

A Policy History of the Community Health Centers Program: 1965-2012

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Johnson's War on Poverty and the Birth of Community Health Centers

Following his landslide presidential victory in the 1964 presidential election, Lyndon Johnson saw the opportunity to implement policy to attack poverty in the United States. The passage of the Economic Opportunity Act later in 1964 established the Community Action Program (CAP) as part of the new Office of Economic Opportunity (OEO). The OEO was housed in the Executive Office of the President in order to cut down on the bureaucracy that might impede innovation. The mission of the OEO and CAP did not initially include health care. However, as other programs, like Head Start, were implemented, staff discovered that lack of access to health care was a major issue for the poor (Mickey 2012).

The idea for Community Health Centers (CHCs), originally called Neighborhood Health Centers (NHCs), was brought to the OEO by Dr. Jack Geiger and Dr. Count Gibson, Jr. in early 1965. Their model was based on the rural South African "community-oriented primary care" program that Geiger helped develop (Hall & Rosenbaum, 2012). In June, 1965, the first neighborhood health centers were funded in Boston and rural Mississippi. In 1966, an additional 6 centers were funded through the Research and Demonstration Office of CAP. The centers were designed to provide comprehensive health care, as well as training and employment services for local residents and consumers of the centers' services. One of the goals of these first centers was consumer involvement. This was encouraged through OEO guidelines that one-half of advisory council or one-third of board members be users of their services or neighborhood residents.

Centers were located in areas with high concentrations of poverty. Consequently, OEO officials assumed that approximately 80 percent of residents would be below the poverty line. Access to services would be based on residence in the neighborhood alone and not otherwise means tested. However, that number turned out to be between 40 and 60 percent for most areas (Zwick 1972). But officials also noticed that residents who were over the poverty line were often not able to afford the full cost of health services. This led to a commonly used (though not legislated) system of sliding-scale, income-based fees.

In 1966 the Comprehensive Health Planning and Public Health Services Act (PL 89-749) authorized funding for regional and state health services. Section 314(e) provide for project grants to develop new types of health service projects which included NHCs. Even though NHCs received most of their funding during the 1960s through the OEO, this Act enabled funding through the Public Health Service in the Department of Health, Education and Welfare (DHEW). The Office of Comprehensive Health Services was also established in CAP to administer NHC grants in late 1966. Senator Edward Kennedy sponsored an amendment to the Economic Opportunity Act that appropriated \$50M to NHCs. By the end of 1971, the federal government had funded over 100 centers (Sardell 1988).

The early NHCs received large grants from the OEO, but their intention was eventually to become financially self-sufficient. The hope was that they would be able to do this by billing Medicare and Medicaid for the services they provided to their patients who were covered by these programs. However, many of the services they offered were not eligible for reimbursement and by "the early 1970s Medicaid

and Medicare constituted less than 20 percent of operating revenues (Mickey 2012).” This problem would continue to plague the program until the mid-1990s.

The Nixon Administration and Decentralization

When Richard Nixon took office in 1969, the federal attitude towards NHCs shifted dramatically. Nixon believed that the central government should not be as involved in providing health services and that the costs of health care should be reduced by private market reforms. Nixon began the dismantling of the Office of Economic Opportunity (this was completed later under the Ford administration), and by fiscal year 1974 all health centers had been transferred to the newly created Bureau of Community Health Services in the Public Health Service’s Health Services Administration under DHEW (Sardell 1988). Grants were awarded through regional DHEW officials rather than through the central office.

Between 1971 and 1973, no new health centers were funded by DHEW and in 1972 they announced that they would phase out funding for NHCs. Nixon also pushed the DHEW to require that NHCs be funded primarily through sources other than federal grants. At this point, Medicare and Medicaid reimbursements were still insufficient to cover the centers’ costs. Moreover, many poor patients were not covered by these programs.

In response to Nixon’s changes, Senator Edward Kennedy (D-Mass), chair of the Senate Health Subcommittee, and Senator Jacob K. Javits (R-NY), a senior member of the subcommittee, commissioned a GAO study to determine the impact of defunding NHCs. The 1973 report published by the GAO stated that self-sufficiency was unlikely and services would need to be cut to meet the requirement. Upset that this policy change could mean an eventual end to the program, Congressman Paul Rogers (D-Fla), chair of the House Health Subcommittee, led a series of meetings with key DHEW officials and members of Congress to resolve the situation. In the end, DHEW agreed to continue funding the centers if they made efforts to become more financially sustainable.

Throughout Nixon’s time in office Congress continued to resist his efforts to eliminate funding for NHCs. In 1973, Congress passed legislation by a wide margin that extended funding for a year for six major health programs, including NHCs. The next year they wrote new legislation that defined “community health centers” and authorized funding for them. Nixon vetoed the legislation but Congress brought similar legislation back again under the Ford administration, and it passed in 1975.

Another development in health policy that impacted NHCs was the passage of the Health Maintenance Organization (HMO) Act in December, 1973. In order for an area to qualify for an HMO, the Department of Health, Education and Welfare had to identify it as “medically underserved.” The Index of Medical Underservice was developed by DHEW and the University of Wisconsin to identify these areas. This measure of medical underservice was later used to identify areas that qualified for neighborhood health center funding (as well as other programs?).

Advocacy and Support for Neighborhood Health Centers

In the early 1970s organizations began forming to advocate for and support the development of NHCs. The traditional medical community and the American Medical Association were ambivalent about NHCs initially, sometimes supporting and other times opposing them. In the midst of a hostile political climate and a lack of strong support from the medical community, groups of NHCs in New York and Boston

began working together to share resources and influence national policy. As the OEO was dismantled, these associations actually received funding from DHEW to provide training to board members of NHCs in their regions. A national association, the National Association of Neighborhood Health Centers, was formed in 1970 to provide training and support more broadly. However, in the early 1970s the New York Association of Neighborhood Health Centers and the Massachusetts League of Neighborhood Health Centers were more active in providing information to Congress (Sardell 1988).

The Ford Administration, Formalization and the Rural Health Initiative

Policies governing NHCs did not change much under the Ford administration. Ford repeatedly requested less funding than Congress allocated in the federal budget for health centers. Despite opposition from the Ford administration, NHC proponents achieved an important victory in solidifying the program. In 1975, the Special Health Revenue Sharing Act (PL 94-63), an amendment to the Public Health Services Act, formalized the NHC program. The new Section 330 replaced the former 314(e). The legislation renamed NHCs “Community Health Centers (CHCs)”, included a requirement that they serve medically underserved areas, specified what services should be offered, and required that a majority of members of the governance board be consumers of the centers’ services. The act identified primary, or required, and supplemental, or optional, services that CHCs should provide. This ensured that future administrations could not reduce the services funded but it shifted the focus to more traditional medical services and away from some of the community health services that centers were designed to provide.

The administration encouraged the Public Health Service to focus on creating efficiency and reducing the duplication of services. The National Health Planning and Resources Development Act of 1974 (PL 93-641) split states into Health Service Areas with a single organization, either a government or non-profit, identified to coordinate health services delivered by other government, non-profit, and for-profit providers (Rubel 1976).

Under the Ford administration the focus and funding of health initiatives, like CHCs, shifted to rural programs rather than urban ones. One way that the Bureau of Community Health Services was able to increase efficiency was by coordinating the rural CHC program with the National Health Service Corps to ensure medical providers were available in underserved rural areas. One of the effects of the shift to a rural focus was that grants were awarded based more on measures of need rather than on the strength of the proposal. Urban areas often had an advantage over rural areas because of the infrastructure and expertise of non-profit organizations and government offices located there, so the Ford administration’s policy made an explicit push to help rural areas set up CHCs.

The Carter Administration and Hospital-affiliated Primary Health Centers

The Community Health Center program was more in line with the Carter administration’s philosophy than either the Nixon or Ford administrations. However, CHC policy remained much the same. The administration encouraged coordination of federal health resources and existing providers and expressed a continued desire for financial self-sufficiency. Although funding for CHCs increased significantly under the Carter administration, no new centers were funded in 1979 and only 10 were funded in 1980 (Sardell 1988). The Rural Health Initiative continued but the focus shifted back to urban CHCs. In 1977, the ability of rural health centers to be self-sustaining was improved by the Rural Health Services Act (Public Law 95-210) which increased Medicare and Medicaid reimbursements and allowed payments for services

by non-physician providers (Lefkowitz 2007).

During the Carter administration Congress and the National Association of Community Health Centers expressed concern that new CHCs did not provide comprehensive health services as they were intended.¹ Even though it had the support of the Carter administration, the CHC program had drifted from the OEO's original vision. The CHCs were intended to be new community resources that created change in the existing system and provided comprehensive community health services. By the late 1970s, however, they had come to be associated with more traditional health care.

In 1978, Senator Javits (R-NY), an early supporter of NHCs, drafted a bill that would allow separate authorization for hospitals to receive CHC funding to provide primary care. Hospitals were not eligible for funding under current legislation because of the requirement that a majority of their board members be consumers of CHC services. The bill became part of an amendment to the Public Health Services Act (P.L. 95-626) and was enacted as a demonstration project to be reviewed in three years. The first centers under this legislation were developed in fiscal year 1980 (Sardell 1988).

In 1980, the Department of Education was created as an office separate from the Department of Health, Education and Welfare. DHEW was renamed the Department of Health and Human Services (HHS) and the Public Health Service remained under this department.

The Reagan Administration and Block Grants

The Reagan administration returned to an antagonistic relationship with the CHC program. Reagan wanted to eliminate all categorical health services grants and create 5 block grants. The CHC program became part of a primary care block grant through the 1981 Omnibus Budget Reconciliation Act. However, the only other program funded through this block grant was Primary Care Research and Development which was related to CHCs. The guidelines for how states could use the primary care block grant funding were so restrictive that it was essentially still a categorical grant for CHCs (Kee and Ladenheim 1995). According to the legislation the program would remain federally administered until 1983. At this point the states had to apply to take over administration of their health centers and receive the block grant. If they did not apply, the centers remained under federal administration. If they did apply, they were required to "fund each health center that received a federal grant in fiscal year 1982 at the same grant level, match a proportion of federal funds, and meet other previously established program requirements, including the requirements that every center provide primary care services and have a consumer-dominated governing board (Sardell 1988)." Instead of encouraging states to take over administration of CHCs, this legislation created a strong disincentive. West Virginia was the only state that applied and chose not to reapply after only one year (Sardell 1988).

In 1982, the Bureau of Community Health Services became the Bureau of Health Care Delivery and Assistance after the Health Services Administration and Health Resources Administration combined into the Health Resources and Services Administration. Budget appropriations for health services were driven by the White House and OMB rather than HHS (Sardell 1988).

¹ The National Association of Neighborhood Health Centers was renamed the National Association of Community Health Centers after the name change at the federal level.

From 1984 to 1986 Congress continually rejected a health center block grant that would be administered by the states and the CHC program remained federally funded. Finally, because of overwhelming Congressional support, Reagan signed the Health Services Amendment Act of 1986 that repealed the primary care block grant and authorized funding for CHCs as categorical grants through FY 1988. The legislation, Public Law 99-280, increased state involvement in the program. The Secretary of Health and Human Services was required to inform state stakeholders if a medical underservice status changed in the state and was allowed to enter into memorandum of agreement with state governments. This allowed states to participate in identifying their need for health services for underserved populations, planning and developing new centers, evaluating existing centers, and offering administrative assistance (The Library of Congress n.d.).

The George H.W. Bush Administration and Federally Qualified Health Centers

The George H.W. Bush Administration did not share Reagan's attitudes toward CHCs and he increased funding for CHCs every year of his term except 1991. In 1992, the Bureau of Health Care Delivery and Assistance was renamed the Bureau of Primary Health Care. The health centers program remained a part of this bureau.

The most significant change for CHCs during this time was to their reimbursement structure. In 1989 and 1990, Congress developed an official Medicare and Medicaid reimbursement category called "Federally Qualified Health Centers" through Section 4161 of the Omnibus Budget Reconciliation Act of 1990 that amended the Social Security Act. This designation was applied to all CHCs that met the legal requirements and received grant money from the federal government². Centers that met the legal qualifications but did not receive grant funding under Section 330 of the Public Health Services Act were termed "look-alikes" and could receive the same reimbursements. By 1996, federal grants were a smaller proportion of CHC revenues than Medicaid reimbursements (Mickey 2012).

The Clinton Administration and the Push for Expanded Insurance Coverage

Despite the Clinton administration's focus on increasing access to health care, it was surprisingly unsupportive of CHCs. Clinton repeatedly requested less funding for CHCs than Congress appropriated for the program. HHS Secretary Donna Shalala wanted health centers be more connected to hospitals. Opponents feared this would reduce the input of the patients they served and take the focus away from the supplementary services that they provided (Mickey 2012). In a memo to President Clinton she also identified the priority of the administration's health care policy as expanding insurance coverage and access to health care for children rather than the broader population of poor and uninsured (Shalala 1996).

There may have been a number of political forces shaping the Clinton administration's choices. Most of Clinton's health care reforms, which failed to pass, focused on expanding coverage for all Americans, not just the poor. The administration may have shied away from discussing programs for the poor in order to keep the focus on a broader goal. There was also a concern from supporters of universal health coverage, including Senator Kennedy, that increased conservative support of CHCs was a strategic move to draw

² The legal requirements are defined in Section 330 of the Public Health Service Act (42 U.S.C. §254b). These include requirements that centers serve areas that demonstrate a need based on a measure of medical underservice, provide a set of required services, meet the management and finance requirements and that the governance include a majority of members who are served by the center (Health Resources and Services Administration n.d.). See Appendix A for full requirements.

the focus away from a greater need for health insurance coverage. Whatever the reasons, the Clinton administration left the CHC program relatively unchanged.

The one significant change during this time was the 1996 Health Centers Consolidation Act (P.L. 104-299). This act was a reauthorization of funding through 2001 for community, migrant, homeless and public housing health centers (Health Centers Consolidation Act of 1996, Pub. L. No. 104-99, § 2, 110 Stat. 3626 (1996) 1996). Homeless and public housing centers were previously funded through separate legislation. After 1996, all centers were funded through Section 330 of the Public Health Service Act.

The George W. Bush Administration and the Health Centers Initiative

The George W. Bush administration was also a champion of the CHC program. Bush's support of CHCs was a strong departure from the policies of previous Republican Presidents Nixon, Ford and Reagan. It was also a new focus for Bush when he campaigned for the presidency in 2000, as health care policy had not been an important component of his platform as Texas governor. Advised by Karl Rove, Mickey (2012) views the Bush administration's support of health centers as a likely political move to draw white female, Catholic, Hispanic and African American voters who were concerned about the Republican Party being uncaring. The health centers program was a relatively inexpensive way to do this compared to other social and health programs (Mickey 2012).

The health centers program remained a key part of President Bush's platform throughout his presidency. As part of the "compassionate conservatism" philosophy, the Bush administration doubled federal grant funding for CHCs. In his first budget message, Bush called for creating or expanding over 1200 centers and increasing health care access to 6.1 million patients. The goal of increasing access by 6.1 million was achieved ahead of schedule. In his 2005 State of the Union address, he again called for the development of more centers, proposing that there be a center in every poor county (Lefkowitz 2007). Funding for the program was protected and increased despite other cuts to discretionary programs and the financial demands of Hurricane Katrina clean-up and the wars in Afghanistan and Iraq.

In 2002, the Health Care Safety Net Amendments (P.L. 107-251) reauthorized and increased the levels of funding for the CHC program through 2006. In 2008, President Bush signed the Health Care Safety Net Act of 2008 (P.L. 110-355) which increased funding and reauthorized the program for four more years. The 2009 American Relief and Recovery Act also appropriated over \$2 billion for expanding centers and upgrading their technology (Rosenbaum 2012).

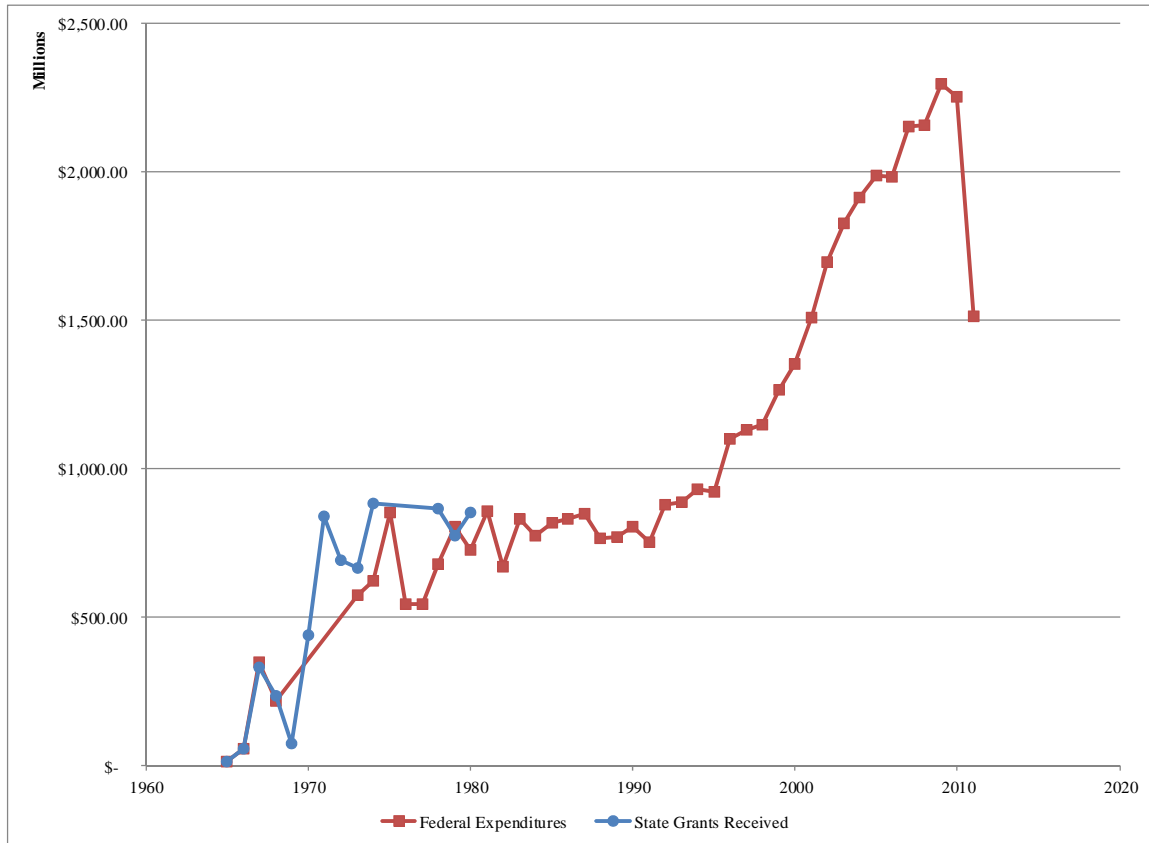
The Obama Administration and the Affordable Care Act

As part of health care reform, President Obama has continued support for the CHC program. Today it is still administered by HHS's Health Resources and Services Administration's Bureau of Primary Health Care.

The 2010 Patient Protection and Affordable Care Act (ACA) permanently authorized the CHC program and specifically appropriated \$11 billion in new funding through 2015. The goal is to double the number of patients receiving care through primary health centers from 20 to 40 million by that date. Under the ACA, all families with incomes below 133 percent of the federal poverty level will be eligible for Medicaid. Those that are above this income level but are still low-income will be eligible for insurance exchange subsidies. This will increase the number of insured health center patients significantly and have

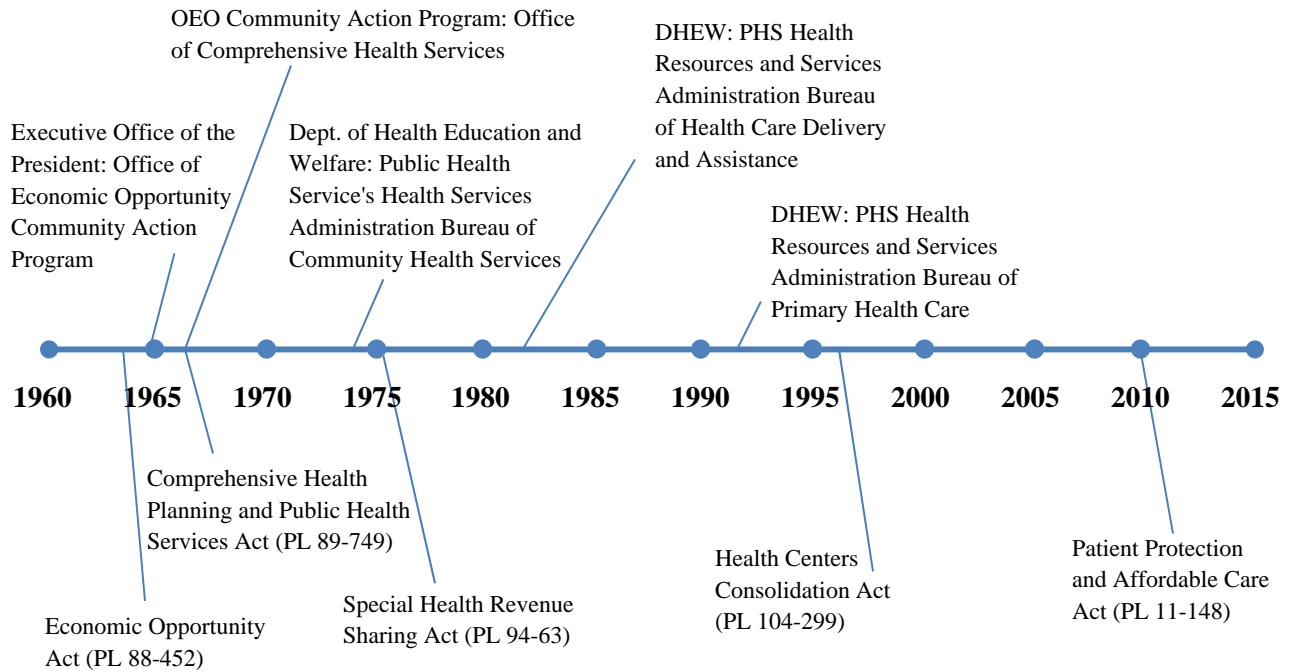
a positive impact on center budgets. Health plans that participate in the exchanges are required to reimburse CHC costs using the Medicaid Federally-Qualified Health Center rates. The ACA also increases Medicare payment rates to CHCs (Rosenbaum 2012).

Figure 1. Community Health Center Funding: Federal Expenditures v. Total Grants Received by States, 1965-2011 (in 2012 dollars)



Notes: Federal expenditure data are expenditures for the CHC/NHC program line-itemed in the federal budget. Actual expenditures were reported in the budget two years following. State grant data is project grants awarded to states under Section 314(e) of the Public Health Services Act. Differences between federal expenditures and state grants received may be due to double-counting of centers or for funding spread over multiple years that is reported in one year only. Source: Budget of the United States Government and U.S. Dept. of Health, Education and Welfare.

Figure 2: Community Health Centers Department and Legislative Changes



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Appendix A

Health Center Program Requirements (Health Resources and Services Administration n.d.)

NEED

1. Needs Assessment: Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)

SERVICES

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

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

3. Staffing Requirement: Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed, and privileged. Section 330(a)(1), (b)(1)- (2), (k)(3)(C), and (k)(3)(I) of the PHS Act)
4. Accessible Hours of Operation/Locations: Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)
5. After Hours Coverage: Health center provides professional coverage for medical emergencies during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4))
6. Hospital Admitting Privileges and Continuum of Care: Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)
7. Sliding Fee Discounts: Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay.
 - o This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.*
 - o No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines.*

- No patient will be denied health care services due to an individual's inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived.
(Section 330(k)(3)(G) of the PHS Act, 42 CFR Part 51c.303(f)), and 42 CFR Part 51c.303(u))
8. Quality Improvement/Assurance Plan: Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include:
- a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;*
 - periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall: *
 - be conducted by physicians or by other licensed health professionals under the supervision of physicians;*
 - be based on the systematic collection and evaluation of patient records;* and
 - identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated*
(Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2))

MANAGEMENT AND FINANCE

9. Key Management Staff: 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/Executive Director/CEO position is required. (Section 330(k)(3)(I) of the PHS Act, 42 CFR Part 51c.303(p) and 45 CFR Part 74.25(c)(2),(3))
10. Contractual/Affiliation Agreements: Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements. (Section 330(k)(3)(I)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a) (2))
11. Collaborative Relationships: Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (section 330 grantees and Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. (Section 330(k)(3)(B) of the PHS Act and 42 CFR Part 51c.303(n))
12. Financial Management and Control Policies: Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26)

13. Billing and Collections: Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)
14. Budget: Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. (Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25)
15. Program Data Reporting Systems: Health center has systems which accurately collect and organize data for program reporting and which support management decision making. (Section 330(k)(3)(I)(ii) of the PHS Act)
16. Scope of Project: Health center maintains its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards. (45 CFR Part 74.25)

GOVERNANCE

17. Board Authority: Health center governing board maintains appropriate authority to oversee the operations of the center, including:
 - o holding monthly meetings;
 - o approval of the health center grant application and budget;
 - o selection/dismissal and performance evaluation of the health center CEO;
 - o selection of services to be provided and the health center hours of operations;
 - o measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and
 - o establishment of general policies for the health center.
(Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)

Note: In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center. (Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv))

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

18. Board Composition: The health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically:
 - o Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.*
 - o The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs,

trade unions, and other commercial and industrial concerns, or social service agencies within the community.*

- No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.*

Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p).

(Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)

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

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

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