ADVOCATES FOR COMMUNITY HEALTH

January 13, 2023

The Honorable Bill Cassidy
520 Hart Senate Office Building
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The Honorable Ton Carper
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The Honorable Tim Scott
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The Honorable Mark Warner
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RE: Request for Information: Ways to Improve Coverage for Dually Eligible Enrollees
Response submitted electronically to dualeligibles@cassidy.senate.gov

To Whom It May Concern:

Advocates for Community Health (ACH) is comprised of leading federally qualified health centers (FQHCs) focused on health equity and innovation to drive health care systems, policies, and health programs. Our members serve over 2.3 million people and provide high-quality, comprehensive primary health care, mental health services, preventive care, and social services to patients most in need, especially during the COVID-19 Public Health Emergency (PHE).

FQHCs are required to provide all services to everyone, regardless of ability to pay, and we reinvest 100% of profits back into patient care. According to the 2021 Uniform Data System (UDS) Statistics[1], health centers serve over 30 million patients, of which 1 in 3 patients live in poverty, and about 30% of patients are children under 18 years of age. Additionally, health centers have played a key role during the PHE by increasing access to care, including virtually, and collaborating with communities to increase access to COVID-19 education, testing, and vaccinations for the most underserved areas.

This request for information focuses on three principles: (1) diversity of needs of the dual eligibles population; (2) range of states' capabilities in supporting the care of duals; and (3) financial incentives that drive health systems' behaviors on outcomes and efficiency. On behalf of the 30 million Americans that use community health centers, we provide the following comments to help Congress understand the dual eligible population from the perspective of our safety net providers:

1. **How would you separately define integrated care, care coordination, and aligned enrollment in the context of care for dually eligible beneficiaries? How are these terms similar and how are they different?**

   It is well known that dual-eligible Medicare and Medicaid patients are often high cost and high need. A recent study looking at 2012 to 2018 Medicare claims shows that duals who used FQHCs

[1] https://data.hrsa.gov/tools/data-reporting/program-data/national

had significantly less hospital care for all duals and fewer emergency department visits in rural areas if FQHCs served as the patient's primary care site after the implementation of the Medicare Prospective Payment System.[2]

However, since the dually eligible tend to have various complex conditions, it is difficult to separately define integrated care and care coordination. Duals require more care coordination to address multiple medical and social needs. Additionally, going to FQHCs varies by subpopulations for dual eligibles[3].

Nevertheless, all patients, especially duals, deserve person-centered, culturally, and linguistically competent care. FQHCs excel at providing such care to all patients. Additionally, many FQHCs already screen for social determinants of health (SDOH). FQHCs promote health equity and treat the person, not the disease. We urge Congress to work with CMS on how Medicaid and Medicare can best align and improve care for dually eligibles.

2. **What are the shortcomings of the current system of care for dual eligibles? What specific policy recommendations do you have to improve coordination and integration between the Medicare and Medicaid programs?**

Currently, FQHCs face workforce challenges like the rest of the healthcare system. This directly effects patient care, especially for duals who tend to need the most care. However, we've heard anecdotally from members that despite funding challenges, FQHCs are left to "figure it out".

Furthermore, as the baby boomer generation ages, the duals population is increasing. Our centers also struggle with the complexities of operationalizing both value-based care and fee-for-service care. Centers face multiple quality metrics and data from multiple sources and payers, all while the Public Health Emergency unwinds. Akin to our proposals in our recent *Health Affairs* article[4] and as centered through our policies and principles, we recommend the following to improve coordination and integration between the Medicare and Medicaid programs:

- FQHCs would benefit from flexible spending and upfront investments, particularly to address infrastructure challenges, combat inflation, and address health equity.
    - As you know, COVID-19 dollars must be spent and accounted for by Q1 2023
    - Temporary COVID funding accounted for 2% to almost 18% of our members' overall budgets, and the most common use for this funding was for workforce investments
    - Many centers serve as health hubs and integrate behavioral health into primary care, and upfront investments can train providers to promote culturally and linguistically competent care

[2] Wright B, Akiyama J, Potter AJ, et al. Health center use and hospital-based care among individuals dually enrolled in Medicare and Medicaid, 2012-2018. Health Serv Res. 2022;57(5):1045-1057. doi:10.1111/1475-6773.13946.
[3] Wright B, Akiyama J, Potter AJ, et al. Characterizing the Uptake of Newly Opened Health Centers by Individuals Dually Enrolled in Medicare and Medicaid. J Ambul Care Manage. 2023;46(1):2-11. doi:10.1097/JAC.0000000000000440.
[4] "By Mission And Definition, Community Health Centers Already Perform Value-Based Care", Health Affairs Forefront, October 4, 2022. doi: 10.1377/forefront.20220930.708414.

- FQHCs require access to data across payers in a timely, digestible manner
    - Having data is one issue; accurate and usable data is the main issue
    - Funding is required for technological and analytical infrastructure, especially for telehealth integration and claims software

- Consider specific flexibilities for FQHCs
    - Permanently allow FQHCs to address behavioral health and medical interventions in their communities by supporting telehealth (audio-visual as well as audio only formats), group setting services, and mobile crisis units. These interventions can help dual eligible patients remain out of the hospital.
    - CMS should explicitly extend new coverage flexibilities to FQHCs in rulemaking whenever possible; for example, when Medicare gains the ability to reimburse or extends flexibilities to a new type of provider, that provider should be able to receive these benefits if they work in an FQHC.

- Expand eligibility and fund the health community-based and behavioral health workforce. These providers help address chronic disease management, integrate behavioral health into primary care, and advance a patient's health literacy and confidence to be an active part in their own care
    - Congress should provide funding – through direct reimbursement or funding through value-based care models – for behavioral health paraprofessionals (e.g., peer support specialists, support staff, bachelor-level social workers) through Medicare and Medicaid, creating additional capacity for those needing treatment while also enabling clinicians to work at top of their licenses.
    - Community Health Workers (CHWs) often assist patients in addressing their SDOH, often a complex issue for dual eligibles. CHWs to save thousands in health care costs per year. A randomized controlled trial showed that CHWs have a $2.47:1 return on investment for the Medicaid program.[5]

- Protect 340B for FQHCs
    - Health center use and engagement in the 340B program exemplifies the intent behind its creation: to maximize federal investment and expand care to underserved communities as effectively as possible.
    - Unfortunately, the 340B program is at risk. The 340B program is not currently working as it should for FQHCs, given states' actions to carve out 340B from Medicaid patients, and pharmaceutical companies refusing to honor discounts at contract pharmacies. This directly affects patient care, especially for those in need.
    - Congress should set a minimum Medicaid reimbursement for all entities of at least the Wholesale Acquisition Cost (WAC) plus dispensing fees.
    - Similarly, Congress should prevent discrimination against 340B entities by PBMs and other actors seeking to reduce reimbursement. These actions undermine the intent of the 340B program.
    - Finally, Congress should permit entities that commit to accountability standards the ability to maintain contract pharmacy arrangements.

[5] Kangovi S et al. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. Health Affairs Vol. 39, No. 2, Feb 2020. doi:10.1377/hlthaff.2019.00981.

- Promote proper reimbursement to providers
    - Unfortunately, Medicaid often reimburses less than Medicare. As one suggestion, CMS could expand California's policies and consider not subjecting primary care practices, providers, and FQHCs to an MLR.
    - Investment should be focused on primary care. A center could be doing well and one sick infant assigned to a center at the end of a calendar year can destroy their MLR.

3. **In your view, which models have worked particularly well at integrating care for dual eligibles, whether on the state level, federal level, or both? Please provide data, such as comparative analyses, including details on outcome measures and control group definitions, to support your response. (Examples of models include but are not limited to: Fully Integrated Dual Eligible Special Needs Plans, Highly Integrated Dual Eligible Special Needs Plans, Financial Alignment Initiative demonstrations, or States that have taken steps to better align the Medicaid and Medicare programs).**

   ACH advocates for dual-eligible, Medicaid patients, and safety-net providers to be part of value-based care. Additionally, we point out the coordination of care available through Program of All-Inclusive Care for the Elderly (PACE). PACE provides comprehensive medical and social services for complex dual eligible who wish to live safely at home. Services include primary care, dentistry, home care, nutritional counseling, social services, transportation, and more.

   However, PACE is not for all. Different models work for different populations. PACE often helps elderly, frail patients needing hospice and wrap around services, which often include family counseling and support. PACE allows these complex patients to receive longer visits to coordinate care. However, there are regulatory and cost barriers. These duals may choose a Medicare Advantage plan. Additionally, although PACE may provide comprehensive care, patients are not enrolled since families would have to give up In-Home Supportive Services (IHSS) payments. Additionally, while Medicare is federally regulated, Medicaid policies vary by state.

   Therefore, we recommend dedicated funding to Health Resources and Services Administration (HRSA) or the Department of Health and Human Services in general to help FQHCs service seniors and the aging population, especially this dual population.

   Secondly, we recommend coordination and funding across agencies to foster a sustainable model of delivery of care. To address social needs and food insecurity, we suggest funding from the United States Department of Agriculture (USDA). FQHCs often compete with food banks or food insecurity is considered out of scope for their center. As social needs increase, healthcare gets pushed down a family's priority due to basic human needs.

4. **After reviewing these models, would you recommend building upon current systems in place (e.g. improving aligned enrollment and/or coordination of care between two separate Medicare and Medicaid plans) or starting from scratch with a new, unified system that effectively assigns each beneficiary to a primary payor based on their needs?**

   While ACH does not have a recommendation, we strive for coordination and streamlining when

possible. We appreciate any policies that automatically enroll patients into care and allow continued coverage. ACH agrees with the Medicaid and CHIP Payment and Access Commission (MACPAC), who mention in their response to this RFI the need for state flexibilities, that states have competing priorities, and that states also face workforce concerns[6].

5. **If you believe a new unified system is necessary, what are key improvements we should prioritize? What would such a system look like? Please provide details on financing, administration (e.g. federal government vs. state government), benefit design elements, on whether such a system should be voluntary or mandatory for states, and consumer choice and patient safety protections.**

   If a new unified system is necessary, we ask that Congress consider FQHCs in any planning committees and stakeholder calls. As noted, before, often FQHCs are excluded from regulations, which delays care to these important centers. Safety net providers also require flexibilities for primary care.

6. **How can disruption be minimized for current beneficiaries should any changes to the current system of coverage be made?**

   FQHC staff and patients require explicit guidance. The current PHE is a prime example. We understand that eligibility renewal concerns are not unique to the PHE. For example, ineligibility may result due to a change in a patient's income. Nevertheless, even with pre-PHE data, continuous enrollment is beneficial for children and non-elderly adults, the very populations who benefit from Medicaid but whose eligibility may vary over time.[7] Up to 14.2 million people may lose coverage during the unwinding of the PHE.[8] Although toolkits and resources are available, our health centers and the entire health system continue to face workforce issues, supply chain disruptions, inflation concerns, and increasing cases and burden of COVID-19 patients, which is affecting the unwinding process. The current PHE and its flexibilities significantly help deliver high-quality care, and without specific guidance for FQHCs, insurance coverage is only one of many issues faced by our centers.

   Therefore, any streamlining flexibilities or automatic enrollment for any duals-focused programs are needed. We agree with MACPAC's strong recommendation to streamline enrollment for the Medicare Savings Programs (MSP) and dual eligible special needs plans (D-SNPs), such as income verification requirements[9].

~~8.~~ **What is the best way to ensure that this system takes into account the diversity of the dually eligible population and is sufficiently targeted to ensure improved outcomes across each sub-group of beneficiaries? How should these sub-groups be defined and how should the**

[6] https://www.macpac.gov/wp-content/uploads/2022/12/12_Congressional-Request-for-Information.pdf
[7] https://www.kff.org/medicaid/issue-brief/unwinding-the-phe-what-we-can-learn-from-pre-pandemic-enrollment-patterns/
[8] https://www.kff.org/medicaid/issue-brief/fiscal-and-enrollment-implications-of-medicaid-continuous-coverage-requirement-during-and-after-the-phe-ends
[9] https://www.macpac.gov/wp-content/uploads/2022/11/Request-for-information-Make-your-voice-heardPromoting-efficiency-and-equity-within-CMS-programsFINAL.pdf

data be disaggregated? Please provide examples of methodology and the evidence-based rationale for each example.

FQHCs already screen and gather data on social determinants of health for patients. Health equity is at the center of all we do. ACH supports collecting and reporting race and ethnicity data as well as other statuses such as disability and sex/gender. We support Congress funding and reimbursing providers for collecting this data. Additionally, this information on race, ethnicity, sexual orientation, gender identity, and disability status should be collected for the workforce to see representation and diversity for who serves our patients.

11. **How does geography play a role in dual coverage? Are there certain coverage and care management strategies that are more effective in urban areas as compared to rural areas?**

    FQHCs know their community best. Therefore, we ask for flexibilities to serve our communities how they need it. For example, some populations and geographies benefit from telecommunication and remote monitoring, mobile units, or home visits.

    This includes allowing a new patient to receive a first visit via telehealth. Additionally, if regulations require an individual to be physically located within a health center's service area, this exacerbates disparities by preventing patients from accessing services via telehealth from the FQHC provider who is positioned and structured to best meet their needs. Meanwhile, patients with private insurance have numerous options for telehealth. Addressing transportation needs can also help care coordination across different geographic areas.

We appreciate your support and the opportunity to provide insight into community health centers' role in providing comprehensive health care to Americans and the dual eligible population. We look forward to working with Congress on this important issue.

For more information, please contact me at apearskelly@advocatesforcommunityhealth.org.

Sincerely,

Amanda Kelly
Chief Executive Officer
Advocates for Community Health