



March 21, 2008

[If by electronic means]  
<http://www.cms.hhs.gov/eRulemaking>

Kerry Weems  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
Room 445-G  
200 Independence Ave, SW  
Washington, DC 20201

Attention: **CMS-2232-P**

**Re: Medicaid Program; State Flexibility for Medicaid Benefit Packages**

Dear Administrator Weems:

The National Association of Community Health Centers, Inc. (“NACHC”) is pleased to respond to the above-cited solicitation from the Department of Health and Human Services (“DHHS”) Centers for Medicare & Medicaid Services (“CMS”) for comments on the proposed rules related to the Medicaid Program: State Flexibility for Medicaid Benefit Packages published at 73 Fed. Reg. 9714 (February 22, 2008).

NACHC is the national membership organization for federally supported and federally recognized health centers (hereinafter interchangeably referred to as “health centers” or “FQHCs”) throughout the country, and is an Internal Revenue Code Section 501(c)(3) organization.

**I. Background**

There are, at present, approximately 1150 FQHCs nationwide serving over 17 million patients. Most of these FQHCs receive Federal grants under Section 330 of the Public Health Service Act (42 U.S.C. §254b) from the Bureau of Primary Health Care (“BPHC”), within the Health Resources and Services Administration (“HRSA”) of DHHS.

Under this authority, health centers fall into four general categories: (1) those centers serving medically underserved areas (invariably poor communities), (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farm worker 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 composed of at least fifty-one percent (51%) users of the health center, and the health center must offer services to all persons in its catchment area, regardless of their ability to pay or insurance status.

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 able to pay or who have insurance, whether public or private, are expected to pay for the services rendered. Approximately 35.7% of the patients served by health centers are Medicaid recipients, approximately 7.5% are Medicare beneficiaries, and approximately 40.1% are uninsured.

## **II. Comments on the Proposed Rule**

NACHC appreciates that proposed rule 42 CFR 440.365 reflects the requirement in Section 1937 (b)(4) of the Social Security Act (SSA) that if and when a state provides benchmark coverage or benchmark –equivalent coverage to certain Medicaid eligibles, it must assure that these individuals have access through such coverage or otherwise, to FQHC services, and that FQHCs are to be reimbursed for such services as provided under the FQHC reimbursement requirements found in Section 1902(bb) of the SSA. We are concerned, however, that CMS did not elaborate further on these requirements, and particularly, that it did not lay out the minimum steps a state must take to assure that these patient and health center protections are effectively implemented.

We believe that it is important that the final rule make clear that there are minimum steps a state must take to be in compliance with these FQHC statutory requirements. Certainly, there is precedent in these proposed rules for doing so. For example, the Social Security Act (SSA), as amended by the Deficit Reduction Act of 2005 (DRA), does not provide any detail as to what would qualify as a “Secretary-approved” benchmark or benchmark-equivalent coverage, however (without commenting as to its contents or sufficiency), we note that CMS’ proposed rule, and preamble thereto, specify to some degree the kind of information a state would have to provide CMS in order to receive Secretarial approval of such a state plan amendment (SPA).

We request therefore that, at minimum, CMS make clear, both in the rule itself and in the preamble, the following with regard to FQHC services and reimbursement:

1. Any Medicaid-eligible recipient who is required to enroll or who, as an “exempt individual,” voluntarily enrolls in benchmark or benchmark-equivalent coverage services, under this rule, remains eligible to receive from an FQHC all of the services included in the definition of the services of an FQHC, as provided in Section 1902(a)(2)(C) of the SSA.

2. To the extent that a state may require any recipient or allow an exempt individual to receive benchmark or benchmark-equivalent coverage through managed care plans, insurance plans, primary care case managers, employer sponsored insurance health plans, or through any other program, contractor, or provider (referred to hereinafter as “plans”), both the state and

these various plans, must be encouraged to contract with FQHCs as providers of services to these Medicaid populations.

3. Any individual who is required or voluntarily chooses to enroll in benchmark or benchmark equivalent coverage must be informed that one (or several) of the providers it may choose to be treated by under this coverage is (or are) an FQHC. These FQHC(s) must be identified by name and address, and the providers employed by the FQHCs should also be identified by name—thereby allowing the enrollee to make an informed choice as to selection of provider under this coverage. However, in the event that the various plans identified in the previous paragraph do not contract with an FQHC, then enrollees who are required to enroll and those who voluntarily enroll in benchmark or benchmark equivalent coverage must be informed clearly that they may still receive Medicaid covered services from FQHCs. Finally, such notification to enrollees would also be necessary, if plans contract with only one or several, but not all FQHCs, in the plan's service area, and such contracting FQHCs are not fully accessible to all enrollees (due to geographic distance, lack of cultural competency, lack of capacity, etc).

4. Both in its final rule and preamble, CMS should underline to the states the importance of full compliance with the FQHC reimbursement requirements of Section 1937(b)(4) of the SSA and rule 42 CFR 440.365. To the extent that a state may contract directly with an FQHC to serve these enrollees, or to the extent that an enrollee seeks and receives services from an FQHC "out of plan" for reasons outlined in the previous paragraph, it is possible that informing states that the requirements of Section 1902(bb) apply may be sufficient. However, in circumstances in which a FQHC contracts with a "plan" (as defined above in paragraph 2), then CMS must make clear that the state is obligated to reimburse the FQHC, at least every four months, the difference between what it has been paid by the plan and what it would be paid under the state's current payment arrangement requirements with FQHCs per Section 1902(bb)(prospective payment system or an alternative payment methodology).

NACHC believes adoption of the above recommendations into the rules and preamble is important to assure that the requirements of 1937(b)(4) are met. We believe they are necessary for several reasons. First, CMS has not promulgated any FQHC service and reimbursement regulations to date, consequently without these clear instructions, states have minimal CMS direction to fall back on. Second, when Medicaid managed care rules and policy were implemented over the past 10-15 years, they initially did not contain clear direction to the states as to the treatment of FQHC services and reimbursement, and resulted in confusion, delays and often wrongful denial of FQHC services to managed care recipients and reimbursement to FQHCs. Hence, the need for clear direction and policy at the outset of this program. Third, and most important: Congress's allowance for the provision of benchmark and benchmark equivalent coverage through SPAs is a significant change in Medicaid law. Equally significant, however, is the clear exception that Congress legislated in Section 1937 with regard to FQHC services and reimbursement. We request that CMS take the necessary steps to provide clear direction to the states on the importance of full compliance with these FQHC protections.

*We appreciate the opportunity to comment on the proposed regulations, and we would welcome the opportunity to further discuss these concerns. If you have questions, please contact, Roger Schwartz, Legislative Counsel and Senior Director of State Affairs, at 202.298.3800.*

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.

Roger Schwartz, Esq.  
Legislative Counsel and  
Senior Director of State Affairs