

POLICY INFORMATION NOTICE

DATE: January 27, 2014

DOCUMENT TITLE: Health Center Program Governance

TO: Health Center Program Grantees
Look-alikes
Primary Care Associations
Primary Care Offices
National Cooperative Agreements

This Policy Information Notice (PIN) provides detailed information regarding Health Center Program governance requirements. The purpose of this PIN is to:

- Convey and clarify statutory and regulatory requirements regarding the structure and functioning of governing boards for all Health Center Program grantees (e.g., section 330(e), (g), (h), and/or (i) grantees) and look-alikes;
- Provide clarification regarding board requirements for public centers under co-applicant arrangements, including public centers funded or designated solely under sections 330(g), 330(h), and/or 330(i) to serve special populations; and
- Outline the eligibility and qualifying requirements for Health Resources and Services Administration approval of a governance waiver for the fifty-one percent patient majority governance requirement for eligible section 330 grantees and look-alikes. This PIN also establishes Health Resources and Services Administration policy that eliminates the monthly meeting requirement from waiver consideration.

Currently funded health center grantees and currently designated look-alikes are encouraged to contact their Project Officer for further assistance regarding the governing board requirements and/or questions that specifically relate to their health center projects. If you have any additional questions or require further guidance on the policies detailed in this PIN, please contact the Bureau of Primary Health Care, Office of Policy and Program Development at BPHCPolicy@hrsa.gov.

/s/

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Attachment

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I. PURPOSE

The purpose of this Policy Information Notice (PIN) is to convey and clarify statutory and regulatory governance requirements for all look-alikes and Health Center Program grantees (e.g., health centers funded under section 330(e), (g), (h), and/or (i) of the Public Health Service (PHS) Act, as amended). The Health Resources and Services Administration's (HRSA) intent is to clarify and convey policies related to Health Center Program governance requirements that are relevant and flexible enough to assist health centers¹ as they continue to develop and expand, while preserving the community-based and patient-directed intent of the Health Center Program. In addition, the PIN:

- Recognizes and accommodates the unique governance needs of section 330(g), 330(h), and/or 330(i) health centers that are funded/designated solely to serve special populations and health centers serving an entirely sparsely populated rural area;
- Provides clarification regarding co-applicant board requirements for public centers, including public centers funded/designated solely under sections 330(g), 330(h), and 330(i) to serve special populations; and
- Outlines the requirements for HRSA approval of waivers for the fifty-one percent patient majority governance requirement for eligible health centers. This PIN also eliminates the monthly meeting requirement from waiver consideration.

PIN 2014-01 supersedes PIN 1998-12, "Implementation of the Section 330 Governance Requirements." Where provisions of this PIN conflict with requirements specified in previous PINs listed below, the provisions in this PIN supersede those in the previous PINs and other program guidance documents:

- PIN 1998-23, "Health Center Program Expectations"
- PIN 1997-27, "Affiliation Agreements of Community and Migrant Health Centers"
- PIN 1998-24, "Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers"
- PIN 1999-09, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities"
- PIN 1999-10, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Nonprofit Entities"
- Regional Program Guidance Memorandum 1989-10, "Community and Migrant Health Networks" and subsequent clarification dated March 11, 1991

In addition, this Governance PIN (2014-01) is the **primary** HRSA policy source for information on Health Center Program governance. Therefore, any other previous program guidance provided on this subject, that is inconsistent with the policy contained in this document is also superseded by this PIN.

¹ Here and throughout the PIN, "health center" refers to designated look-alikes and all organizations funded under section 330 of the PHS Act, as amended, including all health centers funded/designated under section 330(e), (g), (h) and/or (i). Previously, look-alikes were sometimes referred to as Federally Qualified Health Center (FQHC) Look-Alikes.

II. APPLICABILITY

This PIN applies to all health centers funded under the Health Center Program authorized in section 330 of the PHS Act (42 U.S.C. § 254b), as amended. In addition, this PIN applies to those organizations designated as look-alikes under the authority of section 1861(aa)(4) and section 1905(l)(2)(B) of the Social Security Act.²

The Health Center Program governance requirements do not apply to health centers operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act or an urban Indian organization under the Indian Health Care Improvement Act that are funded under section 330 or designated as look-alikes.³ However, such organizations are strongly encouraged to review the governance requirements set forth in this PIN for guidance for ensuring patient participation and input in the direction, organization, and ongoing governance of the health center.

III. GOVERNANCE REQUIREMENTS

Governance requirements for health centers have been set forth in statute, regulations and through various HRSA policies.⁴ This PIN clarifies HRSA's policies in implementing the statutory and regulatory governance requirements of the Health Center Program. Per section 330(k)(3)(H) of the PHS Act (42 U.S.C. § 254b), as amended, all health centers⁵ must demonstrate the establishment of an independent governing board that assumes full authority and oversight responsibility for the health center.⁶ The health center's application must identify and document the members of this governing board that have or will assume full authority and oversight for the health center.

The Health Center Program's implementing regulations (42 C.F.R. § 51c.304 and 42 C.F.R. § 56.304) set forth specific governing board requirements for health centers which are funded under sections 330(e) and (g) as Community Health Centers (CHC) and Migrant Health Centers (MHC), respectively. As there are currently no implementing regulations for 330(h) and 330(i) health center programs, throughout the PIN, statements marked by an asterisk (*) will indicate regulatory requirements that are strongly recommended but not required for health centers funded/designated solely under 330(h) and 330(i). It should be noted, however, that these regulations complement the statutory governance requirements and while specific applicability is tied to section 330(e) and (g) grantees only, they are best practices that all health centers should follow, regardless of the specific community being served.

² These policies and guidelines also apply to Look-Alikes, as per section 1861(aa)(4) and section 1905(l)(2)(B) of the Social Security Act, as amended, they must meet the requirements for health centers funded under section 330 of the PHS Act, as amended, including compliance with governance requirements.

³ Per section 330(k)(3)(H) of the PHS Act.

⁴ Section 330(k)(3)(H) of the PHS Act, as amended, 42 C.F.R. § 51c.304 for CHCs, and 42 C.F.R. § 56.304 for MHCs.

⁵ Except where noted in statute, see 330(k)(3)(H) of the PHS Act, as amended.

⁶ Health centers that receive New Access Point funding must be operational and providing services in the community within 120 days of receiving a grant award, including documentation that they are compliant with the requirements of section 330. Look-alikes must be fully operational, including meeting the statutory, regulatory, and program requirements for grantees funded under section 330 of the PHS Act to be eligible to apply for Look-Alike designation.

A. Governing Board Size

The governing board size parameters are designed to ensure the board achieves diverse representation across the health center's target population(s) and service area as well as provides the expertise necessary for appropriate oversight while maintaining a size that functions effectively for timely decision making.

- The bylaws must define either a specific number of board members or define a limited range.
- Boards must have at least nine and no more than 25 members.* The size of the board may vary based on the complexity of the organization and the diversity of the community served.

Please note that all boards should seek an adequate number of members to ensure the presence of a quorum at each board meeting should there be absent board members, while balancing the need for board functioning. Choosing the minimum number (9) of required members for the board may be problematic and inefficient for board functioning, as the health center will be out of compliance if it loses a board member. Likewise, choosing the maximum number of required (25) members for the board may be problematic and inefficient for board functioning, as decision making may be more difficult for a board of this size.

B. Board Composition

Health center governing boards are comprised of individuals who contribute their time and energy to creating an operationally and fiscally strong organization for the purpose of improving the health of their communities and populations. Health centers must meet the following board composition requirements:

- No board members shall be an employee of the health center or an immediate family member (i.e., spouse, child, parent, brother, or sister by blood, adoption, or marriage) of an employee.*
- The Chief Executive Officer may serve only as non-voting, ex-officio⁷ member of the board.*

1. Patient⁸ Board Members

- A majority of members of the board (at least 51 percent) must be individuals who are served by the health center.
- Patient board members must be a current registered patient of the health center and must have accessed the health center in the past 24 months to receive at least one or more in-scope service(s) that generated a health center visit.⁹
- As a group, patient members of the board must reasonably represent the individuals who are served by the health center in terms of race, ethnicity, and sex. Health centers are also encouraged to consider patient members' representation in terms of other factors such as socioeconomic status, age, and other relevant demographic factors.

⁷ The CEO is generally a member of the board by virtue of being CEO of the health center.

⁸ Patient board members are also often referred to as "user" or "consumer" board members. However for the purposes of this document, only the term "patient" or "non-patient" board member will be used for ease of reference.

⁹ Visits are defined as documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient.

- A legal guardian of a patient who is a dependent child or adult, or a legal sponsor of an immigrant, may also be considered a patient for purposes of board representation.¹⁰

2. Non-Patient Board Members

- The members must be representative of the community currently served by the health center.*
- The board must be comprised of members with a broad range of skills, expertise, and perspectives. Such areas include but are not limited to: finance, legal affairs, business, health, managed care, social services, labor relations, and government.* Any one board member (patient or non-patient) may be considered as having expertise in one or more of these areas. In addition, the board does not necessarily have to include specific expertise in all six of these areas and/or may include additional areas of expertise beyond these areas as appropriate.
- No more than one half (50 percent) of the non-patient representatives may derive more than 10 percent of their annual income from the health care industry.*

3. Special Population Representation

Health centers that receive funding/designation under multiple section 330 subparts (section 330(e) and also section 330(g), (h), and/or (i)) must have patient representation on the governing board from the populations targeted and served by the health center, including the special population(s) specifically defined under sections 330(g), (h), and/or (i) (migratory and seasonal agricultural workers,¹¹ homeless individuals,¹² and residents of public housing,¹³ respectively).

Patient representation must be reasonably reflective of the populations targeted and served. At a minimum, there must be at least one board member that is representative of each of the special populations for which the health center receives section 330 funding/designation. The intent is not to impose targets on board membership, but to be consistent with the statute to ensure that governing boards are sensitive and responsive to the needs of all of their patients, including those who are members of special populations.

¹⁰ Students may participate as board members subject to applicable state law regarding any minimum age requirements for non-profit board members.

¹¹ A migratory agricultural worker means an individual principally employed in agriculture on a seasonal basis within the last 24 months who establish temporary housing for the purpose of this work. A seasonal agricultural workers means an individual employed in agriculture on a seasonal basis, who is not also migratory. Agriculture meaning farming in all its branches, as defined by the Office of Management and Budget-developed (OMB) North American Industry Classification System (NAICS) under the following codes and all sub-codes within—111, 112, 1151, and 1152.

¹² A homeless individual means an individual who lacks housing (without regard to whether the individual is a member of the family), including an individual whose primary residence is a supervised public or private facility that provides temporary accommodations and an individual who is a resident in transitional housing, and includes residents of permanent supportive housing or other housing programs that are targeted to homeless populations.

¹³ The residents of one or more public housing developments (section 3(b)(1) of the United States Housing Act of 1937 (42 U.S.C. § 1437a(b)(1)) and the surrounding areas, as appropriate. This includes agency-developed, owned, or assisted low-income housing, including mixed finance projects, but excludes housing units with no public housing agency support other than Section 8 housing vouchers.

Consistent with legislative intent, patient representation of special populations is best achieved through patients who are members of the special population. Inclusion of advocates who have personally experienced being a member of, represent, have expertise in, or work closely with the special population, however, would meet the requirement for multi-funded/designated health centers to have representation of all the populations for which the health center receives funding/designation. These advocates would not be included in calculating whether the governing board met the patient-majority requirement unless they were also health center patients. Additionally, while advocates may represent special populations on the board as outlined above, health centers should continue efforts to efforts to recruit patient board members from the targeted special population.

For MHCs funded/designated solely under section 330(g), the following differences in MHC board composition, per the regulations in 42 C.F.R. § 56.304, should be noted:

- A majority of members of the board (51 percent) must **be migratory and/or seasonal agricultural workers (current or retired due to age or disability)** and/or members of their families who are served by the health center; and
- No more than **two-thirds** of the non-patient representatives may derive more than 10 percent of their annual income from the health care industry.

C. Organizational/Corporate Bylaws

Organizational/corporate bylaws must be established and approved by the health center's governing board through a board resolution that is signed and dated by the Secretary of the board or other designated official. Individual health center bylaws will vary based on a number of factors, including the size, complexity, and needs of the organization, as well as State laws. As the health center evolves, the bylaws should be reviewed and modified as necessary to remain current. Health center bylaws must specify the following:

- Health center mission.
- Authorities, functions, and responsibilities of governing board as a whole.
- Board membership (size and composition).
- Individual board member responsibilities.
- Process for selection/removal of board members.
- Election of officers.
- Recording, distribution and storage of minutes.
- Meeting schedule and quorum.
- Officer responsibilities, terms of office, and selection/removal processes.
- Description of standing committees (which may include but are not limited to, executive, finance, quality improvement, personnel, and planning committees) and the process for the creation of ad-hoc committees.
- Conflict of interest provisions.
- Provisions regarding board dissolution.

D. Board Authority, Functions, and Responsibilities

The governing board of a health center provides leadership and guidance in support of the health center's mission. However, day-to-day direction and management responsibility for the health center must rest with staff under the direction of the Chief Executive Officer (CEO) or Executive Director. Together, the board, the CEO, and other members of the management team (e.g., Chief Clinical Officer, Chief Financial Officer, Chief Information Officer) comprise the leadership for the health center. To succeed, they should work together to ensure a strong organization.

The board is legally responsible for ensuring that the health center is financially stable and is operating in accordance with applicable federal, state, and local laws and regulations as well as its own established policies and procedures.¹⁴ Therefore, boards should be knowledgeable about the community and marketplace trends and be willing to adapt their policies and positions so the health center may react to these trends. In addition, ensuring the financial health of the organization and developing appropriate short and long term goals for the strategic direction of the health center are critical functions for the board. To effectively fulfill these functions, the board must be engaged in health center planning throughout the year. **The health center governing board must retain (i.e., may not delegate) the following unrestricted authorities, functions, and responsibilities:**

- Holding monthly meetings^{15, 16} and maintaining records/minutes that verify and document the board's functioning.
- Approving applications related to the health center project, including grants/designation applications and other HRSA requests regarding scope of project.
- Approving the annual health center budget and audit.
- Long-term strategic planning, which would include regular updating of the health center's mission, goals, and plans, as appropriate.
- Evaluating the health center's progress in meeting its annual and long-term goals.
- Selecting services beyond those required in law to be provided by the health center, as well as the location and mode of delivery of those services.
- Determining the hours during which services are provided at health center sites that are appropriate and responsive to the community's needs.
- Approving the selection/dismissal and evaluating the performance of the health center's CEO or Executive Director.
- Establishing general policies and procedures for the health center that are consistent with Health Center Program and applicable grants management requirements.

Examples of specific health center policies and procedures to be approved and monitored by the Board include but are not limited to: board member selection and dismissal procedures,

¹⁴ Section 330(k)(3)(D) and (k)(3)(H), 42 C.F.R. § 51c.304(d)(3)(iii), and 42 C.F.R. § 51c.304(d)(3)(v).

¹⁵ Where geography or other circumstances make monthly, in-person participation in board meetings burdensome, monthly meetings may be conducted by telephone or other means of electronic communication where all parties can both listen and speak to all other parties.

¹⁶ Health centers funded/designated solely under 330(g) may meet less than once a month during periods of the year, as specified in the bylaws, where monthly meetings are not practical due to migration out of the area. (42 C.F.R. § 56.304(d)(2))

employee salary and benefit scales, employee grievance procedures, equal opportunity practices, codes of conduct, quality improvement system, fee schedules for services, the sliding fee discount program, billing and collections, financial policies that assure accountability for health center resources, and avoidance of conflict of interest.

In cases where the governing board bylaws establish an **Executive Committee** that has the authority to act on behalf of the full governing board, the actions of the Executive Committee must not supersede the full health center governing board's authorities, functions, and responsibilities. The bylaws must specify the circumstances in which the full health center governing board authorizes the Executive Committee to act on its behalf. The Executive Committee must report all actions taken independently and on behalf of the board to the full governing board, and the full governing board must vote on these actions and record them in the board minutes.

IV. PUBLIC CENTER GOVERNANCE

The term "public center" is defined by the Health Center Program's authorizing statute as a health center funded (or to be funded) through a section 330 grant to a public agency.¹⁷ Public agencies (e.g., state, county, or local health departments) that receive any type or combination of section 330 funding (including section 330(g), 330(h), and/or 330(i) to serve special populations) or look-alike designation **must comply with all health center requirements and regulations except as specifically allowed through an approved waiver or the co-applicant structural exception described further below.**

Public centers may be structured in one of two ways to meet the program requirements. In a direct arrangement, the public agency independently meets all the health center program governance requirements based on the existing structure and vested authorities of the public agency's governing board. In a co-applicant arrangement, the health center project as a whole, because of the public agency and co-applicants' complementary roles, meets all health center program requirements.

A. Public Center Co-Applicant Provision

When the public agency's board cannot independently meet all applicable health center governance requirements, a separate "co-applicant" must be established whose governing board meets section 330 governance requirements. In the co-applicant arrangement, the public agency receives the section 330 grant or the look-alike designation and the co-applicant serves as the "health center board" with the two collectively considered as the "health center" or "public center."

The objective of the co-applicant arrangement is for the co-applicant board as the patient/community-based governing board to set health center policy. The co-applicant's governing board must meet all the size, member selection, and composition requirements, and its members must be identified and documented in the public center's application for section 330 funding or look-alike designation. The co-applicant arrangement may not allow the public agency to override or overrule the final approvals and required decision-making authorities of

¹⁷ Sentence following section 330(k)(3)(M) of the PHS Act, as amended.

the co-applicant board (e.g., through a dual or super-majority voting or prior approval requirements).

The co-applicant provision in section 330(k)(3)(H)(ii) recognizes, however, that public agencies may be constrained by law in the delegation of certain government functions to private entities, and thus permits the public agency to retain authority over general policies for the public center. Therefore, a public center with an approved co-applicant board arrangement does not need further justification for the public agency to 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.¹⁸
- Employee compensation, including wage and salary scales and benefit packages.
- Position descriptions and classification.
- Employee grievance procedures.
- Equal opportunity practices.

While the public agency is the recipient of the health center grant/look-alike designation and is the legal entity held accountable to HRSA for carrying out the approved Health Center Program scope of project, the term “co-applicant” is used, based on the fact that the public agency would not qualify on its own as meeting all the Health Center Program requirements. As noted earlier, for programmatic purposes, HRSA considers both the public agency and the co-applicant collectively as the “health center.” Although the co-applicant governing board must retain the ultimate decision-making on duties and authorities beyond the general types of fiscal and personnel policies described above, the co-applicant arrangement should allow for the co-applicant board and the public agency to work collaboratively in the exercise of governance responsibilities.

B. Additional Governance Requirements for Public Center with Co-Applicant

To facilitate the co-applicant arrangement, HRSA strongly encourages the health center co-applicant board to be formally incorporated to ensure maximum accountability for the patient-majority board per the intent of the Health Center Program. HRSA requires public agencies and their co-applicants to execute and present, for HRSA review and approval: a formal co-applicant agreement between the public agency and the co-applicant; co-applicant governing board bylaws; and articles of incorporation (if applicable). These documents must assure that the co-applicant arrangement meets all applicable Health Center Program requirements including retaining authorities as described above.

The co-applicant agreement is a separate document from the bylaws. This agreement must describe the delegation of authority and define roles, responsibilities, and authorities of each

¹⁸ Please note that the co-applicant governing board must approve the selection, performance evaluation, retention, and dismissal of the health center’s CEO or Executive Director.

party in the oversight and management of the health center, including any shared roles and responsibilities in carrying out the governance functions. Such agreements must ensure that the relationship is structured in compliance with section 330 of the PHS Act, as amended, implementing regulations, and clarifying policies. Decisions regarding how roles and responsibilities may be shared are a matter of choice for the public agency and co-applicant governing board; however, any shared roles and responsibilities, as well as the exercise of retained authorities by each party must be articulated in the co-applicant agreement. Given the level of shared responsibility between the public agency and the co-applicant governing board, it is advisable to include provisions for dispute resolution.

Public centers with co-applicant arrangements are reminded that, as with private non-profit centers, no board member shall be an employee of the health center or an immediate family member (i.e., spouse, child, parent, brother, or sister) of an employee. Since together the public agency and the co-applicant board form the “health center,” no employee or immediate family member of an employee of the public agency or the co-applicant may serve as a member of the co-applicant board.

V. WAIVERS OF GOVERNANCE REQUIREMENTS

Section 330(k)(3)(H)(iii) of the PHS Act allows for the Secretary of Health and Human Services to waive the governance requirements for health centers receiving funds pursuant to subsections 330(g), (h), (i), or (p).¹⁹ Specifically, the statute states that “upon showing of good cause the Secretary shall waive, for the length of the project period, all or part of the requirements of this subparagraph in the case of a health center that receives a grant pursuant to subsections (g), (h), (i), or (p).” In all cases, the existence of an approved waiver does not relieve the health center’s governing board from fulfilling all of the other board responsibilities, authorities, and functions, as described in this PIN and as applicable to the type of health center.

A. Eligibility for Waiver Requests

Upon showing of good cause, the following types of health centers are eligible to request a waiver of the 51 percent patient majority governance requirement:

- Any section 330 funded health center or look-alike serving a sparsely populated rural area (section 330(p) of the PHS Act); or
- Section 330 funded health centers/look-alikes that receive MHC, Health Care for the Homeless (HCH), and/or Public Housing Primary Care funding/designation only and do not receive section 330(e) funding/designation.

While eligible to request a waiver, health centers funded/designated solely under 330(i) and health centers serving a sparsely populated rural areas should carefully note the good cause definition and criteria (see Section V.C: Waivers of Governance Requirements: Criteria and Requirements for Waiver Requests) in considering the submission of a waiver request. Since the target populations of these health center types do not generally face the same barriers as those

¹⁹ Section 330(p) health centers are those serving sparsely populated rural areas. For the purposes of determining eligibility for a governance waiver, a health center is defined as serving a sparsely populated rural area only if its entire service area can be classified as having seven or fewer people per square mile at the time of the waiver application.

served by MHC and HCH health centers, compelling and clear evidence about the characteristics of their patient population must be provided that sufficiently documents their limitations from serving on the health center boards.

Requests for waivers of any other statutory or regulatory governance requirements will not be accepted for consideration.²⁰ Please note that past HRSA practice has allowed health centers to request waivers of the requirement for monthly board meetings. HRSA will no longer allow such waivers given the improved uses of telecommunications and other information technology to overcome previous geographic barriers to monthly meetings.

B. Length of Waiver Approval

For section 330 funded/look-alike designated health centers, governance waivers are in effect for the length of the approved project period. At the end of the project period, as part of the Service Area Competition (SAC)/Look-Alike Renewal of Designation application, health centers that request to continue their waiver must follow the process for governance waiver requests as described in Section V.D: Waivers of Governance Requirements: Waiver Request Process.

C. Criteria and Requirements for Waiver Requests

Eligible health centers requesting waivers of the 51 percent patient governance requirement must demonstrate good cause (as defined below) as to why the health center cannot meet the statutory requirement. In addition, they must present alternative strategies detailing how the health center intends to meet the intent of the statute for ensuring patient participation in the organization, direction, and ongoing governance of the center.

1. Good Cause

Demonstrations of “good cause” must be based upon the unique or innate characteristics of the health center’s special population or service area imposing an undue hardship and/or posing a significant barrier to the health center’s ability to establish a patient majority governing board that meets the statutory requirement. For example, health centers serving a predominately homeless population would demonstrate good cause if they are unable to recruit and retain sufficient numbers of homeless board members; or health centers serving a sparsely populated area would demonstrate good cause if they are unable to retain a patient majority on the board because of the limited number of people available to serve on the board.

An eligible health center requesting a waiver must present adequate documentation that the unique/innate characteristics of the health center’s patients and/or the service area clearly impose undue hardship and significant barriers to the health center in establishing a 51 percent patient governing board. Such documentation must include:

- A description of the population to be served and the characteristics of the population or service area which would necessitate a waiver;
- A description of the health center’s attempts to meet the requirement(s) to date; and

²⁰ Existing waivers of statutory or regulatory health center governance requirements beyond the 51 percent patient majority governance requirement, including those granted under the authority of section 330(e)(1)(B), will expire consistent with the effective date of this PIN. See Section VII: Effective Date.

- An explanation of why these attempts have not been successful.

2. Alternative Mechanism Plan for Addressing Patient Representation

An eligible health center that successfully demonstrates good cause, per the criteria above, must present an acceptable plan for complying with the intent of the statute via an alternative mechanism (see “Sample Alternative Mechanisms” section below for examples). Such a plan must ensure patient input and participation in the organization, direction and ongoing governance of the health center. The plan must provide all of the following:

- Clear description of the alternative mechanism(s) for gathering patient input. If advisory councils or patient representatives are proposed, include a list that identifies these individuals and their reasons/qualifications for participation on the advisory council or as governing board representatives.
- Specifics on the type of patient input to be collected.
- Methods for collecting and documenting such input.
- Process for formally communicating the input directly to the health center governing board (e.g., monthly or quarterly presentations of the advisory group to the full board, monthly or quarterly summary reports from patient surveys).
- Specifics on how the patient input will be used by the governing board in such areas as: 1) selecting health center services; 2) setting health center operating hours; 3) defining budget priorities; 4) evaluating the organization’s progress in meeting goals, including patient satisfaction; and 5) other relevant areas of governance that require and benefit from patient input.

3. Sample Alternative Mechanisms for Addressing Patient Representation

Patient participation in governance is an essential element in designing responsive and effective health service delivery programs that adequately meet the needs of the populations served by health centers. Health centers have developed various alternative mechanisms to assure the input of special populations into the design, operation and governance of health centers. Examples include but are not limited to:

- Substantial involvement (short of a majority) of special population patient board members on the health center’s board of directors.
- Establishment of a patient **advisory council** which meets regularly (at least quarterly) and includes a significant number of special population patients. The advisory council should have a clear line of authority and communication with the health center’s governing board of directors. Members should be identified with reasons/qualifications for participation on the advisory council as part of the waiver request.

Please note that advisory councils are not expected to meet governing board requirements, nor will they be recognized as fulfilling these requirements as they cannot act on behalf of the board of directors nor can the board of directors delegate required authorities to the advisory board. Furthermore, entities using an advisory council as their alternative mechanism must list the health center’s governing board members when completing Form 6A: Current Board Member Characteristics in their application, and NOT the members of their advisory council;

- Inclusion of advocate board members who have personally experienced being a member of, represent, have expertise in, or work with the special population on the health center governing board;
- Focus groups of patients, convened regularly and involving a representative sample of the project's patients;
- Patient interviews conducted throughout the year, involving a representative sample of the project's patients;
- Surveys with patients of special population services; and/or
- Suggestion boxes and complaint lines.

Eligible health centers may wish to consider adopting one or more of the above approaches for assuring meaningful patient involvement under an approved waiver. In all of the above approaches, it will be essential that patient input is documented in writing and a mechanism for formal and regular communication of the input to the health center's governing board is established.

Any mechanism that does not document patients' input in writing and does not provide for formal communication of the input to the health center's governing board will not be considered an acceptable alternative mechanism to the patient majority board. Examples of such unacceptable mechanisms include:

- Written patient satisfaction surveys for populations with limited English proficiency or low literacy rates; and
- Informal input from patients conveyed through health center staff to management.

D. Waiver Request Process

Eligible health centers (i.e., new Health Center Program applicants or existing look-alikes and grantees) that request a new or renewed waiver of the patient majority governance requirement must do so using Form 6B: Request for Waiver of Governance Requirements.

Requests for new waivers may be submitted through:

- Applications for initial designation or for new funding (New Access Points (NAP))/Look-Alike Initial Designation Applications
- Applications for new project periods/SAC/Look-Alike Renewal of Designation applications
- Formal Prior Approval process.²¹

Waiver renewals must be submitted with the health center's SAC/Look-Alike Renewal of Designation applications.

The results of the HRSA waiver review will be communicated to the requesting health center. If the health center does not meet the criteria for good cause and the waiver request is

²¹ Should an immediate need arise for a new/initial waiver of governance requirements in the middle of a budget year/ Look-Alike certification year, the health center should contact their Project Officer. These situations will be resolved on a case-by-case basis.

disapproved, HRSA will provide an explanation for the disapproval, and the health center will be afforded an opportunity to resubmit the waiver request. If the waiver request is approved, the governance waiver will be in effect for the length of the approved project period. Once approved in a SAC/look-alike Renewal of Designation/NAP/look-alike Initial Designation application, a health center will be expected to provide an assurance that the approved alternative mechanism to gain patient input continues to fully meet the intent of the governance requirements.

As noted earlier in the Eligibility for Waiver Requests section, the ONLY health center governance requirement for which HRSA will consider a request for waiver is the 51 percent patient majority requirement. Requests for waiver of the monthly meeting requirements will no longer be accepted or approved as of the effective date of this PIN.

VI. ADDITIONAL CONSIDERATIONS FOR HEALTH CENTER GOVERNANCE

All health centers with existing affiliation agreements or considering new affiliation agreements should examine their arrangements to assure their governing board remains in compliance with all governance requirements as described in this PIN. Specifically, health centers should determine whether any of the health center governing board's (including co-applicant board's) authorities, functions and responsibilities are being or would be compromised or limited in any way by these agreements. Agreements requiring HRSA review from a programmatic and/or grants management perspective may include, but are not limited to:

- Mergers.
- Acquisitions.
- Parent-subsidiary arrangements. In particular, when health centers exist as a subsidiary of another entity, the "parent" entity may not reserve or withhold powers that the health center governing board must exercise under the relevant statute and implementing regulations.
- Establishment of a new entity.
- Subrecipient arrangements.²² Should a health center grantee enter into a subrecipient arrangement with another entity through which the health center provides a sub-award of the section 330 grant funds to the entity (the "subrecipient"), the health center grantee of record must provide adequate oversight of the subrecipient and each subrecipient must have a governing board that is in compliance with the applicable statutory and regulatory policies and the policies set forth in this PIN.
- Contracts for a substantial portion of the project (e.g., contracts for key management staff or core service delivery plan providers and/or services).

Please note that look-alikes may not be owned, controlled or operated by another entity; therefore, parent-subsidiary arrangements, network corporations, etc., may not be eligible for designation.²³ Look-alikes should review PIN 2009-06 and other relevant look-alike program

²²A subrecipient is an organization that "(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of such Act . . ." (§ 1861(aa)(4) and § 1905(l)(2)(B) of the Social Security Act). Subrecipients must be compliant with all of the requirements of section 330 to be eligible to receive FQHC reimbursement from both Medicare and Medicaid. The subrecipient arrangement must be documented through a formal written contract/agreement (Section 330(a)(1) of the PHS Act).

²³ Section 1905(l)(2)(B)(iii) of the Social Security Act, as amended.

guidance before they submit an initial designation, renewal of designation, annual recertification, or change in scope application.

A. Executive Committee

In addition to the overall governing board composition requirements stipulated in section 330 of the PHS Act, the implementing regulations and this PIN, the composition of the Executive Committee is especially important since it may have authority to act on behalf of the full board under specified circumstances. The extent to which Executive Committee board members may be representing or selected by any outside entity should be limited to ensure that the outside entity's authority does not limit/impede/supersede the execution of the health center governing board's required authorities.

B. Delegation of Health Center Authorities, Functions or Responsibilities

It is essential that the health center governing board be vested with its required authorities and that any potential opportunity for an outside entity to limit/deny/impede the execution of these authorities be minimized. In consideration of agreements and contracts between health centers and other entities, in the areas where governing boards must exercise independent authority (Section III.D of this PIN: Governance Requirements: Board Authority, Functions, and Responsibilities), it is important to ensure that:

- No other entity may have an overriding approval authority over the health center board;
- No requirement for a majority of the affiliating or outside entity's board to also exercise approval (i.e., a "dual majority" requirement) may be established;
- No other entity may have veto power, including "super-majority" provisions which give another entity an effective veto power;
- No other entity may have final approval of the overall strategic and operational plan and budget for the health center, except where allowed for public centers with co-applicant boards; and/or
- No other entity aside from the health center board may have the authority to select or dismiss the CEO/Executive Director. This prohibition includes cases where health centers combine the CEO position with that of any other key management staff.

C. Additional Considerations

Beyond the HRSA governance requirements, there are many other federal and state requirements for governing boards. Health centers are encouraged to seek legal advice from their own counsel to ensure that organizational documents and contractual agreements accurately reflect the boards' objectives and requirements. These include but are not limited to:

- Federal fraud and abuse provisions, including the Federal anti-kickback statute;²⁴
- Applicable HHS grant regulations (45 C.F.R. § 74 and 92) and OMB cost circulars;
- Health Center Safe Harbor;²⁵
- Antitrust laws;
- Tax-exempt status of the health center;

²⁴ Section 11288(b)(3)(H) of the Social Security Act, as amended.

²⁵ Section 1128B(b)(3)(H) of the Social Security Act, as amended.

- Medicaid and Medicare reimbursement issues;
- State law;
- IRS requirements for non-profit boards; and
- Board member compensation.²⁶

VII. EFFECTIVE DATE

This policy will become effective upon issuance of this PIN. All new organizations applying for section 330 funding/Look-Alike designation will be evaluated for compliance with these policies. As described in Program Assistance Letter (PAL) 2010-01 “Enhancements to Support Health Center Program Requirements Monitoring,”²⁷ HRSA is committed to assisting health centers to remedy identified areas of non-compliance and to providing reasonable time for health centers to take necessary corrective action through the Progressive Action process.

Existing health centers must review their current governance structure, including bylaws, agreements, and other governance documents to ensure that their governing board structure, authorities, functions, and responsibilities are consistent with the policies in this PIN. Consistent with the Progressive Action policy and process described in PAL 2010-01, HRSA will apply applicable conditions for identified non-compliance with governance requirements and will work with existing health centers to identify appropriate corrective actions necessary to address these areas of non-compliance. While existing health centers are to comply with the policies in this PIN upon issuance, HRSA recognizes that in limited cases, health centers may be able to justify the need for additional time to alter governance structures and/or documents in order to implement corrective actions necessary to comply fully with this PIN. In light of this potential need and in accordance with Section 330(e)(1)(B) of the PHS Act,²⁸ upon written request, HRSA may allow existing health centers up to two years to demonstrate compliance with all governance requirements set forth in this PIN. Any health center that is allowed this additional time to fully comply will be required to provide HRSA with at least quarterly updates regarding its progress in demonstrating compliance.

VIII. TECHNICAL ASSISTANCE AND CONTACTS

For further assistance regarding the governance requirements and the policies in this PIN as they specifically relate to an individual health center’s circumstances, Health Center Program grantees and look-alikes are encouraged to contact their Project Officer. In addition, health centers may contact their state/regional Primary Care Association (PCA) and/or National Cooperative Agreement organizations for assistance on governing board requirements and best practices. A list of the PCAs and National Cooperative Agreement organizations can be found on the HRSA/Bureau of Primary Health Care Web site at: <http://www.bphc.hrsa.gov/technicalassistance/>. The website also

²⁶ While no board member may be an employee of the health center, 42 C.F.R. § 51c.107 permits the use of grant funds (subject to applicable State law regarding reimbursement restrictions for non-profit board members) for certain limited reimbursement of board members as follows: 1) for reasonable expenses actually incurred by reason of their participation in board activities; or 2) for wages lost by reason of participation in the activities of such board if the member is from a family with an annual family income less than \$10,000 or if the member is a single person with an annual income less than \$7,000.

²⁷ Available at <http://www.bphc.hrsa.gov/policiesregulations/policies/pal201001.html>.

²⁸ “Entities that fail to meet certain requirements. The Secretary may make grants, for a period of not to exceed 2 years, for the costs of the operation of public and nonprofit private entities which provide health services to medically underserved populations but with respect to which the Secretary is unable to make each of the determinations required by subsection (k)(3) [(l)(3)].”

contains an overall summary of the key health center program requirements at <http://www.bphc.hrsa.gov/about/requirements/index.html>.

If you have any questions regarding this PIN, please contact the Bureau of Primary Health Care, Office of Policy and Program Development at BPHCPolicy@hrsa.gov.