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COMMITTEES:
ARMED SERVICES
ENVIRONMENTAL AND PUBLIC WORKS
AGRICULTURE
SPECIAL COMMITTEE ON AGING

January 21, 2021

The Honorable Patty Murray
Chairwoman, Subcommittee on Labor,
Health and Human Services,
Education, and Related Agencies
United States Senate
Washington, D.C. 20510

The Honorable Roy Blunt
Ranking Member, Subcommittee on Labor,
Health and Human Services,
Education, and Related Agencies
United States Senate
Washington, D.C. 20510

Dear Chairwoman Murray and Ranking Member Blunt,

As you prepare funding levels for any upcoming coronavirus response package, I am requesting at least $13.5 billion in funding for a new Community Health Center Preparedness Program (CHCPP) that Community Health Centers (CHCs) would be able to use during emergencies and public health crises like the coronavirus (COVID-19) outbreak. CHCs are essential to the health care safety net, and State Health Directors and Congress have turned to CHCs to prepare for and respond to hurricanes, massive fires, water contamination, Severe Acute Respiratory System (SARS), and other health challenges in the past. CHCs have no dedicated source of federal funding related to emergency preparedness, similar to what hospitals can draw upon with the Hospital Preparedness Program (HPP). Therefore, I am requesting at least $13.5 billion in funding for a CHCPP in order to prepare and support CHCs as they respond to public health crises and emergencies like the COVID-19 outbreak. I am also asking for an additional $12.4 billion for workforce funding and infrastructure improvements for health centers.

Community Health Centers, or CHCs, provide affordable primary and preventative health care to the most vulnerable and underserved communities. Over 30 million patients, including almost 400,000 veterans and almost 9 million children, receive quality medical, dental, vision, and behavioral health care services from a CHC. CHCs employ over 250,000 full-time employees nationally, produce nearly $63.5 billion in economic activity, and save our health care system more than $24 billion per year (facts and figures prior to the pandemic). CHCs also help people access healthy food, safe housing, and affordable transportation. In the midst of the addiction epidemic, CHCs are well-positioned providers of substance use disorder and mental health treatment in communities. Services provided by CHCs help patients avoid unnecessary trips to the emergency room and reduce health disparities in our communities[1]. Nearly ten months into the COVID-19 pandemic, health centers are continuing to expand testing and provide much needed services to our underserved

[1] *"America's Health Centers."* Published by National Association of Community Health Centers. August 2019. Available online at: http://www.nachc.org/wp-content/uploads/2019/07/Americas-Health-Centers-Final-8.5.19.pdf

communities, such as vaccine administration. However, cash reserves have rapidly depleted and the situation for many centers is critical – in fact, as of January 1, there are 633 health center sites temporarily closed due to Covid-19.

Congress and Executive Agencies turn to CHCs to help address crises and disasters because of their ability to provide affordable quality care with dedicated and professional staff in community-based settings. CHCs are a touchstone in every community and a hub for care coordination across the health spectrum. CHCs are under the direction of community-based boards that ensure care is meeting local needs, such as being culturally inclusive and linguistically appropriate. CHCs are a direct link between federal resources like the Centers for Disease Control and Prevention (CDC) and local communities delivering care on the ground. CHCs constitute important fundamentals and critical factors in a system of care during crises. With Congressional support, CHCs can implement and sustain national emergency response activities on the front lines of primary care in conjunction with federal partners.

CHCs should be a high priority recipient of federal funding for responding to emergencies as well as the planning and development of emergency responses. The Public Health Service Act authorizes the Secretary of Health and Human Services (HHS) to award supplemental grant funds to CHCs[2], and it also authorizes the CDC to defend against and combat public health threats, including through public health emergency preparedness[3]. The purpose of these grant funds is to implement evidence-based models for increasing access to primary care services, including through addressing emerging public health issues to meet the needs of the population served by CHCs.

Additional funding for CHCs to use during emergencies via the CHCPP would be used to optimize and resource existing national CHC infrastructure as well as to develop and support new efforts, like vaccination administration, vaccine messaging and community collaboration, and a reusable nationwide CHC first response system for natural disasters, pandemics and other emerging health issues like COVID-19. Funding would also support important public health activities such as screening, case management, registry maintenance, lab surveillance, testing and treatment protocols, supply chain tracking, and application development. Health providers are struggling with the resource-intensive response to the COVID-19 outbreak, and this proposed funding could be used to replenish supplies like respirators, masks, and gloves, as well as to provide the surge staffing required for CHCs to operate extended and weekend hours during emergencies.

Specifically, the $13.5 billion being proposed for the CHCPP would be flexible funding that could be applied in the following ways:

- COVID-19 emergency funding required to adequately respond to this public health crisis, including staffing and personal protective equipment (PPE) costs;
- COVID-19 emergency funding to reach underserved and prioritized populations with vaccines and public health messaging;
- Telehealth reimbursement for services already rendered and improved reimbursements rates that are currently insufficient and do not cover cost;
- Equal access to emergency funding for health center 'Look-Alikes.'

[2] See 42 U.S. Code § 254b.Health centers, Section 330, D. 1G. Improve Quality Care / Emerging Public Health
[3] See 42 U.S. Code § 247d–4.Facilities and capacities of the Centers for Disease Control and Prevention

For many years prior to the current pandemic, America's health centers have faced chronic health workforce shortages, and now that workforce has been pushed to its breaking point. Therefore I am requesting at least $6.5 billion for health center workforce investments that could be applied in the following ways and together with these policy improvements:

- Substantially increase funding for the Health Resources and Services Administration's (HRSA) health workforce programs – and include provisions similar to those in the *"Strengthening America's Health Care Readiness Act;"*
- Significantly expand the Teaching Health Center Graduate Medical Education (THC GME) program – as well increase the annual "Per Resident Amount;"
- Permit HRSA to give a funding preference under Title VII workforce programs to applicants whose graduates are more likely to practice in underserved areas;
- Permit 330 grant funding to be used to improve clinician retention.
- Set-aside as large a percentage as possible for these vital workforce funds to be allocated to America's medically underserved areas, so that health centers, Look-Alikes, and other critical frontline providers have access to these critical workers.

The last significant infrastructure investment in Community Health Centers was in the American Recovery and Reinvestment Act of 2009, when health centers served less than 18 million patients. The onset of COVID-19 brought billions of dollars of additional financial losses triggered by site closures, service disruptions, staff quarantine, layoffs, and furloughs. These losses were exacerbated by additional unanticipated expenditures such as PPE, testing supplies, and infrastructure expenses (ventilation, tents, IT and telehealth equipment, space reconfigurations.) Yet, the demand for health center services is greater than ever, especially by the growing number of newly unemployed and uninsured -- human casualties of the pandemic economy. Therefore, I am requesting at least $5.9 billion for health center infrastructure improvements. To maximize effectiveness, it is crucial that any infrastructure investment be flexible in terms of usage (i.e., for purposes such as bricks and mortar, ventilation alterations, tents, IT and telehealth equipment, space reconfigurations, refrigeration and other equipment purchases, etc.) and include legislative language that allows for the availability of funds "until expended."

The work of Congressional Appropriators and Leadership to provide funding for CHCs to use in recent Emergency Supplemental funding is deeply appreciated. Now we must provide this new dedicated, flexible funding in any upcoming COVID-19 response package so that our nation can be better prepared to response to public health crises like the COVID-19 outbreak.

Sincerely,

Kirsten Gillibrand
United States Senator