



October 4, 2010

Centers for Medicare & Medicaid Services
Department of Health and Human Services

Attention: OCIO-9989-NC

P.O. Box 8010
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The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to the above-cited request for comments from the Department of Health and Human Services (HHS), Office of Consumer Information Oversight. NACHC is the national membership organization for federally qualified health centers (hereinafter interchangeably referred to as "health centers" or "FQHCs") throughout the country, and is a 501(c)(3) organization.

Background

NACHC is limiting its comments primarily to issues that are of particular importance to health centers in their efforts to play a critical and supportive role in the implementation of health care coverage expansion and reform as provided in the Patient Protection and Affordable Care Act (ACA), Pub. L No. 111-148, enacted on March 23, 2010. To best explain and support our focus on certain Exchange implementation and enforcement policies, we believe the following background review is appropriate.

There are, at present, more than 1200 FQHCs with more than 7500 sites serving close to 20 million patients nationwide. Most of these FQHCs receive federal grants under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA) of HHS. Under this authority, health centers fall into four general categories: (1) those centers serving medically underserved areas, (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farmworker populations within similar community or geographic areas, and (4) those serving residents of public housing.

To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center's board of directors must be made up of at least fifty-one percent (51%) users of the health center and the health center must offer services to all persons in its area, regardless of one's ability to pay. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of

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providing comprehensive preventive and primary care and enabling services (such as translation, transportation services, smoking cessation classes, etc) to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients from eligible communities, who are not indigent and are able to pay or who have insurance, whether public or private, are expected to pay for the services rendered. Approximately 35 percent of health center patients are Medicaid recipients, approximately 7.5 percent are Medicare beneficiaries, and approximately 40 percent are uninsured. NACHC estimates that the Medicaid expansions mandated in the ACA will result in health centers serving approximately 18.4 million Medicaid recipients by 2015.

Congressional support and funding for health center services and expansion has been bi-partisan and unequivocal, particularly in the past twenty years. Evidence of this support is as follows:

1. Recognizing the importance of health center services to Medicaid beneficiaries, Congress in the Omnibus Budget Reconciliation Act of 1989 made the services of a Federally Qualified Health Center (FQHC) a guaranteed Medicaid benefit offered to beneficiaries in every State Medicaid program. Most important, Congress recognized and acknowledged that Medicaid reimbursement to FQHCs must be sufficient to assure that health centers were paid their full reasonable costs for serving Medicaid patients (so that they would not have to use their Public Health Service Act grant funds to subsidize low Medicaid payments). In the accompanying Committee report, lawmakers wrote:

The Subcommittee on Health and the Environment heard testimony that, on average, Medicaid payments to Federally-qualified health centers cover less than 70 percent of the costs incurred by the centers in serving Medicaid patients. The role of [the federal Health Centers program] is to deliver comprehensive primary care services to underserved populations or areas without regard to ability to pay. To the extent that the Medicaid program is not covering the cost of treating its own beneficiaries, it is compromising the ability of the centers to meet the primary care needs of those without any public or private coverage whatsoever.

U.S. Congress, House Rpt-- Committee Print 101-M, p.63 (1989).

Congress further amended Medicaid payment methodology in 2000, to assure that health centers receive a payment that approximates their costs in serving their Medicaid patients. 42 USC 1396a(bb). This Medicaid FQHC Prospective Payment System (PPS) mandate is almost unique in the Medicaid statute, as Congress is inclined generally to allow states a great deal of leeway in establishing provider payment. However, as explained in the legislative history cited above, this FQHC payment requirement reflects Congressional recognition of the importance of FQHCs' provision of primary care and preventive services to the poor in this county.

2. In 1990, Congress, for reasons similar to its 1989 Medicaid enactment, legislated a similar payment methodology for FQHCs in the Medicare program. In the ACA, Congress amended this payment requirement, effective 2014, and provided that unreasonable payment caps and

screens were not to be applied in any Medicare payment system that CMS may implement for FQHCs in 2014. Section 10501(i)(2) of ACA.

Since the enactment of these Medicaid and Medicare FQHC provisions, both government and taxpayers have benefitted through optimum use of the federal Health Center grant funds to care for more uninsured and under-insured individuals because these specific Medicaid and Medicare FQHC payment requirements have been in place.

3. Significantly, in 2009, Congress—in reauthorizing and expanding the CHIP program—required that CMS reimburse FQHCs for services to CHIP beneficiaries no less than what the center would receive for such services under the Medicaid FQHC PPS system, once again assuring that FQHCs are reimbursed their costs in serving their low-income patients. 42 USC 1397gg(e)(1)(E).
4. Between 2000 and 2008, Congress increased health center grant funding to allow for the doubling of the number of health centers during that eight year period.
5. In the American Recovery and Reinvestment Act of 2009 (ARRA), Pub L No 111-5, Congress appropriated \$500 million in Section 330 grant funds for health center expansion (over and above their \$2.1 billion annual appropriation) and provided an additional \$1.5 billion for health center capital/infrastructure and HIT costs. In that same legislation, Congress also provided funding incentives in the Medicaid (and Medicare) program for providers who could demonstrate meaningful use of certified electronic health records (EHR) technology. Section 4201 of ARRA. Notably, in that legislation, FQHCs are the only non-hospital entity for which Congress established multiple provider eligibility and payments when such providers practice predominantly at FQHCs.
6. Finally, in the ACA, Congress established a Community Health Center Trust Fund that provides \$9.5 billion for health center capacity and service expansion operations over a five year period beginning in 2011 and an additional \$1.5 billion for health center capital projects—and these funds will be available to health centers over and above their annual appropriations. In effect, Congress has signaled and funded health centers to be at the forefront of the expansion and provision of primary care to the many previously uninsured individuals and families who will be covered in 2014 through ACA's Medicaid expansion and Exchange and Qualified Health Plan mandates.

Throughout this 20 year period of health center expansion , and to a great degree the rationale for this expansion, has been the recognition by Congress, by Administrations (both Democrat and Republican), in various academic studies, etc., that health centers provide critical cost-effective and cost-efficient primary and preventive health care and enabling services to a relatively high-risk vulnerable population and that they offer a health care home model that should be a central and necessary component in any legislative effort and subsequent public policy seeking to expand coverage to the uninsured and under-

Section 10104 of the ACA, amends Section 1301 of the ACA by adding a new paragraph (g) which states:

If any item or service covered by a qualified health plan is provided by a Federally-qualified health center as defined in [the Medicaid section of the] Social Security Act to an enrollee of the plan, the offeror of the plan **shall pay** to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under Section 1902(bb) of such Act (emphasis added).

Thus, the ACA makes clear that in furnishing services to an individual who is covered by an Exchange-qualified health plan, health centers are to be paid by such plans no less than what they would have been paid under Medicaid law. This section brings payment to health centers by Exchange-certified Qualified Health Plans (QHP) in line with what they are currently paid (and will continue to be paid in 2014) under the Medicaid and CHIP programs.

Given the requirement that plans pay FQHCs no less than what they would be paid under Medicaid, it seems clear that 1311(c)(2) cannot be read as allowing a plan not to contract with a health center that seeks to be paid on that basis. Otherwise, the ACA would have to be read to require plans to contract with FQHCs unless they ask to be paid what the ACA requires they be paid. It seems clear that Congress could not have intended such an absurd result and that HHS is obligated to read these three provisions to avoid such an absurd result. Clearly, the only appropriate reading would be that FQHCs **must** be contracted by plans and paid **no less** than what they would receive for their service under Medicaid PPS reimbursement. Put another way, HHS could reconcile these three provisions as meaning that the “generally applicable rates of such a plan” (as provided in 1311(c)(2)) **for services furnished by an FQHC** is an amount no less than the FQHC’s Medicaid PPS rate.

Strengthening the rationale for HHS to read these three provisions as suggested above is that only such a reading is consistent with the clear direction of Congressional intent and support of health centers over the past twenty years culminating with passage of ACA. It is inconceivable that Congress would consistently support the growth of health centers over the past twenty years—provide them payment in Medicaid and CHIP that must approximate their costs, provide them malpractice protection and discounted prescription drugs, double their numbers over an eight year period, enhance their accessibility to EHR, increase their funding for health center construction by \$ 1.5 billion, and in the ACA entrust them with sufficient five year funding to double their number of patients from 20 million to 40 million--and in that very same ACA intend to have these three provisions applied in a way that would require plans to contract with only those FQHCs that do not insist on a payment methodology that the same Act requires plans pay them (and is comparable to what they are paid in Medicaid and CHIP).

Other Exchange Requirements that Mandate Inclusion of FQHCs

For the reasons provided above, NACHC believes that HHS regulations must make clear that Exchanges can only certify plans as QHP if those plans are contracting with FQHCs and reimbursing them no less than they would be reimbursed under Medicaid. Equally important, NACHC believes that the above

provisions **as well as other provisions of the ACA**, in effect, require that HHS regulations and Exchanges require plans seeking QHP certification contract with all FQHCs that offer to contract with the QHP, that QHPs assure in their marketing practices that individuals eligible for QHP enrollment are made fully aware of, and are fully informed of, the choice of an FQHC and the names of those specific clinical providers working at each FQHC, and that FQHCs be allowed and supported to play an active role in facilitating the enrollment and determination of the eligibility of applicants for Exchange participation, as well as Medicaid and CHIP participation.

Specifically, the ACA provides that additional responsibilities of Exchanges include, among other things:

1. Ensuring that consumers are able to make informed health care coverage choices and that families and individuals are able to comparatively shop for their coverage, through the use of web portals and other pathways and through grant funded navigator programs and;
2. Creating seamless eligibility and enrollment linkages with Medicaid and CHIP, including use of a HHS-developed single streamline application form, a "no wrong door" system for applicants and enrolling applicants in the appropriate programs without their having to go through additional burdensome steps to find out which program they are eligible for, and the use of web portals through which families can obtain information on their eligibility for different programs.

Clearly, health centers are a perfect venue for Exchanges to ensure their compliance with these two ACA requirements. There are more than 7000 health center sites located in medically underserved communities serving more than 20 million poor and low-income patients, the vast majority of whom are currently uninsured or Medicaid/CHIP recipients. The centers continue to treat these individuals even when they lose their Medicaid eligibility or other coverage and become uninsured, or when they regain such coverage. Health centers, therefore, are perfectly suited, to serve and operate as eligibility and enrollment sites for individuals who are applying for Medicaid, CHIP, or Exchange participation and who may move from program to program as their incomes fluctuate.

Further incentive for Exchanges to require QHPs to contract with health centers is the fact that health centers already engage in substantial on-going interaction—both through meetings and electronically—with State Medicaid and CHIP programs and in a number of states actually carryout Medicaid and CHIP enrollment at their sites. In addition, since a majority of the members of a health center's Board of Directors must be active registered patients of the center, and because of other PHS Act Section 330 grant requirements, health centers are invariably culturally sensitive to the communities they serve and often provide translation services. Consequently, they are able to assure that Exchange applicants and enrollees are able to comprehend and act on the QHP and service choices available to them.

NACHC's Other Recommendations In Response to HHS's Request for Comments

The following recommendations are not necessarily health center specific in nature, but NACHC believes they are critical to successful implementation of the ACA's mandated provisions for expansion of access to health insurance through the establishment of Health Benefit Exchanges:

- 1.** HHS's regulations, to the extent allowed under the ACA, should require states to insure that the governing board of the Exchanges (regardless whether the Exchange is a governmental agency or a non-profit entity) be composed of a broad range of stakeholders including consumers and safety net providers. In addition, the establishment of the Exchange and decisions as to its regulatory authority and responsibilities should be determined through a transparent process, with open meetings and opportunity for participation for all those affected, including insurance companies, plans, providers, consumers, employers, labor organizations, state government officials (particularly Medicaid, CHIP and State Insurance Commission staff), etc.
- 2.** In general, NACHC believes that HHS's regulations, to the extent allowed under ACA, should require States to structure their Exchanges so that they will operate as an assertive regulatory body. As examples:

—Exchanges must be fully empowered under the federal regulations, as they are under the law itself, to actively certify and de-certify QHPs in accordance with the functional requirements of the law. Specifically, the Exchanges should actively ensure that any health plan seeking certification comply with all requirements of the law, including a clear demonstration that it possesses the ability to make payments to providers within its network for covered benefits furnished to enrolled individuals, and that such payments will be made on a timely basis.

—The Exchange must also ensure that, in order to be certified, a health plan must include within its network a sufficient number of providers, who are actually accepting new patients, to ensure ready access to covered benefits and in particular, primary and preventive health care services. Demonstration of sufficient access should include sufficient provider locations within the areas where enrolled individuals live and work, hours of service that are available to enrollees, specific minimum waiting time for an enrollee's first appointment and, particularly important, the availability of appropriate linguistic and culturally-appropriate care. As such, it will be vital that Exchanges secure from QHPs, and make readily available to consumers, all pertinent information about plan operations, network configuration, financial viability, enrollee responsiveness, and provider satisfaction.

—Since Exchanges are responsible for certifying insurers as QHPs, they should adopt and apply certification requirements that will allow for a sufficient number of competing

plans but that also assure that these plans provide good value and consumer protections.

—Exchanges should establish criteria for QHP certification that are oriented to assuring that plans have sufficient numbers of **primary care providers** who are available and accessible to those who are to be enrolled in QHP coverage.

—HHS’s regulations should require states to assure that plans within and outside the Exchange provide consumers with clear and understandable descriptions of the important features of the plan, such as services provided, price and cost-sharing requirements, important exclusions and exceptions to the coverage being offered, and the geographic locations and hours of operation of network providers.

—Exchanges should establish a framework that will assure seamless interaction with the Medicaid and CHIP programs in their state(s).

—Exchange structures and rules should be flexible enough to allow **safety net health plans (SNHP)** to participate as QHPs. SNHPs generally include substantial numbers of providers, such as FQHCs and public hospitals, whose patient base is primarily low-income Medicaid, CHIP and Medicare enrollees. SNHPs have developed expertise to provide continuity of care for these individuals as they move among public programs due to income fluctuation, and therefore SNHPs would be particularly qualified to operate in a system where seamless interaction among these programs and Exchange coverage is critical.

3. HHS’ regulations, to the extent allowed under the ACA, should assure that states implement and promote rules and policies that will minimize adverse selection among or between QHPs. To some degree this end can be achieved if HHS requires the states to aggressively apply the statutory protections against adverse selection that are provided in the ACA, as examples: assuring that the insurance reforms imposed by the ACA (such as banning lifetime and annual dollar limits on coverage) are applied both within and outside the Exchange; requiring individual and small-group plans—both within and outside the Exchange-- to cover “essential health benefits” as defined in the ACA; and firm implementation of several risk adjustment programs provided in the ACA, such as the state assessing plans and insurers with low-risk enrollees and making payments to plans (such as Safety Net Health Plans) and insurers with high risk enrollees.

Conclusion

NACHC appreciates HHS affording it and so many other interested parties the opportunity to provide initial comments regarding the Exchange-related provisions of the ACA. We look forward to responding to proposed rules on this same topic when they are published by HHS. During the interim, NACHC and FQHCs are available to provide whatever assistance or support HHS might request as it endeavors to implement the health care reform provisions of the ACA.

If HHS has any questions or wishes to follow-up with further communication these comments, please contact me at 202-296-0158 or by email at rschwartz@nachc.org.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Roger Schwartz". The signature is fluid and cursive, with the first name "Roger" and last name "Schwartz" clearly distinguishable.

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