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Health Resources and Services Administration

Key HRSA management/administrative issues needing prompt, high-level attention in a new Obama Administration:

- **Visionary, Inspirational Leadership:** There is a need to bring forward clear and organized vision for HRSA programs, both in terms of unmet need and in context of a reformed health care system. This must take the form of better and clearer policy and programmatic direction, and the development of creative partnerships with others (in such areas as HIT, workforce, capital, Emergency Response, and technical support). In the case of health centers, this involves a balance between the need for expansion (for example, NACHC's *Access for All America* Plan) and the need to keep existing centers operating healthily in a rapidly changing environment. HRSA must track, identify, and respond to CHCs in trouble by making available adequate levels of technical assistance to such CHCs, and by reorganizing regional offices to monitor, assist and respond quickly to specific local/regional challenges. Further, HRSA must exert crucial leadership in representing its grantees at highest levels of HHS to secure necessary support for HIT/EHR adoption/use at all grantee sites.

- **Restoring Emphasis on Program Results:** HRSA programs and staff must be encouraged and expected to perform their core missions. All too often in recent years, staff offices – especially general counsel and grants management – have set the agency's pace and direction, and have constrained and impeded program decisions and actions. Program line management staff must be empowered and held accountable, in order to overcome bureaucratic inertia and other impediments that block needed reforms.

- **Intelligent Resource Growth/Management and a Plan for the Future:** There is a need to bring forward a clear and organized vision and sense of mission for HRSA programs, both in terms of unmet need and in the context of a reformed health care system. This involves a balance between the need for CHC expansion (for example, NACHC's *Access for All America* plan, summary attached) and the need to keep existing centers operating healthily in a rapidly changing environment. HRSA must track, identify, and respond to CHCs in trouble by making available adequate levels of technical assistance to such CHCs and by reorganizing regional offices to monitor, assist and respond quickly to specific local and regional challenges.

- **Improving Primary Care Workforce Programs and Aligning Them With HRSA's Service Delivery Programs:** Even as experts chronicle the "near collapse of the primary care workforce", there is a vital need to more closely link the NHSC and other key Health Professions Training Programs with CHCs and other HRSA safety net programs to address the high level of clinical vacancies (issues include promoting primary care careers, workforce diversity, need score and preference for NHSC placements, and need for better coordination at the agency/HRSA level). In addition, the J-1 visa waiver program, which has languished in recent years, must be reinvigorated, in collaboration with the states (which manage a similar effort, the State Conrad 30 program) to ensure that foreign medical graduates who complete a U.S.-based residency training program and wish to remain in the U.S., are permitted to do so only if they practice in an underserved community (preferably with a safety net provider).

- **FTCA Coverage That Fits CHC Innovation and Growth:** There is a critical need to stem the erosion of coverage under FTCA for CHC clinicians, leading to a growing loss of confidence in its availability and scope; FTCA should be viewed and should function as a tool to promote CHC growth and the kind of community-driven practice innovations that CHCs naturally pursue, while saving costs for grantees. Such action would remove the great uncertainty that pervades the field today, causing many or most CHCs to purchase private malpractice insurance to cover instances where such care is clearly covered by private carriers but, it is feared, will not be covered under FTCA current policy (see regulatory issues, below).

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- **Energetic, Committed Advocacy of HRSA Programs to HHS and Other Divisions (esp. CMS):** As noted above, HRSA must exert crucial leadership in representing HRSA grantees at highest levels of HHS to secure necessary support for HIT/EHR adoption and use at all grantee sites. In similar fashion, HRSA must actively engage CMS on proper concern for safety net providers (beginning with FQHCs, but also Ryan White, MCH-funded agencies, Title X FP grantees, etc.), in order to satisfactorily address serious problems such as: delayed Medicaid payments (health centers were inexplicably left uncovered by CMS timely payment rules); difficulties securing approval of changes in scope of services under Medicaid; excessive restrictions on billable visits; exclusion from Medicare payment for Diabetes Self Management Training and from several Medicare demonstration projects (EHR, PQRI, e-prescribing, and others); complications contracting with Part D Plans (including conflicts with PHS Act requirements); and with CMS' MAC program and its rules.

- **Other Pressing Policy Issues**

  - Need to develop mechanisms to adequately screen and monitor FQHC look-alikes for compliance with statutory requirements (especially governance, service area overlap, and care for uninsured).

  - Need to reinvigorate standards employed by prior Administrations (Clinton, Carter) in reaching out to other federal agencies (USDA, HUD, etc.) to develop collaborative mechanisms to meet CHC capital needs (especially in light of 1996 loss of authority to use grant funds, along with creation of loan guarantee authority).

Regulatory Issues

Shortage Designation

- **HRSA's Proposed MUP/HPSA Shortage Designation Rule (July 23, 2008)**—On February 29, 2008, HRSA published a proposed rule in the Federal Register concerning the designations of MUPs and HPSAs that would have impacted care for millions of medically underserved people. Numerous comments were submitted to HRSA most of which (including NACHC's) were critical about the loss of up to half of current designations, the lack of a coherent theory of underserved and access to drive the proposed methodology, and the use of old data. In the July 23 Federal Register (73FedReg42743), HRSA announced that it had received many substantive comments on the rule and that, based on a preliminary review of those comments, it would have to make a number of changes in the proposed rule. Thus, instead of issuing a final rule as the next step, HRSA stated it will issue a new NPRM for further review and public comment. There is still concern, however, that HRSA may issue an interim final rule prior to mid-January, 2009. Such a rule promulgation might contain the same flaws as the earlier proposal and should be halted.

Federal Tort Claims Act

- **Coverage**—HRSA should clarify in a PIN that if a health center activity is approved by HRSA (i.e approved scope of project) and that activity is included in a contract between the center and its employee or contractors, then the health center and employee/contractor will be covered under FTCA regardless whether the individual treated by the center/ employee/ contractor is a patient of the health center . HRSA should also be required to provide model language that will be acceptable for such a health center employee/contractor agreement.

- **Timely Response to Coverage Questions**—HRSA should be required to respond to an FTCA coverage question within 30 days of receipt of the question from a health center.

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Section 340B Prescription Drug Coverage

- **Patient Definition**—HRSA should retain its current three-pronged definition of "patient" for purposes of Section 340B of the Public Health Service Act. Rather than revising these guidelines per its Federal Register publication of January 12, 2007 (72 Fed Reg 1543), HRSA should publish, periodically, explanations of how it interprets the current definition of "patient" along with examples of acceptable and unacceptable practices and helpful Q's and A's.

Drug Enforcement Agency

- **Exemption from Registration Fee**—DEA should restore the exemption from the U.S. Drug Enforcement Registration Fee for CHCs (and other identified federally-supported entities) and their clinicians. Currently, the DEA requires every **site** where Class II or higher drugs are administered or dispensed, and every licensed practitioner who distributes or dispenses such drugs, to be registered in order to legally dispense such drugs. The DEA charges $512 for a 3-year registration, but it exempts all government institutions, law enforcement agencies, and military personnel from payment of those fees. In the past, the DEA also waived the fees for charitable organizations, including CHCs; however, DEA reversed that policy in November of 2006, costing Health Centers more than $6 million annually. Restoration of DEA's former fee exemption for CHCs would allow them to extend care to another 50,000 individuals, including 20,000 uninsured persons.