

March 24, 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-2244-P**

Re: Medicaid Program; Premiums and Cost Sharing

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: Premiums and Cost Sharing published at 73 Fed. Reg. 9727 (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

CMS should ensure that states are provided substantial flexibility in how they structure cost-sharing requirements in their Medicaid programs.

Regulation 42 CFR § 447.62 provides states with the option to impose alternative premiums and cost sharing, which are no longer subject to the limitations previously required under Section 1916(A) of the Social Security Act. Regulation 42 CFR § 447.64 allows states in their state plans to increase premiums, enrollment fees, and other cost-sharing for groups and/or subsets of Medicaid eligible individuals. In light of these new rules, NACHC asks that CMS ensure that states are provided the greatest flexibility in deciding whether or not to impose higher cost-sharing on low-income families. According to the Congressional Budget Office (CBO), an estimated 20 percent of the expected savings in this rule will result from Medicaid beneficiaries losing coverage because of their inability to afford the higher copayments. Children comprise more than half of those expected to lose coverage.

As previously noted Medicaid is the largest sponsor of coverage for health center patients and is the largest revenue source for most health centers. One in eight health center patients are Medicaid eligible. Any decrease in coverage among our patients would be detrimental not only to the patient and their families but to the health center program. Health centers are statutorily required to care for patients who visit the health center regardless of their ability to pay, thus any decrease in Medicaid coverage only results in increasing health centers' already growing population of uninsured patients. Currently, grant funding authorized under Section 330 of the Public Health Service Act enables health centers to serve uninsured individuals, who make up approximately 40% of their patients. However, health center grant funds will not be able to sustain a substantial growth among uninsured patients resulting from a loss of Medicaid coverage. A decrease in Medicaid covered individuals will surely place health centers under substantial financial strain requiring them to deliver uncompensated care to a growing number of the impoverished patients in their communities. We ask that CMS reinforce the ability of state Medicaid agencies to implement these rules in a manner that best meets the needs of their states' Medicaid beneficiaries and community health centers.

In this regard, we specifically request that CMS clearly inform states that should they determine to apply alternative premiums, enrollment fees or similar fees, copayments, coinsurance, deductibles or other cost sharing charges to certain Medicaid eligibles for certain services, as may be allowed in these proposed rules, they can also decide not to apply such cost-sharing requirements with regard to the receipt of FQHC services by these same eligibles. Indeed, we request further that CMS urge states not to apply such cost-sharing to the receipt of FQHC services. We believe such policy is easily justified, if not required, for the following reasons:

1. FQHCs are required under their PHS Section 330 grant to serve all patients regardless of their ability to pay. Consequently, unlike other providers, FQHCs cannot refuse to treat Medicaid patients who fail to meet cost-sharing obligations adopted by states under these new rules. Health centers will incur substantial medical expenses that Medicaid will not reimburse if such cost-sharing is required, particularly with regard to a failure on the part of a Medicaid eligible recipient to pay alternative premiums, enrollment fees or similar fees.
2. For the reasons discussed in the previous paragraph, FQHCs will be forced to use their Section 330 PHS federal grant funds to pay for the cost of services provided to their Medicaid patients. In establishing reasonable cost reimbursement for FQHCs in 1990, and subsequently requiring in 2000 that FQHCs be reimbursed a Prospective Payment System (PPS) rate (or under an alternative payment methodology that paid no less than PPS), Congress has been consistent and clear in maintaining that these mandated rates are intended to ensure that FQHCs do not use their Section 330 grant funds to cover the cost of services for Medicaid patients. Thus, we believe that instructing, or at least urging, states not to apply alternative cost-sharing to the receipt of FQHC services, is the only policy consistent with both the federal grant requirement that health centers treat all patients regardless of their ability to pay and the Congressional mandate that FQHCs not have to use their Section 330 grant funds to subsidize Medicaid services.

In summary, we believe it is important that states are given substantial flexibility in their application of any alternative cost-sharing options in the Medicaid program. Recognizing that health centers are required to provide their patients with care regardless of their ability to pay, we ask that CMS make clear that states' policy changes to cost-sharing requirements will not affect health center reimbursement or their ability to provide quality care to their patients.

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,



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Legislative Counsel and
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