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Office of Public Health and Science  
Department of Health and Human Services  
Attention: Rescission Proposal Comments  
Hubert H. Humphrey Building  
200 Independence Avenue, SW, Room 716G  
Washington, D.C. 20201

**RE: Notice of Proposed Rulemaking – Rescission of the Regulation Entitled  
“Ensuring That Department of Health and Human Services Funds Do Not Support  
Coercive or Discriminatory Policies or Practices in Violation of Federal Law,” 74  
Fed. Reg. 10207, et.seq. (March 10, 2009)**

To Whom It May Concern:

The National Association of Community Health Centers (NACHC) is pleased to respond to the above-cited solicitation (hereinafter, the Rescission Proposal) from the Department of Health and Human Services (HHS). NACHC is the national membership organization for federally-supported and federally recognized health centers (hereinafter interchangeably referred to as “health centers” or FQHCs) throughout the country, and is an Internal Revenue Code Section 501(c)(3) organization. NACHC also serves as a source of information, analysis, research, education, training, and advocacy regarding medically underserved people and communities.

**BACKGROUND**

There are, at present, approximately 1,200 health center entities nationwide, which serve as the health care homes to more than eighteen (18) million persons at more than 7,000 sites located in all fifty (50) states, Puerto Rico, the District of Columbia, the U.S. Virgin Islands and the Pacific Islands. Most of these health centers receive federal grants under Section 330 of the Public Health Service Act (42 U.S.C. §254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA). Under this authority, health centers fall into four general categories: (1) centers serving medically underserved areas and/or populations (invariably poor communities); (2) centers serving homeless populations within a particular community or geographic area; (3) centers serving migrant or seasonal farm worker populations within a particular community or geographic area; and (4) centers serving residents of public housing projects. Although there are some slight differences in the grant requirements for each of these four program types, for all intents and purposes, the ways in which these health centers operate are identical.

The Section 330 grant funds are intended to support the costs of providing comprehensive preventive and primary care (including medical, dental, behavioral health, and pharmaceutical) and enabling services to uninsured and underinsured low-income patients, as well as to maintain the health center’s infrastructure. Patients from eligible communities who are not low-income or

who have insurance (whether public or private) are expected to pay for the services rendered. Approximately 35.4% of the patients served by health centers are Medicaid/SCHIP recipients, approximately 7.6% are Medicare beneficiaries, and approximately 38.9% are uninsured.<sup>1</sup>

FQHCs are required to make services available to all residents of their service areas. *See* 42 U.S.C. §§ 254b(a)(1).<sup>2</sup> In providing a comprehensive continuum of care, FQHCs are required to furnish a wide array of required primary health services, including, among other things, basic primary care services (family medicine, internal medicine, pediatrics, obstetrics and gynecology) and preventive health services, which include (among other services) immunizations and voluntary family planning services. *See* 42 U.S.C. §§ 254b(b)(1)(A)(i)(I) & (III). FQHCs also are required to provide various support services to ensure patient access to services (including those not provided directly by the health center), such as referrals, case management, enabling services, and patient education / health promotion. *See* 42 USC §§ 254b(b)(1)(A)(ii) – (v).

While there are no specific requirements regarding “appropriate” staffing mix, FQHCs are expected to maintain a core staff of providers necessary to provide all required services, including physicians and, where appropriate, physician assistants, nurse practitioners, and nurse midwives, as well as appropriate non-clinical staff. *See* 42 U.S.C. § 254b(a)(1); 42 U.S.C. §254b(b)(1)(A)(i)(I). Notwithstanding, FQHCs must be located in or serve a federally-designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP). Additionally, a substantial number of health centers are located in or serve an area, population or facility that has been designated as a Health Professional Shortage Area (HPSA). Thus, for the vast majority of health centers, recruiting and retaining qualified staff is often challenging, at best.

## COMMENTS ON THE FINAL RULE

NACHC strongly urges HHS to rescind the Final Rule in its entirety. NACHC believes that the Final Rule is very problematic, insofar as it attempts to place an individual’s beliefs in front of access to good quality comprehensive health care, rather than striking a balance between the two. We understand the importance of recognizing the legitimate concerns of health care professionals (and other personnel) faced with providing or assisting with services which they find religiously or morally objectionable, and we support efforts to ensure that such objections are considered and conscience rights are protected. These considerations, however, should not outweigh the rights of patients to receive necessary care – the providers’ rights should not be exercised to the detriment of the patients’ health. Rather, a balance must be struck between the two – a balance not evidenced by the Final Rule.

By not only codifying, but also expanding current law, the Final Rule goes well beyond its stated scope and purpose – to protect from discrimination individual and institutional providers that refuse to perform, receive training in, and/or provide referrals or make arrangements for abortion (and in some cases sterilization) services based on religious beliefs. Rather, it offers broad protection for all health care staff (clinicians and support staff), encompassing any service or

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<sup>1</sup> In addition to those health centers receiving grant funds pursuant to one or more of the Section 330 funding programs, there are certain entities that are designated by the Centers for Medicare and Medicaid Services (CMS) as FQHCs, by virtue of the fact that they meet all of the requirements to receive a Section 330 grant, but do not receive funding from HRSA. For purposes of this comment, unless otherwise noted, we do not distinguish between grantees and FQHC look-alike entities, collectively referring to both types of organizations as “FQHCs” or “health centers.”

<sup>2</sup> There are certain exceptions to this requirement for health centers that receive grant funds solely to serve migrant and seasonal farmworkers, homeless individuals and families, and/or residents of public housing.

activity related to the provision of health care services which an individual finds morally or religiously objectionable, regardless of how attenuated the connection.

Given these issues, and for the reasons discussed below, NACHC believes that the Final Rule will significantly reduce and/or jeopardize access to and availability of essential health care services for medically-underserved populations and areas (in terms of both services and providers) in a manner that disproportionately impacts the poorest and most vulnerable populations among us. Further, the Final Rule lacks the necessary clarity which could minimize potential harm - its broad definition of certain key terms (and lack of definition for others) compound rather than diminish the Rule's negative impact. Taken together, NACHC believes that the Final Rule will result in the very behaviors HHS hopes to avoid – intolerance of individual beliefs, institutionalizing of cultural insensitivity, and limitation (and, in many cases, restriction) of patient access to care.

NACHC believes the Final Rule is particularly harmful for health centers, insofar as its limitations and protections are contrary to and conflict with health centers' broad Section 330-related service obligations as well as obligations under certain state laws. The Final Rule places health centers in a conundrum – unable to comply with both the Rule and their Section 330-related obligations, health centers will be subject to penalty, sanction and/or jeopardizing of their grants regardless of which actions they take, further impacting access and availability of services to underserved communities and ultimately undermining the health care safety-net.

Given these concerns, as discussed in greater detail below, NACHC strongly urges HHS to rescind the Final Rule in its entirety.

## **The Final Rule Reduces and/or Jeopardizes Access to and Availability of Essential Health Care Services and Information for Underserved Populations**

### ***General Impact on Underserved Populations***

NACHC believes that the Final Rule significantly reduces and/or jeopardizes access to and availability of essential health care services and information for medically-underserved populations and areas in a manner that disproportionately impacts the poorest and most vulnerable populations among us.

The Final Rule broadly prohibits discrimination or retaliation against certain federally-funded providers (as well as an organizational provider's workforce) for refusing to perform or to assist in the performance of any part of a health care service or activity which they find religiously or morally objectionable. Compounding this wide-ranging protection are ambiguous definitions of certain key terms as well as the lack of definition of others. For example, "assist in the performance" is defined to include participation in any activity (including counseling and education) with a reasonable connection to a procedure, health service or health service program, and "workforce" is defined to include any employees, volunteers, trainees, and other persons working under the control of the entity. Taken together, the Rule offers very broad protection for any and all health care staff, encompassing any service or activity related to health care, regardless of how attenuated the connection, without limiting either the services to which this protection applies (*i.e.*, clinical, support, administrative) or the individuals (*i.e.*, health care professionals versus other staff) who are protected.

Such broad protection potentially endangers access to and availability of services for all populations in need of health care – effectively, all Americans nationwide. It is particularly dangerous, however, for medically underserved populations who lack consistent health care

resources and capacity, often depending on one (or, at most, a limited number of) community provider(s) to fulfill their health care needs. Effectively, the breadth of the Final Rule encourages inconsistent and unreliable availability of care, dependent on the beliefs of the individual health care professionals or staff rather than the needs of the patients. While communities with numerous health care choices generally will have sufficient capacity to overcome such instability, medically underserved communities and populations typically do not, ultimately resulting in distrust of the providers who turn patients away as well as the health care system overall, which has once again failed the most vulnerable among us. One can imagine the ensuing consequences – delayed care, declining health outcomes, greater health disparities and increased costs (both financial and personal) to name a few, damaging not only the health care safety net but the health care system in general at a time when costs are skyrocketing and reimbursement is plunging.

Access and availability of services could be further reduced by limiting the ability of organizational providers to maintain core staffs of clinicians and support personnel necessary to furnish the services. The Final Rule prohibits discrimination against health professionals in employment, promotion, termination or extension of staff privileges because the professional performed or assisted in the performance (or refused to perform or assist in the performance) of any health care service or activity which they find religiously or morally objectionable. It is not difficult to conceive of a situation under which this prohibition would impact the employment of virtually any number of health care professionals, including obstetricians/ gynecologists, family practitioners, pediatricians, internists, pharmacists, and behavioral health professionals. Similar to the broad protections associated with the provision of services, access and availability will be significantly curtailed by the far-reaching employment-related protection provided by the Final Rule combined with the general shortage of health professionals with which medically underserved areas deal every day.

The examples of how the Final Rule could impact patient access to medically necessary services are numerous:

- Providers who refuse to treat sexually transmitted diseases, provide family planning services, including birth control, or to administer immunizations.
- Pharmacists who refuse to fill prescriptions for HIV/AIDs or contraception.
- Providers or other staff who refuse to furnish referrals to other local providers available to furnish denied services.
- Front desk staff that refuse to schedule appointments for or register patients receiving services which the staff person finds objectionable (thus denying access before the patient even “gets in the door” – regardless of whether the providers are willing and able to administer the vaccinations).

In fact, under the Final Rule, not only could providers limit or restrict the provision of services, they also could justify a refusal to inform or counsel patients regarding available options, thus affecting the ability of patients to make informed decisions regarding their health care.

### ***Specific Health Center-Related Impact***

By definition, medically-underserved areas and populations lack health care choices and are served by one (or a limited number of) community provider(s). Often, health centers are one of the few (or the only) health care providers willing and able to furnish services to underserved and vulnerable populations residing in their communities. As discussed above, a core requirement of the health center program is locating in or serving an MUA/MUP; a vast number of health

centers also serve HPSAs. These labels are indicators of need within a community – their mere existence demonstrates that an area or population is underserved.

Section 330 requires health centers to provide a vast array of primary and preventive care services (including, among other services, voluntary family planning services and immunizations) furnished by a multi-disciplinary team of physicians and mid-level providers, as well as a full complement of non-clinical services to support patient access (*e.g.*, referrals, counseling and case management, enabling services, and patient education / health promotion). In serving their underserved communities, the majority of health centers also provide a broad spectrum of care which they are “ethically” bound to furnish, including potentially life-saving treatment to patients suffering from sexually transmitted diseases, HIV/AIDs and other chronic conditions prevalent in low-income, indigent populations.

In addition to providing services directly, health centers typically utilize a wide network of community providers to assist in providing services that the health center does not (or cannot) provide. Thus, referral systems, counseling and case management are of vital importance to health center patients, many of whom would not be able to navigate an increasingly complex health care system without assistance from the health center.

The Final Rule does not explicitly restrict the provision of any of these services. However, health centers may be unable to meet their service obligations effectively and to provide appropriate (and required) patient aid if health care personnel and support staff are allowed to “opt-out” of performing services which they find objectionable. Compounding this dilemma, given the shortage of available health care professionals in many of the medically underserved communities in which health centers are located, health centers may be unable to find any locally-available providers willing to furnish these services. For example, if health center staff refuses to administer immunizations due to moral / religious convictions and there are no adequate alternatives in the community (or the staff also refuses to furnish referrals to other local providers who may be available), the health center would be non-compliant with its legal requirements under its Section 330 grant.

Ultimately, many health centers may find themselves in the uncomfortable position of choosing between compliance with the Final Rule or with their Section 330-related obligations, in turn jeopardizing their continued receipt of federal grant funds to support the provision of health care to medically-underserved populations, which could further impact access and availability of services to medically underserved patients. By restricting or limiting the services provided by health centers, potentially jeopardizing the health center’s very existence, the Final Rule could shut down a vital source of health care for this country’s most vulnerable populations. Effectively, the Final Rule disproportionately impacts the populations with the fewest health care options – low-income, indigent and minority populations that, if not for health centers, would potentially be without or forgo the receipt of essential health care services.

### **The Final Rule Does Not Provide Sufficient Clarity to Minimize the Potential for Harm Resulting from Ambiguity and Confusion Regarding the Rule**

The Final Rule lacks the necessary clarity which could minimize potential harm - its broad definition of certain key terms (and lack of definition for others) compounds rather than diminishes the Rule’s negative impact, resulting in additional ambiguity regarding the extent of the Rule’s scope. As noted above, “assist in the performance” is defined as participation “in any activity with a reasonable connection to a procedure, health service or health service program, or research activity, so long as the individual involved is a part of the workforce of a Department-funded entity. This includes counseling, referral, training, and other arrangements for the

procedure, health service or research activity” (45 C.F.R. §88.2). However, what constitutes a “reasonable connection” is unclear – does this relate solely to services furnished during the actual provision of clinical services (*i.e.*, as a component of diagnosis and treatment), or would it also include support services that facilitate patient access to care (*e.g.*, such as case management, registration and intake, financial and other non-clinical counseling, *etc.*)?

Similarly, “workforce” is broadly defined to include “employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Department-funded entity, is under the control or authority of such entity, whether or not they are paid by the Department-funded entity, or health care providers holding privileges with the entity” (45 C.F.R. §88.2). Given HHS’ concerns regarding the protection of providers’ conscience rights, it is unclear as to why the Final Rule was designed to protect all personnel (clinical and non-clinical). Further questions arise as to how the Final Rule will be applied to non-clinical support staff members who do not assist in furnishing medical services.

Equally puzzling are the terms that are not defined – “religious belief,” “moral conviction,” “abortion” and “sterilization.” This is particularly troubling, given the potentially broad scope of “religious belief” and “moral conviction” – without further guidance, how can a provider ensure that individuals will not unjustifiably claim either of these as grounds to not perform or assist with a service that the individual simply does not want to furnish? Additionally, by not defining the scope of “lawful sterilization procedure or abortion,” it may be impossible for providers to continue to provide lawful counseling/referral activities as well as certain services related to sterilization (*e.g.*, tubal ligations and vasectomies) and/or reproductive and contraceptive services (including emergency contraceptive services in cases of rape and incest) – or to even know if they are operating in compliance with the Rule.

Taken together, the Final Rule’s explicit prohibitions and the broad, ambiguous definitions (and omissions) could impact the provision of virtually any service (clinical and non-clinical support) by any health care staff. The potential harm cannot be overstated – the Final Rule severely impacts the ability of patients to access necessary medical services (as well as enabling or support services) based solely on an individual’s belief system, regardless of justification.

### **The Final Rule’s Objective Can Be Accomplished through Non-Regulatory Means**

In the Final Rule, HHS states its concern that an environment that is intolerant of individual religious beliefs or moral convictions may discourage individuals from diverse backgrounds from entering health care professions. As a result, HHS believes that the Final Rule is necessary to: (1) educate the public and health care providers on the obligations and protections of current federal non-discrimination laws; (2) ensure compliance with and enforce these laws; (3) ensure that HHS funds do not support coercive or discriminatory practices in violation of these laws; and (4) actively promote open communication within the health care field and between providers and patients, fostering a more inclusive and tolerant health care environment.

HHS apparently believes that the Final Rule is the appropriate vehicle to achieve these goals. In the agency’s view, the Final Rule strikes the balance between the patients’ interests in obtaining health care services and the providers’ rights to be protected from discrimination for refusing to participate in services which they find objectionable. In this respect, HHS contends that the Final Rule is merely a codification of laws already in effect, which protect providers from discrimination for refusing to perform, receive training in, and/or provide referrals or make arrangements for abortion (and in some cases sterilization) services based on religious beliefs.

HHS also contends that the Final Rule does not limit patient access to health care; rather it protects providers from being compelled to participate in, or from being punished for refusing to participate in, services that violate their consciences. HHS goes to great lengths to demonstrate that this protection benefits the patients, arguing that it promotes and fosters open communication, which, in turn, improves the delivery of health care services and strengthens the provider-patient relationship.

HHS, however, is misguided in its thinking. Existing laws protect medical professionals from being forced to provide certain services they deem religiously or morally objectionable, and thus, it is unnecessary to promulgate additional rules to offer such protection. As noted in the Final Rule, current conscience laws allow health care professionals (employees, volunteers, trainees, others under the authority of the entity) to refuse to provide abortion and sterilization services and prohibit requiring an individual to perform or participate in such services. Further, Title VII of the Civil Rights Act of 1964 (29 U.S.C. § 2000e) prohibits discrimination by employers based on an employee's religious beliefs and practices, providing a balance between protecting the employee's right to, among other things, refuse to participate in activities that are contrary to his/her religious beliefs and protecting the rights of the clients served by the employer to receive services.<sup>3</sup>

Unlike the Final Rule, current protections generally are balanced with patient needs, treating both equally as long as that does not place undue hardship on the patient or the employer. For example, Title VII requires employers to reasonably accommodate employees' religious beliefs provided that such accommodation does not place an "undue hardship" on the employer's business. Thus, Title VII protects an employed provider's individual beliefs while ensuring patient access to services. Despite HHS' contention that the Final Rule provides an appropriate balance between the patients' interests and the providers' rights, a clear reading of the Rule demonstrates that is not the case. Rather, the Final Rule tips the scale to the provider – a consequence that will surely impact the underserved and most vulnerable patients with little (or no) choices.<sup>4</sup>

Finally, it is hard to imagine that greater communication within the health care field and between providers and patients can be achieved through the implementation and enforcement of regulations which offer nothing more than additional limitation and restriction. If HHS truly wants to encourage open communication and foster a more inclusive and tolerant health care environment, it would be better served by recognizing the rights of all individuals, regardless of insurance or socio-economic status, to affordable and accessible health care rather than further regulating the availability of services in a manner sure to adversely impact underserved populations.

## **Conclusion**

NACHC understands the importance of recognizing and protecting the legitimate concerns of health care professionals (and other personnel) faced with providing or assisting with services which they find religiously or morally objectionable. However, we believe that HHS is misguided in its attempts to codify protections already in law, while expanding those protections

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<sup>3</sup> We also note that health centers that are accredited by the Joint Commission are required to identify ethical issues and develop and implement a process to handle such issues, which includes assurance that patient care, treatment and services will not be negatively affected when a staff member is excused from participation.

<sup>4</sup> The Final Rule also ignores the interplay with Title VII, leaving one to wonder which rule governs – a consequence which HHS could not have intended.

well-beyond current law as well as the stated scope and intent of the Final Rule itself. Ultimately, NACHC believes that these efforts – regardless of any good intention behind them – will result in the very harm HHS is trying to avoid.

The Final Rule is particularly harmful for medically-underserved communities, reducing and/or jeopardizing access to essential health care services for this nation’s most vulnerable populations and generally undermining the health care safety-net. Insofar as the Final Rule is contrary to and conflicts with health centers’ specific Section 330-related service obligations, it places health centers in a position of having to choose whether to comply with the Rule or with their Section 330-related obligations (further impacting access and availability of services).

The restriction of vital services results in a human toll on the populations served, striking the most vulnerable among us – those without access to and availability of health care choices. If such restriction jeopardizes a center’s Section 330 funds, both health centers and their patients will face not only a crisis of access but also a financial toll on their communities – a threat to the economic health of an already underserved and depressed community, including loss of jobs within the community, loss of revenue to stimulate the local economy, foreclosures impacting the local banking industry, just to name a few potential results.

**For all of these reasons, NACHC strongly urges HHS to rescind the Final Rule in its entirety.**

Thank you for the opportunity to comment on this final rule. If you have any questions about the contents of this document, please call or email me at 202-296-0158; [rschwartz@nachc.com](mailto:rschwartz@nachc.com) .

Sincerely,

Roger Schwartz  
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