National Association of
Community Health Centers, Inc.

June 12, 2006

Randall L. Johnson, Chair
Citizens' Health Care Working Group
7201 Wisconsin Avenue
Suite 575
Bethesda, MD 20814

Dear Mr. Johnson:

Last week, the Citizens' Health Care Working Group (CHCWG) released its interim recommendations for how to make quality health care more accessible and affordable to every American. We at the National Association of Community Health Centers and our member health centers support the overwhelming preponderance of what is contained in each of the Working Group's six major recommendations. At the same time, we find ourselves profoundly concerned that the Working Group, in its initial recommendations, has positioned itself on one side of an important but very complex dispute, which could undermine support for its work and the greater good it was established to serve. In the hopes of averting that outcome, I write to request an opportunity to engage in a dialogue with the Working Group on this important matter.

I want to note at the outset that, like so many individuals and organizations across the country, we have been pleased to support the efforts of the Working Group – through sponsorship of many CHCWG community meetings and participation in nearly all of them – much as we were pleased to have been one of the first national organizations to have endorsed the legislation that called for the Working Group's creation in the first place. We have done so because health centers know first-hand how the American healthcare system fails to make its care available and affordable to everyone. Moreover, as we noted in our endorsement of the Hatch-Wyden legislation, "we whole-heartedly agree…that a nationwide public debate is absolutely essential to lay the groundwork for effective health care reforms."

We are deeply appreciative of the Working Group's recommendation to "advance[e] strategies to improve quality and efficiency while controlling costs" through several federal programs, including Community Health Centers – giving resounding support for the strong vote in the CHCWG's community meetings and internet poll in favor of "expanding neighborhood health clinics" – the second or third most popular option in such venues. We are also supportive of the broad recommendation that, "The federal government [should] lead a national initiative to develop and expand integrated public/private community networks of health care providers aimed at providing vulnerable populations, including low income and uninsured people, and people living in rural and underserved areas, with a source of high quality coordinated health care…" However, the Working Group strays significantly from that broad focus in recommending steps to "expand and modify the FQHC concept to accommodate other

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community-based health centers and practices serving vulnerable populations." As you are probably aware, the term "FQHC" refers to one set of providers, federally qualified health centers, as they are named and defined in the Medicare and Medicaid statute; they are essentially community, migrant, and homeless health centers under another name. That is who we represent, and therein lies the source of our deep concern. Had the Working Group simply recommended that "other entities and practices that serve vulnerable populations" need and deserve a payment system like that which FQHCs have, we would not object. But, in choosing to recommend that the existing FQHC payment system be changed to accommodate those other entities, the Working Group has wandered into an area that has been the source of considerable Congressional debate and deliberation in recent years, in each case with the same result: the Congress has rejected taking such action, principally because of its clear understanding of the implications of doing so.

From their inception in 1965, and from the first legislative authority that defined community health centers in 1975, health centers have been characterized as entities that are governed by policy boards a majority of whose members are registered, active patients who receive care at their health center. While perhaps a seemingly minor point, this feature is in fact of great significance – it marks the only place in the American healthcare system where those receiving the care of an entity are empowered by law to decide how that care is organized and delivered. While other nonprofit entities may have governing boards that direct their activity, in few if any cases do those governing board members depend on the entity they direct for a substantial portion of their healthcare. These 'patient democracies' make health centers unique and special – and that could all be lost if their legislative authority were 'opened up' to accommodate others that either cannot or will not meet this community ownership requirement. That is why we at NACHC, and health centers across the country, have resisted efforts to 'open up' this authority to accommodate others – it would be akin to 'opening up' Rural Health Clinic authority to include urban clinics as well.

Neither we nor anyone connected with health centers believe for a minute that health centers are the only safety net providers out there, or that they can do the job alone. We all have great respect for other health care providers – especially for those who, like health centers, care for large numbers and high proportions of low-income and uninsured/publicly insured individuals and families. Further, we recognize and respect the right (and indeed the responsibility) of representatives of those other providers to advocate for policies and actions that meet their affiliates' needs, and would not oppose such efforts, *so long as they involve seeking independent legislative recognition and do not propose to change the provisions of current law that health centers have worked so hard to secure and to maintain over the past 30 years*. For example, we are currently working very closely with advocates of school-based clinics to support introduction of legislation creating a new program to fund school-based clinics, for which many different types of organizations will qualify. In this case, the representatives and advocates of school-based clinics who feel that they need or deserve federal support for what they do are working to convince the Congress that they deserve such support, and to justify it the same way that health centers had to when they first sought federal Health Centers program funding and FQHC provisions in Medicare/Medicaid – by being held accountable for maintaining an "open door" policy to serve everyone regardless of ability to pay, and for making

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their care affordable to all by use of a prospective system for discounting charges based on income and coverage, as do FQHCs.

We recognize and respect the importance of the Working Group's efforts to the essential task of making our healthcare system work for all Americans, and we want very much to support that work, and the vital policy development efforts that must necessarily follow if this endeavor is to be successful. Hopefully, the dialogue we seek with you will allow us to find a common ground that can achieve that result. I look forward to hearing from you on our request.

Sincerely,

Daniel R. Hawkins, Jr.
Vice President for Federal, State, and Public Affairs

cc: Members, Citizens' Health Care Working Group
The Honorable Orrin Hatch
The Honorable Ron Wyden

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