The National Association of Community Health Centers, Inc.®

ISSUE BRIEF

Reauthorization Series #1

HEALTH CENTERS CONSOLIDATION ACT OF 1996

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for more information, please contact

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National Association of
Community Health Centers, Inc.

January 14, 1997

Dear Health Centers:

Enclosed please find a summary of the major changes in the reauthorizing legislation for health center programs, as contained in the Health Centers Consolidation Act of 1996 which was signed into law on October 11, 1996. The new law consolidates and streamlines four separate authorities into one piece of legislation. The new statutory references - which we all will need to become accustomed to - for unique aspects of these separate programs now are:

Migrant Health - PHS Act Section 330(g)
Health Care for the Homeless - PHS Act Section 330(h)
Health Servs/Resident in Public Housing - PHS Act Section 330(i)
Community Health - PHS Act Section 330 (provisions throughout)

Additionally, the new law combines two former demonstration programs - Rural Health Outreach and Rural Telemedicine - and authorizes them under Section 330A.

Policy and guidance regarding implementation of some of the changes contained in the new law -- such as the loan guarantee authority, the construction limitation, and the budgetary and other changes affecting homeless health programs -- are still in the process of development. As further guidance is developed, future issue briefs will be disseminated in the Reauthorization Series to keep health centers up to date.

If you have any questions about the implications of the Health Centers Consolidation Act of 1996 for your center, please feel free to call Freda Mitchem, NACHC's® Director of Systems Development, on extension 133.

Sincerely,

Tom VanCoverden

Tom Van Coverden
President and CEO

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Issue Brief – Reauthorization Series #1 – Health Centers Consolidation Act of 1996

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I. Overview

President Clinton signed the Health Centers Consolidation Act of 1996 (P.L. 104-299) on October 11, 1996. Under the new law, the four Federal health center programs formerly authorized under Sections 329, 330, 340 and 340A of the Public Health Service Act are consolidated, streamlined, and reauthorized under Section 330 of the Public Health Service Act, as amended. The consolidation of the four health center programs provides some distinct advantages to health centers. In particular, the new law establishes a single set of application and reporting requirements; authorizes planning grant assistance and loan guarantees to health centers that seek to develop and participate in managed care networks and plans; and, eases restrictions on centers' expenditure of nongrant funds. The new law is applicable to grant awards issued on or after October 1, 1996.

Key changes in the new law are identified and discussed in this issue brief. The Bureau of Primary Health Care within the U.S. Department of Health and Human Services ("the Bureau"), is expected to issue guidance as to the interpretation and implementation of the new law. NACHC will publish updates as such guidance becomes available.

II. New Legal Authority for Various Health Center Programs

The four health center programs are incorporated into the new law as follows: the migrant health centers program, formerly Section 329 of the Public Health Service Act (codified at 42 U.S.C. Section 254b), is authorized in Section 330(g) of the new law; the health care for the homeless program, formerly Section 340 of the Public Health Service Act (codified at 42 U.S.C. Section 256), is authorized in Section 330(h) of the new law; the health services for residents of public housing program, formerly Section 340A of the Public Health Service Act (codified at 42 U.S.C. Section 256a), is authorized in Section 330(i) of the new law; and, the community health center program formerly Section 330 of the Public Health Service Act (codified at 42 U.S.C. Section 254c), generally authorized throughout the new Section 330.

III. Definition of Services

A. Primary Health Services

The old and new laws both use the term "primary health services" to describe those services which a funded health center is required to provide. The definition of the services that are considered to be required primary health services has been expanded under the new law. See Comparison Chart, attached. It should be noted that health care for the homeless programs continue to be required to provide substance abuse services in addition to required primary care services. The array of "preventive health services" that are included as required primary health services has been expanded under the new law. Compare Section 330(b)(1)(C) with Section 330(b)(1)(A)(i)(III), as amended. Under the new law, the following preventive health services have been added to the list of required primary health services: prenatal services; screening for

breast and cervical cancer; immunizations against vaccine preventable diseases; and, screening for elevated blood lead levels, communicable diseases, and cholesterol.

Additionally, the list of required primary health services in the new law includes several services that were not included in the list of primary health services under the old law. However, these services, in large part, were included in the definition of "community health center" (see old Section 330(a)). Consequently, these services were generally viewed as required services for Section 330 grantees even though they were not included in the definition of "primary health services" under the old law.

Health centers should note, however, that the new law expands the scope of services included in the definition of "community health center" under the old law. The key changes are as follows:

- health centers are now required to provide referrals for substance abuse and mental health services (see Section 330(b)(1)(A)(ii), as amended);

- health centers are now required to provide services "designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, educational or other related services" (see Section 330(b)(1)(A)(iii), as amended).

This latter provision authorizes health centers to use grant funds, for example, to employ or otherwise support the efforts of outstationed Medicaid eligibility workers.

It should be noted that under Section 340, health care for the homeless programs were authorized to provide mental health services either directly or by referral. The new Section 330 requirement that health centers provide referrals for mental health services does not prohibit grantees under new Section 330(h), authorizing health care for the homeless programs, from directly providing mental health services as an "additional health service" (see below).

The new law specifically provides that health centers that receive grants only under the migrant health center program (Section 330(g), as amended) may be granted a waiver allowing them to forego provision of some required primary health services (see Section 330(b)(1)(B)(i), as amended), and allowing them to provide certain required primary health services only during certain periods of the year (see Section 330(b)(1)(B)(ii), as amended).

Additionally, special consideration is to be accorded to the unique needs of sparsely populated rural areas in the granting of waivers under this section. See Section 330(p), as amended.

B. Additional Health Services

The old law used the term "supplemental health services" to describe those non-required health services which might appropriately be provided by particular centers. See old Section 330(a)(2). The definition of supplemental health services under the old law included a list of many specific services and a catch-all provision including "other services appropriate to meet the needs" of the population served. See old Section 330(b)(2)(A) through (M).

In contrast, the new law uses the term "additional health services" to describe non-required health services. While the new law presents only a few specific examples of services which may be considered to be "additional health services" (i.e. environmental health services and special occupation-related health services for migrant workers), it states that any other services "that are appropriate to meet the health needs of the population served by the health center involved" may be considered to be "additional health services." See Section 330(b)(2), as amended. Thus, the fact that a service is not specifically listed in the new law does not prevent a center from providing that service if the service is appropriate to the population the center serves.

It should be noted, for example, that under Section 340, health care for the homeless program grantees were explicitly authorized to provide podiatry, vision, and dental services at their option. Under the new law these services could be provided to the homeless population as "additional health services."

IV. Changes to Provisions Governing Expenditure of Funds

The new law restricts the purposes for which some types of grant funds have traditionally been allowed to be expended but removes certain restrictions on the expenditure of nongrant funds.

A. New Restriction on Expenditure of Grant Funds

The new law terminates, with one exception, all authority for health centers to expend grant funds on the construction of new buildings and the expansion or modernization of existing buildings. See e.g. old Section 330(d)(2). With regard to buildings, the new law authorizes the expenditure of grant funds only on "acquiring and leasing buildings and equipment." See e.g. Section 330(c)(1)(A), as amended. An exception is carved out for recipients of operating grants, who are authorized to spend funds on "construction" (i.e. the costs associated with expanding and modernizing existing buildings and constructing new buildings) if their construction project was approved prior to October 1, 1996. See Section 330(e)(3), as amended.

B. Removal of Restrictions on Use of Nongrant Funds

The new law provides grantees significant new latitude in expending nongrant funds. Under the old law, most of the restrictions and requirements that apply to health centers' use of Federal funds, including Federal cost principles, were also applied to center use of nongrant funds.

However, there were some exceptions (see old Section 330(d)(4)(C)), and, as a matter of policy, the Bureau eliminated the applicability of Federal cost principles a few years ago (BPHC Policy Information Notice 95-15). The old law also restricted center use of excess program income (e.g. fees, premiums, and third party reimbursements in amounts greater than anticipated). See old Section 330(d)(4)(B).

In contrast, under Section 330(e)(5)(C), as amended, health centers may use nongrant funds (as well as grant funds) for certain specified purposes (e.g. acquiring and leasing buildings and equipment, providing training related to the provision of required primary health services and additional health services, management of health center programs (see Section 330(e)(2), as amended)). In addition, centers may use nongrant funds "for such other purposes as are not specifically prohibited . . . if such use furthers the objectives of the project" (Section 330(e)(5)(C), as amended). It seems possible under the new law that centers may be able to expend nongrant funds for purposes that are no longer authorized by Section 330 but which are not specifically prohibited (e.g. construction).

As a result of this change in the law and in light of the relevant legislative history, the restrictions that apply to health centers' use of Federal grant funds under the Federal cost principles and the procurement and property standards[1], as well as Federal prior approval requirements, should no longer apply to health centers' use of nongrant funds. See Committee Report at page 10. However, because health centers are still required to undergo independent audits, each health center's use of project-related nongrant funds will be subject to outside scrutiny to assure that such funds were not used for purposes specifically prohibited by Section 330 and that funds were expended to further the approved objectives of the project.

V. New Types of Assistance

The new law authorizes two new types of assistance - network planning grants and managed care loan guarantee assistance.

A. Network Planning Grants

The authority to award grants for the planning and development of prepaid health plans (see old Section 330(d)(1)(C)) has been expanded under the new law. The new law authorizes the award of grants for the planning and development of prepaid health plans and **other managed care arrangements**. See Section 330(c)(1)(B), as amended.

Additionally, the new law expands the pool of centers eligible for such grants. Now, the

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[1] Although the Bureau has not yet issued its interpretation of this change in the law, it seems reasonable to expect that if a health center could document that only nongrant funds were used to acquire or improve property, the Federal reversionary interest restrictions would not apply to that property. See 45 C.F.R. 74.32 and 74.34. Undoubtedly, significant Bureau guidance will be forthcoming on this issue.

pool of eligible centers includes not only those centers that have received an operating grant for at least two consecutive years immediately preceding the award, but also those centers that have provided primary care services for at least two consecutive years immediately preceding the award regardless of whether these centers were recipients of operating grants during that period. Compare old Section 330(d)(1)(C) with Section 330(c)(1)(B)(i), as amended.

B. Managed Care Loan Guarantees

The new law provides for managed care loan guarantees, whereby the Federal government guarantees the payment of principal and interest on loans made by non-Federal lenders to health centers to cover the costs of developing, and operating managed care networks or plans. See Section 330(d)(1)(A), as amended. Such loans may be used to establish reserves for the furnishing of services on a pre-paid basis (Section 330(d)(1)(B)(i), as amended) or for necessary costs incurred to enable a Section 330 funded center or centers to develop, operate, and own the network or plan (Section 330(d)(1)(B)(ii), as amended).

The Secretary is required to establish and publish guidelines before implementing the loan guarantee program. See Section 330(d)(1)(C), as amended. Therefore, it is impossible at this time to predict the exact parameters of the managed care loan guarantee program. However, the new law includes numerous provisions with which the Secretary must comply in structuring the program.

Briefly stated, these provisions require that the terms (including the interest rate) of any loan for which a guarantee is sought are reasonable and that the loan would not be available on such terms unless a guarantee was provided (see Section 330(d)(2)(A), as amended). Further, the Federal government may recover from the recipient of a loan guarantee the amount of any payments the Federal government makes on the recipient's behalf (see Section 330(d)(2)(B), as amended).

The new law authorizes the Federal government to collect loan origination fees in an amount equal to the estimated long term cost of the loan guarantees awarded. See Section 330(d)(3)(A) and (B), as amended. However, these origination fees may be waived for good cause. See Section 330(d)(3)(C), as amended.

Significantly, the statute prohibits the Federal government from requiring as security for such a loan guarantee "any center asset that is, or may be, needed by the center or centers involved to provide health services" (see Section 330(d)(2)(A)(i), as amended). This means that in the event of a center's default on a loan, the Federal government could only foreclose on a center's (or centers') assets that are not necessary to provide health services and/or network or plan assets. See Section 330(d)(4)(B), as amended. However, the law also authorizes the Federal government, at the Secretary's discretion, to take a range of specific actions to prevent a center's default, when necessary. See Section 330(d)(4), as amended. Accordingly, the Secretary is accorded broad discretion to implement organizational, operational, and financial reforms, in order to prevent default and protect the government's interests. See Section 330(d)(4), as amended.

The appropriation for the new managed care loan guarantee program for FY97 is $8 million. It is hoped that this amount will leverage $80 million or more in loan guarantees. This depends on the projected default rate for this program as determined by the Office of Management and Budget. The Bureau is already developing guidelines for implementation of this program and has advised that it hopes to be able to accept applications within a few months.

VI. Other Key Changes

A. Planning Grant Provisions

Consistent with the old law, projects eligible to receive planning grants under the new law are required to submit a needs assessment, program design, evidence of efforts to secure financial and community support, and evidence of community involvement. Compare old Section 330(c)(1)(A) through (D) with Section 330(c)(1)(A)(i) through (iv), as amended. However, the new law imposes one additional requirement, namely, that eligible applicants describe proposed linkages between the center and other appropriate provider entities. See Section 330(c)(1)(A)(v), as amended.

B. Migrant Health Centers Program

A key change to the migrant health centers program is the removal of the "high impact areas" designation and preference.

Under the old law, "high impact areas," defined as areas with more than 4,000 migratory or seasonal agricultural workers in residence for more than two months of the year (see old Section 329(a)(5)), received a high priority for grants and project and program assistance. See old Section 329(b)(1) and (d)(1).

The new law does not contain any reference to "high impact areas." As a result, the priority placed upon awarding grants to entities in "high impact areas" is no longer in effect. Nevertheless, we anticipate that relative "need" will remain an important consideration in the Secretary's evaluation of applications.

C. Health Care for the Homeless Program

There are several significant changes to the law governing health care for the homeless programs. It is important to note, however, that the service package of the health care for the homeless program is not materially affected. See discussion of required primary care services and additional health services, above. In a significant change, the new law eliminates the requirement that grantees secure non-Federal matching funds. However, the new law prohibits programs from using Federal grant funds to supplant (replace) other funds or in kind contributions. See Section 330(h)(3), as amended. In this way, the Congress intended to insure that Section 330(g) grant funds expand and supplement the resources available to serve homeless populations rather than replace or supplant other available resources.

In addition, several provisions of the old law are not included in the new law. The following provisions do not appear in the new law: optional provision of continued services for twelve months to formerly homeless persons (see old Section 340(h); limitation on administrative expenses of grantee (see old Section 340(l); and, use of grant funds for referrals to certain advocacy systems (see old Section 340(m)). While the new law does not explicitly allow grantees to use grant funds to provide services to formerly homeless persons for the 12 month period after such persons have secured housing as Section 340 did, there is no indication that Congress intended to restrict their eligibility. It is expected that the Bureau will provide guidance on this issue. Additionally, although the explicit authorization of the use of grant funds for referral to advocacy systems in the old law is not replicated in the new law, it would appear that the new law continues that authority through the broad referral provisions.

D. Residents of Public Housing Program

Key changes to the law governing health services to residents of public housing in large part mirror changes to the health services for the homeless program. The new law eliminates the former requirement that public entities receiving grants to serve residents of public housing secure non-Federal matching funds, and, prohibits programs from using Federal grant funds to supplant (replace) other funds or in kind contributions (see Section 330(i)(2), as amended). In this way, the Congress intended to insure that Section 330(i) grant funds expand and supplement the resources available to serve residents of public housing rather than replace or supplant other available resources. The new law also eliminates the limitation on administrative expenses contained in the old law. Additionally, the new law eliminates the preference under the old law for making grants to resident management corporations and entities that also receive grants under old Sections 330 or 340.

E. Governance Requirements

In a significant departure from the old law, the new law imposes upon all grantees the governing board requirements imposed only upon Section 330 Community Health Center grantees under the old law. The governing board for each grantee must now be composed of individuals a majority of whom are users of the center; the board must meet at least once each month; and, the board must exercise control over a number of specific and essential center functions. See Section 330(j)(3)(H), as amended.

The new law also states that upon a showing of good cause, the Secretary "shall waive, for the length of the project period, all or part of [the governance requirements] . . . " for entities that receive grants to serve seasonal or migratory agricultural workers, homeless persons, residents of public housing, or the residents of sparsely populated rural areas (see Section 330(p), as amended). See Section 330(j)(3)(H), as amended. It is expected that the Bureau will produce guidance as to the conditions necessary to make a showing of good cause.

F. Medically Underserved Population Designation

There are no significant changes between the old law and the new law with regard to the designation, and termination of designation, of medically underserved populations (MUP). The law no longer specifically emphasizes the infant mortality rate as an indicator of an underserved population. See old Section 330(b)(4)(B). Instead, the new law states that the criteria for determining whether a population is medically underserved, among other things, "include factors indicative of the health status" of a population (see Section 330(b)(3)(B)(ii), as amended), which clearly would include infant mortality rates.

Under the new law homeless persons, migrant and seasonal agricultural workers, and residents of public housing are special medically underserved populations. See e.g. Section 330(g)(1), as amended. With respect to whether such special medically underserved populations will be required under the new law to participate in a separate needs designation process, the Bureau appears to be leaning toward a policy that would continue to establish need through the grant application process.

VII. Provision for Allocation of Appropriations to Various Programs

The new law removes the limitations on the percentages of the total appropriation that may be allocated for grants to serve populations that do not meet the definition of a medically underserved population (but which a State's chief executive officer and local officials recommended to the Secretary to be designated as MUPs) and for grants for the planning and development necessary to provide services on a prepaid basis. See old Section 330(g)(B). However, the new law retains the old law's provision restricting to not more than five percent of the total allocation in any given year, the amount that may be allocated to "public centers," the governing boards of which do not establish general policies for such centers (except those public centers funded to serve homeless persons or public housing residents (Section 330(g) or (i)). See Section 330(l)(A), as amended; old Section 330(g)(3).

Additionally, the new law states that in FY97, the proportion of the total appropriation awarded to grantees serving each special population - seasonal or migratory agricultural workers (Section 330(g), as amended), homeless persons (Section 330(h), as amended) or residents of public housing (Section 330(i), as amended) - will be the same as the proportion of the total appropriation awarded to grantees under each of former Sections 329, 340 and 340A in FY96. See Section 330(l)(B)(i), as amended.

In FY98 and again in FY99, the proportion of the total appropriation awarded to entities serving each of these special populations may be "increased or decreased by not more than ten percent" from the proportions allocated in the previous year. See Section 330(l)(2)(B)(ii), as amended. Thus, for example, an appropriation to the migrant and seasonal farm worker program of $50 million dollars in FY97 could be increased to $55 million or decreased to $45 million in FY98.

Subsequent to FY99, the Secretary may recommend to the Congress changes in the distribution of funds among the various medically underserved populations. The rationale for any such changes must be based on an assessment of the relative health care access needs of the targeted populations. See Section 330(l)(3), as amended.

VIII. Section 330A - Rural Health Outreach, Network Development, and Telemedicine Grant Program

This new program arises from the consolidation of two current demonstration programs - the Rural Health Outreach Program and the Rural Telemedicine grant program. Awards under this Section will be made to expand access to, coordinate, restrain the cost of, and improve the quality of essential health services, through the development of integrated health care delivery systems or networks in rural areas and regions. See Section 330A(b).

Grantee networks are intended to become self-sustaining; accordingly, a network is eligible to receive support under this program for only three years. See Section 330A(f).

IX. Conclusion

As this issue brief shows, the new law simplifies and consolidates the programs authorized under old Sections 329, 330, 340, and 340A, and essentially preserves the principle features of the formerly separate programs. Bureau guidance is required for the implementation and clarification of certain parts of the new law. NACHC will provide input to the Bureau with respect to such guidance and will alert the Bureau as to any issues health centers confront in interpreting or attempting to comply with the new law. As questions and issues arise concerning the new law, health center administrators are encouraged to contact Freda Mitchem (202-659-8008), Director, NACHC Department of Systems Development and Policy Administration.

COMPARISON CHART
Primary Health Services Under the Old and New Laws

Primary Health Services Under Old Section 330(b)

(A) services of physicians, physicians' assistants and nurse clinicians
(B) diagnostic laboratory and radiologic services
(C) preventive health services including
- children's eye and ear examinations
- perinatal services
- well child services
- family planning services

(D) emergency medical services
(E) transportation services
(F) preventive dental services
(G) pharmaceutical services

Primary Health Services Under New Section 330(b)(1)(A)(i)

(i) basic health services consisting of
- primary care services provided by physicians, physician assistants, nurse practitioners, and nurse midwives
- diagnostic laboratory and radiologic services
- preventive health services including
  - **prenatal** and perinatal services
  - **screening for breast and cervical cancer**
  - well child services
  - immunizations against vaccine-preventable diseases
  - **screenings for elevated blood lead levels, communicable diseases, and cholesterol**
  - pediatric eye, ear, and **dental** screenings
  - voluntary family planning services
  - preventive dental services
- emergency medical services
- pharmaceutical services

(ii) **referrals to providers of medical services and other health-related services (including substance abuse and mental health services)**

(iii) **patient case management services and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, educational, or other related services**

(iv) **services that enable individuals to use the services of the health center including transportation and bilingual personnel**

(v) **education of patients and the general population served regrading the availability and appropriate use of health services**

NOTES TO COMPARISON CHART

(1) Additions to Required Primary Health Services under the new law are shown in **bold**.

(2) The required primary health services identified in Section 330(b)(1)(A)(ii) through (v), as amended, correspond to old Section 330(a)(3),(5), and (6), which defined the term "community health center" by listing the services such centers provide. These services appear in bold on this comparison chart because, under the old Section 330, these services were not included in the definition of "primary health services".

(3) Health centers should note that the new law's definition of required primary health services not only incorporates services previously included in the definition of "community health center" but also expands the scope of these services. These expanded services appear in **bold and are underlined** in this comparison chart.

(4) The list of primary health services included in the old Section 330 was replicated in the old Section 329 (migrant health center law), and incorporated by reference in old Sections 340 (health care for the homeless program law) and 340A (health care for residents of public housing program law).

(5) It should be noted that health care for the homeless programs are required to provide substance abuse services in addition to these required primary care services. See Section 330(h)(4)(C), as amended. Required substance abuse services are defined as detoxification and residential treatment for substance abuse provided in settings other than hospitals.