

1999-09

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DOCUMENT TITLE: Implementation of the
Balanced Budget Act Amendment of the
Definition of Federally Qualified Health Center
Look-Alike Entities for Public Entities

TO: Community Health Centers
Migrant Health Centers
Federally Qualified Health Center Look-Alikes
Primary Care Associations
Primary Care Offices

The Social Security Act describes a Federally Qualified Health Center (FQHC) Look-Alike as an entity which, based on the recommendation of the Health Resources and Services Administration (HRSA) within the Public Health Service (PHS), is determined by the Secretary to meet the requirements for receiving a grant under section 330 of the Public Health Service Act. This provision permits clinics that do not receive Federal grant funds under the above authority but satisfy the requirements for receiving such monies, to be treated as FQHCs for purposes of reimbursement under Medicare and Medicaid.

Section 4712(d) of the Balanced Budget Act (BBA) of 1997 (Public Law 105-33), modifies the FQHC Look-Alike definition. The Social Security Act, as amended by the BBA, defines an FQHC Look-Alike as an entity which "based on the recommendations of the HRSA within the PHS, is determined by the Secretary to meet the requirements for receiving [a section 329, 330, or 340] grant **including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity**". The effective date of this amendment was August 5, 1997. As a result of this amendment, we placed a moratorium on the processing of new applications for FQHC Look-Alike status as well as the recertification of existing FQHC Look-Alikes. This moratorium was to remain in force until such time as HRSA and the Health Care Financing Administration (HCFA) could formally interpret and implement this statutory change.

The legislative history of the BBA does not illuminate congressional intent as to how the statutory change is to be interpreted and applied to public and private non-profit FQHC Look-Alike entities. The attached Policy Information Notice (PIN) presents HRSA's interpretation of the revised language with respect to public entities. It is the product of extensive discussions between Federal staff representing HRSA and HCFA and with representatives of both public and private non-profit health centers. A separate PIN

provides the interpretation and implementation of the revised language for private non-profit FQHC Look-Alike entities.

Public applicants for FQHC Look-Alike designation or recertification are encouraged to consult the Field Office and Headquarters staff if there are questions about the application of this policy to their particular case. The Bureau of Primary Health Care's Program Assistance Letter 1998-05, issued April 3, 1998, requested currently designated FQHC Look-Alike entities and organizations now seeking FQHC Look-Alike designation to submit additional documents to enable HRSA to complete its assessments. Recertifications and requests for designation that are now in a pending status will be released if determined to be unaffected by the amendment.

/s/

Marilyn H. Gaston, M.D.
Assistant Surgeon General
Associate Administrator

Attachments

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I. INTRODUCTION

Section 4712(d) of the Balanced Budget Act (BBA) of 1997 modifies the definition contained in the Social Security Act for a Federally Qualified Health Center (FQHC) Look-Alike entity. The Social Security Act, as amended by the BBA, defines an FQHC Look-Alike as an entity which “based on the recommendations of the Health Resources and Services Administration (HRSA) within the Public Health Service (PHS), is determined by the Secretary to meet the requirements for receiving [a section 329, 330, or 340] grant **including requirements of the Secretary that an entity may not be owned, controlled or operated by another entity**” (emphasis denotes BBA language). The effective date of this amendment was August 5, 1997, the date the Act was signed. At that time, HRSA and the Health Care Financing Administration agreed to place a moratorium on the processing of applications for FQHC Look-Alike designation.

This Policy Information Notice (PIN) establishes the Bureau of Primary Health Care’s (BPHC) interpretation of the statutory limits on the involvement of “another entity” in the ownership, control and/or operation of a public FQHC Look-Alike entity. It also formally ends the moratorium on HRSA processing of applications from public entities for FQHC Look-Alike designation and recertification.

A separate PIN provides the interpretation of the revised language for private non-profit FQHC Look-Alike entities.

II. COMPLIANCE REVIEW

A public center must be either: (a) a public entity that is structured so as to meet all section 330 requirements, including those applicable to the governing board; or (b) a public entity and a co-applicant entity which together meet the section 330 requirements. All public centers must fit into one category or the other in order to be in compliance.

Under option (b), the public agency must have a co-applicant board which meets the section 330 composition and responsibility requirements except for the requirement that the board establish general policies for the health center. Section 330 allows the public agency to retain general policy setting functions and authorities. The BPHC expects, however, that the community-based governing board will be vested with the authority to manage the health center to the extent allowed by the public entity’s charter, with shared responsibility in the exercise of some authorities. The delegation of authority to the board and shared roles and responsibilities must be fully described in an agreement that is to be submitted with the public entity’s application for FQHC Look-Alike designation or recertification.

We have determined that public entities are not owned, controlled, or operated by another entity when the following guidelines are met:

A. Public Center With No Co-Applicant

In one form of public center, a public entity qualifies as a grantee or FQHC Look-Alike without needing a co-applicant. In this case, the public entity receives the FQHC Look-Alike designation and its board meets section 330 requirements. Thus, the public entity that receives the FQHC Look-Alike designation is the “entity” that cannot be owned, controlled or operated by another entity as stated in the BBA. In this context, the restrictions on the powers that “another entity” may exercise vis-a-vis the public center refer to powers exercised by any separately incorporated entity, or entities, that are otherwise legally distinct from the public entity. This does not include departments or divisions of a single entity (e.g., a city, county, or other single governmental body) that are not legally distinct. Accordingly, no separate entity or entities may own, control, or operate the public entity.

B. Public Center with Co-Applicant Arrangements

In the other form of public center, there is a public entity applicant with a co-applicant entity which, when combined, meet the section 330 governance requirements. In co-applicant arrangements, the public entity receives the FQHC Look-Alike designation, and the co-applicant entity serves as the “health center board”, with the two collectively referred to as the “health center.” The preferred model is to have the co-applicant incorporated as a separate entity, with adopted bylaws which specify its authorities and methods of operation vis-a-vis the public entity. Experience has shown that this method assures maximum accountability for the user majority board and best achieves the purposes of the section 330 programs. It is recognized, however, that incorporation of the co-applicant may not be appropriate or feasible for all public entities and, therefore, is not a requirement.

1. Required Authorities of the Co-Applicant

The governing board selection, composition and responsibility requirements apply to the co-applicant since it functions as the community-based board of the health center. The BPHC has established standards in the context of health center affiliations which pertain also to the relationship between a public entity and its co-applicant. These standards are stipulated in BPHC PIN 1997-27, Affiliation Agreements of Community and Migrant Health Centers, dated July 22, 1997. This PIN addresses compliance with the selection and composition requirements to ensure the board’s independence and the limitations on a third party (e.g., to select and remove board members) which apply to the public entity applicant as well as other third parties.

Section 330 permits the public entity to retain general policy-making authority. (See the discussion following the list of activities and item 2, below.) The purpose of this provision is to recognize that public entities are constrained by law, in some cases, not to delegate certain governmental functions to private entities. At the same time, we recognize the statutory objective of section 330 that the health center's policy setting process be carried out, to the extent possible, by a community-based governing board. This guidance is designed to accommodate, to the extent feasible, both of these objectives.

As provided by statute and regulation, governing boards of health centers are responsible for the following activities:

- a. Selection of the services to be provided by the health center;
- b. Approval of the health center's annual budget, with the overall plan and budget prepared under its direction by a committee consisting of representatives of the health center board, administrative staff, and the medical staff of the health center;
- c. Approval of the selection and dismissal of the Executive Director for the center;
- d. Approval of the application for a second or subsequent grant or FQHC recertification;
- e. Adopt health care policies, including scope and availability of services, locations, and hours of services and quality of care audit procedures;
- f. Assure that the health center is operated in compliance with applicable Federal, State, and local laws and regulations; and
- g. Evaluate center activities including services utilization patterns, productivity of the center, patient satisfaction, achievement of project objectives, and development of a process for hearing and resolving patient grievances.

Relative to the governance authorities required of the health center board as described in (a) through (g) above, we do not require that all authorities be exercised solely by the co-applicant board. It is acceptable for the public entity to share in the exercise of authorities. For example, section 330 requires that the governing board retain the authority for approval of the annual budget but does not preclude arrangements in which active, joint decision-making precedes that approval or in which the public entity also approves the budget. The same approach can apply to the selection of the Executive Director. Other decisions regarding how the authorities may be

shared are a matter of choice. On the other hand, a pure “consensus” approach, without the subsequent required approval by the health center board, would not be acceptable. It also would not be acceptable for the public entity to require an Executive Director to be retained whom the health center board voted to dismiss.

2. Optional Policy Setting Authorities of the Public Entity

Section 330 established that the public entity may retain general policy setting authority. The BPHC recognizes that many public entities are required by law to retain final authority for certain types of activities. No justification is required for arrangements in which the public entity retains authority for the following:

- a. To establish personnel policies and procedures, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal employment opportunity practices; and
- b. To develop management and control systems that are in accordance with sound financial management procedures, including: the provision for an audit on an annual basis to determine, at a minimum, the fiscal integrity of financial transactions and reports and compliance with the terms and conditions of FQHC Look-Alike designation; approval of the annual center budget; establishment of systems for eligibility determination, billing and collection, including partial payment schedules; making other reasonable efforts to collect for costs in providing health services to persons eligible for Federal, State, or local public assistance; and, long range financial planning.

For other decision-making which is to be exercised by the public entity to the exclusion of the co-applicant’s governing board, BPHC requires the submission of explanatory documentation as to the legal basis for the exclusion of the governing board.

3. Agreement Between Public Entity and Co-Applicant

The BPHC requires public entities and their co-applicants to execute, and present for BPHC review and approval, an agreement which describes the delegation of authority and defines each party’s role, responsibilities, and authorities. Such agreements must assure that the relationship is structured in compliance with section 330 of the Public Health Service Act, implementing regulations, and PIN 1997-27, Affiliation Agreements of Community and Migrant Health Centers, and subsequent clarifications.

III. BPHC REVIEW

The HRSA process for reviewing applications for public FQHC Look-Alike designations will continue to be overseen by Headquarters staff in the BPHC, Office of Policy and Program Development.

Public entities that are currently designated as FQHC Look-Alikes and are determined not to meet the requirements of this PIN will have up to 1 year from date of notification of noncompliance to satisfactorily address areas of concern.

Guidance is available to currently designated public FQHCs, or public entities seeking designation, through the appropriate HRSA Field Office (see attached list to this PIN). Questions concerning this PIN should be directed to the Office of Policy and Program Development at (301) 594-4300.

APPENDIX A

HRSA FIELD OFFICES

HRSA NORTHEAST CLUSTER

Boston Field Office

Bruce Riegel, Director
Division of Health Services
DHHS - Field Office I
JFK Federal Building, Rm. 1826
Boston, MA 02203
(617) 565-1482

HRSA NORTHEAST CLUSTER

New York Field Office

Bruce Riegel, Director
Division of Health Services
DHHS - Field Office II
26 Federal Plaza, Rm. 3337
New York, NY 10278
(212) 264-2664

HRSA NORTHEAST CLUSTER

Philadelphia Field Office

Bruce Riegel, Director
Division of Health Services
DHHS - Field Office III
Public Ledger Building
2150 S. Independence Mall West, Suite 1172
Philadelphia, PA 19106-3499
(215) 861-4419

HRSA SOUTHEAST CLUSTER

Atlanta Field Office

Robert Jackson, Acting Director
Division of Health Services
HRSA Southeast Field Office
Atlanta Federal Center
61 Forsyth Street, S.W., Suite 3M60
Atlanta, GA 30303-8909
(404) 562-2996

HRSA MIDWEST CLUSTER

Chicago Field Office

Stephen Enders, DDS, Director
Division of Health Services
DHHS - Field Office V
105 West Adams Street, 17th Floor
Chicago, IL 60603
(312) 353-1658

HRSA WEST CENTRAL CLUSTER
Dallas Field Office

Jay McGath, Acting Director
Division of Health Services
DHHS - Field Office VI
1301 Young Street, 10th Floor, HRSA-1
Dallas, TX 75202
(214) 676-3872

HRSA MIDWEST CLUSTER
Kansas City Field Office

Stephen Enders, DDS, Director
Division of Health Services
DHHS - Field Office VII
Federal Office Building
601 East 12th Street, Rm. 501, FOB
Kansas City, MO 64106
(816) 426-5226

HRSA WEST CENTRAL CLUSTER
Denver Field Office

Jerry Wheeler, Acting Director
Division of Health Services
DHHS - Field Office VIII
Federal Office Building
1906 Stout Street, Rm. 498, FOB
Denver, CO 80294
(303) 844-3204, ext. 205

HRSA PACIFIC WEST CLUSTER
San Francisco Field Office

Antonio Duran, Director
Division of Health Services
DHHS - Field Office IX
50 United Nations Plaza
San Francisco, CA 94102
(415) 437-8090

HRSA PACIFIC WEST CLUSTER
Seattle Field Office

Antonio Duran, Director
Division of Health Services
DHHS - Field Office X
Blanchard Plaza
2201 Sixth Avenue, Rm. 700,
MS RX-23
Seattle, WA 98121
(206) 615-2491