# HRSA Technical Assistance Workshop
# Creating a Successful HRSA Grant

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**Afternoon session:**
**HIGHLIGHTS OF THE HEALTH CENTER PROGRAM**

**May 19, 2010**

# HRSA - America's Health Care Safety Net

- Health centers
- HIV/AIDS
- Maternal and child health
- Health workforce training
- Rural health
- Organ and tissue donation
- 340B drug pricing
- Vaccine injury compensation
- State health access

# Health centers - definition of Federally Qualified Health Centers(FQHCs)

- Medicare and Medicaid statutes define the provider type “Federally Qualified Health Center” (FQHC) (*Social Security Act §1861(aa)(4) and §1905(l)(2)(B) respectively)*
- HRSA administers two types of FQHCs:
  - An entity that receives a grant under section 330 of the Public Health Service Act (PHSA) – commonly referred to as “health centers.”
  - An entity that is determined by DHHS to meet requirements to receive funding without actually receiving a grant.

# Program Administration

- Health Center Program:
  - Discretionary grant program administered by HRSA.
  - Competitive application reviews with announced deadlines.
  - Project periods up to 5 years.

  FQHC Look-Alike Program:
  - Operated under an intra-agency agreement between HRSA and Centers for Medicare and Medicaid Services (CMS).
  - HRSA is responsible for assuring compliance with requirements under section 330 and making recommendations to CMS for designation.
  - CMS has final authority to designate FQHC Look-Alikes.
  - Non-competitive process - applications reviewed on a rolling basis in the order received (no set deadline).

## Program Benefits

- Health Centers:  Access to Federal grant funds to support the costs of uncompensated care
- Federal Tort Claims Act (FTCA) malpractice coverage
- Federal Loan Guarantee Program
- Health Centers and Look alikes: Eligible for –
  - Enhanced reimbursement under Prospective Payment System (PPS) or other state-approved alternative payment methodology for services provided under Medicaid
  - All inclusive rate of allowable cost reimbursement for services provided under Medicare
  - Participation in the 340B (discounted) Drug Pricing Program
  - Health Professional Shortage Area Designation and participation in National Health Service Corps

# Application Review Process

- Health Center Program funding opportunities are announced on:
  - HRSA web site: http://www.hrsa.gov/grants/default.htm
  - Grants.gov: http://grants.gov/
- FQHC Look-Alike Program:
  - application guidance is available at: http://bphc.hrsa.gov/policy/pin0906/
  - Applications are submitted directly the HRSA/BPHC

# Program Requirement Sources

- Health Center Program Statute—Section 330 of the Public Health Service (PHS) Act (42 U.S.C. §254b)
- Program Regulations—42 CFR Part 51c and 42 CFR Parts 56.201-56.604 for Community and Migrant Health Centers
- Grants Regulations—45 CFR Part 74

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

# Funding Opportunities

- FY 2010 Funding
  - No new competitive funding opportunities
- FY 2011 Funding
  - President's budget request includes a total increase of $290 million:
    - Continue New Access Points and Increased Demand for Services funding initiated under ARRA
    - New funding opportunities for:
      - New Access Points
      - Behavioral Health Service Expansion
      - Planning Grants (if funds permit)
- Patient Care Affordability Act – multiple HRSA provisions, more to come soon

# Options

- Free clinic – no insurance, volunteer model
- Rural Health Clinic – enhanced reimbursement, must employ physician assistant or nurse practitioner
- FQHC look alike
- Collaboration → Discuss with nearby Health Center→ Satellite? New access point funding

# Options

- Health Center Program Grant
- Seek out Primary Care Associations and their knowledge of the health care marketplace - see Appendix for PCA list and http://bphc.hrsa.gov/technicalassistance/
- Refer to Appendix for a map of current health center service delivery points in the target area for this conference - - southern New Jersey, southeastern Pennsylvania, northern Delaware and northeastern Maryland

# Overview

- There are **19** Health Center Program Requirements (http://www.bphc.hrsa.gov/about/requirements.htm)

- Requirements are divided into four categories:
  - Need
  - Services
  - Management & Finance
  - Governance

# NEED

# 1. Needs Assessment

Requirement:

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

# Needs Assessment, cont.

- Health center performs periodic needs assessments.

- Assessments document the needs of their target population in order to inform and improve their delivery of appropriate services.

# Needs Assessment, cont.

A Needs Assessment typically includes, but is not limited to data on:

- Population to Primary Care Physician FTE ratio
- Percent of population at or below 200% of poverty
- Percent of uninsured population
- Proximity to providers who accept Medicaid and/or uninsured patients
- Health indicators (e.g. diabetes, hypertension, low birthweight, immunization rates)

# SERVICES

# 2. Required and Additional Services

Requirement:

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

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

# Required and Additional Services

- Ensures the health center is directly providing or has written arrangements and referrals in place to provide a comprehensive array of required and as necessary, additional primary and preventive services that meets the needs of the populations they serve

- All services in scope must be reasonably accessible and available on a sliding fee scale to health center patients.

- In scope referral arrangements must be formally documented in a written agreement (memorandum of agreement/understanding, etc.) that at a minimum describes the manner by which the referral will be made and managed and the process for referring patients back to the health center for appropriate follow-up care.

# 3. Staffing Requirement

## Requirement:

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

- *Note – highly relevant to this requirement are the resources from the National Health Services Corps. Increased availability of loan repayment, part-time loan repayment and anticipated growth of these resources make this an important component of your provider recruitment and retention plan. Listen to the playback of NHSC and Health Centers "Together Making a Difference" dial 1-866-400-9641 for the replay*

# Staffing Requirement

- Staff composition and numbers should support the health center‘s Health Care Plan and required and additional services.

- Staffing should be culturally and linguistically appropriate for the population being served and as noted in the health center’s needs assessment.

# 4. Accessible Hours of Operation/ Locations

Requirement:

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

# Accessible Hours of Operation/ Locations

- The times/hours that services are provided are appropriate to ensure access for the health center's patient population. For example, the health center offer some appointments after normal work hours.

- The locations at which services are provided are accessible to the patient population. For example, sites are generally located in the areas the health center's target population lives/works.

# Accessible Hours of Operation/ Locations

- Appropriate consideration is taken into account in determining site/service locations and hours of operation for health centers serving special populations. For example, services are offered at migrant camps for grantees targeting migrant and seasonal farmworkers.

# 5. After Hours Coverage

Requirement:

*Health center provides professional coverage during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act)*

# After Hours Coverage

- After hours coverage includes the provision, through clearly defined arrangements, for access of health center patients to professional coverage for medical emergencies after the center's regularly scheduled hours.

- Specific arrangements for after-hours coverage (such as in a rural area) may vary by community. However, all health centers must have some type of clear arrangement(s) for after hours coverage.

# After Hours Coverage

- The coverage system should ensure telephone access to a covering clinician (not necessarily a health center clinician) who can exercise independent professional judgment in assessing a health center patient's need for emergency medical care and who can refer patients to appropriate locations for such care, including emergency rooms, when warranted.

# 6. Hospital Admitting Privileges and Continuum of Care

Requirement:

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

# Hospital Admitting Privileges and Continuum of Care

- All health centers must either have admitting privileges for their physicians at one or more referral hospitals, or some other arrangements that ensures continuity of care.

- In cases where hospital admitting privileges and membership are not possible, the health center must have firmly established arrangements for patient hospitalization, discharge planning, and tracking.

# 7. Sliding Fee Discounts

## Requirement:

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

- *This system must provide a full discount to individuals and families with annual incomes at or below 100% of the poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.**
- *No discounts may be provided to patients with incomes over 200 % of the Federal poverty level.**
- *(Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f))*

# Sliding Fee Discounts

- There should be no charge or only a nominal fee for individuals at or below 100% FPL.
- The fee schedule should slide/provide varying discount levels on charges to individuals between 101% and 200% of the FPL.
- There should be no discount for patients above 200% FPL
- The fee schedule must be based on the most recent Federal Poverty Level/Guidelines, available at http://aspe.hhs.gov/poverty/ and should be updated annually.
- Patients must be notified/made aware of the availability of the sliding fee discounts.

# 8. Quality Improvement/ Assurance Plan

## Requirement:

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

- *a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;**
- *periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall: **
  - *be conducted by physicians or by other licensed health professionals under the supervision of physicians;**
  - *be based on the systematic collection and evaluation of patient records;** and
  - *identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.**

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

# Quality Improvement/ Assurance Plan

- QI/QA assessments are conducted (e.g. assessments of the appropriateness of service utilization, quality of services delivered, and/or the health status/outcomes of health center patients, etc.) on a regular basis.

- The health center has a clinical director, who may be full or part time staff, should have appropriate training/ background (e.g. MD, RN, MPH, etc), as determined by the needs/size of the health center.

# Quality Improvement/ Assurance Plan

- The clinical director has clear responsibility, along with other staff as appropriate, for conducting QI/QA assessments/activities.
- The plan includes methods for measuring and evaluating patient satisfaction.
- The health center has clinical information systems in place for tracking/analyzing/reporting key performance data related to the organization's plan.
- The findings of the QI/QA process are used to improve organizational performance.

- Only after the entity is funded as a CHC can you apply for Federal Torts Claim Act coverage
- There are additional requirements beyond what are described in the program requirements such as for clinical treatment protocols
- See Program Assistance Letter Number: 2009-05
- Date: May 1, 2009. New Requirements for Medical Malpractice Coverage Deeming under the Federally Supported Health Centers Assistance Act for Calendar Year 2010

# MANAGEMENT & FINANCE

# 9. Key Management Staff

Requirement:

*Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior review by HRSA of final candidates for Project Director/Executive Director/CEO position is required. (Section 330(k)(3)(H)(ii) of the PHS Act and 45 CFR Part 74.25 (c)(2), (3))*

# Key Management Staff

- Health center has a management team that is the right size and composition.
- Health center has a Chief Executive Officer or Executive Director/Project Director. If this leadership position has changed, prior review of final candidates is required by HRSA.
- The management team (which may include a Clinical Director, Chief Operating Officer, Chief Financial Officer, Chief Information Officer, as appropriate for the size and complexity of the health center) is fully staffed.

# 10. Contractual/Affiliation Agreements

Requirement:

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

# Contractual/Affiliation Agreements

- The health center has the appropriate amount of oversight and the ability to maintain their independence and compliance for all contracted services and affiliation agreements.

- Any contractual arrangements must comply with Federal procurement standards set forth in 45 CFR Part 74 (including conflict of interest standards).

# Contractual/Affiliation Agreements

- Affiliation agreements or contracts must not:
  - Threaten health center's integrity
  - Compromise compliance with any other Program Requirements
  - Limit health center's autonomy

- Health centers with sub-recipient arrangements must ensure that their sub-recipient(s) comply with all statutory and regulatory requirements.

# 11. Collaborative Relationships

Requirement:

*Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing Federally Qualified Health Center(s) in the service area or provides an explanation for why such letter(s) of support cannot be obtained (Section 330(k)(3)(B) of the PHS Act)*

# Collaborative Relationships

- The health center has collaborative relationships with other appropriate providers and organizations in the area, including other Federally Qualified Health Centers (FQHCs).

- Public Housing Primary Care grantees must show how residents are involved in the administration of the program.

- In the SAC application, health centers must have letter(s) of support from service area FQHCs and are encouraged to have letters from other community and health organizations. If no letters or an incomplete set of letters is attached, the health center must have a written explanation of why letters are not available.

# 12. Financial Management and Control Policies

## Requirement:

*Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability.*

*Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26)*

# Financial Management and Control Policies

- The health center has appropriate measures in place to protect their assets and adhere to Federal accounting requirements, including:
  - Accounting and internal control systems that are appropriate to the size and complexity of the organization and reflect Generally Accepted Accounting Principles (GAAP) or GASB, as applicable.
  - Policies and processes that safeguard the organization's assets.

# Financial Management and Control Policies

- A complete audit submission which must include:
  - The auditor's report (including the auditor's opinion, financial statements, auditor's notes and required communications from the auditor)
  - Any management letter issued by the auditor, or a statement signed by an authorized representative of the health center that no management letter was issued.

***Note:*** If any material weaknesses are identified in the audit, these must be addressed by the health center.

# 13. Billing and Collections

Requirement:

*Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)*

# Billing and Collections

- Health centers must have documented billing and collection policies and procedures in place to maximize reimbursement.

- Health centers must have the ability to bill Medicaid and Medicare.

# 14. Budget

Requirement:

*Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. (Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25)*

# Budget

- A complete and clear budget should include: SF-424, budget justification, Form 2 Staffing profile, and Form 3 Income Analysis

- The budget should describe/reflect:
  - How total budget is aligned and consistent with the service delivery plan and patients to be served.
  - How reimbursement will be maximized from third party payors.
  - How the proportion of requested Federal grant funds is appropriate given other sources of income.

# 15. Program Data Reporting Systems

Requirement:

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

# Program Data Reporting Systems

- The health center has systems, including Management Information Systems (MIS) in place that can accurately collect and produce data to support health center oversight and direction.
- The health center submits accurate and timely reports, as required (e.g. UDS, FSR, HCQR).
- The health center provides a complete Health Care and Business Plan with their annual application to demonstrate performance improvement.

# 16. Scope of Project

Requirement:

*Health center maintains their funded scope of project (sites, services, service area, target population and providers), including any increases based on recent grant awards. (45 CFR Part 74.25)*

# Scope of Project

- The section 330 approved Scope of Project stipulates what the total grant-related project budget supports (including program income and other non-section 330 funds).
  - Five core elements: Services, Sites, Providers, Target Population, Service Area
  - Changes in scope may affect eligibility and coverage
  - Significant changes in scope must be approved by HRSA/BPHC (See PINs 2008-01, 2009-02, & 2009-05 for further guidance)

- Health centers are expected to maintain their approved and funded scope of project in terms of number of patients served, visits, services available, providers, and/or sites.

# GOVERNANCE

- Guiding principles in the health center and FQHC Look-Alike Program include:
  - Private non-profit or public entities that must **serve a high need community or population** (i.e., medically underserved areas or medically underserved populations).

  **Governed by a community board** of which at least a majority (51%) are health center patients who represent the population served.

# 17. Board Authority

## Requirement:

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

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

***Note:*** *Upon a showing of good cause the Secretary may waive, for the length of the project period, the monthly meeting requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)*

# Board Authority

Health center's board:

- Meets monthly.
  - **Health centers with Approved Waivers ONLY:** Appropriate strategies are in place to ensure regular oversight, if the Board does not meet monthly.
- Reviews and approves the annual health center (renewal) application and budget.
- Conducts an annual review of the CEO's performance (with clear authority to select a new CEO and/or dismiss the current CEO if needed).

# Board Authority

## Health center's board:

- Reviews and approves the services to be provided and the health center's hours of operation.
- Measures and evaluates the health center's progress in meeting annual and long term clinical and financial goals.
- Engages in strategic and/or long term planning for the health center.

# Board Authority

## Health center's board:

- Reviews the health center's mission and bylaws as necessary on a periodic basis.
- Receives appropriate information that enables it to evaluate health center patient satisfaction, organizational assets and performance.
- Establishes the general policies, which may include, but are not limited to: personnel, health care, fiscal, and quality assurance/ improvement policies for the organization. ***With the exception of fiscal and personnel policies in the case of a public agency grantee in a co-applicant arrangement.***

# Board Authority

- **For Public Center Grantees with Co-Applicant Arrangements ONLY:** Public entity grantee of record has a formal co-applicant agreement that stipulates:
  - Roles, responsibilities and the delegation of authorities.
  - Any shared/split responsibilities between the public center and co-applicant board.

# 18. Board Composition

## Requirement:

*The health center governing board is composed of individuals, a majority of whom are being served by the center and, who as a group, represent the individuals being served by the center. Specifically:*

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

***Note:*** *Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)*

# Board Composition

- A majority (at least 51%) of the Board members receive services (i.e. are patients) at the health center.

- As a group, the "patient/consumer" Board members reasonably represent the individuals who are served by the health center in terms of race, ethnicity and gender. ***Note:*** There is no established ratio for board members to population served; however, it should be reasonably representative of the populations being served (i.e. race, ethnicity, gender).

- **Health Centers with Approved Waivers ONLY:** Appropriate strategies are in place to ensure consumer/patient participation and input (given board is not 51% consumers/ patients) in the direction and ongoing governance of the organization.

# Board Composition

- ***Health Centers that receive part of their section 330 funding to serve special populations and are not eligible for an approved waiver:*** The Board include representation from/for these special populations group(s), as appropriate (e.g. an advocate for the homeless, the director of a Migrant Head Start program, a formerly homeless individual).

- The board has between 9 and 25 members.

- The size of the board is appropriate for the complexity of the organization and the diversity of the community served.

# Board Composition

- The Board includes a member (or members) with expertise in any of the following:
  - Community affairs
  - Local government
  - Finance and banking
  - Legal affairs
  - Trade union and other commercial and industrial concerns
  - Community social service agencies

- No more than 50% of the non-consumer Board members derive more than 10% of their annual income from the health care industry.

# 19. Conflict of Interest Policy

Requirement:

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

- *No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as an ex-officio member of the board.**

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

# Conflict of Interest Policy

- The bylaws or other policy documents include a conflict of interest provision(s).
- No current Board member(s) is an employee of the health center or an immediate family member of an employee.
- The CEO/Program Director does not participate as a voting member of the Board.

# Conflict of Interest Policy

- The health center's conflict of interest policy should address such issues as:
  - disclosure of business and personal relationships, including nepotism, that create an actual or potential conflict of interest;
  - extent to which a board member can participate in board decisions where the member has a personal or financial interest;
  - using board members to provide services to the center;
  - board member expense reimbursement policies;
  - acceptance of gifts and gratuities;
  - personal political activities of board members; and
  - statement of consequences for violating the conflict policy.

# Public Center Requirements

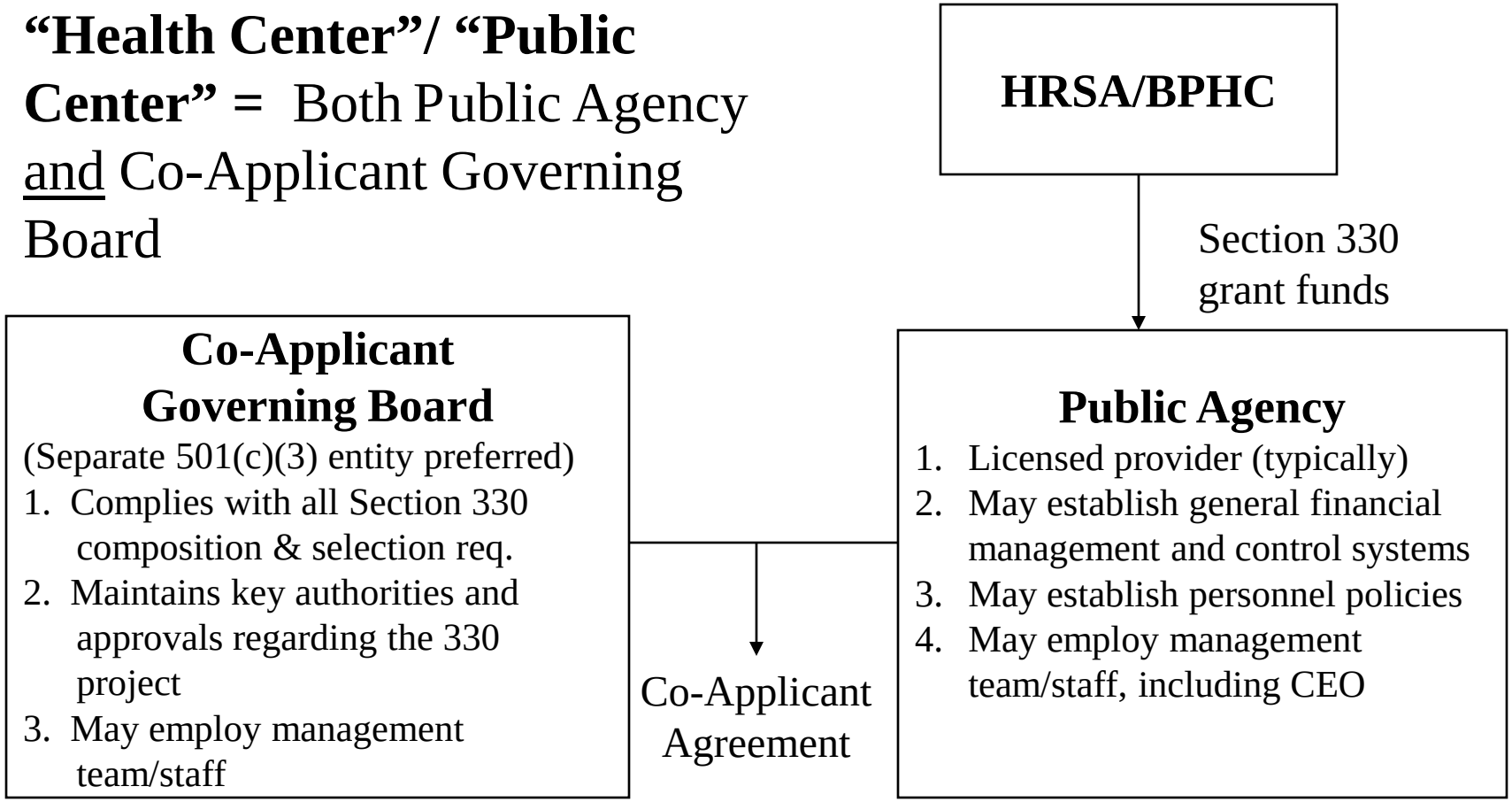
- Private, charitable, tax-exempt nonprofit organization must meet all program requirements (except where waivers permitted).
- Public center (a health center funded (or to be funded) through a grant to a public agency) may be structured in two different ways to meet the program requirements (direct or co-applicant arrangement).
  - **DIRECT:** Public agency meets all of the requirements of the section 330 program directly
  - **CO-APPLICANT ARRANGEMENT:** Public agency with co-applicant governing Board of Directors – collectively the two meet all section 330 requirements and are considered the public center
    - No exceptions from Board composition and selection requirements
    - Special considerations for exercising certain Board authorities
    - May share other responsibilities, provided that the co-applicant Board retains final and ultimate decision-making

# What Is a Public Agency?

- The organization is a State or a political subdivision of a State with one or more sovereign powers
- The organization is an instrumentality of government, such as those exempt under Internal Revenue Code section 115
- The organization is a subdivision, municipality, or instrumentality of a U.S. affiliated sovereign State that is formally associated with the United States
- The organization is operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act or urban Indian organization under the Indian Health Care Improvement Act. Tribal Self-Determination legislation recognizes the primacy of the government-to-government relationship between the United States and sovereign Tribal nations. *(Note: the governing board requirements do not apply to these organizations.)*

# Co-Applicant Arrangement

**"Health Center"/ "Public Center" =** Both Public Agency and Co-Applicant Governing Board



# Co-Applicant Arrangement

- HRSA strongly encourages the co-applicant board be formally incorporated to ensure maximum accountability for the patient majority board per the intent of the Health Center Program.
- Public agencies and their co-applicants must execute, and present for BPHC review and approval, an agreement which describes the delegation of authority and defines each party's role, responsibilities, and authorities.
  - The co-applicant agreement is a separate document from the public center's bylaws.
  - The co-applicant agreement, bylaws, and/or articles of incorporation must assure that the health center co-applicant board retains its full authorities, responsibilities and functions as prescribed in legislation and/or regulation aside from those prescribed "general policies" that may be retained/reserved by the public center.

# Co-Applicant Arrangement

- Consistent with legislative intent, the objective of the co-applicant arrangement is for the community-based governing board to set health center policy to the extent possible.
- Based on legal constraints that certain governmental functions may not be delegated to private entities, the co-applicant arrangement may allow the public agency to retain general fiscal and personnel policy making authority.
- The public agency and co-applicant may have collaborative roles in the exercise of other authorities, as long as these roles are clearly outlined in the co-applicant agreement and are consistent with the statements above.
- A pure “consensus” approach, without the subsequent required approval by the health center board, is not acceptable.

# Public Center: Governance

- A public center with an approved co-applicant arrangement does not need further justification for the public agency to retain final approval for the following:
  - General personnel policies and procedures, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal employment opportunity practices; and
  - General fiscal policies, including internal controls to ensure sound financial management procedures and purchasing policies and standards.
- Conflict of interest requirements: since together the public agency and the co-applicant board form the “health center,” no employee or immediate family member of an employee of the public agency or the co-applicant board, may serve as a member of the co-applicant board.

# Public Center Funding

- Section 330(r)(2)(A) limits the total grant funding to public centers to no more than 5 percent of the appropriated funds for public agencies receiving funding under section 330(e) and 330(g).
- Currently, there are 99 public agency grantees:
  - 66 are State/County/local Health Departments
  - In FY 2009, received approximately $122 million in section 330 grant funding and almost $39 million in ARRA funds

# Technical Assistance Resources

- National and state-based support for training and technical assistance:
  - Primary Care Associations
  - Primary Care Offices
  - National Cooperative Agreements

- Federal TA Support:
  - BPHC Website

For more information:
http://www.bphc.hrsa.gov/technicalassistance/

# Thank You!

# Questions?

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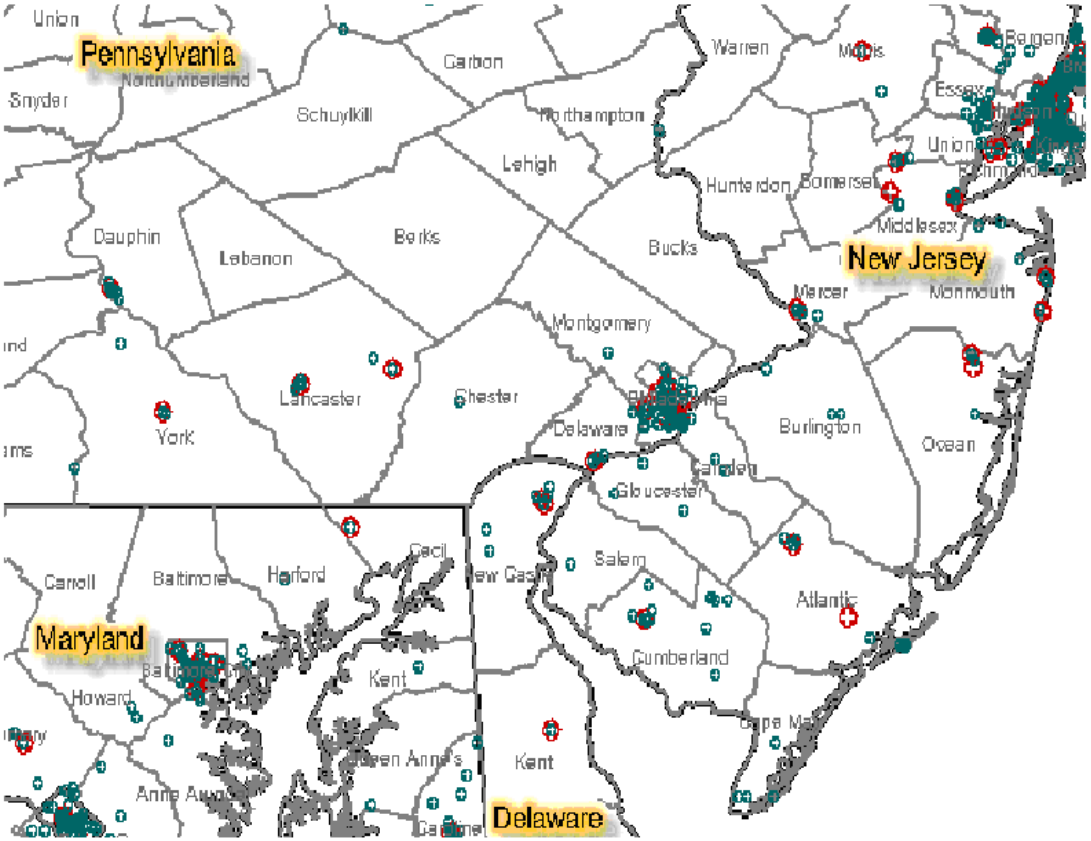
# Appendix

- Map of current health center program service delivery sites
- State Primary Care Offices
- State Primary Care Associations

# Health Center Service Delivery Sites



## Delaware Primary Care Office

Division of Public Health
Delaware Department of Health and Social Services
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Dover, DE 19901
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Delaware is served by the

Mid-Atlantic Association of
Community Health Centers (MACHC)
4483-B Forbes Boulevard
Forbes Center Building II
Lanham, MD 20706
info@machc.com
Phone: (301) 577-0097
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Miguel McInnis, MPH – CEO
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Maryland Primary Care Office

Office of Health Policy & Planning
Department of Health & Mental Hygiene
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Baltimore, MD 21201
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New Jersey Primary Care Office

NJ Department of Health & Senior Services
Office of Primary Care and Rural Health
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New Jersey Primary Care Association

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Pennsylvania Primary Care Office

Pennsylvania Department of Health
Bureau of Health Planning
Division of Health Professions Development
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Pennsylvania Primary Care Association

Pennsylvania
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