



January 19, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8010
Baltimore, MD 21244-8010

Dear Acting Administrator Frizzera,

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) Notice and request for comments on the **Medicaid Program and Children's Health Insurance Program; Model of Interstate Coordinated Enrollment and Coverage for Low Income Children [CMS-2311-NC]**. 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) non-profit organization.

BACKGROUND

There are, at present, approximately 1200 FQHCs 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 providing comprehensive preventive and primary care and enabling services 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. More than 35 percent of health center

MAIN OFFICE
7200 Wisconsin Ave, Suite 210
Bethesda, MD 20814
301-347-0400
301-347-0459 fax

FEDERAL AND STATE AFFAIRS OFFICE
1400 Eye Street NW, Suite 910
Washington, DC 20005
202-296-3800
202-296-3526 fax

patients are Medicaid or CHIP recipients, approximately 7.5 percent are Medicare beneficiaries, and approximately 40 percent are uninsured.

COMMENTS

NACHC applauds the Administration for its attention to developing a Model of Interstate Coordinated Enrollment and Coverage for Low Income Children. As stated in the Notice, the challenges of portability of Medicaid and CHIP coverage across state lines were identified specifically with regard to migrant and seasonal farmworkers in a Report to Congress prepared by CMS issued in 2006 entitled “Study Regarding Barriers to Participation of Farmworkers in Health Programs.” NACHC and other health care advocates participated in CMS-convened discussions leading to the development of that Report and we certainly support CMS’ use of the recommendations from that Report in this Notice. Put another way, in this Notice CMS proposes to use some of the recommendations from the *Farmworkers Report to Congress* as the basis for proposing models of coordination to attempt to solve the problem of gaps in coverage for Medicaid and CHIP children who frequently change their state of residence—we agree with the use of these recommendations.

In fact, health centers in multiple states have been involved in various efforts to provide coverage to these individuals and are eager to share the best practices learned from these experiences. Not surprisingly, our experience show that there are many barriers that stand in the way of reaching these individuals, including but not limited to: residency requirements, differences in state’s eligibility requirements, complexity of application process, language and cultural issues, and the rising cost of coverage. Each of these barriers is important to consider when developing a model of outreach and enrollment.

In 2003, NACHC wrote and published a report titled “Migrant and Seasonal Farmworker Access to Health Care Services and Insurance Coverage: Summary Report on Issues, Resources, and Potential Solutions” (attached). This Report was provided to CMS at the outset of the discussions leading to the Report to Congress, and to some extent, contains more detailed discussion of the difficulties in reaching these populations as well as best practices and potential solutions. Rather than repeat the various suggestions and examples provided in NACHC’s Report, we have attached it to this document and ask that it be incorporated as part of our comments. The Notice and request for Comments specified five areas for consideration in developing a Model process. Our comments on each of the areas are below.

Interstate Compacts and Current Law Flexibility

As was discussed in the Notice, there are several advantages to the Interstate Compact Model and Current Law Flexibility Model. With these models, States have the ability to develop their own agreements with other states, without any need for formal Federal approval. Additionally, they can work within their own State Plan to adapt their requirements to align with those of other States. This flexibility helps States to best meet their beneficiaries’ needs, but does require some additional structure. It can be difficult for States to formally align their program with other States to develop reciprocal recognition of eligibility and enrollment criteria, reimbursement procedures for out of state providers, and covered benefits.

We believe that CMS should explore and promote interstate compacts and flexibility within current law to establish a reciprocal agreement between States in order to reduce access barriers to the Medicaid and CHIP programs. This can be done in a variety of ways, as noted in the attached NACHC Report. The first is an Inter-State Eligibility Transfer which would include an individual securing initial enrollment in one State, while other states could utilize a simple, local enrollment process to accept the individual based on the initial state's eligibility requirements. Another reciprocal process--, Reciprocal Eligibility Determination-- would permit States to fully recognize each others' eligibility requirements as their own. Finally, CMS might want to encourage States to consider an FQHC specific approach, which would allow FQHCs in a State to accept other States' Medicaid card. This would permit FQHCs to bill their own state for the services provided to these individuals.

There are several examples of these kinds of best practices, one of which is the State of Wisconsin's Badger Care Program. Operating since 1998, Wisconsin has created a unilateral rapid enrollment process, which allows the State to issue a Medicaid/CHIP card to any migrant worker with a Medicaid/CHIP card from another state¹. This program enrolls individuals until the last date on which the out-of-state enrollment expires. After the expiration, families that are still in-state can reapply for benefits following the typical in-state procedure. In the cases of those individuals who have enrolled in the Badger Care Program, Wisconsin accepts full responsibility for the cost of the Medicaid/CHIP coverage, because the other states do not participate in the program. Obviously, getting other states to participate in such a program would enhance the chances of such a system assuring continued coverage as farmworker families (and other eligibles) travel to other states.

Another example can be found in Texas. The Texas Association of Community Health Centers, in coordination with the Texas Health and Human Services Commission, has developed the Texas Migrant Care Network. This network does outreach to enroll out-of-state providers in a Network to provide care to Texas Medicaid recipients as they travel out of state. This network expedites payments for services provided to Texas residents enrolled in the Texas Medicaid program. Primary targets of this program are the migrant health centers across the country that serve large numbers of migrant and seasonal workers. In these states, the Primary Care Associations (PCAs) and health centers work together to enroll providers employed by the migrant centers.

Finally, another example is the collaboration among the Health Resources and Services Administration/Maternal Child and Health Bureau, Migrant HeadStart, migrant health centers, and the State of Michigan. This initiative was created to address the need for increased oral health services for immigrant children. This collaboration facilitated by Altarum Inc, is working

¹ Sara Rosenbaum, JD Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care April 2005

with the Michigan PCA, Medicaid officials, and the Migrant Headstart program to similarly identify opportunities and challenges for enrolling in Medicaid children receiving Migrant HeadStart Program services, including those that travel out of state.

On a national level, these examples can be expanded upon to promote the use of a multi-state card or a multi-state provider network. States would need to agree on a uniform set of eligibility criteria, benefits, and reimbursement issues. A multi-state card would reduce the need for an individual to re-enroll in each state's program, thus allowing faster access to services, while a multi-state provider network would allow individuals to receive care from certain providers as needed.

There are a wide variety of opportunities available under the current flexibility and interstate compact models, if States can develop an agreement on the various eligibility requirements and needs of the individuals. NACHC recommends that CMS look further into the specific examples of Badger Care, the Texas Migrant Care Network, and the State of Michigan as excellent resources when developing its model process.

Demonstration Projects

We believe that CMS has articulated very clearly in its Notice the potential for Section 1115 demonstration waivers to facilitate interstate portability projects among the states. Section 1115 demonstration authority could be useful in allowing states to structure interstate compacts that include simultaneous enrollment in multiple states using a multi-state card, creating reciprocity arrangements between states for determining eligibility and multiple states creating interstate standard benefits packages.

Section 1115, in effect, could be used to allow states to develop Medicaid services and eligibility standards and policies that are identical with regard to certain populations, such as farmworkers. The waiver might be used even with regard to setting uniform payment rates among providers in these states. For example, several states might agree to establish a uniform package of services for farmworkers to be provided by FQHCs for a set per visit rate. We emphasize that such a waiver should not be implemented unless the FQHCs involved are supportive of the project, and, particularly, are in agreement as to the bundle of services that are to be included and the uniform per visit payment rate to be paid the centers for such services.

Once again, we refer CMS to the attached NACHC Report, which (on page 13) contains a number of suggestions for specific Section 1115 waiver efforts relating to farmworker portability.

Public/Private Partnerships

The use of a public/private partnership allows States to leverage resources that would possibly not be available without the development of the partnership, therefore allowing States to become more creative in their approaches for outreach and enrollment. The Texas Migrant

Network, discussed above, is an example of this model, allowing States to pilot a program that could potentially be adapted at a larger level. In order for this model to be successful, States must find common ground with Partners to ensure these initiatives can be sustained.

National Children's Health Coverage

As indicated in the Notice, a National Children's Health Coverage Option would require a statutory change related to the definition of residency and eligibility criteria, as well as minimum benefits. It will be especially important to assess the proposed model in light of the current legislative efforts on health reform. NACHC is generally supportive of efforts to establish a National Children's Health Coverage Option with comparable eligibility requirements and minimum benefits for all States.

On a broader note: anticipated national health care reform legislation is expected to expand Medicaid coverage both with regard to covering those with higher incomes than previously allowed and eliminating categorical limits to eligibility. This latter change may be particularly relevant and beneficial to farmworkers, both children and adults. In implementing these anticipated legislative changes, we urge CMS to be mindful of the impediments to farmworker portability and to assure that such implementation builds in policies and rules that will minimize these barriers. NACHC and the nation's federally qualified health centers, as well as the State Primary Care Associations in the various states, stand ready to assist in these efforts.

Once again, NACHC appreciates the Administration's focus on ways to improve and enroll additional children – and hopefully soon, adults – who may be eligible for the Medicaid and CHIP programs but often change their state of residency for any number of reasons. We appreciate the opportunity to share health centers' experiences and views on this important issue and would welcome the opportunity to further discuss these concerns. If you have questions, please contact Roger Schwartz, Associate Vice President, Executive Branch Liaison and Legislative Counsel at 202.296.3800.

Respectfully Submitted,

A handwritten signature in cursive script, appearing to read "Roger Schwartz".

Roger Schwartz, Esq.
Associate Vice President, Executive Branch Liaison
Legislative Counsel