NATIONAL ASSOCIATION OF Community Health Centers

June 14, 2024

Jim Macrae, Associate Administrator
Bureau of Primary Health Care
Health Resources & Service Administration
U.S. Department of Health and Human Services

RE: DRAFT Health Center Program Policy Guidance Regarding Services to Support Transitions in Care for Justice-Involved Individuals Reentering the Community; PIN 2024-05

Dear Associate Administrator Macrae:

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Federally Qualified Health Centers (also known as FQHCs or health centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of an equitable health care system, free from disparities.

As you know, Community Health Centers are the best, most diverse, most innovative, and most resilient part of our nation's health system. For nearly sixty years, health centers have provided high-quality, comprehensive, affordable primary and preventive care, dental, behavioral health, pharmacy, vision, and other essential health services to America's most vulnerable, medically underserved patients in urban, rural, suburban, frontier, and island communities. Today, health centers serve 1 in 11 people at over 15,000 locations. This includes more than 5 million uninsured people, over 15 million Medicaid patients, over 3 million Medicare patients, and over 1 million patients experiencing homelessness.

In addition to medical services, health centers provide dental, behavioral health, pharmacy services, and other "enabling" or support services that facilitate access to care for individuals and families in medically underserved communities, regardless of insurance status or ability to pay. NACHC maintains its role as the national voice for health centers and believes that high-quality primary health care is essential in creating healthy communities. It is the collective mission and mandate of NACHC and the 1,487 health centers around the country to close the primary care gap and provide access to high-quality, cost-effective primary and preventative medical care.

Health centers play a crucial role in caring for patients with complex and chronic health conditions, such as formerly incarcerated individuals, who are at higher risk for adverse health outcomes. Some health centers already have partnerships with their local jails to begin developing care relationships and are ready to engage with them upon release as well.[1] Almost two-thirds (64%) of people in jail and over half (54%) of people in state prisons report a mental health concern,[2] making it imperative they can access health services before being released. We are excited that

[1] https://nhchc.org/wp-content/uploads/2019/08/csh-nhchc_health-centers_justice-involved-pops_final.pdf
[2] https://www.apa.org/monitor/2014/10/incarceration#:~:text=Mental%20illness%20among%20today%27s%20inmates,health%20concerns%2C%20the%20report%20found

this PIN will allow more health centers to cultivate partnerships with carceral facilities in their area to provide much-needed healthcare services to justice-involved individuals reentering the community (JI-R individuals).

We strongly urge HRSA to:

I. **Include individuals in pre-trial in the scope of this draft PIN to ensure equity in accessing health care services provided by health centers.**
II. **Allow flexibility for health centers when working with carceral settings that may be just situated outside of their service area.**
III. **NACHC strongly urges HRSA to explicitly acknowledge that health centers may include within their HRSA-approved scopes of project those services provided to the JI-R individuals pursuant to a "payor" contract with the carceral authority under which the carceral authority retains responsibility to provide payment for such services while the health center maintains responsibility for the clinical services furnished by the health center's clinicians.**
IV. **Clarify that health center services delivered beyond the expected 90-day period to JI-R shall still be considered in scope and eligible for FTCA coverage.**
V. **Implement a "good faith effort" continuity of care standard for health centers providing care to individuals who will not reside in the health centers' service area post-release.**
VI. **Consider barriers facing health centers in their ability to share patient records seamlessly with carceral settings and vice versa, given existing technological impediments at some carceral settings.**
VII. **We also appreciate the amount of healthcare services HRSA outlined in the draft PIN that health centers can provide to the JI-R patient population.**

We appreciate HRSA detailing the definition of a carceral setting in the PIN to showcase the variety of settings health centers can provide care to JI-R individuals and to whom these policies apply.[3] We urge HRSA to consider the pre-trial population as eligible patients due to the large percentage of individuals who are incarcerated in jails and similar facilities. In 2022, 1,230,100 people were incarcerated in the U.S. in both federal and state correctional facilities.[4] Estimates show that over 460,000 people are jailed pre-trial.[5] One tangible example is that on August 1, 2023, 87 percent of the population of New York City's primary jail at Rikers Island was awaiting trial.[6] We recommend HRSA revise this PIN to ensure this vulnerable population can benefit from the services and supports health centers can offer.

Many people are detained pre-trial simply because they cannot afford to pay their bail, which unfairly further marginalizes the low-income population who cannot access healthcare services provided by health centers. With the median felony bail placed at $10,000, that is a difficult amount of money to pay, given that over 30% of people booked in jail in 2022 reported an annual income

[3] https://bphc.hrsa.gov/sites/default/files/bphc/compliance/pin-2024-05-draft.pdf (page 3)
[4] https://bjs.ojp.gov/library/publications/prisoners-2022-statistical-tables#:~:text=The%20U.S.%20prison%20population%20was,from%20yearend%202021%20(1%2C205%2C100).
[5] https://www.prisonpolicy.org/blog/2024/04/15/jails_update/
[6] https://comptroller.nyc.gov/reports/the-state-of-new-york-city-jails/#:~:text=Over%20the%20past%20year%2C%20the,of%20the%20current%20jail%20population.

under $10,000.[7] Considering the large number of individuals in the pre-trial population, it is crucial they have equal access to health care services if their legal process will result with them being released in a designated time period. Individuals who are jailed pre-trial already experience injustices due to their lack of financial resources; for equity reasons, they should not be denied access to affordable and culturally competent health services delivered by their local health centers.

Additionally, adding pre-trial individuals into the parameters of this PIN will align with the precedent set by existing 1115 waivers. In April 2023, the Centers for Medicare and Medicaid Services (CMS) released guidance supporting state applications for a new Section 1115 waiver to provide health care services to JI-R individuals.[8] As of May 2024, 5 states have approved 1115 waivers, and 20 states have waivers pending. According to the guidance and the approved 1115 waivers, CMS does not preclude individuals awaiting pre-trial from receiving said healthcare services. As stated in HRSA's draft PIN, it is informed by CMS' guidance on providing healthcare services to justice-involved individuals reentering the community.[9] If HRSA policy does retain the exclusion of pre-trial individuals, implementation of both policies will be less effective. To better align with the flexibilities CMS afforded states in embarking on this opportunity, NACHC urges HRSA to allow pre-trial individuals to have access to these healthcare services.

Often, the population awaiting pre-trial has previously been incarcerated, also known as being part of a "revolving door" in the U.S. prison system. New research indicates that pre-trial detention has a substantially negative economic impact on individuals, disrupting their labor market activities and causing increased recidivism. The U.S. Department of Justice looked at data from 2008-2018 on recidivism rates in 24 states; the data show that within a year of release, 43% of formerly incarcerated individuals were rearrested.[10] As pillars of the community, health centers have the chance to intervene with this population and help address existing health issues. The average length of detainment awaiting pre-trial is about 26 days or around three and a half weeks.[11] This also falls within the time frame noted in this draft PIN when health centers can begin serving individuals set to reenter the community. Even if some people are released on the day of the arraignment or within one week, time in jail can have a significantly negative impact on that person's health. Justice-involved individuals are also more likely to suffer from mental health conditions and substance use disorder (SUD), [12] which could be further exacerbated when in jail awaiting pre-trial, or they could develop new health problems,[13] especially if they lack access to healthcare services that health centers excel at providing. Health centers should be able to readily provide services to this at-risk and vulnerable population.

I. NACHC recommends HRSA allow flexibility for health centers when working with carceral settings that may be just situated outside of their service area.

[7] https://www.prisonpolicy.org/blog/2024/04/15/jails_update/
[8] https://www.medicaid.gov/sites/default/files/2023-12/smd23003.pdf
[9] https://bphc.hrsa.gov/sites/default/files/bphc/compliance/pin-2024-05-draft.pdf (page 3)
[10] https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/rpr24s0810yfup0818_sum.pdf
[11] https://www.hks.harvard.edu/centers/wiener/programs/criminaljustice/projects/pre-trial-detention#full-project-description
[12] https://www.psychiatry.org/news-room/apa-blogs/justice-involved-individuals-mental-health-and-t
[13] https://www.justiceinitiative.org/publications/pre-trial-detention-and-health-unintended-consequences-deadly-results

NACHC appreciates HRSA expanding health centers' ability to provide care to the JI-R population. However, we urge BPHC to take a more flexible approach to defining services, contingent on factors the health center can control. Given the unique circumstances, health centers need more flexibility to meet the needs of this vulnerable population as they support their transition back into the community.

There is a substantial difference between the locations of prisons and jails. Jails can vary in size and are located in closer proximity to a health center, as they are run by a local law enforcement agency. Smaller jails (1-49 beds) make up the majority of jails around the country and are typically for shorter jail sentences.[14] Prisons, on the other hand, are much larger and can be located hours from health centers either in rural or urban areas. Most recent data gathered through the U.S. Census Bureau from 2018 show that a disproportionate share of prisons and inmates are located in rural areas, while a disproportionate share of inmates are from urban areas.[15] This shows a discrepancy between where the inmate comes from versus where they are eventually incarcerated. One example echoed by health centers in multiple states is the existence of separate jails for male and female inmates. In this example, a patient could be booked at a jail in the health center's area, but then any female inmates booked must be housed at the all-female jail outside of the health center's service area. These women will most likely be coming back into the health center's service area because that is where they are originally booked. To help with continuity of care for that patient, it would be beneficial to allow health centers to work with jails and prisons adjacent to or just outside their service area.

There can also be instances where a health center specializes in providing a specific service that can significantly benefit a subset of JI-R individuals, some of whom may be in a carceral setting outside of the center's service area. There are health centers that conduct outreach with local jails to provide Medication Assisted Treatment (MAT) to JI individuals with opioid use disorders, especially those reentering the community. For instance, Lowell Community Health Center in Massachusetts works closely with the Middlesex Jail and House of Correction, which offers a MAT program while people are incarcerated and the jail coordinates post-release treatment transitions to the health center.[16] This intervention has proven to be one of the most worthwhile, effective partnerships between correctional facilities and health centers.[17] The U.S. is already experiencing a healthcare workforce shortage across a multitude of professions, and research foresees this problem worsening in the future. For instance, a 2019 report from the Association of American Medical Colleges estimates that there could be a shortage of up to 124,000 physicians in the next 12 years.[18] Health centers could be the only providers in certain communities to provide specific services to the JI-R population. A lack of flexibility for health centers regarding which carceral settings they can work with could inadvertently block access to care for this vulnerable population.

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[14] https://www.americanjail.org/jail-statistics
[15] https://www.census.gov/content/dam/Census/library/working-papers/2017/adrm/carra-wp-2017-08.pdf
[16] https://www.commonwealthfund.org/publications/issue-briefs/2024/feb/essential-connections-community-health-centers-role-facilitating
[17] https://www.commonwealthfund.org/publications/issue-briefs/2024/feb/essential-connections-community-health-centers-role-facilitating
[18] https://www.ama-assn.org/practice-management/sustainability/doctor-shortages-are-here-and-they-ll-get-worse-if-we-don-t-act

Furthermore, this service area limitation might render existing arrangements between health centers and carceral settings out of scope within the PIN. We request that HRSA give flexibility and grandfather in existing arrangements between health centers and carceral settings. At a minimum, HRSA should consider an excruciating circumstance exception for health centers working with a carceral setting outside of the service area for reasons related to workforce challenges or location constraints.

II. NACHC strongly urges HRSA to explicitly acknowledge that health centers may include within their HRSA-approved scopes of project those services provided to the JI-R individuals pursuant to a "payor" contract with the carceral authority under which the carceral authority retains responsibility to provide payment for such services while the health center maintains responsibility for the clinical services furnished by the health center's clinicians.

Contractual arrangements for the provision of health care services may take various forms, including contracts under which a health care provider furnishes services to, on behalf of, and under the direction of another entity (i.e., a vendor contract) and contracts under which a health care provider receives payment from a third party but retains authority and responsibility for the services furnished (i.e., a payor contract). It is not uncommon among health centers to utilize the latter approach to provide services to specific populations for which another party retains financial responsibility. For example, health centers furnishing services to beneficiaries under a PACE program not operated directly by the health center may enter into an agreement with the PACE entity under which the PACE entity provides payment and retains a degree of administrative responsibilities (similar to a "third party payor" organization). Notwithstanding, the health center (i) maintains medical records for the services provided; (ii) retains authority for the provision of the services under the direction and control of its Board of Directors and in accordance with the health center's policies and procedures; (iii) provides the services on its own behalf as the provider of record; and (iv) otherwise fulfills the criteria to include the services within the health center's HRSA-approved scope of project, as set forth in Sections IV and V of the draft PIN, with one key exception – payments for the services are provided by the other party rather than through billing traditional third party reimbursement programs and patients.

Health centers may have similar arrangements with a variety of other entities, including but not limited to, school districts, local employers, other social programs caring for certain vulnerable populations, etc. The common thread throughout these arrangements is the fact that the health center is not functioning as a *vendor* to the other entity; rather, the other entity is functioning as a *"non-traditional" payor and administrator* while the health center retains full control over and independent professional judgment for the services rendered and the manner by which they are delivered, as it would for any other services it provides directly to its patients.

Health center arrangements with carceral authorities under which the carceral authority provides payment to the health center and retains certain administrative responsibilities while the center retains control and authority over the services provided to the J1-R individuals fall squarely within the non-traditional payor arrangements described above. Accordingly, such arrangements, and the activities and services provided thereunder, should not be precluded from inclusion within the health center's approved scope of project.

NACHC recognizes that there may be some concerns that allowing health centers to include within their approved scopes of project services provided via a contract with a carceral authority would ultimately

"federalize" a local responsibility and/or obviate the carceral authority's constitutional responsibility to ensure the provision of appropriate health care. This view, however, misunderstands the nature of the contract between the carceral authority and the health center. As noted above, the carceral authority retains the financial and certain administrative responsibility, using its funds to cover the costs of treating the JI-R individuals, as required of it by law. On the other hand, the health center maintains clinical (and clinically-related) responsibility based on the actions of its clinicians, as required by the health center program requirements and guidance on including services within the health center's scope of project. The contract between the carceral authority and the health center is merely another type of arrangement between a health center and a non-traditional payor that reimburses the health center for services furnished to "eligible" patients.

For all of the reasons discussed above, we urge HRSA to allow the aforementioned health center arrangements under which services are provided to the JI-R individuals pursuant to a "non-traditional payor" contract between the health center and the carceral authority to be included within the health center's scope of project.

III. NACHC seeks clarity that health center services delivered beyond the expected 90-day period to JI-R shall still be considered in scope and eligible for FTCA coverage.

Carceral release dates can change for a variety of reasons, often influenced by factors related to the inmate's behavior, legal considerations, and administrative processes. Additionally, parole boards can reconsider the tentative release date when more information about the offense and offender has been collected and the offender's behavior in prison has been observed.[19] Under these circumstances, health centers face a risk when providing services to a JI-R individual, believing they are scheduled for release within 90 days, only for the release date to be extended. Providing services outside the HRSA-approved scope of project means those services are not covered by the Federal Tort Claims Act (FTCA). Without FTCA coverage, health centers and their providers are exposed to potential lawsuits and malpractice claims.[20] This may eventually lead to a health center being forced to purchase private malpractice insurance to cover services outside the approved scope, which can be costly, especially for health centers with limited resources. Ensuring that health center services delivered beyond the expected 90-day period are within the Health Center Program scope prevents potential exposure to lawsuits and the significant financial burden on health centers.

To mitigate these risks, it is crucial for health centers to have clear guidelines and confirmation that services provided to JI-R individuals beyond the expected 90-day release window are indeed within the approved scope and eligible for FTCA coverage. This clarity would allow health centers to continue offering necessary care without the fear of financial or legal liability, ensuring uninterrupted access to healthcare for JI-R individuals. By securing this confirmation, health centers can focus on their primary mission of providing comprehensive and affordable care to underserved populations, thereby enhancing overall community health and stability.

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[19] https://www.uscourts.gov/file/23091/download

[20] https://bphc.hrsa.gov/compliance/ftca/faq#:~:text=If%20the%20health%20center%20is,alleged%20negligent%20performance%20of%20medical%2C

IV. NACHC encourages HRSA to implement a "good faith effort" continuity of care standard for health centers providing care to individuals who will not reside in the health centers' service area post-release.

Health centers are well-positioned to assist JI-R individuals in continuing their access to care and all the health center's in-scope services upon release. In fact, in 2022, nearly all health centers provided behavioral health care, including MAT, for more than 205,000 patients with opioid use disorders, which are increasingly used in jail and prison settings.[21] However, challenges may arise for health centers in ensuring continuity of care for individuals who will not reside in their service area post-release, as they must connect these individuals to a health center or primary care provider in the community where they will live.

Although health centers will certainly do their due diligence to connect JI-R individuals to a new health center based on their residence, it is unclear if the connection will go beyond that point. Establishing a connection with a new health center or provider is merely the first step in ensuring continuity of care. As HRSA Administrator Carole Johnson noted, "poor care transitions as people leave prisons and jails can have devastating consequences."[22] The effectiveness of this transition depends on several factors, including the responsiveness and capacity of the receiving healthcare provider, the willingness and ability of the individual to engage with the new provider, and the consistency of the care received.[23] Additionally, administrative burdens might be placed on health centers, such as obtaining and transferring medical records and addressing any immediate healthcare needs during the transition period. Moreover, once a connection is made between a JI-R individual and a health center or primary care provider in the community where they will reside after their release, current guidelines do not specify if/how the health center will document this connection and how they will track if the patient follows up with their new provider.

A "good faith effort" standard acknowledges the challenges and limitations faced by health centers while emphasizing the importance of making earnest attempts to facilitate care transitions. This approach recognizes the complexities of post-release care coordination, ensuring that health centers are not unfairly held accountable for factors beyond their control. By implementing this standard, HRSA would support health centers in their efforts to mitigate the risks associated with poor care transitions and help clarify how health centers can accurately document their efforts in facilitating continuity of care for JI-R individuals.

V. NACHC asks HRSA to consider barriers facing health centers in their ability to share patient records seamlessly with carceral settings and vice versa, given existing technological impediments at some carceral settings.

NACHC's member health centers (FQHCs and look-alikes) and partner organizations, Primary Care Association (PCA) and Health Center-Controlled Networks (HCCN), are the largest national

[21] https://www.jcoinctc.org/issue-brief-treating-oud-in-justice-involved-populations/#:~:text=Opioid%20use%20disorder%20(OUD)%20is,justice%20settings%20and%20upon%20release
[22] https://www.hhs.gov/about/news/2024/04/10/health-centers-to-support-transitions-in-care-for-people-leaving-incarceration.html
[23] https://psnet.ahrq.gov/primer/inpatient-transitions-care-challenges-and-safety-practices

primary care network providing high-quality culturally responsible care to the nation's underserved. HCCNs help health centers leverage health IT to enhance patient and provider experience, advance interoperability, and use data to enhance value. In 2021, approximately 83% of federally funded health centers participate in an HCCN, an increase from approximately 73% over the past three years.

HCCNs also provide support services for sharing data through health information exchanges (HIEs) and APIs, as well as support services for data privacy and security. HCCNs have a long and successful track record for improving health center operations. They have developed the infrastructures and expertise needed to support their mission-driven health center members in improving population health while reducing costs and prioritizing patient experience and care team well-being. HCCNs are a critical component to health center interoperability and to the successful, meaningful sharing and utilization of health center patient data. These HCCNs help enable health centers' success in interoperability. Furthermore, nearly all health centers (98.7%) of health centers utilize electronic health records (EHRs).[24] Given that this draft PIN states that both the carceral authority and the health center should each maintain a distinct patient record, [25] they will be crucial in helping health centers continue to create and maintain individual patient records for the JI-R population.

We encourage HRSA to amend its policy and consider technological barriers that limit the seamless exchange of patient data. We have heard from some health centers that are already working on these arrangements that their State Department of Corrections still uses paper charts for their incarcerated patients, and more rural/smaller jails also use paper charts as well. The latest data from 2018 found that less than five percent of State Department of Corrections (DOCs) surveyed could exchange structured medical data through their Electronic Health Records. Moreover, when attempting to share medical records with community health care providers or former patients, most DOCs offered copies by mail (42/44 or 95.5%) or fax (31/44 or 70.5%).[26] Fewer states had the capacity to send records through email (14/44, 31.8%) or via an electronic record system (2/44, 4.5%). There has been an increase in states attempting to transition to EHRs, especially given that in 2023, CMS reminded states of available funding to help enhance prison healthcare information technology systems, specifically to help improve data integration to allow record sharing for correctional facilities, state Medicaid agencies, and community-based providers.[27] However, no requirements exist for correctional facilities to maintain unified records for mental health, medical, and dental records.[28]

If health centers are required to maintain continuity of care, it could be administratively burdensome to keep track of the variety of paper health records. Given that the health center must facilitate "continuity of care through access to relevant health data (including transfer and discharge information and the exchange of patient record information) from the carceral setting to the health center," we are concerned about operational barriers to transferring sensitive patient data

[24] https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=EHR&year=2022
[25] https://bphc.hrsa.gov/sites/default/files/bphc/compliance/pin-2024-05-draft.pdf Page 6, Footnote 8
[26] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6848436/
[27] https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf
[28] https://www.ncchc.org/q-a/health-records/

on paper charts. We ask that HRSA consider the barriers facing health centers when attempting to work with correctional facilities who have yet to transition to fully electronic records.

VI. NACHC greatly appreciates the broad array of healthcare services HRSA outlined that health centers can provide this justice-involved patient population.

The in-scope services outlined in this draft PIN closely align with the services health centers already provide as outlined per our Section 330 grant requirements, so health centers are ready to continue to provide these comprehensive health care and care coordination services. Furthermore, the services mirror the allowable services CMS outlined in their guidance to states to include in the 1115 waivers. Having the ability to provide this vast array of services will help set justice-involved individuals on a better path to successfully reentering the community. Many health centers are already leaders in helping support the transition of justice-involved individuals back into their communities. They leverage interdisciplinary care teams, employ community health workers with lived experience with incarceration, train their providers in cultural responsiveness, and generally use trauma-informed care practices when providing services. This is a very complex population to treat; compared to the general population, people who are incarcerated are more likely to have significant health issues, including high blood pressure, asthma, cancer, arthritis, and infectious diseases, such as tuberculosis, hepatitis C, and HIV.[29] Given that health center patients suffer from more chronic diseases compared to the general populations,[30] health centers are well-equipped to provide care to this JI-R population. Additionally, health centers that have been engaged with this population report that they often provide more than just healthcare services but address social drivers of health (SDOH) needs. For instance, connecting this population to housing, food, employment, transportation, and/or family reunification may be a higher priority for people as they prepare for reentry into their community.[31] Health centers are eager to continue to play a critical role in JI-R peoples' lives through offering these comprehensive healthcare and overall support services.

We thank HRSA for the opportunity to comment on this draft PIN and appreciate the consideration of our recommendations to improve proposed policies to ensure health centers can more easily and holistically provide. Given health centers' experience in serving vulnerable populations, they stand ready to work closely with carceral settings to provide high-quality, affordable and comprehensive healthcare services to JI-R population and help them get back on their feet as they return to their communities. If you have any questions, please contact Vacheria Keys, Associate Vice President of Policy & Regulatory Affairs at vkeys@nachc.org.

Sincerely,

[29] https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration#:~:text=Studies%20have%20shown%20that%20when,%2C%20hepatitis%20C%2C%20and%20HIV.
[30] https://www.nachc.org/wp-content/uploads/2023/07/Community-Health-Center-Chartbook-2023-2021UDS.pdf
[31] https://www.healthaffairs.org/do/10.1377/hpb20210928.343531/full/health-affairs-brief-appendix-prison-community-reentry-russ-1635782008594.pdf

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