- Allowable on, in addition to eligible providers:
  - Clinical support staff (nurses, medical assistants)
  - Administrative support staff (front desk, billing, executive, IT, etc.)

Explain how an additional provider will improve access to service for area residents and/or target population. Include the following information: Type of provider, site address, and hours of operation. A signed agreement or letter of intent must be attached to the application.

Describe and justify required clinical or administrative support for additional provider. Include proposed positions, salaries, and FTE dedicated to new expansion.

### *Development*

Allowable funds for:

- Technical assistance including FQHC Development Workshops, Training (CMS, OMB or healthcare)
- Legal services related to expansion
- Specific activities negotiated with DHHS

Provide a brief description of how technical assistance funding will expand the organizational goals, and specifically assist staff and the board of directors in meeting educational and training needs.

Provide a brief description of how development funding will expand the organization's goals.

### **REQUIRED DOCUMENTS**

To ensure that this program increases access for Nevadans and that awardees will be competing for federal funds, the following documents must be completed per the instructions in the most recent New Access Point (NAP) or Service Area Competition (SAC) Funding Opportunity Announcement released by the Bureau of Primary Health Care:

- Attachment 1: Service Area Map and Table
- Form 4: Community Characteristics
- Form 9: Need for Assistance Worksheet
- Clinical Performance Measures
- Financial Performance Measures

### **REQUEST FOR INFORMATION (RFI) APPLICATION PROCESS AND PROCEDURES**

This section must include information on the programs and activities of the agency, the number of people served, geographic area served, staff experience, and/or programmatic accomplishments. Include reasons why your organization is capable of effectively completing the services outlined in the RFA. Include a brief history of your organization and all strengths that you consider to be assets to your program.

The Applicant should demonstrate the length, depth and applicability of all prior experience in providing the requested services. Letters of reference may be included. The Applicant should also demonstrate the skill and experience of lead staff and designate a project manager with experience in planning and providing the proposed services. Applicants must also include their standard governance, which is defined as processes of governing and processes by which the applicant organization is managed. This could include an organization chart and should also include how the applicant plans to comply with Chapter 20: *Board Governance in HRSA's Draft Health Center Program Compliance Manual* requirements concerning mission statement, board of director composition, and bylaws.

Describe the level of need for services in your service area and what group or groups of individuals will be targeted for services by the program.

Applicants should speak to process to include input from consumers, providers, or community members in program identification and quality improvement.

Applicants will need to describe their competency in or progress towards meeting the Health Resources & Services Administration's (HRSA's) nineteen (19) requirements for FQHCs:

## **NEED**

### **1. Needs Assessment**

Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. [Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act]

## **SERVICES**

### **2. Required and Additional Services**

Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. [Section 330(a) of the PHS Act]

Note: Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services. [Section 330(h)(2) of the PHS Act]

### **3. Staffing Requirement**

Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed, and privileged. [Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act]

### **4. Accessible Hours of Operation/Locations**

Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. [Section 330(k)(3)(A) of the PHS Act]

### **5. After Hours Coverage**

Health center provides professional coverage for medical emergencies during hours when the center is closed. [Section 330(k)(3)(A) of the PHS Act and 42 CFR 51c.102(h)(4)]

### **6. Hospital Admitting Privileges and Continuum of Care**

Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. [Section 330(k)(3)(L) of the PHS Act]

### **7. Sliding Fee Discounts**

Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay.

- This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.

- No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines.
- No patient will be denied health care services due to an individual's inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived.

[Section 330(k)(3)(G) of the PHS Act, 42 CFR 51c.303(f), and 42 CFR 51c.303(u)]

### **8. Quality Improvement/Assurance Plan**

Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include:

- A clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;
- Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall:
- Be conducted by physicians or by other licensed health professionals under the supervision of physicians;
- Be based on the systematic collection and evaluation of patient records; and
- Identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated [Section 330(k)(3)(C) of the PHS Act, and 42 CFR 51c.303(c)(1-2)]

## **MANAGEMENT AND FINANCE**

### **9. Key Management Staff**

Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required. [Section 330(k)(3)(I) of the PHS Act, 42 CFR 51c.303(p) and 45 CFR 75.308(c)(2)(3)]

### **10. Contractual/Affiliation Agreements**

Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements. [Section 330(k)(3)(I)(ii), 42 CFR 51c.303(n), (t), Section 1861(aa)(4) and Section 1905(I)(2)(B) of the Social Security Act, and 45 CFR 75]

### **11. Collaborative Relationships**

Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (section 330 grantees and Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. [Section 330(k)(3)(B) of the PHS Act and 42 CFR 51c.303(n)]

## **12. Financial Management and Control Policies**

Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. [Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR 75.300-309, Subparts E and F.]

## **13. Billing and 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. [Section 330(k)(3)(F) and (G) of the PHS Act]

## **14. Budget**

Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. [Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR 75.308 and 45 CFR 75 Subpart E]

## **15. Program Data Reporting Systems**

Health center has systems which accurately collect and organize data for program reporting and which support management decision making. [Section 330(k)(3)(I)(ii) of the PHS Act and 45 CFR 75.342]

## **16. Scope of Project**

Health center maintains its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards. (45 CFR 75.308)

## **GOVERNANCE**

### **17. Board Authority**

Health center governing board maintains appropriate authority to oversee the operations of the center, including:

- Holding monthly meetings;
- Approval of the health center grant application and budget;
- Selection/dismissal and performance evaluation of the health center CEO;
- Selection of services to be provided and the health center hours of operations;
- Measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance; and

- Establishment of general policies for the health center.  
(Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304) 51c.304

### **18. Board Composition**

The health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically:

- Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.
- The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.
- No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.

### **19. Conflict of Interest Policy**

Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center.

- No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the board. [45 CFR 75.327 and 42 CFR 51c.304(b)]

## **SUBMISSION**

Request for Information packets are due **on June 2, 2017 by 4:00 PM** to Cindy Smith at CRSmith@dhhs.nv.gov. Attachments are required to be in PDF or Word format.

## **RESOURCES**

The Bureau of Primary Health Care has links to funding opportunities for New Access Points and program requirements for FQHCs and Look-Alikes.

The Nevada Primary Care Association provides technical assistance to existing and prospective FQHCs and Look-Alikes.

The Bureau of Health Care Quality and Compliance (HCQC) licenses medical and other health facilities in Nevada in accordance with Nevada Revised Statutes Chapter 449 (NRS 449) and with Nevada Administrative Code Chapter 449 (NAC 449).

HCQC also has an agreement with the federal Centers for Medicare and Medicaid Services (CMS) to certify some facilities in accordance with the Code of Federal Regulations (Title 42). The purpose of CMS certification is so facilities can accept federal funds such as Medicare and Medicaid.