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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2380-PN
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2380-PN (Proposed Methodology, Basic Health Program)

To Whom It May Concern:

The National Association of Community Health Centers, Inc. (NACHC) submits the following response to the December 23, 2013 Proposed Federal Funding Methodology for Program Year 2015 the Basic Health Program ("the Payment Notice"). In the Payment Notice, CMS presents its methodology for implementing Section 1331(d)(3)(A) of the Patient Protection and Affordable Care Act of 2010 ("PPACA"), as amended by PPACA § 10104(o). That provision sets forth the amount of the Secretary of Health and Human Services' annual payment to a State to support the operation of its Basic Health Program ("BHP") for a fiscal year.

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 views the BHP, which CMS now proposes to allow states to implement effective January 1, 2015, as providing a low-cost alternative to coverage on the Affordable Insurance Exchanges ("Exchanges") for low-income consumers. The importance of the BHP as a policy option for states is particularly clear today. Premiums and cost sharing burdens on the Exchanges, even with the cost sharing reductions and premium tax credits taken into account, are proving to be higher than expected. The flexibility incorporated into the BHP would allow states to achieve greater efficiencies, especially if they design BHP to complement and resemble the Medicaid and Children's Health Insurance Program (CHIP) benefits, so that federal dollars could go further to serve low-income individuals.

NACHC supports the methodology that CMS has set forth for federal payments to states to fund BHP. For the most part, we also supported the provisions of the Notice of Proposed Rulemaking on BHP that CMS released on September 25, 2013 (the "BHP Proposed Rule"). NACHC's comments are intended to emphasize the important advantages of BHP as an "insurance affordability program"[1] under the Affordable Care Act (ACA), particularly in light of recent developments in the formation of Exchange qualified health plans (QHPs). We also wish to encourage CMS, as it moves forward to finalize BHP

[1] Following CMS's terminology, we refer to Medicaid, the Exchange subsidies, CHIP, and the Basic Health Program as the "insurance affordability programs."

regulations, to acknowledge the critical role of FQHCs in making BHP a high-quality and affordable coverage option for low-income individuals.

I. Background on FQHCs

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, within HRSA. 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 serving a designated medically underserved area or 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 (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.

Health centers are the most significant single source of affordable primary care in the United States. In 2012, almost 72% of health center patients had income at or below the poverty level, and 93% of patients had income of less than twice the poverty level. Thirty-eight percent (38%) of health center patients were uninsured. Health centers are therefore positioned to play a vital role in the expansion of health care to the uninsured under the ACA, and particularly in Basic Health Programs in states that elect to implement that option.

II. Comments

NACHC supports the methodology that CMS has selected for determining the amount of federal funds that the Secretary will deposit in a state's BHP trust fund annually, as explained in the Notice.

The ACA requires the Secretary to provide financial support to a state's BHP in an amount equal to 95 percent of the premium tax credits and the same percentage of the cost sharing reductions (collectively, "the Exchange subsidies") that would be available to eligible individuals enrolled in a BHP standard health plan, had they been enrolled in an Exchange QHP. PPACA § 1331(d)(3)(A)(i). The ACA specifies that these amounts must be determined "on a per enrollee basis," and that the determination must take into account specific enrollee features (age, income, whether the enrollment is for self-only or family coverage, *etc*.). PPACA § 1331(d)(3)(A)(ii).

To implement this requirement, CMS has proposed in the Payment Notice to create "rate cells" so that the same federal BHP payment would apply to all individuals within a cell. We feel that CMS has struck an appropriate balance, taking individual enrollee characteristics into account without making the methodology unduly complex or burdensome.

NACHC wishes to comment not on the specifics of the proposed BHP payment methodology, but instead more generally on BHP's potential to bridge coverage gaps that exist in the other insurance affordability programs under the ACA. The BHP option gives states the ability to use federal funds to create a truly affordable alternative to coverage under a state Exchange or federally facilitated Exchange for low-income individuals.

States implementing BHP will in many cases choose to model the program on their Medicaid and CHIP coverage. This model for BHP has the advantage of creating a more seamless experience for enrollees whose eligibility "churns" between Medicaid and BHP due to income fluctuations. Modeling BHP on Medicaid and CHIP also makes sense because Medicaid and CHIP managed care plans typically cover enrollees at lower cost, and with lower cost-sharing burdens, than commercial plans. While the Exchange subsidies offer some relief to low-income individuals from the financial burdens of enrollment in a QHP, BHP still promises to be a more affordable option. At the same time, because of the amount of federal funding available, states that administer BHP efficiently could secure greater federal participation in costs than they could if they served the same population as an optional population under Medicaid.[2] BHP could be cost-effective for both federal and state governments, making coverage accessible for indigent individuals and reducing the number of low-income uninsured persons.

BHP is particularly critical for noncitizens. If structured to minimize cost-sharing, BHP would be the only government-subsidized health coverage that is meaningfully accessible to lawfully present noncitizens with income under 133% FPL. Health centers are a key source of primary care for this group.

NACHC applauds CMS for its good-faith approach to funding for a program that has the potential to offer a more reasonable, affordable approach to health coverage than the Exchange subsidies. As CMS lays the groundwork for BHP over the coming year through final rules and informal guidance, NACHC urges CMS to acknowledge the critical role FQHCs will have in making BHP succeed. Health centers provide cost-effective and cost-efficient primary and preventive health care and enabling services to a predominantly low-income population. They embody principles of patient-centered primary care that Congress sought to propagate through the ACA.

In our opinion, the federal regulations and informal guidance implementing the network adequacy standards for Exchange QHPs do not sufficiently acknowledge health centers' importance as safety-net providers. As a result, in addition to requiring cost-sharing that is often unmanageable even with subsidy, the Exchange QHP provider networks that have in recent weeks begun offering services are in many instances insufficient to address the primary care needs of low-income, medically underserved individuals.

NACHC accordingly urges CMS, in implementing BHP, to encourage states to design programs that perform better in that regard, and in particular, to take the following measures.

First, NACHC is very supportive of the competitive contracting process required under the statute and elaborated on in the BHP Proposed Rule. As noted in our comments on the BHP Proposed Rule, NACHC encourages CMS to finalize regulations under which the BHP "standard health plans" would be required to include FQHCs in their networks. While we recognize that CMS proposed as an

[2] Robert Wood Johnson Foundation (Dorn), *The Basic Health Program Option Under Federal Health Reform: Issues for Consumers and States* (Mar. 2011), p. 3.

initial approach to allow states to choose whether to adopt Exchange or Medicaid network adequacy requirements, we believe that that the approach of requiring FQHC services to be available to each enrollee (an approach resembling Medicaid managed care) would best advance the goals of the statute, and particularly the goal to take into account "differences in local availability of, and access to, health care providers." PPACA § 1331(c)(2)(B).

Second, to enable FQHCs to participate in BHP standard health plans, the final BHP regulations should either require FQHCs to receive payment consistent with the prospective payment system (PPS) governing FQHC payment under Medicaid or, at minimum, encourage states to place value in the competitive contracting process on standard health plans that propose to reimburse health centers according to the PPS. Along the same lines, we interpret the provision on allowable uses of the BHP trust fund in the BHP Proposed Rule (proposed 42 C.F.R. § 600.705) to permit a state to use the BHP funds to make supplemental payments to FQHCs where payments by the standard health plan do not cover the full PPS rate. (Such a payment structure could be modeled on the FQHC supplemental payments required under Medicaid managed care, pursuant to Social Security Act § 1902(bb)(5).)

Third, NACHC recommends that to align insurance affordability programs and improve the quality of care under Basic Health Programs, CMS amend 42 C.F.R. § 600.405 to clarify that states may use federal BHP funding to provide additional benefits beyond the "essential health benefits." NACHC particularly recommends that CMS clarify in guidance that states are allowed to require standard health plans to cover the benefit described in Social Security Act § 1905(a)(2)(C), which FQHCs provide under Medicaid ("FQHC services").

Fourth, on a more general level, we wish to reiterate the importance of reducing out-of-pocket costs in making the BHP an accessible coverage option for low-income individuals. In the BHP Proposed Rule, in proposed 42 C.F.R. §§ 600.505, 600.510, and 600.520, CMS set forth limits on premiums and cost-sharing under standard health plans for BHP enrollees, which echo the statutory provisions at PPACA § 1331(a)(2)(A). In the competitive contractive process, however, plans should be rewarded for demonstrating that they can reduce enrollees' financial burdens further.

We also note that since, per the statute, the BHP trust fund can be used to reduce premiums and cost sharing for eligible enrolled individuals (*see* PPACA § 1331(d)(2); proposed 42 C.F.R. § 600.705(c), 78 Fed. Reg. at 59150), CMS should encourage states to use excess BHP funds to provide premium and cost sharing assistance to enrollees.

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We appreciate the opportunity to comment on the Payment Notice. These comments for the most part reinforce feedback NACHC has provided in its earlier comments relating to the Basic Health Program. Please do not hesitate to contact me by telephone at (202) 296-0158 or by e-mail at rschwartz@nachc.org if you require any clarification on the comments presented above.

Sincerely,

Roger Schwartz
Associate Vice President, Executive Branch Liaison