Centers for Medicare & Medicaid Services (CMS): Request for Information (RFI) 2022

Access for Coverage and Care in Medicaid & Children's Health Insurance Program (CHIP)

Background Information

- Additional information about the RFI is available at https://www.medicaid.gov/medicaid/access-care/index.html
- RFI Qualtrics survey form: https://cmsmedicaidaccessrfi.gov1.qualtrics.com/jfe/form/SV_6EYj9eLS9b74Npk
- Comments are due April 18, 2022

RFI Responses

Contact Information

Respondent Information Tell us about yourself!

- I am an organization.
- Organization Type: Advocacy
- Organization Name: Advocates for Community Health (ACH)
- Email address: apearskelly@advocatesforcommunityhealth.org

Note to Reviewers:

ACH is focusing on responding to questions to Objective 5, questions 1-3, which focus on Access to Services and payment rates in Medicaid and CHIP.

ACH also provides additional comments related to the RFI, specifically for incorporating equity in healthcare. References were listed within the appropriate comment box.

Objective 5 Responses

Objective 5: **Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible.** *Section 1902(a)(30)(A) of the Social Security Act (the "Act") requires that Medicaid state plans "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." Section 1932 of the Act includes additional provisions related to managed care. Section 2101(a) of the Act requires that child health assistance be provided by States "in an effective and efficient manner…." CMS is interested in leveraging existing and new access standards to assure Medicaid and CHIP payments are sufficient to enlist enough providers to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs. CMS also wants to address provider types with historically low participation rates in Medicaid and CHIP programs (e.g., behavioral health, dental, etc.). In addition, CMS is interested in non-financial policies that could help reduce provider burden and promote provider participation.*

1. What are the opportunities for CMS to **align approaches and set minimum standards for payment regulation and compliance** across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care) and across services/benefits to ensure beneficiaries have access to

services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?

ACH appreciates the opportunity to comment on this request for information. We acknowledge that Objectives 3, 4, and 5 all relate to access to services. Our recommendations closely match the recent vision statement[1] for Medicaid and CHIP and the six strategic priorities of CMS.

ACH is a membership organization of forward thinking Federally Qualified Health Centers (FQHCs). To align approaches for payment, CMS must look at who serves the most vulnerable populations. Health centers serve 1 in 11 people in the country[2], however this statistic varies by population and location, particularly after the implementation of the Affordable Care Act (ACA). For example, in 2021, health centers served 1 in 5 Californians, or about 7.2 million patients[3]. However, between 2014-2019, some California regions tripled their number of FQHC patient encounters[4]. A recent report from Capital Link predicted that, based on patient growth trends, FQHCs are on track to serve up to 38.5 million patients in 2025[5]. Of the 28 million patients that health care centers serve annually, more than 80% are uninsured or publicly insured and more than 90% are from low-income communities.

By definition, Federally Qualified Health Centers support community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. Health Centers provide high-quality, comprehensive primary health care, mental health services, preventive care, social services to patients most in need, including but not limited to migrant workers, residents of public housing, and the homeless population.

ACH agrees with the Health Care Payment Learning and Action Network Alternative Payment Model Framework, which states "Reformed payment mechanisms will only be as successful as the delivery system capabilities and innovations they support[6]". Health centers already work with limited budgets yet provide quality care to all patients. Many FQHCs screen patients using the Protocol for Responding to and Assessment Patients' Assets, Risks, and Experiences (PRAPARE[7]) or other similar social determinants of health screening tool. Objective 3 in this RFI asks about whole person care and cultural competency and language preferences, which are essential measures to close health disparities. During many recent CMS Innovation Center webinars, CMS acknowledged that value-based care participation is not equal. Many Innovation Center model participants do not represent areas in need, such as rural areas[8]. FQHCs already exist in these areas, already screen for health equity in one form or another, and thus FQHCs are a great resource to drive value-based care initiatives. However, the downside risk does not attract FQHCs due to the nebulous, dynamic nature of funding.

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[1] https://www.healthaffairs.org/do/10.1377/forefront.20211115.537685/full/
[2] https://bphc.hrsa.gov/about/healthcenterprogram/index.html
[3] https://www.cpca.org/CPCA/CPCA/About/CHC_Data.aspx
[4] https://www.chcf.org/wp-content/uploads/2021/06/RegionalMarketAlmanac2020CrossSiteAnalysisFQHC.pdf
[5] https://www.caplink.org/images/Capital_Investment_Trends_and_Needs_of_FQHCs.pdf
[6] https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf
[7] https://prapare.org/
[8] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1635

To provide continuous behavioral healthcare throughout COVID-19, FQHCs had to adopt new options of care location. Many clinical care innovations, including those in behavioral health, derive from the ability to deliver care virtually. ACH suggests permanent, adequate reimbursement under Medicare and Medicaid for telehealth—including audio-only services, remote patient monitoring, and other tools that enhance patient care. Therefore, we suggest as part of overall policies, especially for value-based care, that CMS provide safe harbor from anti-kickback laws for health centers assisting patients with technology costs.

Furthermore, ACH suggests that Managed Care Organizations work with FQHCs as part of community investments. FQHCs reinvest all funds back into the community. Currently, several dates require MCOs to coordinate with community-based organizations to help with referrals to social services[9]. Many FQHCs provide or partner with organizations to provide social and/or behavioral support, and thus provide an opportunity to advance addressing social determinants of health.

In Summary, we recommend the following:

1. Integrate health equity into Medicaid payment for health centers, particularly for providing culturally and linguistically competent care to patients.
2. Encourage use of health equity screening tools.
3. Incentivize but do not penalize FQHCs for value-based care efforts and models – meet the providers (and patients) based on their current capacity.
4. Consider mental health integration as part of payment and incentives.
5. Provide access to and reimburse use of telehealth and remote monitoring.
6. Promote Managed Care Organizations to work with FQHCs as part of community investments.

2. How can CMS **assess the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access** and encourage payment policies and contracting arrangements that could have a positive impact on access within or across state geographic regions?

   ACH believes that FQHCs establishing value-based care arrangements should be focused on the needs of their service area, including clinical care and services to address the non-clinical drivers of health. The HHS 2022 Equity Action Plan provides two key features that can help assess the effect of policies and arrangements:
   - Health Equity Assessments
   - Grants

Health equity assessments should understand the landscape of the patient population as well as the healthcare workforce. The ability to recruit, train, and retain health center staff is challenging, particularly with the known burnout exacerbated by COVID-19. The health assessments are critical to seeing the effects of Medicaid & CHIP coverage and what arrangements have a positive impact to the community. However, FQHCs need flexibility for how to implement funding in order to fulfill the needs of the population. These health equity assessments further can help states outline their Medicaid plans and Managed Care Organizations services and priorities.

[9] https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

What is not as clear in the equity action plan is how to address the healthcare workforce within HHS. FQHCs provide an important extension to many hospital-based training programs for both specialty care and primary care providers. CMS can partner with graduate medical education, and CMS can assess if care improves in an area if more training opportunities become available.

In Summary, we recommend the following:

1. Work with FQHCs as part of the agency's action plan for Health Equity Assessments
2. Prioritize flexible funding and grants that support technical assistance to states to establish, expand, or improve capacity building around closing health equity gaps.
3. Integrate FQHCs more fully in graduate medical education.

3. Medicare payment rates are readily available for states and CMS to compare to Medicaid payment rates, but fee-for-service Medicare rates do not typically include many services available to some Medicaid and CHIP beneficiaries, including, but not limited to, most dental care, long-term nursing home care, and home and community-based services (HCBS). What data sources, methods, or benchmarks might CMS consider to **assess the sufficiency of rates for services which are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare?**

Many ACH members have successfully partnered with community-based organizations (CBOs) during COVID-19; these networks should be supported and sustained. Therefore, the issue is not necessarily about sufficient rates for services not covered by Medicare, but rather support for technical assistance. Most Medicaid patients are in Managed Care Organizations (MCOs). ACH suggests that CMS works with HRSA so that community-based organization partnerships can be made an allowable expense under 330 grant funding. Medicaid can also clarify that Medicaid MCOs can contract with FQHCs to serve a similar community hub role.

The new ACO REACH model's health equity adjustment is one way to consider health equity benchmarking. For health equity measures, the Model is considering rurality, income, race/ethnicity, dual-eligibility, language, disability, and other factors[10]. ACH agrees that benchmarks should consider both dual-eligible status and social/geographic factors. With this approach, individual factors are used for benchmark adjustment, and CMS is able to review and distribute health services and funding to areas in need. However, the payment should consider what may not be considered in the payments. Social needs and upstream approaches usually are not factored into payment rates.

In Summary, we recommend the following:

1. Incentivize the development of FQHCs as community hubs with formal relationships with community-based organizations most able to address the social determinants of health.
2. Consider benchmarks that adjust for dual-eligible beneficiaries and local factors that also consider the dynamic nature of an organization's underlying patient population and need to factor for social investments.

Additional Feedback

Using **this text box**, please provide any additional feedback you have for this Request for Information that does not apply to one of the previous questions.

[10] https://innovation.cms.gov/media/document/aco-reach-health-equity-slides

ACH applauds CMS for soliciting recommendations for access of care in Medicaid and CHIP and looks forward to partnering with CMS around this and other topics. ACH has subject matter experts in policy, 340B, FQHC and health center operations, and value-based care arrangements. ACH also closely works with the Association of the Clinicians for the Underserved (ACU).

ACH suggests that Health Centers be designated as community transformation hubs to achieve health equity. These hubs shall address areas including but not limited to access to transportation, food security, education access and quality, health literacy, neighborhood safety, systemic racism, economic security, and the built environment. Activities include assessing the social determinants of health for a Health Center's patient population, partnering with community-based organizations, and receiving technical assistance to plan, develop, and operate health center health equity hubs. Coordination between CMS, HRSA, and HHS is imperative. We strongly encourage the creation of an FQHC task force and that the FQHC perspective be involved for policy decisions, particularly in understanding healthcare beyond physical health.
The current administration released agency equity action plans on April 14, 2022. ACH appreciates the Department of Health and Human Services to encourage communities of color to receive free and low-cost health care, particularly to address the maternal mortality concerns[11]. ACH supports to extend postpartum Medicaid coverage and appreciates the call to action in the HHS Equity Plan[12].

In summary, we recommend the following:

1. Place health equity at the forefront of policy
2. Create a FQHC task force to hear the perspective from those that serve the nation's most vulnerable populations
3. Partner with FQHCs
4. Extend postpartum coverage in Medicaid

We are happy to provide more information if desired.

[11] https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/14/fact-sheet-biden-harris-administration-releases-agency-equity-action-plans-to-advance-equity-and-racial-justice-across-the-federal-government/
[12] https://www.hhs.gov/sites/default/files/hhs-equity-action-plan.pdf