

November 2, 2016

The Honorable Mitch McConnell  
Majority Leader  
U.S. Senate  
S-230 U.S. Capitol  
Washington, DC 20510

The Honorable Paul Ryan  
Speaker of the House  
U.S. House of Representatives  
H-232 U.S. Capitol  
Washington, DC 20515

The Honorable Harry Reid  
Minority Leader  
U.S. Senate  
S-221 U.S. Capitol  
Washington, DC 20510

The Honorable Nancy Pelosi  
Minority Leader  
U.S. House of Representatives  
H-204 U.S. Capitol  
Washington, DC 20515

Dear Congressional Leaders,

We write to you today to urge action at the soonest possible date to address the looming shortfalls and program expirations facing some of the most crucial elements of our health care system. These programs—all of which will see significant funding cuts on Oct. 1, 2017—include:

- the Children’s Health Insurance Program;
- community health centers;
- Medicaid disproportionate share hospital payments;
- Maternal, Infant, and Early Childhood Home Visiting Program; and
- The National Health Service Corps.

Without action by Congress either later this year or early in the next session, major disruptions will begin taking place, negatively impacting children, seniors, new mothers, rural and underserved patients and communities, clinicians, hospitals, and health centers. Each of our organizations represents one or more of these constituencies; yet, today we write to you united in a common request that you act on these issues in a timely manner.

The investments and policies set to expire in the coming year each have bipartisan support—most recently evidenced by an overwhelming vote in both chambers last year. Together, they form the basis of our health care safety net—in primary care, children’s health, hospital care, and workforce recruitment and retention. Yet a failure to renew these investments in a timely manner would reverberate well beyond the safety net: eliminating coverage and access for millions, raising health care costs, and reversing progress made on a bipartisan basis for decades. Sustaining and strengthening these investments and policies will have the opposite effect—building on the goals we all share in health care: better quality, increased access to care, and cost containment.

### **Children’s Health Insurance Program**

Since its bipartisan beginning in 1997, the Children’s Health Insurance Program (CHIP) has worked hand-in-hand with Medicaid to cut child uninsurance to the lowest level ever recorded. CHIP provides coverage for 8 million children in working families that earn too much to qualify for Medicaid but too little to afford private health insurance. Unlike many private insurance plans, which are based on the health needs of adults, CHIP offers comprehensive, age-appropriate

benefits. CHIP plans also offer pediatric appropriate networks of primary care pediatricians, pediatric subspecialists, pediatric surgical specialists, and children's hospitals so children can access medically and developmentally appropriate care. If funding for CHIP expires, families could experience up to a tenfold increase in their out-of-pocket costs for plans that do not have an appropriate benefit package or pediatric network. Simply put, the benefits, networks, and affordability available in CHIP better reflect the needs of children than alternative coverage options.

Current federal funding for CHIP is slated to expire at the end of fiscal year (FY) 2017, which would disrupt coverage for millions of children. To ensure maximum stability for children, Congress should enact a long-term extension by the spring of 2017 so states have the certainty necessary to develop their budgets in early 2017. Historically, providing long-term funding for CHIP has not only contributed to programmatic stability but also to innovations and greater success providing children with coverage that meets their needs.

### **Community Health Centers**

Begun more than 50 years ago and supported through bipartisan administrations and Congresses, community health centers today provide high-quality primary and preventive care to more than 25 million patients in nearly 10,000 underserved communities nationwide. Community health centers save the health care system more than \$24 billion every year by reducing the need for care in costlier settings and preventing and managing complex conditions. The mandatory investment in health centers was begun by Congress in 2010, sustained each year, and extended on a bipartisan basis in 2015—it is set to expire at the end of September 2017. These resources have resulted in some 8 million new patients gaining access to care, while allowing every health center in America to grow its capacity through targeted investment in new locations, expanded hours, additional providers, quality improvement, and new and integrated services like oral health, behavioral health, and substance use disorder treatment and prevention.

Today, the mandatory investment in community health centers of \$3.6 billion annually accounts for more than 70 percent of the total federal grant investment in this nationwide system of care. According to HHS estimates in 2015 (before many of the most recent investments were made), a failure to address this shortfall would result in closure of some 2,200 health center locations, tens of thousands of lost jobs, and most importantly, loss of access to care for more than 7 million patients. To preserve the gains that have been made and strengthen our system of access to care, Congress should expeditiously address this looming funding cliff on a long-term basis.

### **Medicaid Disproportionate Share Hospital Payments**

Hospitals that care for many low-income people, such as county, children's and other essential hospitals, strive to provide high quality care to all patients, including the most vulnerable. Due to their patient populations, many of these hospitals often have lower operating margins than the rest of the hospital industry. Without Medicaid disproportionate share hospital (DSH) payments, hospitals that rely on DSH would see massive funding shortfalls—for essential hospitals, average operating margins would drop to negative 6.2 percent. Congress recognizes the threat that Medicaid DSH payment cuts pose to vulnerable patients and essential hospitals. The Medicare Access and CHIP Reauthorization Act (MACRA) included a one-year delay of Medicaid DSH payment cuts as intended in the Affordable Care Act (ACA) by "rebasin" DSH and extending cuts by one year, to 2025. Under current law, DSH cuts will begin with a \$2 billion cut in FY 2018 and increase by \$1 billion annually through 2024, ending with an \$8 billion cut.

Hospitals must be protected from a \$2 billion DSH payment cut in FY 2018. DSH payments allow hospitals to keep their doors open and continue providing quality care to our nation's most vulnerable. We urge Congress to continue the delay of DSH cuts until a more sustainable solution is reached.

### **Maternal, Infant, and Early Childhood Home Visiting Program**

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, established in 2010, supports voluntary, evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry. The services are provided via various models, which by statute are required to meet rigorous effectiveness standards, with a quarter of funds available to grantees to test promising and innovative practices. MIECHV currently serves children and families in all 50 states, five territories, and numerous tribal organizations. Through the program, trained professionals meet regularly with expectant parents or families with young children in their homes to build strong, positive relationships with families who want and need support. Multiple short-term funding extensions have made it difficult for grantees to plan for long-term needs of the program and the communities they serve. Therefore, an extension of funding for multiple years is critical to ensuring the greatest continued return on investment for this critical program.

### **National Health Service Corps**

Since its inception in 1972, the National Health Service Corps (NHSC) has worked to build healthy communities by placing health care providers dedicated to working in underserved areas of every state and territory of the United States. Today, nearly 10,000 primary care medical, dental, and mental and behavioral health practitioners are providing access to care in rural, urban, and frontier areas of the country with limited access to care. More than 10 million people rely on a NHSC-supported provider for access to primary care service. Placements are made in the highest-need areas of the country, with providers serving in a wide variety of safety-net organizations including community health centers, rural health clinics, critical access hospitals, school-based clinics, Indian Health Service facilities, and community mental health centers, among others. Additionally, more than half of all NHSC placements continue to serve in designated shortage areas 10 years after fulfilling their NHSC commitment.

The NHSC serves as an effective and efficient recruitment tool for many safety-net organizations in dire need of assistance. However, like community health centers, the NHSC is funded on a mandatory basis, and without Congressional action to extend that funding, the program will cease to exist as of next fall. The NHSC is solely funded through the mandatory funding mechanism and has no base appropriation to even continue supporting the existing field placements. Extending and strengthening funding for the NHSC is paramount for the millions of people who rely on the program for primary care services.

These programs represent just a few examples of the more than 20 programs whose funding streams and/or implementing policies are set to expire next year. Other critical priorities, from community-based residency training to diabetes research to access to care for rural seniors to Family-to-Family Health Information Centers, require Congressional action to continue uninterrupted. **As Congress considers the health care priorities set to expire next year, we urge that two main principles be followed:**

1. These **policies and programs cannot be financed by other reductions in the federal commitment to the health care safety net.** In particular, given the close interplay between each

of the priorities listed above and state Medicaid programs, it would be misguided and counterproductive to continue these commitments by cutting Medicaid.

2. Given the complexity and small margin for error that define so much of the health care safety net, **we strongly urge you not to wait until the eleventh hour**, and to proactively address these issues as soon as possible.

The undersigned organizations look forward to working with Congress to address these funding shortfalls over the next several months.

Sincerely,

America's Essential Hospitals  
American Academy of Pediatrics  
Association of Asian Pacific Community Health Organizations  
Association of Clinicians for the Underserved  
Association of Maternal and Child Health Programs  
Association of State and Territorial Health Officials  
Children's Hospital Association  
Family Voices  
First Focus  
National Association of Community Health Centers  
National Association of Counties  
National Association of County and City Health Officials  
National Association of Pediatric Nurse Practitioners  
National Council on Behavioral Health  
National Healthcare for the Homeless Council  
National Rural Health Association  
Nurse-Family Partnership  
Parents as Teachers  
School-Based Health Alliance  
Trust for America's Health  
United Way Worldwide

Cc:

The Honorable Thad Cochran, Chair, Senate Committee on Appropriations  
The Honorable Barbara A. Mikulski, Ranking Member, Senate Committee on Appropriations  
The Honorable Orrin G. Hatch, Chair, Senate Committee on Finance  
The Honorable Ron Wyden, Ranking Member, Senate Committee on Finance  
The Honorable Lamar Alexander, Chair, Senate Committee on Health, Education, Labor and Pensions  
The Honorable Patty Murray, Ranking Member, Senate Committee on Health, Education, Labor and Pensions  
The Honorable Harold Rogers, Chair, House Committee on Appropriations  
The Honorable Nita M. Lowey, Ranking Member, House Committee on Appropriations  
The Honorable Fred Upton, Chair, House Committee on Energy and Commerce  
The Honorable Frank Pallone Jr., Ranking Member, House Committee on Energy and Commerce  
The Honorable Kevin Brady, Chair, House Committee on Ways and Means  
The Honorable Sander M. Levin, Ranking Member, House Committee on Ways and Means