Before the

Federal Communications Commission

Washington, D.C. 20554

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| In the Matter of  Promoting Telehealth for Low-Income Consumers | **)**  **)**  **)**  **)**  **)** | WC Docket. No. 18-213 |

**Comments of National Association of Community Health Centers**

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| September 30, 2019 |  |

**Executive Summary**

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**Comments of the National Association of Community Health Centers (NACHC)**

# Overarching Comments:

## Community Health Centers appreciate the FCC’s recognition of the valuable role that connected care technology can play in expanding access, decreasing costs, and improving health outcomes for low-income patients.

## To best demonstrate the potential impact of connected care, the FCC should work closely with the Centers for Medicare and Medicaid Services (CMS) to pair the CCPP with expansions in Medicaid and Medicare reimbursement for connected care services. *(Relates to paragraphs 12, 27, 30, 31, and 32.)*

# Comments on Specific Paragraphs

* Paragraph 17: NACHC recommends that participating providers be required to focus on health conditions that are generally managed on an outpatient basis.
  + Paragraphs 22, 23, & 26: NACHC strongly recommends that providers be permitted to use CCPP funding to rent, purchase, and/or add service for equipment to be used by patients.
* Paragraph 27: NACHC strongly encourages the FCC to collaborate with the Centers for Medicare and Medicaid Services (CMS) to pair FCC funding with reimbursement under Medicare and Medicaid.
* Paragraph 29: NACHC strongly supports the FCC’s decision to fund the CCPP without reducing funding for the Lifeline Program.
* Paragraph 30 and 31: NACHC supports a discount level of 85%, provided that health centers receive Medicaid and Medicare reimbursement for connected care services.
* Paragraph 32: NACHC supports limiting potential sources for the non-discounted share of costs only if Medicaid and Medicare reimbursement is available for CCPP services.
* Paragraph 32: NACHC recommends that the FCC explicitly prohibit telecom companies from charging more for services and/or devices provided to CCPP patients than they charge for the same services and/or devices provided to non-CCPP patients.
* Paragraph 33: NACHC encourages the FCC to fund a large number of proposals representing varied funding amounts and methodological approaches – and not to arbitrarily how many proposals will be funded in advance.
* Paragraph 36: NACHC supports a three-year funding period for pilot projects, with additional time for “wind-up” and “wind-down” and potential extensions when warranted.
* Paragraph 37: NACHC strongly encourages the FCC to limit participation to ambulatory care providers – i.e., those whose focus is to keep patients living at home
* Paragraph 43: NACHC strongly supports limiting CCPP participation to providers that are located in or serve Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and/or Medically Underserved Populations (MUPs), and note that the NPRM does not explicitly mention MUPs in the main text.
* Paragraph 43: NACHC strongly supports targeting CCPP funds to providers whose primary purpose is to serve low-income and/or medically-underserved patients. However, percentage of patients with Medicaid is not a good proxy for this purpose. Instead, we recommend requiring providers to serve or be located in a HPSA, MUA, or MUP, and awarding preference points based on data on the percentage of a providers’ actual patients who are low -income and/ or medically-underserved.
* Paragraphs 45 & 47: NACHC opposes limiting eligibility to providers who can demonstrate previous experience with connected care, such as Telehealth Resource Centers, Telehealth Centers of Excellence, and Eligible Telecommunications Carriers. Instead, the CCPP should support new providers to expand into these activities, in order to reach new
* Paragraphs 45 & 52: NACHC supports funding providers who can provide robust evaluations of their projects, but opposes limiting eligibility to providers that:
* Agree to partner with external research organizations.
* Can conduct a methodologically-sound clinical trial.

### Paragraph 45, 52, & 55: When establishing evaluation parameters, the FCC should keep in mind the limits on the types of data that health care providers can access. The FCC should also request support from CMS to access Medicaid and Medicare data

### Paragraph 45, 52, & 55: The FCC should request support from CMS to access Medicaid and Medicare data

* Paragraph 56: NACHC strongly encourages the FCC to award priority points to applicants that:
* Currently serve geographic areas or populations where there are well-documented health care disparities.
* Focusing on specific health crises or chronic conditions that are widespread, and are documented to benefit from connected care.
* Serving a large percentage of low-income patients and/or veterans who are eligible for free VA care.
* Focus on keeping patients at home, rather than in medical facilities.

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**Comments of the National Association of Community Health Centers (NACHC)**

The National Association of Community Health Centers (NACHC) hereby comments on the Commission’s Notice of Proposed Rulemaking regarding the establishment of Connected Care Pilot Program (“CCPP”).[[1]](#footnote-1)

NACHC is the national membership organization for America’s Community Health Centers (also called CHCs or Federally Qualified Health Centers.) As discussed below, CHCs are the backbone of the nation’s primary care safety net”, assuring access to affordable primary care for over 29 million medically-underserved patients, in both rural and urban areas. Over 90% of health center patients are low-income, with almost 70% of them having incomes below the Federal poverty level.

Our comments are structured as follows:

* ***Background on Community Health Centers:*** To provide context for our comments and interest in the CCPP.
* ***Overarching Comments***: General comments that apply to all aspects of the CCPP
* ***Comments on Specific Paragraphs of NPRM:*** These comments respond to specific issues raised in the NPRM.

# Background on Community Health Centers

## Community Health Centers are the backbone of the nation’s “primary care safety net” for low-income patients.

A Community Health Center (CHCs) is a health care provider that is authorized under Section 330 of the Public Health Service Act[[2]](#footnote-2). As a backbone of the “health care safety net”, all CHCs are required by law to:

* provide a wide range of medical services. These always include primary and preventive care, and generally include pharmacy, dental, mental health, and addiction treatment.
* care for all individuals who present for treatment, regardless of whether they have insurance or their ability to pay.
* target geographic areas and populations that the Federal government has determined to be “medically underserved.”
* be non-profit or public, and be governed by a Board, the majority of whose members are CHC patients.
* provide services that support patients in accessing and using health care services appropriately, such as interpretation/translation, job search assistance, and education about healthy eating, exercise, etc. By addressing the social factors that contribute to poor health, these services help low-income patients maximize the benefit of the health services they receive.

Nationally, over 12,000 CHC sites provide care to over 29 million medically‐underserved individuals, including one of every three persons living in poverty, one of every five persons living in rural areas, and over 385,000 veterans[[3]](#footnote-3). Almost 70% of CHC patients have incomes below the Federal Poverty Level (FPL); if uninsured or underinsured, these individuals pay no more than a nominal fee for their care. Another 23% of CHC patients have incomes between 101% and 200% FPL; if uninsured or underinsured, they are charged based on a sliding fee scale. Almost one-quarter of CHC patients have no insurance, while almost half have Medicaid and 10% have Medicare.

Because CHCs focus on ensuring health care access for at-risk populations, they are experts on the health care challenges faced by low-income individuals across the country. This includes strategies and services to help individuals access and utilize care appropriately, and to address the social factors that contribute to poor health (e.g. poor quality and/or instable housing, food insecurity, transportation challenges, financial limitations, behavioral health issues). Because CHCs are managed by their own patients, they focus intently on meeting their community’s needs. And as the backbone of the nation’s primary care safety net, CHCs generally run on margins of less than one percent.

# Overarching Comments:

## Community Health Centers appreciate the FCC’s recognition of the valuable role that connected care technology can play in expanding access, decreasing costs, and improving health outcomes for low-income patients.

As the FCC explains in the NPRM, connected care has great potential to expand access, improve health outcomes, and lower costs across the US health care system – all while improving both the patient and the provider’s experience of care. But, as connected care is starting to spread, it is also widening the digital divide, as these services are rarely accessible to lower-income consumers. CHCs see this growing divide first-hand, as our patients often cannot afford the broadband access and equipment necessary to take advantage of these new care options. Complicating this, CHCs are rarely reimbursed for their costs of providing telehealth services.

For this reason, NACHC sincerely appreciates the FCC’s recognition that the “digital divide” is expanding into health care, as well as the Commission’s efforts to address this divide through the creation of the Connected Care Pilot Program (CCPP.) We appreciate the opportunity to provide input on how this pilot program should be designed and we look forward to collaborating with you to demonstrate how connected care can benefit low-income patients and communities.

## To best demonstrate the potential impact of connected care, the FCC should work closely with the Centers for Medicare and Medicaid Services (CMS) to pair the CCPP with expansions in Medicaid and Medicare reimbursement for connected care services. *(Relates to paragraphs 12, 27, 30, 31, and 32.)*

As discussed above, NACHC sincerely appreciates the FCC’s efforts to support the expansion of connected care low-income patients. However, it is important to note that ***the FCC’s efforts alone will be insufficient to unlock the full potential of connected care to improve health outcomes for low-income communities.***

The largest barrier that CHCs face when seeking to expand telehealth services is the lack of insurance reimbursement. As discussed in our comments on the ROI, Medicaid and Medicare generally do not reimburse CHCs for services provided using telehealth or other types of “connected care” technologies. Also, since connected care often replaces a face-to-face office visit – which is reimbursable by insurers – CHCs who use connected care not only incur the cost of that care, but also lose payment for the face-to-face visit. For the average CHC, Medicaid and Medicare account for almost 60% of their patients, another 23% of patients are uninsured. Thus, providing services via connected care technologies places a significant financial burden on safety net providers who already run on very thin margins.

For these reasons, NACHC strongly urges the FCC to work closely with the Centers for Medicare and Medicaid Services (CMS) to explore ways in which the CCPP could be paired with flexibility in Medicare and Medicaid reimbursement. CMS has waiver and demonstration authority under both programs, which it could use to ensure the CCPP providers are fairly reimbursed for the services they provide via connected care. It also has an entire Center – the Center for Medicare and Medicaid Innovation (CMMI) – which is dedicated to identifying and testing creative methods to improve health center for patients. CMMI has broad statutory authority to adjust CMS rules and practices in order to test innovative approaches, and would be a natural partner for FCC in developing the CCPP.

If it would be helpful, NACHC would be happy to assist FCC staff in identifying the best points of contact at CMS. An FCC-CMS partnership – with the former providing support for low-income patients and the latter ensuring adequate reimbursement for providers – would be a powerful combination that could unlock connected care’s true potential to support low- income patients.

# Comments on Specific Paragraphs

* **Paragraph 17: NACHC recommends that participating providers be required to focus on health conditions that are generally managed on an outpatient basis.**

NACHC supports the FCC’s proposal to require projects to focus on health conditions that generally require at least several months to treat. In addition, we recommend that qualifying health conditions be limited to those that are generally managed on an outpatient, non-residential basis. This would ensure that the CCPP targets conditions that patients deal with while living “in the community”, which is where connected care is likely to have the most positive impact.

* + **Paragraphs 22, 23, & 26: NACHC strongly recommends that providers be permitted to use CCPP funding to rent, purchase, and/or add service for equipment to be used by patients.**

NACHC strongly recommends that providers be permitted to use CCPP funding to fund patient equipment, medical devices, and mobile applications for connected care.

While we welcome support to cover the internet connectivity for patients, it is important to note that these represent only a fraction of the total costs related to connected care. The largest cost is generally the provider’s time, which typically is not reimbursed by insurance. (See general comment above.) The cost to obtain and operate patient devices is another cost, and given that almost 70% of CHC patients live below the poverty line, CHCs often absorb some or all of these costs themselves in order to provide connected care to their patients. To help offset these costs, NACHC strongly recommends that CCPP providers be permitted to use program funds to finance costs related to patient devices.

In addition, the following two recommendations reflect health centers’ experience to date with connected care:

* Providers should be permitted and encouraged to use CCPP funds to add minutes and/or service to patients’ personal devices (e.g., cell phones, tablets.) In addition to being cost-effective, this approach increases the likelihood that the patient will have the device with them when it is needed.
* If renting or purchasing patient devices, providers should be encouraged to buy commonly-used devices (e.g., cell phones, tablets) as opposed to vendor-specific devices. This will prevent them from providers being “locked into” relying on a specific vendor for service, upgrades, replacements, etc.
* **Paragraph 27: NACHC strongly encourages the FCC to collaborate with the Centers for Medicare and Medicaid Services (CMS) to pair FCC funding with reimbursement under Medicare and Medicaid.**

As discussed in our overarching comments, the largest barrier CHCs face in expanding telehealth services is the lack of insurance reimbursement. Unless this issue is addressed, efforts such as the CCPP will be limited in their ability to expand connected care to low-income and rural populations.

NACHC strongly encourages the FCC to reach out to CMS – particularly, the Center for Medicare and Medicaid Innovation (CMMI) – to explore ways in which the CCPP can be paired with reimbursement under these programs. If appropriate, NACHC would be happy to help facilitate these connections.

* **Paragraph 29: NACHC strongly supports the FCC’s decision to fund the CCPP without reducing funding for the Lifeline Program.**

As stated in our comments on the RFI, NACHC was very concerned that the CCPP might be funded through reductions to the Lifeline program**.** Millions of CHC patients rely on Lifeline to afford basic phone or Internet access, and reducing Lifeline funding to pay for the CCPP could leave millions of our patients the voice and broadband connectivity services critical to function in today’s digital world. For this reason, NACHC strongly supports the FCC’s decision to fund the CCPP using a separate quarterly collection.

* **Paragraph 30 and 31: NACHC supports a discount level of 85%, provided that health centers receive Medicaid and Medicare reimbursement for connected care services.**

Subject to the caveat below, NACHC agrees that it is appropriate to expect CCPP participants to contribute towards the cost of their project, and we support an 85% discount rate, as this is consistent with the Rural Health Care Program.

However, as discussed above, the costs of broadband connectivity and patient devices represent only a fraction of the total costs that health centers (and other providers) incur when providing connected care; provider’s time is a more significant cost. This is why we strongly urge the FCC to collaborate with CMS to pair the CCPP with demonstration projects that will allow Medicare and Medicaid to reimburse for connected care services. If such reimbursement is not possible, then NACHC recommends that the FCC cover the full costs of broadband and patient devices, in order to lessen the financial losses that health centers will incur when providing connected care.

**Paragraph 32: NACHC supports limiting potential sources for the non-discounted share of costs only if Medicaid and Medicare reimbursement is available for CCPP services.**

Similar to our previous comment, NACHC supports limiting the potential sources for the non-discounted share of costs only if Medicaid and Medicare reimbursement is available for these services. Assuming such reimbursement is available, NACHC thinks it is appropriate to *permit* – but not require – CCPP providers to require patients to contribute towards the non-discounted share, as it increases their “skin in the game.” However, CCPP providers should be allowed to decide how much of that 15% cost to pass on to individual patients, based on their circumstances (e.g., income, other medical expenses, costs for equipment, etc.)

**Paragraph 32: NACHC recommends that the FCC explicitly prohibit telecom companies from charging more for services and/or devices provided to CCPP patients than they charge for the same services and/or devices provided to non-CCPP patients.**

NACHC is concerned that telecom companies might seek to charge more for CCPP patients than non-CCPP patients, particularly if the companies are permitted to cover the non-discounted share. For this reason, we recommend that the FCC explicitly prohibit such practices.

**Paragraph 33:** **NACHC encourages the FCC to fund a large number of proposals representing varied funding amounts and methodological approaches – and not to arbitrarily how many proposals will be funded in advance.**

NACHC supports the FCC’s proposal not to arbitrarily limit the number of projects it will fund under the CCPP. This will give the FCC the flexibility to make funding decisions based on the range and quality of the applications submitted. We also encourage the FCC to fund a large number of pilot projects, representing a range of budget sizes, medical conditions, target populations, and provider types. This will allow for the FCC to gain insight on many different approaches to providing connected care, and ensure that small, community-based providers are not excluded from participation.

**Paragraph 36:** **NACHC supports a three-year funding period for pilot projects, with additional time for “wind-up” and “wind-down” and potential extensions when warranted.**

**Paragraph 37:** **NACHC strongly encourages the FCC to limit participation to ambulatory care providers – i.e., those whose focus is to keep patients living at home**

As the FCC has stated, the purpose of the CCPP is to expand the ability of patients and providers to communicate outside of the “bricks and mortar” of a medical facility, with the goal of improving health outcomes and reducing the need for more intensive care. For this reason, CCPP funding should be limited to those providers whose primary purpose is consistent with this goal -- to keep patients living at home, as opposed to in inpatient or residential facilities such as hospitals and skilled nursing facilities (SNFs.)

**Paragraph 43: NACHC strongly supports limiting CCPP participation to providers that are located in or serve Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and/or Medically Underserved Populations (MUPs), and note that the NPRM does not explicitly mention MUPs in the main text.**

NACHC strongly supports the proposal to limit CCPP participation to areas and populations that have been designated by the Federal government (specifically, the Health Resources and Services Administration) as having a shortage of providers. As the CCPP states, this approach will help ensure a geographic diversity of providers. More importantly, it will help ensure that CCPP funds are directed towards the most medically-underserved individuals. We also note that while HRSA has three distinct types of shortage designations – HPSAs, MUAs, and MUPs – MUPs are referenced only in the footnotes. We therefore recommend that MUPs be referenced in the main text of the Final Rule.

**Paragraph 43: NACHC strongly supports targeting CCPP funds to providers whose primary purpose is to serve low-income and/or medically-underserved patients. However, percentage of patients with Medicaid is not a good proxy for this purpose. Instead, we recommend requiring providers to serve or be located in a HPSA, MUA, or MUP, and awarding preference points based on data on the percentage of a providers’ actual patients who are low -income and/ or medically-underserved.**

NACHC strongly supports the FCC’s efforts to target CCPP funds to providers whose primary purpose is to serve low-income and/or medically-underserved patients. However, the percentage of patients on Medicaid is not an appropriate proxy for this purpose, as there are enormous differences in Medicaid eligibility rules across states. For example, in Texas and Alabama Medicaid covers adults with incomes up to 18% of the Federal Poverty Level (FPL), while in the District of Columbia it covers adults up to 221% FPL.[[4]](#footnote-4) Additionally, particularly in rural areas, the social and economic conditions may be such that an individual and/or family possesses assets that deem them ineligible for Medicaid, despite having incomes well below the Federal Poverty Level.

To most effectively target CCPP funds to providers whose focus on serving low-income and/or medically-underserved patients, NACHC recommends:

* limiting eligibility to providers who serve or are located in a HPSA, MUA, of MUP. (See comment on paragraph 43.)
* providing preference points to providers who demonstrate in their applications that a large percentage of their patients are either low-income and/or medically-underserved. (See comment on paragraph 56 for further discussion.)

**Paragraphs 45 & 47: NACHC opposes limiting eligibility to providers who can demonstrate previous experience with connected care, such as Telehealth Resource Centers, Telehealth Centers of Excellence, and Eligible Telecommunications Carriers. Instead, the CCPP should support new providers to expand into these activities, in order to reach new patients.**

The goal of the CCPP is to expand connected care services to low-income patients who otherwise would not have access to these services, in order to approve their health outcomes. Limiting CCPP participation to existing telehealth providers is contrary to this goal for two reasons:

* The providers who traditionally serve low-income and medically-underserved patients generally lack the financial means to provide connected care services (particularly due to the lack of insurance reimbursement, as discussed above.) Limiting CCPP funding to providers with prior telehealth experience would pull low-income patients away from their traditional providers, disrupting the consistency and coordination of their care – an outcome which is clearly associated with poorer health outcomes.
* There would be no increase in the total number of providers who are able to offer such services. Limiting eligibility in this way would simply expand the size of existing telehealth programs, rather than extending connected care to new providers would generally could not offer such services on their own.

**Paragraphs 45 & 52: NACHC supports funding providers who can provide robust evaluations of their projects, but opposes limiting eligibility to providers that:**

* **Agree to partner with external research organizations.**
* **Can conduct a methodologically-sound clinical trial.**

NACHC supports the FCC’s focus on ensuring a statistically-sound evaluation of the CCPP, and recommends that the quality of an evaluation plan be a critical factor in deciding which proposals receive funding. However, NACHC opposes requiring CCPP providers to

* Partner with an outside research firm. Many health centers possess the ability to conduct a statistically-sound program evaluation on their own, and requiring them to partner with an outside firm could significantly increase the costs – both financial and administrative – to participate in the CCPP.
* Conduct a clinical trial, as a clinical trial is much more intense and complex undertakings than a robust program evaluation, and would require resources and effort far beyond what small community-based providers can generally offer (even if supported by an outside firm.)

### Paragraph 45, 52, & 55: When establishing evaluation parameters, the FCC should keep in mind the limits on the types of data that health care providers can access.

NACHC recommend that any ***mandatory*** evaluation measures (i.e., measures that all participating providers are required to report) focus on factors that are within those providers’ control. For example, while changes in patients’ use of urgent care or emergency rooms could be valuable measure, not all health care providers will be able to access these data. Small community-based providers may encounter particular difficulties, as they may lack the market power to be able to convince hospitals and urgent care facilities to share these data. In such instances, an exception should be included, wherein health care providers should not be required to report on those measures for which they can demonstrate a lack of ability to acquire the necessary data.

Alternative evaluation measures may need to be developed (or an opportunity to propose such measures should be afforded) to include factors such as changes in clinical status (e.g. reductions in A1c levels for diabetes patients), trips to the provider’s office, and/or patient and provider satisfaction. Again, NACHC would suggest consulting with appropriate entities, such as CMS, in determining what would constitute an appropriate, alternative measure. However, in general, health care providers should be permitted to identify evaluation measures for their projects, within general parameters specified by the FCC.

### Paragraph 45, 52, & 55: The FCC should request support from CMS to access Medicaid and Medicare data.

For patients on Medicaid and Medicare, data on the types and amount of care they received -- in addition to the costs of that care -- will be valuable measures for evaluating the impact of the CCPP. CMS collects Medicare data, so NACHC encourages the FCC to reach out to CMS to request access to that data. In contrast, Medicaid data are collected and stored by individual states and many states may be reluctant to share it with individual providers. However, CMS can be a valuable partner in accessing this state-held data. Thus, when the FCC staff talk with CMS about reimbursement issues, it is recommended that their support in accessing Medicare and Medicaid data for evaluation purposes is solicited.

* **Paragraph 56: NACHC strongly encourages the FCC to award priority points to applicants that:**
* **Currently serve geographic areas or populations where there are well-documented health care disparities.**
* **Focusing on specific health crises or chronic conditions that are widespread, and are documented to benefit from connected care.**
* **Serving a large percentage of low-income patients and/or veterans who are eligible for free VA care.**
* **Focus on keeping patients at home, rather than in medical facilities.**

NACHC recommends that priority points be awarded based on the degree to which an applicant is engaged in each of the following factors.

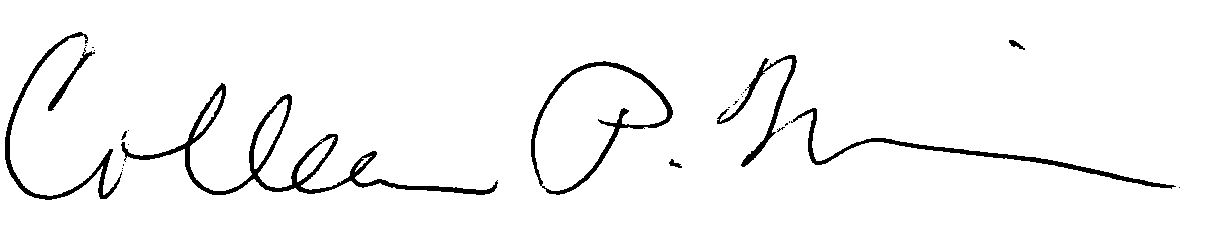
* Currently serving geographic areas or populations where there are well-documented health care disparities. It is important that applicants be able to discuss these disparities in detail, including:
  + how and why they occur,
  + which populations are most affected,
  + their experience to date is working with the impacted populations, and
  + how connected care can improve outcomes.

The ability to address each of these factors in detail will demonstrate that a provider has a deep understanding of the roots of the disparities, and therefore is well-positioned to address them.

* Focusing on specific health crises or chronic conditions that are widespread, and are documented to benefit from connected care (e.g., opioid dependency, diabetes, heart disease, mental health conditions.) Applicants should be required to address the same factors (listed above) to demonstrate their experience with addressing these conditions.
* Serving a large percentage of low-income patients and/or veterans who are eligible for free VA care. (As discussed above, low-income is a much better proxy for need than Medicaid coverage.) NACHC does not support requiring eligible providers to serve a minimum percentage of these patients, as doing so could eliminate rural providers who serve areas with high needs with somewhat higher incomes. However, we recommend that as the percentage of low-income/ VA-eligible patients increases, applicants should receive more priority points.
* Focusing on keeping patients at home. As the goal of the CCPP is to keep patients living in the community, preference should be given to providers who share this goal.

Thank you for the opportunity to submit comments on this proposed rule. Please contact me if NACHC can provide any further assistance.

Respectfully submitted,



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1. *Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213 [↑](#footnote-ref-1)
2. Section 330 of the Public Health Service Act (PHSA) authorizes four types of health centers: Community Health Centers (CHCs), and health centers who target: migrant workers; persons experiencing homelessness; and residents of public housing. As CHCs comprise over 80% of all health centers, and all four types of health centers are subject to the similar rules, the term “Community Health Centers” is commonly used to refer to all four types. The term Federally Qualified Health Center (FQHC), which is found in the Social Security Act, is also sometimes used to refer to Section 330 Health Centers. In this document, we use the terms Community Health Center to refer to all health centers authorized under, and subject to the rules of, Section 330 of the PHSA. [↑](#footnote-ref-2)
3. <http://www.nachc.org/wp-content/uploads/2019/07/Americas-Health-Centers-Final-8.5.19.pdf> [↑](#footnote-ref-3)
4. https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Parents%20(in%20a%20family%20of%20three)%22,%22sort%22:%22asc%22%7D [↑](#footnote-ref-4)