



April 10, 2019

Representative Lucy Weber, Chairwoman
House Health, Human Services, and Elderly Affairs Committee
Legislative Office Building, Room 205
33 N. State Street
Concord, NH 03301

RE: SB 293-FN relative to the federally qualified health care centers and rural health centers

Dear Chairwoman Weber and members of the Health, Human Services, and Elderly Affairs Committee:

Thank you for the opportunity to speak to you on SB 293, which requires the New Hampshire Department of Health and Human Services to reimburse federally qualified health centers (FQHCs) and rural health centers (RHCs) for services provided to Granite Advantage Health Care Program enrollees whose benefits are suspended due to failure to comply with the work requirement. Bi-State Primary Care Association urges the Committee vote SB 293 “ought to pass.” Since the passage of SB 313 in 2018, Bi-State and our members have grown exceedingly concerned about the unintended consequences of the community engagement requirement and the subsequent administrative rules. As you know, beneficiaries in the Granite Advantage Health Care Program must complete 100 hours of qualifying activities in order to maintain eligibility. If a person fails to meet the 100 hours and fails to cure the deficiency, the beneficiary’s coverage will be suspended.

Bi-State Primary Care Association is a non-profit organization that works to expand access to primary and preventive care for all New Hampshire residents. We also represent New Hampshire’s 15 community health centers, which are located in medically underserved areas throughout our state. Community health centers are non-profit organizations that provide integrated oral health, substance use disorder treatment, behavioral health, and primary care services to over 115,000 patients, most of whom live below 200% of the federal poverty level or \$24,120 for an individual.¹ Community health centers must serve patients regardless of their ability to pay or insurance status. Community health centers serve approximately 18% of the state’s Medicaid enrollees and 24% of the state’s population. Because SB 293 addresses a subset of health centers known as federally qualified health centers and rural health centers, my testimony will predominantly address FQHCs and RHCs.

Twelve of our 15 health centers are FQHCs, and one is an RHC. These health centers are regulated and funded in part by the Health Resources and Services Administration. Federal law dictates the services FQHCs and RHCs must provide; it requires health centers to serve patients regardless of their ability to pay or insurance status; it requires patient-majority boards of directors; and it requires HRSA to conduct a thorough site visit of each health center every three years to ensure the health center is in compliance with federal law and regulations. Federally qualified health centers and RHCs receive limited federal funding to provide comprehensive, culturally competent, high-quality primary care, mental health, substance use disorder treatment, and oral health services. Demand for New Hampshire’s FQHC services is higher than non-FQHCs: In the last five years, FQHCs have seen a 13% increase in the number of patients served and a 20% increase in the number of patient visits. The overall demand at the state’s 15 community health centers has also grown, but less so: there was a 6% increase in the number of patients, and a 12% increase in the number of patient

¹ Health Resources and Services Administration, Uniform Data System, NH Rollup (2017), federally qualified health centers are required to submit patient demographics, services offered and received, clinical data, and payer information to the Health Resources and Services Administration annually; BSPCA Survey of Membership (2018).

visits. As is true across the country, in many communities in New Hampshire, the only primary care provider is an FQHC or an RHC.

Health centers receive their initial federal funding under a New Access Point grant. The health care organization must demonstrate its need and request funding accordingly, but there is a cap of \$650,000. Over the years, HRSA has offered base adjustments, competitive and non-competitive service expansion funding, and the opportunity to open additional sites (New Access Point satellite sites). Generally speaking, with each increase in funding, the health center commits to increasing the number of patients seen. These grants can be reduced if the health center does not achieve its patient targets. It is my understanding that the funds do not increase if a health center's uncompensated care increases due to state policy changes, such as the community engagement requirement included in the Granite Advantage Health Care Program.

An unintended consequence of the drafting of the Granite Advantage Health Care Program and the subsequent administrative rules is how grant funded providers, such as the FQHCs and RHCs, pay for services provided to patients whose Medicaid is suspended (rather than terminated) due to failure to meet the 100-hour community engagement requirement. Medicaid beneficiaries who are suspended remain Medicaid enrollees. Federal law requires that state Medicaid programs reimburse FQHCs and RHCs at 100% of the health center's reasonable costs. Congress was very intentional when it created the Medicaid reimbursement requirements for health centers: It was done "[t]o ensure that Federal [Public Health Service] Act grants funds are not used to subsidize health center or program services to Medicaid beneficiaries."² Meaning, HRSA grant funds for FQHCs and RHCs were not intended to supplant Medicaid. When I discovered the potential conflict between the draft rules and Congress's intent, Bi-State worked closely with the New Hampshire Department of Health and Human Services (DHHS) and HRSA, who both contacted the Centers for Medicare and Medicaid (CMS). Based on conversations with HRSA, and information DHHS received from CMS, it is our current understanding that CMS believes, despite legislative history saying the contrary, that health centers may use HRSA grants to pay for services provided to patients whose Medicaid expansion benefits have been suspended due to failure to comply with the community engagement requirement. Bi-State requested CMS provide official notice of this; and at the time this document was written, we have not been provided with that official notice.

The impact to FQHCs and RHCs of the community engagement requirement and the subsequent administrative rules cannot be understated: More than 40% of health center patients are insured by Medicaid. According to Kris McCracken, the CEO of Manchester Community Health Center (MCHC), nearly 40% of MCHC's revenue is Medicaid reimbursement. If just 10% of MCHC's Medicaid patients do not meet the 100-hour community engagement requirement and are subsequently suspended, MCHC will lose approximately \$350,000 in patient revenue. That figure is more than double MCHC's margin from 2018; it represents 7.5 days in operating cash (approximately 40% of MCHC's available operating cash); and is equal to 75% of one full bi-weekly payroll. In addition, because the original Medicaid reimbursement rates were set based on costs in 1999 and 2000, health centers' Medicaid reimbursement has not kept up with the actual cost of providing services. In 2017, New Hampshire's FQHCs experienced a \$10 million Medicaid shortfall.

While the impact of the community engagement requirement on each health center will vary based on their payer mix, the community engagement requirement will undoubtedly increase all community health centers' uncompensated care. Requiring health centers to use their limited HRSA grant dollars to pay for Medicaid enrollees has multiple implications, including reducing the amount of funding available to serve truly uninsured patients. Like other small, non-profit health care organizations, health centers' revenue includes insurance reimbursement, both public and private, grants, and donations. Any reductions in their insurance reimbursement requires the health centers to use their very limited grant dollars for purposes they were not intended for: Medicaid beneficiaries.

² See H.R. Rep. No. 101-247, at 392-93 (1989).

Further, it is also common for grant funding to include clauses in the contracts relating to supplanting Medicaid. For example, once we raised the concern with the health centers' grants, the substance use disorder treatment providers expressed the same concern as to whether or not they were allowed to use their grants from the Bureau of Drug and Alcohol Services to serve patients whose enrollment in the Granite Advantage has been suspended. To my knowledge, CMS has not addressed this question. We have also raised concerns with DHHS regarding how the "suspension" of a beneficiary affects her ability to enroll in other Medicaid programs, including the family planning benefit. The financial eligibility threshold is higher than the eligibility threshold for Medicaid expansion. If a person's enrollment in the Granite Advantage is suspended, can she then qualify for the family planning benefit? Will this be done automatically?

Lastly, we are also very concerned with the administrative burdens placed on all community health centers as a result of the community engagement requirement. There is a tremendous amount of documentation required by the community engagement requirement, including exemption forms, good cause exemptions, determination of medical frailty, etc. This work distracts clinicians from treating patients because of the added forms the clinicians must complete, and strains administrative and billing staff. Health care providers will be responsible for checking each patient's insurance status before their visit, as they do now. The Department continues to implore health care providers to assist in ensuring no patient loses their insurance benefit as a result of noncompliance with the work requirement, and understandably so. No one wants to see a patient lose valuable health insurance coverage. That being said, community engagement requirement creates an added layer – the health center must now verify whether the patient is in compliance with the work requirement and conduct outreach to each patient to notify them of the community engagement requirement and assist the patient in compliance. We have asked DHHS to allow the health centers and other providers to access this information in "batches," rather than patient by patient. It is our understanding that DHHS is researching whether or not its systems have this ability. To further complicate the situation, the navigator network, designed to assist consumers in enrolling in insurance products including Medicaid, no longer exists in New Hampshire. This is a significant reduction in consumer assistance available to Granite Staters.

In short, we believe that the community health centers should be reimbursed for services provided to Granite Advantage Health Care Program beneficiaries whose coverage has been suspended because Congress never intended health centers' HRSA grants to supplant services provided to Medicaid enrollees, and because of the financial and administrative burden placed on the health centers. Safety-net providers cannot bear the financial burden and the uncertainty of compliance with the community engagement requirement. We respectfully request you recommend SB 293 "ought to pass."

Please do not hesitate to contact me if you have any questions or would like more information.

Sincerely,

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