



July 11, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5507-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Request for Information Medicare and Medicaid Programs; Opportunities for Alignment Under Medicaid and Medicare

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to the request for comments (76 Fed. Reg. 28196 et seq., 5/16/11) from the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), regarding opportunities for alignment under the Medicare and Medicaid programs for “dual eligibles.” 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 non-profit, Section 501(c)(3) tax exempt organization.

Background

There are, at present, more than 1200 health centers with more than 8000 sites serving more than 20 million patients nationwide. Most of these health centers 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. Approximately 100 FQHCs do not receive a Section 330 Public Health Service Act grant but have been determined by CMS, per recommendation of HRSA, to meet all the requirements that must be met by Section 330 grantees (Sections 1861(aa)(4)(B) and 1905(l)(2)(B)(iii) of the Social Security Act). These FQHCs are often referred to as “FQHC look-alikes.”

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 51 percent 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

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comprehensive preventive and primary care and enabling services (such as translation, transportation services, smoking cessation classes, etc) 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 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 40 percent are uninsured, and approximately 7.5 percent are Medicare beneficiaries.

FQHCs and Dual Eligibles

In 2009, FQHCs served almost 7.5 million Medicaid patients and 1.4 million Medicare beneficiaries. The Medicare population treated by FQHCs is a rapidly growing part of the FQHC patient population. According to data from HRSA's Uniform Data Systems (UDS) covering the period 1996-2009, the FQHC Medicare patient population increased by 124 percent, with most of the growth taking place between 1998-2009. This Medicare patient increase can be attributed to a number of factors including the expansion in the number of health centers.¹ Over the same time period, health centers have seen continual growth in their Medicaid population as well. It seems reasonable to assume that both the Medicare and Medicaid beneficiary growth rate at centers will continue to increase in the upcoming years since in the Affordable Care Act Congress has funded substantial health center expansion.

Equally important, the Medicare and Medicaid patients being treated at FQHCs tend to be an at-risk population. This can be attributed partially to the fact that health centers are located in medically underserved areas which often are low-income areas and, obviously, are areas where patients have had difficulty accessing care. Because the vast majority of health center patients are low income, a large proportion of their Medicare patients are, not surprisingly, also eligible for Medicaid, that is they are dual eligibles. Dual eligibles are over 1.5 times more likely to experience serious health limitations, more than twice as likely to experience fair to poor health, nearly three times as likely to experience diabetes, and twice as likely to experience asthma.² In short, dual eligibles are significantly more likely to experience worse health arising from conditions whose outcomes can be improved through ambulatory care and are the very patients whose health outcomes might improve through the full range of primary and preventive care, dental care and mental health care services provided by the health care home available to them at an FQHC.

Payments to Health Centers for Dual Eligibles

A brief review of the Social Security Act's Medicare and Medicaid payment requirements for FQHCs is appropriate to help put NACHC's comments in context.

In 1990, Congress passed legislation establishing Federally Qualified Health Center (FQHC) services as a required service in the Medicaid program and mandated that reimbursement to FQHCs be paid on the

¹ Rosenbaum and Shin, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Issue Brief No. 23, George Washington University, School of Public Health and Health Services, Department of Health Policy (April 20, 2011) pages 7-8

² Id.,at page 9

basis of reasonable cost. The legislative history relating to these Medicaid provisions makes clear that Congress established this payment requirement to ensure that health centers would not have to use their Section 330 PHS grant funds to make up for inadequate Medicaid payments. The Medicaid FQHC payment provision was further amended in 2000, to assure that health centers receive a payment that approximates their costs in serving their Medicaid patients. 42 USC 1396d(a)(2)(C) , 1396a(a)(10)(A) and 1396a(bb). This Medicaid FQHC Prospective Payment System (PPS) essentially provides for a per visit payment to a health center based on an all-inclusive per visit rate calculated initially on the basis of the total reasonable cost to the health center of providing all of the ambulatory services furnished by the center which are covered under the State’s Medicaid program—and revised annually to reflect changes in the Medicare Economic Index(MEI) and changes (if any) in the health center’s scope of services.

In 1991, Congress passed legislation for FQHCs in the Medicare statute—providing for reasonable cost reimbursement to FQHCs. Once again, Congress was insuring that health centers would not have to use their Section 330 grant funds to cover the costs of treating Medicare patients.³ Medicare payment methodology for FQHC services was developed by CMS through proposed and final regulations published in 1992 and 1996, respectively. CMS’s proposed and final rules established a rural and urban per visit limit (“cap”) on a health center’s per visit payment, and also applied screens on the number of visits required by health center physicians and mid-level providers (neither of which were mandated by Congress). The FQHC Medicare cap was constructed using the Congressionally-established RHC per visit cap as a base), which is then adjusted annually on the basis of the MEI. To create the FQHC per visit cap, CMS used a series of adjustments to reflect the comprehensive services that health centers provide, the greater proportion of health center providers who are physicians, etc.

Since the time this Medicare policy was first promulgated in June 1992, NACHC has maintained that these caps and screens are inappropriate and require review and revision as they do not accurately reflect the full reasonable cost of health center services to Medicare patients. A 2010 GAO Report—mandated by Congress—reviewed FQHC Medicare cost reports and concluded that that more than 70 percent of FQHCs incurred costs for delivering FQHC services to Medicare beneficiaries that exceeded the Medicare FQHC per visit cap.

The Need for Revising Medicaid Payments to FQHCs for Dual Eligibles

FQHCs often receive a higher per visit FQHC payment from CMS when they provide services to a Medicaid patient than when they serve Medicare patients. This is often the case because Medicaid covers a broader range of services furnished by FQHCs than Medicare (dental services, for example.)—in effect, a Medicaid FQHC service is not the same service as a Medicare FQHC service. The difference in payment is also a result of the fact that Medicare payments are capped at an unreasonably low rate and because Medicare only pays 80 percent of the FQHC per visit rate.

³ Social Security Act, Section 1833(a)(3)(A)

Because of this difference in payments, when a Medicaid patient becomes Medicare eligible, a health center frequently receives lower reimbursement for the same service provided to that patient. For example, if a health center's Medicaid PPS rate is \$125 and its Medicare per visit rate is \$100, the center is paid \$125 for a face to face visit for a Medicaid patient. If that patient turns 65, and becomes a dual eligible, the center is paid \$80 (80 percent of \$100) from Medicare. In that situation, CMS policy appears to allow the state Medicaid agency to pay nothing to the center, or the patient's \$20 Medicare co-payment, or as high as \$45 (the difference between the Medicaid payment and the Medicare payment). Increasing numbers of states are paying the Medicare copayment at best, which means, in the above example, the health center receives \$20 from the Medicaid agency and loses the remaining \$25 simply because the patient has turned 65.

This policy is not only unreasonable but may be contrary federal law which appears to support the premise that the Medicaid rate should apply in this situation. In Section 4714 of the Balanced Budget Act of 1997, Congress amended the Medicaid statute to provide, essentially, that if Medicare pays more than Medicaid for the same service, then when a provider provides the service to a dual eligible, Medicaid need not pay the provider the difference. Thus, for example, if a State Medicaid program pays \$50 for a services and Medicare pays \$100 for the same service and the provider therefore receives \$80 (80 percent) from Medicare for that service for a dual eligible, Medicaid does not have to pay the \$20 difference to the provider since the Medicare payment already exceeds what Medicaid would have paid for the service. Congress passed this legislation in the context of clarifying how much the state would be obligated to cover as a co-payment but the logic of this legislative change seems to be that Medicaid payment prevails over Medicare in determining what the State must pay when Medicare pays more than Medicaid. It seems reasonable then to assume that Medicaid payment would also prevail when its payment exceeds Medicare—and consequently, the State in the case of FQHCs should be paying the FQHC the difference between the Medicare FQHC payment and the Medicaid FQHC/PPS payment.

Conclusion

In summary, the vast majority of health center patients are poor and many of them, for a variety of reasons, are high risk. Dual eligibles being treated by FQHCs invariably are both. Congress legislated a per visit bundled payment for FQHCs both in Medicare and Medicaid to assure that their Section PHS 330 grants funds need not be used to cover these populations, that is, to assure that Medicare and Medicaid paid the center for the costs of treating these patients. For the reasons outlined in this section, under the current Medicare/Medicaid payment system for FQHCs, health centers in many states lose substantial sums of payment simply because the Medicaid patient they are serving turns 65. We believe that states should be informed by CMS that in the case of dual eligibles, the state should pay the FQHC the difference between the center's Medicare FQHC per visit payment and the center's Medicaid FQHC PPS per visit rate. We believe such a clarification in policy fits well into CMS' "search for opportunities to more effectively align benefits and incentives to prevent cost shifting and improve access to care" for dual eligibles.

Thank you for the opportunity to submit these comments. If you have any questions about the comments presented herein, please call or email me at 202-296-0158 or rschwartz@nachc.com.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Roger Schwartz". The signature is written in a cursive style with a large initial "R" and "S".

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National Association of Community Health Centers