

525 Clinton Street  
Bow, NH 03304  
Voice: 603-228-2830  
Fax: 603-228-2464



61 Elm Street  
Montpelier, VT 05602  
Voice: 802-229-0002  
Fax: 802-223-2336

[www.bistatepca.org](http://www.bistatepca.org)

May 12, 2014

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-9943-IFC  
P.O. Box 8016  
Baltimore, MD 21244-8016

*Submitted via [www.regulations.gov](http://www.regulations.gov)*

**Re: CMS-9943-IFC, Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums**

To Whom It May Concern:

Bi-State Primary Care Association (Bi-State) is pleased to offer our comments regarding the above referenced Interim Final Rule with Comment Period published by the Centers for Medicare & Medicaid Services (“CMS”) on March 19, 2014 (79 Fed. Reg. 15, 240) (“the Interim Final Rule”). Bi-State is a non-profit, two-state organization that represents 15 non-profit Community Health Centers (CHCs) with 39 locations in New Hampshire. Bi-State advocates for access to health care for all New Hampshire citizens, with a special emphasis on medically underserved areas. Bi-State fully endorses the comments made by the National Association of Community Health Centers in its letter dated May 12, 2014.

Bi-State’s is commenting on the Interim Final Rule CMS is promulgating regarding a new regulation in 45 C.F.R. Part 156, which contains the standards for health insurance issuers under the Affordable Care Act. The regulation sets forth specific classes of entities from which qualified health plan (“QHP”) issuers are required to accept premium payments on behalf of enrollees (“third-party premium payments”). In addition, the preamble contains language similar to what has appeared in previous informal guidance, which discouraged QHP issuers from accepting third-party payments of premium and cost sharing provided by “hospitals, other healthcare providers, and other commercial entities.”

We ask CMS to clarify in the Final Rule that health centers are a type of entity from which issuers must accept third-party premium payments. This could be done either by adding health centers to the list of entities in the regulation, or by including preamble language noting that an existing category in the regulation (“State and Federal Government programs”) includes health centers. This change would provide clarification consistent with the purpose of the Interim Final Rule. As explained in more detail below, by statute as well as recent Health Resources and Services Administration/Bureau of Primary Health Care (“HRSA/BPHC”) guidance, health centers have the discretion to spend program income associated with HRSA/BPHC operating grants under Section 330 of the Public Health Service Act for any purpose that furthers the objectives of the Section 330 project. This standard clearly contemplates the use of program income to assist low-income

individuals with insurance premiums in order to facilitate their access to all covered services under an insurance plan.

There are, at present, almost 1,300 health centers with more than 9,300 sites serving more than 22 million patients nationwide. Most of these health centers receive Federal grants under Section 330 of the 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 farm worker 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 serve 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 39 percent of health center patients are Medicaid recipients, approximately 36 percent are uninsured, and approximately 15 percent are privately insured.

We respectfully request CMS clarify the Interim Final Rule’s application to health centers. Thank you for the opportunity to comment on the Interim Final Rule. Please do not hesitate to contact me by telephone at 603-228-2830 extension 112 or by e-mail at [tkuenning@bistatepca.org](mailto:tkuenning@bistatepca.org) if you require any clarification on the comments presented above.

Sincerely,



Tess Stack Kuenning, CNS, MS, RN  
President and CEO, Bi-State Primary Care Association