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Assuring compliance with federal governance requirements for FQHC boards

By Robyn Hoffmann, RN, MSN, CHC

For more than 55 years, community health centers have provided comprehensive, culturally competent, high-quality primary care healthcare throughout the United States. Health centers are community-based and patient-directed organizations that deliver primary healthcare services to millions of people regardless of their ability to pay: "In 2021, health centers achieved a historic milestone of serving more than 30 million people . . . including one in three people living in poverty and one in five rural residents."[1]

As designated by the Centers for Medicare and Medicaid Services, Federally Qualified Health Centers (FQHC) receive federal grants under section 330 of the Public Health Service Act (PHS Act) (42 U.S.C § 254b).[2]

Oversight of FQHCs is conducted by the Bureau of Primary Health Care (BPHC), which is one of the six branches of the Health Resources and Services Administration (HRSA) at the U.S. Department of Health and Human Services. "HRSA funds nearly 1,400 health centers and approximately 100 health center program look-alike organizations, collectively operating more than 14,000 service delivery sites in communities across the country."[3]

Federal compliance requirements for FQHCs

In 2018, the BPHC first issued the *Health Center Program Compliance Manual*, which outlines the mandatory requirements for FQHCs. In developing the compliance manual, the BPHC produced a consolidated resource to assist health centers in understanding and demonstrating compliance with health center program requirements. The manual outlines federal requirements across its 21 chapters, which focus on:

1. Health center program eligibility
2. Health center program oversight
3. Needs assessment
4. Required and additional health services
5. Clinical staffing
6. Accessible locations and hours of operation
7. Coverage for medical emergencies during and after hours

8. Continuity of care
9. Sliding fee discount program
10. Quality improvement/assurance
11. Key management staff
12. Contracts and subawards
13. Conflicts of interest
14. Collaborative relationships
15. Financial management and accounting systems
16. Billing and collection
17. Budget
18. Program monitoring and data reporting systems
19. Board authority
20. Board composition
21. Federal Tort Claims Act (FTCA Redeeming Requirements)

The organization of each chapter addresses:

- **Authority,** listing applicable statutory and regulatory citations.
- **Requirements,** summarizing statutory and regulatory requirements.
- **Methods to display compliance,** describing how FQHCs can demonstrate compliance with requirements.
- **Related considerations,** explaining where FQHCs have discretion with respect to decision-making or which may be useful to consider when implementing a requirement.[4]

Federal mechanisms for assuring compliance with health center program requirements

The BPHC monitors FQHCs' compliance with federal requirements through various mechanisms, including FQHCs' timely submission of a series of mandatory reports and periodic on-site reviews—or operational site visit (OSV)—conducted at the health center by BPHC representatives.

Figure 1

Federal reporting requirements for FQHCs include:

- The Uniform Data System (UDS) report:
    - The annual UDS report, which covers the preceding calendar year, includes data on patient characteristics, services provided, clinical processes and health outcomes, patients' use of services, staffing, costs, and revenues.[5]
- The Budget Period Progress Report Non-Competing Continuation (BPR):
    - The BPR submission addresses the progress that a health center has made since its last application to HRSA, its expected progress for the remainder of the budget period and any projected changes.
- The FTCA redeeming application:
    - On an annual basis, a redeeming application must be submitted to the bureau to maintain federal malpractice coverage through the FTCA for the health center, its clinicians, and clinical support staff in the next calendar year.

The on-site OSV provides an objective assessment and verification of the health center's compliance with mandatory statutory and regulatory requirements. For health centers with a three-year project period, the OSV usually occurs within the project's first 14–18 months. The OSV assesses an FQHC's compliance with all program requirements outlined in Chapters 1 through 21 of the *Health Center Program Compliance Manual.*

Two chapters in the manual focus specifically on the governance of an FQHC by its board of directors (BOD):

Chapter 19 addresses the board's authority while Chapter 20 focuses on the board's composition.

Federal compliance requirements that focus on the authority of an FQHC's BOD

The requirements outlined in Chapter 19 ("Board Authority") are based on 42 C.F.R. § 51c.303(i), 42 C.F.R. § 56.303(i), 42 C.F.R. § 51c.304(d), 42 C.F.R. § 56.304(d), and 45 C.F.R. § 75.507(b)(2). Table 1 outlines governance requirements that pertain to board authority.[6]

Chapter 19: Requirements pertaining to board authority
1. The health center must establish a governing board with specific oversight responsibility.
2. The health center's governing board must develop bylaws that specify the board's responsibilities.
3. The health center's governing board must ensure the center complies with applicable federal, state, and local laws and regulations.
4. The health center's governing board must hold monthly meetings and record in meeting minutes the board's attendance, key actions, and decisions.
5. The health center's governing board must approve the selection and termination/dismissal of the health center's project director/CEO.
6. The health center's governing board must have the authority to establish or adopt policies for the conduct of the health center and update these policies when needed. Specifically, the health center's governing board must have authority for: ◦ Adopting policies for financial management practices and a system to ensure accountability for center resources, including periodically reviewing the financial status of the health center and the results of the annual audit to guarantee appropriate follow-up actions are taken. ◦ Adopting a policy for eligibility for services, including criteria for partial payment schedules. ◦ 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. ◦ Adopting healthcare policies, including quality-of-care audit procedures.

7. The health center's governing board must adopt healthcare policies including the following: ◦ Scope and availability of services to be provided within the health center's program project, including decisions to subaward or contract for a substantial portion of the services, ◦ Service site locations, and ◦ Hours of operation of service sites.
8. The health center's governing board must review and approve the annual budget.
9. The health center must develop its overall plan for the health center under the direction of the governing board.
10. The health center's 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.
11. The health center's governing board must assess the achievement of project objectives by evaluating health center activities, including service utilization patterns, productivity (efficiency and effectiveness) of the center, and patient satisfaction.
12. The health center's governing board must ensure that a process is developed for hearing and resolving patient grievances.

Table 1

Supporting materials that demonstrate an FQHC's compliance with board authority requirements

To ensure that an FQHC is meeting this set of requirements, an FQHC's compliance officer and BOD should refer to the *Consolidated Documents Checklist*, which supports the bureau's *Health Center Program Site Visit Protocol.* An FQHC compliance officer should annually confirm the availability of the requisite materials that focus on board authority. The outcome of this analysis should be reported to the board or its governance committee to foster a spirit of "continuous readiness" for demonstrating compliance with federal requirements.[7]

Consolidated Documents Checklist: Board authority requirements
A. Health center organization chart

B. Articles of incorporation

C. Bylaws

D. CEO position/role description

E. The board's calendar or other related scheduling documents for the most recent 12 months

F. Board agendas and minutes for:

    a. The most recent 12 months

    b. Any other relevant meetings during the past three years that demonstrate that board authorities were explicitly exercised, including approving the following main policies:

        i. Sliding fee discount program

        ii. Quality improvement/quality assurance

        iii. Billing and collections (including any policy for waiving or reducing patient fees and, if applicable, refusal to pay)

        iv. Financial management and accounting systems

        v. personnel

G. Sample board packets from two board meetings within the past 12 months

H. Board committee minutes or committee documents from the past 12 months

I. The strategic plan or long-term planning documents from within the past three years

J. The board's most recent evaluation of the CEO

K. The CEO's employment agreement (to address key terms and provisions that focus on selection, evaluation, and dismissal or termination)

L. Agreements with any parent corporation, affiliate, subsidiary, or subrecipient organization (if applicable)

M. Collaborative or contractual agreements with outside entities that may impact the board's authority or functions

Table 2

Developing an annual work plan is one tool that can support the board in meeting these requirements. The board may determine whether to map its annual work plan based on the start of the calendar year, the health center's fiscal year, or the month in which the board holds its annual meeting and election of officers. Activities can be aggregated by month according to those that involve the full board's approval. It can include authorizing the health center's budget, analysis and approval of the report from the health center's external auditor, any proposed changes in hours of operation or sites of care, board meeting minutes, and reports submitted by committees of the board.

Federal compliance requirements that focus on the composition of an FQHC's BOD

The requirements outlined in Chapter 20 ("Board Composition") are based on section 330(k)(3)(H) of the PHS Act, 42 C.F.R. § 51c.304, and 42 C.F.R. § 56.304. Table 3 outlines governance requirements that pertain to board composition.[8]

Chapter 20: Requirements pertaining to board composition
1. The health center's governing board must consist of at least nine and no more than 25 members.
2. The majority (at least 51%) of the health center's board must be patients served by the health center. As a group, these patient board members must represent the individuals served by the health center in terms of demographic factors, such as race, ethnicity, and gender. (This requirement is frequently referred to as the "51% Rule.")
3. Nonpatient board members must be representative of the community served by the health center. They 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.
4. Of the nonpatient board members, no more than one-half may derive more than 10% of their annual income from the healthcare industry.
5. A health center board member may not be an employee of the center, spouse, child, parent, brother or sister by blood or marriage of such an employee. The project director/CEO may be a nonvoting, ex-officio member of the board.

6. The health center's 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's patient population. The selection process in the bylaws or other rules is subject to approval by HRSA.

Table 3

Supporting materials that demonstrate an FQHC's compliance with board composition requirements

To assure that an FQHC is meeting this set of requirements, an FQHC's compliance officer and BOD should refer to the "Eligibility Requirements for Look-Alike Initial Designation Applications: Consolidated Documents Checklist," which supports the bureau's *Health Center Program Site Visit Protocol.* On an annual basis, an FQHC's compliance officer should confirm the availability of the requisite materials that focus on board composition. There is significant overlap between the composition-related obligations and the series of documents that are used to confirm compliance requirements pertaining to board authority. In Table 4, an asterisk (*) flags the documents required for compliance with both sets of board requirements.[9]

Consolidated Documents Checklist: Board composition requirements
A. Health center organization chart*
B. An updated *HRSA Form 6A* (see below) or board roster
C. Articles of incorporation*
D. Bylaws*
E. Co-applicant agreement (if applicable)
F. Documentation regarding board member representation (such as applications, biographies or resumes, and disclosure forms)
G. Billing records from within the past 24 months to verify patient board member's active status

Table 4

HRSA's *Form 6A: Current Board Member Characteristics* (OMB No.: 0915-0285. Expiration Date: March 31, 2023) is a consolidated document that requires entry of the names of all board members, in addition to the following information about everyone:

- Current board office position held
- Area of expertise
- > 10% of income from health industry (yes or no)
- Health center patient (yes or no)
- Live or work in service area
- Special population representative (If yes, specify the special population group. These groups are defined as migratory and seasonal agricultural workers, homeless individuals, and public housing residents.)

Form 6A also calls for documentation of the demographic characteristics of patient board members, as shown in Table 5.[10]

Gender	Number of Patient Board Members
Male	
Female	
Unreported/declined to report	
Ethnicity	
Hispanic or Latino	
Non-Hispanic or Latino	
Unreported/declined to report	
Race	

Native Hawaiian	
Other Pacific Islander	
Asian	
Black/African American	
American Indian/Alaska Native	
White	
More Than One Race	
Unreported/declined to report	

Table 5

On an annual basis, each board member should complete an update to the following series of agreements, which address:

- Confidentiality
- Conflict of interest disclosures
- The board member attestation, which includes:
    - An agreement to participate in and be prepared for monthly board meetings
    - An understanding of the board bylaw requirements pertaining to attendance
    - A statement that the board member is not an employee of the health center or related to an employee by blood, adoption, or marriage
    - A statement that the member will avoid any actual or potential conflicts of interest and notify the board if such a conflict arises

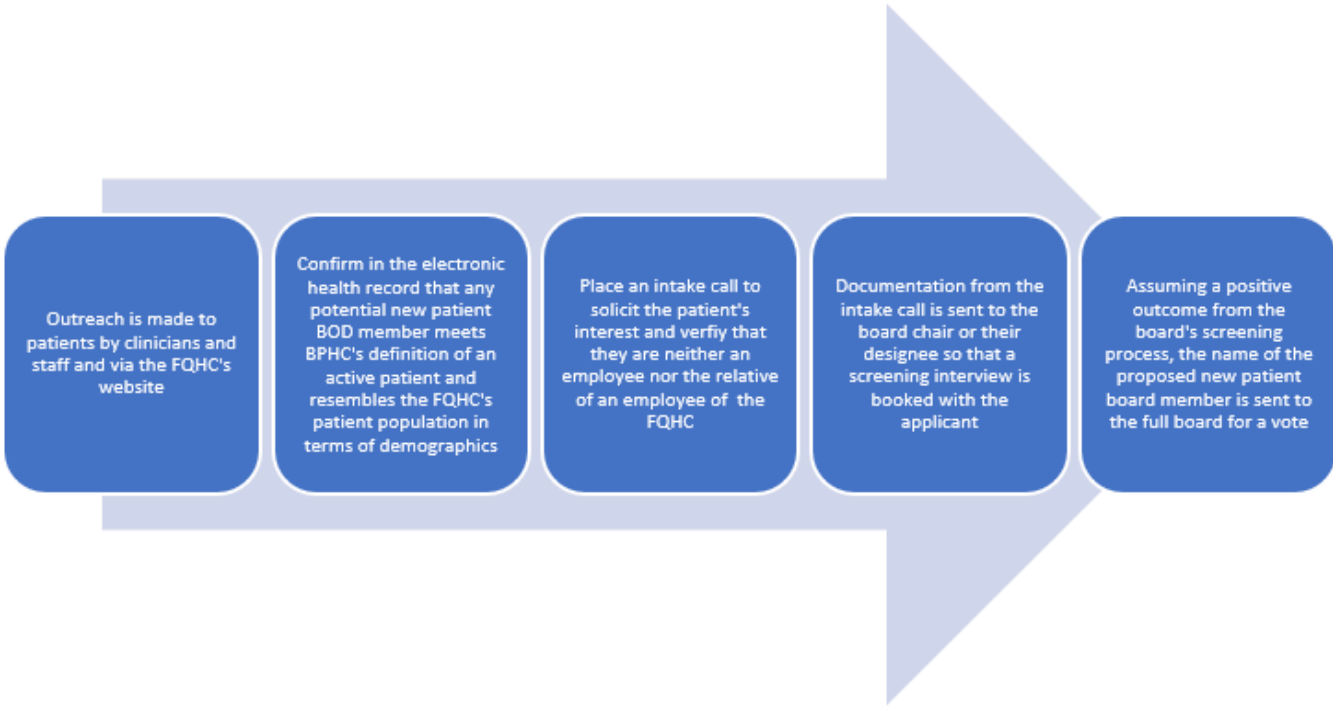
Board recruitment processes

To ensure that board recruitment is conducted in a manner that complies with composition requirements, it is

recommended that a governance policy (board recruitment) be developed and approved by the health center's board. The following figures provide an overview of how new board members can be solicited, when needed, to ensure compliance with board composition requirements.

Figure 2 focuses on the recruitment of active patients of the health center. An "active patient" is an individual who has received at least one service within the health center's approved scope during the past 24 months. A parent or legal guardian of an active health center patient would also meet this definition. Types of visits include medical, prenatal, behavioral health, or dental. To meet the bureau's requirements, the patient board member's visit must have occurred at one of the health center's approved care sites. To assure patient confidentiality, the health center's HIPAA privacy officer should confirm that current or potential patient board members have received an in-scope service during the prior two years. The Figure 2 depicts the process for the recruitment of new patient board members.

Figure 2



When recruiting nonpatient members, it is critically important to remember that no more than one-half of this subset of the board's membership may derive more than 10% of their annual income from the healthcare industry. Therefore, it is recommended that the board develop a governance policy that defines "healthcare industry."

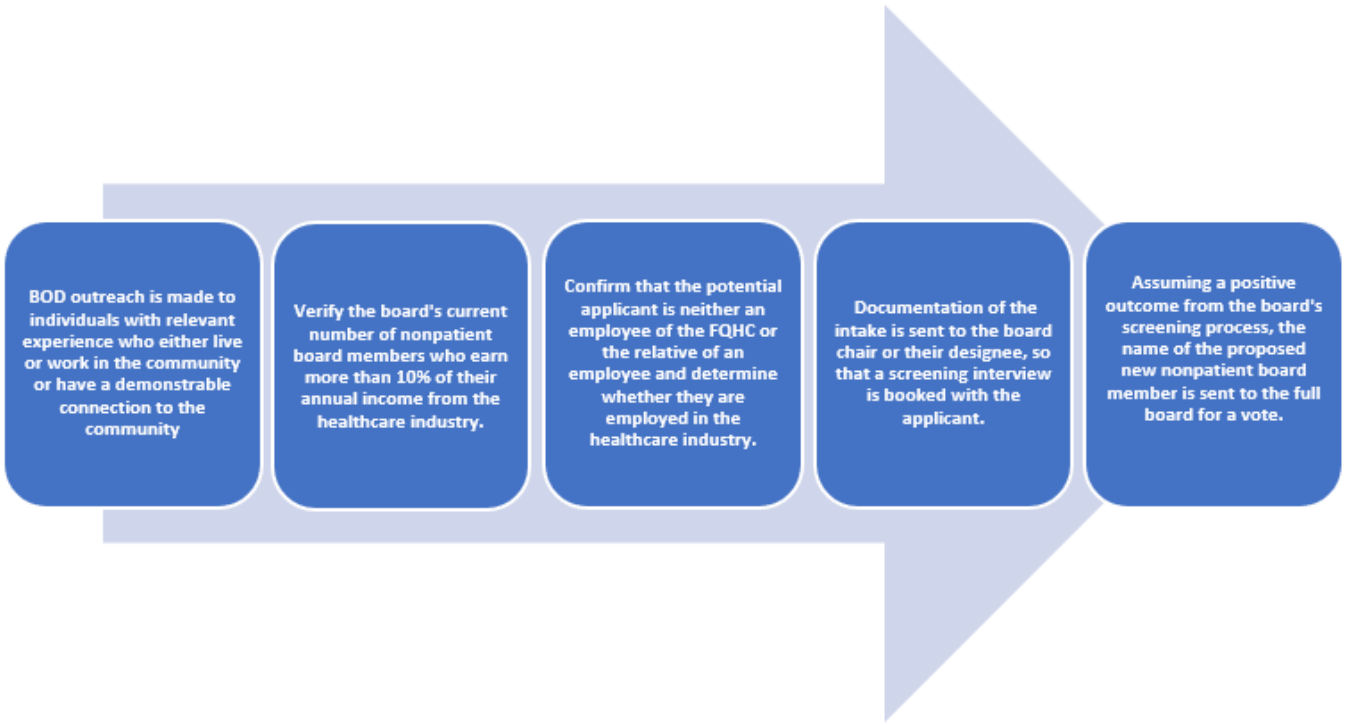
One objective data source that can be considered for defining this term can be derived from the North American Industry Classification System (NAICS). The United States Office of Management and Budget (executive office of the president) issued the NAICS revision in 2022 to provide a consistent framework for the collection, analysis, and dissemination of industrial statistics used by government policy analysts, academics and researchers, the business community, and the public.[11]

A health center can use NAICS subsectors to define the healthcare industry. Examples of NAICS subsectors include:

- 621 (Ambulatory Health Care Services)
    - 621111: Offices of Physicians (except Mental Health Specialists)
    - 621210: Offices of Dentists
    - 621310: Offices of Chiropractors
    - 621320: Offices of Optometrists
    - 621330: Offices of Mental Health Practitioners (except for Physicians)
    - 621340: Offices of Physical, Occupational and Speech Therapists, and Audiologists
    - 621399: Offices of All Other Miscellaneous Health Practitioners
    - 621410: Family Planning Centers
    - 621420: Outpatient Mental Health and Substance Abuse Centers
    - 621498: All Other Outpatient Care Centers
    - 621511: Medical Laboratories
    - 621512: Diagnostic Imaging Centers
    - 621610: Home Health Care Services
    - 621910: Ambulance Services
    - 621999: All Other Miscellaneous Ambulatory Health Care Services
- 622 (Hospitals)
    - 622110: General Medical and Surgical Hospitals
    - 622210: Psychiatric and Substance Abuse Hospitals
    - 622310: Specialty (except Psychiatric and Substance Abuse) Hospitals
- 623 (Nursing and Residential Care Facilities)
    - 623110: Nursing Care Facilities (Skilled Nursing Facilities)
    - 623210: Residential Intellectual and Developmental Disability Facilities
    - 623220: Residential Mental Health and Substance Abuse Facilities

Figure 3 focuses on the recruitment of nonpatient board members.

Figure 3



Conclusion

The BPHC has provided FQHCs with a set of clear program requirements, outlined in the *Health Center Program Compliance Manual* and the associated *Health Center Program Site Visit Protocol.* On an annual basis, the health center's compliance officer should analyze whether the health center has any apparent gaps in meeting the federal requirements. This information should be brought forward to health center leadership and the board for discussion. Any changes in existing federal requirements should be brought forward to the board promptly.

Governance policy recommendations include approving policies that focus on board recruitment and the health center's definition of healthcare industry. The development of an annual work plan can help assure that the board is meets all program requirements stipulated in Chapter 19 of the BPHC's *Health Center Program Compliance Manual*. An annual series of board attestations should be completed to assure compliance with board composition requirements.

Takeaways

- The Bureau of Primary Health Care's *Health Center Program Compliance Manual* is a foundational resource for federally qualified health centers' (FQHCs) governance.
- Two chapters in the *Health Center Program Compliance Manual* outline the Bureau of Primary Health Care's requirements for FQHCs governance, specific to board authority and board composition.
- Board authority includes adopting policies for financial management, eligibility for services, and human resources, approval of the annual budget, and CEO selection.
- The majority (at least 51%) of an FQHC's board must comprise patients served by the health center.
- The compliance officer should regularly communicate with the board to assure "continuous readiness" for

demonstrating the health center's compliance with federal requirements.

1 Health Resources & Service Administration, Bureau of Primary Health Care, "Health Center Program: Impact and Growth," last reviewed August 2022, https://bphc.hrsa.gov/about-health-centers/health-center-program-impact-growth.
2 Health Resources & Service Administration, Bureau of Primary Health Care, "Chapter 1: Health Center Program Eligibility," *Health Center Program Compliance Manual*, 10, last updated August 20, 2018, https://bphc.hrsa.gov/sites/default/files/bphc/compliance/hc-compliance-manual.pdf.
3 Health Resources & Service Administration, Bureau of Primary Health Care, "Health Center Program: Impact and Growth."
4 Health Resources & Service Administration, Bureau of Primary Health Care, "Introduction," *Health Center Program Compliance Manual*, 8.
5 Health Resources & Service Administration, "Health Center Program Uniform Data (UDS) System Data," accessed September 13, 2022, https://data.hrsa.gov/tools/data-reporting.
6 Health Resources & Service Administration, Bureau of Primary Health Care, "Chapter 19: Board Authority," *Health Center Program Compliance Manual*, 73–75.
7 Health Resources & Service Administration, Bureau of Primary Health Care, *Health Center Program Site Visit Protocol: Consolidated Documents Checklist*, "Board Authority," 20, last updated May 26, 2022, https://bphc.hrsa.gov/sites/default/files/bphc/about/consolidated-documents-checklist-requirement.pdf.
8 Health Resources & Service Administration, Bureau of Primary Health Care, "Chapter 20: Board Composition," *Health Center Program Compliance Manual*, 78–80.
9 Health Resources & Service Administration, Bureau of Primary Health Care, "Eligibility Requirements for Look-Alike Initial Designation Applicants," *Health Center Program Site Visit Protocol: Consolidated Documents Checklist*, 23.
10 U.S. Department of Health & Human Services, Health Resources & Services Administration, "Form 6A: Current Board Member Characteristics," https://bphc.hrsa.gov/sites/default/files/bphc/about/form-6a.pdf.
11 North American Industry Classification System Association, "2022 NAICS Code Changes," accessed September 13, 2022, https://www.naics.com/2022-naics-changes.