

RATIONALE FOR COMMUNITY HEALTH CENTER RECOMMENDATIONS

1. Ensuring that Insurer Provider Networks Include Robust Preventive and Primary Care Systems

a. Adequate Reimbursement for Preventive and Primary Health Care

In the early 1990s, Congress instituted a Community Health Center-specific Prospective Payment System (PPS) to guide health center reimbursement under Medicaid, complementing the existing cost-based reimbursement structure under Medicare. The PPS structure (under Section 1902(bb) of the Social Security Act) ensures that health centers receive adequate payment through an all-inclusive per-visit payment rate for comprehensive primary and preventive care services (including physician, nurse, lab, x-ray, health and nutrition counseling, behavioral health, smoking cessation counseling, and case management), this is contrast to the fee-for-service reimbursement system which pays on a per-service basis. The PPS also ensures that discretionary grant funding needed to support other vital purposes (care for those who remain uninsured, health-improving services that are not reimbursed, etc.) will not have to be siphoned off to cover inadequate payment rates. With the passage earlier this year of the Children's Health Insurance Program Reauthorization Act (CHIPRA), the CHIP program will begin paying health centers according to the same PPS structure. Conversely, private insurance pays on average only 50% of the "reasonable cost", and does not recognize some services. Yet, every study concludes that health centers reduce total health care costs by as much as 41%. And this is why Congress—on a strong bi-partisan basis—has retained the PPS payment methodology for nearly two decades. This PPS system was also adapted to work in managed care and new 'benchmark plan' arrangements through a 'wrap-around' mechanism. Extending the PPS payment system to any new insurance plan, public or private, will assure the continued emphasis on preventive care, patient education, and effective case management of chronic conditions.

Conversely, eliminating or eroding this unique payment system would either render many health centers insolvent in short order or, ironically, force them to cut the very services that produce the big overall health care savings.

b. Update the Medicare Payment Methodology to Conform with Medicaid and CHIP

The Medicare FQHC payment methodology, while based on reasonable cost, sets an arbitrary cap and has not been updated in over a decade. Over three-quarters of all Community Health Centers suffer significant losses when they serve underserved Medicare beneficiaries (approximately \$50 million per year)—money that could be used to serve thousands more patients. Legislation introduced by Congressmen Lewis and Emerson in the House (H.R. 1643), and Senators Bingaman and Snowe in the Senate (S. 648), would rectify this situation to conform to the Medicaid PPS (Section 1902(bb) of the Social Security Act) and CHIP. Chairman Baucus has also expressed support in his November 12, 2008 policy paper (*CALL TO ACTION: HEALTH REFORM 2009*).

c. Patient Choice/Ensuring Access to Health Care Homes in Underserved Areas

In any new health care system, there is a danger that some insurers will seek to avoid enrolling people who live in low-income and underserved rural and urban communities, in order to avoid the perceived health risk associated with such individuals. In order to obviate this possibility and ensure that all health insurers will enroll and cover people living in such communities, reform should require that all insurers include an adequate supply of providers located in those communities, as part of their provider networks – this should include at least all Community Health Centers and other primary care safety-net providers located in these communities.

2. Expanding the Prevention-Oriented Community Health Center Delivery System

H.R. 1296/S. 486 would expand the Community Health Center program from serving the current 18 million patients to 60 million patients by 2015. It would also boost the National Health Service Corps (NHSC) from its current field strength of 4,000 to 21,000 by 2015. Together, these efforts would not only provide a Medical Home for 42 million additional people, but also reduce health care spending by an estimated \$80 billion annually, once the 60 million patient-level is reached.

Community Health Center operational grant funding would continue to be used for start-up costs, recruitment of health care professionals, partial subsidies for those remaining uninsured (ex. Mass.), non-covered preventive health services (ex. outreach, translation, transportation, and behavioral health counseling, etc.), HIT implementation and training, public health/emergency management coordination, and related services.

Conversely, failure to strengthen and expand the primary care delivery system will result in inadequate access to care for millions, further overcrowding of emergency rooms (inappropriate care locations), and considerably more cost. Likewise, failure to expand the NHSC and incentivize primary care teaching and practice will result in poorer access and quality outcomes, and significantly increased costs.

3. Providing Low-Cost Private Capital to Accommodate Increased Patient Demand

Our assumption is there will not be sufficient funding to provide appropriated grant funding for facilities and HIT because of increased budget demands. Our proposed language would allow Community Health Centers to, at least, access low-cost private capital as most other non-profit health organizations currently do, with modest adjustments to existing programs (PHS Act-- loan guarantee authority, and the Internal Revenue Code--Single National Bond Issuer and dedicated New Market Tax Credits).

While the economic recovery Act (ARRA) provided a great down-payment toward meeting health centers' capital needs, it will meet only one-fourth of current demand and less than 15% of what is needed under our growth plan. Failure to act will most certainly hinder the ability of Community Health Centers to serve the greatly increased numbers of patients expected under health care reform.