



# **Health Center Program Compliance Manual**

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## Introduction

### Applicability

This Health Center Program Compliance Manual (“Compliance Manual”) applies to all health centers that apply for<sup>1</sup> or receive [Federal award](#) funds under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act ([42 U.S.C. 254b](#)) (“section 330”), as amended (including sections 330(e), (g), (h), and (i)), as well as [subrecipient](#) organizations<sup>2</sup> and Health Center Program [look-alikes](#). Look-alikes do not receive Federal funding under section 330 of the PHS Act; however, to receive look-alike designation and associated Federal benefits, look-alikes must meet the Health Center Program requirements.<sup>3</sup> For the purposes of this document, the term “health center” refers to entities that apply for or receive a Federal award under section 330 of the PHS Act (including section 330 (e), (g), (h) and (i)), section 330 subrecipients, and organizations designated as look-alikes.

This Compliance Manual does not apply to activities conducted outside of a health center’s Health Resources and Services Administration (HRSA)-approved [scope of project](#).<sup>4</sup>

### Purpose

The purpose of the Compliance Manual is to provide a consolidated resource to assist health centers in understanding and demonstrating compliance with Health Center Program requirements. The Compliance Manual also addresses HRSA’s approach to determining eligibility for and exercising oversight over the Health Center Program and details the requirements for obtaining deemed PHS employee status under section 224 (g)-(n) and (q) of the PHS Act.<sup>5</sup>

The Compliance Manual identifies requirements found in the Health Center Program’s authorizing legislation and implementing regulations, as well as certain applicable grants regulations.<sup>6</sup> These requirements form the foundation of the Health Center Program and support the core mission of this innovative and successful model of primary care. The Compliance Manual does not provide guidance on requirements in areas beyond Health Center

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<sup>1</sup> Notices of Funding Opportunity (NOFOs) may include specified timelines for new [awardees](#) to demonstrate compliance with the requirements specified in this Manual following receipt of the Federal Health Center Program award.

<sup>2</sup> 42 U.S.C. 1395x(aa)(4)(A)(ii) and 42 U.S.C. 1396d(l)(2)(B)(ii).

<sup>3</sup> Sections 1861(aa)(4)(B) and 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(4)(B) and 42 U.S.C. 1396d(l)(2)(B)(iii)).

<sup>4</sup> See <http://www.bphc.hrsa.gov/programrequirements/scope.html> for more information on scope of project.

<sup>5</sup> Health Center FTCA Medical Malpractice Program procedures and information, as set forth in the [FTCA Health Center Policy Manual](#), are not superseded by this Manual. See [Appendix A](#) for additional policy issuances which remain in effect.

<sup>6</sup> Section 330 of the PHS Act (42 U.S.C. §254b), as amended, 42 CFR Part 51c and 42 CFR Part 56 for Community and Migrant Health Centers, respectively, and 45 CFR Part 75.

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Program requirements or outside HRSA's oversight authority. In addition, the Compliance Manual is not intended to address best or promising practices or performance improvement strategies that may support effective operations or organizational excellence.

Health Center Program non-regulatory policy issuances that remain in effect after release of the Compliance Manual are listed in [Appendix A](#). With the exception of these policies, the Compliance Manual supersedes other previous Health Center Program non-regulatory policy issuances (Policy Information Notices (PINs), Program Assistance Letters (PALs), Regional Office Memoranda, Regional Program Guidance memoranda, and other non-regulatory materials) related to Health Center Program compliance or eligibility requirements. In case of any conflict between a provision of the Compliance Manual and other HRSA-disseminated non-regulatory materials related to compliance and/or eligibility requirements, the provisions of the Compliance Manual control. Previously published issuances that are superseded by this Manual include, but are not limited to:

- **PIN 1994-07:** Migrant Voucher Program Guidance
- **PINs 1997-27 and 1998-24:** Affiliation Agreements of Community & Migrant Health Centers and Amendment to PIN 1997-27 Regarding Affiliation Agreements of Community and Migrant Health Centers
- **PINs 2001-16 and 2002-22:** Credentialing and Privileging of Health Center Practitioners and Clarification of BPHC Credentialing & Privileging Policy Outlined in PIN 2001-16
- **PAL 2006-01:** Dual Status-Health Centers that are both FQHC Look-Alikes and Section 330 Grantees
- **PIN 2010-01:** Confirming Public Agency Status under the Health Center Program and FQHC Look-Alike Program
- **PIN 2013-01:** Health Center Program Budgeting and Accounting Requirements
- **PIN 2014-01:** Health Center Program Governance
- **PIN 2014-02:** Sliding Fee Discount and Related Billing and Collections Program Requirements
- **PAL 2014-08:** Health Center Program Requirements Oversight<sup>7</sup>
- **PAL 2014-11:** Applicability of PAL 2014-08: Health Center Program Requirements Oversight to Look-Alikes

The Compliance Manual serves as the foundation for HRSA's eligibility and compliance-related determinations and for HRSA's review processes for the Health Center Program. HRSA will update or amend the Compliance Manual as needed to provide further policy clarification with respect to demonstrating compliance with Health Center Program requirements.

### **Structure of the Health Center Program Compliance Manual**

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<sup>7</sup> PAL 2014-08 superseded PAL 2010-01, "Enhancements to Support Health Center Program Requirements Monitoring," which was issued April 8, 2010.

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Chapters in the Compliance Manual are generally organized as follows:

- **Authority:** Lists the applicable statutory and regulatory citations.<sup>8</sup>
- **Requirements:** States the statutory and regulatory requirements.
- **Demonstrating Compliance:** Describes how health centers would demonstrate to HRSA their compliance with the **Requirements** by fulfilling all elements in this section.

***Note:** Health centers that fail to demonstrate compliance as described in this Manual will receive a condition of award/designation. In responding to such conditions, health centers could demonstrate their compliance to HRSA either by submitting documentation as described in the Demonstrating Compliance sections of the Manual or by the health center proposing an alternative means of demonstrating compliance with the specified Requirements, which would include submitting an explanation and documentation that explicitly demonstrate compliance. All responses to conditions are subject to review and approval by HRSA (see Chapter 2: [Health Center Program Oversight](#)).*

- **Related Considerations:** Describes areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing a requirement. When specific examples are provided, they are not intended to be an all-inclusive list. All related considerations are offered with the understanding that health center decision-making and implementation are consistent with all applicable statutory, regulatory, and policy requirements.

### **Additional Health Center Responsibilities**

In addition to the requirements included in this Compliance Manual, organizations receiving Health Center Program Federal awards, including subrecipients, are also subject to other applicable award-related statutory, regulatory, and policy requirements (see 45 CFR Part 75 and the U.S. Department of Health and Human Services (HHS) Grants Policy Statement (GPS),<sup>9</sup> Notices of Funding Opportunity (NOFOs),<sup>10</sup> and Notices of Award (NoAs)). As such, the Compliance Manual does not constitute an exhaustive listing of all requirements that may be included in terms and conditions stated in NOFOs, NoAs, and other applicable laws, regulations, and policies.

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<sup>8</sup> These citations include requirements under the [Uniform Administrative Requirements](#) for all HHS awards (45 CFR Part 75) which are applicable to organizations receiving Federal funding under the Health Center Program (45 C.F.R. 75.101).

<sup>9</sup> Further grants policy information may be found in the HHS Grants Policy Statement and the HRSA SF-424 Application Guide. See <http://www.hrsa.gov/grants/index.html> for more information.

<sup>10</sup> Individual NOFOs may contain specific additional terms and conditions of award beyond those identified in this Manual.



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Health centers (including look-alikes) are subject to the distinct statutory, regulatory, and policy requirements of other Federal programs that they may be eligible for and participate in as a result of the Health Center Program award or designation, such as:

- [Federally Qualified Health Center \(FQHC\)](#) status, payment rates, and requirements under Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act;<sup>11</sup>
- The 340B Drug Pricing Program;<sup>12</sup>
- The National Health Service Corps (NHSC) Program; and
- The Health Center FTCA Medical Malpractice Program (with the exception of the deeming requirements included in the Compliance Manual).<sup>13</sup>

Each health center is responsible for maintaining its operations, including developing and implementing its own operating procedures, in compliance with **all** Health Center Program requirements and all other applicable Federal, state, and local laws and regulations.<sup>14</sup> This includes but is not limited to those protecting public welfare, the environment and prohibiting discrimination; state facility and licensing laws; state scope of practice laws; Centers for Medicare and Medicaid Services (CMS) Conditions for Coverage for FQHCs;<sup>15</sup> and State Medicaid requirements. In fulfilling all of these oversight and compliance responsibilities, a health center may wish to consult its private legal counsel. Health centers may also direct questions to the designated points of contact for these programs.

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<sup>11</sup> 42 U.S.C. 1396a(a)(15) and 42 U.S.C. 1396(a)(bb); and 42 U.S.C. 1395l(a)(1)(Z) and 42 U.S.C. 1395m(o).

<sup>12</sup> Section 340B of the PHS Act, as amended (42 U.S.C. 256b).

<sup>13</sup> Section 224(g)-(n) and (q) of the PHS Act (42 U.S.C. 233(g)-(n), and (q)).

<sup>14</sup> 42 CFR 51c.304(d)(3)(v).

<sup>15</sup> 42 CFR Part 491.

## **Chapter 1: Health Center Program Eligibility**

Organizations applying for funding or designation under the Health Center Program must demonstrate that they are eligible organizations under the Health Center Program statute and regulations. Specifically, organizations applying for funding as health centers or designation as [look-alikes](#) must be private non-profit entities or public agencies.<sup>1</sup> Organizations applying for look-alike designation are also subject to certain additional statutory eligibility requirements.<sup>2</sup>

***In addition to the eligibility requirements described in this Chapter, organizations may be required to comply with certain additional eligibility requirements described in Notices of Funding Opportunity (NOFOs) or look-alike application instructions in order to receive a Health Center Program award or look-alike designation.***

### **Non-Profit Organizations**

An organization would demonstrate to HRSA that it is a private non-profit entity by submitting one of the following types of documentation:

- A copy of a currently valid IRS tax exemption certificate;
- A statement from a state taxing body, state attorney general, or other appropriate state official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals;
- A certified copy of the organization's official certificate of incorporation or similar document (for example, articles of incorporation) showing the state or tribal seal that clearly establishes nonprofit status; or
- Any of the above documents for a state or local office of a national parent organization and a statement signed by the parent organization that the applicant organization is a local non-profit affiliate.

### **Public Agency Organizations**

An organization would demonstrate to HRSA that it is a public agency by submitting one of the following types of documentation:

- A current dated letter affirming the organization's status as a State, territorial, county, city, or municipal government; a health department organized at the State, territory, county, city or municipal level; or a subdivision or municipality of a United States (U.S.)

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<sup>1</sup> Section 330(e)(1)(A) of the PHS Act, 42 CFR 51c.103, and 42 CFR 56.103.

<sup>2</sup> Sections 1861(aa)(4)(b) and 1905(l)(2)(B) of the Social Security Act.

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affiliated sovereign State formally associated with the U.S. (for example, Republic of Palau);

- A copy of the law that created the organization and that grants one or more sovereign powers (for example, the power to tax, eminent domain, police power) to the organization (for example, a public hospital district);
- A ruling from the State Attorney General affirming the legal status of an entity as either a political subdivision or instrumentality of the State (for example, a public university); or
- A “letter ruling” which provides a positive written determination by the Internal Revenue Service of the organization’s exempt status as an instrumentality under Internal Revenue Code section 115.

### **Tribal or Urban Indian Organizations**

Native American tribal organizations, including those defined under the Indian Self-Determination Act<sup>3</sup> or the Indian Health Care Improvement Act<sup>4,5</sup> are eligible to apply for Health Center Program funding or designation. Such organizations would demonstrate their eligibility to HRSA by providing applicable documentation as described in either the [Non-Profit Organizations](#) or [Public Agency Organizations](#) sections above.

### **Additional Eligibility Requirements for Look-Alike Designation**

In addition to demonstrating that it is either a private non-profit entity or a public agency, an organization applying for look-alike designation must demonstrate to HRSA that it satisfies all of the following requirements:

1. It is currently delivering primary health care services to patients within the proposed [service area](#).
2. It is not owned, controlled, or operated by another entity. Specifically, the organization applying for look-alike designation:
  - a. **Owns and controls** the organization’s assets and liabilities (for example, the organization does not have a sole corporate member, is not a subsidiary of another organization), and as such will be able to ensure that the benefits that accrue through look-alike designation as a [Federally Qualified Health Center](#)

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<sup>3</sup> The text of the Indian Self-Determination Act may be found at 25 U.S.C. Ch 46 (<http://uscode.house.gov/view.xhtml?path=/prelim@title25/chapter46&edition=prelim>).

<sup>4</sup> The text of the Indian Health Care Improvement Act may be found at 25 U.S.C. Ch 18: <http://uscode.house.gov/view.xhtml?path=/prelim@title25/chapter18&edition=prelim>.

<sup>5</sup> Per section 330(k)(3)(H), tribal or urban Indian organizations are exempt from Health Center Program governance requirements.

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([FQHC](#)) are distributed to the Health Center Program project (for example, FQHC payment rates, 340B Drug Pricing); and

- b. **Operates** the Health Center Program project. At a minimum, the look-alike applicant organization demonstrates that it maintains a Project Director/Chief Executive Officer (CEO) who will carry out independent, day-to-day oversight of health center activities solely on behalf of the governing board of the applicant organization.
3. It is not currently receiving funding as a Health Center Program Federal [award recipient](#).<sup>6</sup>

*Organizations will not be awarded Federal funding or look-alike designation that would result in “dual status,” whereby the organization becomes both a Federal awardee under section 330 and a look-alike designee. For example, an organization that is currently a Health Center Program awardee would no longer be awarded new look-alike designation status through the Initial Designation process, nor would an organization that is currently a Health Center Program look-alike be awarded Health Center Program funding unless, at the same time, it proposes to include all of its health center [sites](#) within the scope of the Health Center Program award.*

*Health centers that currently have dual status as of the date of release of the Compliance manual will be permitted to maintain such status as long as subsequent Service Area Competition and Renewal of Designation applications are approved by HRSA.*

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<sup>6</sup> Health centers may not maintain or obtain look-alike designation if they are already receiving a [Federal award](#) under section 330 of the Public Health Service Act. Under Section 1905(l)(2)(B) of the Social Security Act: “The term “Federally-qualified health center” means an entity which ... (i) is receiving a [grant](#) under section 254b of this title...or (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 254b of this title...or (iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity.”

## **Chapter 2: Health Center Program Oversight**

*Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. [View the revisions.](#)*

Health centers must comply with all Health Center Program requirements and other applicable Federal statutes, regulations, and the terms and conditions of their [award](#) or [look-alike](#) designation.<sup>1</sup> In keeping with the Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care's (BPHC) oversight responsibilities, HRSA/BPHC monitors and supports health centers in complying with these requirements.

The purpose of this chapter is to:

- Set forth HRSA/BPHC's oversight process for the purposes of monitoring compliance with Health Center Program requirements and assists health centers in maintaining compliance with these requirements.
- Describe when and how HRSA pursues remedies for non-compliance, including taking enforcement action(s) in cases where health centers fail to comply with Health Center Program requirements and other applicable Federal statutes, regulations, and the terms and conditions of the award or look-alike designation.
- Clarify when and how compliance with program requirements and past performance<sup>2</sup> is considered in award or designation decisions.

HRSA/BPHC's Progressive Action process is implemented through its [Electronic Handbooks \(EHB\)](#) system. The EHB system facilitates the tracking of compliance with program conditions placed on a health center's award or designation.<sup>3</sup> This system also communicates these conditions through Notices of Award (NoAs) or Notices of Look-Alike Designation (NLDs), documents the health center's response to these conditions, and documents removal of these conditions when appropriate.<sup>4</sup>

### **Program Oversight**

United States (U.S.) Department of Health and Human Services (HHS) grants regulations, [Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal](#)

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<sup>1</sup> Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended, 42 CFR Part 51c and 42 CFR Part 56 for Community and Migrant Health Centers, respectively, and 45 CFR Part 75.

<sup>2</sup> 42 CFR 51c.305 and 45 CFR 75.205(c)(3).

<sup>3</sup> Throughout this document, requirements or conditions of award are "requirements of Federal designation" for organizations designated by HRSA as look-alikes (see section 1861(aa)(4)(B) and section 1905(l)(2)(B) of the Social Security Act), which must also meet all of the requirements of the Health Center Program.

<sup>4</sup> In the EHB, a health center's response to a condition of award/designation is referred to as a "submission". The removal or lifting of a condition occurs once a submission that adequately addresses the required corrective action has been reviewed, approved by HRSA, and marked as "met" within the EHB.

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[Awards \(Uniform Regulations\)](#)<sup>5</sup> require HRSA to “manage and administer the [Federal award](#) in a manner so as to ensure that Federal funding is expended and associated programs are implemented in full accordance with U.S. statutory and public policy requirements, including, but not limited to, those protecting public welfare, the environment, and prohibiting discrimination.”<sup>6</sup>

Consistent with applicable laws and HRSA’s program oversight responsibilities, health centers are assessed for compliance with these requirements and are provided an opportunity to remedy areas of non-compliance whenever reasonably possible. Immediate enforcement action may be taken against health centers in limited circumstances that are further addressed below.

HRSA may impose specific award conditions<sup>7</sup> if an applicant or recipient/designee:

- Demonstrates undue risk in such areas<sup>8</sup> as:
  - Financial stability;
  - Quality of management systems and ability to meet required management standards;
  - History of performance, specifically the applicant’s record in managing previous Federal awards (timeliness of compliance with applicable reporting requirements and conformance to the terms and conditions of previous Federal awards);
  - Findings from reports and audits; and
  - Ability to effectively implement statutory, regulatory, or other requirements imposed on [non-Federal entities](#).
- Has a history of failure to comply with the general or specific terms and conditions of a Federal award/designation;
- Fails to meet expected performance goals [as prescribed in the terms or conditions of the Federal award or designation]; or
- Is not otherwise responsible.<sup>9</sup>

Specific award conditions may include, but are not limited to, the following:

- Requiring payments as reimbursements rather than advance payments;<sup>10</sup>

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<sup>5</sup> 2 CFR Part 200.

<sup>6</sup> 45 CFR 75.300.

<sup>7</sup> 45 CFR 75.207(a).

<sup>8</sup> 45 CFR 75.205(c).

<sup>9</sup> 45 CFR 75.207(a).

<sup>10</sup> This is also known as “Restricted Drawdown.” When a Federal award recipient is placed on restricted drawdown, all drawdowns of Federal funds from the Payment Management System (PMS) must have approval of HRSA’s Office of Federal Assistance Management, Division of Grants Management Operations, and must comply with all applicable requirements before funds are drawn.

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- Withholding authority to proceed to the next phase of the project until receipt of evidence of acceptable performance within a given period of performance;
- Requiring additional, more detailed financial reports;
- Requiring additional project monitoring;
- Requiring the non-Federal entity to obtain technical or management assistance; or
- Establishing additional prior approvals.<sup>11</sup>

If it is determined that noncompliance cannot be remedied by imposing such additional conditions, one or more of the following actions may be taken as appropriate in the circumstances:

- Temporarily withhold cash payments pending further action;
- Disallow all or part of the cost of the activity or action not in compliance;
- Wholly or partly suspend award activities or terminate the Federal award;<sup>12</sup>
- Initiate suspension or debarment proceedings;<sup>13</sup>
- Withhold further Federal awards for the project or program; or
- Take other remedies that may be legally available.<sup>14</sup>

### **Progressive Action Overview**

In circumstances where HRSA has determined that a health center has failed to demonstrate compliance with one or more of the Health Center Program requirements, a condition(s) will be placed on the award/designation, which will follow the Progressive Action policy and process. Such determinations are typically based upon findings from the review of the Service Area Competition (SAC)/Renewal of Designation (RD) application, a site visit, other compliance-related activities, or through other means.<sup>15</sup> Program conditions placed on the health center's award or look-alike designation describe the:

- Nature of the finding and the requirement it relates to;
- Reason why the condition(s) is being imposed;

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<sup>11</sup> 45 CFR 75.207(b).

<sup>12</sup> *Termination* means the ending of a Federal award, in whole or in part at any time prior to the planned end of period of performance [project period] (45 CFR 75.2). Health Center Program look-alikes will receive formal notification of de-designation as they do not receive a Federal Health Center Program award.

<sup>13</sup> *Suspension of award activities* means an action by HRSA requiring the recipient to cease all activities on the award pending corrective action by the recipient, including restricting the ability to draw down any funds associated with the Federal award (45 CFR 75.375) and is a separate action from suspension under HHS regulations (2 CFR Part 376) (45 CFR 75.2).

<sup>14</sup> 45 CFR 75.371.

<sup>15</sup> HRSA may also assess compliance with requirements through audit data, [Uniform Data System \(UDS\)](#) or similar performance reports, Medicare/Medicaid reports, external accreditation, or other Federal, state, or local findings or reports as applicable, and may conduct onsite verification of compliance at any point within a project/designation period or prior to any final Health Center Program award/designation decisions.

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- Nature of the action(s) needed to remove the condition;
- Time allowed for completing the additional requirement (satisfying the condition(s) through submission of appropriate documentation or specific actions taken), if applicable; and
- Method for requesting reconsideration of the condition.<sup>16</sup>

HRSA is committed to providing a reasonable period of time for these organizations to take corrective actions necessary to demonstrate compliance. Progressive Action is designed to provide a time-phased approach for resolution of compliance issues with program requirements. This Progressive Action process is not intended to address or be used for the oversight and enforcement of all Federal requirements that may be applicable to the award or designation, particularly those with implications for patient safety (see [Immediate Enforcement Actions](#) below).

Should a health center fail to adequately address conditions through Progressive Action, HRSA may utilize available remedies, including terminating all or part of the Federal award/designation status before the health center's current project end date.<sup>17</sup> Such action may be accompanied by a competition to identify another organization to carry out a service delivery program consistent with Federal requirements.<sup>18</sup>

### **Progressive Action Process**

In circumstances where HRSA has determined that a health center has failed to demonstrate compliance with one or more Health Center Program requirements, relevant conditions are placed on the health center's award/designation and communicated through Notices of Award (NoAs) or Notices of Look-Alike Designation (NLDs). In responding to such conditions, health centers could demonstrate their compliance to HRSA either by submitting documentation as described in the Demonstrating Compliance sections of the Manual, or by the health center proposing an alternative means of demonstrating compliance with the specified requirements, which would include submitting an explanation and documentation that explicitly demonstrates compliance. All responses to conditions are subject to review and approval by HRSA.

The Progressive Action process provides a uniform structure and a time-phased approach for notifying health centers of the failure to demonstrate compliance and for receiving health center responses to an identified condition(s) as supported within HRSA's EHB. Through this process, health centers are able to efficiently and effectively respond to conditions, and HRSA is able to promptly review these responses and proceed to next steps, including removal of

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<sup>16</sup> Imposed conditions will include the method for submitting responses to conditions, which would include an opportunity to inform HRSA of any request to reconsider the placement of the condition.

<sup>17</sup> 45 CFR 75.371 and 45 CFR 75.372.

<sup>18</sup> Health Center Program look-alikes that have had their designation period terminated by HRSA under such circumstances or for which HRSA has not renewed a look-alike designation may reapply for look-alike designation through the initial designation application process at any time.



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conditions, as warranted. In addition, the EHB supports the Progressive Action process by clearly noting condition response deadlines in the health center's EHB task list and providing periodic reminders to health centers during the condition response timeframe.

The Progressive Action process includes four distinct condition phases (detailed below), structured to provide specified timeframes for health centers to provide responses that demonstrate compliance, either in the manner prescribed by this Manual or via alternative means. After initial notification of the compliance issue, a health center will be notified via a NoA/NLD at each Progressive Action phase as to the acceptability of the response and whether further action is needed. If the health center fails to respond by the specified deadline or HRSA determines that the health center's response does not demonstrate compliance, the health center will be notified and the next Progressive Action phase will be activated.

- Phase One: An initial NoA/NLD is issued with a condition detailing the specific area(s) where compliance with a requirement has not been demonstrated. Phase One provides ninety (90) days for the health center to submit appropriate documentation that demonstrates compliance or, where applicable, that the health center has developed an adequate action plan (see [Implementation Phase](#) below) for how its organization will demonstrate compliance with the requirement.<sup>19</sup>
- Phase Two: Phase Two provides an additional sixty (60) days for the health center to submit appropriate documentation that demonstrates compliance or that the health center has developed an adequate action plan for how its organization will demonstrate compliance with the requirement (See [Implementation Phase](#) below).
- Phase Three: Phase Three provides an additional thirty (30) days for the health center to submit appropriate documentation that demonstrates compliance or that the health center has developed an adequate action plan for how its organization will demonstrate compliance with the requirement (See [Implementation Phase](#) below).
- Implementation Phase (where applicable): Implementation Phase provides one hundred twenty (120) days for the health center to implement the HRSA-approved action plan and submit appropriate documentation that demonstrates compliance with the program requirement.<sup>20</sup>

HRSA recognizes that health centers may need to make programmatic and organizational changes in response to a condition. Therefore, the Progressive Action process is designed to provide health centers with a reasonable amount of time to take appropriate action in response to a condition and for prompt HRSA review and decision-making. For example, in Phase One, a health center is given 90 days to either demonstrate compliance with the identified program requirement or develop and submit an action plan detailing the steps the health center will implement in order to demonstrate compliance with the requirement. If this plan is approved, a

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<sup>19</sup> Conditions afford a 120-day Implementation Phase when a HRSA-approved corrective action plan would require additional time for the health center to implement related programmatic and organizational changes.

<sup>20</sup> The implementation phase follows HRSA's approval of an adequate action plan submitted in Phase One, Two, or Three.

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NoA/NLD will be issued with an “Implementation Phase” condition notifying the health center that HRSA has approved the action plan and that within 120 days it must submit documentation that compliance with the requirement has been demonstrated in accordance with the HRSA-approved plan.

Conditions in Phase Two (60-day) and Phase Three (30-day)<sup>21</sup> state that if the health center does not adequately address the condition within the allotted timeframe (the last opportunity being Phase Three), the organization will be determined to have failed to comply with the terms and conditions of the Health Center Program award or designation. As a result, the health center’s current project end date may be shortened through the termination of all or part of the Federal award or designation status.

### **Immediate Enforcement Actions**

HRSA may determine that certain findings related to a health center, as a consequence of their nature and/or urgency, cannot be remedied by imposing specific award conditions per the Progressive Action process described above. In such cases, based on the circumstances, HRSA may take one or more of the following immediate remedies:

- Temporarily withhold cash payments (from the Federal award) pending further action;
- Disallow all or part of the cost of the activity or action not in compliance;
- Wholly or partly suspend award activities or terminate the Federal award;
- Initiate suspension or debarment proceedings;
- Withhold further Federal awards for the project or program; or
- Take other remedies that may be legally available.<sup>22</sup>

Situations that cannot be remedied through use of the Progressive Action process and that may require HRSA to apply such immediate enforcement actions include:

- Findings that a health center, in responding to the terms or conditions of award/designation, misrepresented the actions it took to correct areas of non-compliance. For example, a site visit reveals that HRSA lifted a Progressive Action condition based on false or misrepresented information submitted by the health center.
- Documented public health or welfare concerns. Examples may include threats to health center patient safety, violations of state scope of practice regulations or guidelines, inappropriate or illegal prescribing practices, lack of appropriate infection control procedures, and occupational or environmental hazards.

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<sup>21</sup> The BPHC website includes a public Health Center Profile for each individual health center that displays data on the status of a health center’s compliance with Health Center Program requirements based on the presence of any active 60- and/or 30-day Progressive Action conditions. See <http://bphc.hrsa.gov/uds/datacenter.aspx?q=d> to view individual health center data.

<sup>22</sup> 45 CFR 75.371.

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- Failure of the health center organization to demonstrate operational capacity to continue or maintain its health center service delivery program. For example, a health center has ceased operations and is no longer providing primary care services or is providing only minimal services.
- A determination that continued funding would not be in the best interest of the Federal Government. For example, a health center organization's inclusion as an excluded entity on the U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities (LEIE) and/or inclusion on the System for Award Management (SAM) Excluded Parties List System (EPLS),<sup>23</sup> or as an organization that is not qualified per the Federal Awardee Performance and Integrity Information System (FAPIS).<sup>24</sup>

### **Program Compliance and Application Review and Selection**

Project/designation period length is based on an assessment of a health center's compliance with program requirements. Therefore, an existing health center that fails to demonstrate compliance with all Health Center Program requirements may only be awarded Federal Service Area Competition (SAC) funding for a one-year project/designation period.<sup>25</sup>

Further, if a current Health Center Program Federal award recipient has been awarded two consecutive one-year project periods as a result of noncompliance with any Health Center Program requirements, and review of a subsequent SAC application would result in a third consecutive one-year project period due to noncompliance with Program requirements, HRSA will not fund a third consecutive one-year project period.<sup>26</sup> In such circumstances, HRSA may announce a new competition for the [service area](#), in order to identify an organization that can carry out a service delivery program consistent with Health Center Program requirements.

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<sup>23</sup> The Government Services Administration administers the SAM EPLS. The SAM is available at <https://www.sam.gov>.

<sup>24</sup> The FAPIS is available at <https://www.fapis.gov/fapis/index.action>.

<sup>25</sup> Section 330(e)(1)(B) of the PHS Act (42 U.S.C. 254b(e)(1)(B)). In addition, a health center that fails to demonstrate compliance with all Health Center Program requirements, including those in Section 330(k)(3) of the PHS Act, must submit, within 120 days of grant funding, an implementation plan for compliance for HRSA approval. Additional information related to this implementation plan will be included in the applicable Notices of Funding Opportunity and Look-Alike Designation/Renewal of Designation application instructions.

<sup>26</sup> Section 330(e)(4) of the PHS Act states that "Not more than two grants may be made under subparagraph (B) of paragraph (1) for the same entity." While such organizations may apply for future Health Center Program funding under 45 CFR 75.205(c)(3), HRSA may consider factors, including an applicant's history of performance if it has been a prior recipient of [Federal awards](#) or designation when making competitive awards. These factors include, but are not limited to, unsuccessful Progressive Action condition resolution and current compliance with Health Center Program requirements and regulations.

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Consistent with the approach regarding Federal award recipients, HRSA will not renew a Health Center Program look-alike organization's designation if the organization has received two consecutive one-year designation periods and the review of the subsequent RD application would result in a third consecutive one-year designation period. Look-alikes whose designation period has not been renewed may reapply for look-alike designation through the initial designation application process at any time.<sup>27</sup>

In addition, project/designation period length determinations may be impacted by a comprehensive evaluation of the risks to the Health Center Program posed by each applicant if it were to receive an award/designation for a new project or designation period, or for supplemental funding. The specific criteria for determining project period length are further detailed in the applicable Service Area Competition (SAC) Notices of Funding Opportunity (NOFOs) and Look-Alike Renewal of Designation (RD), or supplemental funding application instructions. A health center's ability to demonstrate compliance with program requirements is critical to ensuring continued Federal award support and may, in certain cases, directly impact award decisions for supplemental funding, as outlined in the specific NOFO.

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<sup>27</sup> See <http://www.bphc.hrsa.gov/programopportunities/lookalike/index.html> for more information on the Health Center Program look-alike application process.

## **Chapter 3: Needs Assessment**

*Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. [View the revisions.](#)*

### **Authority**

*Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act; and 42 CFR 51c.104(b)(2-3), 42 CFR 51c.303(k), 42 CFR 56.104(b)(2), 42 CFR 56.104(b)(4), and 42 CFR 56.303(k)*

### **Requirements**

- The health center must define and annually review the boundaries of the catchment area to be served [[service area](#)], including the identification of the medically underserved population or populations within the catchment area in order to ensure that the:
  - Size of this area is such that the services to be provided through the center (including any satellite [service sites](#)) are available and accessible to the residents of the area promptly and as appropriate;
  - Boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and areas served by Federal and State health and social service programs; and
  - Boundaries of such area eliminate, to the extent possible, barriers resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation.
  
- The health center must assess the unmet need for health services in the catchment or proposed catchment area of the center based on the population served, or proposed to be served, utilizing, but not limited to, the following factors:
  - Available health resources in relation to the size of the area and its population, including appropriate ratios of primary care physicians in general or family practice, internal medicine, pediatrics, or obstetrics and gynecology to its population;
  - Health indices for the population of the area, such as infant mortality rate;
  - Economic factors affecting the population's access to health services, such as percentage of the population with incomes below the [poverty](#) level; and
  - Demographic factors affecting the population's need and demand for health services, such as percentage of the population age 65 and over.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

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- a. The health center identifies and annually reviews its service area<sup>1</sup> based on where current or proposed patient populations reside as documented by the ZIP codes reported on the health center's [Form 5B: Service Sites](#). In addition, these service area ZIP codes are consistent with patient origin data reported by ZIP code in its annual [Uniform Data System \(UDS\)](#) report (for example, the ZIP codes reported on the health center's Form 5B: Service Sites would include the ZIP codes in which at least 75 percent of current health center patients reside, as identified in the most recent UDS report).
- b. The health center completes or updates a needs assessment of the current or proposed population at least once every three years,<sup>2</sup> for the purposes of informing and improving the delivery of health center services. The needs assessment utilizes the most recently available data<sup>3</sup> for the service area and, if applicable, [special populations](#) and addresses the following:
  - Factors associated with access to care and health care utilization (for example, geography, transportation, occupation, transience, unemployment, income level, educational attainment);
  - The most significant causes of morbidity and mortality (for example, diabetes, cardiovascular disease, cancer, low birth weight, behavioral health) as well as any associated health disparities; and
  - Any other unique health care needs or characteristics that impact health status or access to, or utilization of, primary care (for example, social factors, the physical environment, cultural/ethnic factors, language needs, housing status).

### **Related Considerations**

The following points describe areas where health centers have discretion with respect to decision-making, or may be useful for health centers to consider when implementing these requirements:

- The health center determines the most appropriate methodologies, tools, and formats for conducting needs assessments (for example, quantitative or qualitative data sources,

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<sup>1</sup> Also referred to as "catchment area" in the Health Center Program implementing regulation in 42 CFR 51c.102.

<sup>2</sup> Compliance may be demonstrated based on the information included in a Service Area Competition (SAC) or a Renewal of Designation (RD) application. Note that in the case of a Notice of Funding Opportunity for a New Access Point or Expanded Services grant, HRSA may specify application-specific requirements for demonstrating an applicant has consulted with the appropriate agencies and providers consistent with Section 330(k)(2)(D) of the Public Health Service Act. Such application-specific requirements may require a completed or updated needs assessment more recent than that which was provided in an applicant's SAC or RD application.

<sup>3</sup> In cases where data are not available for the specific service area or special population, health centers may use extrapolation techniques to make valid estimates using data available for related areas and population groups. Extrapolation is the process of using data that describes one population to estimate data for a comparable population, based on one or more common differentiating demographic characteristics. Where data are not directly available and extrapolation is not feasible, health centers should use the best available data describing the area or population to be served.

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focus groups, patient surveys).

- The health center determines how to complete or update its needs assessments (for example, fulfilling the criteria of a Notice of Funding Opportunity (NOFO), participating in community-wide needs assessments, responding to changes within the community).
- The health center may choose to include additional indicators relevant to its service area and population within its needs assessments.
- The health center may choose to include an additional focus on a specific underserved subset of the service area population (for example, children; persons living with HIV/AIDS; elderly persons), as part of its overall assessment of need in its service area.

## **Chapter 4: Required and Additional Health Services**

*Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. [View the revisions.](#)*

### **Authority**

*Section 330(a)-(b), Section 330(h)(2), and Section 330(k)(3)(K) of the PHS Act; and 42 CFR 51c.102(h) and (j), 42 CFR 56.102(l) and (o), and 42 CFR 51c.303(l)*

### **Requirements**

- The health center must provide the [required primary health services](#) listed in section 330(b)(1) of the PHS Act.
- A health center that receives a [Health Center Program award](#) or [look-alike](#) designation under section 330(h) of the PHS Act to serve [individuals experiencing homelessness](#) must, in addition to these required primary health services, provide substance use disorder services.
- The health center may provide [additional \(supplemental\) health services](#) that are appropriate to meet the health needs of the population served by the health center, subject to review and approval by HRSA.
- All required and applicable additional health services must be provided through one or more service delivery method(s): directly, or through written [contracts](#) and/or cooperative arrangements (which may include formal referrals).
- A health center which serves a population that includes a substantial proportion of individuals of [limited English-speaking ability](#) must:
  - Develop a plan and make arrangements for interpretation and translation that are responsive to the needs of such populations for providing health center services to the extent practicable in the language and cultural context most appropriate to such individuals; and
  - Provide guidance to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***



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- a. The health center provides access to all services included in its HRSA-approved [scope of project](#)<sup>1</sup> ([Form 5A: Services Provided](#)) through one or more service delivery methods,<sup>2</sup> as described below:<sup>3</sup>
- **Direct:** If a required or additional service is provided directly by health center employees<sup>4</sup> or volunteers, this service is accurately recorded in Column I on Form 5A: Services Provided, reflecting that the health center pays for and bills for direct care.
  - **Formal Written Contract/Agreement:**<sup>5</sup> If a required or additional service is provided on behalf of the health center via a formal contract/agreement between the health center and a third party (including a [subrecipient](#)),<sup>6</sup> this service is accurately recorded in Column II on Form 5A: Services Provided, reflecting that the health center pays for the care provided by the third party via

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<sup>1</sup> In accordance with 45 CFR 75.308 ([Uniform Administrative Requirements](#): Revision of Budget and Program Plans), health centers must request prior approval from HRSA for a change in the scope or the objective of the project or program (even if there is no associated budget revision requiring prior written approval). This prior approval requirement applies, among other things, to the addition or deletion of a service within the scope of project. These changes require prior approval from HRSA and must be submitted by the health center as a formal change in scope request. See <http://www.bphc.hrsa.gov/programrequirements/scope.html> for further details on scope of project, including descriptions of the services listed on [Form 5A: Services Provided](#) available at: <https://www.bphc.hrsa.gov/programrequirements/scope/form5aservicedescriptors.pdf>.

<sup>2</sup> The Health Center Program statute states that health centers may provide services “either through the staff and supporting resources of the center or through contracts or cooperative arrangements.” 42 U.S.C. 254b(a)(1) The Health Center Program Compliance Manual utilizes the terms “Formal Written Contract/Agreement” and “Formal Written Referral Arrangement” to refer to such “contracts or cooperative arrangements.” For more information on documenting service delivery methods within the HRSA-approved scope of project on Form 5A: Services Provided, see: <http://bphc.hrsa.gov/programrequirements/scope/form5acolumndescriptors.pdf>.

Other Health Center Program requirements apply when providing services through contractual agreements and formal referral arrangements. Such requirements are addressed in other chapters of the Manual where applicable.

<sup>3</sup> See Chapter 9: [Sliding Fee Discount Program](#) for more information on sliding fee discount program requirements and how they apply to the various service delivery methods.

<sup>4</sup> For purposes of the HRSA-approved scope of project (Form 5A: Services Provided), HRSA/BPHC utilizes Internal Revenue Service (IRS) definitions to differentiate contractors and employees. Typically, an employee receives a salary on a regular basis and a W-2 from the health center with applicable taxes and benefit contributions withheld.

<sup>5</sup> See Chapter 12: [Contracts and Subawards](#) for more information on program requirements around contracting.

<sup>6</sup> For purposes of the HRSA-approved scope of project (Form 5A: Services Provided), services provided via “contract/formal agreement” are those provided by practitioners who are not employed by or volunteers of the health center (for example, an individual provider with whom the health center has a contract; a group practice with which the health center has a contract; a locum tenens staffing agency with which the health center contracts; a subrecipient organization). Typically, a health center will issue an Internal Revenue Service (IRS) Form 1099 to report payments to an individual contractor. See the [FTCA Health Center Policy Manual](#) for information about eligibility for Federal Tort Claims Act (FTCA) coverage for covered activities by covered individuals, which extends liability protections for eligible “covered individuals,” including governing board members and officers, employees, and qualified individual contractors).

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the agreement. In addition, the health center ensures that such contractual agreements for services include:

- How the service will be documented in the patient’s health center record; and
  - How the health center will pay for the service.
- **Formal Written Referral Arrangement:** If access to a required or additional service is provided and billed for by a third party with which the health center has a formal referral arrangement, this service is accurately recorded in Column III on Form 5A: Services Provided, reflecting that the health center is responsible for the act of referral for health center patients and any follow-up care for these patients provided by the health center subsequent to the referral.<sup>7</sup> In addition, the health center ensures that such formal referral arrangements for services, at a minimum, address:
- The manner by which referrals will be made and managed; and
  - The process for tracking and referring patients back to the health center for appropriate follow-up care (for example, exchange of patient record information, receipt of lab results).
- b. Health center patients with [limited English proficiency](#) are provided with interpretation and translation (for example, through bilingual providers, on-site interpreters, high quality video or telephone remote interpreting services) that enable them to have reasonable access to health center services.
- c. The health center makes arrangements and/or provides resources (for example, training) that enable its staff to deliver services in a manner that is culturally sensitive and bridges linguistic and cultural differences.

### **Related Considerations**

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

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<sup>7</sup> For purposes of the HRSA-approved scope of project (Form 5A: Services Provided), access to services provided via “formal referral arrangements” are those referred by the health center but provided and billed for by a third party. Although the service itself is not included within the HRSA-approved scope of project, the act of referral and any follow-up care provided by the health center subsequent to the referral are considered to be part of the health center’s HRSA-approved scope of project. For more information on documenting service delivery methods within the HRSA-approved scope of project on Form 5A: Services Provided, see: <http://bphc.hrsa.gov/programrequirements/scope/form5acolumndescriptors.pdf>.

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- The health center governing board determines which, if any, additional health services to offer in order to meet the health needs of the population served by the health center (subject to review and approval by HRSA).
- The health center determines how to make services accessible in a culturally and linguistically appropriate manner,<sup>8</sup> based on its patient population.
- The health center determines the level or intensity of required and additional services, as well as the method for delivering these services, based on factors such as the needs of the population served, demonstrated unmet need in the community, provider staffing, and collaborative arrangements.
- The health center may, through policies and operating procedures, prioritize the availability of additional services within the approved scope of project to individuals who utilize the health center as their primary care medical home.

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<sup>8</sup> See the National Standards for Culturally and Linguistically Appropriate Services (CLAS) published by the U.S. Department of Health and Human Services at <https://www.thinkculturalhealth.hhs.gov/>. For additional information and guidance. Additional cultural/linguistic competency and health literacy tools, resources and definitions are available online at <https://www.hrsa.gov/cultural-competence/index.html> and <https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/index.html>.

## Chapter 5: Clinical Staffing

### **Authority**

*Sections 330(a)(1), (b)(1)-(2) of the PHS Act; and 42 CFR 51c.303(a), 42 CFR 51c.303(p), 42 CFR 56.303(a), and 42 CFR 56.303(p)*

### **Requirements**

- The health center must provide the [required primary](#) and approved [additional health services](#)<sup>1</sup> of the center through staff and supporting resources of the center or through [contracts](#) or cooperative arrangements.
- The health center must provide the health services of the center so that such services are available and accessible promptly, as appropriate, and in a manner that will assure continuity of service to the residents of the center's catchment area.
- The health center must utilize staff that are qualified by training and experience to carry out the activities of the center.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

- a. The health center ensures that it has clinical staff<sup>2</sup> and/or has contracts or formal referral arrangements in place with other providers or provider organizations to carry out all required and additional services included in the HRSA-approved [scope of project](#).<sup>3</sup>
- b. The health center has considered the size, demographics, and health needs (for example, large number of children served, high prevalence of diabetes) of its patient

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<sup>1</sup> These terms are defined in section 330(b) of the Public Health Service (PHS) Act. For more information, see <http://bphc.hrsa.gov/programrequirements/scope.html>.

<sup>2</sup> Clinical staff includes licensed independent practitioners (for example, Physician, Dentist, Physician Assistant, Nurse Practitioner), other licensed or certified practitioners (for example, Registered Nurse, Licensed Practical Nurse, Registered Dietitian, Certified Medical Assistant), and other clinical staff providing services on behalf of the health center (for example, Medical Assistants or Community Health Workers in states, territories or jurisdictions that do not require licensure or certification).

<sup>3</sup> Health centers seeking coverage for themselves and their providers under the Health Center FTCA Medical Malpractice Program should review the statutory and policy requirements for coverage, as discussed in the [FTCA Health Center Policy Manual](#).

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population in determining the number and mix of clinical staff necessary to ensure reasonable patient access to health center services.

- c. The health center has operating procedures for the initial and recurring review (for example, every two years) of credentials for all clinical staff members (licensed independent practitioners (LIPs), other licensed or certified practitioners (OLCPs), and other clinical staff providing services on behalf of the health center) who are health center employees, individual contractors, or volunteers. These [credentialing](#) procedures would ensure verification of the following, as applicable:
- Current licensure, registration, or certification using a [primary source](#);
  - Education and training for initial credentialing, using:
    - Primary sources for LIPs<sup>4</sup>
    - Primary or other sources (as determined by the health center) for OLCPs and any other clinical staff;
  - Completion of a query through the National Practitioner Data Bank (NPDB);<sup>5</sup>
  - Clinical staff member's identity for initial credentialing using a government-issued picture identification;
  - Drug Enforcement Administration (DEA) registration; and
  - Current documentation of basic life support training.
- d. The health center has operating procedures for the initial granting and renewal (for example, every two years) of privileges for clinical staff members (LIPs, OLCPs, and other clinical staff providing services on behalf of the health center) who are health center employees, individual contractors, or volunteers. These [privileging](#) procedures would address the following:
- Verification of [fitness for duty](#), immunization, and communicable disease status;<sup>6</sup>
  - For initial privileging, verification of current clinical competence via training, education, and, as available, reference reviews;
  - For renewal of privileges, verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews); and
  - Process for denying, modifying or removing privileges based on assessments of clinical competence and/or fitness for duty.

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<sup>4</sup> In states in which the licensing agency, specialty board or registry conducts primary source verification of education and training, the health center would not be required to duplicate primary source verification when completing the credentialing process.

<sup>5</sup> The NPDB is an electronic information repository authorized by Congress. It contains information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers, and suppliers. For more information, see <http://www.npdb.hrsa.gov>.

<sup>6</sup> The CDC has published recommendations and many states have their own recommendations or standards for provider immunization and communicable disease screening. For more information about CDC recommendations, see <http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html>.

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- e. The health center maintains files or records for its clinical staff (for example, employees, individual contractors, and volunteers) that contain documentation of licensure, credentialing verification, and applicable privileges, consistent with operating procedures.
- f. If the health center has [contracts](#) with provider organizations (for example, group practices, locum tenens staffing agencies, training programs) or formal, written referral agreements with other provider organizations that provide services within its scope of project, the health center ensures<sup>7</sup> that such providers are:
  - Licensed, certified, or registered as verified through a credentialing process, in accordance with applicable Federal, state, and local laws; and
  - Competent and fit to perform the contracted or referred services, as assessed through a privileging process.

### ***Related Considerations***

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines its staffing composition (for example, use of nurse practitioners, physician assistants, certified nurse midwives) and its staffing levels (for example, full- and/or part-time staff).
- The health center determines who has approval authority for credentialing and privileging of its clinical staff.
- The health center determines how credentialing will be implemented (for example, a health center may contract with a credentials verification organization (CVO) to perform credentialing activities or it may have its own staff conduct credentialing), including whether to have separate credentialing processes for LIPs versus other provider types.
- The health center determines how it assesses clinical competence and fitness for duty of its staff (for example, regarding clinical competence, a health center may utilize peer review conducted by its own providers or may contract with another organization to conduct peer review).
- The health center determines (consistent with its established privileging criteria) whether to deny, modify, or remove privileges of its staff; whether to use an appeals process in conjunction with such determinations; and whether to implement corrective action plans in conjunction with the denial, modification, or removal of privileges.

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<sup>7</sup> This may be done, for example, through provisions in contracts and cooperative arrangements with such organizations or health center review of the organizations' credentialing and privileging processes.

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- The health center determines (consistent with its contracts/cooperative arrangements) whether to disallow individual providers or organizations from providing health services on the health center's behalf.

## **Chapter 6: Accessible Locations and Hours of Operation**

### **Authority**

*Section 330(k)(3)(A) of the PHS Act; and 42 CFR 51c.303(a) and 42 CFR 56.303(a)*

### **Requirements**

- The [required primary health services](#) of the health center must be available and accessible in the [catchment \[service\] area](#) of the center promptly, as appropriate, and in a manner which ensures continuity of service to the residents of the center's catchment area.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

- a. The health center's [service site\(s\)](#) are accessible to the patient population relative to where this population lives or works (for example, in areas immediately accessible to public housing for health centers targeting [public housing residents](#), or in shelters for health centers targeting [individuals experiencing homelessness, or](#) at migrant camps for health centers targeting [agricultural workers](#)). Specifically, the health center considers the following factors to ensure the accessibility of its sites:
  - Access barriers (for example, barriers resulting from the area's physical characteristics, residential patterns, or economic and social groupings); and
  - Distance and time taken for patients to travel to or between service sites in order to access the health center's full range of in-scope services.
- b. The health center's total number and scheduled hours of operation across its service sites are responsive to patient needs by facilitating the ability to schedule appointments and access the health center's full range of services within the HRSA-approved [scope of project](#)<sup>1</sup> (for example, a health center service site might offer extended evening hours 3 days a week based on input or feedback from patients who cannot miss work for appointments during normal business hours).

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<sup>1</sup> Services provided by a health center are defined at the [awardee](#)/designee level, not by individual site. Thus, not all services must be available at every health center service site; rather, health center patients must have reasonable access to the full complement of services offered by the center as a whole, either directly or through formal written established arrangements. See <http://www.bphc.hrsa.gov/programrequirements/scope.html> for further details on scope of project, including services and column descriptors listed on [Form 5A: Services Provided](#).



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- c. The health center accurately records the sites in its HRSA-approved scope of project<sup>2</sup> on its [Form 5B: Service Sites](#) in HRSA's [Electronic Handbooks \(EHB\)](#).

### ***Related Considerations***

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines which methods to use for obtaining patient input on the accessibility of its service sites and hours of operation (for example, annual survey, focus groups, input from patient board members).
- The health center determines how to measure and consider distance and travel time to or between the health center's sites when assessing its impact on patient access to the health center's services.
- The health center determines how to support patient access to the various service sites included within its HRSA-approved scope of project (for example, whether to provide patient transportation between service sites or use mobile service sites). The health center also determines which service(s) to provide at each site within its HRSA-approved scope of project.

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<sup>2</sup> In accordance with 45 CFR 75.308(c)(1)(i), health centers must request prior approval from HRSA for a "Change in the scope or the objective of the project or program (even if there is no associated budget revision requiring prior written approval)." This prior approval requirement applies to the addition, deletion, or replacement of a service site. These changes require prior approval from HRSA and must be submitted by the health center as a formal change in scope request. See <http://www.bphc.hrsa.gov/programrequirements/scope.html> for further details on scope of project.

## **Chapter 7: Coverage for Medical Emergencies During and After Hours**

### **Authority**

*Section 330(b)(1)(A)(IV) and Section 330(k)(3)(A) of the PHS Act; and 42 CFR 51c.102(h)(4), 42 CFR 56.102(l)(4), 42 CFR 51c.303(a), and 42 CFR 56.303(a)*

### **Requirements**

- To assure continuity of the [required primary health services](#) of the center, the health center must have:
  - Provisions for promptly responding to patient medical emergencies during the health center's regularly scheduled hours; and
  - Clearly defined arrangements for promptly responding to patient medical emergencies after the health center's regularly scheduled hours.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

- a. The health center has at least one staff member trained and certified in basic life support present at each HRSA-approved [service site](#) (as documented on [Form 5B: Service Sites](#)) to ensure the health center has the clinical capacity to respond to patient medical emergencies<sup>1</sup> during the health center's regularly scheduled hours of operation.<sup>2</sup>
- b. The health center has and follows its applicable operating procedures when responding to patient medical emergencies during regularly scheduled hours of operation.
- c. The health center has after-hours coverage operating procedures, which may include formal arrangements<sup>3</sup> with non-health center providers/entities, that ensure:
  - Coverage is provided via telephone or face-to-face by an individual with the qualification and training necessary to exercise professional judgment in assessing a health center patient's need for emergency medical care;

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<sup>1</sup> Medical emergencies may, for example, include those related to physical, oral, behavioral, or other emergent health needs.

<sup>2</sup> See Chapter 6: [Accessible Location and Hours of Operation](#) for more information on hours of operation.

<sup>3</sup> See Chapter 12: [Contracts and Subawards](#) for more information on oversight over such arrangements.

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- Coverage includes the ability to refer patients either to a licensed independent practitioner for further consultation or to locations such as emergency rooms or urgent care facilities for further assessment or immediate care as needed; and
  - Patients, including those with [limited English proficiency](#),<sup>4</sup> are informed of and are able to access after-hours coverage, based on receiving after-hours coverage information and instructions in the language(s), literacy levels, and formats appropriate to the health center's patient population needs.
- d. The health center has documentation of after-hours calls and any necessary follow-up resulting from such calls for the purposes of continuity of care.<sup>5</sup>

### **Related Considerations**

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines the means by which after-hours coverage is provided to health center patients. Examples include: telephone coverage by health center providers, primary care services after hours to address urgent medical conditions on an extended or 24-hour basis at certain service sites, after-hours phone coverage arrangements with other community providers,<sup>6</sup> or “nurse call” lines.
- The health center determines how to make patients aware of the availability of, and procedures for, accessing professional coverage after hours. Examples include after-hours instructions that are: integrated into an automated message on the health center's main phone line explaining how to access after-hours coverage, posted on the door of all health center service sites, provided as part of the initial patient registration process, posted on the health center's website, and/or provided as patient brochures or cards.

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<sup>4</sup> Under Section 602 of Title VI of the Civil Rights Act and the Department of Health and Human Services implementing regulations (45 C.F.R. Section 80.3(b)(2)), recipients of Federal financial assistance, including health centers, must take reasonable steps to ensure meaningful access to their programs, services, and activities by eligible [Limited English Proficient \(LEP\)](#) persons. See <http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html> for further guidance on translating vital documents for LEP persons.

<sup>5</sup> See Chapter 8: [Continuity of Care and Hospital Admitting](#) for more information on continuity of care.

<sup>6</sup> Health centers that are deemed under the Federal Tort Claims Act (FTCA) should ensure that they are familiar with the applicable restrictions on FTCA coverage for services provided to non-health center patients. Review the [FTCA Health Center Policy Manual](#) for further information.

## **Chapter 8: Continuity of Care and Hospital Admitting**

### **Authority**

*Section 330(k)(3)(A) and 330(k)(3)(L) of the PHS Act; and 42 CFR 51.c.303(a) and 42 CFR 56.303(a)*

### **Requirements**

- The health center must provide the [required primary health services](#) of the center promptly and in a manner which will assure continuity of service to patients within the center's catchment area ([service area](#)).
- The health center must develop an ongoing referral relationship with one or more hospitals.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

- a. The health center has documentation of:
  - Health center provider<sup>1</sup> hospital admitting privileges (for example, provider employment contracts or other files indicate the provider(s) has admitting privileges at one or more hospitals); and/or
  - Formal arrangements between the health center and one or more hospitals or entities (for example, hospitalists, obstetrics hospitalist practices) for the purposes of hospital admission of health center patients.
- b. The health center has internal operating procedures and, if applicable, related provisions in its formal arrangements with non-health center provider(s) or entity(ies) that address the following areas for patients who are hospitalized as inpatients or who visit a hospital's emergency department (ED):<sup>2</sup>
  - Receipt and recording of medical information related to the hospital or ED visit, such as discharge follow-up instructions and laboratory, radiology, or other results; and
  - Follow-up actions by health center staff, when appropriate.

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<sup>1</sup> In addition to physicians, various provider types may have admitting privileges, if applicable, based on scope of practice in their State (for example, Nurse Practitioners, Certified Nurse Midwives).

<sup>2</sup> Health center patients may be admitted to a hospital setting through a variety of means (for example, a visit to the Emergency Department (ED) may lead to an inpatient hospital admission, or a health center patient may be directly admitted to a unit of the hospital, such as labor and delivery).

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- c. The health center follows its operating procedures and formal arrangements as documented by:
  - Receipt and recording of medical information related to the hospital or ED visit, such as discharge follow-up instructions and laboratory, radiology, or other results; and
  - Evidence of follow-up actions taken by health center staff based on the information received, when appropriate.

### ***Related Considerations***

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines the number and type(s) of hospitals with which its providers will have admitting arrangements based on the services included in the HRSA-approved [scope of project \(Form 5A: Services Provided\)](#), the patient population served, and the service area.
- The health center determines whether the most appropriate means for hospital admitting is to use its own providers, have arrangements with non-health center providers, or both.
- The health center determines the most appropriate formats and mechanisms for discharge planning and tracking (for example, use of community-wide shared electronic health record, patient hospitalization tracking log).

## **Chapter 9: Sliding Fee Discount Program**

*Note: This chapter contains revisions based on a technical correction. [View the revisions.](#)*

### **Authority**

*Section 330(k)(3)(G) of the PHS Act; 42 CFR 51c.303(f), 42 CFR 51c.303(g), 42 CFR 51c.303(u), 42 CFR 56.303(f), 42 CFR 56.303(g), and 42 CFR 56.303(u)*

### **Requirements**

- The health center must operate in a manner such that no patient shall be denied service due to an individual's inability to pay.<sup>1</sup>
- The health center must prepare a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and must prepare a corresponding schedule of discounts [sliding fee discount schedule (SFDS)] to be applied to the payment of such fees or payments, by which discounts are adjusted on the basis of the patient's ability to pay.
- The health center must establish systems for [sliding fee] eligibility determination.
- The health center's schedule of discounts must provide for:
  - A full discount to individuals and families with annual incomes at or below those set forth in the most recent [Federal Poverty Guidelines \(FPG\)](#) [100 percent of the FPG], except that nominal charges for service may be collected from such individuals and families where imposition of such fees is consistent with project goals; and
  - No discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines [200 percent of the FPG].

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

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<sup>1</sup> See Chapter 16: [Billing and Collections](#) for more information on waiving or reducing charges due to a patient's inability to pay.

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- a. The health center has a sliding fee discount program<sup>2</sup> that applies to all [required](#) and [additional health services](#)<sup>3</sup> within the HRSA-approved [scope of project](#) for which there are distinct fees.<sup>4</sup>
- b. The health center has board-approved policy(ies) for its sliding fee discount program that apply uniformly to all patients and address the following areas:
  - Definitions of income<sup>5</sup> and family;
  - Assessment of all patients for sliding fee discount eligibility based only on income and family size, including methods for making such assessments;
  - The manner in which the health center’s sliding fee discount schedule(s) (SFDS(s)) will be structured in order to ensure that patient charges are adjusted based on ability to pay; and
  - *Only applicable to health centers that choose to have a nominal charge for patients at or below 100 percent of the FPG:* The setting of a flat nominal charge(s) at a level that would be nominal from the perspective of the patient (for example, based on input from patient board members, patient surveys, advisory committees, or a review of co-pay amount(s) associated with Medicare and Medicaid for patients with comparable incomes) and would not reflect the actual cost of the service being provided.<sup>6</sup>
- c. For services provided directly by the health center ([Form 5A: Services Provided](#), Column I), the health center’s SFDS(s) is structured consistent with its policy and provides discounts as follows:
  - A full discount is provided for individuals and families with annual incomes at or below 100 percent of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
  - Partial discounts are provided for individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the current FPG, and

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<sup>2</sup> A health center’s sliding fee discount program consists of the schedule of discounts that is applied to the fee schedule and adjusts fees based on the patient’s ability to pay. A health center’s sliding fee discount program also includes the related policies and procedures for determining sliding fee eligibility and applying sliding fee discounts.

<sup>3</sup> See Chapter 4: [Required and Additional Health Services](#) for more information on requirements for services within the scope of the project.

<sup>4</sup> A distinct fee is a fee for a specific service or set of services, which is typically billed for separately within the local health care market.

<sup>5</sup> Income is defined as earnings over a given period of time used to support an individual/household unit based on a set of criteria of inclusions and exclusions. Income is distinguished from assets, as assets are a fixed economic resource while income is comprised of earnings.

<sup>6</sup> Nominal charges are not “minimum fees,” “minimum charges,” or “co-pays.”

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those discounts adjust based on gradations in income levels and include at least three discount pay classes.<sup>7</sup>

- No discounts are provided to individuals and families with annual incomes above 200 percent of the current FPG.<sup>8</sup>
- d. For health centers that choose to have more than one SFDS, these SFDSs would be based on services (for example, having separate SFDSs for broad service types, such as medical and dental, or distinct subcategories of service types, such as preventive dental and additional dental services) and/or on service delivery methods (for example, having separate SFDSs for services provided directly by the health center and for in-scope services provided via formal written [contract](#)) and no other factors.
  - e. The health center's SFDS(s) has incorporated the most recent FPG.
  - f. The health center has operating procedures for assessing/re-assessing all patients for income and family size consistent with board-approved sliding fee discount program policies.
  - g. The health center has records of assessing/re-assessing patient income and family size except in situations where a patient has declined or refused to provide such information.
  - h. The health center has mechanisms for informing patients of the availability of sliding fee discounts (for example, distributing materials in language(s) and literacy levels appropriate for the patient population, including information in the intake process, publishing information on the health center's website).
  - i. For in-scope services provided via contracts (Form 5A: Services Provided, Column II, Formal Written Contract/Agreement), the health center ensures that fees for such services are discounted as follows:
    - A full discount is provided for individuals and families with annual incomes at or below 100 percent of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
    - Partial discounts are provided for individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the current FPG, and those discounts adjust based on gradations in income levels and include at least three discount pay classes.

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<sup>7</sup> For example, a SFDS with discount pay classes of 101 percent to 125 percent of the FPG, 126 percent to 150 percent of the FPG, 151 percent to 175 percent of the FPG, 176 percent to 200 percent of the FPG, and over 200 percent of the FPG would have four discount pay classes between 101 percent and 200 percent of the FPG.

<sup>8</sup> See Chapter 16: [Billing and Collections](#), if the health center has access to other grants or subsidies that support patient care.



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- No discounts are provided to individuals and families with annual incomes above 200 percent of the current FPG.
- j. For services provided via formal referral arrangements (Form 5A: Services Provided, Column III), the health center ensures that fees for such services are either discounted as described in element “c.” above or discounted in a manner such that:
  - Individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the FPG receive an equal or greater discount for these services than if the health center’s SFDS were applied to the referral provider’s fee schedule; and
  - Individuals and families at or below 100 percent of the FPG receive a full discount or a nominal charge for these services.
- k. Health center patients who are eligible for sliding fee discounts and have third-party coverage are charged no more for any out-of-pocket costs than they would have paid under the applicable SFDS discount pay class.<sup>9</sup> Such discounts are subject to potential legal and contractual restrictions.<sup>10</sup>
- l. The health center evaluates, at least once every three years, its sliding fee discount program. At a minimum, the health center:
  - Collects utilization data that allows it to assess the rate at which patients within each of its discount pay classes, as well as those at or below 100 percent of the FPG, are accessing health center services;
  - Utilizes this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys of patients at various income levels) to evaluate the effectiveness of its sliding fee discount program in reducing financial barriers to care; and
  - Identifies and implements changes as needed.

### **Related Considerations**

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

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<sup>9</sup> For example, an insured patient receives a health center service for which the health center has established a fee of \$80, per its fee schedule. Based on the patient’s insurance plan, the co-pay would be \$60 for this service. The health center also has determined, through an assessment of income and family size, that the patient’s income is 150 percent of the FPG and thus qualifies for the health center’s SFDS. Under the SFDS, a patient with an income at 150 percent of the FPG would receive a 50 percent discount of the \$80 fee, resulting in a charge of \$40 for this service. Rather than the \$60 co-pay, the health center would charge the patient no more than \$40 out-of-pocket, consistent with its SFDS, as long as this is not precluded or prohibited by the applicable insurance contract.

<sup>10</sup> Such limitations may be specified by applicable Federal or state programs, or private payor contracts.

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- The health center determines whether to establish a nominal charge for individuals and families at or below 100 percent of the FPG.
- The health center determines how to document income and family size in health center records.
- The health center determines whether to take into consideration the characteristics of its patient population when developing definitions for income and family size and procedures for assessing patient eligibility for SFDS. For example, the health center may consider the availability of income documentation for [individuals experiencing homelessness](#), build in cost of living considerations when calculating income, permit self-declaration of income and family size.
- The health center determines how and with what frequency to re-assess patient eligibility for the SFDS.
- The health center determines whether to identify individuals who refuse to provide information on income and family size as ineligible for SFDS.
- The health center determines how to make patients aware of sliding fee discounts (for example, signage, registration process).
- The health center determines:
  - Whether to establish more than three discount pay classes above 100 percent of the FPG and up to and including 200 percent of the FPG;
  - What income range to establish for each discount pay class above 100 percent of the FPG and up to and including 200 percent of the FPG;
  - What method to use for discounting fees above 100 percent of the FPG and up to and including 200 percent of the FPG (for example, percentage of fee, fixed/flat fee per discount pay class); and
  - Whether to establish multiple SFDSs (for example, separate SFDSs for medical services and dental services) including, if appropriate, different nominal charges for each SFDS.

## **Chapter 10: Quality Improvement/Assurance**

### **Authority**

*Section 330(k)(3)(C) of the PHS Act; and 42 CFR 51c.110, 42 CFR 51c.303(b), 42 CFR 51c.303(c), 42 CFR 51c.304(d)(3)(iv-vi), 42 CFR 56.111, 42 CFR 56.303(b), 42 CFR 56.303(c), and 42 CFR 56.304(d)(4)(v-vii)*

### **Requirements**

- The health center must have an ongoing quality improvement/assurance (QI/QA) system that includes clinical services and [clinical] management and maintains the confidentiality of patient records.
- The health center's ongoing QI/QA system must provide for all of the following:
  - Organizational arrangements, including a focus of responsibility, to support the quality assurance program and the provision of high quality patient care; and
  - 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 center. Such assessments must:
    - 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;
    - Assess patient satisfaction, achievement of project objectives, and include a process for hearing and resolving patient grievances; and
    - Identify and document the necessity for change in the provision of services by the center and result in the institution of such change, where indicated.
- The health center must maintain the confidentiality of patient records, including all information as to personal facts and circumstances obtained by the health center staff about recipients of services. Specifically, the health center must not divulge such information without the individual's consent except as may be required by law or as may be necessary to provide service to the individual or to provide for medical audits by the Secretary of HHS or his/her designee with appropriate safeguards for confidentiality of patient records.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

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- a. The health center has a board-approved policy(ies) that establishes a QI/QA program.<sup>1</sup> This QI/QA program addresses the following:
  - The quality and utilization of health center services;
  - Patient satisfaction and patient grievance processes; and
  - Patient safety, including adverse events.
- b. The health center designates an individual(s) to oversee the QI/QA program established by board-approved policy(ies). This individual's responsibilities would include, but would not be limited to, ensuring the implementation of QI/QA operating procedures and related assessments, monitoring QI/QA outcomes, and updating QI/QA operating procedures.
- c. The health center has operating procedures or processes that address all of the following:
  - Adhering to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable;
  - Identifying, analyzing, and addressing patient safety and adverse events and implementing follow-up actions, as necessary;
  - Assessing patient satisfaction;
  - Hearing and resolving patient grievances;
  - Completing periodic QI/QA assessments on at least a quarterly basis to inform the modification of the provision of health center services, as appropriate; and
  - Producing and sharing reports on QI/QA to support decision-making and oversight by key management staff and by the governing board regarding the provision of health center services.
- d. The health center's physicians or other licensed health care professionals conduct QI/QA assessments on at least a quarterly basis, using data systematically collected from patient records, to ensure:
  - Provider adherence to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable; and
  - The identification of any patient safety and adverse events and the implementation of related follow-up actions, as necessary.
- e. The health center maintains a retrievable health record (for example, the health center has implemented a certified Electronic Health Record (EHR))<sup>2</sup> for each patient, the

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<sup>1</sup> See Chapter 19: [Board Authority](#) for more information on the health center governing board's role in approving policies.

<sup>2</sup> CMS and the Office of the National Coordinator for Health Information Technology (ONC) have established standards and other criteria for structured data that Electronic Health Records (EHRs) must use in order to qualify for CMS incentive programs. For health centers that participate in these CMS Incentive Programs, further information is available at <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification.html>.

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format and content of which is consistent with both Federal and state laws and requirements.

- f. The health center has implemented systems (for example, certified EHRs and corresponding standard operating procedures) for protecting the confidentiality of patient information and safeguarding this information against loss, destruction, or unauthorized use, consistent with Federal and state requirements.

### ***Related Considerations***

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines whether the position designated with responsibility for the QI/QA program (for example, Clinical Director, QI Director) is full-time, part-time, or combined with another position, and whether it is filled by an employee or via [contract](#).
- The health center determines whether the position designated with responsibility for the QI/QA program is filled by a physician, other licensed health care professional (for example, registered nurse, nurse practitioner), or other qualified individual (for example, an individual with a Master of Public Health or a Master of Healthcare Administration).
- The health center determines which QI/QA methodology(ies) to use.
- The health center determines the type of patient health record system that it will use.
- The health center determines the format, content, and focus of QI/QA reports.

## **Chapter 11: Key Management Staff**

*Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. [View the revisions.](#)*

### **Authority**

*Section 330(k)(3)(H)(ii), and 330(k)(3)(I)(i) of the PHS Act; 42 CFR 51c.104(b)(4), 42 CFR 51c.303(p), 42 CFR 56.104(b)(5), and 42 CFR 56.303(p); and 45 CFR 75.308(c)(1)(ii)(iii)*

### **Requirements**

- The health center must have position descriptions for key personnel [also referred to as key management staff] that set forth training and experience qualifications necessary to carry out the activities of the health center.
- The health center must maintain sufficient key personnel [also referred to as key management staff] to carry out the activities of the health center.
- The health center must request prior approval from HRSA for a change in the key person specified in the [Health Center Program award](#) or Health Center Program [look-alike](#) designation.
- The health center must directly employ its Project Director/CEO.<sup>1</sup>

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

- a. The health center has determined the makeup of and distribution of functions among its key management staff<sup>2</sup> and the percentage of time dedicated to the Health Center

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<sup>1</sup> While the position title of the key person who is specified in the [award](#)/designation may vary, for the purposes of the Health Center Program, this Chapter will utilize the term “Project Director/CEO” when referring to this key person. Under 45 CFR 75.2, the term “Principal Investigator/Program Director (PI/PD)” means the individual(s) designated by the recipient to direct the project or program being supported by the [grant](#). The PI/PD is responsible and accountable to officials of the recipient organization for the proper conduct of the project, program, or activity. For the purposes of the Health Center Program, “Project Director/CEO” is synonymous with the term “PI/PD.”

<sup>2</sup> Examples of key management staff may include Project Director/CEO, Clinical Director/Chief Medical Officer, Chief Financial Officer, Chief Operating Officer, Nursing/Health Services Director, or Chief Information Officer.

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Program project for each position, as necessary to carry out the HRSA-approved [scope of project](#).

- b. The health center has documented the training and experience qualifications, as well as the duties or functions, for each key management staff position (for example, in position descriptions).
- c. The health center has implemented, as necessary, a process for filling vacant key management staff positions (for example, vacancy announcements have been published and reflect the identified qualifications).
- d. The health center's Project Director/CEO is directly employed by the health center,<sup>3</sup> reports to the health center's governing board<sup>4</sup> and is responsible for overseeing other key management staff in carrying out the day-to-day activities necessary to fulfill the HRSA-approved scope of project.
- e. If there has been a post-award change in the Project Director/CEO position,<sup>5</sup> the health center requests and receives prior approval from HRSA.

### **Related Considerations**

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center's governing board determines when a less than full time Project Director/CEO position is sufficient to oversee the day-to-day activities of the HRSA-approved scope of project.
- The health center determines when and if it is appropriate and necessary to contract for key management staff positions (other than the CEO, who may not be a contractor), rather than directly employ such individuals.

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<sup>3</sup> Public agency health centers utilizing a co-applicant structure would demonstrate compliance with the statutory requirement for direct employment of the Project Director/CEO by demonstrating that the public agency, as the Health Center Program awardee/designee of record, directly employs the Project Director/CEO. Refer to related requirements in Chapter 19: [Board Authority](#) regarding public agencies with co-applicants.

<sup>4</sup> Refer to related requirements in Chapter 19: [Board Authority](#) regarding the selection and dismissal of the Project Director/CEO by the health center board as part of its oversight responsibilities for the Health Center Program project.

<sup>5</sup> Such changes include situations in which the current Project Director/CEO will be disengaged from involvement in the Health Center Program project for any continuous period for more than 3 months or will reduce time devoted to the project by 25 percent or more from the level that was approved at the time of award [see: 45 CFR 75.308(c)(1)(ii) and (iii)].

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- The health center determines key management staff position titles (for example, utilizing the title “CEO” or “Project Director”) and how functions are distributed among its key management staff positions (for example, determining in a smaller health center whether it is appropriate to combine the CEO and CFO functions).



## Chapter 12: Contracts and Subawards

*Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. [View the revisions.](#)*

### **Authority**

*Section 330(k)(3)(I) and Section 330(q) of the PHS Act; 42 CFR 51c.113, 42 CFR 56.114, 42 CFR 51c.303(t), and 42 CFR 56.303(t); 45 CFR Part 75 Subpart D; and Section 1861(aa)(4)(A)(ii) and Section 1905(l)(2)(B)(ii) of the Social Security Act*

### **Requirements**

#### **Contracts: Procurement and Monitoring<sup>1</sup>**

- The health center must determine<sup>2</sup> whether an individual agreement that will result in disbursement of Federal funds will be carried out through a [contract](#) or a [subaward](#) and structure the agreement accordingly.<sup>3</sup>
- The health center must request and receive approval from HRSA to contract for [substantive programmatic] work<sup>4</sup> under its Health Center Program [award](#).
- The health center must use its own documented procurement procedures which reflect applicable State, local, and tribal laws and regulations, provided that for procurement actions paid for in whole or in part under the Federal award, the procurements conform with 45 CFR Part 75.

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<sup>1</sup> All procurement standards included in 45 CFR Part 75 apply for procurement actions paid for in whole or in part under the Federal award. These standards do not relieve the non-Federal entity of any contractual responsibilities under its contracts. HRSA will not substitute its judgment for that of the non-Federal entity unless the matter is primarily a Federal concern. Violations of law will be referred to the local, tribal, state, or Federal authority having proper jurisdiction.

<sup>2</sup> Per 45 CFR 75.351(c): “In determining whether an agreement between a [pass-through entity](#) [Health Center Program [awardee](#)] and another [non-Federal entity](#) casts the latter as a [subrecipient](#) or a contractor, the substance of the relationship is more important than the form of the agreement. All of the characteristics listed above [see 45 CFR 75.351(a) and (b)] may not be present in all cases, and the pass-through entity [Health Center Program awardee] must use judgment in classifying each agreement as a subaward or a procurement [contract](#).”

<sup>3</sup> Specifically, the purpose of a subaward is to carry out a portion of the [Federal award](#) and creates a Federal assistance relationship with the subrecipient, while the purpose of a contract is to obtain goods or services for the health center’s own use and creates a procurement relationship with the contractor.

<sup>4</sup> For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for the majority of health care providers. The acquisition of supplies, material, equipment, or general support services is not considered programmatic work. Substantive programmatic work may be further defined within HRSA Notices of Funding Opportunity (NOFOs) and applications.

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- The health center must perform a cost or price analysis in connection with every procurement action paid for in whole or in part by the Federal award in excess of the Simplified Acquisition Threshold.<sup>5</sup>
- The health center must conduct all procurement transactions paid for in whole or in part by the Federal award, in a manner that provides full and open competition consistent with the standards of 45 CFR 75.328. Procurements by non-competitive proposals<sup>6</sup> are allowable only when:
  - The item is available only from a single source;
  - The public exigency or emergency for the requirement will not permit a delay resulting from competitive solicitation;
  - The non-competitive proposal is specifically authorized by HRSA (or, in the case of a [subrecipient](#), the Federal [award recipient](#)) in response to a written request from the Federal award recipient or subrecipient; or
  - Competition is determined to be inadequate after soliciting a number of sources.
- Health center contracts with other providers for the provision of health services within the HRSA-approved [scope of project](#) must include a schedule of rates and method of payment for such services.
- The health center must oversee contractors to ensure their performance is in accordance with the terms, conditions, and specifications of their contracts and to assure compliance with applicable Federal requirements.<sup>7</sup>
- The health center must retain financial records, supporting documents, statistical records, and all other records pertinent to the Health Center Program award carried out under contracts for a period of three years from the date of the submission of the final expenditures report to HHS.

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<sup>5</sup> *Simplified acquisition threshold* means the dollar amount below which a non-Federal entity may purchase property or services using small purchase methods. Non-Federal entities adopt small purchase procedures in order to expedite the purchase of items costing less than the simplified acquisition threshold. The simplified acquisition threshold is set by the Federal Acquisition Regulation at 48 CFR subpart 2.1 and in accordance with 41 U.S.C. 1908. The acquisition threshold is periodically adjusted for inflation.

<sup>6</sup> As defined by 45 CFR 75.329(f), procurement by “noncompetitive proposals” is procurement through solicitation of a proposal from only one source.

<sup>7</sup> The health center is responsible, in accordance with good administrative practice and sound business judgment, for the settlement of all contractual and administrative issues arising out of procurements paid for in whole or in part under the Federal award. These issues include, but are not limited to, source evaluation, protests, disputes, and claims.

### Subawards: Monitoring and Management

- The Health Center Program awardee must determine whether an individual agreement that will result in disbursement of Federal funds will be carried out through a contract or a subaward and structure the agreement accordingly.<sup>8</sup> With respect to subawards:
  - The health center awardee must make documented, case-by-case determinations whether the agreement it makes for the disbursement of Federal program funds casts the party receiving the funds in the role of a [subrecipient](#), consistent with the characteristics outlined in 45 CFR 75.351;<sup>9</sup>
  - The health center awardee must identify subawards as such to the subrecipient, and provide all applicable information to the subrecipient as described in 45 CFR 75.352(a)(1), including the total amount of the Federal Award committed to the subrecipient by the health center awardee;
  - If any of the data elements contained in 45 CFR 75.352(a)(1) change, the health center awardee must include the change(s) in a subsequent subaward modification.
- The Health Center Program awardee must request and receive approval from HRSA to make a subaward under the [Federal award](#).
- The Health Center Program awardee must ensure that, at the time of making a subaward, each subrecipient, which is a subawardee of Federal funds, complies with all applicable requirements specified in the Federal award (including those found in section 330 of the PHS Act, implementing program regulations, and grants regulations in 45 CFR Part 75).
- The Health Center Program awardee must monitor the ongoing activities of the subrecipient to ensure that the subaward is used for authorized purposes and that the subrecipient maintains compliance with all applicable requirements specified in the Federal award (including those found in section 330 of the PHS Act, implementing program regulations, and grants regulations in 45 CFR Part 75).
- The Health Center Program awardee must retain financial records, supporting documents, statistical records, and all other records pertinent to the Health Center Program award as carried out under any subawards for a period of three years from the date of the submission of the final expenditures report to the health center awardee.

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<sup>8</sup> Specifically, the purpose of a subaward is to carry out a portion of the Federal award and create a Federal assistance relationship with the subrecipient, while the purpose of a contract is to obtain goods or services for the health center's own use and creates a procurement relationship with the contractor.

<sup>9</sup> Per 45 CFR 75.351(c): "In determining whether an agreement between a [pass-through entity](#) [Health Center Program awardee] and another [non-Federal entity](#) casts the latter as a subrecipient or a contractor, the substance of the relationship is more important than the form of the agreement. All of the characteristics listed above [see 45 CFR 75.351(a) and (b)] may not be present in all cases, and the pass-through entity [Health Center Program awardee] must use judgment in classifying each agreement as a subaward or a procurement contract."

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- The Health Center Program awardee must consider whether the results of the subrecipient's audits, on-site reviews, or other monitoring indicate conditions that necessitate adjustments to the Health Center Program awardee's own records and whether the Health Center Program awardee must consider taking enforcement action against noncompliant subrecipients as described in 45 CFR 75.371.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

#### **Contracts: Procurement and Monitoring**

- a. The health center has written procurement procedures that comply with Federal procurement standards, including a process for ensuring that all procurement costs directly attributable to the Federal award are allowable, consistent with Federal Cost Principles.<sup>10</sup>
- b. The health center has records for procurement actions paid for in whole or in part under the Federal award that include the rationale for method of procurement, selection of contract type, contractor selection or rejection, and the basis for the contract price. This would include documentation related to noncompetitive procurements.
- c. The health center retains final contracts and related procurement records, consistent with Federal document maintenance requirements, for procurement actions paid for in whole or in part under the Federal award.<sup>11</sup>
- d. The health center has access to contractor records and reports related to health center activities in order to ensure that all activities and reporting requirements are being carried out in accordance with the provisions and timelines of the related contract (for example, performance goals are achieved, [Uniform Data System \(UDS\)](#) data are submitted by appropriate deadlines, funds are used for authorized purposes).
- e. If the health center has arrangements with a contractor to perform substantive programmatic work,<sup>12</sup> the health center requested and received prior approval from HRSA as documented by:

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<sup>10</sup> See 45 CFR 75 Subpart E: Cost Principles.

<sup>11</sup> See 45 CFR 75.361 for HHS retention requirements for records.

<sup>12</sup> For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for the majority of health care providers. The acquisition of supplies, material, equipment, or general support services is not considered programmatic work. Substantive programmatic work may be further defined within HRSA Notices of Funding Opportunity (NOFOs) and applications.

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- An approved competing continuation/renewal of designation application or other competitive application, which included such an arrangement; or
  - An approved post-award request for such arrangements submitted within the project period (for example, change in scope).
- f. The health center's contracts that support the HRSA-approved scope of project include provisions that address the following:
- The specific activities or services to be performed or goods to be provided;
  - Mechanisms for the health center to monitor contractor performance; and
  - Requirements for the contractor to provide data necessary to meet the recipient's applicable Federal financial and programmatic reporting requirements, as well as provisions addressing record retention and access, audit, and property management.<sup>13</sup>

### **Subawards: Monitoring and Management**

- g. If the health center has made a subaward, the health center requested and received prior approval from HRSA as documented by:
- An approved competing continuation/renewal of designation application or other competitive application, which included the subrecipient arrangement; or
  - An approved post-award request for such subrecipient arrangements submitted within the project period (for example, change in scope).
- h. The health center's subaward(s) that supports the HRSA-approved scope of project includes provisions that address the following:
- The specific portion of the HRSA-approved scope of project to be performed by the subrecipient;
  - The applicability of all Health Center Program requirements to the subrecipient;
  - The applicability to the subrecipient of any distinct statutory, regulatory, and policy requirements of other Federal programs associated with their HRSA-approved scope of project;<sup>14</sup>
  - Mechanisms for the health center to monitor subrecipient compliance and performance;
  - Requirements for the subrecipient to provide data necessary to meet the health center's applicable Federal financial and programmatic reporting requirements,

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<sup>13</sup> For further guidance on these requirements, see the HHS Grants Policy Statement, at <http://www.hrsa.gov/grants/hhsgrantspolicy.pdf>.

<sup>14</sup> Subrecipients are generally eligible to receive [FQHC](#) payment rates under Medicaid and Medicare, 340B Drug Pricing, and Federal Tort Claims Act (FTCA) coverage. However, such benefits are not automatically conferred and may require additional actions and approvals (for example, submission and approval of a subrecipient FTCA deeming application).

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as well as provisions addressing record retention and access, audit, and property management;<sup>15</sup> and

- Requirements that all costs paid for by the Federal subaward are allowable consistent with Federal Cost Principles.<sup>16</sup>
- i. The health center monitors the activities of its subrecipient to ensure that the subaward is used for authorized purposes and that the subrecipient maintains compliance with all applicable requirements specified in the Federal award (including those found in section 330 of the PHS Act, implementing program regulations and grants regulations in 45 CFR Part 75). Specifically, the health center's monitoring of the subrecipient includes:
  - Reviewing financial and performance reports required by the health center in order to ensure performance goals are achieved, UDS data are submitted by appropriate deadlines, and funds are used for authorized purposes;
  - Ensuring that the subrecipient takes timely and appropriate action on all deficiencies pertaining to the subaward that may be identified through audits, on-site reviews, and other means; and
  - Issuing a management decision for audit findings pertaining to the subaward.<sup>17</sup>
- j. The health center retains final subrecipient agreements and related records, consistent with Federal document maintenance requirements.<sup>18</sup>

### **Related Considerations**

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines the methods it will utilize to monitor contractor activities and performance. Such monitoring could include:
  - Periodic evaluations of contractor performance (for example, results from reviews of invoices and records, reports from staff of contractor activity) that are shared with the board and management staff; and/or
  - Documentation at the time of contract completion or renewal that the contractor has met the terms, conditions, and specifications of the contract.
- The health center determines the methods it will utilize to settle any contractual or administrative issues arising out of procurements, with respect to contracts (for

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<sup>15</sup> For further guidance on these requirements, see the HHS Grants Policy Statement, at <http://www.hrsa.gov/grants/hhsgrantspolicy.pdf>.

<sup>16</sup> See 45 CFR 75 Subpart E: Cost Principles.

<sup>17</sup> Per 45 CFR 75.521, the management decision [issued by the health center to the subrecipient] must clearly state whether or not the audit finding is sustained, the reasons for the decision, and the expected auditee action to repay disallowed costs, make financial adjustments, or take other action.

<sup>18</sup> See 45 CFR 75.361 for HHS retention requirements for records.

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example protests, disputes, claims) or how to take enforcement actions in the case of subawards.

- The health center determines the methods it will utilize to monitor subrecipient compliance and performance with Health Center Program requirements. Such monitoring could include:
  - Receiving/reviewing copies of the subrecipient governing board's meeting minutes;
  - Performing site visits;
  - Conducting regular check-in calls and updates regarding Health Center Program requirements or new Health Center Program policies;
  - Receiving/reviewing the subrecipient's annual audit;
  - Conducting periodic joint meetings between the two entities' boards, or between the health center's key management staff and the subrecipient's board;
  - Receiving/reviewing periodic written reports from the subrecipient; and/or
  - Sharing data and creating systems for the sharing of financial and medical records for the purpose of Health Center Program data reporting.

## **Chapter 13: Conflict of Interest**

### **Authority**

*Section 330(a)(1) and 330(k)(3)(D) of the PHS Act; 42 CFR 51c.113 and 42 CFR 56.114; and 45 CFR 75.327*

### **Requirements**

- The health center must maintain written standards of conduct covering conflicts of interest<sup>1</sup> and governing the actions of its employees engaged in the selection, award, or administration of [contracts](#) that comply with all applicable Federal requirements.
- No employee, officer, or agent<sup>2</sup> of the health center may participate in the selection, award, or administration of a contract supported by a [Federal award](#) if he or she has a real or apparent conflict of interest.
- Officers, employees, and agents of the health center may neither solicit nor accept gratuities, favors, or anything of monetary value from contractors or parties to subcontracts.
- The health center's standards of conduct must provide for disciplinary actions to be applied for violations of such standards by officers, employees, or agents of the health center.
- If the health center has a parent, affiliate, or subsidiary organization that is not a State, local government, or Indian tribe, the health center also must maintain written standards of conduct covering organizational conflicts of interest.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

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<sup>1</sup> A conflict of interest arises when the employee, officer, or agent (including but not limited to any member of the governing board), any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in or a tangible personal benefit from a firm considered for a contract. See: 45 CFR 75.327(c)1.

<sup>2</sup> An agent of the health center includes, but is not limited to, a governing board member, an employee, officer, or contractor acting on behalf of the health center.



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- a. The health center has and implements written standards of conduct that apply, at a minimum, to its procurements paid for in whole or in part by the Federal award. Such standards:
  - Apply to all health center employees, officers, board members, and agents involved in the selection, award, or administration of such contracts;
  - Require written disclosure of real or apparent conflicts of interest;
  - Prohibit individuals with real or apparent conflicts of interest with a given contract from participating in the selection, award, or administration of such contract;<sup>3</sup>
  - Restrict health center employees, officers, board members, and agents involved in the selection, award, or administration of contracts from soliciting or accepting gratuities, favors, or anything of monetary value for private financial gain from such contractors or parties to sub-agreements (including [subrecipients](#) or affiliate organizations);<sup>4</sup> and
  - Enforce disciplinary actions on health center employees, officers, board members, and agents for violating these standards.
  
- b. If the health center has a parent, affiliate, or subsidiary that is not a State, local government, or Indian tribe, the health center has and implements written standards of conduct covering organizational conflicts of interest<sup>5</sup> that might arise when conducting a procurement action involving a related organization. These standards of conduct require:
  - Written disclosure of conflicts of interest that arise in procurements from a related organization; and
  - Avoidance and mitigation of any identified actual or apparent conflicts during the procurement process.
  
- c. The health center has mechanisms or procedures for informing its employees, officers, board members, and agents of the health center's standards of conduct covering conflicts of interest, including organizational conflicts of interest, and for governing its actions with respect to the selection, award and administration of contracts.
  
- d. In cases where a conflict of interest was identified, the health center's procurement records document adherence to its standards of conduct (for example, an employee

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<sup>3</sup> This includes, but is not limited to, prohibiting board members that are employees or contractors of a [subrecipient](#) of the health center from participating in the selection, award, or administration of that [subaward](#). This also includes prohibiting board members who are employees of an organization that contracts with the health center from participating in the selection, award, or administration of that contract.

<sup>4</sup> Health centers may set standards for situations in which the financial interest is not substantial or the gift is an unsolicited item of nominal value. See [Related Considerations](#) in this chapter.

<sup>5</sup> Organizational conflicts of interest mean that because of relationships with a parent company, affiliate, or subsidiary organization, the health center is unable or appears to be unable to be impartial in conducting a procurement action involving a related organization. See: 45 CFR 75.327(c)(2).

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whose family member was competing for a health center contract was not permitted to participate in the selection, award, or administration of that contract).

### ***Related Considerations***

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines the appropriate methods for employees, officers, board members, and agents to disclose real or apparent conflicts of interest, as it applies to the procurement process.
- The health center determines how to inform its employees, officers, board members, and agents about the health center's standards of conduct (for example, inclusion within operating procedures or staff manuals, as part of disclosure forms/statements, employee and board orientations or trainings).
- The health center determines whether to establish additional standards of conduct that are not addressed by Federal requirements.
- The health center determines whether to set standards that define when a financial interest is not substantial or a gift is an unsolicited item of nominal value and, therefore, could be accepted by employees, officers, board members, and agents of the health center.

## **Chapter 14: Collaborative Relationships**

*Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. [View the revisions.](#)*

### **Authority**

*Section 330(k)(3)(B) of the PHS Act; and 42 CFR 51c.303(n), 42 CFR 56.303(n), and 42 CFR 51c.305(h)*

### **Requirements**

- The health center has made and must continue to make every reasonable effort to establish and maintain collaborative relationships, including with other health care providers that provide care within the catchment area [[service area](#)], local hospitals, and specialty providers in the catchment area of the center, to provide access to services not available through the health center and to reduce the non-urgent use of hospital emergency departments.
- To the extent possible, the health center must coordinate and integrate project activities with the activities of other federally-funded, as well as State and local, health services delivery projects and programs serving the same population.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

- a. The health center documents its efforts to collaborate with other providers or programs in the service area, including local hospitals, specialty providers, and social service organizations (including those that serve special populations), to provide access to services not available through the health center in order to support
  - Reductions in the non-urgent use of hospital emergency departments;
  - Continuity of care across community providers; and
  - Access to other health or community services that impact the patient population.
- b. The health center documents its efforts to coordinate and integrate activities with other federally-funded, as well as State and local, health services delivery projects and programs serving similar patient populations in the service area (at a minimum, this would include establishing and maintaining relationships with other health centers in the service area).

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- c. If the health center expands<sup>1,2</sup> its HRSA-approved [scope of project](#):
- The health center obtains letters or other appropriate documents specific to the request or application that describe areas of coordination or collaboration with health care providers serving similar patient populations in the service area (health centers, rural health clinics, local hospitals including critical access hospitals, health departments, other providers including specialty providers, as applicable); or
  - If such letters or documents cannot be obtained from these providers, the health center documents its attempts to coordinate or collaborate with these health care providers (health centers, rural health clinics, local hospitals including critical access hospitals, health departments, other providers including specialty providers, as applicable) on the specific request or application proposal.

### ***Related Considerations***

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines how to document collaboration or coordination with providers and organizations in its service area (for example, through a memorandum of agreement, letters, membership on a city-wide community health planning council).

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<sup>1</sup> Expanding the HRSA-approved scope of project may occur by adding sites or services through change-in-scope requests, New Access Point competitive applications, or other supplemental funding applications.

<sup>2</sup> Additional requirements for documented collaboration may apply based on specific Notices of Funding Opportunity (NOFOs), Notices of Award (NOAs), [look-alike](#) designation instructions, or other Federal statutes, regulations, or policies.

## **Chapter 15: Financial Management and Accounting Systems**

*Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. [View the revisions.](#)*

### **Authority**

*Sections 330(e)(5)(D), 330(k)(3)(D), 330(k)(3)(N), and 330(q) of the PHS Act; 42 CFR 51c.113, 42 CFR 56.114, 42 CFR 51c.303(d), and 42 CFR 56.303(d); and 45 CFR Part 75 Subparts D, E and F*

### **Requirements**

- The health center must maintain effective control over, and accountability for, all funds, property, and other assets in order to adequately safeguard all such assets and ensure that they are used solely for authorized purposes.
- The health center must have written policies and procedures in place to ensure the appropriate use of Federal funds in compliance with applicable Federal statutes, regulations, and the terms and conditions of the Federal award.
- The health center must develop and utilize financial management and control systems in accordance with sound financial management procedures which ensure at a minimum:
  - The fiscal integrity of grant financial transactions and reports; and
  - Ongoing compliance with Federal statutes, regulations, and the terms and conditions of the Health Center Program [award](#) or designation.
- The health center's financial management system must specifically identify in its accounts all [Federal awards](#), including the Federal award made under the Health Center Program, received and expended and the Federal programs under which they were received (see 45 CFR 75.302). This financial management system must also provide for all of the following:
  - Accurate, current, and complete disclosure of the financial results of each Federal award or program in accordance with the reporting requirements (see 45 CFR 75.341 and 75.342);
  - Records that identify the source (receipt) and application (expenditure) of funds for federally-funded activities. These records must contain information pertaining to Federal awards, authorizations, obligations, unobligated balances, assets, expenditures, income, and interest, and be supported by source documentation (see: 45 CFR 75.302(b)(3));

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- Written procedures that minimize the time elapsing between the transfer of Federal award funds from HHS and the disbursement of these funds by the health center (see 45 CFR 75.305);
  - Written procedures for assuring that expenditures of Federal award funds are allowable in accordance with the terms and conditions of the Federal award and with the Federal Cost Principles (see 45 CFR Part 75 Subpart E).
- A health center that expends \$750,000 or more in Federal awards during its fiscal year must have a single or program-specific audit conducted for that year in accordance with the provisions of 45 CFR Part 75 Subpart F.
  - The health center must use any non-grant funds as permitted under section 330, and may use such funds for such other purposes as are not specifically prohibited under section 330, if such use furthers the objectives of the [health center] project.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

- a. The health center has and utilizes a financial management and internal control system that reflects Generally Accepted Accounting Principles (GAAP) for private non-profit health centers or Government Accounting Standards Board (GASB) principles for public agency health centers<sup>1</sup> and that ensures at a minimum:
  - Health center expenditures are consistent with the HRSA-approved total budget<sup>2</sup> and with any additional applicable HRSA approvals that have been requested and received;<sup>3</sup>
  - Effective control over, and accountability for, all funds, property, and other assets associated with the Health Center Program project;
  - The safeguarding of all assets to assure they are used solely for authorized purposes in accordance with the terms and conditions of the Health Center

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<sup>1</sup> GAAP and GASB are used as defined in 45 CFR Part 75.

<sup>2</sup> A health center's "total budget" includes the Health Center Program [Federal award](#) funds and all other sources of revenue in support of the HRSA-approved Health Center Program [scope of project](#). For additional detail, see Chapter 17: [Budget](#).

<sup>3</sup> Per 45 CFR 75.308, post-award, [Federal award recipients](#) are required to report significant deviations from budget or project scope or objective, and are required to request prior approvals from HHS awarding agencies for budget and program plan revisions (re-budgeting). "Re-budgeting, or moving funds between direct cost budget categories in an approved budget, is considered significant when cumulative transfers for a single budget period exceeds 25 percent of the total approved budget (inclusive of direct and indirect costs and Federal funds and required matching or cost sharing). The base used for determining significant re-budgeting excludes carryover balances but includes any amounts awarded as supplements."

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- Program award/designation;<sup>4</sup> and
- The capacity to track the financial performance of the health center, including identification of trends or conditions that may warrant action by the organization to maintain financial stability.
- b. The health center’s financial management system is able to account for all Federal award(s) (including the Federal award made under the Health Center Program) in order to identify the source<sup>5</sup> (receipt) and application (expenditure) of funds for federally-funded activities in whole or in part. Specifically, the health center’s financial records contain information and related source documentation pertaining to authorizations, obligations, unobligated balances, assets, expenditures, income, and interest under the Federal award(s).
- c. The health center has written procedures for:
- Drawing down Federal award funds in a manner that minimizes the time elapsing between the transfer of the Federal award funds from HRSA and the disbursement of these funds by the health center; and
  - Assuring that expenditures of Federal award funds are allowable in accordance with the terms and conditions of the Federal award and with the Federal Cost Principles<sup>6</sup> in 45 CFR Part 75 Subpart E.
- d. If a health center expends **\$750,000 or more in award funds from all Federal sources** during its fiscal year, the health center ensures a single or program-specific audit is conducted and submitted for that year in accordance with the provisions of 45 CFR Part 75, Subpart F: Audit Requirements and ensures that subsequent audits demonstrate corrective actions have been taken to address all findings, questioned costs, reportable conditions, and material weaknesses cited in the previous audit report, if applicable.
- e. The health center can document that any non-grant funds generated from Health Center Program project activities, in excess of what is necessary to support the HRSA-approved total Health Center Program project budget, were utilized to further the objectives of the project by benefiting the current or proposed patient population and were not utilized for purposes that are specifically prohibited by the Health Center Program.

### **Related Considerations**

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<sup>4</sup> The requirement to safeguard federal assets as described in this bullet substantially reflects the requirement to have written policies and procedures in place to ensure the appropriate use of Federal funds in compliance with applicable Federal statutes, regulations, and the terms and conditions of the Federal award. See Section 330(k)(3)(N) of the Public Health Service Act.

<sup>5</sup> Federal program and Federal award identification would include, as applicable, the Catalog of Federal Domestic Assistance (CFDA) title and number, Federal award identification number and year, name of the HHS awarding agency, and name of the [pass-through entity](#), if any.

<sup>6</sup> The cost principles are set forth in 45 CFR Part 75, Subpart E.

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The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines which accounting software and related systems to use for financial management.
- The health center determines the type, frequency, and format of financial reports used to support the board and the key management staff's ability to carry out its oversight responsibilities.
- The health center determines which specific actions to take in response to negative financial trending and its method for monitoring the results of those actions.



## **Chapter 16: Billing and Collections**

### **Authority**

*Section 330(k)(3)(E), (F), and (G) of the PHS Act; and 42 CFR 51c.303(e), (f), and (g) and 42 CFR 56.303(e), (f), and (g)*

### **Requirements**

- The health center must prepare a schedule of fees for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation.
- The health center must assure that any fees or payments required by the center for health care services will be reduced or waived in order to assure that no patient will be denied such services due to an individual's inability to pay for such services.
- The health center must establish systems for eligibility determination and for billing and collections [with respect to third party payors].
- The health center must make every reasonable effort to enter into contractual or other arrangements to collect reimbursement of its costs with the appropriate agency(s) of the State which administers or supervises the administration of:
  - A State Medicaid plan approved under title XIX of the Social Security Act (SSA) [42 U.S.C. 1396, et seq.] for the payment of all or a part of the center's costs in providing health services to persons who are eligible for such assistance; and
  - The Children's Health Insurance Program (CHIP) under title XXI of the SSA [42 U.S.C. 1397aa, et seq.] with respect to individuals who are State CHIP beneficiaries.
- The health center must make and continue to make every reasonable effort to collect appropriate reimbursement for its costs on the basis of the full amount of fees and payments for health center services without application of any discount when providing health services to persons who are entitled to:
  - Medicare coverage under title XVIII of the SSA [42 U.S.C. 1395 et seq.];
  - Medicaid coverage under a State plan approved under title XIX of the SSA [42 U.S.C. 1396 et seq.]; or
  - Assistance for medical expenses under any other public assistance program (for example, CHIP), grant program, or private health insurance or benefit program.
- The health center must make and continue to make every reasonable effort to secure payment for services from patients, in accordance with health center fee schedules and the corresponding schedule of discounts.

### **Demonstrating Compliance**

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***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

- a. The health center has a fee schedule for services that are within the HRSA-approved [scope of project](#) and are typically billed for in the local health care market.
- b. The health center uses data on locally prevailing rates and actual health center costs to develop and update its fee schedule.
- c. The health center participates in Medicaid, CHIP, Medicare, and, as appropriate, other public or private assistance programs or health insurance.
- d. The health center has systems, which may include operating procedures, for billing and collections that address:
  - Educating patients on insurance and, if applicable, related third-party coverage options available to them;
  - Billing Medicare, Medicaid, CHIP, and other public and private assistance programs or insurance in a timely manner, as applicable;<sup>1</sup> and
  - Requesting applicable payments from patients, while ensuring that no patient is denied service based on inability to pay.
- e. If a health center elects to offer additional billing options or payment methods (for example, payment plans, grace periods, prompt or cash payment incentives), the health center has operating procedures for implementing these options or methods and for ensuring they are accessible to all patients regardless of income level or sliding fee discount pay class.
- f. The health center has billing records that show claims are submitted in a timely and accurate manner to the third party payor sources with which it participates (Medicaid, CHIP, Medicare, and other public and private insurance) in order to collect reimbursement for its costs in providing health services<sup>2</sup> consistent with the terms of such [contracts](#) and other arrangements.
- g. The health center has billing records or other forms of documentation that reflect that the health center:
  - Charges patients in accordance with its fee schedule and, if applicable, the sliding fee discount schedule;<sup>3</sup> and

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<sup>1</sup> For information on Federal Tort Claims Act (FTCA) coverage in cases where health centers are using alternate billing arrangements in which the covered provider is billing directly for services provided to covered entity patients, refer to the [FTCA Health Center Policy Manual](#), Section I.E: Eligibility and Coverage, Coverage Under Alternate Billing Arrangements.

<sup>2</sup> This includes services that the health center provides directly ([Form 5A: Services Provided](#), Column I) or provides through a formal written contract/agreement ([Form 5A: Services Provided](#), Column II).

<sup>3</sup> See Chapter 9: [Sliding Fee Discount Program](#) for more information on the sliding fee discount schedule.

## ***Health Center Program Compliance Manual***

- Makes reasonable efforts to collect such amounts owed from patients.
- h. The health center has and utilizes board-approved policies, as well as operating procedures, that include the specific circumstances when the health center will waive or reduce fees or payments required by the center due to any patient's inability to pay.
- i. If a health center provides supplies or equipment that are related to, but not included in, the service itself as part of prevailing standards of care<sup>4</sup> (for example, eyeglasses, prescription drugs, dentures) and charges patients for these items, the health center informs patients of such charges ("out-of-pocket costs") prior to the time of service.<sup>5</sup>
- j. If a health center elects to limit or deny services based on a patient's refusal to pay, the health center has a board-approved policy that distinguishes between refusal to pay and inability to pay and notifies patients of:
  - Amounts owed and the time permitted to make such payments;
  - Collection efforts that will be taken when these situations occur (for example, meeting with a financial counselor, establishing payment plans); and
  - How services will be limited or denied when it is determined that the patient has refused to pay.

### ***Related Considerations***

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines how to consider both locally prevailing charges and actual costs for services when setting the fee schedule, as well as the data used to determine locally prevailing charges (for example, Medicare, Medicaid, private providers, or commercial sources).
- The health center determines whether to charge a single fee for related health center services, medically-related supplies, and/or equipment. Examples include, but are not limited to, charging a single fee for a well-child visit and the immunizations provided during that visit or combining all prenatal care visits and labs into a single fee.
- The health center determines whether to participate in a specific insurance plan based on its patient population and the costs and benefits of such participation.

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<sup>4</sup> These items differ from supplies and equipment that are included in a service as part of prevailing standards of care and are reflected in the fee schedule (e.g., casting materials, bandages).

<sup>5</sup> See Chapter 15: [Financial Management and Accounting Systems](#) for related information on revenue generated from such charges.

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- If a health center has a funding source that subsidizes or covers all or part of the fees for certain services for specific patients (in accordance with the terms and conditions of such funding sources), the health center may use such funding sources to support discounts greater than those available through the health center's sliding fee discount program.<sup>6</sup>
- If a health center elects to provide its patients access to supplies or equipment (for example, eyeglasses, prescription drugs, dentures) that are related to, but not included in, the service itself as part of prevailing standards of care, the health center determines how to charge its patients for such supplies or equipment (for example, flat discounts, at cost, sliding fee discounts).
- If a health center limits or denies services to patients based on refusal to pay, the health center determines how and when such patients may be permitted to rejoin the practice.

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<sup>6</sup> Health centers that have questions on the appropriate use of other Federal, state, local, or private funds should refer to those program sources for additional guidance. See Chapter 9: [Sliding Fee Discount Program](#) for information on the Health Center Program requirements related to the sliding fee discount program.

## Chapter 17: Budget

### **Authority**

*Section 330(e)(5)(A) and Section 330(k)(3)(I)(i) of the PHS Act; and 45 CFR 75.308(a) and 45 CFR 75 Subpart E*

### **Requirements**

- The health center must develop an annual budget that:
  - Identifies the projected costs of the Health Center Program project;
  - Identifies the projected costs to be supported by Health Center Program [award](#) funds, consistent with Federal Cost Principles<sup>1</sup> and any other requirements or restrictions on the use of Federal funding; and
  - Includes all other non-Federal revenue sources that will support the Health Center Program project, including:
    - State, local, and other operational funding; and
    - Fees, premiums, and third-party reimbursements which the health center may reasonably be expected to receive for its operation of the Health Center Program project.
- The health center must submit this budget annually by a date specified by HRSA for approval through the [Federal award](#) or designation process.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

- a. The health center develops and submits to HRSA (for new or continued funding or designation from HRSA) an annual budget, also referred to as a “total budget,”<sup>2,3</sup> that reflects projected costs and revenues necessary to support the health center’s proposed or HRSA-approved [scope of project](#).
- b. In addition to the Health Center Program award, the health center’s annual budget includes all other projected revenue sources that will support the Health Center Program project, specifically:

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<sup>1</sup> See 45 CFR Part 75 Subpart E: Cost Principles.

<sup>2</sup> A health center’s “total budget” includes the Health Center Program [Federal award](#) funds and all other sources of revenue in support of the health center [scope of project](#).

<sup>3</sup> Any aspects of the requirement that relate to the use of Health Center Program Federal award funds are not applicable to [look-alikes](#).

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- Fees, premiums, and third-party reimbursements and payments that are generated from the delivery of services;
  - Revenues from state, local, or other [Federal grants](#) (for example, Ryan White, Healthy Start) or contracts;
  - Private support or income generated from contributions; and
  - Any other funding expected to be received for purposes of supporting the Health Center Program project.
- c. The health center’s annual budget identifies the portion of projected costs to be supported by the Federal Health Center Program award. Any proposed costs supported by the Federal award are consistent with the Federal Cost Principles<sup>4</sup> and the terms and conditions<sup>5</sup> of the award.
- d. If the health center organization conducts other lines of business (i.e., activities that are not part of the HRSA-approved scope of project), the costs of these other activities are not included in the annual budget for the Health Center Program project.<sup>6</sup>

### ***Related Considerations***

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines how to allocate projected costs between Health Center Program award funds, consistent with Federal requirements, and other projected revenue sources within the annual budget.

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<sup>4</sup> See 45 CFR Part 75 Subpart E: Cost Principles.

<sup>5</sup> For example, health centers may not use HHS Federal award funds to support salary levels above the salary limitations on Federal awards.

<sup>6</sup> As these other lines of business are not included in the health center’s total budget, they are not subject to Health Center Program requirements and not eligible for related Health Center Program benefits (for example, payment as a [FQHC](#) under Medicare/Medicaid/CHIP, 340B Program eligibility, Federal Tort Claims Act (FTCA) coverage).

## **Chapter 18: Program Monitoring and Data Reporting Systems**

### **Authority**

*Section 330(k)(3)(I)(ii) of the PHS Act; 42 CFR 51c.303(j) and 42 CFR 56.303(j); and 45 CFR 75.342(a) and (b)*

### **Requirements**

- The health center must establish systems for monitoring program performance to ensure:
  - Oversight of the operations of the [Federal award](#) [or designation]-supported activities in compliance with applicable Federal requirements;
  - Performance expectations [as described in the terms or conditions of the Federal award or designation] are being achieved; and
  - Areas for improvement in program outcomes and productivity [efficiency and effectiveness] are identified.
- The health center must compile and report data and other information as required by HRSA, relating to:
  - Costs of health center operations;
  - Patterns of health center service utilization;
  - Availability, accessibility, and acceptability of health center services; and
  - Other matters relating to operations of the Health Center Program project, as required.
- The health center must submit required data and information to HRSA in a timely manner and with such frequency as prescribed by HRSA.

### **Demonstrating Compliance**

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

- a. The health center has a system in place for overseeing the operations of the Federal award-supported activities to ensure compliance with applicable Federal requirements and for monitoring program performance. Specifically:
  - The health center has a system in place to collect and organize data related to the HRSA-approved [scope of project](#), as required to meet HHS reporting requirements, including those data elements for [Uniform Data System \(UDS\)](#) reporting; and

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- The health center submits timely, accurate, and complete UDS reports in accordance with HRSA instructions and submits any other required HHS and Health Center Program reports.
  
- b. The health center produces data-based reports on: patient service utilization; trends and patterns in the patient population;<sup>1</sup> and overall health center performance, as necessary to inform and support internal decision-making and oversight by the health center's key management staff and by the governing board.

### ***Related Considerations***

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- In fulfilling HRSA reporting obligations, the health center determines the type of data system(s) (for example, type of Electronic Health Record software, use of practice management system) it will utilize based on its needs and the size and complexity of the health center's operations.
  
- The health center determines the number, format, and types of reports the system generates to support governing board and key management staff internal decision making.

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<sup>1</sup> Examples of data health centers may analyze as part of such reports may include patient access to and satisfaction with health center services, patient demographics, quality of care indicators, and health outcomes.



## Chapter 19: Board Authority

*Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. [View the revisions.](#)*

### **Authority**

*Section 330(k)(3)(H) of the PHS Act; 42 CFR 51c.303(i), 42 CFR 56.303(i), 42 CFR 51c.304(d), and 42 CFR 56.304(d); and 45 CFR 75.507(b)(2)*

### **Requirements<sup>1</sup>**

- The health center must establish a governing board<sup>2</sup> that has specific responsibility for oversight of the Health Center Program project.
- The health center governing board must develop bylaws which specify the responsibilities of the board.
- The health center governing board must assure that the center is operated in compliance with applicable Federal, State, and local laws and regulations.
- The health center governing board must hold monthly meetings<sup>3,4</sup> and record in meeting minutes the board's attendance, key actions, and decisions.
- The health center governing board must approve the selection and termination/dismissal of the health center's Project Director/Chief Executive Officer (CEO).
- The health center governing board must have authority for establishing or adopting policies for the conduct of the Health Center Program project and for updating these

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<sup>1</sup> The governing board of a health center operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or Urban Indian Organizations under the Indian Health Care Improvement Act is exempt from the specific board authority requirements discussed in this chapter. Section 330(k)(3)(H) of the PHS Act.

<sup>2</sup> For public agencies that elect to have a [co-applicant](#), these authorities and functions apply to the co-applicant board.

<sup>3</sup> Where geography or other circumstances make monthly, in-person participation in board meetings burdensome, monthly meetings may be conducted by telephone or other means of electronic communication where all parties can both listen and speak to all other parties.

<sup>4</sup> Boards of organizations receiving a Health Center Program award/designation only under [section 330\(g\)](#) may meet less than once a month during periods of the year, as specified in the bylaws, where monthly meetings are not practical due to health center patient migration out of the area. 42 CFR 56.304(d)(2).

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policies when needed. Specifically, the health center governing board must have authority for:

- Adopting policies for financial management practices and a system to ensure accountability for center resources (unless already established by the public agency as the [Federal award](#) or designation recipient), including periodically reviewing the financial status of the health center and the results of the annual audit to ensure appropriate follow-up actions are taken;<sup>5</sup>
  - Adopting policy for eligibility for services including criteria for partial payment schedules;<sup>6</sup>
  - Establishing and maintaining general personnel policies for the health center (unless already established by the public agency as the Federal award or designation recipient), including those addressing selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices; and
  - Adopting health care policies including quality-of-care audit procedures.
- The health center governing board must adopt health care policies including the:
    - Scope and availability of services to be provided within the Health Center Program project, including decisions to [subaward](#) or [contract](#) for a substantial portion of the services;<sup>7,8</sup>
    - [Service site](#) location(s);<sup>9</sup> and
    - Hours of operation of service sites.
  - The health center governing board must review and approve the annual Health Center Program project budget.<sup>10</sup>
  - The health center must develop its overall plan for the Health Center Program project under the direction of the governing board.
  - The health center governing board must provide direction for long-range planning, including but not limited to identifying health center priorities and adopting a three-year plan for financial management and capital expenditures.

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<sup>5</sup> See Chapter 15: [Financial Management and Accounting Systems](#) for more information on the related requirements.

<sup>6</sup> See Chapter 9: [Sliding Fee Discount Program](#) for more information on the related requirements.

<sup>7</sup> See Chapter 4: [Required and Additional Health Services](#) for more information on the requirements associated with providing services within the HRSA-approved [scope of project](#).

<sup>8</sup> See Chapter 12: [Contracts and Subawards](#) for more information on the requirements associated with such arrangements.

<sup>9</sup> See Chapter 6: [Accessible Locations and Hours of Operation](#) for more information on the requirements associated with health center service sites and hours of operation.

<sup>10</sup> See Chapter 17: [Budget](#) for more information on the requirements of the Health Center Program project budget.

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- The health center governing board must assess the achievement of project objectives through evaluation of health center activities, including service utilization patterns, productivity [efficiency and effectiveness] of the center, and patient satisfaction.
- The health center governing board must ensure that a process is developed for hearing and resolving patient grievances.

### ***Demonstrating Compliance***

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

- a. The health center's organizational structure, articles of incorporation, bylaws, and other relevant documents ensure the health center governing board maintains the authority for oversight of the Health Center Program project, specifically:
  - The organizational structure and documents do not allow for any other individual, entity or committee (including, but not limited to, an executive committee authorized by the board) to reserve approval authority or have veto power over the health center board with regard to the required authorities and functions;<sup>11</sup>
  - In cases where a health center collaborates with other entities in fulfilling the health center's HRSA-approved [scope of project](#), such collaboration or agreements with the other entities do not restrict or infringe upon the health center board's required authorities and functions; and
  - For public agencies with a [co-applicant](#) board,<sup>12</sup> the health center has a co-applicant agreement that delegates the required authorities and functions to the co-applicant board and delineates the roles and responsibilities of the public agency and the co-applicant in carrying out the Health Center Program project.
- b. The health center's articles of incorporation, bylaws, or other relevant documents outline the following required authorities and responsibilities of the governing board:
  - Holding monthly meetings;
  - Approving the selection (and termination or dismissal, as appropriate) of the health center's Project Director/CEO;
  - Approving the annual Health Center Program project budget and applications;

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<sup>11</sup> This does not preclude an executive committee from taking actions on behalf of the board in emergencies, on which the full board will subsequently vote.

<sup>12</sup> Public agencies are permitted to utilize a co-applicant governance structure for the purposes of meeting Health Center Program governance requirements. Public centers may be structured in one of two ways to meet the program requirements: 1) the public agency independently meets all the Health Center Program governance requirements based on the existing structure and vested authorities of the public agency's governing board; or 2) together, the public agency and the co-applicant meet all Health Center Program requirements.

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- Approving health center services and the location and hours of operation of health center sites;
  - Evaluating the performance of the health center;
  - Establishing or adopting policy<sup>13</sup> related to the operations of the health center; and
  - Assuring the health center operates in compliance with applicable Federal, State, and local laws and regulations.
- c. The health center's board minutes and other relevant documents confirm that the board exercises, without restriction, the following authorities and functions:
- Holding monthly meetings where a quorum is present to ensure the board has the ability to exercise its required authorities and functions;
  - Approving the selection, evaluation and, if necessary, the dismissal or termination of the Project Director/CEO from the Health Center Program project;
  - Approving applications related to the Health Center Program project, including approving the annual budget, which outlines the proposed uses of both Health Center Program award and non-Federal resources and revenue;
  - Approving the Health Center Program project's sites, hours of operation and services, including decisions to subaward or contract for a substantial portion of the health center's services;
  - Monitoring the financial status of the health center, including reviewing the results of the annual audit, and ensuring appropriate follow-up actions are taken;
  - Conducting long-range/strategic planning at least once every three years, which at a minimum addresses financial management and capital expenditure needs; and
  - Evaluating the performance of the health center based on quality assurance/quality improvement assessments and other information received from health center management,<sup>14</sup> and ensuring appropriate follow-up actions are taken regarding:
    - Achievement of project objectives;
    - Service utilization patterns;
    - Quality of care;
    - Efficiency and effectiveness of the center; and
    - Patient satisfaction, including addressing any patient grievances.

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<sup>13</sup> The governing board of a health center is generally responsible for establishing and/or approving policies that govern health center operations, while the health center's staff is generally responsible for implementing and ensuring adherence to these policies (including through operating procedures).

<sup>14</sup> For more information related to the production of reports associated with these topics, see Chapter 18: [Program Monitoring and Data Reporting Systems](#), Chapter 15: [Financial Management and Accounting Systems](#), and Chapter 10: [Quality Improvement/Assurance](#).

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- d. The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies in the following areas: [Sliding Fee Discount Program](#), [Quality Improvement/Assurance](#), and [Billing and Collections](#).<sup>15</sup>
- e. The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies that support financial management and accounting systems and personnel policies. However, in cases where a public agency is the [recipient](#) of the Health Center Program Federal award or designation and has established a co-applicant structure, the public agency may establish and retain the authority to adopt and approve policies that support financial management and accounting systems and personnel policies.

### ***Related Considerations***

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center board determines how to carry out required responsibilities, functions, and authorities in areas such as the following:
  - Whether to establish standing committees, including the number and type of such committees (for example, executive, finance, quality improvement, personnel, planning).
  - Whether to seek input or assistance from other organizations or subject matter experts (for example, joint committees for health centers that collaborate closely with other organizations, consultants, community leaders).
  - How often the Project Director/CEO performance is evaluated.
- The health center determines how to set quorum for board meetings consistent with state, territorial or other applicable law.
- The health center board determines the format of its long-range/strategic planning.
- For public agencies with co-applicant boards, the co-applicant board and the public agency determine how to collaborate in carrying out the Health Center Program project (for example, shared project assessment, public agency participation on board committees, joint preparation of grant applications).

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<sup>15</sup> Policies related to billing and collections that require board approval include those that address the waiving or reducing of amounts owed by patients due to inability to pay, and if applicable those that limit or deny services due to refusal to pay.

## **Chapter 20: Board Composition**

### **Authority**

*Section 330(k)(3)(H) of the PHS Act; and 42 CFR 51c.304 and 42 CFR 56.304*

### **Requirements<sup>1,2</sup>**

- The health center’s governing board must consist of at least 9 and no more than 25 members.<sup>3</sup>
- The majority [at least 51 percent] of the health center board members must be patients<sup>4</sup> served by the health center. These health center patient board members must, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender.
- Non-patient health center board members must be representative of the community served by the health center and must be selected for their expertise in relevant subject areas, such as community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.
- Of the non-patient health center board members, no more than one-half may derive more than 10 percent of their annual income from the health care industry.<sup>5</sup>
- A health center board member may not be an employee of the center, or spouse or child, parent, brother or sister by blood or marriage of such an employee.<sup>6</sup> The project

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<sup>1</sup> The governing board of a health center operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or Urban Indian Organizations under the Indian Health Care Improvement Act is exempt from the specific board composition requirements discussed in this document. Section 330(k)(3)(H) of the PHS Act.

<sup>2</sup> For public agencies that elect to have a [co-applicant](#), these board composition requirements apply to the co-applicant board.

<sup>3</sup> 42 CFR 51c.304(a) and 42 CFR 56.304(a) permit that the requirement regarding board size may be waived by the Secretary for good cause shown. HRSA will not grant such waivers except where the health center has demonstrated to HRSA an inability to meet the requirement.

<sup>4</sup> Patient board members are also often referred to as “user” or “consumer” board members. However, for the purposes of this chapter, only the term “patient” or “non-patient” board member will be used for ease of reference.

<sup>5</sup> Per the regulations in 42 CFR 56.304, for health centers awarded/designated solely under [section 330\(g\)](#) of the PHS Act, no more than two-thirds of the non-patient board members may derive more than 10 percent of their annual income from the health care industry.

<sup>6</sup> While no board member may be an employee of the health center, 42 CFR 51c.107 permits the health center to use [Federal award](#) funds to reimburse board members for these limited purposes: 1) reasonable expenses actually incurred by reason of their participation in board activities (e.g., transportation to board meetings, childcare during board meetings); or 2) wages lost by reason of participation in the activities of such board members if the member

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director [Chief Executive Officer (CEO)] may be a non-voting, ex-officio member of the board.

- The health center bylaws or other internal governing rules must prescribe the process for selection and removal of all governing board members. This selection process must ensure that the governing board is representative of the health center patient population. The selection process in the bylaws or other rules is subject to approval by HRSA.
- In cases where a health center receives an award/designation under section [330\(g\)](#), [330\(h\)](#) and/or [330\(i\)](#) and does not receive an award/designation under section 330(e), the health center may request approval from HRSA for a waiver of the patient majority board composition governance requirement by showing good cause.

### ***Demonstrating Compliance***

***A health center would demonstrate compliance with these requirements by fulfilling all of the following:***

- a. The health center has bylaws or other relevant documents that specify the process for ongoing selection and removal of board members. This board member selection and removal process does not permit any other entity, committee or individual (other than the board) to select either the board chair or the majority of health center board members,<sup>7</sup> including a majority of the non-patient board members.<sup>8</sup>
- b. The health center has bylaws or other relevant documents that require the board to be composed as follows:
  - Board size is at least 9 and no more than 25 members,<sup>9</sup> with either a specific number or a range of board members prescribed;
  - At least 51 percent of board members are patients served by the health center. For the purposes of board composition, a patient is an individual who has received at least one service in the past 24 months that generated a health

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is from a family with an annual family income less than \$10,000 or if the member is a single person with an annual income less than \$7,000. For section 330(g)-only awarded/designated health centers, 42 CFR 56.108 permits the use of grant funds for certain limited reimbursement of board members as follows: 1) for reasonable expenses actually incurred by reason of their participation in board activities (e.g., transportation to board meetings, childcare during board meetings); 2) for wages lost by reason of participation in the activities of such board members. Health centers may wish to consult with their legal counsel and auditor on applicable state law regarding reimbursement restrictions for non-profit board members and implications for IRS tax-exempt status.

<sup>7</sup> An outside entity may only remove a board member who has been selected by that entity as an organizational representative to the governing board.

<sup>8</sup> For example, if the health center has an agreement with another organization, the agreement does not permit that organization to select either the chair or a majority of the health center board.

<sup>9</sup> For the purposes of the Health Center Program, the term “board member” refers only to voting members of the board.

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center visit, where both the service and the [site](#) where the service was received are within the HRSA-approved [scope of project](#);

- Patient members of the board, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender;
- Non-patient members are representative of the community served by the health center or the health center's [service area](#);
- Non-patient members are selected to provide relevant expertise and skills such as:
  - Community affairs;
  - Local government;
  - Finance and banking;
  - Legal affairs;
  - Trade unions and other commercial and industrial concerns; and
  - Social services;
- No more than one-half of non-patient board members derive more than 10 percent of their annual income from the health care industry; and
- Health center employees,<sup>10,11</sup> and immediate family members (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage) of employees may not be health center board members.

c. The health center has documentation that the board is composed of:

- At least 9 and no more than 25 members;
- A patient<sup>12</sup> majority (at least 51 percent);
- Patient board members, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender, consistent with the demographics reported in the health center's [Uniform Data System \(UDS\)](#) report;<sup>13</sup>

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<sup>10</sup> For the purposes of health center board composition, an employee of the health center would include an individual who would be considered a "common-law employee" or "statutory employee" according to the Internal Revenue Service criteria, as well as an individual who would be considered an employee for state or local law purposes.

<sup>11</sup> In the case of public agencies with co-applicant boards, this includes employees or immediate family members of both the co-applicant organization and the public agency component (for example, department, division, or sub-agency) in which the Health Center Program project is located.

<sup>12</sup> A legal guardian of a patient who is a dependent child or adult, a person who has legal authority to make health care decisions on behalf of a patient, or a legal sponsor of an immigrant patient may also be considered a patient of the health center for purposes of board representation. Students who are health center patients may participate as board members subject to state laws applicable to such non-profit board members.

<sup>13</sup> For health centers that have not yet made a [Uniform Data System \(UDS\)](#) report, this would be assessed based on demographic data included in the health center's application.



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- Representative(s) from or for each of the [special population\(s\)](#)<sup>14</sup> for those health centers that receive any award/designation under one or more of the special populations section 330 subparts, 330(g), (h), and/or (i); and
- As applicable, non-patient board members:
  - Who are representative of the community in which the health center is located, either by living or working in the community, or by having a demonstrable connection to the community;
  - With relevant skills and expertise in areas such as community affairs, local government, finance and banking, legal affairs, trade unions, other commercial and industrial concerns, or social services within the community; and
  - Of whom no more than 50 percent earn more than 10 percent of their annual income from the health care industry.<sup>15</sup>
- d. The health center verifies periodically (for example, annually or during the selection or renewal of board member terms) that the governing board does not include members who are current employees of the health center, or immediate family members of current health center employees (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage).
- e. In cases where a health center receives an award/designation under section [330\(g\)](#), [330\(h\)](#) and/or [330\(i\)](#), does not receive an award/designation under section 330(e), and requests a waiver of the patient majority board composition requirements, the health center presents to HRSA for review and approval:
  - “Good cause” that justifies the need for the waiver by documenting:
    - The unique characteristics of the population ([homeless](#), [migratory or seasonal agricultural worker](#), and/or [public housing](#) patient population) or service area that create an undue hardship in recruiting a patient majority; and
    - Its attempt(s) to recruit a majority of special population board members within the past three years; and
  - Strategies that will ensure patient participation and input in the direction and ongoing governance of the organization by addressing the following elements:
    - Collection and documentation of input from the special population(s);
    - Communication of special population input directly to the health center governing board; and

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<sup>14</sup> Representation could include advocates for the health center’s section 330 (g), (h), or (i) patient population (for example, those who have personally experienced being a member of, have expertise about, or work closely with the current special population). Such advocate board members would count as “patient” board members only if they meet the patient definition set forth in this chapter.

<sup>15</sup> For example, in a 9 member board with 5 patient board members, there could be 4 non-patient board members. In this case, no more than 2 non-patient board members could earn more than 10 percent of their income from the health care industry.

## **Health Center Program Compliance Manual**

- Incorporation of special population input into key areas, including but not limited to: selecting health center services;<sup>16</sup> setting hours of operation of health center sites;<sup>17</sup> defining budget priorities;<sup>18</sup> evaluating the organization's progress in meeting goals, including patient satisfaction;<sup>19</sup> and assessing the effectiveness of the sliding fee discount program.<sup>20</sup>
- f. For health centers with approved waivers, the health center has board minutes or other documentation that demonstrates how special population patient input is utilized in making governing board decisions in key areas, including but not limited to: selecting health center services; setting hours of operation of health center sites; defining budget priorities; evaluating the organization's progress in meeting goals, including patient satisfaction; and assessing the effectiveness of the sliding fee discount program.

### **Related Considerations**

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- Within the range of 9 to 25 board members, the health center determines the appropriate board size for its organization.
- In addition to race, ethnicity, and gender, the health center determines other relevant demographic or geographic factors to consider when selecting patient or non-patient board members.
- In cases where language or literacy may present a barrier to board members' evaluation of written materials, the health center determines how to make accommodations to ensure the meaningful participation of such board members.
- The health center board determines whether to include non-voting, ex-officio members including, for example, the Project Director/CEO, other health center staff members, or community members on the board, consistent with what is permitted under other applicable laws.

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<sup>16</sup> See Chapter 4: [Required and Additional Health Services](#) for more information on providing services within the HRSA-approved scope of project.

<sup>17</sup> See Chapter 6: [Accessible Locations and Hours of Operation](#) for more information on health center service sites and hours of operation.

<sup>18</sup> See Chapter 17: [Budget](#) for more information on the Health Center Program project budget.

<sup>19</sup> See Chapter 19: [Board Authority](#) for more information on the health center board's required authorities.

<sup>20</sup> See Chapter 9: [Sliding Fee Discount Program](#) for more information on requirements for health center sliding fee discount programs.

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- The health center determines within its policies how to define “health care industry” for purposes of board composition and how to determine the percentage of annual income of each non-patient board member derived from the health care industry.
- For health centers with a HRSA-approved waiver, the health center board determines which strategies<sup>21</sup> to use for receiving input from the special population and ensuring the special population’s participation in the direction and ongoing governance of the health center.

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<sup>21</sup> For example, a health center could utilize an advisory council of special population representatives, could conduct regular focus groups with the special population, or could have one or more patients from the special population serving on the board.

## **Chapter 21: Federal Tort Claims Act (FTCA) Deeming Requirements**

### **Authority**

*Section 224(g)-(n), 224(q) of the PHS Act (42 U.S.C. 233(g)-(n) and (q)); and 42 CFR Part 6*

### **Requirements**

In order to obtain deemed Public Health Service employment status under sections 224(g)-(n) of the PHS Act<sup>1</sup> for themselves and for their “covered individuals,”<sup>2</sup> Health Center Program [awardees](#) and [subrecipients](#) (including those defined as subrecipients under the Health Center FTCA Medical Malpractice Program regulations),<sup>3</sup> hereafter referred to as a “health center” in this chapter, must submit for approval by HRSA an annual deeming application that demonstrates the health center:

- Has implemented appropriate policies and procedures to reduce the risk of malpractice and the risk of lawsuits arising out of any health or health-related functions performed by the health center;
- Has reviewed and verified the professional credentials, references, claims history, fitness, professional review organization findings, and license status of its physicians and other licensed or certified health care practitioners;
- Has no history of claims under section 224 of the PHS Act or, if such a history exists, fully cooperates with the Attorney General in defending against any such claims, and takes any necessary steps to assure against such claims in the future; and
- Will fully cooperate with the Attorney General and other applicable agencies in providing required information under section 224 of the PHS Act.

**Note:** *A health center’s deemed employment status<sup>4</sup> does not imply FTCA coverage in all cases, as health center providers must also comply with statutory individual eligibility requirements,*

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<sup>1</sup> The text of section 224 of the PHS Act may be found at: <http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section233&num=0&edition=prelim>

<sup>2</sup> “Covered individuals” is defined by the [FTCA Health Center Policy Manual](#) to mean “governing board members, officers, employees, and certain individual contractors.” The term does not include [volunteer health professionals](#) of deemed health centers, who may be deemed as PHS employees under section 224(q), and as to whom an individual deeming application is required.

<sup>3</sup> *Subrecipient*, as used in this chapter means, as described in 42 CFR 6.2, an entity that receives a Federal award or a contract from a covered entity to provide a full range of health services on behalf of the covered entity. *Covered entity* means an entity as described in 42 CFR 6.3 which has been deemed by the Secretary, in accordance with 42 CFR 6.5, to be covered by 42 CFR Part 6.

<sup>4</sup> Deemed employment status extends to covered individuals based on evidence of their relationship with the covered entity (i.e., officer, governing board member, health center employee, qualified individual contractor, or volunteer health professional), pursuant to section 224(g)-(n) and (q) of the PHS Act, and 42 CFR Part 6. Volunteer health professionals may receive deemed employment status based on individual applications by the sponsoring,

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*and covered actions must be taken within the scope of deemed PHS employment. When FTCA matters become the subject of litigation, the U.S. Department of Justice and the Federal courts may assume significant roles in certifying or determining whether or not a given activity falls within the scope of employment for purposes of FTCA coverage. For more information, review the FTCA Health Center Policy Manual available at:*

*<https://bphc.hrsa.gov/ftca/pdf/ftcahcpolicymanualpdf.pdf>.*

### **Demonstrating Compliance**

***A health center would demonstrate compliance with the FTCA requirements by providing documentation in its annual deeming application, in the form and manner prescribed by HRSA, and consistent with (but not necessarily limited to) the following:***

#### **Credentialing and Privileging / Quality Improvement and Quality Assurance**

- a. The health center is currently compliant with all of the [credentialing](#) and [privileging](#) requirements of Chapter 5: [Clinical Staffing](#) and all requirements within Chapter 10: [Quality Improvement/Assurance](#) prior to the deeming determination.

#### **Risk Management**

- a. The health center has and currently implements an ongoing health care risk management program to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation and that requires the following:
  - Risk management across the full range of health center health care activities;
  - Health care risk management training for health center staff;
  - Completion of quarterly risk management assessments by the health center; and
  - Annual reporting to the health center board which includes: completed risk management activities; status of the health center's performance relative to established risk management goals; and proposed risk management activities that relate and/or respond to identified areas of high organizational risk.
- b. The health center has risk management procedures that address the following areas for health center services and operations:
  - Identifying and mitigating the health care areas/activities of highest risk within the health center's HRSA-approved [scope of project](#), including but not limited to tracking referrals, diagnostics, and hospital admissions ordered by health center providers;
  - Documenting, analyzing, and addressing clinically-related complaints and "near misses" reported by health center employees, patients, and other individuals;

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deemed health center. Whether a specific activity is covered by the FTCA will also require a determination or certification that the activities at issue occurred within the scope of deemed PHS employment.

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- Setting and tracking progress related to annual risk management goals;
  - Developing and implementing an annual health care risk management training plan for all staff members based on identified areas/activities of highest clinical risk for the health center (including, but not limited to, obstetrical procedures and infection control) and any non-clinical trainings appropriate for health center staff (including HIPAA medical record confidentiality requirements); and
  - Completing an annual risk management report for the board and key management staff.
- c. The health center provides reports to the board and key management staff on health care risk management activities and progress in meeting goals at least annually, and provides documentation to the board and key management staff showing that any related follow-up actions have been implemented.
- d. The health center has a health care risk management training plan for all staff members and documentation showing that such trainings have been completed by the appropriate staff, including all clinical staff, at least annually.
- e. The health center designates an individual(s) (for example, a risk manager) who oversees and coordinates the health center's health care risk management activities and completes risk management training annually.

### **Claims Management**

- a. The health center has a claims management process for addressing any potential or actual health or health-related claims, including medical malpractice claims, that may be eligible for FTCA coverage. In addition, this process ensures:
- The preservation of all health center documentation related to any actual or potential claim or complaint (for example, medical records and associated laboratory and x-ray results, billing records, employment records of all involved clinical providers, clinic operating procedures); and
  - Any service-of-process/summons that the health center or its provider(s) receives relating to any alleged claim or complaint is promptly sent to the HHS Office of the General Counsel, General Law Division, per the process prescribed by HHS and as further described in the FTCA Health Center Policy Manual.
- b. The health center has a designated individual(s) who is responsible for the management and processing of claims-related activities and serves as the claims point of contact.

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- c. The health center informs patients using plain language that it is a deemed Federal PHS employee<sup>5</sup> via its website, promotional materials, and/or within an area(s) of the health center that is visible to patients.
- d. If a history of claims under the FTCA exists, the health center can document that it:
  - Cooperated with the Attorney General, as further described in the FTCA Health Center Policy Manual; and
  - Implemented steps to mitigate the risk of such claims in the future.

### ***Related Considerations***

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines how to obtain its health care risk management training (for example, through one of HRSA’s national cooperative agreements or technical assistance contracts) and which trainings to require for covered individuals and the individual(s) designated with risk management responsibilities (for example, risk manager).
- The health center determines what other types of liability coverage to obtain, such as private “gap” or “tail” insurance, directors and officer insurance, and general liability insurance, for activities that may not be eligible for FTCA coverage.
- The health center determines how to conduct and document the completion of quarterly risk management assessments.
- With the exception of health centers that use volunteer health professionals, as to which requirements are prescribed by law,<sup>6</sup> the health center determines how to inform patients that it is a deemed Federal Public Health Service employee.

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<sup>5</sup> For example: “This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals.” For more information, see <http://www.bphc.hrsa.gov/ftca/>.

<sup>6</sup> Section 224(q)(2)(D) of the PHS Act.

## **Appendix A: Health Center Program Non-Regulatory Policy Issuances That Remain in Effect**

The following policy issuances most often referred to as Policy Information Notices (PINs) remain in effect and are not superseded by the Health Center Program Compliance Manual:

- PIN 2007-09      Service Area Overlap: Policy and Process  
(<http://bphc.hrsa.gov/programrequirements/policies/pin200709.html>)
  
- PIN 2007-15      Health Center Emergency Management Program Expectations  
(<https://bphc.hrsa.gov/about/pdf/pin200715.pdf>)
  
- PIN 2008-01      Defining Scope of Project and Policy for Requesting Changes  
(<http://bphc.hrsa.gov/programrequirements/policies/pin200801.html>)
  
- PIN 2009-02      Specialty Services and Health Centers' Scope of Project  
(<http://bphc.hrsa.gov/programrequirements/policies/pin200902purpose.html>)
  
- PIN 2009-05      Policy for Special Population-Only Grantees Requesting a Change in Scope to Add a New Target Population  
(<http://bphc.hrsa.gov/programrequirements/policies/pin200905specialpops.html>)

The following HRSA/BPHC policy documents and resources also remain in effect and are not superseded by the Health Center Program Compliance Manual:

Federal Tort Claims Act Health Center Policy Manual  
(<https://bphc.hrsa.gov/ftca/pdf/ftcahcpolicymanualpdf.pdf>)

Additional Scope of Project/Change in Scope Resources  
(<http://bphc.hrsa.gov/programrequirements/scope.html>)

Site Visit Resources  
(<http://bphc.hrsa.gov/programrequirements/svguide.html>)

Uniform Data System (UDS) Resources  
(<http://bphc.hrsa.gov/datareporting/reporting/index.html>)



## Glossary

*Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. [View the revisions.](#)*

**330(g) Migratory and Seasonal Agricultural Worker (MSAW):** For the purposes of health centers receiving a Health Center Program award or designation under section 330(g) of the Public Health Service Act, the population served includes:

- Migratory agricultural workers who are individuals whose principal employment is in agriculture, and who have been so employed within the last 24 months, and who establish for the purposes of such employment a temporary abode;
- Seasonal agricultural workers who are individuals whose principal employment is in agriculture on a seasonal basis and who do not meet the definition of a migratory agricultural worker;
- Individuals who are no longer employed in migratory or seasonal agriculture because of age or disability who are within such catchment area; and/or
- Family members of the individuals described above.

Agriculture refers to farming in all its branches, as defined by the North American Industry Classification System under codes 111, 112, 1151, and 1152.

(Section 330(g) of the PHS Act)

**330(h) Homeless Population:** For the purposes of health centers receiving a Health Center Program award or designation under section 330(h) of the Public Health Service Act, the population served includes individuals:

- Who lack housing (without regard to whether the individual is a member of a family);
- Whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations;
- Who reside in transitional housing; and/or
- Who reside in permanent supportive housing or other housing programs that are targeted to homeless populations.

Under section 330(h) a health center may continue to provide services for up to 12 months to formerly homeless individuals whom the health center has previously served but are no longer homeless as a result of becoming a resident in permanent housing and may also serve children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness.

(Section 330(h) of the PHS Act)

**330(i) Residents of Public Housing:** For the purpose of health centers receiving a Health Center Program award or designation under section 330(i) of the Public Health Service Act, the population served includes residents of public housing and individuals living in areas immediately accessible to public housing. Public housing includes public housing agency-developed, owned or assisted low-income housing, including mixed finance projects, but

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excludes housing units with no public housing agency support other than Section 8 housing vouchers. (Section 330(i) of the PHS Act)

**Additional Services (Additional Health Services):** Services that are not included as [required primary health services](#) and that may be offered as appropriate to meet the health needs of the population served by the health center. (Section 330(b)(2) of the Public Health Service Act)

**Awardee (award recipient):** *Formerly referred to as “grantee.”* A public or nonprofit non-Federal organization that carries out the [Federal award](#) under the Health Center Program as a recipient or [subrecipient](#). (45 CFR 75.2)

**Co-Applicant:** For public agency health centers only. The established body that serves as a public center’s governing board when the public agency determines that it cannot meet the Health Center Program governing board requirements directly. (Section 330(r)(2)(A) of the Public Health Service Act)

**Contract:** A contract is used for the purpose of obtaining goods and services needed to carry out the project or program under a Federal award. It does not include a legal instrument, even if the health center considers it a contract, when the substance of the transaction meets the definition of a Federal award or subaward. Characteristics of a contract are when the contractor:

- (1) Provides the goods and services within normal business operations;
- (2) Provides similar goods or services to many different purchasers;
- (3) Normally operates in a competitive environment;
- (4) Provides goods or services that are ancillary to the operation of the Federal program; and
- (5) Is not subject to compliance requirements of the Federal program as a result of the relationship (although similar requirements may apply for other reasons, including as a result of contractual provisions).

(45 CFR 75.2 and 45 CFR 75.351)

**Credentialing:** The process of assessing and confirming the license or certification, education, training, and other qualifications of a licensed or certified health care practitioner.

**EHB: HRSA’s Electronic Handbooks:** HRSA’s Web-based grants interface, used for all Health Center Program award or designation management activities.

**Federal award (award, Federal grant):** The Federal financial assistance that a [non-Federal entity](#) receives directly from a Federal awarding agency, such as HRSA, or indirectly from a [pass-through entity](#). For the purposes of the Compliance Manual (unless specified differently), this refers to Federal award funding under section 330 of the Public Health Service Act or the “Health Center Program award.” (45 CFR 75.2)

**Federal Poverty Guidelines (FPG):** The Federal Poverty Guidelines (FPG) are a simplification of

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the poverty thresholds, which are updated each year by the Census Bureau, and are used for administrative purposes — for instance, determining financial eligibility for certain Federal programs. The guidelines reflect annual income levels below which a person or family is considered to be living in poverty, and the amounts increase according to the size of the family. The guidelines are updated annually by HHS in the Federal Register.

(<https://aspe.hhs.gov/poverty-guidelines>)

**Federally Qualified Health Center (FQHC):** A Medicare/Medicaid designation administered by CMS. Eligible organizations include organizations receiving grants under section 330 of the PHS Act, [look-alikes](#), and certain tribal organizations. (Section 1861(aa)(4)(B) and section 1905(l)(2)(B) of the SSA)

**Fitness for duty** *Formerly referred to as “health fitness”:* Fitness for duty, for purposes of this Compliance Manual, means the ability to perform the duties of the job in a safe, secure, productive, and effective manner.

**Form 5A: Services Provided:** Official documentation of the required and additional health services (See Chapter 4: [Required and Additional Health Services](#)) included in a health center’s HRSA-approved [scope of project](#), and their corresponding mode(s) of service delivery. This form is contained in the health center’s folder in [EHB](#).

(<http://bphc.hrsa.gov/programrequirements/scope.html>)

**Form 5B: Service Sites:** Official documentation of the [service delivery sites](#) (see [Service Site](#)) included in a health center’s HRSA-approved [scope of project](#). This form is contained in the health center’s folder in [EHB](#). (<http://bphc.hrsa.gov/programrequirements/scope.html>)

**Limited English Proficiency (LEP):** LEP persons include individuals who do not speak English as their primary language and/or who have a limited ability to read, write, speak, or understand English; and who may be eligible to receive language assistance with respect to the particular service, benefit, or encounter. (<http://www.hhs.gov/civil-rights/index.html>)

**Look-Alike:** Organizations that do not receive a Health Center Program [Federal award](#) but are designated by HRSA as meeting Health Center Program requirements. (Section 1861(aa)(4)(B) and section 1905(l)(2)(B) of the SSA)

**Non-Federal Entity:** A State, local government, Indian tribe, institution of higher education (IHE), or nonprofit organization that carries out a [Federal award](#) as a [recipient](#) or [subrecipient](#). (45 CFR 75.2)

**Pass-Through Entity:** A [non-Federal entity](#) that provides a [subaward](#) to a [subrecipient](#) to carry out part of a Federal program. (45 CFR 75.2)

**Primary Source Verification:** Verification by the original source of a specific credential of the accuracy of a qualification reported by an individual health care practitioner. Primary source

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verification could include direct correspondence, telephone, fax, e-mail, or paper or online reports received from original sources (for example, telephone confirmation from an educational institution that the individual graduated with the degree[s] listed on his or her application, confirmation through a state's database that a provider's license is current, reports from credentials verification organizations).

**Privileging:** The process of authorizing a health care practitioner's specific scope and content of patient care services.

**Required Services (Required Health Services):** Required services are those services that a health center must provide, as defined in Section 330(b)(1) of the Public Health Service Act. (Section 330(a)(1) of the Public Health Service Act)

**Scope of Project:** Defines the [service sites](#), services, providers, [service area\(s\)](#), and target population included in the HRSA-approved Health Center Program project. ([Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes](#))

**Service Area** (also referred to as a "catchment area"): The precise boundaries, as defined by the health center, of the geographic area to be served under the Health Center Program project, including identified medically underserved population or populations within that area. (42 CFR 51c.102)

**Service Site:** Locations where a health center either directly or through a [subrecipient](#) or contractual arrangement provides services and where all of the following conditions are met:

- Health center encounters are generated by documenting in the patients' records face-to-face contacts between patients and providers;
- Providers exercise independent judgment in the provision of services to the patient;
- Services are provided directly by or on behalf of the health center, whose governing board retains control and authority over the provision of the services at the location; and
- Services are provided on a regularly scheduled basis. ([Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes](#))

**Special Population [Special Medically Underserved Population]:** HRSA may award funding or designation under sections 330(g), (h), or (i) of the PHS Act for the delivery of services to a special medically underserved population. See definitions for [330\(g\) Migratory and seasonal agricultural workers](#); [330\(h\) Homeless individuals](#); and [330\(i\) Residents of public housing](#).

**Subaward:** An award provided by a pass-through entity to a [subrecipient](#) for the subrecipient to carry out part of a [Federal award](#) received by the pass-through entity. It does not include payments to a contractor or payments to an individual that is a beneficiary of a Federal program. A subaward may be provided through any form of legal agreement, including an agreement that the pass-through entity considers a [contract](#). See also "[Pass-Through Entity](#)." (45 CFR 75.2)

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**Subrecipient:** Per 45 CFR 75.2, a [non-Federal entity](#) that receives a [subaward](#) from a [pass-through entity](#) to carry out part of a Federal program but does not include an individual that is a beneficiary of such program. A subrecipient may also be a [recipient](#) of other [Federal awards](#) directly from a Federal awarding agency.

Characteristics which would lend support to the classification of the non-Federal entity as a subrecipient include when the non-Federal entity:

- (1) Determines who is eligible to receive what Federal assistance;
- (2) Has its performance measured in relation to whether objectives of a Federal program were met;
- (3) Has responsibility for programmatic decision making;
- (4) Is responsible for adherence to applicable Federal program requirements specified in the Federal award; and
- (5) In accordance with its agreement, uses the Federal funds to carry out a program for a public purpose specified in authorizing statute, as opposed to providing goods or services for the benefit of the pass-through entity. (45 CFR 75.2)

**Uniform Data System (UDS):** The UDS is a core set of information appropriate for reviewing the operation and performance of health centers. The UDS annually collects a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues.

<http://bphc.hrsa.gov/datareporting/reporting/index.html>

**Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (45 CFR Part 75):** *Sometimes referred to as the "HHS grant regulations."* Final requirements for [Federal awards](#) to [non-Federal entities](#) located in Title 2 of the Code of Federal Regulations as adopted by HHS at 45 CFR Part 75. These requirements supersede and streamline requirements from previous OMB Circulars A-21, A-87, A-110, and A-122 ; Circulars A-89, A-102, and A-133; and the guidance in Circular A-50 on Single Audit Act follow-up. (45 CFR Part 75)

**Volunteer Health Professional (VHP):** For the purposes of being deemed as PHS employees for the purposes of liability protections under section 224(q) of the PHS Act, a health care practitioner shall be considered to be a volunteer health professional at a deemed health center if the following conditions are met:

- (1) The service is provided to patients at the sponsoring health center facilities or through offsite programs or events carried out by the sponsoring health center;
- (2) The deemed health center is sponsoring the health care practitioner;
- (3) The health care practitioner does not receive any compensation for the service from the patient, the sponsoring health center, or any third-party payer (including reimbursement under any insurance policy, health plan, or Federal or state health benefits program). However, the health care practitioner may receive repayment from the health center for reasonable expenses incurred in providing the service to the

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patient;

- (4) Before the service is provided, the health care practitioner or the deemed health center posts a clear and conspicuous notice at the site where the service is provided of the extent to which the legal liability of the health care practitioner is limited pursuant to subsection 224(q);
- (5) At the time service is provided, the VHP is licensed or certified in accordance with applicable Federal and state laws regarding the provision of the service; and
- (6) The sponsoring health center must maintain all relevant documentation certifying that the VHP meets the requirements to be considered a volunteer.

(Section 224(q) of the PHS Act)