Federal Requirements Related to FQHC Status: Introductory Guidance

Background

Statutes, Regulation, and Policies that Form the Framework for the Health Center Grant Program

Section 330 of the Public Health Service ("PHS") Act ("Section 330")[1] is the overarching legislation which authorizes grant funding for the planning, development, and operation of health centers,[2] and sets forth the basic requirements regarding organizational structure, governance, and administrative, financial, personnel, and clinical operations that health centers must satisfy to receive and maintain such funding.

This legislation was implemented and expanded through the promulgation of regulations by the Department of Health and Human Services ("DHHS")[3] (hereinafter, the "implementing regulations"). While the legislation provides the basic framework under which health centers receive and use grant funds, the regulations specify the manner in which particular legislative provisions are interpreted and implemented. For example, in Section 330(k)(3)(H), Congress requires health centers to establish and be governed by a consumer-controlled Board of Directors and sets forth the basic authorities of the Board; the health center implementing regulations[4] build on this requirement by specifying additional size, composition, and selection requirements, as well as specific functions and responsibilities for Boards.

The Bureau of Primary Health Care ("BPHC"), an office within the Health Resources and Services Administration ("HRSA") within DHHS, is responsible for administering the health center program and provides additional operational assistance by issuing policies (Policy Information Notices, or "PINs"), guidelines (Program Assistance Letters, or "PALs") and other forms of guidance. As a whole, the various forms of BPHC guidance set the standards which represent BPHC's position regarding a range of issues—from internal corporate concerns to arrangements with other entities—by interpreting, explaining, expanding, and even updating the

1 42 U.S.C. § 254b.

2 For purposes of this guidance, the term "health center" refers to both grantee and Federally Qualified Health Center look-alikes ("FQHC LAs"), unless otherwise indicated. Certain requirements discussed in this Toolkit, such as Federal procurement and property standards and Federal cost principles, apply solely to entities receiving Federal funds. In the context of health centers, any such requirements apply to Section 330 grantees, but not FQHC LAs. Other programmatic requirements (in particular, requirements addressed by the Health Center Site Visit Guide, apply to all health centers (i.e., grantees and FQHC LAs).

3 42 C.F.R. Part 51c and 42 C.F.R. Part 56.

4 42 C.F.R. § 51c.304.

health center-related rules which were published in 1976 and which, by themselves, may not address certain matters (e.g., public centers and other Section 330 provisions enacted after 1976).

Of particular importance are the Health Center Program Requirements (typically referred to as "the Nineteen Requirements"), which were revised in 2014.[5] The Nineteen Requirements represent the legal standards mandated by the health center program authorizing statute[6] and the implementing regulations.[7]

The Nineteen Requirements are grouped into four sections that generally reflect the core components of the health center program:

1. Need: Facilities located in or serving a medically underserved area or population;
2. Services: Provision of comprehensive primary and preventive care services furnished regardless of ability to pay, or payor or insurance status;
3. Management and finance: Appropriate management and financial systems to ensure autonomy and fiscal viability; and
4. Governance: Governance by a community-based board that meets certain composition requirements and autonomously exercises certain authorities.

In effect, the Nineteen Requirements guidance replaces the Health Center Program Expectations, PIN 98-23 (Aug. 17, 1998) ("Program Expectations"), which long represented the BPHC's expectations for health centers but which are no longer applicable. Similar to the Nineteen Requirements, the Program Expectations reiterated the statutory and regulatory requirements for health center programs (the "musts"). The key difference, however, was the additional information provided in the Program Expectations (the "shoulds"), which expanded upon the legal requirements, representing BPHC's recommendations or "best practices."

The main tool by which HRSA currently evaluates a health center's compliance with the Nineteen Requirements is the operational site visit assessment (OSV) utilizing the current fiscal year Health Center Site Visit Guide.[8] HRSA has indicated that every health center will be the subject of an OSV at least once every project period. HRSA's site reviewers generally apply a strict construction of the Nineteen Requirements. Health centers are accordingly advised to leave ample time to prepare for an upcoming OSV, using the Health Center Site Visit Guide and the applicable PINs and PALs for guidance.

HRSA has also provided policy clarification and updated program guidance regarding the Progressive Action process, which was developed to support the review and oversight of

5 *Health Center Program Requirements* (Feb 2014).
6 Section 330 of the Public Health Service Act (42 U.S.C. § 254b).
7 42 C.F.R. Part 51c (and Part 56 for migrant health center programs).
8 See Health Resources and Services Administration, *Health Center Site Visit Guide* (Nov 2014/Fiscal Year 2015).

Nineteen Requirements.[9] According to PAL 2014-08, failure to adequately address conditions through the Progressive Action process will serve as documentation that a health center has materially failed to comply with the terms and conditions of the grant award. In such case, the health center's current project period may be shortened and include the withdrawal of support through the cancellation of all or part of the grant award before the current project period end date, and may result in the announcement of a competition for this service area to identify an organization that can carry out a service delivery program consistent with the Nineteen Requirements.

Other key HRSA PINs and PALs governing health center operations include:

- PIN 2014-02 *Sliding Fee Discount and Related Billing and Collections Program Requirements* (Sept 22, 2014);
- PAL 2014-10 *Updated Process for Change in Scope Submission, Review and Approved Timelines* (Aug 28, 2014);
- PIN 2014-01 *Health Center Program Governance* (Jan 27, 2014);
- PIN 2013-01 *Health Center Budgeting and Accounting Requirements* (Mar 18, 2013);
- PIN 2008-01 *Defining Scope of Project and Policy for Requesting Changes* (Dec 31, 2007);[10] and PIN 2009-03 *Technical Revision to PIN 2008-01 Defining Scope of Project and Policy for Requesting Changes* (Jan 13, 2009); and
- PIN 97-27 *Affiliation Agreements of Community and Migrant Health Centers* (Jul 22, 1997); and PIN 98-24 *Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers* (Aug 17, 1998).

In addition to the grant-specific law, regulation, and policies discussed above, health centers are subject to various DHHS-wide requirements and regulations. For example, by virtue of their Federal funding, health centers must comply with the U.S. Department of Health and Human Services Grants Policy Statement.[11]

Equally important are the administrative requirements contained in Supercircular/Omnicircular "Uniform Guidance" published by the Office of Management and Budget ("OMB") and federal

9 PAL 2014-08 *Health Center Program Requirements Oversight* (Jun 11, 2014).

10 PIN 2008-01 applies solely to grantee health centers. However, FQHC LAs must also define their scopes of project based on the same 5 elements, which, in turn, establishes the project for which certain Section 330-related benefits can be utilized. The FQHC LA rules regarding the scope elements and how to make changes to them are set forth in the FQHC LA application. See PIN 2009-06 Federally Qualified Health Center Look-Alike Guidelines and Application (Sept 22, 2009) (amended by PIN 2009-07 *Amendment to PIN 2009-06, FQHC Look-Alike Guidelines and Application* (Nov 23, 2009) and PIN 2010-02 *Amendment to PIN 2009-06: FQHC Look-Alike Guidelines and Application, Additional Submission Requirements for Change in Scope Applications* (Aug 24, 2010)), and PAL 2013-10 *Look-Alike Program Update: On-Site Compliance Reviews for Initial Designation and Designation Period Changes* (Sept 16, 2013).

11 U.S. Dept of Health and Human Services, *Grants Policy Statement* (Jan 1, 2007).

award-making agencies, including but not limited to DHHS. DHHS created a new 45 C.F.R. Part 75 to incorporate the implementing regulations.

Specific Programmatic / Federal Funding Requirements for Health Centers

All health centers are subject to specific requirements based on their participation in the health center program. Further, grantees, by virtue of their receipt of federal funds authorized under Section 330, are subject to additional requirements that relate to the benefit of receiving these funds. These cover virtually every facet of health center operations and include requirements defining:

- The Section 330-related scope of project (which, in turn, determines, in part, the particular health center's eligibility for certain FQHC-related benefits);
- Key operational requirements (e.g., needs assessment and patient surveys, fee schedules and schedule of discounts, quality assurance plan, strategic plan, and cultural and linguistic competency plan);
- Standards for eligibility for, and utilization of, FQHC-related benefits (i.e., Federal Tort Claims Act coverage; Section 340B Drug Pricing Program);
- General limitations related to the receipt of federal funds and participation in Federal assistance programs (i.e., Byrd Anti-Lobbying Amendment; Debarment and Suspension rules); and
- Other requirements for entities receiving federal funds.

Scope of Project

In general, the health center's scope of project defines the activities and locations that can be supported by the total approved Section 330-related project budget, including the Section 330 grant funds, program income, and other non-Section 330 funds pledged to the project. The scope of project is comprised of five core elements—sites, services, providers, service area(s), target population(s)—for which the use of Section 330 grant funds have been approved.[12]

With limited exceptions, all sites, services, and other activities / locations must be listed on the applicable scope forms to be included within the health center's approved scope of project:

- Form 5 – Part A for Services Provided;
- Form 5 – Part B for Service Sites; and,
- Form 5 – Part C for Other Activities or locations that do not meet the definition of site, are provided on an irregular basis, and/or are offered on a limited basis.

Additionally, health centers should describe all core elements specifically in the approved grant application. PIN 2008-01 provides detailed information on each of the five core elements,

[12] See PIN 2008-01 and PAL 2014-10.

including how BPHC defines each element and the appropriate way in which to record them on the scope and other application forms.[13]

If a health center seeks to add/delete a service, or add, delete or relocate a site, it must secure HRSA prior approval for the desired change.[14] PIN 2008-01 provides general criteria for approval as well as special instructions on requesting approval for specific types of services and sites.[15] Generally, the request will be approved if it:

- Does not require any additional Section 330 funding;
- Does not shift resources away from the provision of services to the health center's current target population(s);
- Furthers the health center's mission by increasing/maintaining access and improving/maintaining quality of care for the target population(s);
- Is fully consistent with Section 330, the implementing regulations, and the Nineteen Requirements;[16]
- Provides for appropriate credentialing and privileging of providers;
- Does not eliminate or reduce access to a required service;
- Does not result in a diminution of the level or quality of health services provided to the target population(s);
- Continues to serve a Medically Underserved Area ("MUA") or Medically Underserved Population ("MUP"), in whole or in part (the site itself does not have to be located in an MUA to serve it as long as the health center organization serves a MUA / MUP);
- Demonstrates approval by the health center's Board of Directors; and
- Does not significantly affect the operation of an existing health center in the same or adjacent service area.[17]

In 2014, HRSA initiated a scope alignment validation (SAV) process for all health centers and updated the Forms 5A and 5B. The changes to Forms 5A and 5B are summarized in PAL 2014-06.[18] HRSA also published various resources to assist health centers in their scope change process, including the following:

- Form 5A Service Descriptors;

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13 PIN 2008-01 at pp. 4 - 16.

14 Id. at pp. 16 - 17.

15 Id. at pp. 17 - 22.

16 Note that PIN 2008-01 refers to the Program Expectations, which, as discussed earlier in this guidance, are no longer applicable.

17 Id. at pp. 21-22. There are additional requirements that must be met if adding a specialty service or adding target populations (applicable solely to special population grantees), which are set forth in PIN 2009-02 Specialty Services and Health Centers' Scope of Project (Dec 18, 2008) and PIN 2009-05 *Policy for Special Populations-Only Grantees Requesting a Change in Scope to Add a New Target Population* (Mar 23, 2009).

18 PAL 2014-06 *Documenting Scope of Project in Updated Forms 5A and 5B* (May 13, 2014).

- Form 5A Column Descriptors;
- Add a New Service to Scope;
- Delete Existing Service;
- Form 5B Instructions;
- Add New Service Site;
- Convert Admin-Only to Service Delivery Site;
- Convert Existing Service Delivery Site to Admin-Only Site;
- Delete Existing Service Delivery Site; and
- Replace Existing Service Delivery Site.[19]

To obtain a change in scope, the health center must submit its request through HRSA's Electronic Handbook ("EHB") system, which will lead the health center through the various steps necessary to complete the request. HRSA will notify the health center of its final decision within 60 days of receiving a complete change in scope request submission. In unique cases, HRSA may extend the review period beyond 60 days if additional analysis is warranted.[20] HRSA expects health centers to implement approved changes (e.g., open the approved site or begin providing the approved new service) within 120 days of receiving the Notice of Award or HRSA notification approving the change.[21]

Sliding Fee Discount Program

As part of your health center's ongoing compliance program efforts, it is critical to become familiar with, and comply with, Section 330(k)(3)(G) of the Public Health Service Act, 42 CFR Part 51c.303(f) and 42 CFR Part 51c.303(u), and PIN 2014-02: *Sliding Fee Discount and Related Billing and Collections Program Requirements*. PIN 2014-02 is the primary HRSA policy resource on the Health Center Program sliding fee discount and related billing and collections program requirements, and supersedes all other previous Health Center Program guidance and policy issued on these requirements.

The Health Center Program sliding fee discount program requirements include establishing:

1. A schedule of fees for services;
2. A corresponding schedule of discounts for eligible patients that is adjusted based on the patient's ability to pay (referred to as the sliding fee discount schedule (SFDS)); and
3. Governing board-approved policies and the organization's supporting operating procedures, including those around billing and collections.

[19] These resources are available by searching HRSA's website.
[20] PAL 2014-10 at p. 2.
[21] Id. at p. 3.

The three elements are briefly described below. This Introductory Guidance only highlights certain key requirements. It is not a comprehensive outline of the applicable requirements, and should not be relied upon in evaluating your health center's compliance with the sliding fee discount program requirements.

1. Fee Schedule

Health centers are required to prepare "a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation."[22] The health center's fee schedule must address all in-scope services (required and additional) and be used as the basis for seeking payment from patients as well as third party payors. The health center must adjust its fees, as appropriate, based on regular cost analyses, as well as changes in the local health care market.

2. Sliding Fee Discount Schedule

Health centers are required to prepare "a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay."[23] The implementing regulations explain that:

> such schedule of discounts shall provide for a full discount to individuals and families with annual incomes at or below those set forth in the most recent CSA Poverty Income Guidelines (45 C.F.R. § 1060.2) and for no discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines, except that nominal fees for services may be collected from individuals with annual incomes at or below such levels where imposition of such fees is consistent with project goals.[24]

PIN 2014-02 specifies that a SFDS must have at least three discount pay classes above 100% and at or below 200% of the Federal Poverty Guidelines (FPG). PIN 2014-02 further specifies that any health center that chooses to establish a nominal charge must ensure that patients are not impeded in accessing services due to an inability to pay. Specifically, a nominal charge must be a fixed fee that does not reflect the true value of the service(s) provided and must be considered nominal from the perspective of the patient. In addition, the nominal charge must be less than the fee paid by a patient in the first "sliding fee discount pay class" beginning above 100% of the FPG.

Neither Section 330 nor its implementing regulations authorize health centers to discount charges for services to patients who earn annual incomes greater than 200% of the FPG. Accordingly,

[22] See Section 330(k)(3)(G)(i).
[23] See Section 330(k)(3)(G)(i).
[24] See 42 C.F.R. § 51c. 303(f).

health centers should not use Section 330 funds and/or grant-related funds (such as program income) to support or subsidize the costs of services provided to such individuals and families.

The eligibility determination process for the SFDS must be conducted in an efficient, respectful, and culturally appropriate manner to assure that administrative operating procedures for such determinations do not themselves present a barrier to care. Patient eligibility for a sliding fee discount should be renewed/reviewed at least once a year or upon the patient's next visit to the health center.

In order to facilitate patient access and utilization, health centers must ensure that patients are made aware of the sliding fee discount program. Specifically, health centers should establish multiple methods for informing patients of the sliding fee discount program (e.g., signage, registration process). In addition, information about the sliding fee discount program must be available in appropriate languages and literacy levels for the health center's target population.

3. Billing and Collections

With certain exceptions, health centers are required to charge and use best efforts to collect from such patients the full charges in accordance with their fee schedules, without taking into account any discounts. Notwithstanding, health centers must assure that no patient will be denied health care services due to his or her inability to pay for such services.

PIN 2014-02 indicates that sound billing and collections policies and their supporting operating procedures are critical to a health center's ability to carry out both the sliding fee discount program requirement and the requirement to maximize revenue from public and private third party payors. For example, health centers must establish policies and supporting operating procedures that identify circumstances with specified criteria for waiving charges. These procedures must also identify specific health center staff with the authority to approve the waiving of charges. In addition, if the health center offers payment incentives or reserves the right to terminate patients for their refusal to pay, such practices must be set forth in operating procedures.

PIN 2014-02 provides more information regarding each of the three key elements of a health center's sliding fee discount program described above. PIN 2014-02 also highlights additional requirements, such as the SDFS eligibility screening process, governing board oversight of the sliding fee discount program, discounts for patients with third party coverage who are also eligible for the sliding fee discount schedule, charges for equipment and supplies, and required policies and procedures.

Additional resources set forth in this Toolkit include the following:

- Sliding fee discount program: Sample policy and procedure

- Sliding fee scale / nominal fee eligibility documentation: Sample form

Health Center Board Governance

The community-based governing board is a core pillar of the health center program. As set forth below, each health center Board of Directors is charged with the important responsibility of providing leadership and guidance in support of the health center's mission. Monitoring and maintaining compliance with the governing board requirements is accordingly critical for all health centers. In fact, 3 of the 19 health center program requirements (*i.e.*, program requirements 17, 18 and 19) are specific to the governing body.

Governance requirements for health centers are set forth in Section 330 of the Public Health Service Act, the implementing regulations, and through various HRSA policies. PIN 2014-01: *Health Center Governance* is the primary HRSA policy source for information on health center program governance.

While this section of the Introductory Guidance summarizes four key requirements applicable to the health center governing board, it is important to note that it is not a summary of *all* applicable requirements. Health centers are accordingly advised to closely review the statute, implementing regulations, and applicable HRSA guidance for additional information.

1. Board Composition

Boards must have at least 9 and no more than 25 members. The size of the Board may vary based on the complexity of the organization and the diversity of the community served. The majority of directors on a health center Board must be individuals served by the health center, often referred to as "consumer members" or "patient members." BPHC clarified the definition of a patient in as: "*a current registered patient of the health center who has accessed the health center in the past 24 months to receive at least one or more in-scope service(s) that generated a health center visit."*[25] Visits are defined as "*documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient*."[26]

Patient members, as a group, must be representative of the community served by the health center in terms of demographic factors such as race, ethnicity, and sex.[27] PIN 2014-01 indicates

[25] PIN 2014-01 at 5.

[26] Upon showing of good cause, the following types of health centers are eligible to request a waiver of the 51% patient majority governance requirement: (1) any Section 330 funded health center or look-alike serving a sparsely populated rural area (Section 330(p)); or (2) Section 330 funded health centers/look-alikes that receive Migrant Health Center, Health Care for the Homeless, and/or Public Housing Primary Care funding/designation only and do not receive Section 330(e) funding/designation. For more information, see PIN 2014-01, pages 11-12.

[27] 42 C.F.R. § 51c.304(b)(1)

that health centers are encouraged to consider other demographic factors, such as socioeconomic status and age.[28] Health center Boards should continually monitor their composition to ensure that they remain representative of the community, with attention paid to whether the patient members continue to represent any changing demographics of the populations served.

HRSA also sets out various requirements for non-consumer board members. First, non-patient members must be representative of the community currently served by the health center. This is often established by living or working in the health center's service area or by having other close connections to the community (*e.g.*, previously living or working in the community, family members connected to the community, living in a nearby community, *etc.*). Second, non- patient members should be selected for expertise in a broad range of skills, expertise, and perspectives such as finance, legal affairs, business, health, managed care, social services, labor relations, and government. Third, HRSA limits the number of non-patient members that work in the health care industry. Specifically, no more than one-half of the non-patient members may earn more than 10% of their income from the health care industry. "Health care industry" is not explicitly defined, but commonly includes both clinical professions and administrative, managerial, or other work in a health care setting (*e.g.*, a private physician's office, a hospital, or an insurance company).

Finally, no member of the Board (patient or non- patient) may be an employee of the health center or an immediate family member (i.e., spouse, child, parent, brother, or sister by blood, adoption, or marriage) of a health center employee.

Special Population Representation: Some health centers receive funding under multiple Section 330 subparts (Section 330(e) and also Section 330(g) (*i.e.*, migratory and seasonal agricultural workers), (h) (*i.e.*, homeless), and/or (i) (*i.e.*, residents of public housing)). At a minimum, there must be at least one board member that is representative of each of the special populations for which the health center receives Section 330 funding/designation. The intent of this requirement is to ensure the health center's Board is sensitive and responsive to the needs of all patients, including those who are members of special populations. PIN 2014-01 specifies that patient representation of special populations is best achieved through patients who are members of the special population. However, due to the unique nature and circumstances of these populations, representation may also include advocates for special populations who have personally experienced being a member of the population (*e.g.*, a person who has formerly experienced homelessness), work closely with the specific population, or have other relevant expertise.

2. Board Responsibilities and Authorities

[28] PIN 2014-01 at 5.

Health center Boards are expected to be actively involved in establishing priorities, core policies, and oversight of the health center. Health center boards must meet at least once a month and maintain minutes that verify and document the Board's actions at such monthly meetings.[29]

The following authorities and responsibilities must be exercised autonomously by the Board:

- Selecting, evaluating and, if necessary, dismissing the health center's Executive Director/Chief Executive Officer (CEO);
- Establishing and adopting health care policies and procedures, including locations and hours of services, scope and availability of services, and quality of care audit procedures;
- Establishing and adopting personnel policies and procedures, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices;
- Establishing and approving policies regarding financial management practices, including a system to assure accountability for health center resources, and developing and approving the annual project budget and plan, center priorities, eligibility for services including criteria for partial payments schedules, and long-term financial planning;
- Approving the health center's annual budget, annual audit and any applications related to the health center project, including grants/designation applications and other significant HRSA requests regarding scope of project;
- Evaluating the health center's activities, including service utilization patterns, productivity, patient satisfaction, achievement of project objectives, and a process for hearing and resolving patient grievances;
- Approving the health center's bylaws, and any amendments to the bylaws;
- Engaging in long-term strategic planning, which would include regularly updating of the health center's mission, goals, and plans; and
- Evaluating the health center's progress in meeting its annual and long-term goals. [30]

Note that under the public center model, where the health center is composed of both the public entity and the co-applicant Board, the public entity may retain authority for the establishment of certain fiscal and personnel policies and matters. In addition, although the co-applicant Board must retain the ultimate decision-making on duties and authorities beyond general types of fiscal and personnel policies, the co-applicant arrangement should allow for the co-applicant Board and the public agency to work collaboratively in the exercise of governance responsibilities.

3. Corporate and Contractual Affiliation Considerations

[29] 42 CFR 51c.304(d)(2).
[30] 42 U.S.C. 254b(k)(3)(H);42 CFR 51c.304(d)(3); PIN 2014-01.

In order to ensure that health centers do not violate governance and related requirements in the context of collaborations with third parties, HRSA has issued "affiliations" PINs, namely PIN 1997-27 *Affiliation Agreements of Community and Migrant Health Centers, and* PIN 1998-24 *Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers.* Highlights include that the following:

- No other entity may have an overriding approval authority over decisions which the health center Board is required to make;
- No other entity may have veto power, including "super-majority" provisions which give another entity an effective veto power;
- No other entity may have final approval of the overall strategic and operational plan and budget for the health center, except where allowed for public centers with co-applicant boards;
- No other entity may have the authority to select or dismiss the CEO/Executive Director. This prohibition includes cases where health centers combine the CEO position with that of any other key management staff; and/or
- No third parties may appoint:
  - A majority of the health center Board,
  - A majority of the non-patient board members,
  - A majority of the Executive Committee, or
  - The Board Chair.

The above restrictions should be considered and the applicable PINs should be reviewed prior to entering into any contractual or affiliation relationship.

4. Organizational/Corporate Bylaws

Organizational/corporate bylaws must be established and approved by the health center's Board. As the health center evolves, and as state law and HRSA requirements change, the bylaws should be reviewed and modified as necessary to remain current. HRSA expects that health center bylaws describe the following:

- Health center mission;
- Authorities, functions, and responsibilities of governing board as a whole;
- Board membership (size and composition);
- Individual board member responsibilities;
- Process for selection/removal of board members;
- Election of officers;
- Recording, distribution and storage of minutes;
- Meeting schedule and quorum;
- Officer responsibilities, terms of office, and selection/removal processes;

- Description of standing committees (which may include but are not limited to, executive, finance, quality improvement, personnel, and planning committees) and the process for the creation of ad-hoc committees;
- Conflict of interest provisions; and
- Provisions regarding board dissolution.
- Provisions to include in the health center's corporate bylaws: Checklist

Advice and Recommendations[31]

Continued eligibility for Section 330 grant funding or FQHC LA status, and the Section 330-related benefits attributed to such status are contingent on a health center's ongoing compliance with all applicable statutory and regulatory requirements and program policies, several of which are listed above. Accordingly, health centers should monitor their compliance and ensure that they have appropriate policies and procedures in place, which are periodically reviewed and updated.

- "Inventory" of Section 330-related documents: Checklist

[31] The Authors of these materials include attorneys at the law firm of Feldesman Tucker Leifer Fidell LLP. The advice and recommendations consist of general guidance based on Federal law and regulations, and do not necessarily apply to all health centers under all facts and circumstances. Further, these materials do not replace, and are not a substitute for, legal advice from qualified legal counsel.