

**HRSA-12-114
FY 2012 State and Regional Primary Care Association (PCA) Cooperative
Agreements Funding Opportunity Announcement (FOA)**

Frequently Asked Questions (FAQs)

Below are common questions and answers for the FY 2012 State and Regional Primary Care Association (PCA) Cooperative Agreements funding opportunity. The FAQs are available on the PCA Technical Assistance website at <http://www.hrsa.gov/grants/apply/assistance/pca>. New FAQs will be added as necessary, so please check this site frequently. The FAQs are organized under the following topics:

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ISSUE: General Information – NEW!

1. NEW What types of training and technical assistance should PCAs provide to health centers?

PCAs should take a state/regional-wide approach to training and technical assistance. This includes conducting an annual needs assessment and developing a T/TA strategy that is responsive to and addresses the needs of health centers across the state/region. PCAs should be focused on preventative training and TA for a broad range of health center needs. To use resources most effectively, PCAs are discouraged from providing one-on-one, crisis-oriented TA to health centers, and their budgets should reflect a broad focus on the state/regional needs.

Please note that PCAs may need to provide one-on-one TA as part of their statewide strategy. For example, New Start health centers often require more TA as they work to become fully operational, and depending on the number of New Starts in a given state or region, it could be an effective use of resources to conduct one-on-one TA aimed specifically at helping a New Starts establish their boards. However, PCAs must be strategic and selective about when a

one-on-one format is the most effective way to deliver TA within the context of addressing the needs of all health centers within the state/region.

2. NEW What is an Operational Site Visit and how will it be implemented?

Beginning in 2012, all BPHC grantees will receive an Operational Site Visit at least once every 5 years. These visits are designed to provide for a full organizational assessment of the 19 Program Requirements across all operational areas – fiscal, clinical, administration, and governance, as well as focus on areas for clinical and financial performance improvement. The visits are an essential tool for gathering objective, baseline information on the compliance and performance of all grantees, and PCAs are encouraged to participate along with the team of expert consultants and HRSA staff (e.g., Project Officer, Branch Chief).

3. What is the purpose of the PCA funding opportunity?

The purpose of the PCA funding opportunity is to establish cooperative agreements with state and regional organizations to provide training and technical assistance (T/TA) to potential and existing section 330 health centers in the following areas:

- **Statewide/Regional Health Center T/TA Activities:** Conduct statewide/regional health center T/TA activities based on the identified statewide/regional T/TA needs in the areas of Program Requirements and Performance Improvement.
- **Statewide/Regional Program Assistance:** Conduct statewide/regional program assistance activities based on statewide/regional and/or HRSA/BPHC priorities.

4. Are there required T/TA focus areas and performance measures?

Yes. A summary of required PCA T/TA focus areas and performance measures is provided on pages 3-6 of the FOA. The extent and type of activities should be based on statewide/regional health center needs.

5. Does the PCA funding support T/TA activities for only section 330-funded health centers or a broader array of HRSA grantees?

The T/TA services supported with these funds must be available and accessible to existing health centers and potential health centers as noted in the FOA, regardless of PCA membership or HRSA grant status. This does not include other HRSA supported programs such as a Ryan White, Title V, etc. For statewide/regional program assistance (i.e., statewide/regional surveillance analysis), such services must be available to all potential section 330 health centers.

- **Existing Health Centers** include Health Center Program grantees (e.g., section 330 grantees) and Federally Qualified Health Center (FQHC) Look-Alikes.
- **Potential Health Centers** include organizations that seek to become section 330 grantees (e.g., Planning Grant awardees, community based safety net providers).

6. Are there any funding priorities?

No. There are no opportunities for applicants to earn priority points.

ISSUE: Award Information

7. What is the cap for federal funds that can be requested?

The cap is based on the annual level of federal section 330 funding that is currently provided to the state or region. This applies to any year of the proposed project period. Applicants can obtain information on the annual level of federal section 330 funding by contacting Denise Nguyen at bphcpca@hrsa.gov. Current awardees applying to continue serving their State/region

should reference Line 19 (Future Recommended Funding) on the most recent Notice of Award (NoA), not Line 13, as noted in the FOA.

8. When will PCA funds be awarded?

The PCA awards will be issued on or around September 1, 2012.

9. How many PCA cooperative agreements does HRSA intend to award?

HRSA anticipates awarding approximately 51 cooperative agreements for federal fiscal years 2012-2016.

10. What is the length of the project period?

Subject to the availability of appropriated funds, the project period will be up to 5 years. Funding beyond the first year is dependent on the availability of appropriated funds for T/TA in subsequent fiscal years, satisfactory performance, and a decision that funding is in the best interest of the federal government.

11. Are the approximate award levels for each state/region the same for each year of the 5-year project period?

Yes, the approximate award levels for each state/region are anticipated to be the same throughout the 5-year project period. Refer to question 8 for additional information.

12. This funding opportunity announcement has a project period start date of September 1, 2012. Will existing PCA awardees with a project period end date of March 31, 2012 receive additional funding for the project period April 1, 2012 through August 31, 2012?

All current PCA awardees with a project period end date of March 31, 2012 have received a five month project period extension (an extension with funds) from April 1, 2012 to August 31, 2012. Notification of the project period extension was provided in a revised NoA issued on March 1, 2012.

ISSUE: Eligibility

13. Who can apply for PCA funding (HRSA-12-114)?

Eligible applicants include domestic public or private, non-profit or for-profit entities that can provide T/TA on a statewide/regional basis to community-based organizations. Faith-based and community-based organizations are eligible to apply for these funds. Tribes and tribal organizations are eligible to apply for these funds.

14. Is this funding opportunity an open competition?

Yes. HRSA-12-114 is a New and Competing Continuation funding opportunity. Applications may be submitted from new organizations that are not currently receiving funding under section 330(l) as well as organizations that are currently receiving funding under section 330(l). Please note that applicants with no experience working with potential or existing health centers and community-based providers with similar missions will not be competitive.

15. Does an organization need to be a current section 330(l) grantee to be eligible to apply for PCA funding?

No. However, eligible applicants who are not currently receiving section 330(l) funding must have a statewide/regional T/TA delivery plan that will be operational within 30 days of Notice of Award.

ISSUE: Funding Restrictions – **NEW!**

16. NEW Where can I find the HHS Policy on the Use of Appropriated Funds for Conferences and Meetings, Food, Promotional Items, and Printing and Publications?

The policy can be accessed at

http://www.hhs.gov/asfr/ogapa/acquisition/effspendpol_memo.html.

17. NEW Are we (PCAs) expected to provide T/TA free of charge to health centers?

The T/TA should be affordable and accessible. Any T/TA activity in which PCAs use HRSA funds must be made available to **all** existing health centers (i.e., Health Center Program grantees and FQHC Look-Alikes) within the state/region, regardless of PCA membership. It will be a violation of the grant award if PCAs refuse to work with an existing health center. PCAs should provide equal access to T/TA services without regard to PCA membership.

18. Are there activities that are ineligible for PCA funding?

Yes. PCA funding may not be used for the following activities:

- Construction/renovation of facilities;
- Activities not approved under the cooperative agreement;
- Reserve requirements for state insurance licensure; or
- Support for lobbying/advocacy efforts.

19. How do you define advocacy efforts?

Advocacy is defined as using federal section 330 funding to actively support or plead to a local, state, and/or federal congressional representative for support of a cause on behalf of another entity/organization. For additional information on the funding restrictions, contact Angela Wade, Grants Management Specialist (GMS), at 301-594-5296 or awade@hrsa.gov.

20. Can section 330 funding be used to provide education on health centers and health care needs within the state/region?

Yes. Applicants may propose activities (e.g., issue briefs) to analyze issues impacting health centers and the underserved. Such analysis on issues may be made available to the general public and other stakeholders such as policy makers, health centers, other safety net providers, community leaders, and potential partners. However, educational documents related to any pending or existing legislation cannot be created utilizing federal funding.

21. Can organizations provide direct patient care with this funding?

No. This funding is specifically for an organization to provide T/TA to existing and potential section 330 health centers within the state/region.

ISSUE: Application Development

22. Is there a page limit for the PCA application?

Yes. There is an 80-page limit (approximately 10 MB) on the length of the total application when printed by HRSA. Please refer to Tables 2-4 of the FOA for more information on what is counted in the page limit.

23. Does HRSA have guidelines (e.g., font type, font size) for the Project Narrative of the PCA application?

Yes. Applicants should submit single-spaced narrative documents with 12-point, easily readable font (e.g., Times New Roman, Ariel, Courier) and 1-inch margins. Smaller font (no less than 10-point) may be used for tables, charts, and footnotes.

24. What should an applicant do if the abstract changes between the Grants.gov submission and the EHB submission?

Under “Project Summary/Abstract” in EHB, an applicant can view the original abstract submitted via Grants.gov and replace it by selecting “update” to upload a revised abstract. Alternatively, an applicant may choose to leave the abstract submitted via Grants.gov in place and upload a revised abstract (clearly marked as a revision) as part of Attachments 8-12: Other Relevant Documents.

25. What letters of support should be included in the PCA application?

The letters should be dated and detail both formal and informal collaboration and coordination with other HRSA supported providers of T/TA (e.g., National Cooperative Agreement awardees, Primary Care Offices) and other state-based organizations (e.g., State Quality Improvement Organizations, Regional Extension Centers, State Offices of Rural Health, medical associations).

ISSUE: Budget – NEW!

26. NEW How should I develop the 5-year budget presentation, given that the project period is from September 1, 2012 to March 31, 2017?

The budget presentation will consist of 5 separate 1-year budgets. These should be full year budgets, and adjustments will be made accordingly by HRSA should your application receive funding. Note that you’ll have the opportunity to provide updates to the budget each year during your non-competing continuation progress reports.

27. Who can I contact for specific questions about budget preparation, including eligible costs?

Contact Angela Wade, Grants Management Specialist (GMS), at 301-594-5296 or awade@hrsa.gov.

28. Should the budget presentation include non-federal funding (i.e., other program funding to represent the cumulative total funding used for T/TA activities)?

No. Budget requests should only identify federal section 330 funding. Do not identify other program income in the Standard Form 424A, detailed line-item budget, or budget justification. Applicants can provide information on other program income and resources in the Collaboration section of the Project Narrative.

29. Does HRSA require applicant organizations to have an indirect cost rate?

No. Applicants are only required to have an indirect cost rate agreement if they are budgeting for indirect costs. If an organization does not have an indirect cost rate agreement, costs that would fall into such a rate (e.g., administrative salaries) may be charged as direct line-item costs. If an organization wishes to apply for an indirect cost agreement, more information is available at <http://rates.psc.gov>.

30. If an applicant organization has an indirect cost rate, what needs to be included in the application?

Applicants must include a copy of the indirect cost agreement in Attachments 8-12: Other Relevant Documents.

31. Is the budget justification the same as a budget narrative?

Yes, for the purpose of the PCA FOA, they are the same. The sample budget justification provided on the PCA TA website includes a box for providing any narrative explanation of costs necessary beyond what is provided in the line-item descriptions.

32. What should be included in the budget justification?

A detailed budget justification in line-item format must be completed for EACH requested 12-month period of Federal funding. All applicant organizations must submit a 5-year budget justification. The budget justification must detail the costs of each line item within each object class category from the SF-424A: Budget Information – Non-Construction Programs. It is important to ensure that the budget justification contains detailed calculations explaining how each line-item expense is derived. For subsequent budget years, the narrative explanation should highlight the changes from year one or clearly indicate that there are no substantive budget changes during the project period.

ISSUE: Project Work Plan Form – NEW!

33. NEW What is the timeframe for the Project Work Plan?

The Project Work Plan should cover a full 12-month period from September 1, 2012 to August 31, 2013. You will have the opportunity to craft work plans for the additional years during your non-competing continuation progress reports.

34. Is there a format for the Project Work Plan?

Yes. Applicants will enter information directly into the format within HRSA’s Electronic Handbooks (EHB).

35. What are the requirements of the Project Work Plan?

The table below summarizes the minimum and maximum number of key components required in each section of the Project Work Plan.

Key Components	Section A		Section B1 (Clinical)		Section B2 (Financial)		Section C		Character Limit
	Min.	Max.	Min.	Max.	Min.	Max.	Min.	Max.	
Goal	1	1	2	2	2	2	N/A	N/A	N/A
Key Factor	3	5	3	5	3	5	N/A	N/A	500
T/TA Focus Area	3	5	1	3	1	3	7	9	200
Activity	2	5	2	5	2	5	2	5	200
Person/Area Responsible	1	5	1	5	1	5	1	5	200
Time Frame	1	5	1	5	1	5	1	5	200
Expected Outcome	1	5	1	5	1	5	1	5	200
Comments	This is an optional field in the form and can be left blank.								500

36. What is the minimum and maximum number of Key Factors that applicants can propose in the work plan?

Applicants must identify 3 to 5 key factors that impact performance on the goals, including at least 1 restricting factor and 1 contributing factor. The key factors should be based on data from the HRSA program reports (e.g., Universal Data System reports, program requirement reports, PCA satisfaction survey results) and annual T/TA needs assessments.

37. Can applicants conduct two or more of the same T/TA Focus Area in the Project Work Plan?

No. Applicants may not propose duplicate T/TA Focus Areas in the Project Work Plan. A maximum of two Other T/TA Focus Areas may be added in each section. Only pre-defined T/TA Focus Areas will count toward the requirement.

38. What is the minimum and maximum number of Activities that can be proposed for each T/TA Focus Area?

Applicants must identify 2 to 5 major Activities for each T/TA Focus Area. For each Activity, identify at least 1 Person/Area Responsible, 1 Time Frame, and 1 Expected Outcome.

39. How should applicants develop Expected Outcomes?

Applicants must identify at least one quantifiable outcome that will result directly from their T/TA activity. Since this is a 12-month Project Work Plan, short-term expected outcomes must be measurable by the end of the budget period (e.g., number of health centers to receive training by the end of the first year of the cooperative agreement). However, longer term expected outcomes may also be proposed since some activities will not have measurable outcomes within one year, as these outcomes will not occur until subsequent years of the project period (e.g., staff retention rates).

40. Should the Project Work Plan cover 1 year (one budget period) or all 5 years of the project period?

The Project Work Plan should cover the first budget period (1 year) and address ONLY activities to be supported under the HRSA PCA cooperative agreement. Organizations selected for funding **must** submit annual Project Work Plan updates within the 5-year project period.

41. Are applicants required to conduct statewide or regional T/TA needs assessments annually?

Yes. Organizations are required to conduct T/TA needs assessments of existing health centers in the state or region and provide annual updates. If a T/TA needs assessment has not been conducted within the past twelve months, organizations may propose appropriate statewide/regional T/TA focus areas and activities based on previous knowledge or lessons learned over the past 2 to 3 years.

42. Should the Project Work Plan tie back to the needs addressed in the Project Narrative?

Yes. The T/TA Focus Areas and Activities proposed in the Project Work Plan should align with the Need, Response, and Evaluative Measures/Impact sections in the Project Narrative. Instructions for preparing the Project Work Plan are in Appendix B of the FOA.

43. Will the Project Officer (PO) be involved in the development of the Project Work Plan?

The PO is not involved in the development of the Project Work Plan during the application development phase. However, the PO will review the Project Work Plans of funded applications and, if necessary, negotiate with the PCA on any required revisions and/or as appropriate, place conditions on the NoA to address areas of non-compliance.

44. Will the Project Work Plan count toward the 80-page limit?

No. The Project Work Plan will not count toward the 80-page limit.

45. Will the Project Work Plan be uploaded into EHB?

No. Applicants will complete the Project Work Plan Form online directly in EHB. Refer to the PCA Cooperative Agreement User Guide on the PCA TA website for step-by-step instructions (with screen shots) on how to complete the form online.

ISSUE: Performance Goals

46. What are the required performance goals?

Applicants must establish their target percentage goals for the end of the project period. The five performance goals include:

Required Performance Measures

Program Requirements Goal	
A1	XX% of Health Center Program grantees with no program conditions on their Notice of Awards. (NoAs).
Clinical Performance Improvement Goals	
B1.a	XX% of Health Center Program grantees in the state/region that meet or exceed performance on one or more Healthy People 2020 performance measure goal(s).
B1.b	XX% of Health Center Program grantees with Patient-Centered Medical Home (PCMH) recognition.
Financial Performance Improvement Goals	
B2.a	XX% of Health Center Program grantees with cost increase less than National average.
B2.b	XX% of Health Center Program grantees without going concern issues.

47. Can organizations propose additional performance goals to the Project Work Plan?

No. However, as desired, applicants can add other unique T/TA Focus Areas and Activities for the existing performance goals. Applicants should ensure that proposed activities align with the existing goals.

48. How should applicants develop their target percentage goals?

Organizations should utilize HRSA program reports (e.g., Uniform Data System reports, program requirement reports, annual PCA satisfaction survey results) and annual T/TA needs assessments to develop their target percentage goals for the end of the project period.

Additional online resources include:

- HRSA Health Center Program: <http://www.bphc.hrsa.gov/>
- Healthy People 2020: <http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx>
- National Health Expenditures: http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorial.asp#TopOfPage

49. Where can I obtain information regarding the HRSA program reports?

For information regarding HRSA program reports, applicants should contact the Office of Training and Technical Assistance Coordination at 301-443-9820.

ISSUE: Attachments

50. How should attachments be formatted?

All attachments should be provided to HRSA in a computer-readable format (i.e., do not upload text as images). To the extent possible, HRSA recommends PDF files but will accept Microsoft Word or Excel files. Limit file names to 100 characters and do not use spaces or special characters when naming files. Applicants should avoid Excel documents with multiple spreadsheets as individual worksheets may not print out in their entirety. Be sure to upload the attachments in the appropriate field in the EHB.

51. Can applicants upload additional attachments?

Yes. Applicants may upload additional relevant material in Attachments 8-12. Please note that all attachments will be included in the 80-page limit.

52. Who in the organization is considered “key personnel” for Attachment 2 (Position Descriptions) and Attachment 3 (Biographical Sketches)?

Key personnel includes any individual who will be directly involved in the activities proposed under the cooperative agreement. Key personnel may include the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Information Officer (CIO), Chief Operating Officer, (COO), and Program Leads, among others as determined by the applicant.

53. What is the difference between a Position Description (Attachment 2) and a Biographical Sketch (Attachment 3)?

A position description outlines the key aspects of a position (e.g., position title; description of duties and responsibilities; position qualifications; supervisory relationships; skills, knowledge, and experience requirements; travel requirements; salary range; work hours). A biographical sketch describes the key qualifications of an individual that make him/her qualified for a position (e.g., past work experience, education/training, language fluency, experience working with the cultural and linguistically diverse populations to be served).

54. How is the Staffing Plan (Attachment 1) different from the Position Descriptions (Attachment 2) and Biographical Sketches (Attachment 3)?

The staffing plan is a presentation and justification of **all staff** required to execute the project as opposed to the other attachments that are limited to key personnel. A staffing plan template is provided on the PCA TA website.

ISSUE: Application Submission – **NEW!**

55. **NEW** Where can I find instructions for uploading the Project Narrative and Budget Information (SF-424A and Budget Justification)?

Instructions for uploading the documents were released via EHB on April 12, 2012. The email was sent to all contacts listed in the SF-424 (Application for Federal Assistance). This includes the Project Director, Authorizing Official, and Business Official. If you did not receive the information, please contact Denise Nguyen at bphcpca@hrsa.gov or 301-594-4300.

56. **NEW** What type of contracts should we include in the Summary of Contracts and Agreements (Attachment 7)?

Based on your assessment, include contracts or agreements for entities that will provide significant T/TA support under this cooperative agreement.

57. Where can I get the FY 2012 PCA FOA?

The PCA FOA is available at Grants.gov. Follow the instructions below:

- Go to <http://www.grants.gov>.
- Under the Quick Links header on the right, select the Grant Search link.
- Under the Search by Funding Opportunity Number field, enter HRSA-12-114 and click the SEARCH button.
- Click the FOA title (State and Regional Primary Care Association).
- Click on the Application button (to the right of the Synopsis and Full Application buttons).
- Under Instructions and Application click on the Download link.
- Click on the Download Application Instructions link.

58. How do I submit my application and when is it due?

There is a two phase application submission process for the FY 2012 PCA funding opportunity. The Grants.gov deadline is April 2, 2012 and the EHB deadline is April 26, 2012. Refer to Tables 1-4 in the FOA for details on the documents required in each phase.

59. When can applicants begin the EHB submission process?

Applicants can begin Phase 2 in HRSA EHB only after Phase 1 in Grants.gov has been successfully completed by the Grants.gov due date and validated by HRSA. The Authorizing Official(s) registered in Grants.gov will be notified by email when the application is ready within EHB for Phase 2, approximately 7 business days following the Grants.gov submission. Each PCA applicant will receive an email notification through the EHB that provides a link to the PCA electronic submission.

60. How will applicants be notified if their application was not successfully submitted in Grants.gov and/or EHB?

Each system will generate a confirmation message. Applicants should monitor their e-mail accounts, including spam folders, notifications, and/or error messages from Grants.gov and EHB to ensure that there are no submission or validation errors. All submission errors must be corrected and the application must be successfully submitted before the Grants.gov and EHB deadlines.

ISSUE: Technical Assistance and Contact Information

61. If I encounter technical difficulties when trying to submit my application in Grants.gov, who should I contact?

Refer to http://www.grants.gov/applicants/applicant_fags.jsp or call the Grants.gov Contact Center 24 hours a day, 7 days a week (excluding Federal holidays) at 1-800-518-4726 or support@grants.gov. Register as early as possible since registration may take up to one month.

62. If I encounter technical difficulties when trying to submit my application in HRSA EHB, who should I contact?

Contact the BPHC Helpline Monday through Friday, 8:30 AM to 5:30 PM ET (excluding Federal holidays) at 1-877-974-2742 or BPHCHelpline@hrsa.gov. The BPHC Helpline will remain open until 8:00 PM ET on the EHB application due date. Applicants may also refer to the *HRSA Electronic Submission User Guide* available at <http://www.hrsa.gov/grants/apply>.

63. Who should I contact with budget-related questions?

Applicants with questions concerning the business, administrative, or fiscal issues related to the PCA application may contact Angela Wade, Grants Management Specialist (GMS), at 301-594-5296 or awade@hrsa.gov.

64. Who should I contact with programmatic questions concerning the PCA application requirements and process?

Refer to the PCA TA website at <http://www.hrsa.gov/grants/apply/assistance/pca> for TA slides, a replay of the applicant TA call, FAQs, and samples, among other resources. Applicants may also contact Denise Nguyen in the Bureau of Primary Health Care's Office of Policy and Program Development at BPHCPCA@hrsa.gov or 301-594-4300.

DATA CLARIFICATION

ISSUE: Health Center Program Requirements – **NEW!**

65. Why did we not receive a Health Center Conditions Report for our state?

The Health Center Conditions Report was provided only if the health centers in your state had conditions placed on their Notice of Awards (NoAs). In the State Performance Profile, if the metric ‘% of Health Center Program grantees with no program conditions on their Notice of Awards (NoAs)’ is 100% for your State, then there were no conditions to report. If the percentage is less than 100% and you did not receive a report, please contact Denise Nguyen at BPHCPCA@hrsa.gov or 301-594-4300 to request for the report.

66. Can we get a list of health centers that have conditions placed on their NoAs so that we can provide targeted T/TA?

No. For this competitive funding opportunity, we encourage you to use the summary data to focus on statewide/regional T/TA activities, rather than targeted T/TA to individual health centers. A more detailed report including individual health center conditions will be provided to the PCAs after the competition is closed.

ISSUE: Healthy People 2020 – **NEW!**

67. To address the Healthy People 2020 Goal, are we limited to the six clinical measures outlined in the State Performance Profile?

Yes. You are required to address at least one of the six clinical measures provided in the State Performance Profile. These are measures that health centers are currently reporting on that relates to the Healthy People 2020 goals. However, you can propose additional clinical measures.

68. For the ‘Female Patients with Pap Test’ indicator, should we use the UDS Table 6A or 6B? Also, should we be concerned with discrepancies between any of these numbers and UDS Table 3A?

This measure was calculated using the data provided in UDS Table 6B. Exclusions and measure criteria may cause the number of pap tests to not match with the data in Table 6A and the number of women to not match the data in Table 3A.

69. For the metric ‘% Children Immunized’, can an individual be two ages in one year for recording and reporting purposes?

An individual is two ages in a measurement year. For the purposes of the childhood immunization, if the individual turns the appropriate age during the measurement year, he/she is counted for the measure (if all other criteria are met).

70. How is the metric ‘% Low Birth Weight’ calculated?

For the low birth weight measure, low and very low birth weight (<1500 grams and 1500-2499 grams) is included in the calculation.

71. For the ‘% Prenatal Patients Served in the 1st Trimester’ indicator, is the desired outcome related to ALL prenatal patients or, exclusively, those that are grantee-related?

The calculation of the trimester of entry into prenatal care measure includes women having their first visit with the grantee and women having their first visit with another provider (not the funded grantee).

ISSUE: Patient Centered Medical Home – NEW!

72. Is BPHC looking at only NCQA recognition or NCQA, AAAHC, and The Joint Commission? Our records are not matching the number you provided.

HRSA's PCMH data includes grantees who were recognized through the HRSA PCMHHI, HRSA Accreditation Initiative, and those that achieved recognition independently through NCQA. The data provided in the profiles for accreditation is as of January 1, 2012 and for NCQA as of March 12, 2012. For NCQA data we only know of data on HRSA PCMH Initiative participants. We realize that some health centers have obtained PCMH recognition independently or through another PCMH initiative that is utilizing NCQA recognition.

In early March, NCQA cross-walked our list of 8,000 sites against all of their PCMH recognized organization to help us identify independent recognition. Please note, NCQA does not have an internal way of designating a service delivery site as health center vs. hospital vs. a private provider. They also have no common identifier between the 8,000+ site list we provided them and their own internal tracking. This only exists for the PCMHHI where we both use the H80 number.

73. How should we keep HRSA updated on centers that receive PCMH recognition?

With the various initiatives taking place, we realize the barrier to obtaining information on all recognized centers. If a PCA notices a discrepancy in the number of recognized grantees please contact BPHCPCA@hrsa.gov. In addition, if you know your State has PCMH Initiatives and/or pilots taking place, please notify BPHC so we can start collecting this information.

74. Does PCMH recognition include only Level 3 or any level?

Recognition includes any level. Some of the recognition organizations don't have the differentiation between levels and recognize the entire organization and all service delivery sites. For example, The Joint Commission and AAAHC recognize all service delivery sites. NCQA is the only national recognition organization that utilizes levels.

75. How does the BPHC define PCMH recognition?

The BPHC's definition of PCMH recognition is as follows: A health center is considered to have achieved PCMH recognition if they have at least a site recognized.

ISSUE: Cost Increase Less Than National Average – NEW!

76. Please clarify the performance profile measure 'percent of Health Center Program Grantees with cost increase less than National Average'. What health center cost increase are you comparing?

We calculate the TOTAL COST AFTER ALLOCATION OF FACILITY AND ADMINISTRATION' (UDS Table 8A, line 17, column c) per TOTAL PATIENTS (UDS Table 3A, line 39, sum of column a + b) for 2009 and 2010, and then calculate the annual percentage change in this measure using the prior year's (2009) value as the base. The '% of Health Center Program Grantees with cost increase less than National Average' metric provides the number and

percent of Grantees whose 'percent increase in cost per patient' is less than the CMS National Health Expenditure rate (NHE).

77. What is the national average for cost increase that BPHC is using for this measure?

National Health Expenditures, estimated by CMS annually, track health care spending by (a) type of service or product (b) major source of funds and (c) type of sponsor (the entity that is ultimately responsible for financing the health care bill, such as a private business, household, or government). The CMS NHE is 3.94% (which was derived from the 2009 historical and 2010 projected total health expenditure data published by CMS at the following webpage: http://www.cms.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage). This metric applies to the total number of grantees who submitted 2010 UDS data.

78. What formula was used to calculate the 'percent of Health Center Program Grantees with cost increase less than National Average'?

$$\% \text{ of HC Grantee with cost increase} < \text{CMS NHE} = \frac{\# \text{ of grantees whose 'percent increase in cost per patient' } < \text{CMS NHE rate (3.94 \%)}}{\# \text{ of 2010 UDS grantees with valid cost and patient data for 2009 and 2010}}$$

79. What formula was used to calculate the 'cost per patient' from the UDS?

$$\text{Cost Per Patient} = \frac{\text{TOTAL COST AFTER ALLOCATION OF FACILITY AND ADMINISTRATION (UDS Table 8A, line 17, column c)}}{\text{TOTAL PATIENT (UDS Table 3A, line 39, sum of column a + b)}}$$

Note that numerator does not include administration and facility cost.

80. What formula was used to calculate the "Cost per Patient Increase Less than National Average"?

$$\% \text{ Increase in cost per patient} = \frac{\text{Cost per patient in 2010} - \text{Cost per patient in 2009}}{\text{Cost per patient in 2009}}$$

81. For the percentage of health center program grantees with cost increase less than National average, was any consideration given for health centers that have added big sites (e.g., capital projects)?

This measure accounts for the change in total operating costs per patient served. As centers add sites, the associated capital (construction and renovation) expense will not be included in total operating costs; but as the sites become operational and begin to serve patients, the measure will pick up the incremental operating costs and additional patients served. That is, the measure does not account for the fact that some health center sites may be relatively new and may have initial start-up operating costs (or serve fewer patients) that older, more established, sites may not have. We want to stress looking at your baseline and defining that baseline and looking towards - making sure there is no significant increases in the cost per patient. Our goals are to stay below the National average.

- 82. Would it be possible to redefine cost per patient to the entire total cost of patient care rather than primary care, which in often times we're trying to actually increase the expenditure on in order to hold down the hospital emergency department and admissions and readmissions cost?**

We need to have a standard set of data across the program thus we cannot replace one with the other but you can provide both. The health center cost per patient is a standard measure for health center program reporting. However, a performance goal on total cost is an acceptable additional measure.

ISSUE: Without Going Concern Issues – NEW!

- 83. For this measure, are you referring to “going concern” as identified by auditors, or an “A-133 finding” identified by auditors? What year/time frame is this data from?**

The metric ‘% of Health Center Program Grantees without going concern issues’ provides the number and percentage of grantees that currently have no going concern issues identified in their audit report for the 2010 submission year. This metric includes those grantees whose 2010 audit report has been reviewed as of March 28, 2012. Note: This is not “A-133 finding definition.”

- 84. What does ‘going concern’ mean?**

In general, the term refers to findings that an auditor notes on an annual audit that identifies a concern about the ongoing viability of an organization. For example, a health center has been identified by an auditor as potentially having some financial difficulties within the next year, so there is a concern regarding the health center’s ability to continue to operate.

- 85. Can you provide a list of health centers that have been identified as having going concern issues in our state?**

We cannot share grantee level information during this competitive opportunity, but you may be able to identify the grantees through your ongoing work with the health centers. We encourage you to use the summary data to focus on state level interventions and develop statewide/regional T/TA to prevent grantees from having going concerns in the future.

ISSUE: General Questions – NEW!

- 86. When were the revised data reports released to the PCAs?**

The revised data reports were released on April 5, 2012 to each PCA’s Chief Executive Officer (CEO).

- 87. Who should we contact if we have not received the revised data reports for our state?**

To obtain the revised data reports, please contact Denise Nguyen at BPHCPCA@hrsa.gov or 301-594-4300.

- 88. Can we use more current data, in addition to the 2010 UDS baseline data?**

Yes. If you have access to more recent data from the health centers in your state/region, you can use that in combination with the 2010 data that we have provided.

- 89. In regards to the denominator, would we know if our denominator is ever not 100% of our grantees?**

Since we provide the numerator and percentage and you know how many grantees are in your State, you can work backwards to determine the denominator.

90. Can you provide more guidance on how we should set our performance goals for the next 5 years?

We encourage you to be aggressive, but also realistic and grounded in what your health center experience is now, as well as what you see in the immediate couple of years. Focus on improving from where you are today and where your health centers are today to meet the goals but understand and take into consideration the context within which your health centers are operating.