



To: Health Center Partners CEOs
From: Vernita Todd, SVP External Affairs
CC: Henry N. Tuttle, CEO
Date: 3/22/2018

Bureau of Primary Health Care Regulatory Update

Community Health Centers heard updates from both the Associate Administrator, Jim Macrae, and Deputy Associate Administrator, Tonya Bowers from HRSA's Bureau of Primary Health Care. They addressed the new funding in the 8th Balanced Budget Act (BBA) of 2018; and the changes that were made to the 330 statute that governs the FQHC program. See the [Administrator's full slides](#). Below is a brief summary of pertinent changes.

Funding

CHC mandatory funding was granted for two fiscal years. Since the decision was made nearly half-way into FY18, the funding is really only good for 22 months. CHC grants are authorized to go along with the government's fiscal year, but the *actual* funding follows a calendar year. This means that **Community Health Centers currently funded through the 330 program will have mandatory funds through December 31, 2019. It's important to note that the "Funding Cliff" will be triggered again at the end of the FY19 year - which is September 30, 2019.**

The mandatory funding was, by far, the heaviest lift when considering CHC funding. But, Community Health Centers must also encourage Congress to make the program funding whole on the discretionary side (\$1.5B) when they address the upcoming Continuing Resolution - set to expire on March 23, 2018. **Because of this delay, BPHC is only giving month-to-month Notice of Awards through June 2018.**

- FY18: BBA included an additional \$200M for Community Health Centers
It is not likely that NAP applications will be opened for these limited dollars; keep a close eye out for capital improvement opportunities or additional supplemental funding grants to address opioids
- FY19: BBA included an additional \$400M for Community Health Centers
BPHC has not decided how these funds will be distributed, but will try to match the Administration's priorities
- \$400M will be carved out for Community Health Centers
The President has carved out \$400M for Community Health Centers to address opioids in his latest budget. Congress has not yet indicated their expectation for these funds, but it will happen quickly as awards will be granted by September 30th.

330 CHANGES

This [one-page summary](#) has been created by NACHC to highlight changes to statute for Community Health Centers. As we continue to learn more about how these changes impact health center, this summary will be updated.

- **HRSA requirements**

HRSA is no longer permitted to fund Community Health Centers who are out of compliance for more than 2 years. Historically, a CHC with “grant conditions” have been eligible for funding for a period of up to 4 years. Congress has indicated that this is no longer acceptable and will only allow HRSA funding for **2 years** to a CHC deemed out of compliance. This has triggered the “One, One & Done” (1,1,D) rule, which is really concerning for Community Health Centers.

The good news is this rule ONLY applies to unresolved grant conditions at the time of a SAC application, or the end of the one-year project period. The corrective action (30/60/90) period still applies, and if a CHC has the condition lifted prior to the SAC or end of project period, the new (1,1,D) rule is not triggered. With proper due diligence and use of the newly released compliance manual, Community Health Centers can adequately prepare for site visits. If any conditions are placed on the grant, it will be critical to have them resolved within the defined corrective action period, to avoid this penalty.

Start Practicing Now! Resources can be found in the links below:

[OSV Support Documents](#)

[Health Center Staff Documents Checklist](#)

[OSV Tracking Resource](#)

[Health Center Compliance Manual](#)

[Compliance Manual FAQs](#)

[Progressive Action Conditions Library](#)

*Note: The HCP/HQP Network grant is also subject to an Operational Site Visit.

Review the [requirements for the Network here](#).

- **Community Health Center requirements**

1. Community Health Centers must directly employ their CEO, no contracting
2. Policies and Procedures must be in place that ensure proper use of federal funds. This is critically important regarding issues of Women’s Health and Medical Marijuana.
Templates and draft policies will be made available in the coming months.

- **Clarification on New Access Points (NAP) & Expanded Services (ES)**

Language was clarified to grant HRSA permission to award NAP and ES awards, with a focus on providing grants to the areas of highest need – while being cognizant of service area overlap and encouraging collaboration around New Access Points.

- **NIH Precision Medicine Initiative**

\$25M included in FY18 budget to allow Community Health Centers to participate in the NIH Initiative.

Quality Focus

The HRSA focus on quality puts the spotlight squarely on the Diabetes clinical measurement. Roughly 12% of health center patients used the emergency department or were hospitalized due to their diabetes. *Studies show that ambulatory costs for health center patients with diabetes is nearly \$1,700 less than in private practices.* If the health center program could make collective gains with patients with uncontrolled diabetes (lowering by 1.25%), **the system would save \$3B over a three-year period!**

To that end, HRSA specific goals for Diabetes measure:

1. Increase the percentages of children and adults who receive weight screenings & counseling
2. Reduce the proportion of persons with diabetes with an HbA1c value greater than 9 percent
3. Increase the proportion of Community Health Centers that meet the Healthy People 2020 goal for uncontrolled diabetes for each racial/ethnic group

UDS

For the past several years, BPHC has been trying to prepare Community Health Centers for a “new and improved” UDS system. This UDS modernization project will create a streamlined process to submit and modernize data with the goal of providing insight into the care CHCs are providing.

- The *process* goals are to automate data transmission to decrease reporting burdens on CHCs, and to promote transparency.
- The *content* goal is geared toward generating a more robust data set which filters down to the granular levels of our populations to get relevant information that will allow CHCs to achieve better health outcomes.

In short, while we have been collecting data, it may not have been valid, and we may not have been asking the right questions. In addition to getting stronger with the types of questions asked, BPHC hopes to make the transfer of information easier. Stay tuned!

One-time Funding

BPHC plans to make one-time awards related to improving the quality of care, primarily in the area of chronic conditions, workforce, care coordination, technology, and work with emerging public health emergencies (Zika, Opioids, etc.) Community Health Centers will be used as models for addressing these issues and must be able to sustain the effort beyond the first year with **no additional dollars. Think innovation! How could you make a difference?**

Grants will be announced in the BPHC Digest. You can even set up alerts for a particular type of grant funding. [Subscribe Here](#) and share with your team so you can all be in the know!

Other HRSA News

- Updated geographic and populations Health Professions Shortage Areas (HPSA) were released in November.
- Auto HPSAs will release before the NACHC CHI conference in August.
The following two issues were resolved in our favor:
 1. Community Health Centers can use UDS data when submitting for HPSA scores.
 2. Community Health Centers can be scored at the organizational level, not the site level.
- Auto HPSA goes into effect on **July 1, 2019**.

Additional information will follow on federal and state legislative priorities, along with a summary of congressional visits, in our monthly Policy Blast.

In service,



SVP, External Affairs
March 22, 2018