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**March 28, 2014**

Center for Medicare & Medicaid Services  
Department of Health and Human Services  
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Submitted via [www.regulations.gov](http://www.regulations.gov)

**RE: Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 78 Fed. Reg. 79082, et. seq. (December 27, 2013)**

To Whom It May Concern:

The National Association of Community Health Centers (NACHC) is pleased to provide the following comments on the above-referenced notice of proposed rulemaking (“the Proposed Rule” or “NPRM”). NACHC is the national membership organization for federally-supported and federally-qualified 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, more than 1200 health centers, with over 9000 sites, serving over 22 million patients nationwide. 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 (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. Except for a limited number of public health centers (*i.e.*, health centers operated by local governmental units such as health departments), each health center is a charitable, nonprofit, tax-exempt Internal Revenue Code Section 501(c)(3) corporation formed under the laws of the state in which it operates.

To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center’s board of directors must be composed of at least fifty-one percent (51%) users of the health center, and the health center must offer services to all persons in its catchment area, regardless of their ability to pay or insurance status. BPHC’s grants are intended to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services to uninsured and underinsured indigent patients, as well as maintaining the health center’s infrastructure.

Patients from eligible communities who are not indigent and able to pay or who have insurance, whether public or private, are expected to pay for the services rendered.

Health centers are the most significant single source of affordable primary care in the United States. In 2010, almost seventy-two percent (72%) of health center patients had incomes at or below the poverty level, and ninety-three percent (93%) of patients had income of less than twice the poverty level. Thirty-eight percent (38%) of health center patients were uninsured. Health centers are therefore positioned to play a vital role in the expansion of health care to the uninsured under the ACA. As a result of the coverage expansion mandated by the ACA, health centers' total patient base is projected to rise from 19.5 million in 2010 to 50 million by 2019.<sup>1</sup>

### **Health Centers and Emergency Preparedness**

In recent years, emergency preparedness efforts have typically focused on traditional first responders and hospitals as the epicenter of healthcare preparedness and response. However, events in the past ten years have demonstrated the importance of a coordinated healthcare sector response beyond traditional first responders and hospitals. In order to effectively meet the needs of a mass casualty incident, pandemic, natural disaster or terrorist attack, non-traditional first responders and other entities from the healthcare continuum must be involved in emergency management preparedness efforts.

Health centers are one such non-traditional first responder. For more than 45 years, health centers have provided comprehensive, culturally competent, quality health care services to medically underserved communities and vulnerable populations. Also during that time, health centers have played a vital role in emergency and disaster response.

As champions for the community, health centers foster a level of grassroots emergency preparedness that reaches deep into the underserved and vulnerable populations they care for daily. The scope and depth of their response is tremendous. From the 2011 EF-5 earthquake in Joplin, Missouri to Superstorm Sandy, there are countless examples of health centers as some of the most effective responders to the complex and immediate needs of communities in the wake of widespread disaster. Health centers, after all, have a pre-existing network that facilitates cooperation and the delivery of care in challenging environments. For many health centers, that includes utilizing their own mobile clinics to reach into the community to provide care and resources to an area impacted by an emergency when needed. Without a doubt, health centers provide comprehensive, whole community care in the wake of tragedies, emergencies and disasters.

Health centers are also integral players in local, state and national emergency preparedness and response efforts. Many states are including health centers in their Emergency Support Function plans. Throughout the country, many health centers are participating in Assistant Secretary of Preparedness and Response's Hospital Preparedness Program through various planning, training and exercise initiatives. Additionally, as healthcare coalitions are expanding to include broader representation from the healthcare spectrum, health centers are increasingly joining these efforts and their role in emergencies is becoming more prominent.

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<sup>1</sup> Kaiser Comm'n for Medicaid and the Uninsured, *Community Health Centers: Opportunities and Challenges of Health Reform* (Aug. 2010), Fig. 9.

## **Comments on the Proposed Rule**

NACHC supports CMS's goal of establishing a comprehensive, consistent, flexible and dynamic regulatory approach to emergency preparedness and response through the development of a national emergency preparedness framework for Medicare- and Medicaid- participating providers, such as FQHCs. NACHC further supports CMS's development of regulations to encourage proper coordination with federal, state, regional, tribal, and local emergency preparedness systems. While there is still much more work to be done, NACHC believes that these regulations can serve as a strong foundation on which to build a coordinated and consistent methodology to emergency preparedness and response by health care providers and governments at all levels.

***NACHC applauds CMS's decision to tailor FQHC emergency preparedness requirements to the unique nature of FQHCs.***

NACHC appreciates CMS's recognition of the particular characteristics of FQHCs and welcomes CMS' proposal that each FQHC develop a comprehensive emergency preparedness plan addressing the types of services the facility has the capacity to provide in an emergency. Many FQHCs are eager to develop further their emergency preparedness protocols – including risk assessments, policies and procedures, communication plans, and training/testing activities – but, as CMS acknowledges in the Proposed Rule, the communities in which FQHCs are located are diverse with respect to the FQHC's size, available human and material resources, geographic location, and ability to coordinate with community resources. Therefore, NACHC agrees that the specific requirements of these protocols should be flexible and scalable to accommodate the wide variation in FQHCs and the disparity among FQHCs in their current levels of emergency preparedness.

***NACHC supports the inclusion of emergency preparedness requirements for FQHCs into CMS's regulations for Medicare- and Medicaid- Participating Providers.***

Historically, FQHCs have relied on policy guidance like BPHC Policy Information Notice (PIN) 2007-15, Health Center Emergency Management Program Expectations, BPHC Program Assistance Letter (PAL) 2002-02; Emergency Preparedness and the Potential Role for Health Centers in Community Response, as well as the limited emergency procedure requirements found at 42 C.F.R. §491.6 to steer their emergency planning efforts to incorporate emergency preparedness fundamentals into their operations. These preparedness efforts assist health centers to increase their capacity to respond to and support the community before, during and after a disaster.

The emergency preparedness requirements set forth in the regulation are similar to those set forth in PIN 2007-15 and PAL 2002-02. As such, health centers are already well-positioned to comply with these regulations when they become final. While the requirements are similar to HRSA's guidance PIN 2007-15 and PAL 2002-2, demonstrating compliance with the rule will likely increase administrative burdens on FQHCs. NACHC requests that, upon implementation of the Final Rule, CMS reduces any additional administrative burdens to FQHCs to only those that are essential to accomplish its goals for this rule or, in the alternative, to consider additional funding to ensure that FQHCs have adequate resources to demonstrate ongoing compliance.

As stated above, due to the unique characteristics of FQHCs, some centers are further along in their emergency preparedness efforts than others. NACHC is concerned, therefore, that CMS may have underestimated the time and cost burdens associated with compliance of the NPRM's provisions. For example, while CMS specifies the types of management and staff it expects to participate in emergency management, it is unclear from the NPRM whether CMS has considered that FQHCs may lose revenue as a result of clinicians devoting some of their patient time to team-based emergency preparedness planning and training activities. NACHC encourages CMS to consider how to compensate FQHCs for this type of lost productivity.

***NACHC supports the development of additional infrastructure to support the participation of FQHCs in emergency preparedness and response activities.***

NACHC recognizes that the Proposed Rule establishes emergency preparedness requirements for participation in Medicare and Medicaid programs. In order to ensure that health centers can participate meaningfully in a coordinated emergency planning and response, additional support for FQHC participation should be developed by CMS and other agencies within HHS, like HRSA.

NACHC requests that CMS review an approach to allow FQHCs to recoup reimbursement for emergency services provided to members of the community outside of the FQHC. As discussed above, FQHCs are frequently on the front lines of emergency response. Instead of waiting for patients to come to the FQHC for services, like a hospital, FQHCs are reaching into the community to provide primary care—oftentimes knocking on doors and walking through affected neighborhoods to seek out their patients. Under this model, which is a highly effective form of emergency response, FQHCs have no mechanism to seek reimbursement.

NACHC believes that the provision of a reimbursement mechanism for health care providers like FQHCs that allows for patients to be seen outside of the four walls of the facility would allow for more robust collaboration during emergency response. As will likely be the case with other community providers who participate in emergency preparedness and response efforts, FQHCs need financial support to maintain, coordinate and participate in emergency preparedness and response efforts in a meaningful way. CMS should consider utilizing current reimbursement methodologies to compensate FQHCs for participation. For example, CMS could reimburse FQHCs for these essential emergency services by either allowing health centers to build the costs for their emergency response into their PPS rates or by paying an additional fee in addition to the PPS rate, similar to the manner in which CMS funds FQHC case management. By providing the opportunity for reimbursement for these services, CMS would be acknowledging the essential work that health centers do when responding to emergencies in their communities—seeking out and providing primary care to their patients in their homes, neighborhoods and communities.

***NACHC encourages CMS to continue its consideration of patient privacy.***

As the NPRM notes, FQHCs must develop a communication plan that includes a means of providing information about the general condition and location of patients under the facility's care consistent with the Health Insurance Portability and Accountability Act (HIPAA) regulations. In the event of an emergency, the ability to access and share PHI will be invaluable. The HIPAA Privacy Rule permits health centers to share PHI without patient authorization for treatment, payment, and health care operations, and as such, should not create barriers to patient care during emergency situations. Though

the HIPAA Security Rule may present potential difficulties inherent in implementing effective administrative, physical, and technical safeguards, Covered Entities can likely address these concerns with advance planning and preparation. NACHC encourages CMS to ensure that the final emergency preparedness regulations are harmonious with HIPAA regulations.

### **Conclusion**

Thank you for the opportunity to respond to the Proposed Rule on Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. If you have any questions about the contents of this document or the proposal itself, please call or email me at 202-296-0158 or [rschwartz@nachc.com](mailto:rschwartz@nachc.com).

Sincerely,

A handwritten signature in cursive script, appearing to read "Roger Schwartz".

Roger Schwartz  
Associate Vice President of Executive Branch Liaison