August 30, 2013

Jennifer Joseph, PhD, MSEd, Director
Office of Policy and Program Development
Bureau of Primary Health Care
Health Resources and Services Administration
OPPDBudgetPIN@hrsa.gov

RE: Solicitation of Comments for Draft Policy Information Notice (PIN), Health Center Budgeting and Accounting Requirements, PIN 2013-01 Section V.B.

Dear Ms. Joseph:

The Michigan Primary Care Association (MPCA) appreciates the opportunity to comment on Policy Information Notice (PIN) 2013-01, Health Center Budgeting and Accounting Requirements ("the PIN" or "PIN 2013-01"), which provides clarification applicable to federally-qualified health center (FQHC) grantees and look-alike entities.

MPCA is the voice for 36 Health Center organizations in Michigan which provide quality, affordable, comprehensive primary and preventive health care for more than 600,000 patients annually at over 220 sites across the state.

After reviewing the Policy Information Notice (PIN) in detail MPCA consulted with national partners and Michigan's Health Centers through a facilitated conference call and via email to prepare the comments below for consideration. MPCA appreciates the efforts of the Health Resources and Services Administration (HRSA) in providing clarification and we understand the importance of maintaining transparency and accountability with regard to the expenditure of federal funds. We strongly believe in and advocate for the establishment of systems that support and promote a high level of accountability; however, as discussed in greater detail below, the traditional and statutorily-required flexibility afforded health centers to respond quickly to the ever-changing health care marketplace should not be sacrificed to achieve such a goal. Furthermore, MPCA believes that because the PIN imposes substantial alterations to the requirements governing the terms and conditions of Health Center program grants, those changes should be made through a formal rulemaking process rather than by issuing policy guidance. This process would provide an opportunity for HRSA to share its interpretation of the relevant requirements under Section 330 and better understand how, as a practical matter, HRSA's proposals will affect individual Health Centers.

Comments

MPCA does not agree with a number of the provisions contained in Section V.B of the PIN. Each new restriction that HRSA seeks to impose in that section – a default rule that expenditures of non-grant funds must conform with the grants cost principles; prior approval requirements for non-grant expenditures that do not fall within eight narrow categories; and the limitation of non-grant fund expenditures to those "consistent with approved in-scope activities" – is inconsistent with the authorizing statute and/or its legislative history. In our opinion, the PIN exceeds HRSA's authority to impose such restrictions, limitations, and requirements on the use of non-grant funds by a Health Center. And, by attempting to extend to non-grant funds the restrictions and limitations placed on the use of the Section 330 funds, HRSA will negatively impact Health Centers' ability to operate effectively and to grow programs at a time of tremendous transformation of the health care industry.

The PIN Adopts an Interpretation of Section 330(e)(5)(D) That is Improper

At the most general level, the PIN contravenes the PHSA because Congress has made clear that it did not want Health Centers' non-grant expenditures to be subject to cost principles, administration requirements, or prior approval requirements. Section 330(e)(5)(D) provides that non-grant funds "shall be used as permitted under this section, and may be used for such other purposes as are not specifically prohibited under this section if such use furthers the objectives of the project." In each of four substantive amendments to the PHSA (in 1978, 1988, 1992 and 1996) Congress not only broadened Health Centers' discretion in using non-grant income, but also directed the Secretary not to unduly restrict this discretion by imposing limitations that are not in the statute. Congress also articulated the policy behind these changes, namely that Health Centers should be encouraged to seek other funding sources and business opportunities without being constrained by onerous federal oversight. Congress thus has unambiguously barred the types of restrictions on the uses of non-grant funds that HRSA proposes in Section V.B. Imposing these new requirements will undermine both the plain language of Section 330 as well as Congressional intent.

Furthermore, requiring "otherwise-unallowable" expenditures of non-grant funds to fall within specific categories was explicitly rejected by Congress in 1996 (and also is inconsistent with the statement in the PIN that health centers must comply with "any relevant rules identified or established by the funding source," since non-grant revenue includes grant funds from private, local, and State agencies). Similarly, imposing prior approval requirements for costs that do not fall within the eight specifically-authorized categories, and limiting those expenditures to three acceptable purposes (increase services, increase patients and/or improve quality), also is an inappropriate interpretation of the statute and runs counter to Congress' intent to "reliev[e]centers from the requirements for prior Federal approval for things like equipment purchases and procurement and property standards."[1]

Section V.B is also based on the assumption that expenditures of non-grant funds must fall narrowly within the health center's approved scope of project. On this issue, as well, HRSA's proposal conflicts with both the terms of the statute and legislative intent. Section 330 provides that grantees must use non-grant funds either (1) as permitted under [Section 330]; or (2) "for

[1] We believe that the prior approval requirements described in PIN 2013-01 would be administratively cumbersome and disruptive of important priorities for HRSA, as well as for Health Centers. Agency resources would be diverted from policy matters to case-by-case adjudication of proposed expenditures.

such other purposes as are not specifically prohibited under [Section 330] if such use *furthers the objectives* of the project." (Emphasis Added). Therefore, any expenditure that advances a Health Center's project goal of making health care more accessible to the underserved – not just expenditures that narrowly fall within the health center's scope of project narrative – would meet this definition of "furthers the objectives of the project."[2]

This is particularly relevant today given the ongoing emphasis on delivery system reform. Health Centers have in the past used non-grant income to launch Health Center-controlled managed care plans (e.g. Community Choice Michigan) and invest in networks to improve quality. Today, Health Centers are playing a key role in the development of new models such as accountable care organizations (ACOs) but participating in these new ventures involves significant financial outlays. Investments in these ventures are precisely the types of "critical business opportunities in the competitive [healthcare] marketplace" that Congress sought to encourage Health Centers to pursue when it loosened the restrictions on Health Centers' use of non-grant revenue in the HCCA amendments.

In addition, Health Centers continue to be on the forefront of integrating vital supports that fall outside of HRSA's concept of scope of project but are critical to the health of patients and communities given the impact of the social determinants of health. Such services include community gardening, fitness and exercise programs, famers markets and violence prevention to name just a few. As far back as the 1960s, Health Center physicians in the Mississippi Delta wrote prescriptions for food for malnourished families and arranged to have the prescriptions filled at local grocery stores and charged to the Center's pharmacy budget. It would be tragic to see the program's long-standing history of providing non-traditional, community-oriented services like these negatively impacted by this PIN. And, although these efforts may not fall directly within the approved scope of project, we believe they are consistent with Health Center missions, the needs of patient populations and the statutory standard of "further[ing] the objectives" of the project.

The Proposed Requirements in the PIN Are a Departure from Longstanding Agency Practice

In 1995, HRSA issued PIN 95-15 and in 1996 Congress enacted the Health Center Consolidation Act (HCCA). The HCCA significantly increased, not decreased, Health Centers' flexibility to use their non-grant funds. At a minimum, HRSA guidance on budget requirements in 2013 should conform to (or explain its departure from) the prior policy, and for those aspects of PIN 95-15 that were superseded in 1996 by the HCCA, to implement the HCCA by further increasing Health Center flexibility in this area. Instead, the PIN substantially reduces flexibility and reinstates restrictions that Congress took out of Section 330.

The need for flexibility is even greater today than in 1995. HRSA explained in a letter accompanying PIN 95-15 that that policy "was developed in the context of a changing health care environment and reinvention of government" and would serve to enable Health Centers to serve their patients more efficiently. Another key benefit of the approach in the PIN was that it "[p]rovides for an advance understanding regarding permissibility of costs." Today, each of these factors is critically important. Health centers are expected to perform competitively on the new Health Insurance Exchanges and – due to an environment of increased compliance

[2] It bears noting that the scope of project or the approved project is a concept arising out of OMB Circulars A-110 and A-102 (45 CFR parts 74 and 92). These are regulatory requirements of general application that cannot on their own modify a specific statutory provision, especially one designed to free grantees from those very requirements.

scrutiny – they need to be able understand budget rules in advance rather than seeking approvals on an *ad hoc*, case-by-case basis.

Contrary to both the statutory amendments and HRSA's own precedent, PIN 2013-01 sets forth a policy of much more limited grantee discretion in the use of non-grant funds than was reflected in PIN 95-15. PIN 2013-01, effectively a revision of PIN 95-15, not only disregards the changes wrought by the HCCA in 1996 but also repudiates the principles in PIN 95-15 without any explanation. This runs counter to the basic administrative law principle that agencies must explain a change in its longstanding position, particularly when that change of position effectively invalidates a prior regulation or guidance.

HRSA Should Withdraw the PIN and Instead Use Notice-and-Comment Rulemaking

There is long-standing precedent that if a federal agency issuance constitutes a "legislative rule," then the agency is required to promulgate the rule through either formal (hearing) rulemaking or informal (notice-and-comment) rulemaking. Under the Administrative Procedure Act (APA) and related case law, the key feature of a legislative rule is that it changes the law, supplementing a statute rather than simply interpreting it. While styled as guidance, PIN 2013-01– and particularly Section V.B – does much more than simply restate existing law. It installs substantive changes in existing law and policy and imposes on Health Centers new obligations not present in the statute, including (1) imposing the federal cost principles on non-grant funds, (2) setting forth eight specific categories of permissible "otherwise-allowable" expenditures, (3) imposing detailed prior approval requirements for non-grant costs that do not fit into the eight permissible categories, and (4) requiring that all expenditures of non-grant funds be "in-scope."

The restrictions that HRSA seeks to impose through this PIN amount to a legislative rule. And, in our opinion, HRSA has an obligation to use notice-and-comment rulemaking. The purpose of notice and comment – to provide for meaningful public involvement in the making of law and "force important issues into full public display" – is diluted by HRSA's decision to style this issuance as a Policy Information Notice.[3]

The PIN Places Undue Burden on Health Centers

In addition to the legal impact of this PIN, one cannot ignore that the requirements will constitute a significant burden on grantees and look-alike entities. Health Centers will bear additional costs for staff time to implement these changes; Center staff will be distracted from more substantive work to comply with new administrative requirements imposed in the PIN; Centers will have less ability to develop robust operating reserves; Centers will experience delays in program advancement and as a result of the need to seek prior approval; and, Centers will be unnecessarily administratively constrained in a healthcare environment which requires swift, creative leadership at the local level to maintain a competitive and financially sound organization. Also, these types of administrative requirements, prior approvals and insufficiently defined processes are exactly the type of regulatory action which cause alarm and uncertainty amongst Center leadership and give pause to communities and organizations considering

[3] The PIN in Section IV also requires separate budgets for grant and non-grant funds. While the PIN classifies this as a "clarification" of existing policy and not available for comment, as the discussion in the legislative history makes clear, the total budget concept has been around for literally decades and this change is not a clarification but in fact a major departure from past agency practice. All of our objections to the process followed form making the changes to the non-grant provisions apply with equal force to the budgetary changes in Section IV. They should be the subject of a proper rulemaking.

developing new Health Centers. These additional burdens fly in the face of the statutory changes discussed above, as well a long-standing Congressional intent that the burden and costs of program implementation should not outweigh services delivered to beneficiaries.

Thank you for the opportunity to respond to the above-referenced solicitation. Please do not hesitate to contact me by telephone at 517-827-0474 or by email at rcienki@mpca.net if you have any questions or comments or if you require any clarification on the comments we have provided.

Sincerely,

Rebecca Cienki, MPH
Chief Operating Officer
Michigan Primary Care Association

CC: Jim Macrae, MA, MPP, Associate Administrator
Tonya Bowers, Deputy Associate Administrator