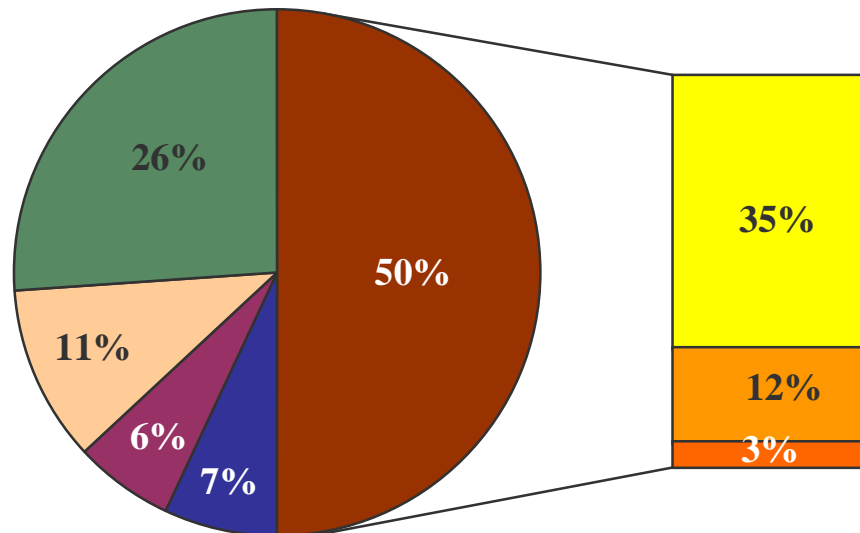


Keys to Success of the REACH Initiative

- Sustaining Current Services: Adequate funding to sustain current Health Center operations
- Expanding the Safety Net: Sufficient growth in federal support to expand services and sites, including new Health Centers (New Starts)
- Assistance in Meeting Workforce Needs: Both federal and state support for clinicians
- Capital Financing: Support for new/expanded facilities and equipment
- Maintenance of State and Local Support: No Cutbacks in State/Local Primary Care Funding or in Medicaid/CHIP Coverage

Importance of State and Local Support to Health Centers

Health Center Budget Proportions by Source



BENEFITS FOR WHICH HEALTH CENTERS ARE ELIGIBLE

The following list summarizes various benefits that accrue (or may accrue) to health centers that receive grants under Section 330 of the Public Health Service ("PHS") Act (42 U.S.C. 254b). Benefits designated by an asterisk are available to both health centers funded under Section 330 and Federally Qualified Health Center ("FQHC") "look-alikes" (i.e., health centers that DHHS designates as FQHCs based on a determination that they meet all Section 330 requirements but do not receive Section 330 grants).

1. Access to Federal grants, i.e., expansion grants, to support the costs of otherwise uncompensated comprehensive primary and preventive health care and "enabling services" delivered to uninsured and underinsured populations at sites within the Section 330 approved scope of project. FQHC "look-alikes" are eligible to apply for "new start" Section 330 grants when funding is available for such purposes.
2. Access to Federal grants to support the costs of planning and developing a network or plan for the provision of health services which may include the provision of services on a prepaid basis or through another managed care arrangement, to some or all of the individuals served by the Section 330 grantee.
3. Access to Federal loan guarantees of the principal and interest on loans made by non-Federal lenders for the costs of developing and operating managed care networks or plans which are majority owned and/or controlled by Section 330-supported health centers.
4. Access to grant support and loan guarantees for capital improvements.
5. Access to Federal Tort Claims Act ("FTCA") coverage (in lieu of purchasing malpractice insurance) for the Section 330-supported health center and its health care professionals, including certain contracted professionals, providing services to health center patients within the approved scope of project and the professionals' employment/contractor agreements.
- *6. Access to favorable drug pricing under Section 340B of the PHS Act, which allows FQHCs (including "look-alikes") to purchase covered outpatient prescription pharmaceuticals for health center patients at substantially discounted prices for distribution either directly by a health center pharmacy or through contract with a retail pharmacy.
- *7. Access to reimbursement under the Prospective Payment System ("PPS") or other state-approved alternative payment methodology (which is predicated on a cost-based reimbursement methodology) for Medicaid services and cost-based reimbursement for services provided under Medicare. Available under the Medicaid program even if FQHC is a subcontractor to a managed care plan.

- *8. Absent an alternative approved by the Centers for Medicare and Medicaid Services (“CMS”), right to have State Medicaid agencies outstation Medicaid eligibility workers on FQHC site. FQHCs can also contract with State Medicaid agencies for FQHC staff to carry out (and be reimbursed for) outstationing activities at FQHC sites.
- *9. Reimbursement by Medicare for "first dollar" of services rendered to Medicare beneficiaries, i.e., deductible is waived.
- *10. Safe harbor under the Federal anti-kickback statute for waiver of co-payments to the extent a patient is below 200% of Federal income poverty guidelines and therefore entitled to a discount based on the health center's application of its schedule of discounts.
- *11. Access to providers through the National Health Service Corps if the health center's service area is designated a Health Professional Shortage Area (“HPSA”).
- *12. Access to the Federal Vaccine For Children program, which distributes to FQHCs (and other eligible providers) vaccinations at no charge for either the vaccine or its delivery to FQHCs to be provided by the FQHC to uninsured children. FQHCs are also eligible to participate in the Pfizer Sharing the Care Program.

Prepared by Feldesman, Tucker, Leifer, Fidell & Bank LLP – January, 2002

How Health Centers Have Fared in Recent State Budget Negotiations – 03/02

State	Dedicated State funding for Health Centers	Proposed or Enacted Cuts to Funding	Additional Comments
Alabama			State provides no \$
Alaska			Non-Reporting
Arizona	\$15 million primary care grants; \$2.6 million for capital construction	\$4.6 million in cuts to primary care grants; zero funding for capital construction	Special session convened to impose more cuts; may eliminate CHC grants
Arkansas	\$900,000 equally divided among 9 CHCs		This is not line item funding, but from Governor's discretionary budget
California	\$50 million in capital construction grants; \$31 million in primary care grants	No changes in capital construction funds; initial proposal to cut primary care grants by \$10 million; current proposal is to fund at \$31 million plus \$17.5 million to make up some of the losses from another program's elimination	\$17.5 million increase is not seen as new money for health centers as they will lose a total of \$28 million under another program's elimination. So even with the \$17.5 augmentation, health centers still stand to lose \$10.5 million
Colorado	\$6 million primary care grant program from tobacco settlement funds; \$2 million one-time grant program for dental access expansion		Health centers received 79% of primary care grants and 60% of dental access grants
Connecticut	\$4.55 million in primary care grants to health centers; \$750,000 in contracts to health centers to pay for outreach workers	\$600,000 cut to primary care grants in November 2001 special session ; Governor proposes an additional \$1.3 million in cuts for FY03	
Delaware			State provides no \$
Florida			State provides no money, but legislation is pending to establish a \$4.7 million primary care grant program for health centers
Georgia	\$500,000 line item for community and migrant health centers	Governor proposes \$250,000 reduction in budget supplemental; legislature has voted to restore full funding; final action is pending	
Hawaii	\$2 million primary care grant program to health centers	No specific budget cut details yet, but depts. have been told to cut, health centers expect reduction in grants	PCA recently testified in support of increasing line item by \$1.2 million to meet growing needs
Idaho			Legislation was introduced in 2001 to create a primary care grant program for health centers; did not get voted out of Committee and has not been reintroduced

State	Dedicated State funding for Health Centers	Proposed or Enacted Cuts to Funding	Additional Comments
Illinois	\$3 million in grants to health centers to establish new sites or expand services	No formal cuts proposed to health center funding at this time, although health centers say reduction is possible due to budget deficits	PCA testified in favor of \$2 million increase to meet growing needs
Indiana	2001 biennium budget provided a \$31 million line item for health centers		FY01 = \$15 million FY02 = \$16 million + \$1 million authorized for capital project needs
Iowa	\$155,000 state loan repayment program		
Kansas	\$1.5 million in primary care grants	4-8% cut proposed	16 state clinics were funded, including 6 health centers
Kentucky			State provides no \$
Louisiana			Non-Reporting
Maine	\$700,000 for grants to 29 health centers	Was not renewed	Single non-recurring allocation
Maryland			State provides no \$
Massachusetts	\$5 million in tobacco settlement funds for grants to health centers; \$7 million health center relief fund for reducing barriers to access; \$4.5 million for school based health centers; other grant programs at smaller funding levels	Frozen access to \$7 million relief fund	
Michigan	\$2.5 million line item for primary care grants		State has proposed doubling the account to \$5 million
Minnesota	\$2.8 million in grants to health centers from one-time IGT funds; \$600,000 line item for health centers; \$30 million over 5 years earmarked from tobacco settlement funds for health centers; \$800,000 in dental access grants to health centers	Governor proposes elimination of \$800,000 dental access grants	Access to \$30 million is contingent upon approval of Commerce Commissioner, expected to sign off later this year; Governor proposes eliminating implementation of Medicaid breast and cervical cancer expansion option
Mississippi	\$4 million annual primary care grant program to hlth. centers		This is a \$20 million, five year program
Missouri	\$5 million tobacco settlement earmark for grants to health centers; \$1.7 million in grants to help health centers recruit and retain providers; \$1 million in special outreach funds for health centers	Governor proposes eliminating all of the \$7.7 million in health center funds	House Committee has voted to restore funds. Final outcome unknown at this time
Montana			State provides no \$
Nebraska	\$1 million in tobacco settlement funds for grants to health centers		

State	Dedicated State funding for Health Centers	Proposed or Enacted Cuts to Funding	Additional Comments
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Nevada

Non-reporting

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State	Dedicated State funding for Health Centers	Proposed or Enacted Cuts to Funding	Additional Comments
Utah	\$500,000 line-item for health centers	\$20,000 cut was imposed in special session	FY03 funding was increased to \$600,000; HIFA waiver approved waive FQHC Medicaid PPS payment requirements for expansion population
Vermont			State provides no \$
Virginia	\$235,000 provided to health centers each year for indigent pharmaceutical program		
West Virginia	\$7 million line item of funding for primary care grants to health centers; \$400,000 line item for mortgage payments to health centers; \$350,000 line for item for health center capital costs	\$350,000 line item for health center capital costs was eliminated	
Wisconsin	\$5.5 million in last budget biennium was earmarked in a grant program for health centers	Governor has proposed the elimination of the funding and the program's authorization; legislative supporters are pushing to restore some portion of the funding	
Wyoming			State provides no \$
District of Columbia			City provides no \$
Puerto Rico			Commonwealth provides no \$

STATE COMPLIANCE WITH MEDICAID OUTSTATIONING MANDATE

November, 2001

STATE	OEW COMPLIANCE	STATE BARRIERS TO OUTSTATIONING
Alabama		
Alaska	partially compliant	
Arkansas	fully compliant	Medicaid agency has 45 days to complete an application; OEWs only have 30 days, inc. agency's processing period
Arizona	not compliant	
		The state has delegated control to the counties; they will place an OEW at a center for a few hours at random times during the week which makes it a function of luck rather than access for patients
California	partially compliant	OEWs currently help families apply for SCHIP (separate program) but FQHCs are not reimbursed for these expenses
Colorado	partially compliant	
Connecticut	fully compliant	
Delaware		
Dist. Columbia	not compliant	FQHC OEWs are often pulled from the field and required to work in the Mcaid agency offices when vacancies arise or when other permanent workers go on vacation or sick leave. A required weekly staff meeting at the Mcaid agency also prevents OEWs from being placed a full 5 days
Florida	partially compliant	
Georgia		
Hawaii	partially compliant	
Idaho	partially compliant	
Illinois	not compliant	
Indiana	partially compliant	
Iowa	partially compliant	
Kansas		
Kentucky	not compliant	
Louisiana	not compliant	
Maine	not compliant	
Maryland		
Massachusetts	partially compliant	
Michigan	partially compliant	
Minnesota		
Mississippi	partially compliant	
Missouri	partially compliant	
Montana	partially compliant	
Nebraska	partially compliant	
New Hampshire	not compliant	
		Currently, only Mcaid apps are allowed to be processed by OEWs. Also OEWs only see clients by appt -- no walk-ins
New Jersey	mostly compliant	
New Mexico	partially compliant	
New York	not compliant	
		The State only places an OEW in one health center and that worker must process 25 applications per week.
Nevada	partially compliant	

		<p>OEWs won't do eligibility or enrollment of clients residing in other counties. Also, OEWs are not trained in how to assist with enrollment into various beneficiary programs in the State, requiring them to refer clients back to the Mcaid office for other types of application assistance, defeating the OEW purpose.</p>
North Carolina	partially compliant	
North Dakota	not compliant	
		<p>Only one FQHC has an OEW by State contract. OEW handles Mcaid apps, follow up for children under Healthy Start, and adults/children under 100% FPL (Healthy Families). Biggest problem is lack of OEW placement in most FQHCs.</p>
Ohio	partially compliant	<p>No consistency to OEW schedules at FQHC, resulting in poor enrollment numbers (which State tried to use to say the FQHCs did not need OEWs). In addition, the State funds OEW positions at an extremely low salary (\$20K/yr), making the positions hard to fill. On a positive note, the State did purchase laptop computers for all OEWs to utilize on-site.</p>
Oklahoma	mostly compliant	
Oregon	fully compliant	
Pennsylvania	not compliant	
Puerto Rico	not compliant	
		<p>State network of Family Resource Counselors (FRCs) who perform outstationing functions have access to DHS workers to resolve problems; DHS staff meet regularly with FRCs to discuss mutual concerns; regional managers as well as State central office staff are open to working with FRCs and health centers in resolving any problems.</p>
Rhode Island	partially compliant	
South Carolina	partially compliant	
South Dakota		
Tennessee	partially compliant	
		<p>Texas requires that OEWs meet a volume requirement of 20 completed applications per week (including all required verifications) before state will pay 100% of costs; requirement is difficult for most FQHCs to meet, since OEWs will not accept walk-ins and, for non-electronically-linked OEWs, it may take up to 3 hours to complete a single application. Also, OEWs often spend one day a week at Mcaid office entering information into the system (even those who are electronically linked do this). OEWs work during the operating hours of the Mcaid agency (usually 8am - 5pm), not the extended operating hours of the FQHC. OEWs are not required to (and do not) complete SCHIP applications (separate program).</p>
Texas	partially compliant	
Utah	fully compliant	
Vermont	not compliant	
Virginia	partially compliant	
Washington	partially compliant	
		<p>The State has refused to implement a coordinated and comprehensive tracking system. This makes it very difficult for FQHC OEWs to track the status of their applications and or to compile reliable monthly reports.</p>
West Virginia	mostly compliant	
Wisconsin	fully compliant	
Wyoming	mostly compliant	