NATIONAL ASSOCIATION OF Community Health Centers

Main Office
7501 Wisconsin Ave.
Suite 1100W
Bethesda, MD 20814
301.347.0400 Tel
301.347.0459 Fax

Division of Federal, State and Public Affairs
1400 Eye Street, NW
Suite 910
Washington, DC 20005
202.296.3800 Tel
202.296.3526 FAX

January 12, 2015

Center for Consumer Information & Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted via email to: FFEcomments@cms.hhs.gov

Re: 2016 Draft Letter to Issuers

To Whom It May Concern:

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to CMS' request for comments on the 2016 Draft Letter to Issuers. 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 Section 501(c)(3) tax-exempt organization.

Currently, more than 1300 health centers with more than 9000 sites serve nearly 23 million patients nationwide. Most of these health centers receive federal grants under Section 330 of the Public Health Service Act ("PHS Act") from the Bureau of Primary Health Care ("BPHC"), 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 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 41 percent of health center patients are Medicaid recipients, approximately 8 percent are Medicare beneficiaries, and approximately 35 percent are uninsured.

Effective implementation of coverage under the Marketplaces is important to health centers, just as health center participation is critical to the success of the Marketplaces. Health centers provide cost-effective and cost-efficient primary and preventive health care to a predominantly low-income population, and they embody principles of patient-centered primary care that Congress sought to propagate through various provisions of the ACA.

Comments on the Draft Letter

As with years past, NACHC will focus its comments on those issues that most directly affect health centers and the patients that they serve. Attached also find NACHC's comments on the recent Notice of Proposed Rule Making (NPRM) on the 2016 Benefit and Payment Parameters, as we believe many of the issues we will discuss below are also covered there.

Essential Community Provider Requirements

NACHC appreciates the recognition of the role of federally qualified health centers (FQHCs) as Essential Community Providers (ECPs) in serving our nation's most vulnerable population. However, as we have mentioned in past comments on previous Draft Letters to Issuers, NACHC believes that adequate access to primary care services is a critical component of any QHP network, and FQHCs are the largest single source of primary care in medically underserved areas. Improving access to primary care is a leading tenet in the Affordable Care Act and thus, while we believe that CMS should include an "any willing provider" requirement for all ECPs, we recommend that; at a minimum, CMS require QHPs to offer any willing FQHC a legally compliant contract. This approach would have a greater impact on expanding meaningful access to the low-income and medically underserved.

NACHC applauds CMS' expansion of the ECP standard to include additional providers, as it will help to strengthen the network of providers that serve low income and medically underserved individuals. NACHC believes that access to care is critical and the expansion of eligible providers as ECPs will likely lead to better access. However, we have concerns with the expansion and want to confirm that it remains in line with the stated goals of the ECP requirement, ensuring the low income and medically underserved population have appropriate access to care. As noted earlier, FQHCs have a requirement to be open to all, regardless of ability to pay and are not able to turn patients away based on their insurance status. Those ECPs defined in statute have similar requirements to serve low income patients or be located in a medically underserved area, but it is not clear that the new providers added to the ECP list share this same requirement. If these new providers do not accept any and all patients within their communities or are not accepting new patients, it would be highly problematic and we do not believe they should be allowed to qualify as an ECP. Allowing new provider types to qualify as ECP without the requirement to serve their communities' vulnerable populations would be detrimental to access to care. Without additional protections and oversight, a QHP could include one of these new providers in its network, representing that it is meeting the ECP and network adequacy requirements, when that provider may not actually be serving the population at need, effectively rendering the ECP requirement meaningless. We believe that CMS must ensure that each new category of ECP provider is

actually offering and providing care to the population at need and recommend CCIIO provide additional monitoring and enforcement for those ECPs that qualify under the expansion to ensure that they are appropriately providing care to the low income and medically underserved. In finalizing the 2016 Letter to Issuers, we request that CMS further clarify how it will ensure these new providers are adequately providing care to those individuals in need.

Payments to FQHCs

The 2015 Letter to Issuers included the following paragraph specific to the FQHC payment requirements, which proved to be helpful, as many QHPs have indicated to health centers that they were not aware of the FQHC payment requirements.

> ***Requirements for Payment of Federally Qualified Health Centers***
> *We reiterate the importance of issuers complying with 45 C.F.R. 156.235(e) regarding payment of FQHCs. For covered services provided by an FQHC, QHP issuers must pay an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the SSA for such item or service, as specified in section 1302(g) of the Affordable Care Act. Section 156.235(e) does allow the QHP issuer and FQHC to mutually agree upon payment rates other than those that would have been paid to the center under section 1902(bb) of the SSA, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer. We note that state law may define covered services for closed-panel HMO plans to be limited to those services provided by in-network providers. In such cases, this requirement would not apply to non-covered services, which would include non-emergent out of-network services if provided by FQHCs if such services are not treated under state law as covered services. Otherwise, we would expect issuers to pay FQHCs for covered services in accordance with section 1902(bb) of the SSA. We encourage issuers and FQHCs, as well as other ECPs, to develop mutually beneficial business relationships that promote effective care for medically underserved and vulnerable populations. We intend to assess available data to understand the degree to which such patients are cared for effectively and to inform our future regulatory approach.*

This paragraph was not included in the 2016 Draft Letter and NACHC believes that it should be added back to this letter. However, as in years past, we would request that the language in that paragraph should be amended to more accurately reflect the ACA, § 1302(g)'s requirements. We believe the language allowing for a "mutually agreed upon rate," likely a rate that is less that the PPS rate in Social Security Act 1902(bb), is contrary to the statute, which requires that QHPs pay an FQHC its PPS rate. Payment at that 1902(bb) level is critical to ensuring the viability of the FQHCs in the Marketplaces. Congress specifically acknowledged the critical role of FQHCs in providing coverage on the Marketplaces, by requiring adequate payment by QHPs for services rendered by FQHCs in PPACA § 1302(g)). In fact, CMS/CCIIO has recognized Congress' endorsement of adequate payment to FQHCs in its conclusion that when a QHP enrollee receives services from an FQHC that has not contracted with the QHP, "the QHP issuer must pay the FQHC the Medicaid PPS rate for the items and services provided to the plan

enrollee."[1] NACHC has submitted previous comments on this point at length and respectfully request that CMS consider adding this language into the 2016 Letter to Issuers, with the appropriate revisions.

Thank you for the opportunity to provide comments on the 2016 Draft Letter to Issuers. Should you have any questions or comments regarding our comments, please contact Susan Sumrell at ssumrell@nachc.org or 202.296.3800.

Sincerely,

Susan J. Sumrell
Deputy Director, Regulatory Affairs
National Association of Community Health Centers

[1] Letter of June 8, 2012 from Timothy Hill, Dep. Director, CCIIO, to Dan Hawkins, NACHC's Senior Vice President of Policy.

NATIONAL ASSOCIATION OF Community Health Centers

Main Office
7501 Wisconsin Ave.
Suite 1100W
Bethesda, MD 20814
301.347.0400 Tel
301.347.0459 Fax

Division of Federal, State and Public Affairs
1400 Eye Street, NW
Suite 910
Washington, DC 20005
202.296.3800 Tel
202.296.3526 FAX

Centers for Medicare and Medicaid Services
Center for Consumer Information and Insurance Oversight
By Email: http://www.regulations.gov

December 22, 2014

RE: Comments to Proposed Rule – Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016

To Whom It May Concern:

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to the above-referenced proposed rule, "Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016" published at 79 Fed. Reg. 70674 (Nov. 26, 2014). 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 Section 501(c)(3) tax-exempt organization.

I. Overview of Comments

Among other things, the proposed rule provides standards for the Affordable Insurance Exchanges/Health Insurances Marketplaces created under the Affordable Care Act (ACA), including that of essential community providers (ECPs) in qualified health plans (QHPs) and network adequacy for QHPs. As health centers are key ECPs, NACHC's comments focus on ECP contracting requirements and on network adequacy in QHPs' coverage.

As NACHC noted in its comments to CCIIO's 2015 Draft Letter to Issuers in the Federally-Facilitated Marketplaces, rigorous implementation of the ACA provisions on ECPs, and more specifically its provisions relating to FQHCs participation as ECPs, is critical in order for the Marketplaces to offer adequate coverage in medically underserved areas. Effective primary care is the centerpiece of many of the ACA's reforms, and FQHCs are a key source of primary care for low-income individuals who will have access to affordable health insurance coverage for the first time as a result of the ACA.

FQHCs are "essential," in part, because they continue to serve as the safety net care system for uninsured populations in underserved areas. As the ACA coverage expansions do not relieve the problem of the uninsured, it is critical that FQHCs be reimbursed adequately by all payors so that the funding they receive (most of it federal) specifically to care for the uninsured is properly directed to that purpose—and is not used to subsidize care otherwise covered by private insurance companies.

As further described below, NACHC provides comments for consideration on the expansion of the ECP definition and contracting requirements as well as further changes to the network adequacy standards, all with a view toward the same goal: promoting real and meaningful access for QHP enrollees to health care for low-income and medically unserved populations.

II. Background on Health Centers and Affordable Insurance Marketplaces

Currently, more than 1300 health centers with more than 9000 sites serve nearly 23 million patients nationwide. Most of these health centers receive federal grants under Section 330 of the Public Health Service Act ("PHS Act"), 42 U.S.C. § 254b, from the Bureau of Primary Health Care ("BPHC"), 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. Approximately 41 percent of health center patients are Medicaid recipients, approximately 8 percent are Medicare beneficiaries, and approximately 35 percent are uninsured.

Effective implementation of coverage under the Marketplaces is important to health centers, just as health center participation is critical to the success of the Marketplaces. Health centers provide cost-effective and cost-efficient primary and preventive health care to a predominantly low-income population, and they embody principles of patient-centered primary care that Congress sought to propagate through various provisions of the ACA.

In the ACA and its implementing regulations, Congress and HHS recognized the critical role of health centers and other safety-net providers in Marketplace QHP networks. Specifically, § 1311(c)(1) of the Patient Protection and Affordable Care Act (PPACA) provides that Marketplaces

> 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 Public Health Service Act, and hence are a category of ECPs. This is the statutory underpinning for most of our comments herein. We note that the statutory requirement provides "shall…include" and not merely "offer."

In PPACA, Congress specifically acknowledged the critical role of FQHCs in providing coverage in the Marketplaces by requiring adequate payment by QHPs for services rendered by FQHCs:

> If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) 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 . . . for such item or service.

PPACA § 1302(g)). Section 1902(bb) of the Social Security Act, in turn, contains the requirement that States pay FQHCs furnishing Medicaid services according to a cost-related prospective payment system (PPS) methodology. By knitting together the Marketplace programs with the Medicaid payment requirement, Congress sought to ensure that FQHCs are contracted as ECPs and would obtain adequate payment in the Marketplaces. Obtaining adequate payment is critical for health centers because Section 330 of the PHS Act requires that a health center grantee "[make] and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled . . . . to medical assistance under . . . [a] private health insurance program ." 42 U.S.C. § 254b(k)(3)(F). The reason that Congress, in Section 330, required health centers to seek sufficient payment from all payors was to ensure that Section 330 grant funds, dedicated to covering the costs of serving uninsured and underinsured individuals, would not be diverted to subsidize the costs of serving patients with full insurance coverage. Congress reiterated this obligation in the context of QHPs operating in the Marketplaces by requiring, in PPACA § 1302(g), payment to FQHCs at the Medicaid PPS rate.

Indeed, CMS/CCIIO has recognized Congress' endorsement of adequate payment to FQHCs in its conclusion that when a QHP enrollee receives services from an FQHC that has not contracted with the QHP, "the QHP issuer must pay the FQHC the Medicaid PPS rate for the items and services provided to the plan enrollee." Letter of June 8, 2012 from Timothy Hill, Dep. Director, CCIIO, to Dan Hawkins, Senior VP, NACHC (attached as Attachment A hereto).

III. Comments

Our comments focus on: (1) the ECP definition and contracting requirements; (2) the network adequacy requirements; and (3) the FQHC payment provision in the proposed rule.

A. ECPs (45 C.F.R. § 156.235)

NACHC applauds the proposed rule's stated goal "to strengthen the [ECP] standard in accordance with section 1311(c)(1)(C) of the Affordable Care Act, which requires that a QHP's network include ECPs, where available, that serve predominantly low-income and medically-underserved populations." 79 Fed. Reg. 70727. We believe this is the right starting point as well. However, we believe there are instances in which this stated goal is not adequately kept in mind and would like to highlight them as part of these comments.

The proposed rule attempts to further the stated goal by proposing that the definition of ECPs be expanded to include, **"**Other providers that provide health care to populations residing in low-income zip codes or Health Professional Shortage Areas" 79 Fed. Reg. 70727. NACHC is supportive of the stated expansion of the ECP definition, which encourages greater access to care. However, we want to ensure that those additional providers are of the type that are open to anyone in the community. Expanding meaningful access to health care for the low-income and uninsured populations is a worthy goal in line with PPACA § 1311(c)(1). However, we believe there is a risk in expanding the ECP definition to include providers who may not or are not legally required to accept any and all patients within their communities; allowing QHPs to conclude and represent that they are meeting network adequacy requirements when the providers they have contracted with will not really be seeing new patients and when there are FQHCs and other ECPs that are ready, willing, and able to see new patients. To protect against such a result, this particular expansion of the ECP definition would need to be accompanied by additional monitoring and enforcement on the part of HHS to ensure that the other providers have the capacity to serve the community and are accepting new patients.[1]

The proposed rule states that the general ECP standard would be satisfied if the issuer "would be required to offer contracts for participation in the plan for which a certification application is being submitted to the following: (1) all available Indian health providers in the service area . . . and (2) at least one ECP in each ECP category . . . in each county in the service area, where an ECP in the category is available and provides medical or dental services that are covered by the issuer plan type. We expect that issuers will offer contracts in good faith. A good faith contract should offer the same rates and contract provisions as other contracts accepted by or offered to similarly situated providers that are not ECPs." 79 Fed. Reg 70727.

NACHC believes that adequate access to primary care services is a critical component of any QHP network, and FQHCs are the largest single source of primary care in medically underserved areas. Primary care is the linchpin of the "triple aim" reflected in the ACA: reducing costs, improving the quality of care, and improving patients' experience. QHP issuers can best achieve those goals in underserved areas if their plans include FQHCs. Thus, while we believe that HHS should include in these regulations an "any willing provider" requirement for *all ECPs*, we recommend that; at a minimum; HHS require QHPs to offer any willing FQHC a legally compliant contract. This approach would have a greater impact on expanding meaningful access to the low-income and medically underserved populations than the attempt to expand the ECP definition addressed above.

[1] Similarly, Table 10 in the proposed rule (at 70727) includes in the description of "Other ECP Providers" a catch-all of ". . . and other entities that serve predominantly low-income, medically underserved individuals." We suggest that this catch-all language be further clarified because it is unclear what other providers are contemplated by this language and the general description does not sufficiently identify how those other providers would promote meaningful access to their communities. As above, our concern is with QHPs that contract with the other providers in order to meet the ECP requirement; however that provider may not be accepting new patients.

Previously, NACHC requested that HHS clarify the showing that an issuer must make with respect to a QHP's narrative justification of how its network meets the standards of providing care to low-income and medically underserved populations. The proposed rule attempts to provide further detail in this regard via the new paragraph (b)(3). In addition to the ECP Supplemental Response form mentioned in the proposed rule, we continue to believe that HHS can best monitor the adequacy of the representation of ECPs in the issuer's provider network by (1) requiring the issuer to identify the ECPs to which it intends to offer a contract, *and* (2) requiring the issuer to provide for CMS's review model provider agreements for each ECP type in order for CMS to evaluate whether the contract terms are reasonable and legally compliant. CMS should *not* accept as evidence of an ECP's participation in an issuer's plan the issuer's representation that the ECP presently participates in other products offered by the issuer, or the issuer's representation that the issuer merely has offered or will offer the ECP a contract (without any evidence of contract terms).

For ECPs, the terms of proposed provider contracts are more important than the mere offering of contracts in an ECP's determination of whether it is feasible to participate in QHPs' networks. This is why it is particularly important that HHS require, as a condition of certifying a QHP on a federally-facilitated Marketplace, that issuers present model agreements with each type of ECP for CMS's review. CMS will have no means of determining whether those requirements are met unless, as administrator of the FFM, CMS engages in a more searching review of potential contracts with providers than is indicated in the proposed rule and the ECP Supplemental Response form.

Such review is important to health centers because health centers' participation in QHPs' networks will be largely contingent on each health center's ability to secure payment at its Medicaid PPS rate or, at a minimum, a level sufficient to ensure that its costs of providing care to Marketplace enrollees are fully covered. (See, however, our comments in Section III-C). Both PPACA and its implementing regulations require (as a condition of QHP certification) that this payment requirement be met – with the regulation including a qualification that a QHP and FQHC may agree upon a rate other than Medicaid PPS so long as the rate is at least equal to the QHP's generally applicable rate. *See* PPACA § 1302(g); 45 C.F.R. § 156.235(e). It would be difficult as a practical matter for an FQHC to participate in a plan on the Marketplace unless the issuer offers a contract that complies with the statutory requirements.

B. Network Adequacy Standards (45 C.F.R. § 156.230)

The proposed rule seeks to add a new section (b)(2) to strengthen the provider directory requirement. NACHC is supportive of this endeavor and believes that it is an important step forward in improving access to care for the consumer. However, we believe that in order for the provider directory to be meaningful and "user-friendly" to the health care consumer that both individual providers within an FQHC as well as the FQHC itself be listed in the directory so that no matter how the consumer identifies his or her provider the relevant listing can be found. We also suggest that the provider directory be mandated to include a definitions section that defines the term "FQHC" and the full range of services that FQHCs provide because most consumers are not familiar with that term or why they would want to have an FQHC within their network.

C. FQHC Payment (45 C.F.R. § 156.235)

We note that the proposed rule proposes a change in language in 45 C.F.R. § 156.235(e) by deleting the word "mutually" in the context of the QHP/FQHC agreement as to payment rates. The preamble to the proposed rule does not address the reason for this change, nor note that there is a change in the wording. We presume that the change is being made to eliminate a redundancy because an agreement by its very nature should be mutual. However, if the elimination is intended to allow QHPs flexibility with respect to their obligation to pay FQHCs their Social Security Act section 1902(bb) rates, NACHC strenuously objects to such a proposal. Payment at that 1902(bb) level is critical to ensuring the viability of the FQHCs in the Marketplaces. Congress specifically acknowledged the critical role of FQHCs in providing coverage on the Marketplaces, by requiring adequate payment by QHPs for services rendered by FQHCs in PPACA § 1302(g)).

The legislative history behind Section 330 emphasizes the principle that Section 330 funds should not be used to subsidize the costs of other programs. As a result, Section 330 health centers are required "to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled . . . to medical assistance under . . . [a] private health insurance program." 42 U.S.C. § 254b(k)(3)(F). When Congress required QHPs operating on the Marketplaces to make payment to FQHCs at the Social Security Act, section 1902(bb) level, it had the same concern about avoiding subsidies from one program to another in mind. CMS/CCIIO has expressly recognized this concern in connection with the letter issued by the Deputy Director of CCIIO (Attachment A).

For these reasons, NACHC, in its comments in response to the NPRM that included 42 C.F.R. §156.235(e), maintained that CMS' allowance for a QHP payment to an FQHC that was less than the Social Security Act, section 1902(bb) rate, was contrary to and in violation of the PPACA. We continue to maintain that position and respectfully request that the agency reconsider this provision to more closely align with the statute.

Thank you for the opportunity to comment on the proposed rule. Please do not hesitate to contact me by telephone at 202-296-3800 or by email at: ssumrell@nachc.org if you require any clarification on the comments presented above.

Sincerely,

Roger Schwartz
Associate Vice President, Executive Branch Liaison
National Association of Community Health Centers

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

June 8, 2012

Daniel R. Hawkins, Jr.
Senior Vice President
National Association of Community Health Centers
7200 Wisconsin Ave, Suite 210
Bethesda, MD 20814

Dear Mr. Hawkins:

Thank you for your letter regarding the payment issues related to Federally-qualified health centers (FQHCs) by qualified health plans (QHPs) that would operate in State-based Exchanges. We appreciate your thoughts and concerns about this important issue.

As you noted, 45 CFR §156.235(e) of the final rule published on March 27, 2012, *Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers*, states that if an item or service is provided by an FQHC to an enrollee of the QHP, the QHP issuer must pay an amount that is not less than "the amount of payment that would have been paid to the center under §1902(bb) of the Social Security Act (SSA) for services that are covered by the QHP and provided by an FQHC to a covered individual" (Medicaid PPS rate). However, the QHP issuer and the FQHC may mutually agree upon payment rates other than the Medicaid PPS rate. Specifically, the preamble to §156.235(e) indicates that a QHP issuer must pay the relevant Medicaid PPS rate, or may pay a mutually agreed upon rate to the FQHC, provided that such rate is at least equal to the QHP issuer's generally applicable payment rate.

Therefore, we believe that, consistent with §§ 1302(g), 1311(c)(1)(C), and 1311(c)(2) of the Affordable Care Act, §156.235(e) and the preamble are sufficiently clear in expressing that a QHP issuer must pay an FQHC the relevant Medicaid PPS rate for the items and services that the FQHC provides to a QHP enrollee, if the QHP issuer and the FQHC have not contracted on a mutually agreed upon rate that is at least equal to the QHP issuer's generally applicable payment rate. This would generally mean that if a QHP issuer does not have a contract with an FQHC, the QHP issuer must pay the FQHC the Medicaid PPS rate for the items and services provided to the QHP enrollee.

Thank you for your ongoing interest in the implementation of the Affordable Care Act, and for taking the time to write about this important issue.

Sincerely,

Timothy Hill, Deputy Director
Center for Consumer Information and Insurance Oversight

NATIONAL ASSOCIATION OF
Community Health Centers

March 27, 2012

Steve Larsen
Centers for Medicare and Medicaid Services (CMS)
Center for Consumer Information and Insurance Oversight (CCIIO)
200 Independence Ave., S.W.
Room 733H-02
Washington, DC 20201

Dear Mr. Larsen:

On behalf of health centers and the 20 million patients that they serve, I am writing to you today to address an important issue regarding health center participation in Qualified Health Plans (QHPs) that can be approved to operate in State Based Exchanges under the final rule on the Establishment of Exchanges and Qualified Health Plans, to be published in the Federal Register on March 27, 2012.

The Affordable Care Act included an important provision for health centers (see Section 10104 (b)(2) of PPACA adding subsection (g) to Section 1302 of PPACA), requiring that if an item or service that is otherwise covered by a QHP is provided at a federally qualified health center (FQHC), the QHP must pay the FQHC at least the amount it would have received under Medicaid (as defined in Section 1902(bb) of the Social Security Act), which we refer to as the PPS rate. We strongly supported this provision because it is critical to the success of health centers participation in the Exchanges, as it guarantees a fair and adequate payment for the items and services that health centers provide to our nation's most vulnerable patients.

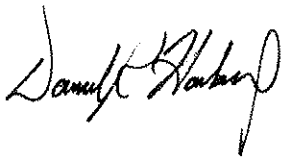
The final rule includes language codifying the FQHC payment provision by requiring that QHPs reimburse an FQHC no less than its Medicaid PPS rate, unless a different rate is mutually agreed upon by both the QHP and the FQHC (see 45 CFR § 156.235(e)). While we believe that QHPs should pay each FQHC its Medicaid PPS rate in all cases, whether in or out of network, we appreciate your attention to this provision, and we are asking that you clarify that a QHP issuer is required to pay an FQHC its Medicaid PPS rate for the items and services the FQHC provides to a QHP enrollee in an instance where the FQHC is not contracted to provide items and services with the QHP issuer. In other words, if an enrollee of a QHP is treated by an FQHC that does not have a contract with the QHP, the center must be paid by that QHP no less than the FQHC's Medicaid PPS rate. We believe that this additional clarification would help assure that this requirement in PPACA is carried out as intended, at least in the case of out-of-network care, and is necessary to ensure that QHPs provide adequate reimbursement for the care provided at health centers to their patients in such cases. We believe the current language in the final rule may be misinterpreted by some and would very much appreciate your help reconfirming the intent of this important PPACA provision.

MAIN OFFICE
7200 Wisconsin Ave, Suite 210
Bethesda, MD 20814
301-347-0400
301-347-0459 fax

FEDERAL AND STATE AFFAIRS OFFICE
1400 Eye Street NW, Suite 910
Washington, DC 20005
202-296-3800
202-296-3526 fax

Thank you for your consideration of this request for clarification and for your support for health centers. Should you or your staff have any questions on this issue, please contact Roger Schwartz at 202.296.0158.

Sincerely,



Daniel R. Hawkins, Jr.
Senior Vice President
Public Policy and Research