

Comments & Response on Draft Policy Information Notice “Health Center Program Governance”

On August 20, 2009, the Health Resources and Services Administration (HRSA) issued the draft Policy Information Notice (PIN), “Health Center Governance Requirements and Expectations,” for public comment on its website. The purpose of this Final PIN, “PIN 2014-01: Health Center Program Governance,” is to convey and clarify statutory and regulatory requirements regarding the operation and composition of governing boards for all Health Center Program grantees (i.e., Section 330(e), (g), (h), and (i) grantees) and look-alikes (i.e., Section 1861(aa)(4) and section 1905(l)(2)(B) of the Social Security Act).¹

Fifty-one parties, including both individuals and groups, submitted a total of 251 comments regarding the draft PIN. After review and careful consideration of all comments received, HRSA amended the PIN to incorporate certain recommendations and suggestions from the public. In addition, since issuing a proposed PIN for comment, the Health Center Program in 2010 adopted system and process enhancements to improve program monitoring through the implementation of the Progressive Action policy and process detailed in Program Assistance Letter (PAL) 2010-01 “Enhancements to Support Health Center Program Requirements Monitoring.” The final PIN reflects these changes. Below is a summary of major comments and HRSA’s responses. Please note that minor changes may have been incorporated that are not summarized below.

Issue: Governing Boards’ Understanding of Expectations

Comments

One commenter suggested that governing board members be required to sign a statement of understanding, acknowledging that he or she has read and understands the expectations associated with serving on a health center board. The commenter further stated that such a requirement would likely reduce HRSA’s administrative burden in responding to board member questions that are adequately addressed in published guidance.

HRSA Response

HRSA has considered the comment, but believes that the question of whether or not to impose a statement of understanding requirement on board members is an individual health center decision.

¹ Previously, Look-Alikes were sometimes referred to as “Federally Qualified Health Center Look-Alikes.”

Issue: Look-Alike Applicability

Comments

One commenter sought clarification as to whether look-alikes would have a multi-year designation period or an annual review.

HRSA Response

HRSA has addressed these concerns in look-alike designation application instructions issued since the draft PIN was made available for public comment. The most recent policy related to the Health Center look-alike program is available at: <http://www.bphc.hrsa.gov/about/lookalike/index.html>. Look-alikes receive designation periods similar to project periods for Health Center Program grantees.

Issue: Mischaracterizing Compliance Requirements

Comments

Three commenters stated that HRSA should more clearly differentiate between requirements and best practices in Section III. One commenter further stated that HRSA should explicitly identify the requirements in Section III as “best practices” for section 330(h) and section 330(i) grantees.

HRSA Response

HRSA has recognized these concerns and removed certain items from the requirement status.

Issue: Eliminate the Special Population Board Member Requirement for Multi-Funded

Comments

Three commenters stated various reasons why HRSA should not require a multi-funded health center (e.g., a health center receiving a grant/designation under section 330(e) in addition to a grant/designation under section 330(g), (h), and/or (i)) to include a special population representative on its board. One commenter specifically stated that such a requirement was not supported in law. Commenters also addressed difficulties in retaining special population representatives on the board. One commenter further suggested that special population advocates be permitted to fill this role on the board.

HRSA Response

While HRSA recognizes the concerns of the commenters, HRSA has concluded that receipt of grant funding under section 330(g), (h), and/or (i) requires board representation from that statutorily designated special population. In response to a related comment, HRSA has made an allowance for special population representatives on the board to include special population advocates. However, such advocates do not

count towards the patient majority requirement unless they are also health center patients.

Issue: Clarification of Board Member Income Restrictions

Comments

Five commenters requested further specificity and examples of what types of income derived from the health industry are considered in determining compliance with the composition requirements for non-patient board members.

HRSA Response

The health center regulations at 42 CFR 51c.304 state that no more than one-half of non-patient board members can be “individuals who derive more than 10 percent of their annual income from the health care industry.” Health centers should have an established and reasonable policy/procedure to assist in defining the health industry and in determining the financial income of its board members from the health industry.

Issue: Requirements as Opposed to Best Practices

Comments

Six commenters raised concerns with the list of bylaw requirements in Section III(C) and the retained powers list in Section III(D). Commenters sought clarification on which bylaw specifications and board-retained authorities are requirements and which are “best practices,” emphasizing that several of the bullet points are improperly listed as requirements (e.g., not supported by law). One commenter further stated that the bylaw list was too detailed, which might cause conflicts with state corporations laws. Commenters suggested deleting those bylaw provisions not common to a majority of health centers, especially the conflict of interest and executive succession policies, which have broader applicability beyond what would be included in the bylaws.

HRSA Response

In response to this comment, HRSA has reevaluated the lists in Section III(C) and III(D) and modified them to reflect only those items that are required through issuance of this PIN.

Issue: Migrant Health Center Board Meeting Exception

Comments

One commenter pointed out that there was no mention in Section III(D) of the exception in 42 CFR 56.304(d)(2) for migrant health center board meetings during non-harvesting months.

HRSA Response

In response to this comment, HRSA has included a reference in Section III(D) to the monthly meeting exemption in 42 CFR 56.304(d)(2) for stand-alone migrant health centers during non-harvesting months.

Issue: Clarifying Division of Authority between Public Agencies and Co-applicants

Comments

Six commenters sought clarification as to what authorities must be retained by co-applicant boards and requested further specificity and examples on what constitutes “general policy” within the purview of the public agency. Commenters specifically asked whether items in the list must actually be actively conducted by the board or whether the board may simply ensure that they have been done by another party.

HRSA Response

HRSA has considered these comments and addressed the concerns by modifying Section IV to enhance clarity around co-applicant retained powers.

Issue: Applicability to Migrant Voucher Programs

Comments

Three commenters requested clarity regarding how the PIN would apply to Migrant Voucher Programs.

HRSA Response

Consistent with regulations applying to Migrant Voucher Programs (42 CFR 56.603) and the accompanying Federal Register Notice dated November 25, 1977 (42 Fed. Reg. 60,406-60,407), HRSA provides the following clarification: Existing migrant voucher programs that serve small pockets of migratory and seasonal farmworkers during short periods of time and that do not offer a range of primary care services at a delivery site or sites would not be required to establish traditional health center governing boards. However, HRSA/Bureau of Primary Health Care is aware that many migrant voucher programs currently contain significant migrant health center components that include the direct provision of primary care services to migrant and/or seasonal farmworkers, and, for these grantees, the requirement that they establish a traditional health center governing board would apply. HRSA will work with these programs on a case-by-case basis to determine the applicability of the governing board requirements contained in this PIN and to assist as needed with development of a plan to come into compliance with these requirements.

Issue: Public Agency Authority over Chief Executive Officer (CEO)

Comments

One commenter suggested that the PIN should explicitly specify that the public agency's power to hire/fire health center employees does not include the CEO.

HRSA Response

Revisions have been made to Section IV to enhance clarity on public center governance including the authorities the co-applicant is required to retain related to the CEO.

Issue: Additional Restrictions for Public Agencies

Comments

Twelve commenters sought additional restrictions on public agencies' ability to retain control over fiscal and personnel policies. Commenters suggested that public agencies should be required to cite the state law or laws prohibiting the delegation of such powers.

HRSA Response

Section 330(k)(3)(H) of the Public Health Service (PHS) Act states that public agencies may retain the authority to establish general policies for the center. HRSA interprets these "general policies" to be limited to fiscal and personnel policies, as they are inherently governmental and appropriate to be retained by the public agency as the grantee of record. HRSA is therefore not requiring documentation or citation of state or local law to demonstrate that the public agency is indeed constrained by law in delegating decisions to a co-applicant board in these limited areas of general fiscal and personnel policies and procedures.

Issue: Fewer Restrictions for Public Agencies

Comments

Five commenters raised concerns with the application of a "constrained by law" test in Section IV(A)(2)(b) and suggested that a "constrained by law" test is not supported by law.

- Commenters stated that describing co-applicants as "entities" does not allow for the possibility that a co-applicant board may not be incorporated.
- One commenter sought further guidance on how to proceed when a public agency's legal constraints prevented section 330 compliance. Commenters suggested that HRSA provide a structural exception for public agencies (especially states) that by law cannot have a co-applicant governing board with ultimate authority or allow alternative governance arrangements so long as they are consistent with Health Center Program intent.

HRSA Response

As noted above, section 330(k)(3)(H) of the PHS Act states that public agencies may retain the authority to establish general policies for the center. HRSA interprets these “general policies” to be limited to fiscal and personnel policies, as they are inherently governmental and appropriate to be retained by the public agency as the grantee of record. In cases of a public center with co-applicant model, HRSA permits the public agency to retain authority only for general fiscal and personnel policies and procedures.

- HRSA has edited the PIN so that co-applicant governing boards are not described as “entities.” HRSA continues to encourage co-applicant boards to be formally incorporated.
- As described in Section IV of the PIN, HRSA allows two ways for public agencies to meet requirements of section 330 and the program regulations. First, a public agency may satisfy all requirements on its own, without the aid of a co-applicant. Second, where the public agency cannot satisfy the governance requirements on its own, it has the option of establishing a co-applicant arrangement with a co-applicant board so that they may together satisfy the governance requirements of section 330 and the program regulations. Edits have been made to Section IV in an effort to enhance clarity around what is expected and required of the co-applicant arrangement.

Issue: Unfair Burden on Public Agencies

Comments

Two commenters stated that the PIN was unfair in its shift of final authorities to the co-applicant board, while the public agency remained fiscally liable and responsible for the grant. Commenters suggested permitting public agencies to appoint public employees to the co-applicant board or allowing a “phase out” of public agency control under the supervision of both parties and HRSA.

HRSA Response

HRSA has recognized the concerns reflected in the comments and clarified the expectations and requirements of co-applicant arrangements in Section IV, including emphasizing that the public agency is the recipient of the grant and the legal entity held accountable to HRSA for carrying out the approved Health Center Program scope of project.

Issue: Conflict Resolution Options

Comments

Two commenters requested that HRSA require, or at least recommend, the existence of a conflict resolution plan for public agency and co-applicant board arrangements, suggesting that it would help reduce the intensity and duration of possible internal public center disputes. Commenters suggested that HRSA recommend the inclusion of a dispute resolution provision in the co-applicant agreement.

HRSA Response

In response to this comment, HRSA added language on inclusion of dispute resolution in the co-applicant agreement as a good business practice. HRSA will also address conflict resolution options in technical assistance to co-applicant public center grantees/look-alikes.

Issue: Discontinuing Public Agencies or More Strict Enforcement of Requirements

Comments

Nine commenters stated that public agencies should not be permitted to circumvent section 330 requirements by establishing a co-applicant board, and that HRSA should be strictly enforcing the co-applicant requirements on public centers. Commenters suggested HRSA perform at least one site visit and assessment per project period for co-applicant public centers, as well as requiring co-applicant agreement revisions when necessary and levying penalties where needed.

HRSA Response

HRSA has clarified that section 330 allows a public center and a co-applicant board together to meet the Health Center Program's governance requirements, with the objective that every health center's policy setting process be carried out by a community-based governing board. As with all HRSA health centers, HRSA Project Officers monitor public centers to ensure that all governance requirements are met, which includes conducting periodic site visits. Consistent with current practice, where necessary, HRSA provides increased support and technical assistance to improve centers' compliance with governance requirements.

Issue: Grandfathering of Section 330(h) Health Centers with Current Waivers

Comments

Three commenters stated that many of the governance requirements including the waiver policy should not apply to section 330(h) funded health centers. Commenters further stated that HRSA did not appear to have considered the structures of section 330(h) health centers that are part of much larger homeless assistance organizations that have highly effective boards that are not consistent with the PIN's requirements. Commenters suggested that section 330(h) health centers should be exempt from board size, patient majority, employee board member prohibition, non-delegable duties, and monthly meeting requirements, as well as not be subject to the showing of good cause for the obtainment of a waiver. Commenters further suggested that these organizations be grandfathered in so that any possible service disruptions may be avoided.

HRSA Response

HRSA recognizes the concerns raised in these comments. This was partially addressed through the implementation of the Progressive Action policy and process in 2010. As described in PAL 2010-01 “Enhancements to Support Health Center Program Requirements Monitoring,” 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. HRSA will provide ongoing support and technical assistance to those health centers encountering obstacles to compliance with applicable governing board requirements.

Issue: “Clear and Compelling” Evidence of Inability to Comply with Board Composition Requirements

Comments

One commenter sought further clarification and examples on what constitutes “clear and compelling” evidence of an inability to meet board composition requirements.

HRSA Response

Due to the varying circumstances across health centers and the fact-specific nature of such assessments, HRSA will apply the “clear and compelling” standard based upon all of the specific facts associated with the individual situation. Because of this, HRSA does not believe it would be helpful to provide examples within this document. Health centers that are concerned about their ability to comply with the policies outlined in the PIN should contact their project officer.

Issue: Allowance of Monthly Board Meeting Waivers under Certain Conditions

Comments

Seven commenters expressed dissatisfaction over the proposed PIN’s elimination of waivers of monthly meetings policy. Commenters stated that disallowing the waiver of monthly meetings for health centers who need it, especially migrant health centers, will increase absenteeism and make governing board actions more difficult due to a frequent lack of quorum. Commenters also stated that barriers exist beyond those that technology may solve. Commenters requested that HRSA consider both grandfathering existing monthly meeting waivers and allowing less frequent than monthly meetings where the grantee can show that section 330 statutory intent and other requirements are met.

HRSA Response

HRSA recognizes the concerns of commenters. Monthly meetings have been a statutory requirement of health centers since the program received its own separate legislative authority in 1975 and, as such, are a key tenet to health center governance. In the PIN, HRSA has clarified expectations for community advisory councils (as opposed to governing boards) and included language on the monthly meeting

exemption in 42 CFR 56.304(d)(2) for health centers funded/designated solely under 330(g) during non-harvesting months. HRSA will provide ongoing support and technical assistance to those health centers encountering obstacles to compliance with the monthly board meeting requirement.

Issue: Shorter Timeframe for Governance Waivers

Comments

Eight commenters requested a standard waiver period that would be significantly shorter than the project period, e.g., one to two years. Commenters stated that such a shortened timeframe would encourage health centers to continually strive for compliance with all section 330 governance requirements.

HRSA Response

Though HRSA recognizes the concern expressed by the commenters, the waiver period is aligned with the project period by statute. In addition, HRSA has amended the language around alternative mechanisms to address the concern that health centers should continually strive for full compliance with governance requirements.

Issue: Clarify and Add to Definition of “Good Cause”

Comments

Two commenters requested further clarification on what constitutes “undue hardship and significant barriers” when demonstrating good cause for a waiver request, as well as who makes the decision as to whether an applicant has met the criteria. One commenter also stated that the example in Section V(C)(1) for a sparsely populated area was unclear, asking how this would affect the patient majority requirement given the technological advances discussed in Section V(A). This commenter suggested that HRSA add a requirement to either include a plan to overcome barriers preventing a patient majority board by the next Service Area Competition (SAC) application or discuss why it would be unable to overcome these barriers by that time.

HRSA Response

The unique circumstances of each health center make a specific definition of “undue hardship and significant barriers” difficult to standardize. HRSA will continue to address what constitutes evidence of “undue hardship and significant barriers” upon reviewing the specific facts associated with the individual health center’s situation.

Issue: Stronger Application Requirements and Enforcement of Majority Waiver

Comments

Eleven commenters stated that HRSA needs to evaluate the effectiveness of alternative mechanism plans, as well as ensure that board composition meets section 330 requirements. Commenters suggested that HRSA require patient majority waiver

applicants to submit letters of support from leading providers for the special populations served to support the alternative mechanism plan and substantiate claims of difficulty in meeting board composition requirements. Commenters further suggested that HRSA require evidence of efforts to create effective patient advisory boards as part of a health center's budget period renewal (BPR), instead of or in addition to evidence of the inability to establish a patient majority governing board.

HRSA Response

HRSA recognizes the concerns expressed by these commenters and will monitor alternative mechanism effectiveness and board composition compliance through subsequent evaluations by HRSA staff.

Issue: Preference for Patient Advisory Board as Alternative Mechanism

Comments

One commenter suggested that HRSA explicitly state a strong preference for the creation and maintenance of a patient advisory board as the alternative mechanism, particularly for section 330(h) grantees.

HRSA Response

HRSA recognizes the concern expressed in the comment and acknowledges that, in general, the most desirable alternative mechanism may be a patient advisory board or substantial involvement (short of a majority) of special population patient board members on the health center's board of directors. However, the unique circumstances of individual health centers may result in the use of other forms of alternative mechanisms.

Issue: Clarify When Waiver Requests May Be Submitted

Comments

One commenter requested further clarification in Section V(D) as to when waiver requests may be submitted, asking whether it was possible to submit a request during years of non-competing (BPR) renewals for the remainder of the project period, e.g., between years two and three of a five year project period.

HRSA Response

In response to this comment, HRSA has added clarifying language to Section V(D) regarding when and how a health center may request a new waiver during a project period.

Issue: Relax Section 330 Governance Requirements on Subrecipients

Comments

Nine commenters stated that subrecipients should not be unduly burdened by section 330 requirements, because this consequently discouraged organizations from “contracting” with health centers that need their services, adding that section 330 funds typically make up a small percentage of subrecipients’ operating budgets. Commenters suggested providing subrecipients with the option of waiving section 330 requirements where grant funds constitute a small portion of the subrecipient’s operating budget.

HRSA Response

The PIN acknowledges that health centers may enter into various types of arrangements with other organizations that involve the use of grant funds. The PIN clarifies that these relationships include both procurement contracts for goods and/or services and subrecipient arrangements. Deciding on the type of relationship to be established requires appropriate governing board/management review and oversight by the health center directly receiving the section 330 grant. Unlike contractors, subrecipients must comply with all section 330 program requirements, and as such are eligible for Federally Qualified Health Center benefits. HRSA will not make exceptions to statutory or regulatory language.

Issue: Provide Standard Timeline

Comments

Three commenters stated that the project period timeline places an unequal burden on health centers, as many health centers may have less time to comply with the PIN due to their project periods ending sooner than others. Commenters suggested that HRSA use a different timeline, such as two years.

HRSA Response

This concern was partially addressed through the implementation of the Progressive Action policy in process in 2010. As described in PAL 2010-01 “Enhancements to Support Health Center Program Requirements Monitoring,” 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. In response to this comment, HRSA has revised the language in Section VII to reflect current Health Center Program oversight processes. With sufficient documentation, HRSA may allow existing health centers with complex scenarios up to 2 years to come into compliance with these governance requirements, consistent with its statutory authority.