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September 25, 2008

Office of Public Health and Science  
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**RE: Notice of Proposed Rulemaking – Proposed “Provider Conscience Regulation,” 73 Fed. Reg. 50274, et.seq. (August 26, 2008)**

To Whom It May Concern:

The National Association of Community Health Centers (NACHC) is pleased to respond to the above-cited solicitation from the Department of Health and Human Services (HHS). NACHC is the national membership organization for federally-supported and federally recognized health centers (hereinafter interchangeably referred to as “health centers” or FQHCs) throughout the country, and is an Internal Revenue Code Section 501(c)(3) organization. NACHC also serves as a source of information, analysis, research, education, training, and advocacy regarding medically underserved people and communities.

### **BACKGROUND**

There are, at present, approximately 1,200 health center entities nationwide, which serve as the health care homes to more than eighteen (18) million persons at more than 7,000 sites located in all fifty (50) states, Puerto Rico, the District of Columbia, the U.S. Virgin Islands and the Pacific Islands. Most of these health centers receive federal grants under Section 330 of the Public Health Service Act (42 U.S.C. §254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA). Under this authority, health centers fall into four general categories: (1) those centers serving medically underserved areas and/or populations (invariably poor communities), (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farm worker populations within similar community or geographic areas, and (4) those serving residents of public housing. Although there are some slight differences in the grant requirements for each of these four program types, for all intents and purposes, the ways in which these health centers operate are identical.

BPHC’s grants are intended to provide funds to assist health centers with the costs of providing comprehensive preventive and primary care (including medical, dental, behavioral health, and pharmaceutical) and enabling services to uninsured and underinsured low-income patients, as well as to maintain the health center’s infrastructure. Patients from eligible communities who are not low-income or who have insurance (whether public or private) are expected to pay for the services rendered.

Approximately 35.4% of the patients served by health centers are Medicaid/SCHIP recipients, approximately 7.6% are Medicare beneficiaries, and approximately 38.9% are uninsured.<sup>1</sup>

FQHCs are required to make services available to all residents of their service area. See 42 U.S.C. §§ 254b(a)(1).<sup>2</sup> In providing a comprehensive continuum of care, FQHCs are required to furnish a wide array of required primary health services, including, among other things, basic primary care services (family medicine, internal medicine, pediatrics, obstetrics and gynecology) and preventive health services, which include (among other services) immunizations and voluntary family planning services. See 42 U.S.C. §§ 254b(b)(1)(A)(i)(I) & (III). FQHCs also are required to provide various support services to ensure patient access to services (including those not provided directly by the health center), such as referrals, case management, enabling services, and patient education / health promotion. See 42 USC §§ 254b(b)(1)(A)(ii) – (v).

While there are no specific requirements regarding “appropriate” staffing mix, FQHCs are expected to maintain a core staff of providers necessary to provide all required services, including physicians and, where appropriate, physician assistants, nurse practitioners, and nurse midwives, as well as appropriate non-clinical staff. See 42 U.S.C. § 254b(a)(1); 42 U.S.C. §254b(b)(1)(A)(i)(I). Notwithstanding, FQHCs must be located in or serve a federally-designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP). Additionally, a substantial number of health centers are located in or serve an area, population or facility that has been designated as a Health Professional Shortage Area (HPSA). Thus, for the vast majority of health centers, recruiting and retaining qualified staff is often challenging, at best.

#### **COMMENTS ON THE PROPOSED RULE**

NACHC believes that the Proposed Rule is very problematic, insofar as it attempts to place an individual’s beliefs in front of access to good quality comprehensive health care, rather than striking a balance between the two. We understand the importance of recognizing the legitimate concerns of health care professionals (and other personnel) faced with providing or assisting with services which they find religiously or morally objectionable, and we support efforts to ensure that such objections are considered and conscience rights are protected. However, NACHC believes that these considerations should not outweigh the rights of patients to receive necessary care – the providers’ rights should not be exercised to the detriment of the patients’ health. Rather, a balance must be struck between the two – a balance not evidenced by the Proposed Rule.

In the preamble to the Proposed Rule, HHS states that it is

Concerned that ... an environment ... that is intolerant of individual conscience, certain religious beliefs, ethnic and cultural traditions, and moral convictions may discourage individuals from diverse backgrounds from entering health care professions ... A trend that isolates and excludes some [providers] among various religious, cultural and/or ethnic groups from participating in the delivery of health care is especially troublesome considering current and anticipated shortages of health care professionals ... [73 Fed. Reg. 50276]

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<sup>1</sup> In addition to those health centers receiving grant funds pursuant to one or more of the Section 330 funding programs, there are certain entities that are designated by the Centers for Medicare and Medicaid Services (CMS) as FQHCs, by virtue of the fact that they meet all of the requirements to receive a Section 330 grant, but do not receive funding from HRSA. For purposes of this comment, unless otherwise noted, we do not distinguish between grantees and FQHC look-alike entities, collectively referring to both types of organizations as “FQHCs” or “health centers.”

<sup>2</sup> There are certain exceptions to this requirement for health centers that receive grant funds solely to serve migrant and seasonal farmworkers, homeless individuals and families, and/or residents of public housing.

HHS further contends that the Proposed Rule does not limit patient access to health care; rather, it protects providers from being “compelled to participate in, or from being punished for refusal to participate in, a service that, for example, violates their conscience.” [73 *Fed. Reg.* 50277]. HHS attempts to equate federal nondiscrimination laws, which protect access to care for patients, many of whom are vulnerable and without health care options, with federal provider conscience protections, arguing that provider conscience rules are necessary to protect health care professionals from discrimination which could impede their ability to practice.

HHS, however, is misguided in its thinking. Presently, medical professionals are protected from being forced to provide certain services they deem religiously or morally objectionable. As noted in the Proposed Rule, current conscience laws allow health care professionals (employees, volunteers, trainees, others under the authority of the entity) to refuse to provide abortion and sterilization services and prohibit requiring an individual to perform or participate in such services. Further, Title VII of the Civil Rights Act of 1964 (29 U.S.C. § 2000e) prohibits discrimination by employers based on an employee’s religious beliefs and practices, providing a balance between protecting the employee’s right to, among other things, refuse to participate in activities that are contrary to his/her religious beliefs and protecting the rights of the clients served by the employer to receive services.<sup>3</sup>

Unlike the Proposed Rule, current protections generally are balanced with patient needs, treating both equally as long as that does not place undue hardship on the patient or the employer. For example, Title VII requires employers to reasonably accommodate employees’ religious beliefs provided that such accommodation does not place an “undue hardship” on the employer’s business. Thus, Title VII protects an employed provider’s individual beliefs while ensuring patient access to services. The Proposed Rule does not provide such balance. Rather, it tips the scale to the provider – a consequence that will surely impact the underserved and most vulnerable patients with little (or no) choices.<sup>4</sup>

Given the overly broad, and at times vague and ambiguous language of the Proposed Rule, NACHC believes that it will ultimately result in the very behaviors HHS hopes to avoid – intolerance of individual beliefs, institutionalizing of cultural insensitivity, and limitation (and, in many cases, restriction) of patient access to care. By not only codifying, but also expanding (or, in the case of Title VII, ignoring) current law, the Proposed Rule goes well beyond its stated scope and purpose. Rather than simply protecting providers from discrimination based on religious beliefs, it broadly protects all health care staff (clinicians and support staff) from being required to perform or participate in any service related to the provision of health care services regardless of how attenuated the connection (or from reprisals based on refusal to do the same) so long as the affected individual deems the activity religiously or morally objectionable – without any limitation. In doing so, HHS goes beyond Congressional intent in enacting current protections, disregarding the needs of patients in favor of the beliefs of providers/staff while inappropriately expanding the scope of current protections.

For the reasons discussed below, NACHC believes that the Proposed Rule would be particularly harmful for health centers. The Proposed Rule is contrary to and conflicts with health centers’ service obligations required under Section 330 (and some state laws), jeopardizes access to and availability of essential health care services for medically-underserved populations and areas (in terms of availability of both services and providers) in a manner that disproportionately impacts the poorest and most vulnerable populations among us, and generally undermines the health care safety-net. If finalized, the

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<sup>3</sup> We also note that health centers that are accredited by the Joint Commission are required to identify ethical issues and develop and implement a process to handle such issues, which includes assurance that patient care, treatment and services will not be negatively affected when a staff member is excused from participation.

<sup>4</sup> The Proposed Rule also ignores the interplay with Title VII, leaving one to wonder which rule governs – a consequence which HHS could not have intended.

Proposed Rule would place health centers in a conundrum – unable to comply with both the Rule and their Section 330-related obligations, health centers would be subject to penalty, sanction and/or jeopardizing of their grants regardless of which actions they take. **Thus, NACHC strongly urges HHS to withdraw the Proposed Rule in its entirety.**

If, however, HHS decides to proceed with a final rule, NACHC requests that HHS specifically exempt health centers from its application to ensure that the centers can continue to serve and provide essential access to care to their medically underserved populations free from fear of penalty, sanction or jeopardizing of Section 330 grant funds. Short of a complete exemption, NACHC requests that , at a minimum, HHS take the following actions:

- Modify the scope of the final rule to limit it to current law, thus making the rule consistent with its stated purpose and providing a balance between protecting individual beliefs and ensuring patient access to services.
- Modify the application of the final rule to clarify that it will apply only to the extent that it is not contrary to and does not conflict with requirements of the HHS program for which the affected entity receives federal funds. Should the affected entity determine such conflict exists, NACHC requests clarification that the HHS program requirements will take precedence over the final rule.
- Modify the definition of “assist in the performance” to clarify that it applies solely to assistance furnished during the actual provision of clinical services, thus excluding support services that facilitate patient access to care (*e.g.*, such as case management, referrals, registration and intake, counseling, *etc.*).
- Clarify the scope of “lawful sterilization procedure or abortion” to ensure that it does not impede the provision of lawful counseling/referral activities as well as certain services related to sterilization (*e.g.*, tubal ligations and vasectomies) and/or reproductive and contraceptive services (including emergency contraceptive services in cases of rape and incest)
- Given the potentially broad scope of “moral conviction,” add parameters/guidelines regarding what would and would not constitute instances of “moral conviction” to ensure that individuals cannot unjustifiably claim this as grounds to not perform or assist with a service that the individual simply does not want to provide.

### **The Proposed Rule Is Contrary to and Conflicts with Section 330-Related Service Requirements**

The Proposed Rule would significantly impede (and in some instances, effectively bar) health centers from furnishing required services to their underserved populations by prohibiting the centers from:

- “[R]equir[ing] any individual to perform or assist in the performance of any part of a health service program or research activity funded by the Department if such service or activity would be contrary to his religious beliefs or moral convictions.”<sup>5</sup> [73 *Fed. Reg.* 50283; Section 88.4(d)(1)]

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<sup>5</sup> This prohibition applies to any entity that “[C]arries out any part of any health service program or research activity funded in whole or in part under a program administered by [HHS] ....” [73 *Fed. Reg.* 50283; Section 88.3(g)(1)].

- Discriminating against an institution or individual health care entity “on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortion as part of the federal program for which it receives funding.”<sup>6</sup> [73 *Fed. Reg.* 50283; Section 88.4(b)(2)]

The substantial negative impact of these prohibitions is compounded by both broad definitions of certain key terms as well as the lack of definition of others. In particular, “assist in the performance” is defined to mean participation “in any activity with a reasonable connection to a procedure, health service or health service program, or research activity, so long as the individual involved is a part of the workforce of a Department-funded entity. This includes counseling, referral, training, and other arrangements for the procedures, health service or research activity.” [73 *Fed. Reg.* 50282; Section 88.2]. Similarly, “workforce” is broadly defined to include “employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Department-funded entity, is under the control or authority of such entity, whether or not they are paid by the Department-funded entity.” [73 *Fed. Reg.* 50282-3; Section 88.2]. What are not defined, however, are the terms “religious belief,” “moral conviction,” “abortion” and “sterilization.

When these definitions and omissions are viewed together, it is no exaggeration to suggest that virtually any service (clinical and non-clinical support services) provided by any health center staff (paid and non-paid) may be impacted by the Proposed Rule. As discussed above, health centers are required to provide a vast array of primary and preventive care services furnished by a multi-disciplinary team of physicians and mid-level providers (including, among other services, voluntary family planning services and immunizations), as well as a full complement of non-clinical services to support patient access. Further, in serving underserved populations, health centers often provide a broad spectrum of care, including potentially life-saving treatment to patients suffering from sexually transmitted diseases, HIV/AIDs and other chronic conditions prevalent in low-income, indigent populations.

In addition to providing services directly, health centers typically utilize a wide network of community providers to assist in providing services that the health center does not (or cannot) provide. Thus, referral systems, counseling and case management are of vital importance to health center patients, many of whom would not be able to navigate an increasingly complex health care system without assistance from the health center. By broadly defining “assist in the performance” to include various forms of patient assistance, health centers will not only be limited in furnishing required and other necessary clinical services, but will also be limited in providing appropriate (and required) aid.

The Proposed Rule does not explicitly restrict health centers from providing these services. However, if health care personnel and support staff are allowed to “opt-out” of performing services which they find objectionable, effectively health centers will be unable to meet their statutory and regulatory obligations to furnish required services to all residents of their service area, as well as other services which they are “ethically” bound to provide (*e.g.*, treatments for STDs, HIV/AIDs and other chronic conditions) and which support patient access to care (*e.g.*, referrals and case management). Adding to this dilemma, given the shortage of available health care professionals in many of the medically underserved communities in which health centers are located, health centers may be unable to find any locally-available providers willing to furnish these services.

For example, health centers are required to provide access to childhood immunizations, either directly or through established arrangements within the community. If a health center’s provider staff refuses to administer immunizations due to moral / religious convictions and there are no adequate alternatives in the community, the health center would be non-compliant with its legal requirements under its Section 330 grant. Even when appropriate local alternatives are available, if the health center staff refuses to

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<sup>6</sup> This prohibition applies to any entity that “[R]eceive[s] federal funds appropriated through the appropriations act of [HHS] to implement any part of any federal program ....” [73 *Fed. Reg.* 50283; Section 88.3(c)].

provide referrals to these other providers, effectively access will be denied. Finally, if the front desk person has religious / moral objections to vaccinations and thus, refuses to register a patient presenting for his/her immunizations, patient access will be denied – he/she will not even “get in the door” – regardless of whether the providers are willing and able to administer the vaccinations.

The examples of how the Proposed Rule could impact a health center’s ability to provide required services (and ultimately, patient access) are numerous – providers who refuse to treat sexually transmitted diseases, providers who refuse to provide family planning services, including birth control, pharmacists who refuse to fill prescriptions for HIV/AIDs, front desk staff who refuse to schedule appointments for undocumented patients, *etc.* In fact, under the Proposed Rule, not only could providers limit or restrict the provision of services, they also could justify a refusal to inform or counsel patients regarding available options, thus affecting the ability of patients to make informed decisions regarding their health care.

Given the breadth of the prohibitions cited above and the vagueness of certain terms, NACHC believes that the Proposed Rule would unduly restrict health centers’ ability to comply with their Section 330 service requirements. Insofar as compliance with the Proposed Rule may prohibit health centers from complying with their Section 330 service requirements, it jeopardizes health centers’ continued receipt of federal grant funds to support the provision of health care to medically-underserved populations, thus further impacting access and availability of services.

### **The Proposed Rule Jeopardizes Access to and Availability of Essential Health Care Services for Underserved Populations**

In limiting the health centers’ ability to provide the array of clinical and non-clinical services required by Section 330 (as well as other services appropriate for the needs of their populations), the Proposed Rule negatively impacts access to and availability of essential health care services for medically underserved populations. Often, health centers are one of the few (or the only) health care providers willing and able to furnish services to underserved and vulnerable populations residing in their communities. As discussed above, a core requirement of the health center program is locating in or serving an MUA/MUP; a vast number of health centers also serve HPSAs. These labels are indicators of need within a community – their mere existence demonstrates that an area or population is underserved. By restricting or limiting the services a health center can provide, the Proposed Rule effectively closes off a vital source of health care for this country’s most vulnerable populations. Effectively, the Proposed Rule disproportionately impacts the populations with the fewest health care options – low-income, indigent and minority populations that, if not for health centers, would potentially be without or forgo the receipt of essential health care services.

In addition to limiting the services themselves, access could be significantly reduced by limiting the ability of health centers to maintain the core staff of providers and support personnel necessary to furnish the services. In particular, the Proposed Rule prohibits health centers from:

- Discriminating “against any physician or other health care professional in the employment, promotion, termination or extension of staff privileges because he performed or assisted in the performance, or refused to perform or assist in the performance of a lawful sterilization procedure or abortion on the grounds that doing so would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions concerning abortions or sterilization procedures themselves.”<sup>7</sup> [73 *Fed. Reg.* 50283; Section 88.4(c)(1)].

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<sup>7</sup> This prohibition applies to any entity that “[R]eceive[s] a grant, contract, loan, or loan guarantee under the Public Health Service Act...” [73 *Fed. Reg.* 50283; Section 88.3(f)(1)]

This provision prohibits employment discrimination based solely on performance of or refusal to perform sterilization and abortion procedures. However, given that health centers often employ professionals who perform a myriad of procedures within their fields, it is not difficult to conceive of a situation under which this prohibition would impact the employment of an obstetrician/ gynecologist, family practitioner, pediatrician, internist, pharmacist, behavioral health professional who may be asked to provide services related to sterilization (*e.g.*, tubal ligations and vasectomies) and/or reproductive and contraceptive services (including emergency contraceptive services in cases of rape and incest), but who may claim a religious or moral objection to providing such services.

It is our understanding that the Proposed Rule does not prohibit the manner by which health centers hire, fire, or promote staff performing services other than sterilization and abortion. However, given that the Proposed Rule prohibits requiring individuals to perform or assist in the performance of any objectionable health service and the shortage of health professionals with which health centers deal every day, NACHC believes that all of the health centers' employment decisions effectively will be limited.

### **The Proposed Rule Could Undermine the Health Care Safety-Net for Millions**

As discussed above, the restriction of vital services results in a human toll on the populations served, striking the most vulnerable among us – those without access to and availability of health care choices. If such restriction jeopardizes a center's Section 330 funds, both health centers and their patients will face not only a crisis of access but also a financial toll on their communities – a threat to the economic health of an already underserved and depressed community, including loss of jobs within the community, loss of revenue to stimulate the local economy, foreclosures impacting the local banking industry, just to name a few potential results.

A recent study of the impact that investment in community health centers has on the economy indicated that for every \$1 in grant funding received by the health center, it earned approximately \$3 in third party revenue (and approximately \$4 if additional federal, state and local grants and contracts are included).<sup>8</sup> This return on investment translates into, among other things, additional health care services, new community jobs and significant investment in non-health care-related community services and supplies. Thus, health centers are not only important safety-net providers, but also economic engines fueling their respective communities – just as increased investment in health centers stimulates the local economy, loss of centers would more than likely depress it.

### **Conclusion**

NACHC understands the importance of recognizing and protecting the legitimate concerns of health care professionals (and other personnel) faced with providing or assisting with services which they find religiously or morally objectionable. However, we believe that HHS is misguided in its attempts to codify protections already in law, while expanding those protections well-beyond current law and statutory intent as well as the stated scope and intent of the Proposed Rule itself. Ultimately, NACHC believes that these efforts – regardless of any good intention behind them – will result in the very harm HHS is trying to avoid.

The Proposed Rule would be particularly harmful for health centers serving medically underserved communities nationwide – it is contrary to and conflicts with health centers' service obligations required under Section 330, jeopardizes access to essential health care services for medically-underserved

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<sup>8</sup> See Shin, P., Finnegan, B., Rosenbaum, S., *How Does Investment in Community Health Centers Affect the Economy?*, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Research Brief #1, The George Washington University School of Public Health and Health Services, Department of Health Policy (February 25, 2008).

populations and areas, and generally undermines the health care safety-net. If finalized, the Rule would place health centers in a position of having to choose whether to comply with the Rule or with their Section 330-related obligations, subjecting centers to penalties, sanctions and/or jeopardizing of their grants regardless of which actions are taken. **For all of these reasons, NACHC strongly urges HHS to withdraw the Proposed Rule in its entirety.**

If, however, HHS decides to proceed with a final rule, NACHC requests that HHS specifically exempt health centers from its application to ensure that the centers can continue to serve and provide essential access to care to their medically underserved populations free from fear of penalty, sanction or jeopardizing of Section 330 grant funds. Short of a complete exemption, at a minimum, NACHC requests that HHS modify the rule as identified upfront in this comment to ensure that appropriate safeguards are in place to protect patient access while simultaneously protecting individual beliefs.

Thank you for the opportunity to comment on these proposed rules. If you have any questions about the contents of this document, please call or email me at 202-296-0158; [rschwartz@nachc.com](mailto:rschwartz@nachc.com) .

Sincerely,

A handwritten signature in black ink, appearing to read "Roger Schwartz". The signature is written in a cursive style with a large initial "R".

Roger Schwartz  
Associate Vice President of Executive Branch Liaison