

The BPHC Newly Funded TA Web Guide Resources for New and Existing Grantees

Developed by:

The U.S. Department of Health and Human Services (HHS)
Health Resources and Services Administration (HRSA)
Bureau of Primary Health Care (BPHC)
Office of National Assistance and Special Populations (ONASP)

The BPHC Newly Funded TA Web Guide is a self assessment tool designed to help new BPHC grantees provide high-quality primary health care from the day they open their doors for business. The Guide is a central hub for links to HRSA-approved templates, information pages, policy documents, and many other resources. The intent of the Web Guide is to help Health Center grantees improve their quality and efficiency, work within Health Center Program Requirements, and access Federal policies, programs and resources intended for the specific needs of Health Centers.

This document is a printable version of all of the content available on the Web Guide. It was developed by the BPHC's ONASP and is hosted at: <http://bphc.hrsa.gov/technicalassistance/newguide/index.html>

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Introduction

Welcome to the BPHC Newly Funded TA Web Guide!

Purpose: This site is designed to assist new and existing Health Center Grantees in their efforts to establish and promote an organizational culture that is committed to continuous performance improvement and the delivery of high quality, effective and safe patient care.

The Web Guide contains resources:

- To help grantees achieve full implementation and compliance with Health Center program requirements.
- To access many Federal programs and resources intended to benefit and support health center best practices.
- On suggested program practices
- Printable questions to assist with self-assessments.
- Dozens of links to sample documents, information pages, and policy information.

While the Web Guide was built primarily with Newly Funded Health Centers in mind, much of the content may be beneficial to existing grantees and [Look-Alikes](#) as well. To begin, please click on any of the headers listed below that may be of interest to you.

Web Guide Content and Structure: Below is a listing of Health Center-related topics, covering federal programs of special interest to Health Centers such as [340B drug pricing](#) and the [Federal Tort Claims Act](#), as well as pages for each of the 19 [Health Center Program Requirements](#).

The Web Guide site contains portions of the [Health Center Site Visit Guide](#), adapted for grantee use. The Health Center Site Visit Guide is utilized by HRSA staff and consultants conducting site visits to:

- Verify that health centers are in compliance with statutory and regulatory requirements of section 330 of the Public Health Act
- Identify clinical, financial and other priority performance improvement areas (e.g. Electronic Health Records adoption, Patient Centered Medical Home recognition, etc.)

Your most recent Section 330 grant application and Notice of Award (NoA) are the documents that define the Scope of Work you have agreed to carry out as a BPHC grantee. It will be very helpful to have these documents on-hand as you review the Web Guide, especially in answering the questions found throughout the guide. The EHB [user guide](#) to New Access Point grantees is also a good reference for helping new and existing grantees navigate the electronic system for official submissions to HRSA. Specific EHB reference materials and assistance are available to help new and existing grantees navigate the electronic system to submit official submissions to HRSA by contacting the BPHC Helpline bphchelp@hrsa.gov or 877-974-2742.

Regarding Non-Federal Technical Assistance Resources: BPHC hosts an online [Samples and Templates Resource Center](#) that contains many valuable templates and documents. **All non-Federal resources cited in the Web Guide are meant to be used only as “sample” documents. They are for use as aids to consultants and grantees, but are not considered official guidance by BPHC.** The contents of such

documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.

Regarding Key Questions: Within this resource there are over 30 sets of questions derived from the Health Center Site Visit Guide for each of the 19 Health Center Program Requirements. These questions are commonly used by BPHC personnel and consultants to assess grantee compliance with program requirements and to identify areas for performance improvement activities. Grantees may find it beneficial to work with the questions and/or checklists on their own, or in conjunction with a site visit. **Web Guide questions are intended as self-assessment tools. They do not assure complete conformity to program rules. Such assessments are determined through an iterative process with Project Officers, annual continuation applications, performance reports, site visits with specialized consultants, and other programmatic resources.**

Policies related to the Health Center Program are communicated to grantees through Policy Information Notices (PINs) and Program Assistance Letters (PALs):

- PINs define and clarify policies and procedures that grantees funded under Section 330 must follow.
- PALs summarize and explain items of significance for health centers, including for example, HRSA program implementation activities, recently enacted laws, final regulations, and/or new HHS initiatives.

Weekly Primary Health Care Digest:

For your convenience, BPHC has created the Primary Health Care Digest that provides information on upcoming funding opportunities, training (T) and technical assistance (TA) sessions, and useful information from Federal and non-Federal resources. Please contact your Project Officer if you do not receive it. Also recommend keeping your EHB contact up to date, or you could sign up via the widget on the BPHC home page.

We hope you find the Newly Funded TA Web Guide and the weekly Primary Health Care Digest useful resource tools as we work together to improve the health of the Nation's underserved communities and vulnerable populations.

1. Getting Started

1a. Your Notice of Award and First Steps

This section covers the information found in your Notice of Award, highlighting important information that you will need to refer to periodically.

Contact Your Federal Project Officer and introduce yourself (listed on your NoA). Your Project Officer (PO) is your primary point of contact for programmatic issues such as: health center program requirements, performance improvement, technical assistance needs, and other services and responsibilities directly related to the Health Center Program.

- Confirm the timing of your Federal funding (Project and Budget Period start dates/end dates).
- Confirm when the next Federal grant application is due, and whether it is competitive or a progress report (Service Area Competition (SAC) vs. Budget Period Progress Report (BPR)).
- Discuss program and grant conditions that are listed in your NoA.

Set up times to communicate with your Project Officer periodically, e.g., monthly, quarterly, to keep each other posted on developments (Note that your Project Officer will also contact you soon after you have received your NoA and will also want to set up periodic calls). Grantees should also contact Project Officers whenever they have questions and/or wish to talk through possible changes/adjustments in plans, staffing, etc. that were described in the approved application.

Contact Your Grants Management Specialist to introduce yourself (listed on your NoA-note that your Grants Management Specialist may also participate on the introductory call your Project Officer sets up soon after you have received your NoA). Your Grants Management specialist is your point for contact for matters related to administrative management of your grant, such as drawdown of funding, Federal payment management systems, and regular financial reporting.

Confirm details and conditions noted on your NoA, or requests that involve significant changes to the budget that was approved as part of the most recent grant, if necessary.

Review HRSA's Grants Management Workshop Presentation Materials (October 2010) that cover management of your grant, reporting requirements, Electronic Handbook overview, terms and conditions and other aspects of HHS/HRSA grants management, found [the Manage your Grant](#) website.

Enroll in the HHS Payment Management System. Payment of grants to grantees occurs through the [HHS PMS](#), a fully automated and full service centralized grants payment and cash management system. If you have not done so already, contact your Grants Management Specialist (GMS), listed on your NoA, to begin setting up your PMS account.

Locate your organization's important documents prior to talking to your project officer, including:

- Bylaws
- Articles of Incorporation
- Most recent NoA
- Most recent health center grant application
- Most recent strategic plan
- Most recent financials

Official Points of Contact in Grants.Gov and EHB. Send a letter or email to the Federal project officer and to the grants management specialist requesting an official change of contact in Grants.gov for any grants you have from the Federal government. This includes setting permissions for staff to register to work on specific grant functions. You will need prior approval from your project officer to change your profile as an Authorizing Organization Representative (AOR). Pay particular attention to maintaining current contact information in EHB for your organization. In addition, please make sure you have at least one other individual in your organization registered in EHB who can access and submit documents as needed if the Authorizing Official is not able to/absent. Please contact [System Award Management](#) once awarded to make changes such as organizational name and address changes that are to be reflected in EHB. For more information on EHB, please contact the BPHC Help Line at bphchelpline@hrsa.gov or 1-877-974-BPHC Monday through Friday (except Federal holidays) 8:30 AM to 5:30 PM (ET).

Review financials, ensuring that you are on schedule to draw down and obligate Federal funding, as approved, prior to the conclusion of the grant period. Federal funding should not sit in an interest-bearing account for more than 72 hours. Please refer to [45 CFR Part 74.22](#) and/ or consult your Grants Management Specialist for additional information.

For a useful guide to HRSA-related terminology, go to [Health Center Program Terms and Definitions](#).

Contact other key people in your State for introductions and background.

Contact your State Primary Care Office (PCO) responsible for shortage designations. Some States also have recruitment assistance (including J1 Visa Waivers) and State primary care grant resources. PCOs are listed the [HRSA Primary Care Health Center Program](#).

Contact your State's Primary Care Association (PCA). State/Regional PCAs are private, non-profit organizations that provide training and technical assistance to health centers and other safety-net providers, support the development of health centers in their State, and enhance the operations and performance of health centers. Your PCA can offer assistance with understanding and implementing Health Center Program requirements such as governance, grants management, clinical or quality improvement support, training or orientation of new staff, and answering general questions. You could find the contact information for the PCAs at [The National Association of Community Health Centers](#).

Consider asking your PCA about mentoring opportunities with other health centers in your State or region.

1b. Medicare/Medicaid/Other Payment

This section provides a brief overview of the steps needed to enable your health center to be reimbursed by Medicare and Medicaid under the FQHC payment system. Detailed information on this topic is available in [PAL 2011-04](#), “Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit.”

Medicare and Medicaid’s Reimbursement System for FQHCs: Both Medicare and Medicaid have payment systems that are unique to Federally Qualified Health Centers (FQHCs). These systems are designed to reflect the relatively higher intensity of health center patients and the broader range of services that health centers provide. Payment is made on a per-visit basis, meaning that FQHCs receive a standardized, predetermined amount for each visit, regardless of which services were actually provided.

Note that being approved for a health center grant through Section 330 or receiving a designation as a Look-Alike is not sufficient for a health center to be reimbursed under the FQHC payment system. Rather, a health center must apply to be enrolled in each program as an FQHC, and this application must be approved, before payment under the FQHC system begins. Under Medicare (and many State Medicaid programs,) payment as an FQHC is not retroactive to services provided prior to the date the application was approved. For these services, health centers may bill Medicare under the name of individual providers, and will be reimbursed based on traditional payment systems (e.g., the physician fee schedule under Medicare.)

Enrolling and Billing Under Medicare

We recommend beginning the process of enrolling in Medicare and Medicaid as soon as possible. In general, it is advisable to apply for your Medicare number first, as many states require this before processing your Medicaid application. For more information, contact your state [Medicaid office](#).

How to prepare and submit a Medicare Enrollment Application: For information on how to prepare and where to submit a Medicare enrollment application, see [PAL 2011-04](#), “Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit.”

Importance of prompt submission of Medicare enrollment application: Given that reimbursement under the Medicare FQHC system does not begin until the date the enrollment application is approved, health centers are strongly advised to submit this application as soon as possible and to remain in regular contact with the Medicare contractor about how the review process is progressing. Medicare regulations state that health centers must be operational on the date that they submit the enrollment application. Therefore, health centers are strongly encouraged to have the application ready for submission on the first day the site becomes operational.

Each permanent and seasonal site must be enrolled individually: Medicare considers each permanent and seasonal health center site to be a unique FQHC. Therefore, each site must enroll individually and receive a unique Medicare Billing Number.

Billing under the FQHC per-visit payment system: Once it has been approved as a FQHC, a health center submits claims to its Medicare contractor using CMS Form UB-04, which must be submitted electronically.

How Medicare per-visit payment rates are set: Initially a FQHC will be assigned an “interim per visit rate” by its Medicare contractor, based on an estimate of its costs for caring for Medicare patients. At the end of the first fiscal year, the FQHC files a “Medicare Cost Report” which reports its actual costs. The Medicare contractor reviews this report and determines a per visit rate. It then adjusts this rate downward if it determines that the individual providers did not meet productivity standards, and/or if the rate exceeds the Upper Payment Limits established by CMS. The Medicare contractor then determines the total amount due based on this final rate, and compares it to the amount actually paid. If the amount paid was less than the amount owed, the Medicare contractor pays the difference to the FQHC; if the amount due is less than the amount already paid, then the FQHC must repay the Medicare contractor. Therefore, new FQHCs are encouraged to closely monitor their costs versus per visit rates throughout their first year, as they could either owe or receive a potentially large amounts based on this adjustment.

Once the first cost report is submitted and accepted, the rate determined based on that report will be used in the following year, with another adjustment being made (if necessary) after the year is over.

Reimbursement for Medicare Advantage (Managed Care) Patients: FQHCs are guaranteed to receive their full per-visit rate for their Medicare patients who participate in managed care plans. In these situations, the FQHC negotiates payment rates directly with the Managed Care Organization (MCO), and receives reimbursement directly from the MCO. The FQHC must then bill Medicare for the difference between what the MCO paid and what how much they would have received under the standard per-visit payment system. This amount is called the “wrap-around” payment, and Medicare contractors are required to make these payments not less often than every 3 months.

Enrolling and Billing Under Medicaid

Enrolling in Medicaid: Each State Medicaid program establishes its own policies about how health centers are to enroll, and when reimbursement under the FQHC system begins. For example, many States require a health center to be approved by Medicare as an FQHC before it can apply to Medicaid. Also, some States make payments under the FQHC system retroactive to the date the health center applied or became operational, while others make no retroactive adjustments. To determine the policies in your State, contact your [State Medicaid Office](#) or [Primary Care Association](#).

Billing under the Medicaid FQHC per-visit payment system: Each State determines how FQHCs are to bill Medicaid. To determine the practices in your State, contact your State Medicaid office or Primary Care Association.

How Medicaid payment rates are set: In most States, the per-visit payment rates made to FQHCs under Medicaid are referred to as “Prospective Payment System” (PPS) rates. For a new FQHC, the base rate is set by the Medicaid office, based on the FQHC’s first year costs, the rates in effect for similar FQHCs in the area, or a combination of both. In future years, this base rate is increased annually using CMS’s estimate of health care inflation. It is very important that new FQHCs ensure that the initial PPS rates

are set appropriately, as once they are established it is very difficult to change them, other than by the annual inflation update.

State Medicaid programs have the option of using an Alternative Payment Mechanism (APM) instead of a PPS. For an APM to be permissible, it must, 1. Result in total payments at least as high as under the PPS, and 2. Be approved by the health center. Again, it is important that health centers closely study a proposed APM system before accepting it.

Reimbursement for patients in managed care: Similar to Medicare, FQHCs are guaranteed to receive their full per-visit rate for their Medicaid patients who participate in managed care plans. As with Medicare, the FQHC negotiates payment rates directly with the Managed Care Organization (MCO) and the FQHC bills Medicaid for the difference between what the MCO paid and how much it would have received under the standard per-visit payment system. State Medicaid programs are required to issue these “wrap-around payments” at least once every four months.

For additional information about Medicare and Medicaid, see the [CMS FQHC](#) website. This site includes additional links to policies, billing/payment, enrollment/recertification, listserv signup, coding, coverage, manuals and a range of other resources.

Affordable Care Act: Enrolling as a participating provider with commercial and managed care payers active in the area. Under the Affordable Care Act, uninsured people will be able to purchase health insurance cover beginning in January 2014 through state insurance exchanges. The insurance will be sold be managed care plans known as Qualified Health Plans. These plans have sought to contract with health centers, as health centers fulfill one category of Essential Community Providers requirements that are needed by MCOs to demonstrate adequate provider networks to serve newly insured patients. It is critical that your health center be in touch with QHPs and the state Primary Care Association to understand the state marketplace and your strategic position. Look at [The Affordable Care Act and HRSA Program](#) for additional information.

The Affordable Care Act (ACA) enrollment activities are scheduled to begin October 1, 2013. BPHC’s Office of National Assistance and Special Population, has worked with grantees and other federal partners to develop outreach, enrollment and retention strategies which focuses on enrolling and retaining current center users and outreach strategies to enroll other community members. Please look at the following webcast Grantee Enrichment Session: [Health Insurance Marketplace and Medicaid Expansion Outreach & Enrollment in Health Centers Part 1.](#)

You could find information about the ACA and Health Centers in the following [health center fact sheet](#). In addition, you can contact your State Primary Care Association (PCA) for additional ACA information and assistance. PCAs collaborate with grantees in their states to:

- Ensure that health centers have timely and necessary information about their state’s consumer assistance training requirements and rollout of new affordable insurance options;
- Coordinate health center outreach and enrollment activities with other consumer assistance efforts in the state;
- Provide technical assistance and training on effective health center outreach and enrollment strategies; and
- Monitor successes and barriers to health center outreach and enrollment activities.

Health centers should develop a list of the largest commercial insurance providers in their community, and request enrollment applications from them as soon as possible. To find a list of payers, go to the National Association of Insurance Commissioners web site and click on [your State](#).

Each private insurer – including each MCO operating under either Medicare or Medicaid – will have its own enrollment forms and requirements. New health centers are encouraged to obtain and submit these applications as soon as possible.

Insurance, Fees and Billing

Contact Your State Compensation Insurance Commission for worker’s compensation fee schedule and forms. The US Department of Labor has many resources on this topic. Information on worker’s compensation can be found by selecting your State at the United States Department of Labor [Division of Federal Employees' Compensation](#) website.

Develop a Fee Schedule. It is important to determine reasonable costs or the locally prevailing charges for all services in your approved scope of project (e.g. primary care, dental, mental health, substance abuse, etc.). Your financial advisor, PCA, or NACHC may be able to provide TA. Medicare / Medicaid charges are publicly available information to help you get started in developing your listing of fees for all office visits, procedures, and services. Medicare schedules are found at the [Center for Medicare & Medicaid Services](#) website. The schedule of fees is also the first step in developing the corresponding schedule of discounts (sliding fee discount schedule/sliding fee scale) that must be applied to all services in the approved scope of project for eligible patients (see [Program Requirement 7](#) for more information on Sliding Fee requirements).

Develop Accounts Receivable systems and policies. This should be part of a larger Financial Policies and Procedures Manual. The National Association of Community Health Centers ([NACHC](#)) and/or your [PCA](#) may have additional TA resources on this topic. Order CPT, HCPCS, ICD-9/10 and other coding manuals if you are doing your own billing.

Complete the EHB Scope Verification Module. Grantees are allowed up to 120 days following the date of the Notice of Award (NoA) indicating approval for the change in scope to implement the change (e.g. open the site or begin providing a new service) ...” The foundation for this policy is the Bureau of Primary Health Care’s (BPHC) expectation for the timely implementation of change in scope requests (CIS) and/or scope changes occurring via approved applications to add a new service or a new service site. Timely implementation is defined as fully implementing approved scope changes within 120 days from the date of the Notice of Award approving the change. Grantees must **verify** implementation of these changes within EHB). See [PAL 2009-11](#) for more information.

1c. 340B Drug Pricing

What is the 340B Drug Pricing Program?

The 340B Drug Pricing Program is administered by HRSA's Office of Pharmacy Affairs (OPA). The 340B Program limits the cost of covered outpatient drugs to certain Federal grantees, including section 330-funded health centers. Participation in the Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce Federal resources, reaching more eligible patients and providing more comprehensive services.

Related Legislation

The [340B Drug Pricing Program](#) resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act.

How to Enroll

To enroll in the 340B program, health centers must submit the appropriate registration form to the HRSA Office of Pharmacy Affairs. Registration forms are located on the [340B database](#).

340B Prime Vendor Program

In addition to the cost savings available through the 340B Program, the 340B Prime Vendor Program (PVP) provides additional savings to 340B participants registered with the Prime Vendor. The PVP provides drug distribution and price negotiation services for covered entities, and has been able to negotiate additional discounts below the 340B price for more than 2,800 brand name and generic drugs. The PVP is free to all 340B covered entities, but the covered entity must enroll in the PVP. For more information, call 1-888-340-2787 or visit the [PVP website](#). Please note that the NoA contains the following term regarding grantee responsibility on this topic: "If your organization purchases or reimburses for outpatient drugs, an assessment must be made to determine whether the organization drug acquisition practices meet Federal requirements regarding cost-effectiveness and reasonableness (See 42 CFR Part 50, Subpart E, and OMB Circulars [A-122](#) and [A-87](#) regarding cost principles). If your organization is eligible to be a covered entity under Section 340B of the Public Health Service Act and the assessment shows that participating in the 340B Drug Pricing Program and its Prime Vendor Program is the most economical and reasonable manner of purchasing or reimbursing for covered outpatient drugs (as defined in section 340B), failure to participate may result in a negative audit finding, cost disallowance or grant funding offset."

Links and Additional Resources

HRSA Office of Pharmacy Affairs [340B Program Website](#).

340B Prime Vendor: email: ApexusAnswers@340Bpvp.com. Phone: 1-888-340-2787. Live chat at: [340B Prime Vendor Program](#) (8:30am – 6:30pm ET, M-F)

**Note: All non-Federal documents are for use as aids to consultants and grantees, the contents of such documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA, and should not be considered official guidance by BPHC. Any "sample" documents must be tailored to the health center's unique circumstances and needs.*

1d. Federal Tort Claims Act

What is the Federal Tort Claims Act (FTCA)?

The Federally Supported Health Centers Assistance Act of 1992 and 1995 granted medical malpractice liability protection through the Federal Tort Claims Act (FTCA) to HRSA-supported health centers. Under the Act, health centers are considered Federal employees and are immune from lawsuits, with the Federal government acting as their primary insurer.

Overview

Since its enactment in 1946, the Federal Tort Claims Act (FTCA) has been the legal mechanism for compensating people who have suffered personal injury by the negligent or wrongful action of employees of the U.S. government. Under Section 224 of the Public Health Service Act, as amended by the Federally Supported Health Centers Assistance Act of 1992 and 1995, employees of eligible health centers may be deemed to be Federal Employees qualified for protection under the FTCA. Eligible health centers must submit an original deeming and annual renewal deeming application to BPHC. FTCA coverage is not assured from year to year. Each year, health centers are approved after they demonstrate that they meet all the requirements of the FTCA program.

There is no cost to participating health centers or their providers, and they are not liable for any settlements or judgments that are made. The Federal Government assumes responsibility for these costs. Covered individuals (i.e., governing board members, officers, employees, and certain individual contractors) are considered Federal Employees immune from suit for covered activities. Covered activities are acts or omissions in the performance of medical, surgical, dental, or related functions resulting in personal injury, including death, and occurring within the scope of employment. More specifically, covered activities include those activities that:

- Are approved within each covered individual's scope of employment (this term includes activities within an applicable individual contract for services with the health center);
- Are within the scope of the approved Federal section 330 grant project of the deemed health center; and
- Take place during the provision of services to health center patients and, in certain circumstances, to non-health center patients.

A patient who alleges acts of medical malpractice by a deemed health center, for covered activities, cannot sue the center or the provider directly, but must file an administrative claim with the appropriate agency of the Federal government before filing suit. Additionally, FTCA litigation must be filed in Federal district court.

These claims are reviewed and/or litigated by the U.S. Department of Health and Human Services, Office of the General Counsel and the Department of Justice according to FTCA requirements. HRSA pays for all settlements and judgments from a separately appropriated Health Center FTCA Judgment Fund. To learn how your Health Center can become deemed under FTCA, go to the HRSA [Health Center Application Process](#) website.

Related Legislation, Regulations, and Policies

Congress enacted FTCA medical malpractice protection for Federally-supported health centers through the Federally Supported Health Centers Assistance Act (FSHCAA) of 1992 (P.L. 102-501) and FHSCAA of 1995 (P.L. 104-73), later codified as 42 U.S.C. Section 233 (a) – (n).

HRSA/BPHC has issued numerous Program Information Notices (PINs) and Program Assistance Letters (PALs) related to the Health Center FTCA Program. In 2011, [PIN 2011-01](#), the FTCA Health Center Policy Manual was released. The Manual is the primary source for information on the FTCA for the Health Center Program grantees and related stakeholders. It consolidates all of the major FTCA PINs and PALs into one document.

Links and Additional Resources:

FTCA Program [Home Page](#).

FTCA [Overview Presentation](#).

FTCA [Deeming Module User Guide](#).

FTCA [Policies](#).

For more information, please contact the Bureau of Primary Health Care Help Line at 1-877-974-BPHC or bphchelp@hrsa.gov.

1e. National Health Service Corps

What is the National Health Service Corps?

The [National Health Service Corps](#) (NHSC), through scholarship and loan repayment programs, helps [Health Professional Shortage Areas](#) (HPSAs) in the United States get the medical, dental, and mental health providers they need. Since 1972, more than 30,000 clinicians have served in the Corps, expanding access to health care services and improving the health of people who live in urban and rural areas where health care is scarce. About half of all NHSC clinicians work in HRSA-supported Health Centers, delivering preventive and primary care services to patients regardless of their ability to pay. Health Centers automatically qualify as NHSC sites. See the [NHSC Service Site Reference Guide](#) for more information.

Full- and Half-Time NHSC Opportunities

The NHSC offers both full- and half-time positions. Qualifying providers can search for all NHSC job opportunities [NHSC Jobs Center](#). The Affordable Care Act contains provisions allowing current providers to convert from full-time to half-time. More information on this opportunity is found at the [NHSC Loan Repayment](#) section.

Scholarship

The [NHSC Scholarship](#) is a competitive program that pays tuition, fees and provides a living stipend to students enrolled in accredited medical (MD or DO), dental, nurse practitioner, certified nurse midwife, and physician assistant training. Upon graduation, scholarship recipients serve as primary care providers between 2 and 4 years in a community-based site in a high-need HPSA that has applied to and been approved by the NHSC as a service site.

Awards are made to applicants most committed to serving underserved people and most likely to build successful careers in HPSAs and meet future needs for care throughout the Nation.

Loan Repayment

The NHSC [Loan Repayment Program](#) offers fully trained primary care physicians (MD or DO), family nurse practitioners, certified nurse midwives, physician assistants, dentists, dental hygienists, and certain mental health clinicians \$60,000 to repay student loans in exchange for 2 years serving in a community-based site in a high-need HPSA that has applied to and been approved by the NHSC as a service site. After completing their 2 years of service, loan repayors may apply for additional years of support.

The loan repayment program recruits both clinicians just completing training and seasoned professionals to meet the immediate need for care throughout the Nation.

Links and Additional Resources:

NHSC [Home Page](#).

NHSC [Loan Repayment Information](#).

[NHSC and Indian Health Service \(IHS\) Collaborative Program](#)

1f. Health Information Technology and Meaningful Use

What is Health Information Technology?

Health IT is technology used to record, store, protect, retrieve, and transfer clinical, administrative, and financial information electronically within health care settings. Health IT is a tool by which clinicians and others can improve population health and the quality and efficiency of patient care.

Why Implement Health IT?

Recent research demonstrates that increased use of information technology is an important step in improving quality of care and patient safety. The recent focus on health IT adoption was initiated by the Institute of Medicine (IOM) report in 1999, [To Err is Human: Building a Safer Health System](#), which highlighted improved use of computerized applications as a core strategy for improving safety and quality of the health care system.

The use of health IT to improve quality of care and patient safety has received substantial support from Federal agencies. The [Agency for Health Research and Quality \(AHRQ\)](#) funded the [National Resource Center for Health IT \(NRC\)](#) in 2004 and approximately \$166 million in health IT projects throughout the United States. HRSA has supported the adoption of health IT by health centers, other safety net providers and ambulatory care providers since the 1980s through various grant programs ranging from operational funding to funding [Health Center-Controlled Networks \(HCCNs\)](#) to improve quality through health IT.

What is HRSA's Vision for Health IT?

HRSA's vision is to leverage the power of health IT to improve patient outcomes, quality, and reduce health disparities for people who are uninsured, isolated, or medically vulnerable. As part of its mission, HRSA aims to provide health centers, other safety net providers, and ambulatory care providers with tools to successfully implement health IT in a manner appropriate for their care settings and their patients' needs and abilities. The [Health IT Toolbox](#) Series is a central component of this effort. In addition HRSA has begun to tie the use of health IT to other quality improvement initiatives and models. The [HCCN grant program](#), for example, has goals related to improving quality through achieving [Healthy People 2020](#) goals and through recognition of health centers as Patient-Centered Medical Homes (PCMHs).

Financial incentives are available for the “meaningful use” of Electronic Health Records (EHRs)

The American Recovery and Reinvestment Act (ARRA) made [financial incentives](#) available to eligible professionals and hospitals for “Meaningful Use” of Electronic Health Records (EHRs): ARRA created financial incentives to encourage health care providers to adopt and use EHRs. The term “meaningful use” is often used to refer to the EHR Incentive Program from the Centers for Medicare & Medicaid Services (CMS) and to the incentive payments, as a provider must use the Health IT in a “meaningful” way (e.g., for e-prescribing) in order to be eligible for the payments.

Incentive payments are made to individual providers; rather than to the health centers: The [ARRA](#) statute requires that incentive payments must be made to eligible professionals, i.e., to *individual* providers, rather than to the health center itself. This is the case even if the EHR-related expenses that resulted in the incentive payments were paid by the health center. Providers may choose to give their

incentive payments to their health center, through a process known as “assignment.” However, providers are **not** required to assign their payments. Also, providers may use the payments for any purpose (professional or personal) they choose.

Health Center providers are likely to apply for EHR incentive payments through Medicaid: While both Medicare and Medicaid offer incentive payments to eligible providers to use EHRs, all providers must choose to receive payments from only one of these programs. Because of the way they are reimbursed and the patient population typically served by health centers, health center providers are likely to apply for payments through Medicaid.

To apply for the Medicaid EHR Incentive Program, contact your State Medicaid agency. The policies and timelines for applying vary by State.

To qualify for Meaningful Use EHR Incentive Program payments, eligible professionals must use certified EHR technology. Working with CMS, the [Office of the National Coordinator for Health IT \(ONC\)](#) has established standards for certifying EHRs. To receive incentive payments, eligible professionals must use an [EHR that is certified](#) specifically for the EHR Incentive Program.

Links and Additional Resources:

[HRSA Health IT and Quality Website](#): Tools for Improving Quality.

HRSA Health IT Adoption [Toolbox](#)

HRSA Health IT and [Quality Resource Toolbox](#)

HRSA Health IT for [Children’s Health Toolbox](#).

[Rural Health](#) IT Adoption Toolbox.

HRSA Health IT and Quality [Webinar Archives](#).

Patient Centered Medical Home: [HRSA Patient-Centered Medical/Health Home Initiative](#)

HRSA Information Session on [Many Paths to PCMH](#). This is a TA session held back in May of 2012

[AHRQ Report](#) on Ensuring That Patient-Centered Medical Homes Effectively Serve Patients With Complex Health Needs.

[AHRQ Report](#) on Coordinating Care in the medical Neighborhood: Critical Components and Available Mechanism.

[AHRQ PCMH Resource Center](#)

Centers for Medicare & Medicaid Services [EHR Incentive Programs](#).

HRSA: Medicare and Medicaid EHR Incentive Programs FQHCs’ [FAQs](#).

HHS Office of the National Coordinator for Health Information Technology

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2. Need

2a. Program Requirement 1: Needs Assessment

Requirement: Health center has a documented assessment of the needs of its target population, and has updated its service area if/when appropriate.

Authority: Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)

Documents/Resources to Review: 1) Most recent Needs Assessment(s); 2) Service Area Map.

Links and Additional Resources:

Your grant application’s [Form 1A](#): “General Information Worksheet” contains information on your proposed target population. This link is for reference purposes only.

BPHC Health Center [Need Policy Page](#).

[Data Resources for Demonstrating Need for Primary Care Services](#): A guide on how to find, extrapolate, and utilize data to make informed decisions and maintain a good understanding of community needs in your service area.

[The UDS Mapper](#): A useful tool for determining service areas, and assessing service area overlap, among other concerns. You will need to sign up for a free account.

HRSA [Geospatial Data Warehouse](#): Information and assistance about HRSA’s mapping features and the applications to assist you in creating a map of your neighborhood or potential service area.

As a self-assessment tool, please refer to the Program Requirement 1: Needs Assessment section, page11, of the [Health Center Site Visit Guide for HRSA Grantees](#).

3. Services

3a. Program Requirement 2: Required and Additional Services

This page contains information and checklists to help assess whether a grantee provides all of the required services directly or through written arrangements and referrals, as well as optional services as appropriate.

Requirement: Health center provides all required primary, preventive, and enabling health services (defined in section 330(b)(1)(A) of the PHS Act) and provide additional health services (defined in section 330(b)(2)) as appropriate and necessary, either directly or through established written arrangements and referrals. Note: Grantees that receive (section 330(h)) funding to serve homeless individuals and their families must provide substance abuse services among their required services.

Authority: Sections 330(a) and 330(h)(2) of the PHS Act

Documents/Resources to Review: 1) Clinical Practices and Operating Policies and Procedures, 2) Documentation of services provided via formal written agreements and/or via formal written referral arrangements. Review the status of required clinical and non-clinical services in [Form 5A](#) as submitted in the Newly Funded Health Center application. The services listed require verification within 120 days of award, as described in PIN 2009-11: New Scope Verification Process. Please see PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes for information and instructions regarding how to update required and additional services as part of the scope of project.

Links and Additional Resources:

BPHC Health Center [Services Policy Page](#).

The Samples and Templates Resource Center [Services Page*](#).

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As a self-assessment tool, please refer to the Program Requirement 2: Required and Additional Services section, page 12, of the [Health Center Site Visit Guide for HRSA Grantees](#).

3b. Program Requirement 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.

Authority: Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act

Questions based on review of the application and implementation status:

- Is the core staff, (those responsible for carrying out both clinical and enabling services) appropriate for serving the patient population?
- Are all staff appropriately credentialed and licensed?

Documents/Resources to Review: 1) Staffing Profile; 2) Contracts, Agreements, and Subrecipient Arrangements related to staffing (as applicable); 3) Credentialing and Privileging Policies and Procedures; 4) Personnel Manual; 5) Personnel Files Checklist/Matrix; 6) Position descriptions; 7) Staff evaluation forms; 8) Provider contracts; 9) Orientation guide for new staff; 10) Employee satisfaction surveys; 4) HRSA/BPHC Credentialing Policies ([Policy Information Notices 2002-22 and 2001-16](#)).

Links and Additional Resources:

Your grant application's [Form 2](#): "Proposed Staffing Profile" contains information on your proposed staffing plan. This link is for reference purposes only.

HRSA Policy Information Notice (PIN) [2002-22](#): Clarification of Bureau of Primary Health Care Credentialing & Privileging Policy Outlined in [PIN 01-16](#).

The Samples and Templates Resource Center [Policy Template*](#)

The Samples and Templates Resource Center's main page for [Personnel documents](#); See the documents,

- [Employee Handbook CHC*](#),
- Safety Net Dental Clinic Manual [Credentialing and Privileging](#) section*, and
- [Personnel Policies and Procedures*](#).

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As a self-assessment tool, please refer to the Program Requirement 3: Staffing section, page 17, of the [Health Center Site Visit Guide for HRSA Grantees](#).

3c. Program Requirement 4: Accessible Hours of Operation/Locations

Requirements:

- Health center provides services at **times** that assure accessibility and meet the needs of the population to be served.
- Health center provides services at **locations** that assure accessibility and meet the needs of the population to be served.

Authority: Section 330(k)(3)(A) of the PHS Act

Documents/Resources to review: 1) Hours of Operation, 2) Most recent EHB BHCMIIS [Form 5B](#): Service Sites [Note that the form lists only the TOTAL number of hours per week each site is open, not the specific schedule], 3) Service Area Map with site locations noted, 4) [HRSA/BPHC Scope of Project Policies](#).

Links and Additional Resources:

HRSA Health Center [Patient Satisfaction Survey](#).

The Samples and Template Resource Center [Services Page](#) *.

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As a self-assessment tool, please refer to the Program Requirement 4: Accessible Hours of Operation/locations section, page 21, of the [Health Center Site Visit Guide for HRSA Grantees](#).

3d. Program Requirement 5: After Hours Coverage

Requirements:

- Health center provides professional coverage during hours when the center is closed.

Authority: Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4)

Documents/Resources to review: Policy for after-hours coverage. 2) HRSA/BPHC Health Center Collaboration [Program Assistance Letter 2011-02](#).

Links and Additional Resources: Your [State PCA](#) may have more information on this topic. The Commonwealth Fund article: [After-Hours and its coordination with Primary Care](#)

As a self-assessment tool, please refer to the Program Requirement 5: After Hours Coverage section, page 22, of the [Health Center Site Visit Guide for HRSA Grantees](#).

3e. Program Requirement 6: Hospital Admitting Privileges and Continuum of Care

Requirements:

- Health center physicians have admitting privileges at one or more referral hospitals, or other arrangements to ensure continuity of care (including discharge planning, and patient tracking).
- If hospital arrangements (including admitting privileges and membership) are not possible, the applicant organization has firmly established arrangements for hospitalization, discharge planning, and patient tracking to ensure continuity of care.

Authority: Section 330(k)(3)(L) of the PHS Act

Documents/Resources to review: 1) Hospital or other arrangements, 2) Most recent EHB BHCMI Form 5C: Other Activities/Locations (hospitals where health center providers have admitting privileges should be noted on the form); HRSA/BPHC Health Center Collaboration [Program Assistance Letter 2011-02](#).

Links and Additional Resources: Your [State PCA](#) may have more information on this topic.

Patient Centered Medical Home: [HRSA Patient-Centered Medical/Health Home Initiative](#)

[AHRQ PCMH Resource Center](#)

As a self-assessment tool, please refer to the Program Requirement 6: Hospital Admitting Privileges and Continuum of Care section, page 23, of the [Health Center Site Visit Guide for HRSA Grantees](#).

3f. Program Requirement 7: Sliding Fee Discounts

Requirements:

- 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 the Federal poverty guidelines, 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.

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

Documents/Resources to Review:

- 1) Schedule of Fees/Charges for all services in scope; 2) Sliding Fee Discount Schedule/Schedule of Discounts (often referred to as the "sliding fee scale"); 3) Implementing policies and procedures for Sliding Fee Discount Schedule; 4) Sliding fee signage and/or notification methods;
- 5) [Most recent Federal Poverty Guidelines](#); 6) [HRSA/BPHC Scope of Project Policies](#).

Links and Additional Resources:

Your grant application's [Form 3](#): "Income Analysis Form." Part 1 of this form contains information on your sliding fee scale. This link is for reference purposes only.

HRSA, [BPHC TA resources page](#) for sliding fee scale, with links to slide scale fee regulations, poverty guidelines, and requirements.*

HHS [definitions and measures of poverty](#).

The Samples and Templates Resource Center [Management and Finance](#)*:

See the documents: [Info on SFDS from BPHC website](#)*,

- [Sample Sliding Fee Discount Policy and Procedures](#)*,
- [Sample Sliding Fee Eligibility Application](#)*, and
- [Sample Sliding Fee Scale](#)*.

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As a self-assessment tool, please refer to the Program Requirement 7: Sliding Fee Discounts section, page 24, of the [Health Center Site Visit Guide for HRSA Grantees](#).

3g. Program Requirement 8: Quality Improvement/Assurance Plan

Requirements:

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.

Authority: Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2)

Documents/Resources to Review: 1) Quality Improvement /Quality Assurance (QI/QA) plan and related policies and procedures (including Incident Reporting System and Risk Management Policies); 2) Clinical Director’s job description; 3) HIPAA-Compliant Patient Confidentiality Policies and Procedures; 4) Clinical Care Policies and Procedures; 5) Clinical Information Tracking Policies and Procedures; 6) HRSA/BPHC [Federal Tort Claims Act \(FTCA\) Health Center Policy Manual](#) (if applicable).

Links and Additional Resources:

The BPHC Quality, [Risk Management and Quality Improvement Page](#).

HRSA [Quality Improvement Page](#); see “Tips for Implementing Your Quality Improvement Program,” “How to Leverage Resources to Design a Successful Health Center Quality Improvement Program,” and “Maximizing the Effectiveness of Quality Improvement Plans.”

The Agency for Healthcare Research and Quality maintains the “[Innovations Exchange](#)” where you can go to find evidence based research and tools to help solve clinical quality and patient care process problems. In addition, AHRQ’s Center for Primary Care, Prevention, and Clinical Partnerships (CP3) expands the knowledge base for clinical providers and patients and to assure the translation of new knowledge and systems improvement into primary care practice. CP3 supports and conducts research to improve the access, effectiveness, and quality of primary and preventive health care services in the United States – more information is available at the [CP3 website](#).

Report to Congress: [Efforts to Expand and Accelerate Health Center Program Quality Improvement](#).

The Samples and Templates Resource Center [Quality Assurance Page*](#)

See:

- [QI Policies and Procedures*](#),

- [How to Develop a Risk Management Plan*](#),
- [Sample Performance Improvement Plan-Primary Health Care*](#), and
- [Sample Risk Management Plan*](#).

The Samples and Templates Resource Center [Clinical Documentation*](#) page.

See:

- [Guideline for Records Maintenance*](#).

The Samples and Templates Resource Center: [Sample Performance Improvement Plan*](#).

The Samples and Templates Resource Center: [Health Care Plan*](#) page.

The ECRI Institute: [Clinical Risk Management Program*](#) page.

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As a self-assessment tool, please refer to the Program Requirement 8: Quality Improvement/Assurance Plan section, page 27, of the [Health Center Site Visit Guide for HRSA Grantees](#).

4. Management and Finance

4a. Program Requirement 9: Key Management Staff

Requirement: Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior review by HRSA of final candidates for Project Director/Executive Director/CEO position is required.

Authority: Section 330(k)(3)(H)(ii) of the PHS Act and 45 CFR Part 74.25 (c)(2),(3)

Documents/Resources to Review: 1) Health center organizational chart; 2) Key management staff position descriptions and biographical sketches; 3) Key management vacancy announcements (if applicable).

Links and Additional Resources:

[Executive Officer Performance Assessment*](#)

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As a self-assessment tool, please refer to the Program Requirement 9: Key Management Staff section, page 31, of the [Health Center Site Visit Guide for HRSA Grantees](#).

4b. Program Requirement 10: Contractual/Affiliation Agreements

Requirements: Health center exercises appropriate oversight and authority over all contracted services. Health center assures that any sub recipient(s) meets the Health Center Program requirements.

Applies only to grantees s with subrecipients.

Authority: (Section 330(k)(3)(l)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a) (2))

Where to look for answers: 1) Contracts for core providers, including key management staff if applicable (e.g., CMO, CIO, CFO); 2) Contracts or MOAs/MOUs for other substantial portion(s) of the project; 3) Subrecipient Agreement(s) if applicable; 4) Any other key affiliation agreements if applicable; 5) Procurement policies and procedures; 6) HRSA/BPHC [Affiliation Agreement Policy Information Notices](#) (PINs 97-27 and 98-24); 7) Federal procurement grant regulations ([45 CFR Part 74.41-74.48](#)) applicable to all contractual arrangements in scope.

Links and Additional Resources:

Your grant application's [Form 8](#): "Health Center Affiliation Certification and Health Center Affiliation Checklist" contains your existing agreements with other entities. This link is for reference purposes only.

[PIN 1997-27](#): Affiliation Agreements.

[PIN 1998-24](#): Amendment to PIN 1997-27 Regarding Affiliation Agreements of Community & Migrant Health Centers.

[Program Assistance Letter 2011-02](#)

As a self-assessment tool, please refer to the Program Requirement 10: Contractual/Affiliation Agreements section, page 32, of the [Health Center Site Visit Guide for HRSA Grantees](#).

4c. Program Requirement 11: Collaborative Relationships

Requirements:

- 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 FQHC Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained.

Authority: Section 330(k)(3)(B) of the PHS Act and 42 CFR Part 51c.303(n)

Documents/Resources to Review: 1) Letters of Support; 2) Memoranda of Agreement/Understanding; 3) HRSA/BPHC Health Center Collaboration [Program Assistance Letter 2011-02](#).

Questions from review of the Newly Funded Health Center application and current status:

- Does the health center work to establish and maintain collaborative relationships with other health care providers in its service area, in particular other health centers?
- If there is another Federally Qualified Health Center(s) (FQHC), rural health clinic, critical access hospital or other safety net provider in the health center's service area, was the grantee able to secure letter(s) of support from these organizations?
- If the health center was unable to get letter(s) of support from these other safety net providers, why not and is the grantee working to improve or implement collaborative relationships with these organizations?

Links and Additional Resources:

UDS Mapper tool, available at [USD Mapper](#) (free login required).

PIN [97-27](#): Affiliation Agreements of Community and Migrant Health Centers.

PIN [98-24](#): Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers.

Program Assistance Letter (PAL) [2011-02](#): Health Center Collaboration

As a self-assessment tool, please refer to the Program Requirement 11: Collaborative Relationships section, page 34, of the [Health Center Site Visit Guide for HRSA Grantees](#).

4d. Program Requirement 12: Financial Management and Control Policies

Requirements:

Health center maintains accounting and internal control systems that:

- Are appropriate to the size and complexity of the organization.
- Reflects Generally Accepted Accounting Principles (GAAP).
- Separates functions in a manner appropriate to the organization's size in order to safeguard assets and maintain financial stability.

Health center assures that:

- An annual independent financial audit is performed in accordance with Federal audit requirements. Note: A complete audit includes: 1) Auditor's Report; 2) A-133 Compliance Supplement, and 3) Reports to Board/Management letters issued by the auditor.
- A corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report is submitted.

Authority: Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26

Questions from review of the Newly Funded Health Center application and current status:

- Are the grantee's accounting and internal control systems:
 - Appropriate to the organization's size and complexity?
 - Reflective of GAAP?
 - Designed to separate functions in a manner appropriate to the organization's size in order to safeguard assets?
 - Designed to separate functions in a manner appropriate to the organization's size in order to maintain financial stability?
- Is an audit performed annually, in accordance with Federal requirements?
- Did the grantee's corrective action plan address all findings, questioned costs, reportable conditions, and material weaknesses (if applicable) found in the Audit Report?
- Does the Board review the grantee's corrective actions regularly?

Documents/Resources to Review: 1) Most recent independent financial audit and management letter, including Audit Corrective Action plans based on prior year audit findings, if applicable; 2) For Newly Funded Grantees: Most recent monthly financial statements if a first audit has not been completed; 3) Financial Management/Accounting and Internal Control Policies and Procedures; 4) Office of Management and Budget Circular A-133.

Links and Additional Resources:

The BPHC Health Center [Management and Finance Policy Page](#).

Printer-Friendly Updated FY 2012 [Clinical and Financial Performance Measures](#):

The Samples and Templates Resource Center [Financial Management and Control Policies](#) Page*.

The Samples and Templates Resource Center [Business Plan](#) page*.

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As a self-assessment tool, please refer to the Program Requirement 12: Financial Management and Control section, page 35, of the [Health Center Site Visit Guide for HRSA Grantees](#).

4e. Program Requirement 13: Billing and Collections

Requirements:

Health center has systems in place to maximize collections and reimbursement for its costs in providing health services. These systems include written policies and procedures addressing:

- Billing
- Credit
- Collections

Authority:

Section 330(k)(3)(F) and (G) of the PHS Act

Documents/Resources to Review: 1) Policies and procedures for credit, collection, and billing; 2) Encounter form; 3) Most recent income analysis (Form 3); 4) HRSA/BPHC [Program Assistance Letter 2011-04](#): Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit.

Links and Additional Resources:

Your grant application’s [Form 3](#): “Income Analysis Form” contains your assumptions and projections for billing and collections. This link is for reference purposes only.

Additional information on the Affordable Care Act can be found at healthcare.gov. Resources for consumers and providers are available as well as links to additional health insurance program information including Medicare and Medicaid

The Samples and Templates Resource Center [Billing and Collections Page](#)*

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As a self-assessment tool, please refer to the Program Requirement 13: Billing and Collections section, page 39, of the [Health Center Site Visit Guide for HRSA Grantees](#).

4f. Program Requirement 14: Budget

Requirements:

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.

Authority:

Section 330(k)(3)(D), Section 330(k)(3)(l)(i), and 45 CFR Part 74.25

Documents/Resources to Review: 1) Annual health center budget; 2) Operating Plan; 3) Most recent Health Center Required Financial Performance Measures/UDS Report

Links and Additional Resources:

Your grant application's [Form 3](#): "Income Analysis Form" contains your budgetary assumptions. This link is for reference purposes only.

The Samples and Templates Resource Center [Financial Management Page](#)*

Samples and Templates Resource Center [Business Plan Page](#)*

Health Center Budgeting and Accounting Requirements. [PIN 2013-01](#)

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As a self-assessment tool, please refer to the Program Requirement 14: Budget section, page 42, of the [Health Center Site Visit Guide for HRSA Grantees](#).

4g. Program Requirement 15: Program Data Reporting Systems

Requirements:

Health center has systems in place which:

- Accurately collect and analyze data for program reporting.
- Support management decision making.

Authority:

Section 330(k)(3)(I)(ii) of the PHS Act

Documents/Resources to Review:

1) Most recent UDS report and UDS Health Center Trend Report; 2) Most recent Clinical and Financial Performance Measures Forms (see Appendix C for further detail); 3) Strategic Plan; 4) Annual Operating Plan; 5) HRSA/BPHC [UDS Reporting Information](#); 6) HRSA Federal Financial Report Information (FFR) Resources.

Links and Additional Resources:

BPHC [UDS Website](#).

Federal Financial Report (FFR) [Quick Guide](#).

- In addition, an audio replay and transcript of a FFR training session is available on the HRSA Grants web page [Manage Your Grant](#).

Health Center [Clinical and Financial Performance Measures](#).

Program Assistance Letter (PAL) [2008-06](#), Background and Purpose of the Performance Measure Implementation for Health Center Program Grantees.

PAL, [Program Assistance Letter 2013-07](#) Uniform Data System Changes for Calendar Year 2014.

National Association of Community Health Centers, [Business Planning Guide](#)*.

The Samples and Templates Resource Center [Practice Management Information System Page](#)*

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As a self-assessment tool, please refer to the Program Requirement 15: Program Data Reporting Systems section, page 43, of the [Health Center Site Visit Guide for HRSA Grantees](#).

4h. Program Requirement 16: Scope of Project

Requirements:

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

Authority:

Authority: 45 CFR Part 74.25

Questions based on review of the Newly Funded Health Center application and current status:

- Is the grantee prepared to carry out their funded scope of project in terms of number of patients served, visits, services available, providers, and/or sites? (If applicable)
- Do the Forms 5A, 5B, and 5C match current plans/practice and is there a plan in place to verify site(s) and services within 120 days of NoA?

Documents/Resources to Review: 1) Most recent Health Center UDS Trend Report; 2) Form 1A from most recent section 330 grant application (to review patient projections); 3) Health center's official scope of project (EHB BHCMIIS Forms 5A, 5B and 5C); 4) Form 2 Staffing Profile from most recent section 330 grant application; 5) HRSA/BPHC [Scope of Project Policies](#).

Links and additional resources:

[PIN 2008-01](#): Defining Scope of Project and Policy for Requesting Changes.

[PIN 2009-03](#): Technical Revision to PIN 08-01, Defining Scope of Project and Policy for Requesting Changes.

[PIN 2009-02](#): Specialty Services & Health Centers' Scope of Project

[PIN 2009-05](#): Policy for Special Populations-Only Grantees Requesting a Change in Scope to Add a New Target Population

[PIN 2013-01](#): Alignment of EHB Change in Scope Module with Change in Scope Policy, and Printable Previews of Scope Forms and Checklists

[PAL 2013-03](#): Alignment of EHB Change in Scope Module with Change in Scope Policy

As a self-assessment tool, please refer to the Program Requirement 16: Scope of Project section, page 48, of the [Health Center Site Visit Guide for HRSA Grantees](#).

5. Governance

5a. Program Requirement 17: Board Authority

Requirements:

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

Note: In the case of public centers with co-applicant governing boards, the public agency is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center

Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the monthly meeting requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p).

Authority:

Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304

Documents/Resources to Review:

1) Corporate Bylaws; 2) Minutes of Board Meetings; 3) Governance Policies and Procedures; 4) Corporate Compliance Policies and Procedures (Compliance Officer, Compliance Committee); 5) Corporate Compliance Plan; 6) Board Annual Meeting Schedule; 7) If Applicable: [Form 6B](#): Waiver of Governance Requirements from Newly Funded Health Center NAP application.; 8) Organizational Chart; 9) If applicable, Co-Applicant Agreement (for [public center grantees](#)).

Links and Additional Resources:

Your grant application's [Form 6A](#): "Current Board Member Characteristics" contains basic information on your board structure. This link is for reference purposes only.

The BPHC Health Center [Governance Policy Page](#) .

The BPHC [Governing Board Handbook](#)

The Samples and Templates Resource Center [Board Authority Page*](#)

The Samples and Templates Resource Center [Governance, Board Structure, Functions and Activities Page*](#)

The Samples and Templates Resource Center: [Board and Management Reports*](#).

**Note: All non-Federal documents are for use as aids to consultants and grantees, the contents of such documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA, and should not be considered official guidance by BPHC. Any “sample” documents must be tailored to the health center’s unique circumstances and needs.*

As a self-assessment tool, please refer to the Program Requirement 17: Board Authority section, page 51, of the [Health Center Site Visit Guide for HRSA Grantees](#).

Note: Portions of program requirements notated by a double asterisk “**” indicate regulatory requirements that are recommended **but not required** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

† Waivers may only be requested by applicants requesting/receiving targeted funding **solely** to serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330 (h)), and/or residents of public housing (section 330(i)) and that are **NOT** requesting general (Community Health Center - section 330(e)) funds. **These grantees are still required to fulfill all other statutory Board responsibilities and requirements.**

* In a co-applicant arrangement, the public center (the grantee of record) is permitted to retain responsibility for establishing general policies (fiscal and personnel policies) when constrained by State law in the delegation of certain government functions to private agencies. The co-applicant structure, therefore, creates an arrangement that still adheres to the statutory intent of section 330 (allowing the majority of the health center’s policy setting authorities to be carried out by the patient/community-based (co-applicant) health center governing board) while satisfying local or State law pertaining to the public center. No justification is required for arrangements in which the public center retains authority for the establishment of the following types of general policy: fiscal and personnel policies.

5b. Program Requirement 18: Board Composition

Requirements:

The health center Governing Board is composed of individuals, a majority of whom are being served by the center and, who 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*.

Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p).

Authority:

Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304

Documents/Resources to Review:

1) Composition of Board of Directors/[Form 6A](#): Board Composition from most recent Continuation (SAC or BPR) or Newly Funded Health Center NAP application; 2) Corporate Bylaws; 3) Board member applications and disclosure forms; 4) **If Applicable:** [Form 6B](#): Waiver of Governance Requirements from most recent SAC; 5) [Form 4](#): Community Characteristics.

Links and Additional Resources:

HRSA Newly Funded Health Center [NAP Application Page](#).

The Samples and Templates Resource Center [Board Composition Page*](#)

**Note: All non-Federal documents are for use as aids to consultants and grantees, the contents of such documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA, and should not be considered official guidance by BPHC. Any "sample" documents must be tailored to the health center's unique circumstances and needs.*

Note: Portions of program requirements notated by a double-asterisk "***" indicate regulatory requirements that are recommended **but not required** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

As a self-assessment tool, please refer to the Program Requirement 18: Board Composition section, page 55, of the [Health Center Site Visit Guide for HRSA Grantees](#).

5c. Program Requirement 19: Conflict of Interest Policy

Requirements:

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 Officer may serve only as a non-voting ex-officio member of the board.**

Authority:

45 CFR Part 74.42 and 42 CFR Part 51c.304(b)

Documents/Resources to Review:

1) Corporate Bylaws; 2) most recent update of Conflict of Interest policy and related procedures; 3) Procurement policies and procedures.

Links and Additional Resources:

The Samples and Templates Resource Center [Sample Conflict of Interest Disclosure*](#)

**Note: All non-Federal documents are for use as aids to consultants and grantees, the contents of such documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA, and should not be considered official guidance by BPHC. Any "sample" documents must be tailored to the health center's unique circumstances and needs.*

Note: Portions of program requirements notated by a double asterisk "***" indicate regulatory requirements that are recommended **but not required** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

As a self-assessment tool, please refer to the Program Requirement 19: Conflict of Interest Policy section, page 59, of the [Health Center Site Visit Guide for HRSA Grantees](#).