Recommendations in Blending Senate Committee Health Reform Legislation

NACHC has expressed strong support for both Senate Committee-passed versions of health care reform legislation. Each Committee has included vital provisions that will strengthen and expand health centers' ability to provide high-quality primary and preventive care to newly insured patients The recommendations below focus on priority provisions for health centers, ***where differences exist between the two Committee-passed versions*** *of the legislation.*

As the Senate works to blend the two Committee-passed bills together, NACHC recommends that the final bill:

1. Protect Health Centers from Underpayment by Exchange Plans

Section 2242(g) of the Finance Committee legislation would ensure that FQHCs do not lose revenue when treating newly insured patients gaining coverage through the new health insurance exchanges. This would be accomplished by extending the PPS payment rate (currently used by the Medicaid program to determine payments for health centers' services) to private insurance plans participating in the Exchange. The provision ensures that discretionary grant funding needed to support other vital purposes will not have to be siphoned off to cover inadequate payment rates from federally-subsidized plans.

2. Provide for Appropriate, Predictable Medicare Reimbursement to Health Centers

Sec. 3031A of the Finance Committee legislation updates the outdated Medicare reimbursement system for FQHCs, and aligns current Medicare payments with the successful FQHC Prospective Payment System (PPS) currently in place in Medicaid and CHIP. The provision also requires Medicare to appropriately reimburse eligible preventive services when such services are provided to Medicare beneficiaries in the FQHC setting. This provision would mitigate the current payment cap for FQHCs, which currently forces 75% of health centers to lose revenue serving Medicare patients.

3. Ensure Full Participation by Safety-Net Providers in Exchange Plans

Section 3101(m)(1)(D) of the HELP Committee legislation outlines a requirement that plans offered through the exchange must include within their provider networks those health care providers that serve predominantly low-income, medically-underserved individuals, such as providers participating in the 340B drug discount program. This provision would ensure that as uninsured patients gain coverage, the plans covering them will not exclude those low-income communities and individuals most in need of access to care.

4. Grow the Federal Investment in Primary Care, Prevention and Public Health

Section 171 and Section 427 of the HELP Committee legislation calls for annual increases in the amount of funding authorized to be appropriated for the Health Centers program and the National Health Service Corps program, respectively. Separately, **Section 302** authorizes directed spending for a new Prevention and Public Health Fund, totaling $80 billion over 10 years. These investments are a critical component of preparing the nation for health reform, in order to ensure reform not only expands coverage, but expands access, improves quality, and controls costs.

5. Fund the Training of Medical Residents in Community-based Settings

Sec. 3038 of the Finance Committee Legislation includes two provisions designed to encourage and support the training of primary care residents in community-based settings like health centers. The provision would establish a new grant authority within the Public Health Service Act for the establishment and operation of community-based residency training programs, as well as a new stream of dedicated funding through Medicare for the ongoing operation of these programs. This program would increase the number of residents training in primary care, and the number completing that training in community-based settings like health centers.

6. Outline an Inclusive Process for the Redefining of Medically Underserved Populations (MUPs) and Health Professional Shortage Areas (HPSAs)

Section 173 of the HELP Committee legislation establishes a process of "negotiated rulemaking" to determine criteria and methodology for defining these important measurements, which in turn effect location of future health centers, priority in National Health Service Corps placements, and a number of other federal policy decisions. While the target implementation dates for the new rule should be pushed back to provide more time for input, the collaborative process is preferable since it would examine the various issues involved in these complex designations.