NATIONAL ASSOCIATION OF Community Health Centers

July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicaid Program; Ensuring Access to Medicaid Services (CMS–2442–P)

The National Association of Community Health Centers (NACHC) is the national membership organization for federally qualified health centers (also known as FQHCs or health centers). Health centers are federally-funded or federally-supported nonprofit, community-directed provider clinics that serve as the health home for over 30 million people, including 1 in 6 Medicaid beneficiaries and over 3 million elderly patients. It is the collective mission and mandate of over 1,400 health centers around the country to provide access to high-quality, cost-effective primary and preventative medical care as well as dental, behavioral health, and pharmacy services and other "enabling" or support services that facilitate access to care to individuals and families located in medically underserved areas, regardless of insurance status or ability to pay.

Health centers serve some of the nation's most vulnerable patients; nearly 70% of health center patients are under 100 percent of the Federal Poverty Level (FPL), and 90% are under 200 percent FPL. Additionally, 80 percent of health center patients are uninsured or publicly insured.[1] Therefore, FQHCs rely on adequate Medicaid payments for services to provide patients access to affordable and timely services. Accessible and affordable health care is critical in maintaining and advancing their health and well-being. NACHC supports this proposed rule, which seeks to enhance transparency and institute further payment protections for healthcare providers.

NACHC welcomes the opportunity to comment on this proposed rule and discuss the anticipated implications of these proposed changes on health centers and the patients they serve. In 2001, Congress created FQHC PPS because of the significant role FQHCs play in serving the Medicaid population. PPS also helps ensure predictability and stability for health centers while protecting other federal investments. The FQHC PPS rate is calculated from the historical costs of providing comprehensive care to Medicaid patients. The mission of the Health Center Program is to reserve federal grant dollars for the uninsured, and to stretch their resources to serve all patients, regardless of their ability to pay. Federal oversight is integral to the continued financial viability and success of health centers. NACHC encourages CMS to adopt our recommendations to protect FQHCs' PPS rate and hold states accountable.

NACHC urges CMS to ensure FQHCs have the same payment protections for prospective payment system (PPS) and Alternative Payment Methodologies (APMs) as other providers

[1] https://www.nachc.org/wp-content/uploads/2023/04/Community-Health-Center-Chartbook-2023-2021UDS.pdf

do for their Medicaid payments. CMS' rationale behind the revised access to care proposals[2] is that payment adequacy is essential to ensuring that services are sufficiently available. The Supreme Court in *Armstrong v. Exceptional Child Center* reinforced that CMS has the primary responsibility to evaluate if states establish payment rates that reflect the cost of services and do not impede a provider's ability to serve their patients.[3] Unlike other Medicaid providers, FQHCs still have a private right of action to sue state governments over noncompliance with Medicaid FQHC PPS payment requirements. States should make a good faith effort to establish and maintain compliant rates to avoid legal conflicts between states and FQHCs.

While FQHCs have statutory payment protections, that does not mean FQHCs are immune to payment adequacy concerns.[4] Last year, 20 states used PPS as the reimbursement methodology for FQHC Medicaid services.[5] Many states have not implemented the basic statutory requirements of the PPS methodology[6] which are essential for PPS to serve as a meaningful cost-related payment methodology. The consequences of states' failure to establish FQHC PPS methodologies as required under the statute have compounded over time. The cumulative impact of nonadherence to the federal PPS requirements has resulted in many states' FQHC PPS rates falling significantly short of the health centers' costs of furnishing services. These problems can stem from various pain points.

A fundamental challenge is that the Benefits Improvement and Protection Act (BIPA) of 2000 required health centers to transition in 2001 from a cost-based retroactive payment to the PPS, which is based on a health center's full amount of reasonable costs in 1999-2000.[7] This law established for existing FQHCs a per-visit baseline payment rate equal to 100 percent of the center's average costs per visit incurred during 1999 and 2000 which were reasonable and related to the cost of furnishing such services.[8] The general formula for establishing a PPS rate was to take the average of the total reasonable costs for 1999/2000 and divide it by the average of the total visits for those years (i.e., total costs / total visits = PPS rate). If the initial rate set for FQHCs was originally too low to cover the costs of services, that results in a continued trajectory of financial instability for the FQHC. Today, health centers are feeling financial strain, hurting their ability to innovate and enhance patient services.

Furthermore, a similar problem could also occur for entities that qualified as an FQHC after FY2000, also known as "new start" FQHCs. Their PPS rate is established differently from health centers that existed before FY2000.[9] When a state is determining the PPS rate of a new health center, federal law requires a state to look to a health center or centers that (1) are in the same or adjacent areas, and (2) possess a similar caseload.[10] As with FQHCs existing at the time of passage of BIPA, new start FQHCs' PPS rates must subsequently be adjusted annually for Medicare

[2] Section II.C
[3] https://www.scotusblog.com/case-files/cases/armstrong-v-exceptional-child-center-inc/
[4] SSA § 1902(bb)
[5] NACHC 2022 PCA Annual Assessment
[6] SSA § 1902(bb)
[7] In December 2000, Congress required states to change their FQHC payment methodology from a retrospective to a prospective payment system ("PPS").
[8] 42 U.S.C. § 1396a(bb)(1)-(5).
[9] SSA § 1902(bb)(4)
[10] SSA § 1902(bb)(4)

Economic Index and to reflect changes in the scope of service. However, if states establish rate-setting methods for new starts that do not comply with these requirements, this could result in new starts potentially receiving rates that are deficient and failing to meet federal law requirements.

Besides payment adequacy for Medicaid PPS, some FQHCs receive an APM payment from their state, which may not always be adequate. According to a 2022 NACHC survey, 10 states have decided to use an APM as the reimbursement methodology for FQHCs instead of PPS.[11] The federal law requires states to (1) employ APM models for FQHCs that, at minimum, meet the current PPS reimburse rate and (2) the FQHC must agree to the new APM rate.[12] Unfortunately, health centers often experience challenges with the state satisfying both requirements. This particularly can occur when states decide to delegate a wraparound payment to MCOs, without putting an APM in the state plan from the beginning. We have heard from FQHCs whose CMS Regional Offices have approved managed care entity contracts containing these wraparound delegations without verifying whether the state had an approved APM. This could lead to FQHCs getting paid less than the Medicaid PPS rate, which goes against federal law and hurts the financial viability of health centers contracting with MCOs.

NACHC urges CMS to require states to monitor the rate adequacy of FQHCs. It is unclear if CMS intends to include PPS under the payment rate transparency requirements[13] outlined in paragraph (b)(1) when it proposes requiring state agencies to publish all "Medicaid fee-for-service payment rates." NACHC understands CMS' perspective that requiring states to disaggregate the components of encounter rates, like PPS, would be challenging and complex. To ensure FQHCs are paid adequately for their services, NACHC requests CMS monitor rates by doing the following:

- **CMS should issue guidance reaffirming the guidance provided in the 2001 Medicaid FQHC PPS Q's and A's[14] and the 2016 SHO letter on FQHC network participation and payment under managed care.[15]** These fundamental pieces of guidance appear to have been removed from the CMS website. By reaffirming these two guidance documents, it will better ensure protections for FQHCs regarding reimbursement as well as network adequacy.

- **CMS should require CMS Regional Offices to review key components of states' FQHC PPS implementation within their region and determine whether existing provisions in the state plan comply with federal law.** Furthermore, they should ensure states implementing regulations do not deviate from the legally compliant state plan and whether the state has delegated to managed care entities the obligation to pay PPS rates without first procuring CMS approval of an APM containing that modification, as required by the 2016 SHO letter. As mentioned previously, NACHC has heard from state Primary Care Associations that some CMS Regional Offices may have approved managed care contracts, including the delegation

[11] NACHC 2022 PCA Annual Assessment
[12] SSA § 1902(bb)(6)
[13] 42 CFR 447.203(b)
[14] https://www.nachc.org/wp-content/uploads/2015/11/PPS-Q-As-2001.pdf
[15] https://www.dhcs.ca.gov/services/Documents/CareCoordination/FQHC_and_RHC_Supplemental_Payment_Requirements.pdf

of the FQHC PPS, without ascertaining first whether the state had obtained approval of an APM.

- **NACHC also recommends CMS clarify that FQHCs are included in protections for payment rate reductions in 42 CFR 477.203(c).** As written, it is unclear whether this provision, which includes heightened requirements "for any State plan amendment that proposes to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access," applies to payment changes relevant to FQHCs.

While it might seem that rate reduction would not be a concern for providers paid on a cost-related basis (through PPS/APMs), states could "restructure" rates in various ways, such as imposing new limits on allowable costs, resulting in an inevitable decrease in rates. Another circumstance could be where states propose to eliminate FQHC APMs focused on supporting patient-centered or comprehensive services (e.g., APMs including capitated payment methodologies) and revert to the PPS methodology (or to a less generous APM). FQHCs need the same protections from payment rate reductions just like other providers, and we urge CMS to include them in this provision.

Preserving and protecting the PPS rate is integral to the continued financial stability of health centers and their ability to provide high-quality, affordable care to all patients, regardless of their ability to pay. By law and mission, no FQHC can restrict how many Medicaid patients it treats if payment is too low. Safeguarding PPS payments will allow health centers to continue serving as a trusted health care hub for their community for years to come.

Thank you for your consideration of these comments. We appreciate CMS' initiative to further strengthen the Medicaid program, increase transparency, and enhance payment protections. NACHC looks forward to continuing to partner with CMS on advancing these Medicaid initiatives. If you have any questions, please contact Vacheria Keys, Director of Policy and Regulatory Affairs, at vkeys@nachc.org.

Sincerely,

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National Association of Community Health Centers