STORAGE NAME: h0615.hcc.doc
DATE: February 20, 2002

HOUSE OF REPRESENTATIVES

COUNCIL FOR HEALTHY COMMUNITIES
ANALYSIS

BILL #: HB 615

RELATING TO: Community Health Center Access

SPONSOR(S): Representative(s) Bilirakis & others

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH PROMOTION YEAS 10 NAYS 0
(2) FISCAL POLICY & RESOURCES YEAS 12 NAYS 0
(3) COUNCIL FOR HEALTHY COMMUNITIES YEAS 16 NAYS 0
(4)
(5)

I. SUMMARY:

THIS DOCUMENT IS NOT INTENDED TO BE USED FOR THE PURPOSE OF CONSTRUING STATUTES, OR TO BE CONSTRUED AS AFFECTING, DEFINING, LIMITING, CONTROLLING, SPECIFYING, CLARIFYING, OR MODIFYING ANY LEGISLATION OR STATUTE.

HB 615 establishes the community health center access program in the Department of Health. The bill:

- Provides a short title, the "Community Health Center Access Program Act."
- Provides Legislative findings and intent, which provide justification as to the need for this program.
- Directs the Department of Health to develop a program for the expansion of the provision of comprehensive primary and preventive health services by federally qualified health centers, via the provision of financial assistance to those centers that apply, and demonstrate a need, for assistance. Factors to be included in applications and used in selecting centers for financial assistance are specified.
- Specifies the establishment of a review panel of specified membership, to review center applications. Applicant funds may be used for expansion of caseloads and services, or for capital improvement projects specific to patient facilities. Elements to be used in reviewing proposals, which are to be weighted in scoring and evaluating proposals, are specified.
- Authorizes the Department of Health to contract with the Florida Association of Community Health Centers, Inc., to administer the program and provide technical assistance to centers selected to receive financial assistance.

While the bill does not contain a specific appropriations amount, the Department of Health indicates that the Governor's Legislative Budget Request will contain a request of $4.6 million for purposes of this program. Of this amount, $1 million will be state General Revenue, $1 million will be local matching funds, and $2.6 million will be federal Medicaid matching funds.

On January 8, 2002, the Committee on Health Promotion adopted 2 amendments. These amendments specified consistent reference throughout the bill to "federally qualified health centers," and eliminated reference to "community health centers."

SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

In providing for the "Community Health Center Access program," this bill increases the responsibility of the state, and the Department of Health in particular, with regard to federally qualified health centers.

B. PRESENT SITUATION:

Community Health Centers—Generally

Community health centers were created in June 1976 under Section 330 of the Public Health Service Act. As amended via the Health Centers Consolidation Act of 1996, the Act also includes the Migrant Health Center Program, the Health Care for the Homeless Program, and primary care for residents of public housing. Community health centers receive federal funding under Section 330 of the Public Health Service Act (42 U.S.C. 254b et seq.) to provide primary health services for medically underserved and special populations including migrant and seasonal farmworkers, the homeless, and public housing residents. Almost one-half of the patients served are uninsured; another 25% are Medicaid patients.

Community health centers provide access to health care for underserved populations, without regard to the patient's ability to pay. Community health centers are located in areas where a needs assessment demonstrates a high degree of poverty, a low physician-to-population ratio, or a large Medicaid population where such coverage is not widely accepted by the private sector providers. There must also be active community support for the proposed Center.

People living in medically underserved areas, both rural and inner city, may have to travel great distances to receive primary care due to a lack of available health care providers. These areas are usually economically depressed, with high unemployment, under-employment, and high poverty rates. Other factors, such as greater distances to the nearest hospital or a lack of other physicians with whom to share call coverage, may also discourage physicians from practicing in underserved areas.

Community health centers accept all forms of insurance and those patients without insurance are charged according to a sliding fee schedule based on federal poverty guidelines. For the lowest income patients, a minimal fee is requested but is never a barrier to receiving treatment. Community health centers are supported by patient fees, Medicare, Medicaid, other insurance programs, county service contracts, local grants, and donations.

Community health centers serve a highly disproportionate share of Medicaid and uninsured patients. Unlike most clinical practices where there is a mix of patients with both private and public insurance, community health centers are unable to "shift the cost" of treating the uninsured. Although their federal grant dollars assist in meeting the shortfall, it is a careful balance.

Each community health center is governed by a Board of Directors with the federal requirement that 51 percent of the board members be consumers or actual users of the community health center. This helps to guarantee that community health centers respond to and meet the needs of the communities they serve.

Many low-income people in medically underserved areas rely on seasonal or short-term jobs and their insurance status may change several times during the year. It is also highly likely that some members of the family, particularly children, may be covered under a public insurance plan, while other family members are not. The utilization of community health centers provides continuity of care regardless of the patient's insurance status and allows all members of the family to utilize the same health care provider. This continuity and accessibility increases the likelihood of prompt detection of health problems and the prevention of many serious illnesses. Early discovery and management of conditions such as diabetes, cancer, tuberculosis, and cardiovascular disease can greatly improve treatment outcomes and reduce costs. Delayed care is a serious health problem among low income and geographically isolated populations and often leads to more serious long term health problems.

Community health centers are federally mandated to provide primary health care services. These services include at least the following:

- Diagnosis, treatment and consultative referral -- all patients are assessed, diagnosed, and managed by a primary care physician, which routinely means a family practitioner or internist.
- Diagnostic laboratory and radiology procedures -- most community health centers perform their own lab and x-ray procedures. If they cannot be performed on premises, the centers have contractual agreements that permit them to refer patients to an appropriate testing facility.
- Preventive health services -- including medical social services, nutritional assessment and referral, health education, children's ear and eye examinations, perinatal services, well childcare, and immunizations. Where appropriate, the centers may enter into an agreement with another entity to provide certain services in order to avoid duplication and to better utilize dollars.
- In-patient care -- all but the most rural centers have staff physicians who carry local hospital admitting privileges so that when a patient requires emergency or routine hospitalization, the center physician assumes responsibility for primary inpatient care. All community health centers have after-hours services available for their patients.
- Transportation services -- this assures that patients who do not have access to private or public transportation are not denied access to the health care system. Most community health centers have vans or cars used solely for patient transportation.
- Preventive dental services -- these include oral hygiene instruction, oral prophylaxis, and topical application of fluorides as well as basic dental services.
- Pharmaceutical services -- because a significant number of community health center patients cannot afford the medicine at outside or private pharmacies, it is essential that affordable medication be available. A majority of community health centers have in-house pharmacies or at least, pre-packaged medication. Those centers unable to afford the heavy cost of an in-house pharmacy have contractual relationships with local pharmacies.

In addition to the primary care services described, community health centers provide many supplemental services that are not required under federal grant regulations but are recognized as

important and often essential to the delivery of quality, comprehensive health care. Some of these include:

- Mental health services
- Mammograms
- Nutrition education
- Podiatry
- Ophthalmology
- OB/GYN
- Translation and outreach services
- HIV/AIDS Counseling and Care
- Ultrasound
- Substance abuse counseling
- Optometry

A March 10, 2000, report of the General Accounting Office to the U.S. Congress (Report No. GAO/HEHS-00-39) noted that those community health centers which were best at adapting to the changing health care environment are more likely to succeed than those centers which lack this adaptive ability. That report provides extensive additional background information for the interested reader, and can be found at: http://www.gao.gov

Community health centers are in the process of receiving increased federal funds, with a goal of doubling the number of patients served over a five-year period. The Resolution to Expand Access to Community Health Centers (REACH) is a multi-year effort. Year One included additional funding of $150 million; Year Two, the current year, $175 million increase; and Year Three, an additional $175 million. Grant award of these funds to individual community health centers is somewhat dependent on the center's ability to demonstrate the receipt of additional local and state funding.

Community Health Centers—Florida

Information from the Department of Health indicates that the 27 federally-funded community health centers in Florida provided primary health care to 456,000 patients at 128 clinic locations during Calendar Year 2000 (according to federal Uniform Data System reports). Florida's centers are about equally divided between rural and urban settings, and many have been in existence since the initial federal authorization for these centers. All of Florida's community health centers receive federal Section 330 grant funding as community health centers. Many also receive specific funding for their migrant and homeless health care programs.

Community health centers and federally qualified health centers are widely recognized as safety-net providers, as evidenced by various references throughout the Florida Statutes, as follows:

Statute Section	Context
154.505	Primary Care for Children and Families Grant Program, specifically entities with which participation should occur for purposes of the program
381.0056	School health services, and provider entities for such services
381.0406	Rural health networks, and points of entry for network services
383.216	Community-based prenatal and infant health care, and community providers to be represented on coalitions
409.908(16)	Reimbursement of Medicaid providers, specifically cost-based reimbursement
409.9117	Medicaid primary care disproportionate share program
409.912	Cost effective purchasing of health care, and authorization for contracts
409.9122	Mandatory Medicaid managed care enrollment; programs and procedures
420.623	Local coalitions for the homeless

According to the Medicaid services expenditure information made available as part of the September 28, 2001, Social Services Estimating Conference, federally qualified health centers in

Florida will be reimbursed approximately $35 million by Medicaid during the current state fiscal year.

Effective January 1, 2001, in compliance with section 702 of the 2000 federal Benefits Improvement and Protection Act (BIPA), the Florida Medicaid program will implement a Prospective Payment System (PPS) and repeal the reasonable cost-based reimbursement for federally qualified health centers (FQHCs). Beginning January 1, 2001, Florida will pay current FQHCs the average of their Medicaid per diem rates in effect for the clinic's fiscal years 1999 and 2000 (calculating the payment amount on a per visit basis). Beginning October 1, 2001, each FQHCs' Medicaid per diem rate will be increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services. This increase shall be made annually on October 1. An FQHC may apply for an adjustment to its current Medicaid per diem rate if the FQHC experiences a change in its scope of service(s), which on a per visit basis is greater or less than 3% of the current per diem rate. New FQHCs entering the Florida Medicaid program will have their initial rate based on the average of the rate being paid to other FQHCs in the same county or district. In situations where there are no other FQHCs in the same county or district, the new FQHC will be required to submit a cost report for a rate to be set. After the initial year of Medicaid reimbursement, payments to new Medicaid-participating FQHCs shall be set using the MEI methods used for other FQHCs.

C. EFFECT OF PROPOSED CHANGES:

HB 615 establishes the community health center access program in the Department of Health. See the SECTION-BY-SECTION ANALYSIS which follows for additional details.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Establishes the community health center access program in the Department of Health, as follows:

Subsection (1) provides a short title, the "Community Health Center Access Program Act."

Subsection (2) provides: Legislative findings that address the need for access for basic health care services by low-income Floridians, and the traditional role federally qualified health centers have played in providing cost-effective, comprehensive primary and preventive care services for the uninsured; and intent that recognizes the increased federal investments in community health centers, the intent to leverage that investment through the expansion of services offered by these centers, and the intent that such a program support the federal, state, and local resources to expand the service delivery system.

Subsection (3) directs the Department of Health to develop a program for the expansion of the provision of comprehensive primary and preventive health services by federally qualified health centers, via the provision of financial assistance to those centers that apply and demonstrate a need for assistance. Factors to be included in applications and used in selecting centers for financial assistance are:

- Preference to communities that have few or no community-based primary care services or in which current services fail to meet local needs.
- A requirement that services be rendered based on a sliding fee schedule based on income.
- Innovative and creative uses of federal, state, and local health care resources.
- A requirement that program funds be used to pay for expanded center caseloads or services or capital improvement projects that result in expanded caseloads or services.
- Authorization for in-kind support from other sources.
- Authorization for encouragement of coordination among federally qualified health centers, other private sector providers, and publicly supported programs.

Subsection (4) specifies the establishment of a review panel to review center applications for financial assistance. The panel is to consist of 4 persons appointed by the Secretary of Health and 3 persons appointed by the Chief Executive Officer of the Florida Association of Community Health Centers, Inc.

Applicant funds may be used for expansion of caseloads and services, or for capital improvement projects specific to patient facilities.

Elements to be used in reviewing proposals, which are to be weighted in scoring and evaluating proposals, are:

- Target population.
- Health benefits.
- Cost-effectiveness measurement methods.
- Patient satisfaction measurement methods.
- Internal quality assurance process.
- Projected health status outcomes.
- Data collection methods.
- Resources to be dedicated to the proposal, including cash, in-kind, voluntary, or other resources.

Subsection (5) authorizes the Department of Health to contract with the Florida Association of Community Health Centers, Inc., to administer the program and provide technical assistance to centers selected to receive financial assistance.

Section 2. Provides for a July 1, 2002, effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

See "Expenditure" explanation below.

2. Expenditures:

While the bill does not contain a specific appropriations amount, the Department of Health indicates that the Governor's Legislative Budget Request will contain a request of $4.6 million for purposes of this program. Of this amount, $1 million will be state General Revenue, $1 million will be local matching funds, and $2.6 million will be federal Medicaid matching funds.

The Department of Health indicates the need for 0.5 FTE staff for purposes of this program. Associated costs are as follows:

Recurring or Annualized Continuation Effects:
Salaries/Benefits:

Other Personal Services

Health Services & Facilities Consultant (.5 FTE)	$20,340	$20,340
EXPENSES: Rent, Telephone, Supplies	$ 1,500	$ 1,500

Total Recurring Costs $21,840 $21,840

The department indicates that first-year start-up costs will be absorbed by the department, thus there are no non-recurring costs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may result in a decrease in costs incurred by providers of uncompensated care. The bill may result in an increase in competition among providers serving Medicaid patients in those communities where health centers are located, assuming those centers successfully compete for financial assistance under this program.

D. FISCAL COMMENTS:

Local governments may be asked to contribute some local matching funds by those community health centers seeking financial assistance under this program.

III. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take actions requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the expenditure of funds.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of state tax shared with counties or municipalities.

IV. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

In its analysis, the Department of Health noted that "(t)here is no rulemaking authority in the bill. It may be the sponsor doesn't want the agency to adopt rules, however the bill lacks specificity as to a number of issues like the scoring weights for the evaluation criteria."

C. OTHER COMMENTS:

Department of Health comment: In its analysis of the bill, the department noted the following:

- The bill allows for, but does not require, the coordination of health care services provided for under the act with the other public and private sector providers of health care, such as the health departments.
- It allows for, but does not require, the provision of any matching resources.
- The Department of Health currently administers the Primary Care for Children and Families Challenge Grant Program (authorized under pt. V, ch. 154, F.S.) which has a similar objective of providing access to health care to low-income Floridians. The stated intent of this program is to function as a partnership between state and local governments and private sector health care providers to foster the development of coordinated primary health care delivery systems which emphasize volunteerism, cooperation, and broad-based participation by public and private health care providers. Counties that have received funding under this program have included federally qualified health centers as providers where financial arrangements were satisfactory to counties and health centers.

Health Promotion staff comment: The bill makes varying references to "community health centers" and "federally qualified health centers" as if these were synonymous terms. Under federal regulations, there are distinctions between these terms. These federal distinctions may be irrelevant for purposes of this proposed state program. On the other hand, specific consistent reference to "federally qualified health centers" would ensure no uncertainty as to which providers were eligible for participation in this state program.

V. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On January 8, 2002, the Committee on Health Promotion adopted 2 amendments. These amendments specified consistent reference throughout the bill to "federally qualified health centers," and eliminated reference to "community health centers."

VI. SIGNATURES:

COMMITTEE ON COMMITTEE ON HEALTH PROMOTION:

Prepared by:	Staff Director:
Phil E. Williams	Phil E. Williams

AS REVISED BY THE COMMITTEE ON FISCAL POLICY & RESOURCES:

Prepared by:	Staff Director:
Douglas Pile	Lynne Overton

AS FURTHER REVISED BY THE COUNCIL FOR HEALTHY COMMUNITIES:

Prepared by:	Council Director:
Phil E. Williams	David M. De La Paz