Public Centers Monograph

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This monograph was originally written and published in 2014 by Patricia Fairchild, Vice President, and Pamela Byrnes, Senior Consultant, at John Snow, Inc (JSI). JSI is a public health consulting firm headquartered in Boston, Massachusetts.

Many people provided input into the original monograph. This includes interviews with over thirty CEOs, Directors, board members, and staff of public centers from across the country. The authors also conducted nine interviews with public center CEOs or Directors representing centers housed in public health departments, county and city governments, and public universities. Two discussion forums were held at the National Health Care for the Homeless Council Annual Conference and the National Association of Community Health Center Policy & Issues Forum both in March 2013. The authors also conducted interviews with several state Primary Care Associations. Finally, valuable input was provided by people who have worked with public centers in the Bureau of Primary Health Care Office of Policy and Program Development.

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I. Introduction

This monograph discusses the category of health centers known as "public centers," previously known as public entities.

Public centers include Health Center Program awardees funded under Section 330 of the Public Health Service Act[1] (PHS Act) as well as health centers designated as a look-alike under the authority of Section 1905(l) (2)(B) of the Social Security Act.[2] Public centers are health centers where the entity receiving the grant or the entity designated as a look-alike is a public agency.

Section 330 of the Public Health Service Act includes a provision allowing both private non-profit organizations and public agencies to receive health center funding. Neither the PHS Act nor Health Center Program Regulations,[3] however, provide much detail on specific requirements for public centers. Most of the implementation guidelines are embedded in program requirements and guidance issued by the Health Resources and Services Administration (HRSA), which through its Bureau of Primary Health Care (BPHC), administers the Health Center Program. The intent of this monograph is to discuss and clarify requirements and guidelines related to public centers, as well as to provide information about how existing public centers have addressed some of the complexities of the model.

The monograph includes:

- Review of the authorizing legislation, the Health Center Program Regulations, and the HRSA Health Center Program Compliance Manual;
- Discussion of some key considerations and challenging aspects of public centers;
- Discussion of factors that contribute to or impede success of public centers; and
- Frequently asked questions related to public centers.

While the monograph aims to address the full range of issues related to implementing a public center, the model is very complex and is evolving as the health care environment changes. New and unique issues are inevitable. HRSA guidance related to public centers is also evolving as more is learned about their successful implementation, challenges, and unique requirements. The best approach to ensuring adherence to HRSA requirements, for both existing public centers and for agencies interested in developing a public center, is to review current guidance on the HRSA website (**www.hrsa.gov**), and specifically, the Health Center Program and/or with state and national associations that are familiar with the requirements.

1 Section 330 of the Public Health Service Act (42 USCS § 254b), as amended.

2 Section 1861(aa)(4) and section 1905(l)(2)(B) of the Social Security Act, as amended.

3 42 C.F.R. 51c. (for community health centers) and 42 C.F.R. Part 56 (for migrant health centers).

II. Statutory and Regulatory Requirements

The PHS Act authorizes the Health Center Program. It designates four types of health centers in four sub-sections: Section 330(e) - Community Health Centers (CHC); Section 330(g) Migrant Health Centers (MHC); Section 330(h) Health Care for the Homeless (HCH) programs; and Section 330(i) Public Housing Primary Care (PHPC) programs. Requirements for both private non-profit and public centers are contained in the PHS Act and in the Code of Federal Regulations (CFR) at 42 C.F.R. 51c and 42 C.F.R. Part 56.56

The Health Center Program Compliance Manual is the principal resource to assist health centers in understanding and demonstrating compliance with Health Center Program requirements. As stated in the law, Health Center Program Site Visit Protocol (SVP) is the tool for assessing compliance with Health Center Program requirements during Operational Site Visits (OSVs). Operational Site Visits (OSVs) provide an objective assessment and verification of the status of each Health Center Program awardee or look-alike's compliance with the statutory and regulatory requirements of the Health Center Program.

As stated in law, all health centers, whether private non-profits or public agencies must:

- Serve **a high need community or population**, i.e. medically underserved areas (MUA) or medically underserved populations (MUP);
- Be **governed by a community board** of which a majority (at least 51%) are health center patients who represent the population served;
- Provide **comprehensive primary care** services as well as enabling/supportive services such as education, translation, and transportation that promote access to health care;
- Ensure services are **available to all** with fees adjusted based upon ability to pay;
- Meet other performance and accountability requirements regarding administrative, clinical, and financial operations.

The Social Security Act authorizes the Look-Alike Program and cites specific benefits associated with that designation. The law says look-alikes must meet the requirements for health centers funded under Section 330 of the PHS Act, including compliance with governance requirements. Because look-alikes must meet all the requirements of Health Center Program grantees, they are not discussed separately in this monograph.

The PHS Act contains few specific references to public centers. In summary, the PHS Act:

- Explicitly allows grants to public agencies;
- Makes limited exceptions regarding the policy making responsibilities of the governing board of a public center; and
- Limits the amount of the Health Center Program's annual appropriation that can be awarded to public centers.

Appendix 1 summarizes references to public centers in the PHS Act and Regulations.

Other than the references summarized in Appendix 1, the law is silent on public centers, which means that all requirements, except those explicitly exempted, apply equally to private non-profit and public health centers. Furthermore, requirements in the law apply across all the law's sub-sections –CHC, MHC, HCH, and PHPC except as noted.

In addition to the authorizing legislation, Federal Regulations have been issued for two parts of the Health Center Program.[4] The regulations have the binding power of law unless overruled by statute. Any health center that receives funding and/or is designated as a look-alike as a CHC and/or MHC, even if it is combination with HCH and/or PHPC, must adhere to the regulations.

The Regulations provide additional requirements for health centers and, as with the law, apply equally to private non-profits and public centers and to grantees and look-alikes. Key additional requirements in the regulations relate to health center governance and sliding fee discount implementation.

4 42 CFR Part 51c applies to Section 330(e), CHCs and 42 CFR Parts 56 applies to Section 330(g), MHCs.

III. HRSA Health Center Program Compliance Manual and Notice of Funding Opportunity (NOFO) Applications

In 2017, HRSA issued the Health Center Program Compliance Manual. 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 was subsequently amended in 2018 to reflect the changes to Section 330 that were enacted in February 2018 as a result of the Bi-Partisan Budget Act of 2018.

The Compliance Manual is comprised of multiple chapters, each of which addresses the legal authority, statutory and regulatory requirements, and ways to demonstrate compliance with individual requirements of the Health Center Program. Collectively, these requirements form the foundation of the Health Center Program and support the core mission of this innovative and successful model of primary care.

Included within the chapters of this the Compliance Manual are discussions regarding requirements that are unique to public centers and requirements from which public centers may be exempt. As with the law and regulations, the Compliance Manual applies equally to private non-profit and public centers unless a specific exception is noted. In addition, a Notice of Funding Opportunity (NOFO) for the Health Center Program – such as the New Access Point (NAP) application, Service Area Competition (SAC), and the look-alike (LAL) application – include instructions specific to public centers.

The Compliance Manual is referenced throughout this publication and is the authoritative source for identifying the requirements found in the Health Center Program's authorizing legislation and implementing regulations, as well as certain applicable grants regulations.

The current Compliance Manual can be downloaded here:

https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html

IV. Key Considerations and Challenges for Public Centers

In developing this monograph, several public centers and Primary Care Associations (PCAs) were consulted and participated in either roundtable discussions or one-on-one interviews. In addition, clarifying discussions were held with HRSA staff. Based on this feedback, three key areas for consideration by public centers were identified which may pose challenges in implementing the model. These are: organizational structure and governance, fiscal management, and personnel management.

A. Organizational Structure and Governance

The overarching organizational and governance issues related to public centers are:

- **Definition of Public Agency:** *What types of agencies qualify to receive a grant or look-alike designation as a public center?*
- **Co-applicant Governing Boards:** *When must a public center have a co-applicant governing board? What is the composition of the co-applicant board?*
- **Co-applicant Agreements:** *What is the role of the co-applicant board and its relationship to the public agency? How must the roles and relationship be documented?*
- **Agency Implementing the Health Center Program:** *What entity is designated as the Health Center Program grantee or look-alike? Does it exercise its required authorities and responsibilities?*
- **Meeting Governance Requirements:** *What are the requirements for governing board membership? What are the functions and authorities the governing board must perform?*
- **Allowable Waivers:** *In what situations is it allowable to request a waiver of governance requirements? What requirements may be waived?*

1. Definition of Public Agency

In relation to what qualifies as a public agency for the purposes of Health Center Program grantees or look-alikes, some types of agencies are clearly “public,” while the status is less clear for others. Simply receiving public funds does not qualify an agency to apply as a public center. Public health departments, county commissions, and public universities, for example, would all normally be qualified as public agencies. In some jurisdictions, however, these agencies have been “spun-off” into quasi-public entities or even private non-profits. The actual status of entities that have been spun-off varies considerably from those that share tax IDs and other designations with the public parent to those, such as some hospital authorities, that are at best tangentially connected other than receiving public funds.

HRSA provides guidance in the Compliance Manual on how an organization would demonstrate that it is a public agency and what documentation needs to be submitted. It includes:[5]

- 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.) 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: HRSA also allows Native American tribal organizations, including those defined under the Indian Self-Determination Act or the Indian Health Care Improvement Act, to apply for Health Center Program funding or designation. These organizations must demonstrate their eligibility to HRSA by providing applicable documentation as described in the Compliance Manual.

2. Co-applicant Governing Boards

The Health Center Program has very clear requirements both for the membership composition of the governing board and the authorities that it must be exercise. See Sub-Section 5 below for a summary of these requirements. Public agencies may either meet all health center governance requirements directly (i.e. the governing body of the public agency meets all health center governance requirements related to membership, function, and authorities), or a "co-applicant" governing board must be established.

The Compliance Manual defines the term "co-applicant" as "[T]he 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." The term "co-applicant" is used to signify that the public agency would not qualify on its own as meeting all requirements for either a Health Center Program grant or look-alike designation. In public centers with a co-applicant governing board, HRSA considers both the public agency and the co-applicant collectively as the health center. Together, the public agency and co-applicant board meet all Health Center Program requirements and comprise the public center or health center. The public agency and co-applicant board work collaboratively to implement the approved health center project.

The co-applicant governing board is separate from, and independent of, the public agency. In a public center, a co-applicant board essentially mirrors a governing board of a private non-profit health center, both in terms of composition and authorities. It includes a representative majority of consumer/patient representatives, it meets monthly with a quorum present, and it fulfills all the required authorities of a governing board with exceptions for the establishment of certain financial and personnel policies. The objective of the co-applicant arrangement is for the co-applicant board as the patient/community-based governing board to set health center policy.

The public agency that is the grantee or look-alike, may have a role in forming the initial co-applicant board in collaboration with the community, but from then on the co-applicant board is self-perpetuating. The co-applicant board establishes and has authority to modify its own bylaws or governing rules, as long as they remain aligned with the co-applicant agreement (see discussion below). The co-applicant agreement, along with the co-applicant board

5 Health Center Program Compliance Manual, https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/hc-compliance-manual.pdf.

bylaws/governing rules define the respective roles and responsibilities of the public agency and co-applicant board, including shared or collaborative roles and responsibilities.

To facilitate the co-applicant arrangement, the health center co-applicant board is strongly encouraged (but not required) to be formally incorporated. Such incorporation is beneficial both because the independent status elevates the stature of the co-applicant and maximizes its' accountability and because it enables the co-applicant to do functions reserved to incorporated entities such as receive and disburse funds and hire staff. For example, if the co-applicant is incorporated, it can conduct independent fundraising and compete for grants that may not be available to public agencies (e.g. foundation funding). Further, there may be legal risks in being unincorporated. Even if the co-applicant board is not incorporated, it must have bylaws or operating rules that describe how it will select members and fulfill its responsibilities.

In order to fulfill its functions and authorities, the co-applicant governing board should have sufficient resources. Resources include staff and/or financial support for meetings, funds for travel to health center related meetings, and funds for board development/training. As part of the health center budget development, the governing board, and not the public agency, should decide (within reason) what is needed to support the board.

The majority of public centers have co-applicant governing boards. This is because few public agencies have governing bodies that are able to comply with all of the Health Center Program governance requirements. In most cases, public centers that are operating without co-applicant boards have received a waiver from HRSA for the requirement for a patient majority (see discussion of waivers below under sub-section 6). Very few public agencies can comply with the requirement that patients comprise a majority of the board because most have boards that are appointed or elected. It is unlikely that a public agency would include a stipulation that a person running for election or seeking appointment has to be a patient of the health center, or that a certain proportion of those elected or appointed must become patients of the health center. The few places public agency boards have been able to meet the consumer majority requirement are remote rural areas where the health center is the only primary care provider and most of the residents in the area are patients.

Even if a public agency is able to meet or is granted a waiver on the patient majority requirement, it still must demonstrate it can effectively fulfill all the required authorities. Because public agencies usually have responsibility for many programs in addition to the health center, their governing bodies often have difficulty meeting monthly to address health center business and/or to fulfill all required authorities. In cases where the public agency cannot adequately fulfill all functions and authorities, a co-applicant board must be established.

The composition of the co-applicant board must meet the size and membership requirements spelled out in the law, regulations and Compliance Manual, *Chapter 20: Board Composition* (including a representative patient majority, 9-25 members, restrictions on the proportion of non-patient members who earn their income from the health care industry, and restrictions on employees or their immediate family members serving on the board; greater detail on these requirements are found in Sub-Section 5 below). If permitted in the co-applicant's bylaws or governing rules, the public agency, or other agencies, may appoint members to the board as long as those appointees are not employees or immediate family members of employees of the co-applicant organization and/or the public agency component (such as the department, division, or sub-agency) in which the Health Center Program project is located, and as long as it adheres to policy requirements regarding governing board membership.

Currently, *Chapter 20: Board Composition* of the Health Center Program Compliance Manual states that the health center must have 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, including a majority of the non-patient board members." For example, according to the Compliance Manual, 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.

Similarly, the co-applicant board must generally exercise the board authorities and functions described in the law, regulations and Compliance Manual. The public agency (as the grantee or look-alike designee) may establish and retain the authority to adopt and approve policies that support financial management and accounting systems and personnel policies. In the Compliance Manual, *Chapter 19: Board Authority* prohibits any other individual, entity, or committee from reserving approval authority or veto power over the health center board with regard to the required authorities and functions. This restriction applies equally to public centers; the public agency shall not restrict or infringe upon the co-applicant board's required authorities and functions. The Compliance Manual states that for public agencies with a co-applicant board, "the health center has a co-applicant agreement that delegates the required authorities and functions to the co-applicant board." In this sense, the co-applicant board and the public agency have flexibility to determine how to collaborate in carrying out their respective obligations related to the Health Center Program project.

In order for a co-applicant board to fulfill its required authorities, including evaluating health center progress, ensuring long-term viability, and assessing the quality of services, it must receive timely, complete, and relevant information. This includes HRSA-required quality and financial measures and Uniform Data System (UDS) data. Often the information required for a health center to evaluate and plan is different from the data and information normally collected and reported by a public agency. Furthermore, collecting data in a format useful to the health center may mean significant systems revisions and/or cumbersome "work-arounds." A mutually acceptable approach to data collection and reporting is most likely if the public agency and the co-applicant board have a strong and collaborative relationship.

3. The Co-applicant Agreement

Public centers that have a co-applicant board must have a formal, written co-applicant agreement that is signed by both the co-applicant board and the public agency.

The co-applicant agreement delegates the required roles, responsibilities, and required functions and authorities of each party in overseeing and managing the public center in general and in carrying out the Health Center Program project. The co-applicant agreement also details any shared roles and the responsibilities in carrying out governance functions. As noted previously, the co-applicant agreement cannot undermine or diminish the authorities required for the co-applicant governing board.

The co-applicant agreement should be viewed as a blueprint for how the public agency and co-applicant governing board work collaboratively to oversee and manage the health center project. It can and should be the start of a strong and meaningful relationship between the co-applicant board and the public agency. It should not be viewed as mechanism to give one entity an imbalance of power or to find loop-holes in requirements.

Provisions for sharing responsibility are allowed and even encouraged as long as such sharing does not give the public agency the ability to override or overrule final approvals and required authorities of the co-applicant board. For example, in many places the public agency is prohibited by state laws or its charter from relinquishing budget authority to another entity, but health center requirements state that the governing board must have final budget approval for the health center project. Sharing responsibilities becomes essential when potential conflicts exist between the public agency's need to comply with state, county, or municipal laws and the health center's need to comply with Health Center Program requirements. See additional discussion and an example of shared responsibility for budget approval under Part B of this Chapter "Fiscal Management and Health Center Budgeting" below.

Since HRSA does not prescribe standard content or format for co-applicant agreements, each public agency and co-applicant board should collaboratively develop the agreement for their health center project.

Engaging collaboratively in the development of the co-applicant agreement can help ensure both entities understand and agree to their respective roles and responsibilities. The co-applicant agreement must align with the articles of incorporation, bylaws and/or internal governing rules of the co-applicant board. That is, if the bylaws define certain responsibilities for the co-applicant board, the co-applicant agreement should also reflect that the board has those responsibilities. Based on feedback from health centers and Primary Care Associations (PCAs), issues addressed in a co-applicant agreement may include:

- A general statement of the purpose of the agreement;
- Overall shared goals for operating the health center program;
- Selection of co-applicant board and committee members and specifically how many (if any) and which categories of members are appointed by the public agency (in alignment with the aforementioned requirement related to board member and board chair selection). Note: the bylaws or operating rules of the co-applicant board should detail the selection and removal processes for co-applicant board members;
- Responsibilities of the co-applicant board, ensuring all required authorities are addressed and how responsibilities are shared with the public agency, if applicable;
- Responsibilities of the public agency, including how responsibilities are shared with the co-applicant board.
- The public agency's role in establishing financial and personnel policies, if any, should be specifically addressed;
- Clauses regarding dispute resolution, termination with and without cause, and renewal.

Typically, the co-applicant agreement describes roles and responsibilities at a fairly high level. Most public centers also develop operating policies and procedures and/or a matrix of which does what/when. Such operating policies or responsibility matrices ensure all functions are fulfilled as planned and protect both entities when personnel changes result in loss of institutional memory regarding how the program functions.

As an example, one county-based health center developed a "map" of the authorities of the county and the co-applicant board, drawing lines to the health center board, the grantee/designee, or both depending on where the primary responsibility rested. They essentially created an organization chart for decision-making, clearly defining the roles of each. Others have developed lists or matrices that identify key functions and what agency or person is responsible for each function including when responsibilities are shared. Two such examples are included in the Appendix. These examples are not meant to be prescriptive; many variations on what functions are listed and how responsibilities are assigned are possible.

Note: a current co-applicant agreement that is dated and signed by both entities is required with the original Health Center Program grant or look-alike application and with each subsequent Service Area Competition or look-alike recertification application.

4. Agency Implementing the Health Center Project

Determining what entity is the grantee or look-alike and whether that entity is actually managing the health center, can be complex. For example, in some public centers, the applicant of record is a county or city government (e.g. the county commission, county board of supervisors, city council, or mayor's office). Sometimes, however, the county/city governmental entity has delegated implementation and management of the health center to a specific part of the government (e.g. a health department or a hospital district). In these cases, the governmental entity may either fully delegate or may reserve some authority over the health center.

The final responsibility for the health center remains with the grantee/look-alike agency of record and its co-applicant board (if applicable). While the grantee/look-alike of record must maintain authority, it may delegate day-to-day operational management to designated staff. However, delegating responsibility for implementing the health center to staff of other agencies may further complicate an already complex model and should be carefully considered. For example, delegation may mean that the co-applicant agreement must be a multi-entity agreement rather than one between a single public agency and another entity with a patient-majority board. This could introduce internal layers of review and approval that make it difficult for the health center to function efficiently. It also makes the program more difficult to explain to new staff within the health center or the public agencies, as well as to outside parties, including HRSA.

The agency designated as the grantee/look-alike of record may also have implications for who can serve on the health center's governing or co-applicant board. Under the Compliance Manual, no member of the health center governing board can be a paid employee or an immediate family member of an employee of the grantee or the look-alike designee. 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 component of the public agency in which the Health Center Program project is located or of the co-applicant may serve as a member of the co-applicant board. For example, if a health department is managing the health center but the actual grantee is the city, city employees, such as a City Manager, may be prohibited from serving on the governing board. Because this is a very complex issue, public centers should consult with their Project Officer regarding board membership.

HRSA requirements do not prohibit employees from serving on board committees. Committee membership is defined in the board's bylaws or operating rules. If those (and state law) permit non-board members from serving on committees and do not explicitly exclude employees and/or their family members then committee membership is allowed.

5. Meeting Governance Requirements

The Health Center Program has very clear requirements both for the authorities that reside with the governing board as well as the membership composition of the board. These requirements are listed in the PHS Act, and expanded upon in the Code of Federal Regulations and the Compliance Manual. Public centers should address these requirements in the bylaws or operating rules for the governing board and, if applicable, in their co-applicant agreement. HRSA has summarized the requirements in the Compliance Manual in *Chapter 19: Board Authority* and *Chapter 20: Board Composition*.

Chapter 19: Board Authority
(https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-19.html#titletop) includes the following requirements**:**

- The health center must establish a governing board 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 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 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;**
  - Adopting 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;** 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
  - Service site location(s); and
  - Hours of operation of service sites.
- The health center governing board must review and approve the annual Health Center Program project budget.
- 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.
- 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.

**Note: HRSA allows public agencies that receive the grant or the look-alike designation to establish and retain the authority to adopt and approve those policies above that are marked with this double asterisk **.

Chapter 20: Board Composition (https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-20.html#titletop) includes the following requirements**:**

- The health center's governing board must consist of at least 9 and no more than 25 members.
- The majority [at least 51%] of the health center board members must be patients 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% of their annual income from the health care industry. [This is two-thirds (66% for MHCs).]

- 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. [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.] The project 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.

*** NOTE: HRSA allows health centers designated as MHC, HCH and/or PHPC only to waive requirements marked with a triple asterisk *** upon a showing or good cause and submission of a plan to ensure patient participation and input into the direction and governance of the health center.

A Table summarizing each requirement, the types of health center the requirement applies to, whether there are special considerations for public centers and when a waiver of a requirement may be considered by HRSA is included in the Appendix.

6. Allowable Waivers

HRSA policy determines what aspects of the governance requirements may be waived and HRSA should be consulted regarding currently allowable waivers. As of the date of this monograph, as amended, HRSA is considering waiver requests related to patient majority board composition only. Only health centers that receive MHC, HCH and/or PHPC funding/designation solely and do not receive section 330(e) – CHC – funding/designation are eligible for a waiver. In addition, any section 330 funded health center or look-alike serving a sparsely populated rural area is eligible.

If a public center is operating with a co-applicant board, any waiver request applies to the co-applicant board, not the public agency board. *Chapter 20: Board Authority* summarizes the requirements for waiver submissions. Any organization/agency requesting a waiver must justify why it cannot meet the statutory requirements requested to be waived by documenting the unique characteristics of the special population or the service area that creates an undue hardship in recruiting a patient majority and the organization's attempts to do so within the last three years.

Further, the submission must present alternative strategies that will ensure special population patient participation and input into the direction and ongoing governance of the organization thus assuring the intent of the requirement is met. Many successful approaches have been implemented to engage and get input from patients including focus groups, advisory councils, and surveys. Forming an advisory council, for example, can ensure routine input is received on strategy and policy; this approach may also provide a pipeline of potential members for the governing or co-applicant board. Prior to establishing an advisory council, it is important to ensure that there is adequate staffing to support the council and that the role of the council is clear.

In all of the approaches, it is essential that patient input is collected and documented in writing, communicated directly to the health center governing board through formal and regular communication mechanisms, and incorporated into key authorities such as selection of services, setting of hours of operation, defining budget priorities, evaluating progress in meeting goals, and assessing effectiveness of the sliding fee discount program.

B. Fiscal Management and Health Center Budgeting

The key financial and budget issues related to public centers are:

- **Fiscal Policies:** *Which policies may be established by the public agency?*
- **Health Center Budget Approval:** *Who has final approval of the health center budget? How does a public center reconcile Health Center Program requirements with local statutes regarding budget approval when statutes conflict?*
- **Isolating and Using Health Center Resources:** *Why is it necessary to separate health center costs and revenue within the overall agency budget? What discretion does the public agency have regarding adjusting the budget and expending program income?*

All requests to waive allowable governance requirements must be submitted in writing to HRSA as part of the original Health Center Program grant or look-alike designation application. Waivers are in effect for the length of the approved project or designation period. Waiver requests must be updated and resubmitted at the beginning of every new project/designation period (i.e. with every SAC application and look-alike recertification application). Waiver requests are not automatically granted. A waiver is in place only when HRSA has provided written approval of the waiver request.

1. Fiscal Policies

The PHS Act permits the public agency to retain the responsibility for establishing general policies for the public center. In *Chapter 19: Board Authority*, HRSA has defined this to mean (1) financial management practices and a system to ensure accountability; and (2) general personnel policies. HRSA guidance recognizes that public centers may require flexibility related to these policies due to legal constraints on the delegation of some governmental functions to private entities. However, a public center is still required to adhere to the statutory objectives of the PHS Act, which require that health center policies be established by the patient-majority, co-applicant health center governing board, or with input from an advisory board, as applicable. The co-applicant agreement must clearly identify which policies are established by each entity and approaches for sharing responsibility for development. Remember this is an allowance for agencies that are restricted in delegating these functions. Some co-applicant governing boards are able to exercise these authorities on their own.

Chapter 15: Financial Management and Accounting Systems of the Compliance Manual describes in greater detail the policies and procedures HRSA considers vital for health center finance.

These policies and procedures include (as stated in the Compliance Manual):

- Effective control over, and accountability for, all funds, property, and other assets in order to safeguard all assets and ensure they are used solely for authorized purposes.
- Appropriate use of Federal funds in compliance with applicable Federal statutes, regulations, and the terms and conditions of the Federal award.
- Financial management and internal control systems in accordance with sound financial management procedures which ensure fiscal integrity of grant financial transactions and reports in addition to ongoing compliance with Federal statutes, regulations, and the terms on the Notice of 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).

- 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.

In keeping with the intent of the PHS Act, the public agency should, to the extent possible, solicit input from the co-applicant or advisory board regarding how its policies impact the health center. For example, established procurement policies may impede the health center from meeting HRSA deadlines.

Responsibilities to establish fiscal policies related to billing and collections for self-pay patients, including the establishment of the nominal fee and the sliding fee discount program policies and procedures, cannot be retained by the public agency. Rather, they must be developed with input from and approved by the health center co-applicant/governing board. Because these policies are often greatly impacted by community norms and practices, and they are typically integral to minimizing financial barriers to care, patients and community representatives are in the best position to develop appropriate policies.

2. Health Center Budget Approval

The health center statute and regulations require that the health center board must approve the annual Health Center Program grant application and budget – or in the case of look-alikes, the annual program budget. At the same time, because the public center operates within a governmental structure, state or local charters or laws may constrain the extent budget approval can be delegated to a non-governmental body. In fact, several states and localities have statutes that preclude ceding budget authority to an outside body. In these cases, it is critical that good communication and collaboration exists between the public agency and health center board and that both entities recognize and respect the responsibilities of the other. These situations call for a back-and-forth process that allows the health center board to participate in a meaningful way in budget development and approval, but within the public agency's budgetary process. As the CEO of one public center said, "It can work, but you can't put walls up. Everyone has to recognize they are a part of the whole – have to understand the overall rules and regulations."

In the end, however, *the health center board must be able to sign-off on the final health center grant or look-alike program budget or the process will be considered out of compliance with Health Center Program requirements.* At the same time, the health center governing board cannot stalemate the budgeting process. If the co-applicant board refuses to take action on the health center budget, it may risk being considered non-compliant by HRSA and jeopardize continued federal funding/certification.

An approach to collaborative budget development with joint approval by both the health center co- applicant board and the public agency could be done as follows:

1. Health center management develops the Health Center Program Project budget (the budget) in consultation with the governing board and public agency staff, ensuring that all in-scope services are adequately supported and that all program revenues – from patient services, grants, and other sources – are returned to the health center program.

2. The budget is approved by the health center board and forwarded to the public agency to be included in the overall agency budget.

3. The agency budget is reviewed and approved as required by laws governing the public agency.

4. Should the agency make any adjustments to the health center budget, it goes back to the health center board for final approval.

If the process is collaborative from the outset, there should be few surprises and little need for re-negotiation in the final phases of budget development. Because budget development and approval is usually time-sensitive and may involve many participants, the process should be defined both at a high level in the co-applicant agreement and in detail, with time frames and assigned responsibility for each step, in operating procedures.

3. Isolating and Using Health Center Resources

This issue is equally relevant for public centers with co-applicant boards and those with direct governance arrangements, as well as for grant-funded and look-alike health centers.

Chapter 17: Budget of the Compliance Manual requires health centers to establish an annual budget that reflects the projected costs of operations and the projected revenues from all sources necessary to accomplish the service delivery plan within the health center scope of project. This is referred to as the health center's "total budget".

The Compliance Manual and HRSA scope-related policy address what is included in the health center scope of project, as well as budgeting and accounting requirements for the health center's total budget. This guidance should be consulted when budgeting, using and accounting for health center related funds. In general, according to the statute, all Health Center Program grant funds and all projected program income collected from health center activities (including fees, premiums, third party reimbursements; state, local and non-Section 330 federal grants; private support and any other projected funds for the Health Center Program project) may only be used to support activity within the HRSA approved scope of project.

Many public centers struggle with educating and gaining the support of public agency staff to make the necessary changes to standard agency financial systems and reports in order to support the unique financial information needs of the health center. For example, health centers often require developing or adapting billing and collection systems to maximize revenue collected from patients and public and private insurers. While some public agencies have operated service programs that require billing and collecting revenue and have highly functioning systems, many have predominantly operated grant-support or publicly-funded programs. These may have rudimentary or non-existent practice management systems for generating and tracking service-related revenue. For health centers, billing and collecting fees related to patient services is an essential revenue source, often accounting for 75%-90% of the programs budget so must be a focus both for management and governing boards.

Even when support is strong among public agency leadership and staff, tailoring agency systems to collect and produce required information can be challenging. Almost all public health centers say that keeping funds separate and getting the information they need to manage the health center in a way that is useful is one of the most challenging aspects of pubic centers. As one CEO said "…bookkeeping gets hairy." To ensure that a health center maximizes revenue, adequately plans, accounts for and tracks health center-related funds (consistent with the requirements of Chapter 15 of the Compliance Manual), and enables the governing board to fulfill its fiduciary responsibility, it is essential that the public agency and health center staff and board work collaboratively to ensure that both operating systems and reporting are appropriate for the Health Center Program.

The best way to assure that health center-related resources are appropriately tracked, allocated, and reported, is for health center funds to be separated from the public agency's other budget centers. This is accomplished by making the health center budget, including all of its expenses and revenues, a separate cost center in the overall agency budget. For example, one public center interviewed has designated the health center as a department of the agency with its own departmental budget. As noted by the CEO, "In our case, basically [the health center]

operates as a private non-profit separate cost center with a department budget. However, the audit is done as a part of the county audit process. That the health center is described as a department is a confusing area for HRSA to understand so we need to really explain it."

Similarly, another organization has its budget in a separate enterprise fund where all dollars coming in and going out are kept completely separate. At this public center there is a lot of service integration between the health center and other programs run by the organization so budgeting is done on a per-service basis. All funds are separated based on whether they are tied to the health center's approved scope of project. For example, even though programs share intake and an EHR, expenses and revenues related to primary care are tracked and kept separate from mental health. Consistent with keeping resources separate, is ensuring health center resources are used as the health center budget dictates.

While it is acceptable for health center management to go through the public agency's procedures for getting and using funds, subject to the financial management and budgeting requirements in the Compliance Manual, Chapters 15 and 17, respectively, the health center's resources must be made available for purposes designated in the health center budget. Restricting access to health center resources potentially puts the public center out of compliance. In addition, Federal grant regulations require that significantly redirecting resources away from identified budget items requires HRSA approval.

The public agency also cannot retain program revenues beyond those committed in the health center budget for uses that do not support and further the Health Center Program project. According to the PHS Act, non-grant funds, including excess program income, may be used for purposes not specifically prohibited under the statute *as long as such use furthers the objectives of the health center project*. Thus, all revenues generated from health center activities within its approved scope of project must support expanding access to health center services and for other purposes that benefit the health center's existing and proposed patient populations, and not for other functions of the public agency.[6]

C. Personnel Management

Key issues related to personnel in a public center are:

- **Employment of Health Center Staff including the CEO or Program Director:** *Who employs the health center CEO or Program Director? Who employs other staff? How is the requirement that the governing board select, evaluate, and dismiss the CEO or Program Director implemented? How are reporting lines of staff to the CEO/Program Director maintained?*
- **Personnel Policies:** *How are personnel policies established and implemented for staff working in the health center program?*

1. Employment of Health Center Staff including the CEO or Program Director

The PHS Act requires all health centers, including public centers, to directly employ their CEOs or Program Directors (see Appendix 1, citing Section 330(k)3)(H)). Neither the PHS Act nor the Regulations address which component of the public center – the public agency or the co-applicant board – should maintain this employment relationship. However, the Compliance Manual states that "[P]ublic agency health centers utilizing a co-applicant structure would demonstrate compliance with the statutory requirement for direct employment of the

6 Compliance Manual, Chapter15, element e.

Project Director/CEO by demonstrating that the public agency, as the Health Center Program awardee/designee of record, directly employs the Project Director/CEO."[7]

However, HRSA does require that the governing board, whether it is the board of the public agency or a co-applicant board, select, evaluate, and dismiss, if necessary, the health center CEO or Program Director. Furthermore, the health center CEO/Program Director must report to and be directly responsible to the governing board for all aspects of the health center project. This authority is specific to the person designated as the *health center* CEO or Director. It does not apply to the public agency CEO or Director unless they are the same.

In most public centers all staff, including the CEO or health center Program Director, are employed by the public agency. There are many good reasons for this including fringe benefit packages that are often better than a health center could afford on its own and strong human resource departments that aid in recruitment and retention. However, employment of staff by the public center also brings challenges. For example, the CEO or Program Director effectively has two bosses: one within the supervisory structure of the public agency and the other the governing board of the center. Similarly, other staff may report both to the CEO/Program Director and to their designated supervisors within the public agency. Such dual reporting is challenging but works well when there is uniformity of expectations about performance between the two entities and collaboration and agreement on hiring and evaluating staff.

Due to the complexities and demands of the Health Center Program, most health centers need a full-time CEO/Program Director to ensure success. However, in some smaller centers, the responsibilities for managing the health center may be assigned to agency staff, such as a health department director/administrator, who also has other programmatic responsibility within the public agency. If this is the case, the governing board must still approve the person as CEO/Program Director for the health center. The board also must be comfortable that the dual role provides adequate management support for the health center and does not pose a conflict of interest.

Strategies that have contributed to success when health center staff are employed by the public agency include:

1. The public agency allows some customization of standard agency job descriptions to include job functions specific to the health center (see example for CEO below). In some places creation of new job classifications has been required to meet the needs of the health center. The entities engage in joint recruitment (e.g. utilizing the public agencies HR department for posting positions, collecting resumes, conducting initial screening in relation to minimum job requirements, conducting background checks and license verifications, etc.) while enabling health center staff to choose final candidates, conduct interviews, check references, and recommend the final selection.

2. The entities engage in joint performance evaluation, e.g. the health center supervisor provides written input into the standard public agency evaluation and participates in supervisory/evaluation meetings.

Discussions between both entities occur before any decision of reassignment, disciplinary action, or dismissal occurs. In other words, each entity recognizes the others role. As the official employer, the public agency must make sure all personnel meet its hiring and performance standards, but it must also recognize that the health center may have unique personnel needs and that staff working in the health center have the best knowledge to fill and assess staff performance in meeting those needs.

Because the CEO/Program Director position is so critical to the success of the health center program, the health center should develop detailed, collaborative procedures for selecting, evaluating, and dismissing the CEO/Pro-

7 Compliance Manual, Chapter11, element d, footnote 3. It is unclear at this time whether public centers in which the CEO/Project Director is currently employed by the co-applicant board will be required to transition such employment to the public agency.

gram Director. The process should include a job description that specifically addresses the person's responsibilities and reporting relationships for the health center as well as any other public agency responsibilities and reporting; a recruitment committee comprised of public agency and governing board representatives; input of the board on CEO/Program Director compensation; and a written evaluation of performance by the governing board that becomes an official part of and is factored into the annual public agency evaluation. The health center governing board must have final approval on selection/dismissal and performance evaluation of the health center CEO/Program Director. In regard to dismissal, this means that the health center governing board can remove the CEO/Program Director from his or her responsibilities for managing the health center but the public agency retains authority regarding whether the person is reassigned within the public agency.

EXAMPLE: CEO JOB DESCRIPTION

In most public centers the CEO of the health center is employed by the public agency and reports both to the public agency and to the health center co-applicant board. The position may be assigned full-time to the health center or the position may function both as health center CEO/Program Director and in some public agency roles such as health department administrator. Some public health centers use only the public agency job description for the health center CEO/Program Director. Public agency job descriptions are often written for a general job classification and may be somewhat generic. Such a job description does not provide guidance for the CEO/Program Director regarding his or her responsibilities specific to the health center nor does it give the governing board any benchmark by which to evaluate the CEO/Program Director. Preferable approaches that some public health centers have been able to implement are:

1. Develop a customized job description in the public agency personnel system for the health center CEO/Program Director that encompasses both the person's responsibilities in the public agency structure and their specific responsibilities for the health center. When this approach is used both the public agency and health center board should jointly evaluate the CEO.

2. In places where the public agency job description cannot be easily changed, some health centers have developed an addendum to the public agency description that is specific to the CEO/Director's health center responsibilities, is approved by the governing board and is used by the board as the basis for its evaluation of the CEO. Ideally, the board's evaluation is provided to the public agency for inclusion in the public agency.

Key responsibilities that should be included in a health center CEO/Program Director job description but may not be in a standard public agency job description include:

- Reports directly to the health center Board of Directors
- Has ultimate accountability for implementing health center strategic, fiscal and operational plans, policies and goals
- Oversees organization-wide quality improvement process including recommending priorities, setting performance standards, and implementing improvements
- Recruits, hires, supervises senior management team
- Oversees operations including financial and clinical functions.

2. Personnel Policies

The PHS Act enables public centers to establish general policies, including personnel policies. Personnel policies may include:

- Employee selection, performance review/evaluation, and dismissal procedures (with input from the co-applicant board for the CEO/Program Director);
- Employee compensation including wage and salary scales and benefit packages (with input from the co-applicant board for the CEO/Program Director);
- Position descriptions and classifications (with input from the co-applicant board for the CEO/Program Director);
- Employee grievance procedures;
- Equal opportunity practices;
- Nepotism and conflict of interest/ethical standards.

Because public agencies have public accountability, their personnel policies are generally very complete and compliant with all Federal, state, and local laws and regulations. However, agency personnel policies are rarely tailored to the health center program, i.e. they apply across a broad array of programs or departments under the public agency. Sometimes this means that existing job classifications and/or salary scales are not applicable to or appropriate for the health center. While the PHS Act enables the public agency to have final approval of personnel policies and it can be a difficult bureaucratic process to change these policies, health center governing boards should review the policies and advise on aspects of the policies that may impede the health center from achieving its goals. For example, some public centers have successfully added new job classifications and/or changed salary scales to aid in recruitment and retention.

V. Factors Contributing To, Inhibiting Success

As the preceding discussion indicates, public centers can have complex organizational, governance, financial, and personnel structures. While each public center is unique, experience has shown that some factors in the design and implementation of public centers contribute to their success while others inhibit success. This chapter discusses some of the key factors impacting the success of public centers.

A. Factors Contributing to Success:

Care Integration

Depending on the type of public agency that the health center is part of, the health center may have the opportunity to take advantage of a broad range of services, often under the same roof. For example, if a public center is part of a health department or hospital, it can develop a collaborative model whereby patients have access to primary care, behavioral health, dental care, specialized family planning, nutrition programs, lead screening, STD and HIV/AIDS care, and/or diagnostic testing. Some public centers have fully integrated services including intake, care management, and Electronic Health Records (EHR). Patients in these centers have seamless access and cannot distinguish whether the services are provided by the health center or another part of the agency. Staff teams are integrated at all levels – providers and management alike. Beyond health care some public agencies also offer other programs such as housing, job support, or eligibility determination. When services are integrated, the opportunity exists to develop a truly holistic program that can impact not only medical care but also social determinants of health.

EXAMPLE: INTEGRATION OF SERVICES – TWO APPROACHES

Example #1: Merged Health Center and Health Department

In this example, the health department is actually subsumed under the health center. This enables the health center to fully integrate the public health services offered through the health department with health center primary care services. Patients can be managed more efficiently because they have a single medical record that is inclusive of all services they use. One challenge in this model can be tracking expenses and revenues to ensure that health center scope of project requirements and benefits are appropriately separated from non-health center, out of scope activities outside of a health center's Scope of Project.

Example #2: Separate Organizations with Integrated Services

In this example, the public agency operates behavioral health and primary care services under separate organizational departments but integrates them at the service level. The two services are co-located, use a single point of entry and shared EHR. For patients there is no apparent separation between the organizations when they come to access services. The public agency has designed a blended management team so that managers work across the health center and behavioral health programs. Staff is integrated at all levels. Patients have seamless flow and don't know which staff people work for which organizational unit. Everyone has a combined care management team. Again, the challenge in this model is to track and separate expenses and revenues, benefits and requirements between the health center in-scope activities and those outside of scope.

While integration is the ideal, it should be noted that funding regulations or structural impediments may work against full integration. For example, in some states, family planning services are reimbursed through the Federal Title X program at higher rates and for additional services that are not paid for by Medicaid. In these cases, family planning cannot be fully integrated into the primary care program without reducing revenue so many public centers choose to keep the services separate.

Contributed Resources – Human and Financial

Some public centers benefit greatly in terms of enhanced resources from being part of a public agency and conversely, the public agency often benefits from operating the health center.

- **Enhanced financial resources:** The most obvious benefit to the public agency is the additional financial resources that are brought into a community by virtue of fair payment for the full cost of services. While the public agency must use these resources for the health center, the additional reimbursement may enable enhanced services and/or release other public funds that previously supported primary care services. There are many other potential benefits.
- **Material public agency support for the health center:** Many public agencies contribute funding, space, or in-kind staff to the health center. Some public center CEOs say that bureaucratic processes imposed by the public agency contribute to high administrative overhead costs and others cite high personnel costs, but many find that the resources a public agency provides far exceed the costs. One person interviewed said, "we get way more back than we put in."
- **Access to expertise:** The positive contributions include not only in direct support, but also access to expertise within the public agency. For example, health centers that are part of a state university may gain access to the latest technologies and faculty; health centers that are part of a public hospital system may gain access to specialty care that otherwise would not be available to the patients.
- **Joint benefit from teaching future health professionals:** Health centers that are part of public university noted mutual benefit from serving as a teaching site for health professions students: the students expand capacity and energize staff and patients at the health center while the health center provides a high quality placement for students, training the next generation of primary care workforce.
- **Inclusion in public agency personnel systems:** While some health center CEOs cite high overhead and personnel costs when part of a public center, most value being part of the public agency personnel system. Public agencies often have generous fringe benefits. They also have extensive human resource (HR) departments that can support recruitment, staff development, credentialing, and other HR functions for the health center. However, not all public HR systems function effectively for health centers. Sometimes job categories are not appropriate for the health center, recruitment processes may be cumbersome, the HR department may have multiple demands and not prioritize the health center, or established salary structures may impede recruitment and retention. In the worst case, hiring freezes within a public agency may impede a health center fulfilling its goals and scope of project commitments.

Collaboration, aligned missions, respect and trust

Public centers that judge their program a success typically talk about having missions that are aligned and supported by a collaborative relationship between the public agency and health center board and staff, as well as a mutual recognition of the obligations and responsibilities of each party. When these pieces are in place, there is generally a strong level of trust between the public agency and the health center governing board and staff. As one CEO said "you have to educate everyone and you have to be firm that these are the rules, period. Then you have to make it work in the existing system. It takes education on both sides." Building on personal relationships, such as when a long-time employee of the public agency is selected as the health center Director, can help establish collaboration

and trust but collaboration must also be institutionalized to be sustained and grow over time. The most successful programs all indicated that the CEO/Program Director of the health center and their counterpart in the public agency meet weekly and spoke even more frequently.

B. Factors Inhibiting Success:

Lack of support for co-applicant boards

Some public agencies do not fully appreciate the importance of their partnership with the co-applicant board and the value that board brings to the health center. When the public agency has that perspective, it may marginalize the board in one or more of the following ways:

- refusing to provide staff or financial support for board activities or development;
- dictating times and locations of board meetings for the convenience of the agency rather than board members;
- refusing to provide useful and timely data and information related to the health center;
- not consulting the board on key policy or staffing decisions;
- writing a legally dense and complicated co-applicant agreement that requires the board to have its own attorney (which it may not have funds to hire); or,
- being critical or patronizing about board decisions.

Since a public center can only exist, in most cases, with both the public agency and the co-applicant board, some of these actions are not allowable under health center requirements; others undermine the functioning of the board and can lead to board apathy, attrition, and difficulty in recruitment. Public centers succeed when the public agency understands and embraces that governance by a consumer-majority board is central to the health center operation and a fully functioning board is essential to its success.

Constraints due to the structure of the public agency

Many public centers express frustration with the bureaucracy and systems of public agencies saying they often tie their hands or slow their progress. Some ways this occurs include:

- restrictions on purchasing – both in terms of how it is done (having to go with the lowest bid) and lengthy procedures with multiple sign-offs;
- restrictions on IT systems – the health center may be required to use a system that is not designed for primary care, does not support efficient practice management, and does not produce the reports that they need. Furthermore, needed modifications to these systems may be difficult to achieve due to agency reluctance, conflicting priorities or system limitations;
- restrictions on travel, continuing education, and contractor selection that may impede some public centers from being able to attract and keep quality staff and/or stay abreast of health center program requirements. Hiring freezes and salary caps can compound this. One CEO commented that they had to figure out a way around a limit on full time employees (FTEs) that the public center was allotted by the agency in order to fulfill their scope of project and budget commitments.

These structural and system impediments are most readily addressed when high level staff at the public agency understands the unique requirements, supports the mission and is willing to advocate and intervene on behalf of the health center. Otherwise, the health center must factor known constraints into its operational planning and budgeting.

Conflict between mission of health center and public agency constraints

This challenge relates to the health center's responsibility to respond to unmet need in the community and particularly effects public centers that are part of cities or counties. Publicly funded agencies are often restricted to certain geographic areas, e.g. a health department or public hospital may only be authorized to use its resources for a residents of a specific county or other political subdivision. Restrictions on the public agency may conflict with the governing board's assessment of need and its plan for services. For example, the board may want to open a site in a neighboring county to address an unmet need. Limitations on the public agency could prohibit such expansion and could also impact the health center's ability to expand its Federal funding base, as they are limited in the locations for which they can seek funding to open new sites. When missions are aligned and strategic planning is done collaboratively, there is more opportunity for dialog and joint decision-making that may enable creative solutions to these constraints. For example, a public health center could form partnerships or other collaborations with other entities to address unmet need. Or an existing public center could serve as a mentor to another public agency to develop services for its county.

Public agency capacity to respond to HRSA requirements

HRSA has established specific time frames for certain activities such as opening new sites under a change in scope or New Access Point, or responding to grant conditions. Changes in a public center have to go through multiple layers for approval. Some institutional delays can be shortened when the public agency staff understands HRSA requirements and are willing to advocate on behalf of the health center. When delays are unavoidable, the health center should, as early as possible, notify HRSA about the reason for the delay, and work with their project officer to establish a realistic time frame.

Personnel with conflicting priorities

In many public centers, key staff, particularly those who fulfill management and administrative functions, have other agency responsibilities. For example, a Chief Medical Officer for the health center may also be the Medical Director for the health department or the Chief of Staff of a hospital. The Chief Financial Officer often manages all of the agency's grants and programs. Even the CEO may have other functions such as Health Department Director. HRSA requirements related to key management staff state that the "health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/CEO position is required." This means that a public agency must ensure that staff with multiple functions has sufficient time allotted to the health center and that all functions for the health center are being fulfilled. In some public centers, staff may resent the addition of the health center to their job requirements especially because health center requirements are often new and different. Health center leadership must recognize and address this as it occurs.

Conflicting state and Federal policies

There are many potential areas where state policy may conflict with Federal regulations or policies. When not discussed and addressed, these can lead to significant tension between the public agency and co-applicant board. Conflicting policies regarding budget approval have already been discussed. Other areas of conflicting policies include sliding fee discount policies and eligibility screening. One area that was cited by several public center CEOs/Program Directors regards public agency requirements that a health center document that a patient has been

rejected by Medicaid as a prerequisite for eligibility for a sliding fee discount. Health center statute and regulations state that health centers should make efforts to maximize revenues and to participate in public insurance programs. However, Medicaid is a voluntary program; no one can be forced to enroll or be penalized for not enrolling. Proof of rejection cannot be a condition for eligibility for discounted fees. When the public agency and co-applicant board work collaboratively to establish policies related to insurance screening and eligibility for sliding scales often compromises can be found. For example, the health center may have policies that state that every patient receives education and screening by staff related to coverage programs for which they could be eligible. If staff determines the patient is not eligible the patient would automatically become eligible for the sliding scale or patients could choose to sign a statement declining to apply for Medicaid (or other programs) making them eligible for the sliding scale.

VI. Frequently Asked Questions (FAQs)

A. Program Requirements:

Question: What is considered credible evidence that we are meeting the Health Center Program requirements? Is there any template or checklist?

Answer: The Health Center Program Requirements are the same for public centers as for private non-profit centers, except that the requirement related to board authority enables public centers to retain authority for establishing fiscal and personnel policies. The Health Center Program Compliance Manual and the Health Center Program Site Visit Protocol[8] provide guidance on how to demonstrate compliance with the program requirements, including the appropriate documentation. The co-applicant agreement and co-applicant board bylaws or operating rules (where applicable) describe how requirements are being addressed collectively by the public agency and co-applicant board.

B. Organizational Structure:

Question: Is it possible to transition from a public center to a private non-profit or vice versa? What is the process?

Answer: Yes, it is possible and has been done. Since converting from a public center to a private non-profit, or the reverse, requires a change in the Health Center Program grantee or look-alike designee, the change normally happens only at the start of a new project period (i.e. with the Service Area Competition, SAC, grant or look-alike recertification application). To prepare, there is both an internal process - negotiations between the public agency and the co-applicant board, and an external process - negotiations with and adhering to requirements of HRSA. In the best situation the internal process is driven by a friendly agreement to separate with both sides approaching HRSA to facilitate the separation. In these cases, the existing grantee (e.g. the public agency), does not re-apply for the grant or designation. Instead, the co-applicant board or another entity applies as a private non-profit health center. If the end of the project period is far off and the survival of the health center is at stake, HRSA may decide to issue a special SAC, called a SAC-Additional Area, to expedite the process, but this is unusual. In situations where the separation is not mutually agreed to or friendly, the process may be more complicated and contentious. It is best to communicate with HRSA about the circumstances to determine available options.

C. Governance:

Question: How does a co-applicant board get established?

Answer: Typically, the public agency, in collaboration with people representing the target population, collaborating organizations and key stakeholders from the community, develops the initial board. Because the board must comply with the composition requirements, patients of existing clinic services or future potential patients must be included on that board. In some cases, the public center will get its start from the efforts of people in the community

8 Health Center Program Compliance Manual: https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf; Health Center Program Site Visit Protocol: https://www.bphc.hrsa.gov/programrequirements/svprotocol.html.

and that group may naturally transition into becoming the consumer-based co-applicant board. Once the initial co-applicant board is established it becomes responsible for recruiting and electing members based on its bylaws or operating rules.

Question: Why would a public center that has a waiver on the board composition requirement still be required to have a co-applicant board?

Answer: Being compliant with HRSA requirements goes beyond having a board that complies with the consumer majority rules. The health center board must also comply with other composition requirements related to, for example, size of the board and composition of the non-consumer board members. Further, the board must exercise all of the required authorities (with exceptions for certain fiscal and personnel policies) and must be actively "minding the shop." It can be difficult, if not highly improbable, for a county commission or university Board of Trustees, for example, to focus their resources and energies on the health center to the extent necessary given competing demands. Even beyond the requirements, health centers are very complex organizations that function in a highly regulated environment. Doing a good job of stewardship requires attentiveness, knowledge of the health center environment, and active participation. It is a significant commitment.

Question: How is the co-applicant agreement developed? Is there a template or checklist?

Answer: There is no template or checklist. Each public center should develop the co-applicant agreement in a collaborative process between the public agency and the co-applicant board. It is possible that a sample agreement can be obtained from another public center that has been approved by HRSA. However, HRSA policies have changed over time. The best approach is to check with the health center's Project Officer as the agreement is being drafted. Another resource for health centers is their state/regional Primary Care Association (PCA).

Developing the co-applicant agreement can be a wonderful opportunity for the co-applicant board and the public agency to collaborate and coordinate and to develop mutual respect. Health center implementation will go a lot more smoothly if both parties work together in deciding who does what from the start.

D. Fiscal Policies:

Question: Some health department services are free but the health center charges a fee for its services. How do we reconcile this?

Answer: The health center is required to have a fee schedule that reflects the actual costs of providing care and is consistent with locally prevailing rates. Further, the health center is required to charge patients according to their ability to pay (i.e. have a sliding fee discount schedule). In developing the health center scope of project, the services that are provided by the health center and supported by the Health Center Program grant or look-alike designation scope of project, are those for which a fee schedule must be applied. These are also the services that are eligible to be billed at FQHC payment rates for Medicaid and Medicare. All other services provided by the public agency, or by the health center but outside of their approved scope of project are not subject to the Health Center Program requirements, including those for sliding fee discount schedule.

Question: Can the public agency refuse to provide resources/funding for expenses that are included in the approved health center budget?

Answer: No. HRSA expects health centers to carry out the budget that has been approved so all items included in the approved budget must be funded appropriately.

Question: HRSA requires an audit of the health center but we are a part of a much larger system. Do we have to have a separate audit done?

Answer: No. You need to provide HRSA with the portion of the overall audit that pertains to the health center. You should consult your HRSA project officer to determine what portions of the overall audit should be submitted to HRSA. You are not expected to provide a separate health center audit.

Question: Some of the required financial performance measures are impossible for us to get data on. Do we have to report on all of them?

Answer: No, as a public center you are only required to report on total cost per patient and medical cost per medical visit.

E. Personnel Policies:

Question: Is it permissible for the Director of the Health Department to also serve as the CEO for the health center?

Answer: Yes, but with some caveats. First, the governing board must approve the Health Department Director serving in the role of health center CEO. Second, most health centers benefit from a full-time CEO/Program Director. HRSA requirements in Chapter 11 of the Compliance Manual (Key Management Staff) state: "The health center must maintain sufficient key personnel [also referred to as key management staff] to carry out the activities of the health center." Usually only small health centers can function with a part time CEO and then only if the person is supported by other management staff.

Question: If the health center CEO/Program Director is an employee of the public agency does that create a potential conflict of interest?

Answer: It can. However, the CEO is expected to be directly responsible to the health center governing board and as such should be looking out for the interests of the health center at all times. This is one reason the co-applicant agreement is so important in how it lays out the authorities of the co-applicant board regarding the selection, evaluation and removal of the CEO.

Question: Can the public agency dismiss the health center CEO if the co-applicant board does not agree? Can the co-applicant board dismiss the CEO if the public agency does not agree?

Answer: The employer of record (the public agency in this case) has the ultimate right to dismiss an employee based on its personnel policies and there really is no recourse for the co-applicant board. The co-applicant board must, however, be involved in selection and have final approval of the new CEO. If the co-applicant board wants to dismiss its CEO, it can remove the person from his or her position with the health center but cannot require the public agency to dismiss the person from the agency.

Question: Can the public agency "borrow" health center staff for non-health center activities? For example, can they move a provider to a non-health center clinic to fill a gap?

Answer: The public agency may do so but only if support of that provider/staff person is paid for from sources other than those of the health center and the move does not jeopardize the health center fulfilling its scope of project. Health center resources cannot be used to pay salaries or any other costs associated with work outside of the health center's approved scope of project. This would include any malpractice or other liability insurance that is specific to the health center program. Further, the public agency cannot take dedicated staff if it creates an inability for the health center to fulfill its scope of project obligations unless an alternative is provided.

VII. Conclusion

The public center model has many potential benefits. It provides opportunities for leveraging resources, financial and otherwise. Patients and the community can benefit from a wide range of health care services and social support programs. The health center can benefit from increased resources in terms of funding, connections to needed expertise, and well-developed administrative infrastructures.

The public agency can benefit from the additional resources the health center brings into the community, from opportunities to integrate primary care into other health care or teaching missions and from positive public relations. However, public centers are complex and require diligence and careful attention to the requirements and intent of the Health Center Program to be successful. When the model works, all participants are able to manage inherently conflicting expectations, program requirements and systems. When it doesn't, the health center and public agency are at odds and may engage in an ongoing power struggle, all to the detriment of providing high quality, accessible health care to people who need it. All of this is compounded by relatively little specific Federal policy related to public centers.

While the intent of this monograph is to provide information to help in the implementation of the public center model, it is critical that everyone understands and adheres to the requirements; asks questions when confused; and asks for clarifications when answers are conflicting or unclear.

The best public centers have developed truly integrated programs allowing patients to move seamlessly through a sophisticated and holistic system. These public centers are distinguished by the level of communication among the leadership and staff of the two organizations, the level of respect between the governing bodies, and critically, a shared mission and vision. The successful public centers emphasize the common mission and set the expectation of a true collaboration at the beginning of the process. As one Director commented, "We have the opportunity to operate as partners in the community. We invest in educating the county, the community and our board. Communication and mutual respect are the keys to being successful."

Appendices

Appendix 1:
References to Public Centers in Section 330 of the Public Health Service Act

Appendix 2:
Assignment of Responsibility for Key Functions: Public Agency and Co-Applicant Board

Appendix 3:
Matrix Delineating Selected Public Agency and Co-Applicant Responsibilities for XYZ Health Center

Appendix 4:
Summary of Governance Requirements

Appendix 1
References to Public Centers in Section 330 of the Public Health Service Act

Public centers are specifically cited in the following subsections of Section 330 of the PHS Act:

1. Section 330(e)(1)(A) authorizes grants "for the costs of the operation of *public and non-profit private health centers* that provide services to medically underserved populations." Section 330(c)(1)(A) contains a similar provision for planning grants.

2. Section 330(k)(3)(H) defines the governance requirements for all health centers. A subparagraph under that section, 330(k)(3)(H)(ii) defines the responsibilities and authorities of the governing board as follows "meets at least once a month, selects the services to be provided by the center, schedules the hours during which such services will be provided, approves the center's annual budget, approves the selection of a director for the center who shall be directly employed by the center, and, *except in the case of a governing board of a public center* establishes general policies for the center". *Chapter 19: Board Authority* of the Health Center Program Compliance Manual clarifies that public centers may retain responsibility for personnel and financial policies but that all other policies must be established or adopted by the governing board.

3. Section 330(K)(3) states that the "term *'public center'* means a health center funded (or to be funded) through a grant under this section to a public agency." No additional definition as to what qualifies as a public agency is given in the law. HRSA has clarified the definition of a "public agency" in Chapter 1 of the Health Center Program Compliance Manual. See discussion of HRSA policy above.

4. Section 330(r)(2)(A) limits the amount of the annual appropriation for public centers funded under 330(e) - CHCs and 330(g) – MHCs that are operating with a co-applicant governing board, to no more than 5% of the total appropriation.

Appendix 2
Assignment of Responsibility for Key Functions: Public Agency and Co-applicant Board

EXAMPLE ONLY

POLICY (From Example Health Center Policy and Procedure Manual)

The CHC is a public entity with certain expectations for governance as outlined in the Health Center Program Compliance Manual. The specific requirements are provided below.

Language outlining approval authority is outlined in the following documents.

a) ***CHC Board of Directors By-laws:*** Reference Article where general parameters are defined

b) ***Co-applicant Agreement:*** Created in (Date) for the Anywhere County Health Department and CHC Board to jointly apply for a Health Center Program grant.

Anywhere County Health Department is a public agency and, as a Health Center Program grantee, retains the responsibility of establishing and implementing fiscal and personnel policies. This product is a result of the integration of the Community Health Center into a public entity. Day-to-day leadership and management rest with staff under the direction of the Health Center Director.

The CHC Board of Directors, hereafter the "Board," will comply with all Health Center Program requirements, will be knowledgeable about community needs and healthcare trends and shall have the responsibility for ensuring that the Health Center pursues its mission, maintains its funded scope of project and survives in an evolving health care marketplace.

1. To provide further clarity for the approval process the following approval responsibilities are recommended:

Items Requiring Approval:	*CHC Board*	*Public Agency Board*
Federal grant	X	X
Other grants	X	+ $50,000
Financial oversight	X	
Budget	X	X
Fees	X	X
Sliding fee & collection policies	X	
Purchasing/Contracts	X	with financial obligation
Hire & evaluation of ED	X	X
Personnel policies		X
Facilities/lease	X	X
Sets clinic policy	X	
Scope of services	X	
Hours of operation & locations	X	X
Quality of care audit procedures	X	
Credentialing		
Patient satisfaction & grievance process	X	
Strategic Plan	X	
Selection of Board members	X	

2. Regular communication between the CHC Board of Directors and [Anywhere] County Commissioners is very important. Some of the specific methods include:
   a) One County Commissioner regularly attends the Health Center Board meetings.
   b) Monthly Board minutes are sent to County Commissioners.
   c) The Health Center Director as a [Anywhere] County Department Head meets with Commissioners on the same schedule as other Department Heads. Minutes of that meeting will be provided to the CHC Board of Directors in the Executive Director packet.
   d) Commissioners are invited to attend CHC Board meetings as needed when critical issues are to be discussed.
   e) The Board Chair will present the Executive Director evaluation to the Board of Commissioners (BOC) when completed.
   f) The Board Chair may attend meetings with the BOC when critical issues are discussed.

Appendix 3
Matrix Delineating Selected Public Agency and Co-applicant Responsibilities for XYZ Health Center

EXAMPLE

Function	XYZ Health Center Co-applicant Governing Board	XYZ Health Center CEO/ Program Director and staff	Public Agency
Annual Health Center Program Grant Application and Budget:			
Annual Budget	Approves plans and priorities prior to Health Center Program grant application budget development; approves grant application and budget prior to inclusion in submission to HRSA and prior to development of full agency budget; approves any recommended changes to the budget made by the public agency prior to finalization.	Works with public agency staff to prepare Health Center Program grant application and budget; Presents final application and budget to: 1. The co-applicant board for approval and 2. The public agency for incorporation into overall agency budget.	Approves agency budget including health center budget; approves Health Center Program grant application; refers any recommended changes back to co-applicant board for final approval.
Financial Policies			
Purchasing	Receives, reviews and approves financial reports	Authorizes purchases per budget, policy and procedural requirements	Establishes and administers purchasing policies.
Accounts Payable	Receives, reviews and approves financial reports	Compares A/P reports to standards and forwards analysis to co-applicant Board	Establishes polices, maintains systems and pays all invoices per policies
Billing and Accounts Receivable (A/R)	Approves credit and collection policies; approves fee schedule	Develops billing and A/R reports and forwards analysis to Board	Bills for all services per agency procedures and Board policies; supports CEO in development of A/R reports for Board.
Annual Audit	Reviews and accepts audit; reviews and approves corrective action, as necessary	Implements any required	Ensures audit is completed in compliance with A-133
Partial Payment Schedules	Approves sliding fee discount program policies and procedures; approves nominal fee.	Presents proposed changes to Board for discussion and approval.	Implements sliding fee discount policies
Quality Improvement/Assurance:			
Client Satisfaction	Provides recommendations on content and implementation of survey; reviews results; recommends improvements	Implements survey and summarizes findings	Provides technical support to Board and CEO to develop and implement survey and analyze results
Quality Plan	Approves annual QA plan and receives regular reports on QA activities	Reviews results of quality assessments and regularly reports findings to Board	Supports CEO in developing goals/measures and implementing plan.
Patient Grievances	Reviews and approves patient grievance policies	Investigates and abates grievances and reports grievance activity to Board	Supports implementation of grievance process
Credentialing and Privileging	Approves credentialing and privileging policies	Supports credentialing and privileging; implements delegated aspects of policies and procedures	Approves credentialing and privileging policies; implements delegated aspects of policies and procedures

Function	XYZ Health Center Co-applicant Governing Board	XYZ Health Center CEO/ Program Director and staff	Public Agency
Planning and Operations:			
Scope of Services	Reviews and approves	Develops and recommends to Board	Provides input
Locations and Hours	Reviews and approves	Develops and recommends to Board	Provides input; reviews and approves, refers any recommendations for change to co-applicant Board for consideration
Strategic Planning	Participates in development, approves final	Develops with input from Board	Provides input.
Human Resources:			
Personnel Policies and Procedures	Provides input	Communicates HR policies and procedures and impact	Develops and implements
Salary and Benefit Scales	CEO compensation – reviews compensation surveys, etc. and approves final compensation package; all other staff - provides input	Communicate non-CEO salary and benefit policies and procedures and impact	CEO compensation – commissions compensation survey, develops compensation package and presents both to Board for approval; all other staff - develops and implements
Selection of CEO	Provides input on CEO responsibilities and qualifications; participates in interview process; selects from final candidate list	n/a	Solicits candidates, credentials candidates, recommends final candidate list, including preferred candidate if applicable, and employs candidate chosen for the position.
Evaluation of CEO	Evaluates performance related to health center functions and in accordance with public agency policies; shares evaluation with public agency	Self-evaluation	Evaluates performance related to public agency functions and standards; incorporates health center Board evaluation; shares evaluation with health center Board.
Dismissal of CEO	Approves dismissal from health center	n/a	Recommends dismissal and, as applicable, terminates employment.
Selection and Dismissal of Other Staff	Delegates all staff-related issues to the CEO	Supervises staff on all health center related functions; coordinates supervision with public agency as necessary.	Responsible for all the procedural aspects of selection and retention subject to policies and procedures
Governance:			
Monthly Board Meetings	Establishes and maintains monthly Board meeting schedule and calendar	Schedules meetings, prepares and distributes agendas, Board reports and related information; generates and distributes Board minutes	Attends Board and committee meetings as defined in bylaws.
By-Laws	Develops/amends bylaws; Insures that By-Laws are current, meet all legal and regulatory requirements and provide an effective framework for governance.	Interprets HRSA regulatory requirements for Board	N/A
Board Training	By-laws; develops Board operating policies for the procedural functioning of the Board	N/A	Supports Board training and development priorities established by Board.

Recruits and elects Board members; ensures compliance with Board composition requirements.	Maintains list of Board members and notifies Board when Board composition requires modification.	Recommends potential Board members; as applicable, appoints Board members per bylaws	Supports Board training and development priorities established by Board.
Approves and implements policies	Assists in implementing policies	Provides input into policies	Provides input into policies

Appendix 4
Summary of Governance Requirements

Chapter 19 "Board Authority"			
Requirement	**Applicable Health Center Types**	**Special Considerations for Public Centers**	**Considered for Waiver?**
Develop bylaws	All	No	No
Assure center is operated in compliance with applicable Federal, State, and local laws and regulations	All	No	No
Hold monthly meetings	All	No	No
Have minutes for all meetings	All	No	No
Select, dismiss, evaluate CEO/Program Director	All	No	No
Establish policies – financial management, partial payment schedules, personnel, health care, QI/A	All	Yes: public centers may retain authority for a limited set of fiscal and personnel policies only.	No
Adopt policies regarding scope and availability of services, site locations, hours of operation	All	No	No
Approval of health center grant application and budget	All	No	No
Provide direction for strategic planning including identifying priorities and adopting 3-year financial management and capital expenditure plans	All	No	No
Monitor financial status, review audit results and ensure follow-up action	All	No	No
Evaluate organization progress, performance and activities of the center including achievement of objectives, service utilization patterns, quality of care, productivity, patient satisfaction	All	No	No
Ensure a process is developed for hearing and resolving patient grievances	All	No	No

Chapter 20 "Board Composition"			
Requirement	**Applicable Health Center Types**	**Special Considerations for Public Centers**	**Considered for Waiver?**
9-25 members	All	No	No
Consumer/patient majority	All	No	MHC, HCH, PHPC – only health centers, Sparsely Populated
Consumer members representative in terms of demographic factors including race, ethnicity and sex	All	No	MHC, HCH, PHPC-only health centers
Non-consumer members with relevant experience	All	No	No
Limitations on non-consumer members earning 10% of their income from the health care industry	MHC, no more than 66%, recommended for all. All others – no more than 50%	No	No
Board members and their immediate family may not be health center employees	All	No – but requirement applies to employees of both the co-applicant organization and the organization and the public agency component (such as the department, division or sub-agency) in which the Health Center Program project is located	No
Chief executive may serve only as a non-voting ex-officio member of the board	All	No	No