



October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-9974-P**
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers

To Whom It May Concern:

The National Association of Community Health Centers, Inc. ("NACHC") submits the following comments in response to the proposed rule regarding Exchange functions in the individual insurance market published by the Department of Health and Human Services ("HHS") on August 17, 2011 (the "Exchange proposed rule"). NACHC is the national membership organization for federally supported and federally recognized health centers (referred to here interchangeably as "health centers" or "FQHCs") throughout the country, and is an Internal Revenue Code Section 501(c)(3) organization.

NACHC is limiting its comments to issues that are of particular importance to health centers in their efforts to play a critical and supportive role in the expansion of health care coverage in the United States as provided in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, enacted on March 23, 2010; and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, enacted on March 30, 2010. (Following CMS's practice, we refer below to these two pieces of legislation, collectively, as the Affordable Care Act, or "ACA.")

I. Background on FQHCs

There are, at present, more than 1200 health centers, with over 8000 sites, serving more than 20 million patients 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"). 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

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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 Internal Revenue Code Section 501(c)(3) corporation formed under the laws of the State in which it operates.

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 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 maintaining 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.

II. Comments

The ACA provides for the creation of Affordable Insurance Exchanges ("Exchanges") in each State to enable individuals to purchase health insurance. The ACA also provides assistance with purchasing coverage through a qualified health plan ("QHP") on the Exchange by providing for an income tax credit to defray the cost of premiums, and for cost-sharing reductions (collectively, the "Exchange subsidies"). The Exchange subsidies are available to applicants with family income between 100% and 400% federal poverty level ("FPL"), and to non-citizens with income under 100% FPL who are lawfully present in the United States but ineligible for Medicaid due to Medicaid immigration status requirements.

In addition, the ACA mandates a dramatic expansion of Medicaid eligibility and gives states the option of creating a third coverage option for low-income consumers, called a Basic Health Program.¹ The Exchange proposed rule, in conjunction with two proposed rules published on August 17, 2011 by the Centers for Medicare and Medicaid Services ("CMS") and the Internal Revenue Service ("IRS"),² seeks to harmonize the eligibility processes for these insurance affordability programs.

Effective implementation of the Exchanges and Exchange subsidies is important to health centers, just as health center participation is critical to the success of the Exchanges. Health centers provide critical cost-effective and cost-efficient primary and preventive health care and enabling services to a

¹ Following HHS's terminology, we refer to these programs, along with CHIP, collectively as the "insurance affordability programs."

² See CMS, Proposed Rule, Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 76 Fed. Reg. 51148 (Aug. 17, 2011) ("Medicaid proposed rule"); Department of the Treasury, Internal Revenue Service, Proposed Rule, Health Insurance Premium Tax Credit, 76 Fed. Reg. 50931 (Aug. 17, 2011) ("Tax Credit proposed rule").

predominantly low-income population, and they embody principles of patient-centered primary care that Congress sought to propagate through various provisions of the ACA. Almost 72% of health center patients have income at or below the poverty level, and 93% of patients have income of less than twice the poverty level. Almost 38% of health center patients in 2010 were uninsured, as contrasted with 17% of the U.S. population at large.

As a result of the coverage expansion mandated by the ACA, health centers' total patient base is projected to rise from 19.5 million in 2010 to 50 million by 2019. One recent study predicted that as of 2019, health centers nationwide will serve about 4,500,000 Exchange enrollees, or 9% of health centers' total patient population.³

In the ACA, Congress recognized the critical role of health centers and other safety-net providers in Exchange QHP networks, by requiring that QHPs contract with health centers, where available, and by requiring that QHPs pay health centers adequate rates.⁴

In keeping with health centers' critical role as safety-net providers, the rules governing eligibility for the Exchanges and Exchange subsidies should take into account the needs and concerns of specific populations, disproportionately uninsured and low-income, that frequently access care at health centers. These populations include migrant and seasonal farm workers, persons with limited English proficiency, and non-citizens who are lawfully present in the United States but ineligible for Medicaid. The proposed rule contains positive provisions that promote equitable treatment of these groups, but NACHC's comments below focus on suggestions to strengthen protections for these populations.

NACHC also applauds the proposed rule for setting forth a straightforward approach to the application and eligibility redetermination processes for coverage on the Exchange and Exchange subsidies, relying

³ See Kaiser Comm'n for Medicaid and the Uninsured, *Community Health Centers: Opportunities and Challenges of Health Reform* (Aug. 2010), Fig. 9

⁴ PPACA § 1311(c)(1) provides that Exchanges "shall require that to be certified a [qualified health] plan shall, at a minimum . . . include within health insurance plan networks those essential community providers, where available, that serve predominately low-income medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act." FQHCs are listed as covered entities under Section 340B of the PHS Act, and hence are a category of essential community providers. Congress reinforced its support for the role of FQHCs in the success of the Exchanges in HCERA by providing for adequate payment for services rendered by FQHCs. HCERA provides:

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.

HCERA § 10104 (amending PPACA § 1302(g)). For further analysis of treatment of health centers under these provisions of the ACA, NACHC refers HHS to NACHC's comments on the HHS proposed rule concerning establishment of Exchanges and QHPs, published July 15, 2011, **which are attached with these comments.**

principally on the applicant's attestation of facts related to eligibility and uses electronic data sources, where necessary, to verify the attestation.⁵

A. Residency

NACHC recommends that in the final regulation, HHS incorporate several revisions that recognize the unique concerns of migrant and seasonal farm workers, and that increase the consistency between Exchange and Medicaid residency requirements.

1. Definition of Residency (Proposed 45 C.F.R. § 155.305(a)(3))

The proposed rule defines "residency," in the case of an individual over age 21 who is not institutionalized, is capable of indicating intent, and is not receiving an optional State supplementary payment, as that the person "*intends to reside* in the State within the service area of the Exchange, including without a fixed address, in which the applicant is requesting coverage." Proposed 45 C.F.R. § 155.305(a)(3) (emphasis added).

HHS notes in the preamble to the proposed rule that this wording precludes visitors to a service area, but accommodates "those individuals who may transition between service areas of different Exchanges, such as seasonal workers and individuals seeking employment in the State or service area of the Exchange." 76 Fed. Reg. at 51206. HHS also clarifies in the preamble that the "intends to reside" standard does not require that an individual intend to reside in the Exchange service area for the entire benefit year.⁶ *Id.*

It is positive that the definition of residency in the proposed rule does not require intent on the part of the applicant to remain permanently in the service area of the Exchange. In this same vein, NACHC recommends that in order to align the Exchange definition with the definition in the Medicaid proposed rule (*see* proposed 42 C.F.R. § 435.403(h) and 76 Fed. Reg. at 51160), and to reflect HHS' intent to accommodate the situation of migrant and seasonal farm workers, HHS add a second, alternative means of satisfying the residency standard: "Has entered the State with a job commitment (whether or not currently employed)."

2. Attestation of Residence (Proposed 45 C.F.R. § 155.315(c)(1))

HHS notes in the preamble to the proposed rule that "the eligibility and enrollment function should be consumer-oriented, minimizing administrative hurdles and unnecessary paperwork for applicants." 76 Fed. Reg. at 51203. NACHC applauds HHS for this effort. Application and redetermination processes

⁵ In its comments on the CMS proposed rule, also filed on October 31, NACHC urges CMS to conform Medicaid rules more closely to the Exchange proposed rule by further streamlining Medicaid eligibility redetermination processes and revising provisions relating to the application of modified adjusted gross income (MAGI) in Medicaid.

⁶ As provided in the July 15, 2011 HHS proposed rule concerning establishment of Exchanges, an Exchange QHP enrollee may terminate his or her coverage in a QHP at any time with appropriate notice to the Exchange or QHP. Proposed 45 C.F.R. § 155.430(b)(1), 76 Fed. Reg. 41918.

that require the submission of documentary evidence of residency (such as leases, utility bills, etc.) can be particularly burdensome for migrant and seasonal farm workers.

The proposed rule provides that in general, the Exchange “must verify an applicant’s residency in the service area of the Exchange by accepting his or her attestation without further verification.” Proposed 45 C.F.R. § 155.315(c)(1), 76 Fed. Reg. at 51231. However, it also provides:

If the State Medicaid or CHIP agency elects to examine electronic data sources for all applicants to verify residency, the Exchange must proceed in accordance with 42 CFR 435.956(c) and 42 CFR 457.380(c), and the policy of the State Medicaid or CHIP agency.

Proposed 45 C.F.R. § 155.315(c)(2). The rationale for this requirement, we presume, is that the Medicaid proposed rule gives State Medicaid and CHIP agencies flexibility to choose not to rely on the applicant’s or beneficiary’s attestation of residency, but instead to impose “other reasonable verification procedures.” These procedures must rely principally on information obtained electronically but can include seeking additional information from the individual. See proposed 42 C.F.R. §§ 435.952, 435.956(c)(1). In order to achieve uniformity between the Exchanges and Medicaid, the proposed rule requires the Exchange to follow where the Medicaid program in the State where the Exchange is located uses more rigorous eligibility verification procedures.

NACHC urges the agencies, HHS and CMS, to resolve the lack of uniformity between the Medicaid and Exchange proposed rules in favor of greater simplicity and less onerous requirements on applicants and beneficiaries. If they do not, then the coordinated eligibility and enrollment systems contemplated by PPACA § 1413 will be impracticable. Requiring the Exchanges to conform to the policies of State Medicaid agencies that elect to require paper documentation would undermine HHS’s goal of minimizing administrative burdens on applicants and would complicate the operation of regional Exchanges. CMS should promulgate a final Medicaid regulation that resembles the proposed 45 C.F.R. § 155.315(c)(1), and HHS should delete the proposed 45 C.F.R. § 155.315(c)(2).

B. Citizenship, Status as a National, or Lawful Presence

NACHC welcomes the provisions of the ACA recognizing the eligibility of non-citizens for Exchange coverage and Exchange subsidies. Coverage on the Exchange is available to an individual who is “reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.”⁷ PPACA § 1312(f)(3). In addition, while the ACA limits eligibility for Exchange subsidies to persons with income between 100% and 400% FPL, non-citizens with income below 100% FPL who are lawfully present in the United States but ineligible for Medicaid by virtue of immigration status are nonetheless deemed to be “qualified taxpayers” who may access Exchange subsidies. PPACA §§ 1401(a), 1402(b).

⁷ In contrast, Medicaid eligibility is limited to non-citizens who are “qualified aliens,” a category that includes, among others, lawful permanent residents, refugees, and asylees. Some qualified aliens are subject to a five-year bar on accessing Medicaid. The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) removed the “five-year bar” for some, but not all, categories of Medicaid applicants.

NACHC urges HHS to clarify in the final regulation several issues relating to Exchange and Exchange subsidy eligibility for lawfully present non-citizens.

1. “Reasonably Expected”

Under the proposed rule, as under the statute, a lawfully present non-citizen is eligible to enroll in an Exchange QHP only if “reasonably expected to be [in that status] for the entire period for which enrollment is sought.” Proposed 45 C.F.R. § 155.305. The proposed rule does not set forth a standard for “reasonably expected,” and HHS invites comment on the topic.

NACHC urges HHS not to include in the final regulation a new substantive “reasonably expected” standard that would limit non-citizens’ eligibility for Exchange coverage. First, HHS rightly noted that the period for which an applicant seeks enrollment need not be a year. 76 Fed. Reg. at 51206. On the contrary, although the Exchanges will use year-long QHP enrollment periods, an enrollee may terminate his or her Exchange coverage at any time with appropriate notice to the Exchange or the QHP. See proposed 45 C.F.R. § 155.430(b)(1), 76 Fed. Reg. at 41918. It would undermine Congress’ broad term, “lawfully present,” which encompasses admission in a non-immigrant status or on a “temporary” basis such as Temporary Protected Status (TPS),⁸ to interpret the “reasonably expected” language as a requirement that the applicant demonstrate entitlement to remain in the United States for a specified period of time.

In addition, we note that neither PPACA § 1401(a), which provides for premium tax credit eligibility for an “alien lawfully present,” nor PPACA § 1331(e)(1)(B), which makes certain “aliens lawfully present” eligible for the Basic Health Program, includes a requirement that the person be reasonably expected to remain in that status. Adding an independent immigration status-related requirement to the regulation on Exchange eligibility, 45 C.F.R. § 155.305, would create inconsistency among the programs and make it difficult for the programs to use the same electronic verification sources to determine eligibility based on immigration status.

2. Eligibility for Exchange Subsidies

The proposed rule clarifies that non-citizens lawfully present in the United States who are ineligible for Medicaid, and whose income is less than 100% FPL, are eligible for Exchange subsidies. Proposed 45 C.F.R. § 155.305(f)(2). Subsection 155.305, concerning eligibility for cost-sharing reductions, provides that the Exchange “must use the following eligibility categories for cost-sharing reductions. . . .” *Id.* § 155.305(h). The lowest listed income category is 100-150% FPL.

NACHC requests that HHS clarify this subsection to provide that the non-citizens referred to in subsection (f)(2), who have income below 100% FPL, are deemed to have income of 100% FPL and

⁸ The proposed rule published on July 15, 2011 defined “lawfully present” by reference to 45 C.F.R. § 152.2 (the standard applied for Pre-Existing Insurance Plan Program coverage). This standard includes a person “in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission,” as well as persons currently under Temporary Protected Status (TPS).

should be included in the 100%-150% eligibility category for purposes of determining the cost-sharing reduction.

C. Incarcerated Individuals

NACHC strongly supports the provisions in the ACA and the proposed rule stating that persons who are incarcerated “pending the disposition of charges” (unlike other incarcerated individuals) are eligible to enroll in QHPs on the Exchange. PPACA § 1312(f)(1)(B); proposed 45 C.F.R. § 155.305(a)(2). As one of the primary safety net providers (and in many instances, the only such provider) in the community, health centers are responsible for providing services to all residents of the underserved communities in which they are located. Health centers are concerned about the potential deficiencies in care for individuals both during incarceration and upon release. Many incarcerated individuals are health center patients before incarceration and if they remain in the community after release, they will remain (or become) health center patients. Allowing persons in jail pending the disposition of charges to continue to receive care is one step toward ensuring more adequate care for this population.

Thank you again for the opportunity to comment on this proposed rule. Please do not hesitate to contact me by telephone at (301) 347-0400 or by e-mail at rschwartz@nachc.org if you require any clarification on the comments presented above.

Sincerely,



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