



June 1, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2287-P2
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 above-cited solicitation from the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) for comments on the proposed rules related to the Medicaid Program: Rescission of School-Based Services Final Rule, Outpatient Services Definition Final Rule, and Partial Rescission of Case Management Services Interim Final Rule (42 CFR Parts 431, 433, 440 and 441).

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) organization.

BACKGROUND

There are, at present, approximately 1200 FQHCs nationwide serving close to 18 million patients. 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

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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. Approximately 35 percent of health center patients are Medicaid recipients, approximately 7.5 percent are Medicare beneficiaries, and approximately 40 percent are uninsured.

COMMENTS ON THE PROPOSED RULE

NACHC supports CMS' rescission of the "Elimination of Reimbursement Under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School" final rule, the "Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition" final rule, and certain provisions of the "Optional State Plan Case Management Services" interim final rule. We agree that these regulations were overly restrictive and would have a negative effect on the provision of care for Medicaid beneficiaries nationwide.

As we read the revised proposed rule relating to case management services, it appears that CMS proposes to remove two regulatory provisions that were of concern to NACHC and were noted as such in our previous comments (attached). Specifically, we support CMS's proposed removal of 42 CFR 441.18(a)(4) and 441.18(a)(6). However, it appears that CMS does not propose to remove 42 CFR 441.18(d) regarding the application of cost-allocation methodologies appropriate for Medicaid case management services "that are also furnished by another federally-funded program." If we are correct on this point, then NACHC believes that it is of utmost importance that CMS makes clear to State Medicaid agencies that this rule does not provide a basis for states requiring a health center to use its Section 330 grant funds to cover any portion of the cost of case management services or targeted case management services provided by the health center to its Medicaid patients. Such a requirement would be inconsistent with the long-standing recognition on the part of Congress and HHS that Medicaid and Medicare are first payors for Medicaid and Medicare covered services provided to Medicaid and Medicare patients of a health center.

Congress has made clear in Section 330 of the PHS Act that, as a requirement of its grant, a health center is obligated to contract with the State Medicaid agency to assure that it is reimbursed by that program for the services it provides to Medicaid recipients, and that the center "must make every reasonable effort to collect reimbursement for its costs in providing health services "to its Medicaid recipients. Section 330(k)(3)(E)(i)(I) and (F) of the PHS Act. Thus, while we recognize that Section 1915(g)(4) of the Social Security Act, as amended by the Deficit Reduction Act of 2005, provides generally for the allocation of costs of any part of a service that is reimbursable under another federally funded program, the above-cited and more specific long-standing requirement of Section 330 establishes a clear statutory requirement that a health center must first bill its Medicaid agency for Medicaid-covered services for Medicaid patients and use its 330 grant funds to pay for similar services for its uninsured patients.

This Medicaid as first payor exception was underlined through Congress's legislating specific FQHC reimbursement requirements in Medicaid and Medicare. By mandating reasonable cost reimbursement

for FQHCs in Medicaid and Medicare in 1989 and 1990 respectively, and FQHC Prospective Payment System (PPS) reimbursement in Medicaid for health centers in 2000, Congress underlined its intent to “ensure that Federal PHS Act grant funds are not used to subsidize health center or program services to Medicaid beneficiaries....” H.R. Rep. No. 101-247, at 393, reprinted in 1989 U.S.C.C.A.N. 2119.

Over the past 25 years, Congress has provided states with a great deal of leeway in how they will reimburse Medicaid providers. Perhaps the only exception to that rule has been its provision of specific reimbursement requirements and methodology for FQHCs. Indeed, when Congress amended the case management provisions of the Medicaid statute through the DRA, it also provided states with additional flexibility in the provision of certain services to certain groups of Medicaid eligibles—however, in doing so, it specifically excluded the provision of, or payment for, FQHC services from such state flexibility. Section 1937(b)(4), as amended by section 6044 (a) of Public Law No. 109-171. In short, the PHS Act and Social Security Act consistently provide for Medicaid reimbursement paying for services to health center patients who are Medicaid recipients and PHS grant funds being used for the uninsured. We ask that CMS insure that this rule of law remains in place by making clear to state Medicaid agencies that health centers are not required to use their Section 330 grant funds to pay any portion of the center’s cost in providing case management services to its Medicaid patients.

We appreciate the opportunity to comment on these proposed regulations 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