



**National Association of  
Community Health Centers, Inc.**

March 15, 2007

*[If by electronic means]*

<http://www.cms.hhs.gov/eRulemaking>

*[If by overnight or express mail]*

Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-2258-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, M.D. 21244-1850

*[If by hand or courier]*

Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-2258-P  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

**RE: Medicaid Program; Cost Limit for Providers Operated by Units of  
Government and Provisions to Ensure the Integrity of Federal-State  
Financial Partnership [File Code CMS-2258-P]**

To Whom It May Concern:

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 non-Federal share of Medicaid payments published at 72 Fed. Reg. 2236 (Jan. 18, 2007).

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.

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## **I. Background**

There are, at present, more than 1000 FQHCs nationwide. 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. Except for a limited number of public health centers (*i.e.*, health centers operated by local governmental units such as health departments), each health center is a charitable, nonprofit, tax-exempt IRC Section 501(c)(3) corporation formed under the laws of the particular state in which it operates. Although there are some slight differences in the grant requirements for each of these four program types, for all intents and purposes, the ways in which these health centers operate are identical.

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<sup>1</sup> 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**

### **A. *General Comments***

NACHC recognizes that CMS is obliged to protect the integrity of the Medicaid program and to address perceived abuses. However, we urge CMS to withdraw this proposed rule for two reasons. First, as explained in further detail below, the proposed rule impermissibly conflicts with the underlying federal statute, in which Congress forbade the federal government from restricting how States use their funds and

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<sup>1</sup> The term “community” in this context refers to either a geographic area or the specific population toward which the program is aimed.

legitimized the practice of claiming funds transferred from governmental entities, including health care providers, as part of their non-federal share of expenditures.

Second, NACHC believes that CMS has underestimated substantially the adverse impact this proposed rule will have on the ability of safety net providers--such as health centers--to provide critical health care services to thousands and thousands of uninsured poor in this country. This impact will be felt by health centers in a number of ways: some health centers are parts of units of government that may not have taxing authority, others are public entity health centers (without taxing authority) that have contractual arrangements with such units of government or with their state Medicaid agency, others receive funding from their state uncompensated care fund, and all will feel the effect of cutbacks in Medicaid services and eligibles as states attempt to recover from the financial impact of these rules. Indeed, on a broader level, we believe the proposed rule has the potential to undercut publicly supported metropolitan and rural healthcare systems that play a key role in responding to the crises this country currently faces in the increasing numbers of low-income individuals who are uninsured and/or who lack access to health care services.

**B. *Defining a Unit of Government* (§ 433.50)**

The proposed rule would limit the State's share in claiming Federal Financial Participation ("FFP") to funds from "units of government", which the proposed rule has defined as "a State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority." 72 Fed. Reg. at 2246. This definition contradicts the statutory scheme established by Congress for units of government. As noted in the preamble to the proposed rule, Congress created an exemption for units of government at Section 1903(w)(6)(A) of the Social Security Act ("Act") when it significantly reduced States' use of provider related taxes and donations to fund the non-Federal share of Medicaid payments. 72 Fed. Reg. at 2237. That provision states:

Notwithstanding the provisions of this subsection, ***the Secretary may not restrict States' use of funds*** where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this subchapter, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

42 U.S.C. § 1396b(w)(6)(A)(emphasis added).

In contravention to this statutory language, the proposed rule would restrict States' use of funds by narrowing the category of funds which may satisfy the non-Federal share of Medicaid payments. The federal statute defines "unit of government" as

“a city, county, special purpose district, or other governmental unit in the State”. 42 U.S.C. § 1396b(w)(7)(G). The proposed rule, in contrast, requires units of government to have taxing authority. Because not all units of government have taxing authority—some merely are subject to governmental administration or control—the proposed rule disqualifies a class of funds that Congress had permitted States to use as the State share. In so doing, the proposed rule departs from the clear language of Congress, is arbitrary and capricious, and is unlikely to withstand a *Chevron* analysis.<sup>2</sup>

Moreover, CMS misstates its statutory authority. In its preamble to the proposed regulation, CMS states that “the Medicaid statute provides that units of government within a State may transfer State and/or local tax revenue to the Medicaid agency for use as the non-Federal share of Medicaid payments.” 72 Fed. Reg. 2238. Instead, the statute provides that such funds be “*derived* from State or local taxes”. U.S.C. § 1396b(w)(6)(A) (emphasis added). Under a standard dictionary definition, “derive” means “obtain or issue from a source”.<sup>3</sup> Consequently, federal law allows units of government to transfer any funds that can be traced to tax revenues. This means that units of government do not need to have their own taxing authority; they can transfer funds from other government units which have taxing authority.

Similarly, under the proposed rule, government health care providers would be considered as units of government only when they have generally applicable taxing authority or are “able to access funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider’s expenses, liabilities, and deficits, so that a contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues.” *Id.* This definition also conflicts with Congressional language to allow States to use funds from government health care providers—regardless of whether those providers have taxing authority—to satisfy the State share.

When it sanctioned these practices in 1999, Congress must have recognized that not all government health care providers had taxing authority. Indeed, many government healthcare entities were then, and are now, separately incorporated entities or operated under contract to a unit of government. What makes these providers different from other providers—and explains why Congress exempted them from the general prohibition of provider donations—is that these providers are under the administrative control or operation of a unit of government and exist solely to serve an inherently public purpose.

For example, in Illinois, certain health centers operate under a “public entity” model, in which they are operated within state or local government. There is no typical model and each utilizes a different governance structure. These health centers have contractual arrangements with the state Medicaid agency to certify expenditures above reimbursement for purposes of securing federal matching contributions which are given back to the health center. These health centers do not have taxing authority and therefore would not meet the new definition of “unit of government”. Consequently, under the

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<sup>2</sup> *Chevron USA, Inc. v. Natural Resources Defense Council*, 467 U.S. 837, 837 (1984).

<sup>3</sup> American Heritage Dictionary, 2<sup>nd</sup> College Ed. (1983).

proposed rule, the health centers could lose hundreds of thousands of dollars in federal resources that further the public entity's mission of providing health care to indigent populations.

Because proposed 42 C.F.R. § 433.50 is inconsistent with applicable federal law and would cause substantial harm to patients who access health care through safety net providers, including health centers, we strongly urge CMS to withdraw this proposed regulation.

### ***Retention of Payments (§ 447.207)***

The proposed rule would require that all providers retain the full amount of Medicaid payments provided to them for services. Aside from the constitutional implications under the takings clause of the U.S. Constitution<sup>4</sup> that would result if private health care providers could not freely transfer their payments from Medicaid (*i.e.*, use those payments to pay the provider's own expenses), this overly broad regulation clearly conflicts with the statutory exception in Section 1903(w)(6)(A) of the Act for government health care providers:

Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this subchapter, ***regardless of whether the unit of government is also a health care provider***, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

42 U.S.C. § 1396b(w)(6)(A)(emphasis added).

The proposed rule would be unlikely to survive judicial scrutiny because it renders the italicized language meaningless. There is no reason for Congress to have inserted the phrase “regardless of whether the unit of government is also a health care provider” unless it had intended to continue to allow government health care providers to refund Medicaid payments—which are derived from State taxes—to the State. While it is true that these refunds have allowed some States to pay for costs that were outside the Medicaid program, this financing mechanism was expressly permitted by Congress under Section 1903(w)(6)(A) of the Act for these government health care providers.

Furthermore, these funds from government health care providers have been essential to States for financing health care to indigent populations. CMS asserts that Congress has not “expressly addressed” whether the Medicaid program should help finance the cost of providing services to non-Medicaid populations. 72 Fed. Reg at 2238. However, the financing mechanism described above specifically allows government

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<sup>4</sup> U.S. Constitution, Amendment V.

health care providers to do just that. Consequently, prohibiting government health care providers from returning funds would reduce federal funds that have provided access to vital health care services for uninsured populations.

Because proposed 42 C.F.R. § 447.207 is inconsistent with applicable federal law and would cause substantial harm to patients who access health care through safety net providers, including health centers, we believe it should be withdrawn..

### **III. Conclusion**

For the reasons discussed above, NACHC believes that the proposed rule is contrary to Federal law. We also believe that it is unnecessary because, as stated in the preamble to the proposed rule, CMS currently carries out oversight through its review and approval of state plan amendments relating to state payments, in which the great majority (90%) of these proposals are approved. *See* 72 Fed. Reg. at 2237.

Finally, health centers have a particularly important stake in CMS giving thoughtful reconsideration to this proposed rule. As noted at the outset of this letter, health centers, by virtue of their mission and the terms of their Section 330 grant, serve all those in their medically underserved area regardless of their patients' ability to pay. The uninsured comprise an increasing percentage of health center patients. In fact, between 1990 and 2005, the uninsured served by health centers has increased by 128% and the Section 330 grants received by health centers now covers only about 52% of centers' costs for serving the uninsured.

Adoption of these proposed rules will result in other providers having to cut back on the number of uninsured they can treat, with the predictable result that these individuals will go to health centers, which, in turn, will soon be overwhelmed with uninsured patients. In short, even health centers that are not currently receiving uncompensated care funds from units of government will feel the impact of these rules—with their financial viability, and consequently, their ability to serve any of their patients (including Medicaid) will be put at risk.

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, at 202-296-0158 or [rschwartz@nachc.org](mailto:rschwartz@nachc.org).

Sincerely,

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, JD  
Legislative Counsel and Director of State Affairs