cc: Melanne, Chris

ONE HUNDRED THIRD CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON GOVERNMENT OPERATIONS
2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6143

October 15, 1993

Mr. Howard Paster
Assistant to the President
for Legislative Affairs
The White House
Washington, D.C. 20500

Dear Mr. Paster:

I wanted to bring the attached letter to the First Lady to your attention because of your important role in formulating the President's Health Care Reform bill. The letter signatories have expressed their concerns about Community Health Center/Migrant Health Center funding and the manner in which money would be distributed to community-based providers under the Administration's health care plan. I hope the Administration can properly address these concerns.

If you need any assistance contact Frank Clemente of my staff at 225-5051. Thank you for your prompt consideration of this pressing matter.

Sincerely,

John Conyers, Jr.

HRC took a call from him 11/15

cc: Melanne
Chris

Congress of the United States
House of Representatives
Washington, DC 20515

October 15, 1993

First Lady Hillary Rodham Clinton
Office of the First Lady
Old Executive Office Building, Room 100
Washington, D.C. 20500

PAM NOV 1 [illegible]

Dear Mrs. Clinton:

We wish to bring to your attention a serious concern that we have with respect to the Administration's current Access Initiative contained in the national health reform plan and its impact on medically underserved populations -- most notably underserved inner-city neighborhoods and rural communities.

As we understand it, the Administration's plan recognizes that medically underserved communities suffer from an acute shortage of accessible health services, especially preventive and primary health care services, and that the people living there will need additional support services beyond those covered in the plan's comprehensive benefit package (such as community outreach, transportation, or translation services), in order to make the provision of covered services effective for them.

We applaud your recognition of these special needs, and the proposed new resources for the National Health Service Corps and school-based clinics. We are, however, quite concerned at both the exceedingly limited amount of funding specified in your plan for Community and Migrant Health Centers (C/MHCs) and with the manner in which the plan would distribute funds to community-based primary care providers.

It appears the Administration only plans to make available an additional $100 million annually for C/MHCs in 1996 (current funding level is $644 million). An additional $700 million would be available annually for "flexible capacity and enabling services" in 1996.

We have three concerns. First, the increase for C/MHCs is very small given the need and their proven track record. Today, Community Health Centers provide comprehensive preventive and primary care to more than 7 million medically underserved Americans -- only 15% of the 43 million medically underserved Americans who need access to such care. Despite the poorer overall health of their patients, studies have shown that health centers are tremendously cost-effective, and have dramatically improved the health of their patients and the communities they service.

Second, it appears that the $800 million increase is partially paid for by offsets in other necessary Public Health Service programs that serve these same population groups. Our understanding is that the offsets in 1996 may be as high as $342 million, or 43 percent of the proposed increase.

Third, we understand that most of the funds under the new "flexible capacity and enabling services" category would be administered under a totally new program, which parallels the existing C/MHC program in every respect except the governing board requirements, eligibility for funding, and Federal accountability (reporting/auditing) requirements. The new program would make grants available to a wide variety of organizations, including private health plans, with little or no community involvement. The C/MHC program has, for the past three decades, provided funds to community-owned and community-operated organizations, whose governing boards are required to have at least a majority-consumer membership. This Community Board Requirement has assured grants go to the right place, and that the services of health centers are responsive to community needs.

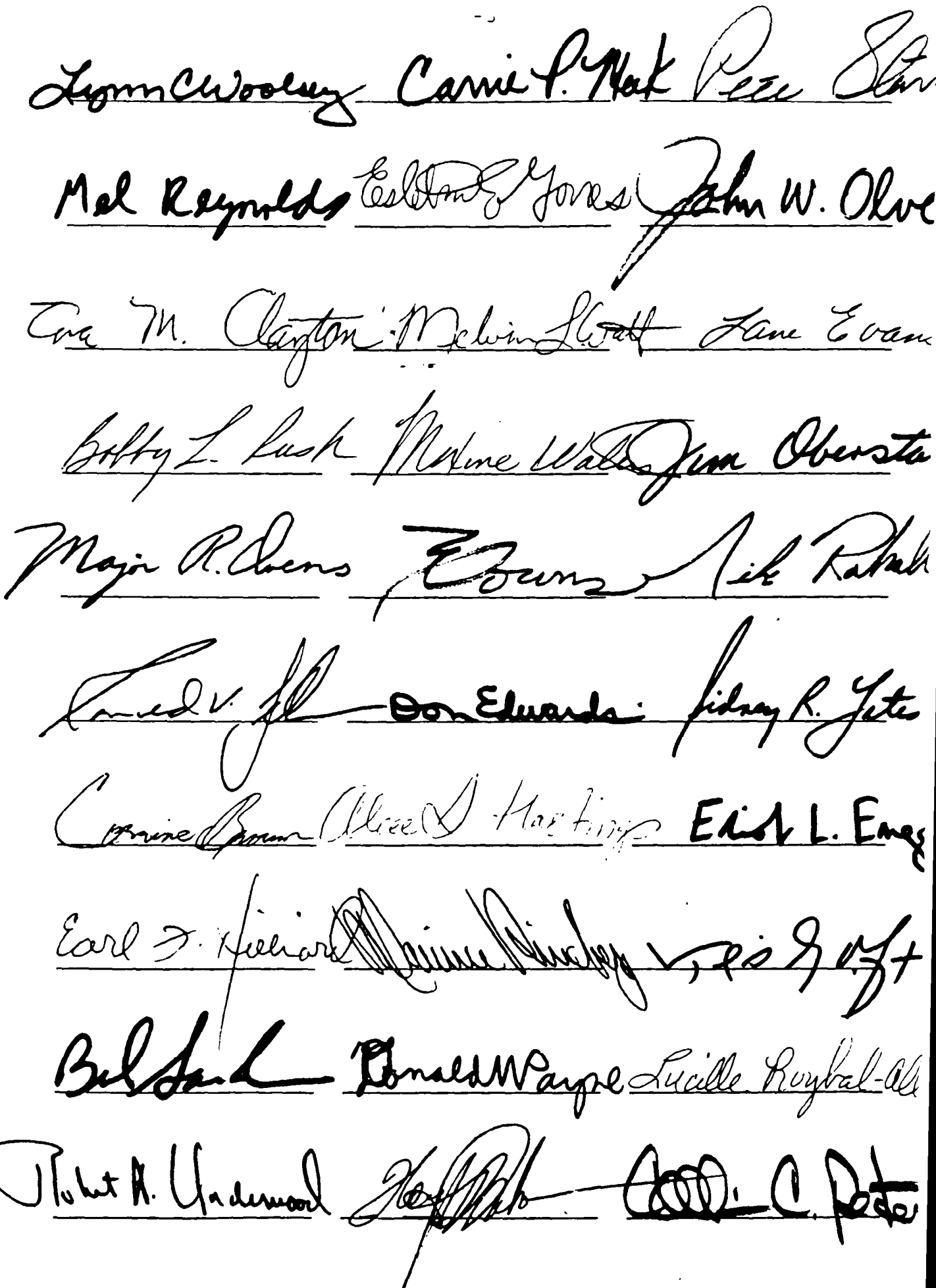
Health centers were founded with a vision of community and consumer empowerment, and their experience over the past 30 years provides an object lesson on how consumer involvement and community empowerment can succeed where other models have failed. In this sense, health centers may be our best (and perhaps last) hope for communities in shaping their health care system and making it responsive to their needs. This will be particularly important if health reform is to rely on managed care systems and market forces for its success. Managed care entities and HMOs historically have avoided the poor and underserved because of their unique needs and inherently higher costs. The poor and underserved are in the health care predicament they are in because they have been neglected by the current health care market.

We truly believe that any Access Initiative should build on what works. Therefore, we urge you to significantly increase the proposed funding level for health centers in the Administration's plan and maintain the "community involvement requirements" for any flexible capacity and enabling services. Finally, we believe that no offsets should be taken from existing programs. Funds provided to health centers, family planning and other vital programs should be retained and re-invested in these programs to expand their capacity to meet vital needs, which will continue even after health reform is implemented.

We ask your personal attention to the matters raised herein, and we stand ready to discuss these concerns with you in further detail, should you so desire.

Sincerely,

Tom Barrett Nancy Pelosi



Neil Abercrombie   Henry Bonilla

Eddie Bernice Johnson   Ron Coleman

[illegible]   Jo' [illegible]   [illegible]

Glenn Poshard

Members Signed on Community Health Center Letter
To The First Lady

Rep. Conyers
Rep. Reynolds
Rep. Evans
Rep. Olver
Rep. Dellums
Rep. Roybal-Allard
Rep. Torres
Rep. Stark
Rep. Owens
Rep. Clayton
Rep. Towns
Rep. Oberstar
Rep. Hilliard
Rep. Rahall
Rep. Fields
Rep. Watt
Rep. Meek
Rep. Barrett
Rep. Waters
Rep. Woolsey
Rep. Pelosi
Rep. Hinchey
Rep. Payne
Rep. Sanders
Rep. Yates
Rep. Engel
Rep. Hastings
Rep. Corrine Brown
Rep. Don Edwards
Rep. Rush
Rep. Velazquez
Rep. Bonilla
Rep. Underwood
Rep. Fish
Rep. Flake
Rep. Abercrombie
Rep. E.B. Johnson
Rep. Poshard
Rep. Lewis
Rep. Serrano
Rep. Wheat
Rep. Nancy Johnson
Rep. Ron Coleman
Rep. Collin Peterson

THE WHITE - - -

[DATE]

The Honorable John Conyers, Jr.
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Conyers:

Thank you for writing about your concerns with the Access Initiative in the Health Security Act. We recognize, as you do, that a Health Security Card will not alone guarantee that all Americans receive appropriate medical care. The programs in the Access Initiative are designed to assure that individuals in medically underserved communities have real access to the full range of services in the comprehensive benefit package, needed support services, and an adequate choice of culturally sensitive providers and health plans. The Health Security Act proposed by the President builds on the community and migrant health center program and provides support for these centers and other community-based providers.

You have raised specific concerns about the level of funding for community and migrant health centers. The Health Security Act authorizes $600 million in new funds for community and migrant health centers over fiscal years 1995 through 2000. In addition, a new capacity expansion program ($2.7 billion over fiscal years 1995 to 2000) will be available to community and migrant health centers as well as other providers in medically underserved areas to build new health care facilities, support capital improvements for existing facilities, and link current primary care providers with inpatient institutions through information systems and telecommunications. The enabling services program ($1.2 billion over fiscal years 1996 to 2000) will be available to community and migrant health centers as well as other providers in medically underserved areas to provide translation, transportation, child-care and outreach services. Expansion of the National Health Service Corps ($950 million over fiscal years 1995 to 2000) will increase the supply of practitioners available to serve in community and migrant health centers.

You also raised concerns about offsets in funding for Public Health Service programs. The offsets do not represent a reduction in the ability of Public Health Service programs like community and migrant health centers to provide services. The offsets represent the amount of federal appropriations that will not be needed because, with universal coverage, health plans will make payments for those services for those individuals who were previously uninsured or underinsured.

Finally, we agree that Access Initiative grants should continue to reward community-based providers. The Access Initiative will integrate publicly-funded providers with private providers and health plans. To receive funding under this program, providers and plans must demonstrate significant community involvement as well as the ability to provide access to health services for all individuals in underserved areas.

The Health Security Act calls for substantial new funds for the Access Initiative over fiscal years 1995 through 2000. We are committed to assuring a secure funding stream for these programs and look forward to working with you and other members of Congress to define the appropriate mechanism to do so.

Please feel free to contact me with any additional concerns or questions.

Sincerely, Yours

Hillary Rodham Clinton

DRAFT RESPONSE TO CONYERS ET AL LETTER

Dear:

Thank you for taking the time to write ~~to me~~ about your concerns with the Access Initiative contained in the Health Security Act. You raise many important issues in your letter, ~~including~~ the level of funding for community and migrant health centers, offsets in funding, and the ability of new programs to meet community needs. ~~In response,~~ I would like to ~~provide you~~ first ~~with~~ a ~~full~~ description of the proposed access programs and then address your specific concerns.

The President recognizes, as you do, that a Health Security Card will not, in and of itself, guarantee that all Americans receive appropriate medical care. The programs in the Access Initiative are designed to assure that underserved populations -- including Americans living in inner-city and rural areas -- not only have access to the full range of services included in the comprehensive benefits package under health care reform, but also have an adequate choice of culturally sensitive providers and health plans. The ~~policies~~ that the President has put forward build on the success of the community and migrant health center program and assure that community health centers and other providers currently supported through public funds are given the resources they need to participate successfully in the new system.

The Health Security Act uses six interrelated approaches to expand capacity in underserved areas and to remove barriers that isolated, culturally-diverse, or hard-to-reach populations face in obtaining access to care.

- **Current Safety-Net Programs**. First, current safety-net programs such as community and migrant health centers, programs for the homeless, family planning, Ryan White, and maternal and child health will be maintained and strengthened under reform.

  Providers funded under these programs will receive automatic designation as *essential community providers*. This will guarantee them payment for covered services from all health plans. Equally important, it will assure that vulnerable populations have continuing access to practitioners with experience meeting their special needs, regardless of which health plan they choose to enroll in.

- **Practitioner Supply**. The supply of practitioners in underserved areas will be increased under reform. This will be accomplished by expanding the National Health Service Corps approximately five-fold from its current field strength of 1,600; by

redirecting residency training to substantially increase the ratio of primary care physicians to specialist physicians; and ~~by~~ supporting the training of primary care physicians, physician assistants, and advanced practice nurses.

Special programs to increase the representation of minorities among health professionals will help to overcome access barriers that stem from cultural gaps.

- **Capacity Expansion**. Capacity ~~expansion~~ will be expanded in inner-city and rural areas ~~will be actively supported~~ under reform. This will be accomplished both by expanding the successful community and migrant health center program and through a new competitive grant and loan program supporting the development of community-oriented practice networks and health plans.

The new program is designed to integrate federally funded providers with other providers in underserved areas, bolstering their ability to coordinate care, negotiate effectively with health plans, and form their own health plans. It will increase the level of service available in underserved areas by supporting the creation of new practice sites and by renovating and converting existing practice sites, including public and rural hospitals. In addition, it will improve access to specialty care in urban and rural underserved areas -- and improve coordination of care -- by linking providers in practice networks with each other and with regional and academic medical centers through information systems and telecommunications.

Grants and loans under the new program will be made to groups of providers working in medically underserved areas or caring for underserved populations. In making awards, preference will be given to groups that include the maximum number of different types of federally funded providers and that link these providers with those not supported by public funds. All providers included in the community practice networks will receive automatic designation as *essential community providers*.

To be designated by the Secretary to receive grants and loans under the new program, a community practice network or health plan must:

- Show evidence of significant community involvement in the initiation, development, and ongoing operation of the project;

- Provide health services to all individuals, including those not covered under the Health Security Act;

- Provide services in the language and cultural context most appropriate to the populations residing in the area;

- Eliminate other access barriers to the maximum extent possible; and

- Conduct an ongoing quality assurance and community health status improvement program.

- **Outreach/Enabling Services**. The Access Initiative also incorporates a new competitive grant program that will expand federal support for enabling services, such as transportation, translation, child-care, and outreach.

  These grants will assure that isolated, culturally-diverse, hard-to-reach persons not served by other programs get the supplemental services they need to obtain access to medical care. They will also help individuals who have been denied access ~~to the current medical care system shift their care patterns away from emergency rooms and~~ receive earlier and more appropriate primary care services.

  Awards in this program will be made to community practice networks, community health plans, and other public and private not-for-profit organizations (such as community health centers) with experience and expertise in providing outreach and enabling services for underserved populations. These grants will supplement support for enabling services provided through existing Public Health Service programs.

- **Mental ~~Health~~ and Substance Abuse Initiatives.** The Health Security Act also includes new funds to assure that low-income, hard-to-reach individuals know about and take advantage of the expanded mental ~~health~~ and substance abuse treatment benefits included in the comprehensive benefits package.

  Working through the existing Community Mental Health Services and the Substance Abuse Prevention and Treatment formula grants, these funds will support enabling services -- community and patient outreach, transportation, translation, education -- for low-income individuals and other vulnerable groups (such as the homeless, dually-diagnosed, or severely mentally ill). In addition, they will build up the currently inadequate infrastructure for delivering mental ~~health~~ and substance abuse services in communities and facilitate integrating these services within the broader health care system.

- **School-Age Youth.** Finally, the Access Initiative incorporates two new programs to reach out to one of Nation's most vulnerable groups -- school-age youth and adolescents. The Comprehensive School Health Education initiative will establish a national framework within which States can create school health education programs that improve the health ~~and well being~~ of students, grades K through 12, by addressing ~~locally relevant priorities~~ and reducing behavior patterns associated with preventable morbidity and mortality. ~~This program will be targeted to areas with high needs, including~~ poverty, births to adolescents, and sexually-transmitted diseases among school-aged youth.

  The School-Related Services program will support the provision of health services --

including psychosocial services and counseling in disease prevention, health promotion, and individualized risk behavior -- in school-based or school-linked sites. Grants will be made to States for the development and implementation of state-wide projects targeted at high-risk youth ages 10-19. In states that do not take this initiative, grants will be available to local community partnerships including public schools, experienced providers, and community organizations.

As you can see, the President has chosen a multifaceted approach to achieve real access to medical care for all Americans. Under the current system, our challenge is to find and fund providers to care for indigent populations. Under the Health Security Act, the challenge shifts to creating a single tier system in which newly insured people have an adequate choice of culturally-sensitive providers and health plans. Expanding the community and migrant health center program will be the cornerstone of this strategy in some communities, but it will not be sufficient to achieve this objective in all parts of the country. We also need flexible programs that will help diverse types of underserved communities attract the types of primary care practitioners and specialists that are currently in short supply in their areas, offer ~~their residents~~ an array of practitioners and practice settings ~~from which to receive health care services~~, meet the enabling needs of diverse populations, and link ~~up~~ providers with each other ~~so as~~ to assure the availability of the full range of services in the comprehensive benefits package.

You have raised specific concerns about [insert from p. 1] Community and migrant health centers should thrive under the new programs. The Health Security Act authorizes $600 million in new funds for community and migrant health centers over fiscal years 1995 through 2000. In addition to this targeted funding, a substantial portion of the resources from other programs will also benefit community and migrant health centers.

- The new capacity expansion program ($2.7 billion over FY 1995-2000) will provide funds that can be used to build new health centers, to support capital improvements of existing centers, and to link centers with other providers and institutions through information systems and telecommunications.

- Expansion of the National Health Service Corps ($950 million over FY 1995-2000) and other workforce initiatives ($820 million over FY 1995-2000) will increase the supply of practitioners from which health centers can draw.

- The new enabling services program ($1.2 billion over FY 1996-2000) will provide health centers with an additional source of funding to provide their populations with translation, transportation, child-care, and outreach services.

- The essential community provider designation program will assure health centers of payment for covered services from all health plans.

You also raised concerns about offsets in Public Health Service Programs. ~~In response to the offset issue that you raise, it is worthwhile pointing out that Community~~

The President and I strongly support your view that we should build on the Community and health centers given the [illegible] have made enormous contributions they have made in the past and made PHS

and migrant health centers will continue to get paid in full for all of their services even if federal appropriations for Public Health Service programs decrease to account for increased revenues from health plans. The source of payment will change, however. Payment for covered services will come from health plans instead of the federal government. Payment for enabling services will come from the community and migrant health center program as well as the new enabling services program.

With regard to your final point, the new programs do not make grants available to private health plans with little or no community involvement. Instead, the Access Initiative supports the development of community health plans centered around community health centers, integrating these centers with other publicly and privately funded providers caring for underserved populations. As you can see from the description above, the requirements of the new program oblige providers in the community practice networks and health plans to work together to meet the needs of their populations. They must provide services to all comers, provide translation services to individuals who do not understand or speak English, eliminate access barriers to the maximum extent possible, and work to improve community health status.

The President has made a strong commitment to providing the necessary funds to assure access to medical care under reform. The Health Security Act authorizes $9.345 billion to be appropriated for the programs in the Access Initiative over fiscal years 1995 through 2000. We are committed to assuring a secure funding stream for these programs and look forward to working with Congress to define the appropriate mechanism to accomplish this end.

I hope the information in this letter is helpful and I will be pleased to arrange a briefing to address any further concerns you may have. The President and I appreciate the important role that you have played in advocating for underserved and vulnerable populations and the enormous contribution that community health centers have made in meeting these needs. One of our foremost goals is to build on this dedication and expertise to provide all Americans with real health security.

Sincerely yours,

Hillary Rodham Clinton

THE WHITE HOUSE

WASHINGTON

November 18, 1993

The Honorable John Conyers
Chairman
Committee On Government Operations
2157 Rayburn House Office Building
Washington, DC 20510

Dear Mr. Chairman:

Director Brown asked me to provide you with information on provisions of the Health Security Act related to substance abuse. This legislation will provide more comprehensive substance abuse coverage than currently is available to most Americans.

For the first time, all Americans will have coverage for substance abuse treatment. Right now, only one in five Americans have any coverage for substance abuse disorders. And, many of those who do have substance abuse coverage face lifetime limits which can effectively short circuit ongoing access to relapse treatment. The Health Security Act does not have any lifetime limits.

Currently some Americans, who might otherwise be eligible for health insurance, are denied coverage based on a pre-existing substance abuse disorder. The Health Security Act makes exclusion based on pre-existing conditions illegal.

By January 1, 2001, the Health Security Act requires that limits on treatment be eliminated and replaced by a managed benefit. Until that time, the structure of the substance abuse benefit is designed to provide incentives to expand the existing inadequate capacity. This means in 2001, when limits have been replaced by a managed benefit, capacity sufficient to provide treatment services will be in place.

The structure of the benefit is designed to offer a flexible, continuum of care that allows health plans to tailor treatment programs appropriate for individuals' special needs. The emphasis is on encouraging health plans to move to a more flexible managed benefit approach which offers a wide array of services.

At first the benefit continues to use day and visit limits similar to current insurance policies. However, from the start it provides coverage for a wider range of services than in typical insurance today, using substitution structuring to encourage flexibility and care management.

You also should know that under the Act, screening and assessment, diagnosis, crisis services and medical management services, such as methadone treatment, do not have visit limits.

The article in today's Washington Post indicated that the length of some substance abuse and mental illness treatments had been "cut in half". In the draft legislative language a 60 day annual aggregate limit for inpatient days was included. It continues to be true that individuals may receive up to 60 days inpatient treatment if they meet certain criteria.

However, the policy intent never was to use 60 inpatient days as the base for substitution for intensive non-residential and outpatient treatment. The intent was to use 30 inpatient days as the base for the substitution for intensive non-residential and outpatient, therefore, the article was misleading when it says the benefit was cut in half.

Another important aspect of the benefit is that treatment options are not limited to residential settings and traditional outpatient treatments. Less restrictive, non-residential treatment such as partial hospitalization, home based services, crisis services, ambulatory detoxification and behavioral services prevention and day treatment can be provided up to 120 days, or outpatient substance abuse counseling and relapse prevention visits may be available up to 120 days.

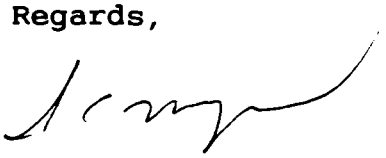
The inclusion of this array of treatment options in various settings represents a new direction for the delivery of substance abuse treatment services. The growth of new types of service providers in response to this benefit structure should stimulate the development of the additional provider capacity so desperately needed.

The Health Security Act also provides funding for services designed to help remove barriers to treatment for substance abusers, including community outreach, transportation and translation services. Other initiatives include, new school-based programs aimed at educating school children about substance abuse prevention, including tobacco and alcohol, and increased support for existing school-based programs such as the Prevention, Treatment and Rehabilitation Model Projects for High-Risk Youth. In addition, the National Institutes of Health will be provided increased funding for medical and behavioral research projects, giving priority to substance abuse as a target for new research dollars.

The coverage for substance abuse in the Health Security Act is intended to complement existing federal support for drug abuse treatment services directed at the hard-core user population. The Administration's Interim National Drug Control Strategy makes it a priority to add to our Nation's treatment capacity. Pursuant to the President's Executive Order of this week, Dr. Brown will submit his recommendations for appropriate FY 95 funding levels for treatment services to expand capacity and target the treatment needs of hard-core drug users.

You can be assured of this Adminstration's commitment to addressing the serious substance abuse problems facing our Nation. If I can be of further assistance please contact me directly.

Regards,



Ira C. Magaziner
Senior Advisor to the
President for Policy
Development

THE WHITE HOUSE

WASHINGTON

February 1, 1994

The Honorable John Conyers, Jr.
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Conyers:

Thank you for writing about your concerns with the Access Initiative in the Health Security Act. We recognize, as you do, that a Health Security Card will not alone guarantee that all Americans receive appropriate medical care. The programs in the Access Initiative are designed to assure that individuals in medically underserved communities have real access to the full range of services in the comprehensive benefit package, needed support services, and an adequate choice of culturally sensitive providers and health plans. The Health Security Act proposed by the President builds on the community and migrant health center program and provides support for these centers and other community-based providers.

You have raised specific concerns about the level of funding for community and migrant health centers. The Health Security Act authorizes $600 million in new funds for community and migrant health centers over fiscal years 1995 through 2000. In addition, a new capacity expansion program ($2.7 billion over fiscal years 1995 to 2000) will be available to community and migrant health centers as well as other providers in medically underserved areas to build new health care facilities, support capital improvements for existing facilities, and link current primary care providers with inpatient institutions through information systems and telecommunications. The enabling services program ($1.2 billion over fiscal years 1996 to 2000) will be available to community and migrant health centers as well as other providers in medically underserved areas to provide translation, transportation, child-care and outreach services. Expansion of the National Health Service Corps ($950 million over fiscal years 1995 to 2000) will increase the supply of practitioners available to serve in community and migrant health centers.

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Finally, we agree that Access Initiative grants should continue to reward community-based providers. The Access Initiative will integrate publicly-funded providers with private providers and health plans. To receive funding under this program, providers and plans must demonstrate significant community involvement as well as the ability to provide access to health services for all individuals in underserved areas.

The Health Security Act calls for substantial new funds for the Access Initiative over fiscal years 1995 through 2000. We are committed to assuring a secure funding stream for these programs and look forward to working with you and other members of Congress to define the appropriate mechanism to do so.

Please feel free to contact me with any additional concerns or questions.

Sincerely yours,

Hillary

Hillary Rodham Clinton