Federal Talking Points | 2024 P&I

Core Messages

- Thank you. Community Health Centers (CHCs) appreciate the ongoing Congressional support. This support and past funding have enabled health centers to grow to serve over 31.5 million patients in urban, suburban, rural, and frontier communities. Health centers play a unique role in communities that is not and cannot be filled by others. We know without your continued prioritization of our funding we would not be able to serve as many of your constituents as we are currently.
- CHCs comprise the largest network of primary care providers in the country, providing high-quality, affordable primary care to over 31.5 million patients living in medically underserved communities. The number of patients accessing care at health centers has grown by 6 million, or 24%, since 2015. Over 1,400 CHC grantees provide care at 15,000 locations across the country.
- Over 100 million Americans are medically disenfranchised and are at risk of not having access to a usual source of primary care due to a shortage of providers in their community. The number has nearly doubled from 56 million in 2014. This increase is largely due to consolidation across the health system and a worsening shortage of primary care providers, driven by increased provider specialization, an uneven distribution of providers, and mass resignation following the COVID-19 pandemic. Without CHCs 15 million more people would be at risk of not having a usual source of primary care.
- In addition to positive effects for patients and cost savings for payers, CHCs positively impact the economies in which they operate by employing workers and supporting additional jobs and economic activity in the area. In 2021, Community Health Centers across the US supported: 500,000+ direct and indirect jobs; Nearly $85B in economic output; and, More than $37B in labor income.
- Only 5% of total US Health Care spending is on Primary Care. That's compared to 38% for hospital care and 20% on prescription drugs.
- Boosting investments in primary care could create an estimated savings of $2.4 billion in California alone and reduce 89,000 emergency room visits.
- CHC patients have 24% lower overall medical expenditures and 25% lower ambulatory expenditures than non CHC patients. Children receiving care at CHCs had significantly lower total medical expenditures (–35 percent), ambulatory expenditures (–40 percent), and prescription- drug expenditures (–49 percent) compared with children receiving care outside of CHCs.

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Health Center Funding

- CHCs receive federal funding through two pathways (1) the annual discretionary funding (30 percent) and the multi-year base funding from the CHC Fund (70 percent).
- The CHCF has funded a relatively constant number of CHCs since 2015, but the number of sites operated by these CHCs has increased significantly, from less than 10,000 in 2015 to nearly 16,000 in 2021.
    - Meanwhile, the number of patients served by CHCs has increased dramatically, rising by nearly 6 million, or 24 percent, from 2015 to 2021.
- In inflation-adjusted terms, federal funding for CHCs has dropped 9.3 percent while the number of patients has jumped 24 percent.
    - Taken together, inflation-adjusted, per-patient funding has declined 27 percent.
    - To achieve the same per-patient, inflation-adjusted spending level established in 2015, federal funding should be increased by $2.1 billion.
- Both sources of federal funding for CHCs expire on March 8.
    - There is bipartisan and bicameral support for legislation that extends and increases health center funding. Congress must agree on a final bill to provide maximal funding before the deadline.
- H.R. 5378 - The Lower Costs, More Transparency Act passed the House of Representatives in December 2023 by a strong bipartisan vote of 320-71.
    - $4.4 billion per year for CHCs through December 2025.
    - $350 million per year for the National Health Service Corps through December 2025.
    - More than doubles the Teaching Health Center Graduate Medical Education program over seven years to $300 million.
- S. 2840 - The Bipartisan Primary Care and Health Workforce Act was reported out of the Senate Health, Education, Labor and Pensions Committee last year.
    - $5.8 billion per year for CHCs for three years to fund a base grant adjustment for existing health centers, expand service hours and school-based health centers, and implements new requirements for nutrition and behavioral health services.
    - One-time $3 billion for health center capital projects, prioritizing dental and behavioral health projects.
    - $950 million annually for the National Health Service Corps for three years.
    - $300 million per year for the Teaching Health Center Graduate Medical Education program for five years.
    - CBO expects that the provision in section 102 that would provide $5.8 billion annually over the 2024-2026 period for CHC funding would reduce net direct spending for federally subsidized health insurance because funding those centers would lead to more cost-effective patient care than the care that patients would otherwise receive.

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We urge leaders in both chambers to work together to pass a bipartisan multi-year extension at the maximal funding level that recognizes the pressing needs of health centers, such as rising costs associated with care delivery, unmet patient needs and workforce challenges.

Urgently pass full-year appropriations for Fiscal Year 2024 that protects CHC funding and provides targeted investments to boost services and the primary care workforce.

340B Funding Reform

- Beginning mid-2020, pharmaceutical manufacturers started overcharging covered entities (CEs) on 340B drugs shipped to CE contract pharmacies. (NACHC Chart).
- For more than 30 years, the 340B Program has provided critical resources that enable CHCs to deliver affordable and accessible healthcare services to the most underserved and vulnerable communities.
- The 340B Program allows CHCs to purchase outpatient medications at lower prices. Health centers reinvest the savings into activities that further the mission of improving patients' lives, as required by health center grants.
- This contribution to their operating margin enables each health center to meet the unique needs of their communities, like dental care, behavioral health, specialty care, interpretation services, food banks, housing support, and co-pay assistance programs.
- Unfortunately, over the last three years, CHCs have lost mission-critical resources from the 340B program, while the CHC Program hit a historic record of more than 31.5 million patients.
- The 340B statute's ambiguity has created instability in the program, causing health center patients to be at risk of losing access to affordable and comprehensive health care services.
- With over 90% of CHC patients at or below 200% of the Federal Poverty Level, there is no question that CHCs exemplify the type of safety net program the 340B Program was intended to support.
- CHCs use 340B drug discounts to provide uninsured and underinsured patients access to affordable medicines for chronic conditions such as diabetes and asthma.
- Ambiguities in the 340B statute have restricted patients' access to discounted medications and allowed Pharmacy Benefit Managers (PBMs) to benefit from the program at the expense of the safety-net.

We urge Congress to amend the 340B statute to protect access for the true safety-net providers.

Preserve the 340B Program to protect its true intent to help support safety net providers serving low-income and vulnerable patients. The 340B Program needs stability so safety net

providers can effectively care for patients that otherwise would not have access to affordable healthcare services and the medications on which they depend.

Incorporate a contract pharmacy policy into the 340B statute to create consistency and safeguards for compliance and accountability. For instance, outlining statutory requirements for contract pharmacies to protect against abusive practices and ensure vulnerable patients benefit from the program.

Create statutory requirements for health insurers and PBMs to prohibit discriminatory practices that divert 340B resources to for-profit companies and away from safety-net providers and vulnerable patients.

Establish transparency and accountability requirements to increase federal oversight by mandating covered entities to report basic 340B information to ensure the program's integrity.

Reform 340B eligibility to remove covered entities that do not uphold their obligation to provide affordable health care services and medications to significant number of safety-net patients and underserved communities.

Workforce Funding Priorities

The crisis:

- Primary care is the only part of the health care system that results in longer lives and more equity, yet it's only 5% of healthcare expenditures in the US, and, only 21% of physicians are choosing to go into primary care. A lack of investment in primary care further reduces the incentive for graduates to choose this path.
- The US doesn't graduate enough primary care and internal medicine residents. Of internal medicine graduates in 2018, only 13% pursued primary care and less than 9% wanted this role. That's compared to 54% in subspecialty fellowships and 33% becoming hospitalists.
- California is experiencing a serious workforce shortage, particularly in CHCs. The shortage is not limited to providers – our CHCs are struggling to recruit and retain ancillary and administrative staff as well.
- CHCs reported high vacancy rates and prolonged periods of time to fill staff vacancies for key positions. Recruitment and retention are top issues-
    - Recruiting a physician, dentist, and nurse practitioner was the most challenging. Clinics reported needing an average of 27.4 weeks to fill a physician vacancy, 21.8 weeks to fill a dentist and 23 weeks to fill a nurse practitioner vacancy.

    - Retention issues post-pandemic due to burnout and moral injury hurt health centers. In 2023, the average 12-month turnover reported by CHCs was 27.4% which jumped from 9.5% in 2020 and 19.4% in 2021.
- Primary care is not getting better in underserved communities. HRSA has designated medically underserved areas (MUAs) as rural or urban areas with too few primary care providers, high infant mortality, high poverty levels or high elderly populations. As of 2020, there were roughly 56 primary care physicians per 100,000 people in MUAs across the nation compared with nearly 80 physicians in non-MUAs. That means MUA physicians would need to see 1800 patients per provider per year.
- HRSA estimates that over the next 15 years, the nation will need over 68,000 primary care physicians, nearly 9,000 dentists, and over 100,000 psychiatrists and psychologists, 100,000 medical assistants and over 32,000 dental assistants by 2036.
    - In San Diego County, 18,500 more BH workers are needed by 2027!
    - Different data sources show different projected demand figures ranging from bad to worse.
- California is amid a behavioral health transformation; the state will need support to meet the workforce needs for successful implementation where CHCs play an integral role in care delivery.

The Opportunity:

- The Quadruple Aim is a value-based health care strategy that aims to improve the health of populations, patient experience, and provider experience while reducing costs. The provider experience and the focus of workforce was added in the last decade as it became more apparent that high quality health care requires a high quality health workforce.
- A third of people leave their workplace because of compensation and benefits. The other two thirds leave because of culture, work-life balance, and professional development.
- California passed a healthcare worker minimum wage law increasing the minimum wage for CHC workers to $21 in 2024, $22 in 2025, and $25 in 2027.
    - CHCs want to increase wages for its employees but will need federal regulatory support to help sustain these increased wages because of PPS limitations. We need your help for this third.
- Teaching Health Center Graduate Medical Education (THCGME) programs are a shining example of what it looks like to invest in transparent, high-quality training programs to develop the next generation of providers.
- Of the $24 billion invested in physician training by CMS, only the $300 million for THCGME is transparent and accountable to outcomes.

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- The US population is shifting toward the South and West, yet most GME training continues to occur in the Northeast and Midwest. Why you should invest in more THCGME funding, particularly for CA:
    - One in four THC graduates are practicing in federally qualified health centers, 7% in critical access hospitals, and 4% in rural health clinics.
    - THC graduates are more likely than non-THC graduates to practice in medically underserved areas, in rural locations, and within five miles of their training site.
    - Dentists trained in THCs are 20% more likely to practice in health centers than non-THC dental residency graduates.
    - One in five THC graduates identified as a member of an underrepresented minority group, compared with 15% of all US medical residents in training from 2021-2022.
    - Combined savings of the THC program may have resulted in an estimated $1.8 billion in Medicaid and Medicare savings from 2019 to 2023.
- Important CHC Programs:
    - The National Health Service Corps (NHSC) connects primary healthcare clinicians to people with limited access to healthcare in high-need areas. Thousands of NHSC providers serve at more than 10,000 CHC sites. In 2022, only 379 of 586 eligible clinicians practicing in California were awarded funds. With additional funds, the NHSC program will continue to serve as a gateway to health center service.
    - The Teaching Health Center Graduate Medical Education (THCGME) Program trains providers in CHC settings. Health centers operate over one-third of THCGMEs, and over 90 percent of residents have trained in a medically underserved or rural community.
    - The Nurse Corps Scholarship and Loan Repayment Program pays student tuition, fees, and other educational costs in exchange for a commitment to working in a healthcare shortage area after graduation. The program supports more than 600 clinicians at CHC.
    - Nurse Practitioner Residency Program trains over 300 nurse practitioner residents in medically underserved communities and/or primary care settings.

Support bipartisan efforts for maximal funding for critical workforce programs as part of negotiations on a health package before the March 8 funding deadline.

- The Bipartisan Lower Costs, More Transparency Act (H.R. 5378)
- The Bipartisan Primary Care and Health Workforce Act (S. 2840)

The Secretary of HHS and the Secretary of VA should be directed to submit a report to Congress and make publicly available data on federal graduate medical education programs (GME) and

invest in the ones that work to build pipelines, expand the existing flow or providers, and contribute to overall health access.

Develop and expand the behavioral health workforce, serving populations across the lifespan, including rural and medically underserved areas.

Establish a new Health Care Workforce Innovation fund within the Health Resources and Services Administration Bureau of Health Workforce. A new flexible fund would enable new pipeline programs, such as pre-apprenticeship, apprenticeship, and career laddering programs that offer certifications for participants and provide a pathway to a rewarding career in health care.

Revamp the Public Service Loan Forgiveness Program to provide additional incentives for non-clinical, non-allied health professionals and administrative, clinical support staff (information technology, finance, revenue cycle, communications, grants management, and special programs) who work in CHCs.

We ask for your support in allocating funding that allows HRSA to reinstate annual grants to aid CHCs with integrating behavioral health into primary care.

Value Based Care and Payment Reform

- The future of health care is Value-Based Care (VBC) and Payment Reform.
- Federal efforts are progressing with intent to normalize Medicaid systems into VBC environments.
- It has been proven in multiple state Medicaid models.
- It is Population Health Management (managing populations entire health across the continuum of care).
- If aligned with payment, it empowers CHCs to fully engage and manage both clinical care and social care (SDOH).
- Investments into CHCs through VBC methodologies impact quality of care and access to quality primary care.
- CHCs are critical to the engagement in VBC activity – they are backbone to primary care in California and across the nation.
- Risk Bearing Organizations/Networks (Integrated Health Partners) are the support engine to initiation and/or advancement into VBC.
- Networks, like Integrated Health Partners (IHP) provide support from managed care contracting and operations to coding/documentation, credentialing, compliance, quality

process improvement, clinical evidence-based medicine best practices, patient outreach/engagement, data warehousing/analytics, and population health management tools/techniques.

- CHCs can focus on the patient care while the network carries the admin burden at a low admin cost. The cost of networks is funded either directly by members or via shared savings models. They are kept lean to ensure full return to primary care to maximize outcomes.

We urge federal support for networks (like IHP) to drive Value-Based Care (VBC) models.

CHCs need bridge funding to help with implementing or joining networks and move to risk-based models.

Federal support to conduct a needs assessment and impact analysis of existing health care Medicaid reform efforts to understand contradicting strategies or impacts to patients and providers in Value-Based Care.

Develop standardization of VBC and create strategic alignment of health care reform initiatives that impact Medicaid patients.

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