



MEMORANDUM



NATIONAL ASSOCIATION OF
Community Health Centers

To: Health Care Policy Working Group, Obama Health Care Transition Team
From: National Association of Community Health Centers
Re: Community Health Care Policy Priorities
Date: December 9, 2008

Dear Senator Daschle and Members of the Working Group –

First of all, congratulations to each of you on your new role and thank you for your leadership in setting the direction of America's health care policy.

As you well know, our country is at a critical juncture, with health care costs spiraling upward, access to care elusive for millions, and a system where new technologies and high-quality care are too often the privilege of the few. We are also at a moment of tremendous opportunity. With the right policy interventions, we can greatly control costs, expand access to care to all who need it, and bring that care to a level of quality unrivaled in the world.

We wholeheartedly support your call for significant health reform, and in particular for making affordable health coverage available to all Americans. We fervently believe that an effort to strengthen our nation's system of **primary health care** will bring tremendous value to the broader health care reform effort, in terms of reduced costs, expanded access, and higher quality of care. Specifically, a strategic expansion of **Community Health Centers and the Primary Care health workforce** will be central to achieving these goals. Already the "health care home" to more than 18 million low-income and uninsured Americans, Health Centers nationwide have committed to a bold plan for expansion. This plan, called **ACCESS for All America**, calls for serving 30 million patients in Health Centers by 2015, through operational growth, a strengthened workforce, and capital development.

Senator Daschle, as you stated in your book, "**CRITICAL: What We Can Do About the Health Care Crisis**":

"Finally, we should increase the number of Community Health Centers, government-funded clinics that provide basic care to the poor and uninsured. These clinics are a godsend for many people across the country, particularly those who live in rural areas with a shortage of health-care providers. Even if we achieve 'universal' coverage, there will be some percentage of people who still fall through the cracks. These clinics will serve as a safety net. This is one area where I must applaud President Bush: He has expanded the number of Community Health Centers by nearly a third since he took office. That said, more needs to be done."

As you and your team examine the nation's health care priorities and the direction of reform, there are a number of steps we consider crucial to a well-functioning health care system. This document lays out our broad **principles for health care reform**, our **2009 legislative priorities** (including economic stimulus and FY10 Budget and Appropriations), and our **regulatory priorities** for HRSA, CMS and other agencies.

We look forward to working with you in the months ahead to advance these goals.

Sincerely,

Tom Van Coverden
President and CEO



Health Care Reform



AMERICA'S HEALTH CENTERS and HEALTH CARE REFORM: TURNING IMPROVED COVERAGE INTO BETTER HEALTH CARE ACCESS

Our Health Care System is Failing. Everyone agrees that the current health care system in America is not working. As a nation, we spend too much money on health care, while the number of uninsured and underserved people continues to rise, and the quality of care remains inadequate. Not only are 46 million people completely uninsured, but 56 million Americans – many of whom actually *have* health insurance coverage – have no health care access because they live in communities where there are too few primary care providers.

The bad news is that unless something dramatic is done, it's only going to get worse. **The good news** is that the essential pre-requisite for creating an effective, primary care-grounded system of care is within our reach, if we redirect our efforts toward what works, rather than what's always been done.

Reform is About Coverage AND Care. We agree with the vast majority of Americans that health reform must significantly improve access to affordable and adequate insurance coverage. However, expanding insurance alone will not guarantee that every person will have access to high-quality, appropriate, and cost-effective health care services. In the year following Massachusetts' implementation of its landmark health reform initiative, even as coverage rates soared, the number of adults reporting an inability to find a source of primary health care doubled.

In order to achieve a well-functioning primary care system, it will take as much planning and policy development as it will to retool any other aspect of the health care system. Simply reducing expenditures for inpatient care will not yield advances in primary care. Therefore, it is important that the goal of assuring a primary health care home for everyone is explicit and that this objective receives the same careful attention as other health system reforms.

Greater access to primary and preventive health care, specifically through medical or health care homes, holds great promise for attacking the access-cost-quality problem while minimizing or even eliminating disparities within all three areas. One recent report noted that **if every American made appropriate use of primary care, the health care system would realize \$67 billion in savings annually.**

The Primary Care Imperative: Virtually all health care experts support a major investment in a revitalized primary care system, underscoring **the importance of moving primary care to a central place on the nation's health reform agenda.** Extensive evidence shows that regardless of how its effect is measured, the results are the same when primary care is strengthened: the cost savings are greater; the health outcomes are improved; and health care disparities are reduced. Primary care makes an enormous difference to health care outcomes, quality and costs.

Health Centers are Making a Difference! America's Community Health Centers have demonstrated conclusively over the past forty-plus years that improving access to high-quality, continuous care to people and communities with limited or no access to other sources of care improves health outcomes, narrows health disparities, and generates significant savings to the health care system and economic benefits to low income communities. So much of this success can be attributed to their community boards, which have ensured the centers' responsiveness to community needs while bringing solid oversight and accountability to their operations. Today, some 1,200 Community Health Centers provide high-quality, affordable, preventive and primary health care to 18 million people nationwide regardless of their ability to pay, in more than 7,200 locations. All who seek care are welcomed equally and served with professionalism and excellence, as confirmed in numerous studies.



Health Centers fulfill all the characteristics of being a medical home, and are high performers of care despite their at-risk patient mix. Research shows the quality of their care is equal to or better than other providers, and they meet or exceed quality performance results in the private sector. They have compiled a remarkable record of achievement in providing care of superior quality, with exceptional cost-effectiveness and efficiency. *Their costs of care rank among the lowest, and they reduce the need for more expensive emergency room, in-patient and specialty care, saving billions for taxpayers and society – up to \$18 billion last year alone* – while bringing much-needed economic benefits to the low income communities they serve.

A Plan for America’s Health Care Future: America’s Health Centers have developed a framework for change – the **ACCESS for All America (AAA)** Initiative, designed to reduce the ranks of America’s medically disenfranchised by preserving, strengthening and expanding Health Centers to reach a total of 30 million patients by the year 2015. *Once Health Centers reach 30 million patients by 2015, they will generate as much as \$40 billion annually in cost savings for the entire health care system, while bringing \$40.7 billion in annual economic benefits and supporting 460,000 jobs in their local communities.* The **ACCESS for All America** plan is envisioned to eventually reach 56 million Americans, with Health Centers serving as the model and innovation leader for what primary care practice could become.

An Investment That Produces a REAL Return! America now has the chance to make a real investment that will pay off for years to come. Investing in the growth of Community Health Centers today is a smart choice for the health of Americans tomorrow. **Health Centers are an excellent public investment, generating substantial benefits for patients, communities, insurers, and governments – indeed, for all of America!**

AN AGENDA FOR HEALTH CARE REFORM

In order to truly meet the need for affordable, accessible, high-quality health care across the country, it is imperative for policymakers to take the following actions:

- 1. Ensure Universal Availability of Affordable Coverage for Quality Health Care**, with strengthened Medicaid and SCHIP programs for all low-income families and individuals.
- 2. Enhance the Availability of Primary Care in Underserved Communities** by continuing to significantly increase funding for Community Health Centers in accordance with the **ACCESS for All America** plan, in order to extend the reach of Health Centers to all underserved communities over the next 15 years.
- 3. Ensure a Strong Primary Care Workforce** by increasing support for clinical training and placement programs (especially the National Health Service Corps) designed to meet three key workforce goals: reversing the decline in the primary care workforce, expanding workforce diversity, and developing culturally proficient providers.
- 4. Strengthen Existing Payment Systems for Primary Care** by improving the public insurance programs’ payment structures for primary care. This includes reforming the current Medicare payment system for Health Centers and ensuring adequate payments for Health Centers in SCHIP. It also should include adoption of payment methods for private practices that reflect the value of primary care and improved access to such care.
- 5. Improve Access to Low-cost Capital Financing** by increasing the tools available to make much-needed capital investments in both existing and new Health Centers and other key providers – using grants, loans, loan guarantees, bonds and/or tax credits – and covering both facilities and equipment needed to help modernize the delivery of care, especially vital Health Information Technology adoption among primary care providers.



2009 Legislative Priorities



Investing in Health Centers as Economic Stimulus

With the U.S. economy in crisis, the new Administration's top priority must be to stimulate the economy while meeting the pressing needs of families hit by the economic downturn.

A one-time, immediate investment in Community Health Center infrastructure will bring health care to an additional **2.8 million Americans**, while creating **billions in economic stimulus** in needy communities and **approximately 50,000 new high-quality jobs**. This investment should follow these three tracks:

- **Operations:** A one-time investment of **\$248 million in the Health Centers Program** would make health care quickly available to 2.8 million additional individuals, including 750,000 uninsured.
- **Workforce:** A one-time investment of **\$90 million in the National Health Service Corps (NHSC)** would place 1,000 health care providers in underserved areas to serve an additional 2 million low-income people, half in Community Health Centers.
- **Capital:** Several investments and policy changes would provide Health Centers with the financing tools to meet their immediate facilities needs, including: an allocation of **New Markets Tax Credits** for Health Centers, improvements to HRSA's existing **Loan Guarantee Program**, and creation of a **single national issuer** of tax-exempt bonds for Health Centers.

These investments will produce **significant stimulus at low cost**, and will bring needed access to health care to individuals, families and communities nationwide.

Health Center Growth and the FY10 Budget

The last 8 years have seen an historic federal investment in the growth of Health Centers, resulting in access to care for an **additional 8 million patients**, and nearly a doubling of Health Center sites to well over 7,000. Yet the need for primary care access remains great – some 56 million are “medically disenfranchised”, Americans with and without insurance who have no access to primary care services.

In recognition of this continued need, and the success of the Health Center expansion, last year Congress unanimously passed the **Health Care Safety Net Act of 2008 (H.R. 1343/P.L. 110-355)**, which called for the continued expansion of Health Centers and the National Health Service Corps. In line with this authorizing statute, we request that in the Administration's Fiscal Year 2010 Budget, you include the following funding levels for these two vital programs:

- **\$2.602 billion for the Community Health Centers Program**, including \$100 million in base grant adjustments for existing centers.
- **\$235 million for the National Health Service Corps**, including \$156.2 million for Scholarships and Loan Repayment.

These investments will bring care to more than **3 million additional low-income Americans**, and bring more than **4,000 primary care clinicians** to those communities most in need.



Strengthening and Enhancing Payments for Preventive and Primary Care

Health Centers' have achieved unparalleled success in expanding care to vulnerable populations while maintaining the highest quality. Instrumental to this success has been a payment system designed to recognize the unique challenges and financing of Health Centers operations.

Ensuring adequate payment for Health Center services from all insurers, public and private, will be crucial to expanding access to Health Centers in a stable, predictable manner. These payment reforms must go hand-in-hand with a continued investment in Health Center growth.

In recent years, Congress has attempted to replicate the success of Health Centers' **Medicaid Prospective Payment System (PPS)** in other public insurance programs:

- **Medicare:** The **Medicare Access to Community Health Centers (MATCH) Act of 2007 (S.2188/H.R. 2897)** would replace Health Centers' current Medicare payment system with a PPS Mirroring that in Medicaid. Finance Committee Chairman Baucus has called for this policy change in his "Call to Action" plan, and the GAO is studying the issue, pursuant to MIPPA 2008 (P.L . 110-275).
- **SCHIP:** Both the **Children's Health Insurance Program Reauthorization Act of 2007 (H.R. 976)**, passed by both Houses of the 110th Congress and vetoed by President Bush, and the **Children's Health and Medicare Protection Act of 2007 (H.R. 3162)** contained a new PPS for Health Centers in the SCHIP Program.

In addition, payment systems for private practitioners must be reformed to more appropriately reflect the essential role and value of primary care within the system, and to encourage coordinated, team-based care.

Workforce Development and Capital Investment for Health Centers

No plan to expand the reach of Health Centers to millions of additional new patients can be complete without ensuring a robust primary care workforce and access to low-cost capital financing. We recommend several steps toward these goals:

Workforce:

- Increasing the commitment to the **National Health Service Corps**, which provides loan repayment and scholarships to primary care clinicians who commit to serving the underserved. Currently half of all NHSC placements are in Health Centers, and there are more than 5 willing applicants for every funded scholarship and loan repayment award. P.L. 110-355 sets the framework for this expanded investment.
- Invest in **health professions training programs** that focus on primary care, service to the underserved, and creation of a health workforce that is racially, geographically, and socioeconomically diverse.

Capital:

- Providing an allocation of **New Markets Tax Credits** specifically for Health Centers would set the wheels in motion to bring \$1.8 billion in new capital financing to Health Centers, for an initial investment of \$150 million over two years.
- Making improvements to the existing federal **Loan Guarantee Program (LGP)** for Health Centers to raise the guarantee to **100%** of the loan, and allow the HRSA LGP to be used in conjunction with **tax-exempt bonds**.
- Authorizing a national entity to issue tax-exempt bonds on behalf of Health Centers.



Regulatory Priorities



Centers for Medicare and Medicaid Services (CMS)

Medicaid

- **Timely Payment**—States frequently delay payments to Health Centers. In some cases, the delay is in payment of claims, other times it is a delay in reconciling cost reports (in states that pay on the basis of reasonable cost rather than PPS), and in some states it is late payment in FQHC managed care wrap-around. Federal regulations require payment of 90% of all clean claims within 30 days of the date of receipt and 99% within 90 days. But that rule only applies to individual practitioners, those in a group, and those in a shared health facility. All other providers, including FQHCs, need only be paid within 12 months. *42 CFR 447.45(d)*. The regulation should be revised to specifically add FQHCs to the 30 day/90 day payment time limit category with regard to claims filed; to require reconciliation of cost reports within a specific time limit (possibly 90 days from date of submission); and to require managed care wrap-around payment from the state to the FQHC no less than every 120 days (as required in statute). Time limits should also be applied to states' responding to FQHC requests for change in scope.
- **1115 Waivers**—CMS should not allow states to waive the FQHC service or reimbursement mandates unless the affected health center(s) agrees to the waiver.
- **Number of Billable Visits Per Day**—a number of states only allow a health center to bill one FQHC visit per day, even if the patient is treated that day by a health center physician, dentist, and psychologist (one-stop shopping). Medicare regulations allow for a medical visit, a mental health visit, and a DSMT visit on the same day. CMS should require states to allow FQHCs to bill Medicaid for least two visits per patient per day. A better approach would be to require allowance of three visits per day if a center also provides dental care. This could probably be done via State Medicaid Director letter, since there are currently no Medicaid FQHC regulations.
- **Outstationing Eligibility Workers**—CMS should be requiring states to comply with the statutory requirement (42 USC 1396a(a)(55)) regarding outstationing eligibility workers at FQHCs and reimbursing Health Centers for the costs of health center staff providing outstationing in place of state or county employees. Strengthening the current outstationing regulations (42 CFR 435.904) would be the best way to do this.
- **Grant Offsets**—In some states that pay FQHCs on the basis of reasonable costs, the state will first offset the Health Centers cost by subtracting from those costs any "restrictive" grant that the center has received from a private philanthropy, the state or the federal government (except for Section 330 grant funds). This results in reducing reimbursement to the health center. Medicare used to follow a similar policy but eliminated the regulation that allowed for such a policy in 1983. CMS should instruct states that they can no longer apply this policy to FQHC Medicaid reimbursement. This could be done via State Medicaid Director Letter.
- **Inpatient and Other Services Offsite**—A number of states will not reimburse an FQHC for services provided in a hospital. Usually this policy is premised on a similar prohibition in Medicare FQHC regulations but the Medicare rule is based on a provision in the Medicare statute that does not exist in the Medicaid statute. States should be informed that they are to allow FQHCs to be reimbursed on an FQHC per visit basis for



services delivered at a hospital if the patient is a patient of the health center and the service is one that is normally provided at the health center (for example, a FQHC provider making rounds at the hospital where the center patient is hospitalized). States should also be instructed to allow centers to be reimbursed for an FQHC visit when it treats its patients at other offsite localities, such as the patient's home, a nursing home, etc. State Medicaid Director Letter could do this.

Medicare

- **Health Center Participation in CMS Demonstration Projects** – Because Health Centers are paid on the basis of reasonable cost rather than fee-for-service, CMS concludes that they cannot participate in some CMS demonstration projects and initiatives including the EHR demonstration, PQRI and others. There does not appear to be any legal prohibition on CMS establishing an incentive payment structure in these demonstration projects for Health Centers. May or may not require regulatory change depending on the Medicare demo in question and whether CMS has promulgated regulations relating to a particular demo.
- **Review of Medicare Administrative Contractor (MAC) Process** – In light of FQHC's unique reimbursement under Medicare, NACHC requested that CMS exempt FQHCs from the MAC process and, instead, that CMS continue to contract with one intermediary for all FQHCs. CMS turned down NACHC's request. CMS should be required to revisit and reverse this decision.
- **TRoop (true out of pocket costs)**—CMS will not treat payments by an FQHC towards a beneficiary's cost-sharing under Part D Medicare prescription drug coverage as an incurred cost (TRoop) by the beneficiary in reaching his or her annual out-of-pocket limit. In effect, this means patients of a health center with income between 150%-200% FPL are locked into the so-called coverage gap "donut hole" and the health center will have to continue using its Section 330 grant funds to cover much of that beneficiary's Part D drug costs. CMS should clarify in Guidance, or if need be revise its regulation, to provide that FQHCs can use their non-grant fee income to cover these patients cost-sharing and that such expenditures would qualify as a patients' TRoop.
- **Part D Contracting**—Medicare Part D Plans should be required to contract with FQHC pharmacies and to assure CMS that provisions within their contracts with FQHCs will not conflict with a health center's Section 330 grant requirements nor jeopardize its FTCA coverage.
- **Site Certification** –Medicare FQHC regulation provides that the date on which an FQHC site can be reimbursed as an FQHC is the date on which CMS accepts a signed agreement from the FQHC. Instead, the effective date should be retroactive to the date the center applied for site certification, otherwise the health center loses many months of FQHC reimbursement due to lengthy delays in CMS approval, which usually are not the fault of the applicant FQHC. This will require a regulatory change of 42 CFR 489.13(a).
- **Coverage for Diabetes Self Management Training Services** – The Deficit Reduction Act of 2005 allowed for coverage of Diabetes Self Management Training (DSMT) and Medical Nutrition Therapy (MNT) services as billable visits at Health Centers. However, it is unclear how Health Centers should bill for DSMT services provided in a group (as recommended by CMS). NACHC has requested CMS to make clear that an FQHC can bill for a DSMT group visit, but CMS has not responded with a policy to allow for this. Does not require a regulatory change, just a policy clarification.



- **CMS Rules that Should be Rescinded**
 - CMS SCHIP Directive (*CMS SHO #07-001*) August 17, 2007
 - All Rules that Were Subject to Medicaid moratoria extension in Iraq Supplemental Bill
 - Final Rule: State Flexibility for Medicaid Benefit Packages (42 CFR Part 440, December 3, 2008; 73 *Fed Reg* 73693)
 - Final Rule: Medicaid Program; Premiums and Cost Sharing (42 CFR Parts 447 and 457, November 25, 2008; 73 *Fed Reg* 71828)
 - Final Rule: Medicaid Coverage of Outpatient Hospital Services (42 C.F.R. 440, 447, November 7, 2008; 73 *Fed Reg* 68158)
 - Proposed Rule: Medicare Program: Changes in Conditions of Participation Requirements and Payment Provisions for Rural Health Clinics and Federally Qualified Health Centers (CMS-1910-P2; June 27, 2008; 73 *Fed Reg* 36696)
 - Proposed “Provider Conscience” Rule (73 *Fed Reg* 50274, August 26, 2008)
 - Proposed Rule: HIPAA Administrative Simplification: Modification to Medical Data Code Set Standards to Adopt ICD-10 (73 *Federal Register* 49796 et seq., August 22, 2008)

Health Resources and Services Administration

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.



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.