



**National Association of Community Health Centers
Collective Comments In Response to Policy Options on Delivery, Coverage and Financing
Comprehensive Health Reform**

Submitted to the Senate Finance Committee

Community Health Centers on Health Reform

On behalf of the 18 million patients currently served by community health centers, in over 7,200 communities nationwide, we at the National Association of Community Health Centers (NACHC) commend Chairman Baucus, Ranking Member Grassley and other Members of the Committee for your leadership, energy, vision, dedication, and commitment to seeking the effective means of reforming our country's health care system so that it works for everyone, and especially for those who for far too long have been forgotten and left behind. We appreciate this opportunity to comment on the options put forth by the Committee with regard to the delivery, coverage and financing components of health reform. We strongly believe a reformed health care system must integrate coverage, appropriate financing, access and quality. As such, we have incorporated all of our comments to the Committee's three reports, *Transforming the Health Care Delivery System*, *Expanding Health Care Coverage* and *Financing Comprehensive Health Reform*, into this single document.

Our message to policy makers is simple: in order to make health care reform a true success, we must ensure that access to care is front and center. Community health centers' 40-plus year track records of success demonstrates that we are well equipped to play a pivotal role in a reformed delivery system – providing patients access to quality health care while yielding over 18 billion in savings to the overall health system. We have been active participants in the health reform process and discussions underway, and, with your support, are putting the American Reinvestment and Recovery Act (ARRA) investments to work in our communities, serving an additional 2,868,111 patients and creating and preserving 11,949 jobs nationwide so far.¹ We look forward to the opportunity to expand this successful partnership in a reformed health system, providing everyone in need with access to a comprehensive health care home.

NACHC on Health Care Delivery

Discussion:

We believe that reform should guarantee that everyone – especially those who are medically underserved – has access to a medical or health care home, where they can receive high quality, cost-effective care for their health needs. Even people who have an insurance card can be medically disenfranchised, but it is low-income, uninsured, rural, and minority populations who are disproportionately affected by the inequitable distribution of health care resources and barriers to coverage that characterize the current health care system. These individuals, and the millions of others who confront additional barriers to care, require a source of regular,

¹ <http://www.hhs.gov/recovery/hrsa/healthcentergrants.html>

continuous primary and preventive care—a medical home. The health center model is a living example of the medical home in practice: it is patient- and family-centered, coordinated, comprehensive and continuous, and has been proven to yield better health outcomes, remove barriers to needed care, and minimize health disparities.

A reformed health care delivery system will hinge on having an available, trained workforce of health professionals ready to serve in communities nationwide. We currently have an acute shortage of primary care professionals, doctors, nurses and other non-physician providers; leaving over 60 million Americans are “medically disenfranchised,” lacking access to a regular source of primary care. In addition, as the Massachusetts coverage expansion experience shows, insurance is only the first step to health care; since that state embarked on its groundbreaking initiative to achieve near-universal coverage three years ago, its own shortage of physicians statewide has made it difficult for many people to access primary care. **Expanding the prevention-oriented community health center delivery system consistent with the ACCESS for All America Act of 2009 (H.R. 1296/S. 486) will ensure a health care home for 60 million people in underserved communities within the next six years.** Community health centers are uniquely equipped to care for the distinct needs of the communities they serve.

We agree with the Committee that providers must be incentivized and adequately compensated to practice primary care in certain underserved areas of the country. The National Health Service Corps (NHSC) program is a highly-successful but under-funded pipeline for trained primary care professionals – doctors, dentists, nurses and other non-physician providers – to practice in medically underserved areas nationwide. Limited program resources have left many underserved communities unable to access the NHSC pipeline. The funding levels called for in the **Access for All America Act of 2009 (H.R. 1296/S. 486) would boost the NHSC from its current field strength of 4,000 to 21,000 by 2015.** These two programs, expanded in concert, would not only provide a **medical home for 60 million people**, but also **reduce health care spending by an estimated \$80 billion annually**, once the 60 million patient-level is reached.

We strongly support the Committee’s stated intention to reform policies related to training and education of health care professionals. Health Centers have faced a growing challenge in recruiting and retaining primary care health professionals willing to serve in underserved areas. **We fully support an increased focus on primary care training, efforts to ensure the availability of residency programs in rural and underserved areas, and programs designed to foster that training in community-based settings such as health centers, and would support measures to make it financially sustainable.**

We also agree that other payment policies need to be implemented, in particular policies that promote comprehensive, patient-centered preventive and primary health care such as that provided by medical and health care homes. Evidence abounds that primary care providers are severely under-compensated, and this under-compensation has led directly to the serious and growing shortage of such providers. For health centers and rural health clinics, as we will note more extensively below, we strongly recommend extending the current Medicaid Prospective

Payment System (PPS) to other payers; for other primary care providers, we defer to the Committee and other experts in the matter of the most effective payment system.

High-functioning health care systems also require adequate facilities and equipment. While normally, most non-profit health organizations are able to access capital for such purposes, smaller ambulatory care systems such as health centers are too often locked out of such venues. We strongly recommend steps to allow health centers and other ambulatory care providers located in underserved areas to, at least, access low-cost private capital as most other non-profit health organizations currently do, through modest adjustments to existing programs. While the ARRA provided an historic down-payment toward meeting health centers' capital needs, the \$1.5 billion made available will meet only one-fourth of current demand and less than 15% of what is needed over the next 6 years.

Recommendations:

- **Expand the prevention-oriented community health center delivery system consistent with the ACCESS for All America Act of 2009 (S.486/H.R. 1296) to provide a health care home for 60 million people in underserved communities nationwide.**
- **Provide 21,000 primary health care professionals (physicians, dentist, nurses, etc) to serve in federal shortage areas, through a strategic expansion of the National Health Service Corps program, in line with the funding levels called for in the Access for All America Act (S.486/H.R. 1296).**
- **Improve health professions education to increase the focus on primary care training, ensure the availability of residency programs in rural and underserved areas, and foster training in community-based settings such as health centers.**
- **Provide Community Health Centers with access to low-cost capital through financing programs now available to other non-profit health care providers to accommodate increased patient demand resulting from expanded coverage.**

NACHC on Coverage

Discussion:

America's health centers believe that health reform should strive, first and foremost, to achieve universal coverage that is available and affordable to everyone, and especially to low-income individuals and families. From the perspective of the nation's health centers, our current public programs – Medicare, Medicaid and CHIP – are uniquely qualified to meet the needs of our most vulnerable communities. Patients can access not just primary care, but a full spectrum of services tailored to meet their individual and family needs including case management, transportation and language assistance as well as dental care, mental health services and prescription assistance programs.

Community Health Centers strongly **support expanding Medicaid to cover at least everyone with incomes up to 150% of the federal poverty level without restriction**, and higher if possible. This would include ALL individuals, adults as well as children, individuals as well as families, because these are the very people who most need the services and benefits offered through Medicaid. Regarding options put forth for consideration involving possible purchase of

private coverage through Health Insurance Exchanges (HIEs) for such populations, health centers strongly recommend that any such purchase be effectuated by the Medicaid program directly, given its experience and expertise in such transactions in the case of managed care products over the years. In all such cases, Medicaid will need to coordinate and assure availability and coverage of Medicaid services and benefits not made available through such private coverage to those individuals, again in much the same way as has been accomplished for Medicaid beneficiaries in managed care arrangements in the past.

We also support making Medicare coverage available to those individuals over age 55 or even age 50, who do not have access to employer or other public coverage, on a "buy-in" basis. This generation is currently the fastest-growing age group of health center patients, and far too many have NO access to affordable coverage.

The health center program is able to generate system-wide savings and success because current federal public payers, namely Medicaid and CHIP, reimburse them adequately and predictably for all of the cost-effective preventive and primary care they provide. Under Medicaid and, beginning in October 2009, under CHIP, health centers are reimbursed through the FQHC Prospective Payment System (PPS). The Medicare Access to Community Health Centers (MATCH) Act of 2009 (S. 648/H.R. 1643) would align Medicare reimbursement under the health center PPS, extending this reimbursement system to all existing public payers, consistent with the Chairman's recommendation in his *Call to Action* White Paper last year, which cited health centers' Medicaid PPS as a "successful model" and called for mirroring that system in the Medicare program. **We urge Congress to ensure that the model health center PPS used by Medicaid, and recently adopted by CHIP, is extended to all other reimbursement systems under national health insurance.**

The PPS structure ensures that health centers receive adequate payment through an all-inclusive per-visit payment rate that balances both higher and lower costs for all of the services they provide to the publicly insured patients they see. The current third-party insurance payment structure dis-incentivizes many health care providers from offering patients coordinated case management and other enabling services, as well as the cost-effective preventive care that health centers provide, and which has been proven to save the health care system money overall. The PPS structure for health centers appropriately and predictably reimburses health centers for the comprehensive care we provide. **The same should be ensured in any expanded insurance model, whether public or private.**

As coverage expands, we must also ensure patients have access to doctors who will treat them. As noted earlier, health centers support adequate and reliable primary care provider reimbursement by all public and private payers to reflect the value – in system-wide cost savings and improved health outcomes – that these doctors provide.

We appreciate the Committee's recognition that those with the lowest incomes tend to be more vulnerable and we support the proposal that plans serving this population be required to include safety net providers within their provider networks. We further urge the Committee to

establish a minimum set of standards for all health plans operating under a health insurance exchange that seek to serve low-income or vulnerable populations. **Any health insurance provider network in the new health care system must include Community Health Center and other key safety net providers to ensure patient choice and access to health care homes in underserved areas.**

We also support the options put forth in the Committee's options paper on *Expanding Health Care Coverage*:

- **Improvements to Medicaid enrollment and retention** simplifications to:
 - **Streamline eligibility:** requiring states to implement 12-month continuous eligibility, an enrollment website, enroll at FQHCs, DSH hospitals and DMVs, and extend administrative auto-renewal.
 - **Portability:** As under CHIPRA, initiate a model process for the coordination of enrollment, retention and coverage of all Medicaid beneficiaries who frequently change their state residency, including steps to require interstate coordination to ensure that beneficiaries' home-state Medicaid programs cover them when they are out of state.²
- **Phase-Out Medicare Disability Waiting Period:** eliminate or reduce two-year Medicare disability waiting period. By definition, these patients are among the most vulnerable in our nation and should not be denied critically needed health services.³
- **Improvements in CHIP Eligibility and Coverage:** expand eligibility to 275 percent of poverty, limit cost-sharing under CHIP to Medicaid's cost-sharing rules. and extend the EPSDT requirement for all children enrolled in CHIP. EPSDT is an essential requirement for children in Medicaid, assuring access to all medically necessary care and it has long been a missing requirement of the CHIP program. however, we disagree that states should be prohibited from using income disregards, which could cause many currently enrolled children to lose that coverage.⁴
- **Optional Benefits:** giving provider status to podiatrists, optometrists, free-standing birth centers.⁵
- **Prescription Drugs:** making prescription drugs a mandatory benefit for categorically and medically needy Medicaid patients.⁶
- **Dual Eligibles:** establishing a new Medicaid demonstration authority for exploration of alternative approaches to coordinating care for dual eligibles.⁷
- **Preventive Services & Cost Sharing:** removal or limitation of beneficiary cost-sharing (co-pay, deductible or both) for preventive services covered under Medicare and Medicaid and rated A or B by the U.S. Preventive Services Task Force.⁸

² SFC coverage report pp. 23 - 25.

³ SFC coverage report pp. 37-38

⁴ SFC coverage report, pp. 21-22

⁵ SFC coverage report p. 24.

⁶ SFC coverage report p. 26

⁷ SFC coverage report p. 35.

⁸ SFC coverage report pp. 45-47.

- **Health Disparities:** steps to address health disparities by requiring SSA to collect data on Medicare enrollees, eliminating the 5-year waiting period for non-pregnant adults, and expanding the Maternal and Child Health Services Block Grant program.⁹
- **Language Access:** extending the 75% matching rate for translation services to Medicaid beneficiaries, establishing CLAS standards for private insurers in the HIE, and establishing grants for outreach/enrollment efforts (ie: to fund multi-lingual help lines/data collection).¹⁰

Recommendations:

- **Expand Medicaid to cover at least everyone with incomes up to 150% of the federal poverty level without restriction.**
- **Make Medicare coverage available to those over age 55 or even age 50, who do not have access to employer or other public coverage, on a "buy-in" basis.**
- **Ensure that the model FQHC Prospective Payment System used by Medicaid, and recently adopted by CHIP, is extended to all other reimbursement systems under national health insurance.**
- **Ensure that health centers and other key safety-net providers are included in all insurance provider networks in the new health care system to ensure patient choice and access to health care homes in underserved areas.**

NACHC on Financing of Health reform

Discussion:

We agree with the Committee that responsible health care reform must provide health care coverage for all Americans while simultaneously reducing the rate of growth in health care spending.¹¹ A recent national study in collaboration with the Robert Graham Center found that people who use health centers as their usual source of care have **41% lower total health care expenditures** than people who get most of their care elsewhere. As a result, **health centers saved the health care system \$18 billion last year alone.**¹² In effect, the investment in primary and preventive care that Medicaid and CHIP, and for the most part Medicare, make in paying health centers adequately yields significant savings to the health care system and to taxpayers.

Health centers provide cost savings across the health care spectrum, increasing quality and improving patient outcomes:

- **Cost-Savings Through Reduced ER Use:** Counties with community health centers had 25% fewer uninsured ED visits per 10,000 uninsured population than those counties without a health center site.¹³

⁹ SFC coverage report p. 60.

¹⁰ SFC coverage report p. 60.

¹¹ SFC financing report p. 1.

¹² NACHC and the Robert Graham Center. *Access Granted: The Primary Care Payoff*. August 2007.

www.nachc.com/access-reports.cfm.

¹³ Rust, George et al. "Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties," *Journal of Rural Health* Winter 2009 25(1):8-16.

- **Reducing Health Disparities for Low-Income Populations:** As the proportion of a state's low-income population served by health centers grows, the black/white and Hispanic/white health gap narrows in such key areas as infant mortality, prenatal care, tuberculosis case rates, and age-adjusted death rates.¹⁴
- **Improving the Quality of Health Care:** Health center quality of care is comparable to or better than care delivered elsewhere and racial and ethnic disparities are eliminated in communities with health centers after adjusting for insurance.¹⁵

The Health Centers program is an unprecedented health care success story, improving patient outcomes and reducing health disparities in communities nationwide. Entities ranging from Office of Management of Budget (OMB) to the Institute of Medicine (IOM) to the Government Accountability Office (GAO) have recognized the efficiency and effectiveness of this model, which hinges on the ability to provide comprehensive primary care to all who are served. Literally dozens of studies done over the past 25 years, right up to this past year, have concluded that health center patients are significantly less likely to use hospital emergency rooms or to be hospitalized for ambulatory care-sensitive conditions, and are therefore less expensive to treat than patients treated elsewhere.¹⁶ **Health centers stand ready to contribute to lowering the overall cost of care and to generating long-term cost-savings for the health care system, even as they improve and expand access to preventive and primary health care for those most in need of such care, as one mechanism to finance a reformed health care delivery system.**

We also support the options put forth in the Committee's options paper on *Financing Comprehensive Health Reform*:

- **Medicare Cost-Sharing:** efforts to "simplify" Medicare beneficiary cost-sharing obligations and make them more consistent with benefits available in the private sector, including \$5-10 copays for primary care visits and maximum beneficiary cost-sharing for all Parts A & B services.¹⁷
- **Medicare Cost-Sharing – means testing for Part D premiums:** requiring beneficiaries whose incomes exceed certain thresholds to pay higher premiums for Part D drug coverage, set at the same levels and adjusted in the same manner as under Part B.¹⁸

¹⁴ Shin P, Jones K, and Rosenbaum S. Reducing Racial and Ethnic Health Disparities: Estimating the Impact of High Health Center Penetration in Low Income Communities. Prepared for the National Association of Community Health Centers, September 2003.

www.gwumc.edu/sphhs/departments/healthpolicy/downloads/GWU_Disparities_Report.pdf

¹⁵ Hicks LS, et al. "The Quality of Chronic Disease Care in US Community Health Centers." November/December 2006 *Health Affairs* 25(6):1713-1723.

¹⁶ McRae T. and Stampfly R. "An Evaluation of the Cost Effectiveness of Federally Qualified Health Centers (FQHCs) Operating in Michigan." October 2006 Institute for Health Care Studies at Michigan State University.

www.mpca.net. Falik M, Needleman J, Herbert R, et al. "Comparative Effectiveness of Health Centers as Regular Source of Care." January - March 2006 *Journal of Ambulatory Care Management* 29(1):24-35. Falik M, et al. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers." 2001 *Medical Care* 39(6):551-56.

¹⁷ SFC financing report pp. 14-15.

¹⁸ SFC financing report pp. 15-16.

- **Updating Payment Rates for Inpatient Services:** adjusting current GME and DSH payment levels to better reflect the actual costs hospitals currently incur in treating low-income and uninsured individuals, and in training medical residents; and consolidating Medicare and Medicaid payments to hospitals as a way to streamline and better account for and coordinate federal funding within the DSH and GME payment areas.¹⁹

Recommendation:

- **Invest in Community Health Centers as a mechanism for promoting prevention and primary care and controlling long-term health system costs.**

Conclusion

Every American needs health reform to deliver three things:

- Affordable, comprehensive coverage that includes medical, dental, mental health, and other key benefits such as vital preventive and primary health care services;
- A medical or health care home, such as a health center, that understands them and their health care needs and is committed to serving them and their communities over the long run (this includes especially the 60 million “medically disenfranchised” people who have NO regular source of preventive and primary health care); and –
- The assurance that their health care home will remain viable through payment policies that pay them adequately for the care they furnish and that reward them for the value and quality they produce.

We stand ready, willing, and able to work with the Committee, and with everyone involved to ensure the success of health reform and redeem its promise to improve health and lower costs for all.

¹⁹ SFC financing report pp. 7-9.