NATIONAL ASSOCIATION OF Community Health Centers

July 5, 2011

Center for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2328-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 *Fed. Reg. 26342*, *et. seq.* (May 6, 2011)

To Whom It May Concern:

The National Association of Community Health Centers (NACHC) is pleased to respond to the above-cited proposed rule from the Center for Medicaid & Medicaid Services (CMS) relating to Sec. 1902(a)(30)(A) of the Social Security Act (42 U.S.C. 1396a(30)(A)), which requires state plans for medical assistance to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available to the general population in the geographic area."

NACHC is the national membership organization for federally-supported and federally-qualified health centers (hereinafter interchangeably referred to as "health centers" or FQHCs) throughout the country, and is an Internal Revenue Code Section 501(c)(3) organization. NACHC also serves as a source of information, analysis, research, education, and training regarding medically underserved people and communities.

Background

There are, at present, more than 1,200 health centers nationwide, which serve as the health care homes to twenty (20) million persons at more than 8,000 sites located in all fifty (50) states, Puerto Rico, the District of Columbia, the U.S. Virgin Islands and the Pacific Islands. Most of these health centers 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) centers serving medically underserved areas and/or populations (invariably poor communities); (2) centers serving homeless populations within a particular community or geographic area; (3) centers serving migrant or seasonal farm worker

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populations within a particular community or geographic area; and (4) centers serving residents of public housing projects.[1] Although there are some slight differences in the grant requirements for each of these four program types, for all intents and purposes, the ways in which these health centers operate are identical.

Approximately 35 percent of the patients served by health centers are Medicaid/CHIP recipients, approximately 7.5 percent are Medicare beneficiaries, and approximately 40 percent are uninsured. FQHCs are required to make services available to all residents of their service areas. *See* 42 U.S.C. §§ 254b(a)(1).[2] In providing a comprehensive continuum of care, FQHCs are required to furnish a wide array of required primary health services, including, among other things, basic primary care services (*e.g.*, family medicine, internal medicine, pediatrics, obstetrics and gynecology), preventive health services, and support services to ensure patients have the ability to access all required health care services, such as referrals, case management, enabling services (*e.g.*, transportation, translation), and patient education/health promotion. *See* 42 U.S.C. §§ 254b(b)(1)(A).

The Section 330 grant funds received by health centers from BPHC are intended to support the costs of providing this comprehensive array of preventive and primary care and enabling services to uninsured and underinsured low-income patients. As a result of furnishing these services, health centers save the national health care system an estimated $24 billion a year by helping patients avoid emergency rooms and making better use of preventive services including screening, diagnosis and management of chronic illnesses such as diabetes, asthma, heart and lung disease, depression, cancer and HIV/AIDS.

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 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 (H.R. Rep. No. 101-247, at 392-93, reprinted in 1989 U.S.C.C.A.N. 2118-19). Amendments to Title XIX were passed by Congress in 2000 to implement a prospective payment system (PPS) for FQHCs that would continue to ensure that FQHCs receive fair payment for the delivery of FQHC services to Medicaid patients.

[1] In addition to those health centers receiving grant funds pursuant to one or more of the Section 330 funding programs, there are certain entities that are designated by the Centers for Medicare and Medicaid Services (CMS) as FQHCs, by virtue of the fact that they meet all of the requirements to receive a Section 330 grant, but do not receive funding from HRSA (FQHC look-alike entities). For purposes of this comment, unless otherwise noted, we do not distinguish between grantees and FQHC look-alike entities, collectively referring to both types of organizations as "FQHCs" or "health centers."

[2] There are certain exceptions to this requirement for health centers that receive grant funds solely to serve migrant and seasonal farmworkers, homeless individuals and families, and/or residents of public housing.

Comments on the Proposed Rule

Effective Date of Medicaid Payment Rate Reductions through State Plan Amendments.

NACHC welcomes the increased transparency and methodological consistency that the proposed rule would bring and is supportive of CMS' commitment to beneficiary access in the face of limited state budgets. However, the proposed rule does not state that—consistent with Federal court opinions—Medicaid payment rate reductions under a State Plan Amendment (SPA) cannot be retroactive. As such, NACHC encourages CMS to revise the proposed rule to clarify that reductions in Medicaid service payment rates would be effective from the time of final approval by CMS rather than upon submission of the SPA. Section 1902(a)(30)(A) requires state plans for medical assistance to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." The proposed rule attempts to standardize a system for states to make such assurances by requiring states to consider the following prior to submission of a SPA that proposes to reduce or restructure Medicaid service payment rates:

- Data trends and factors considering, at a minimum, (1) the extent to which an enrollee needs are met, (2) the availability of care and providers, and (3) changes in beneficiary utilization of covered services; and
- Input from beneficiaries and affected stakeholders in determining the extent of beneficiary access to the affected services and the impact that the proposed rate change will have, if any, on continued service access.[3]

Under current rules, a SPA providing for additional Medicaid services, expanded eligibility, or increased rates of payments for existing services is deemed "approved" and therefore effective retroactive to the first day of the quarter in which the SPA was submitted to CMS.[4] However, the proposed rule is unclear as to whether CMS intends for SPAs *decreasing* Medicaid service payment rates to also be retroactive. For the reasons described below, NACHC urges CMS to revise the proposed rule to clarify that reductions in Medicaid payment rates would be effective from the time of final approval by CMS rather than upon submission of the SPA.

[3] *Id.* at 26361-26362.

[4] "For purposes of FFP, the following rules apply: (a) New plans. The effective date of a new plan-- (1) May not be earlier than the first day of the quarter in which an approvable plan is submitted to the regional office; and (2) With respect to expenditures for medical assistance, may not be earlier than the first day on which the plan is in operation on a statewide basis. (b) Plan amendment. (1) For a plan amendment that provides additional services to individuals eligible under the approved plan, increases the payment amounts for services already included in the plan, or makes additional groups eligible for services provided under the approved plan, the effective date is determined in accordance with paragraph (a) of this section. (2) For a plan amendment that changes the State's payment method and standards, the rules of Sec. 447.256 of this chapter apply. (3) For other plan amendments, the effective date may be a date requested by the State if CMS approves it." 42 C.F.R. §430.20.

First, CMS does not have the legal authority to engage in retroactive rulemaking. In *Bowen v. Georgetown University Hospital,* 488 U.S. 204 (1988), the Supreme Court addressed the issue of whether the Secretary of Health and Human Services (the Secretary) had the authority to promulgate retroactive cost limits on Medicare expenditures. The threshold question considered by the Court was whether the Medicare Act authorized retroactive rulemaking, which the Court answered by stating, "a statutory grant of legislative rulemaking authority will not, as a general matter, be understood to encompass the power to promulgate retroactive rules unless that power is conveyed by Congress in express terms."[5] Here, the legislative authority for the proposed rule does not contain express authorization of retroactive rulemaking.[6] As such, a proposed rule that attempted to retroactively reduce Medicare payment rates would not satisfy the Court's standard in *Bowen*.

Second, the ability of States to impose retroactive payment rates could jeopardize the financial viability of FQHCs by suddenly exposing them to months or even years of "overpayments". Because the Affordable Care Act requires Medicaid providers to return overpayments within 60 days of identifying the overpayment, such obligations would be due and payable to Medicaid agencies within an extremely short time frame.[7] To mitigate such harm, a Medicaid provider would be forced to set aside any payment amounts exceeding the proposed reductions and follow the reduced provider reimbursement rates contained in the unapproved SPA.

Permitting that result, however, would effectively allow a State to implement payment reductions prior to receiving Federal approval from CMS. In *Exeter Memorial Hospital Association v. Belshe*, the U.S. Court of Appeals for the Ninth Circuit upheld the Eastern District of California's decision to deny a State's Medicaid reductions in advance of federal approval.[8] In that case, Exeter (a Medicaid provider) sought and won a preliminary injunction stopping the California Department of Health Services from enforcing decreased Medicaid reimbursement rates prior to the SPA's approval by HHS.[9] The court found that the state's implementation of the new rate structure in advance of federal approval was invalid and found that Exeter "at the very least" had "established the 'possibility' of irreparable harm" if the decreased reimbursement rates established by the SPA were to continue.[10]

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[5] Indeed, the Court found that even language as explicit as , "Such regulations shall…provide for the making of suitable retroactive corrective adjustments" did not bestow blanket authority upon states to promulgate rules retroactively; rather, such language "establish[ed] a procedure for making case-by-case adjustments to reimbursement methods." *Bowen v. Georgetown*, 488 U.S. 204, 209 (1988) discussing. 42 U.S.C. 1395x(v)(1)(A)(ii).
[6] *See* 42 U.S.C. 1302(a), stating, "The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which each is charged under this Act."
[7] "An overpayment must be reported and returned…by the later of— (A) the date which is 60 days after the date on which the overpayment was identified; or (B) the date any corresponding cost report is due, if applicable." 42 U.S.C. 1320a-7k(d).
[8] *Exeter Memorial Hospital Association v. Belshe*, 145 F.3d 1106 (9th Cir. 1998).
[9] *Exeter Memorial Hospital Association v. Belshe*, 943 F.Supp. 1239 (1996).
[10] *Id.*,at 1245.

In sum, NACHC welcomes the increase in transparency and methodological consistency that the proposed rule would bring and is supportive of CMS' commitment to beneficiary access in the face of limited state budgets. However, the proposed rule does not clearly state that the effective date of a SPA that reduced Medicaid service payment rates would not be retroactive. This omission could jeopardize the financial stability of hundreds of FQHCs. As such, NACHC urges CMS to revise the proposed rule to make clear that reductions in Medicaid service payment rates would be effective from the time of final approval by CMS rather than upon submission of the SPA.

The Need for a More Forceful and Clearer Rule

NACHC's broader concern regarding this proposed rule is that it does not appear to go much beyond establishing an information gathering process. It does not provide standards upon which CMS would gauge the adequacy of the state's obligation to assure access to care. It does not establish any uniform reporting system that would allow for comparisons of state practices or state statistics. It should set uniform measures of access for which states must collect data -- the number of participating providers, geographic location and travel time would be relevant considerations. Also, the proposed rule is vague in establishing any form of sanctions that might apply if a state is non-compliant with the statutory requirement.

We also do not agree with CMS' proposal to exempt Medicaid managed care from the purview of a state having to document meaningful access to Medicaid services—since the majority of Medicaid patients are currently enrolled in managed care programs.

In addition to NACHC's earlier statement in the previous section of our comments regarding a state's obligations when it plans to reduce provider payment rates, NACHC is also concerned about the vagueness of that proposal. The proposed rule requires that the state submit an access review whenever its submits a SPA "that would reduce provider payment rates or restructure provider payments" when the changes "could result in access issues" Proposed rule 42 CFR 447.203(b)(3). It is unclear whether the state or CMS would make this determination. If a state has the authority it could, arguably, conclude on its own that its planned reduction in payments would not raise access issues, and therefore it would not be obligated to submit data—which means that CMS could not challenge the state's actions. We believe the rule should be clear that all SPAs that will reduce provider rates—whether by reducing fee schedules or by changing a payment methodology--should require an access review.

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,

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