ADVOCATES FOR COMMUNITY HEALTH

November 04, 2022

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Administrator
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Department of Health and Human Services
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RE: Request for Information: Make Your Voice Heard
Sent via electronic transmission at https://www.cms.gov/request-information-make-your-voice-heard.
Responses are listed in blue and were limited to 5000 characters for each topic.

Tell Us About Yourself

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Individual/Organization Type: Organization
Organization Name: Advocates for Community Health

Request for Information Topics

TOPIC 1: Accessing Healthcare and Related Challenges

CMS wants to empower all individuals to efficiently navigate the healthcare system and access comprehensive healthcare. We are interested in receiving public comment on personal perspectives and experiences, including narrative anecdotes, describing challenges individuals currently face in understanding, choosing, accessing, paying for, or utilizing healthcare services (including medication) across CMS programs.

Examples may include, but are not limited to:

- Challenges accessing comprehensive and timely healthcare services and medication, including primary care, long-term care, home and community-based services, mental health and substance use disorder services;
- Challenges in accessing care in underserved areas, including rural areas;
- Receiving culturally and linguistically appropriate care (e.g., tailoring services to an individual's culture and language preferences);
- Challenges with health plan enrollment;
- Challenges of accessing reproductive health services;
- Challenges of accessing maternal health services;
- Challenges of accessing oral health services and the impact on overall health;
- Understanding coverage options, and/or technology to support access to coverage; and,
- Perspectives on how CMS can better communicate quality standards and accessibility information to individuals, particularly those with social risk factors.

ACH Response:

As background, 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. We have 26 members in 11 states and Puerto Rico and represent over 21,000 full time employees.

As we state in our recent Health Affairs Article, By mission and definition, community health centers already perform value-based care. 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 Statistics, 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.

Health Equity is at the forefront of all our principles and priorities. Therefore, these topics, while important, are cross-cutting.

The most pressing issue for healthcare access currently is the Public Health Emergency (PHE). In preparing for the expiration of the PHE, states are focusing on unwinding efforts to ensure health insurance coverage for patients (Topic 4).

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. Up to 14.2 million people may lose coverage during the unwinding of the PHE. Although toolkits and resources are available, our health centers and 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.

Additionally, we would be remiss if we did not mention medication accessibility and the 340B program. In today's health care environment, FQHCs depend on the 340B program to meet their mission to care for their patients, putting every dollar received back into the communities they are serving. Numerous external evaluators have found that payer reimbursement rates consistently fail to cover the cost of the comprehensive services provided in the community health center environment. In fact, when Congress created the 340B program in 1992, they recognized this reality – that the 340B drug pricing program would allow these providers to "stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." By allowing the purchase of drugs at a discounted price, the 340B program enables health centers to serve more patients, at a higher level of complexity, than they otherwise could. Effectively, 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.

- Recommendations for how CMS can address these challenges through our policies and programs.

ACH Response:

ACH recommends the following:

- Medicaid continuous enrollment and Medicaid waivers flexibilities (Cross-cutting with Topic 4)

  For example, the new Oregon waiver allows continuous Medicaid coverage until the age of six. As CMS describes, additionally, Individuals older than six will be able to keep their coverage for up to two years, even if their household income fluctuates.

- Provide a parity principle and apply the same regulations of primary care to FQHCs

  Often in regulations, FQHCs are not included for certain flexibilities. FQHC flexibilities often lag 2-3 years despite the fact we provide the same primary care services as other sites. We recommend CMS consider FQHCs when establishing regulations, working with Medicare Administrative Contractors (MACs), and finalizing Change Requests (CRs). Additionally, FQHCs may need distinct codes for tracking purposes, such as for Remote Patient Monitoring, which can improve access to care for patients.

  The most notable and recent example includes the latest CY 2023 Physician Fee Schedule Final Rule (CMS-1770-F). FQHCs were not included in the proposal for changes to the level of supervision for "incident to" behavioral health services for Licensed Professional Counselors, Licensed Marriage and Family Therapists. As such, CMS must rely on further rulemaking to change regulations for FQHCs and rural health centers. This greatly affects access to care for our patients. As UDS data shows, health centers are experiencing an increase of 138,000 patients seeking behavioral health services (as in mental health and substance use disorder services). 54% and 31% of virtual visits were mental health and substance use disorder related, respectively. While we understand the legal and logical outgrowth issues involved in rule making, we recommend CMS work with ACH so that our patients are included in priority healthcare decisions and regulations.

- Explicit guidance for FQHCs for patient care and unwinding efforts (Cross-cutting with Topic 4)

  ACH appreciates the numerous fact sheets, resources, and efforts to mitigate unwinding. We researched the regulations and guidance, but we require more clarity. Therefore, ACH asks for guidance on the following questions:
  - Will CMS permit states to claw back Medicaid funds that have already been paid to health centers? For example, in the case of a beneficiary who is determined to be ineligible for benefits and has been for six months, are states permitted to recoup reimbursement for those six months?
  - Can states use presumptive eligibility for populations beyond those specifically named in statute to help with beneficiaries that come back into the program after being found ineligible? If they are interested in doing so would this be through waiver or state plan amendments?

- CMS should clarify that states are not permitted to mandate that Medicaid Managed Care Organizations (MCOs) reimburse for 340B drugs at actual acquisition cost or force providers to carve out.

  While CMS has not indicated that MCOs must reimburse actual acquisition cost, more states are moving in that direction and/or MCOs are including it as a condition of contracting. 340B savings are an essential part of value-based contracting between FQHCs and MCOs and should not be undermined. In order to preserve the essential savings provided by the 340B program, CMS and the Health Resources and Services Administration (HRSA) must protect FQHCs against actual acquisition cost and/or forced carve-out policies within Medicaid managed care arrangements.

- The Centers for Medicare & Medicaid Services (CMS) should exempt FQHCs from the actual acquisition cost fee for service Medicaid reimbursement methodology and instill additional guardrails to forced "carve-out" policies.

  Requiring states to pay actual acquisition cost for 340B drugs defies the intent and proven impact of the program. It also limits FQHCs' ability to participate and succeed in value-based care. Therefore, CMS should update its 2016 outpatient drug rule to clarify that states are permitted to reimburse above actual acquisition cost under fee for service Medicaid for drugs purchased under the 340B program at FQHCs and provide a federal floor that supersedes state policy.

- Please see our recommendations under Topic 2 where we suggest ways to recruit and retain a diverse healthcare workforce who can provide culturally and linguistically appropriate care.

- Please see our recommendations under Topic 3 where we recommend specific ways to advance health equity through our community health centers.

- Lastly, please see our recommendations under Topic 4 where our members specifically name ways to improve access to care to our patients.

TOPIC 2: Understanding Provider Experiences

CMS wants to better understand the factors impacting provider well-being and learn more about the distribution of the healthcare workforce. We are particularly interested in understanding the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, documentation and reporting requirements, operations, or communications on provider well-being and retention.
Examples may include, but are not limited to:

- Key factors that impact provider well-being and experiences of strained healthcare workers (e.g., compassion fatigue, retention, maldistribution);
- The increasing use of digital health technology on provider well-being and attrition;

- Feedback regarding compliance with payment policies and quality programs, such as provider enrollment requirements on healthcare worker participation in underserved populations, and what improvements can be made;
- Impact of CMS policies on patient panel selection, and on providers' ability to serve various populations; and
- Factors that influence providers' willingness or ability to serve certain populations, particularly those that are underserved and individuals dually eligible for Medicare and Medicaid.

ACH Response:

ACH provides specific policy recommendations and rationale below and in other sections of this RFI. Compassion fatigue, healthcare workforce retention, and workforce burden are well documented. Therefore, ACH focuses on possible solutions. We urge CMS to work with ACH on any next steps.

- Recommendations for CMS policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations

ACH Response:

ACH provides the following recommendations to support provider well-being and increase provider willingness to serve certain populations:

1. Integrate principles from the National Academy of Medicine's (NAM) October 2022 National Plan for Health Workforce Well-Being

   Many of ACH's workforce policy principles align with NAM's workforce plan. We support their recommendations that promote health workforce well-being, reduce stigma, and educate the public on the importance of health professional's mental health. This includes supporting the education and workforce of mental health professionals that directly work with the healthcare team. Additionally, as the national plan recommends, CMS should "ensure health workers do not experience unnecessary punitive actions when seeking mental health services."

2. Address health care workforce burnout and build resilience.

   Due to the ongoing demands of the COVID-19 pandemic as well as the constantly shifting needs of a highly complex patient population, providers are suffering mental health effects. Community health centers must have the resources to support them. Therefore, we recommend funding for evidence-based interventions at community health centers to ensure that providers are connected to behavioral health resources and peer support. This includes reducing stigma of mental health for healthcare staff and promoting public awareness.

3. Include FQHCs for convening bodies and task force so that our workforce needs are heard and incorporated into proposed solutions and interventions.

4. Reduce barriers to provider loan forgiveness.

   FQHCs are understaffed, yet loan forgiveness programs are not fully utilized. Reducing barriers to participation or streamlining the program could have significant impact, particularly. ACH recommends HHS provides guaranteed loan forgiveness eligibility for providers working in FQHCs, and/or provide allotments to FQHCs through 330 grants for clinicians and other eligible staff. The Medicare Graduate Medical Education program should ensure FQHCs are explicitly included. Additionally, mental health providers and nurses who serve FQHCs should be included in loan forgiveness programs and other incentive initiatives.

5. Along with Health Resources and Services Administration (HRSA), CMS should prioritize workforce diversity through data, evaluation, and funding.

   Despite strong evidence that representative workforce improves health outcomes, HRSA does not collect data, nor evaluate health centers, on the diversity of their workforce. As part of annual reviews, HRSA should require FQHCs to submit data on race, ethnicity, sexual orientation, gender identity, and disability status of their workforce. As of 2021,according to UDS data, 48% of patients at FQHCs had Medicaid and 10% of patients have Medicare or are dually eligible. Therefore, **about 18 million Americans use CMS insurance coverage at FQHCs**. Over time, HRSA should incorporate these measures into formal evaluation criteria and establish a pool of funding to ensure that centers are able to recruit and hire diverse staff.

6. Improve and expand the workforce pipeline for FQHCs.

   FQHCs often struggle to find qualified staff for a range of positions, which impacts their ability to grow and innovate. Therefore, we recommend increasing funding for top programs at the Department of Labor and Department of Education that support FQHC workforce development, including community college partnerships and apprenticeship programs. This also includes CMS reimbursing for Community Health Worker (CHW) services as a frontline public health worker who is a trusted member of both the community and care team and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery (American Public Health Association CHW definition).

7. Work with HRSA for workforce priorities

   FQHCs often struggle to support leadership development among providers in all areas of patient care. While Medicare and Medicaid provide primary care to millions of Americans, HRSA should develop standardized leadership training to encourage and facilitate career ladder mobility within health centers.

8. Streamline documentation to reduce healthcare team burden, as promoted by the Patients over Paperwork Initiative

TOPIC 3: Advancing Health Equity

CMS wants to further advance health equity across our programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities. We want to better understand individual and community-level burdens, health-related social needs (such as food insecurity and inadequate or unstable housing), and recommended strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.
Examples may include, but are not limited to:

- Identifying CMS policies that can be used to advance health equity:
    - Recommendations for CMS focus areas to address health disparities and advance health equity, particularly policy and program requirements that may impose challenges to the individuals CMS serves and those who assist with delivering healthcare services;
    - Recommendations on how CMS can better promote and support accommodations, including those from providers and health plans, for people with disabilities and/or language needs or preferences;
    - Input on how CMS might encourage mitigating potential bias in technologies or clinical tools that rely on algorithms, and how to determine that the necessary steps have been taken to mitigate bias. For example, input on how we might mitigate potential bias with clinical tools that have included race and ethnicity, sex/gender, or other relevant factors. Further, input on potential policies to prevent and/or mitigate potential bias in technology, treatments or clinical tools that rely on clinical algorithms.
    - Input on how CMS coverage and payment policies impact providers, suppliers, and patients, especially in the treatment of chronic conditions and the delivery of substance use disorder and mental healthcare, including individuals who are dually eligible for Medicare and Medicaid; and
    - Feedback on enrollment and eligibility processes, including experiences with enrollment and opportunities to communicate with eligible but unenrolled populations.

ACH Response**:**

As the 2021 Uniform Data System demonstrates, FQHCs deliver equitable care. For example, 63% of patients identify as racial/ethnic minority, 96% of health centers served patients who identified as transgender. Additionally, health centers have vaccinated over 14.6 million Americans, 66% of whom were racial and ethnic minority patients. In fact, 74% health centers screen for social risk factors, which is priority to CMS and the Innovation Center.

Please see below for our recommendations and rationale for policies that can promote health equity.

- Understanding the effects on underserved and underrepresented populations when community providers leave the community or are removed from participation with CMS programs

ACH Response**:**

As FQHCs, we serve patients regardless of their ability to pay. Therefore, we urge CMS to understand approaches that impact the ability of providers to participate in Advanced Alternative Payment Models. Often, Accountable Care Organizations benefit large hospital systems. We must keep in mind that not all FQHCs are ready for downside risk. Therefore, explicit guidance on policies can help centers decide if they can participate.

Beneficiary alignment and attribution defines the population for which we are held accountable. Therefore, we appreciate public facing payment and beneficiary attribution methodology papers, which help our centers review the policies of each model. Transparency allows centers to understand attribution and total cost of care calculations.

For providers, each model has different flexibilities. Practices need explicit guidance for how providers come into play. We hear from our centers how FQHCs are stuck between a Value-Based Care world and Fee-For-Service world, yet our centers are subject to multiple regulations and different quality measures across payers. What is financially sustainable for the system (CMS) may not be sustainable for our centers. Therefore, our centers unfortunately are stuck in a loop of focusing on sickness instead of investing in wellness.

We highlight two examples of the additional burdens to our centers:

First, we often see private practices cherry pick their patients, and FQHCs are "stuck" with the most vulnerable patients, particularly individuals with substance use disorders. We see many times that one of our FQHCs will meet their medical loss ratio (MLR). However, on December 27, two very sick newborns will be attributed to an FQHC, which affects the MLR. Any savings and profits generated directly go back into patient care. Therefore, without reinvesting patient care, FQHCs cannot continue to provide comprehensive care that often integrates behavioral health. These additional burdens can dissuade FQHCs from participating in CMS programs.

Second, CMS must understand how climate change affects our centers. Dr. Parinda Khatri, an ACH member from Tennessee's Cherokee Health Systems, testified in September for the Hearing on Preparing America's Health Care Infrastructure for the Climate Crisis. She described how her pediatric center had to close for 10 days due to a breakdown of the air-conditioning system. The current systems could not handle 6 months of temperatures greater than 90 degrees, a scenario quickly becoming a reality due to climate change.

- Recommendations for how CMS can promote efficiency and advance health equity through our policies and programs.

ACH Response**:**

As we lay out in our Health Affairs article and expand here, we recommend the following areas where CMS can address health disparities:

1. Promote culturally and linguistically competent care, particularly through training for providers and increasing the health literacy of patients.

ACH provides recommendations under Topic 2 where we advocate for a diverse workforce and training through data, funding, and education.

2. Make patient and claims data accessible and understandable in a timely manner.

   FQHCs need data from all payers, including Medicaid Managed Care Organizations, in a timely, digestible manner, especially for quality reporting requirements. Depending on a health center's capacity, sometimes our internal data analytics is more powerful because data is more real-time. However, our data analytics is highly dependent on having an internal data team of several subject matter experts. Having the right staff and ongoing resources to support this part of the team can be a barrier for FQHCs to participate in alternative payment models.

   Like other practices, FQHCs struggle with data inaccuracy barriers like those experienced by other health systems, including data lag, internal inconsistency, lack of a master patient index, the need to match claims and data from various sources and managed care organizations. These errors affect reporting requirements and possibly payments. Additionally, data is inconsistent in measuring race/ethnicity, sex/gender, and disability status, to name a few.

3. 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.

4. Provide transparency for provider and beneficiary overlap rules for attribution financial calculations for Innovation Models.

5. Consider Medicaid patients, not just Medicare beneficiaries, for Alternative Payment Models. Therefore, consider multi-payers, PACE programs, Medicaid plans, and managed care organizations.

6. Allow flexibility with incentives based on the patient population, such as allowing flexibility to provide transportation services and promote behavioral health integration interventions.

   There is precedence for this flexibility in primary care. For example, the Innovation Center's Comprehensive Primary Care Plus (CPC+) Model paid an average of about $25 per Medicare beneficiary per month in 2019. Additionally, FQHCs already integrate behavioral health and substance use treatment into primary care. Flexibility of allowable providers can help promote health equity.

7. 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.

8. Allow money or grants to alleviate infrastructure startup costs and inflation, particularly for data analysis and technical assistance needs.

   This money can be used for expanding language technology and combat climate change. As we describe, severe storms and heat affect our buildings and affect our patient's health, particularly

for rural and immigrant populations. FQHCs worry about patient care once PHE supplemental funding goes away.

Past examples include the Accountable Investment Model (AIM Model) with upfront and ongoing payments. The Medicare Shared Savings finalized upfront and quarterly payments for certain new, low revenue, and inexperienced ACOs. Additionally, recent Medicaid waivers help address food insecurity and other Health Related Social Needs.

9. Expand eligible providers such as community health workers.

   The Innovation Center should work with the Center for Medicare (CM) and the Center for Medicaid and CHIP to ensure FQHCs are included in policy discussions. In the most recent CY 2023 Physician Fee Schedule, CMS requested information for including Community Health Workers. We advocate that the Innovation Center and other centers at CMS extend flexibilities for primary care to include FQHCs for policy consideration. Community Health Workers are one flexibility that FQHCs can use to advance health equity.

10. Limit quality measures but make them count. Add in social determinants of health measures.

    As we note, most FQHCs already screen for social determinants of health. Many Managed Care Organizations require screening of SDOH and use of Z codes. Therefore, we suggest that the administration partner with MCOs and CBOs to understand best practices for SDOH screening and more importantly, follow up and referral. While screening is needed, the follow up is what drives health equity and improves patient outcomes.

TOPIC 4: Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE, such as eligibilty and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.
Examples may include, but are not limited to:

- Impact of COVID-19 PHE waivers and flexibilities and preparation for future health emergencies (e.g., unintended consequences, disparities) on providers, suppliers, patients, and other stakeholders**.**

ACH Response:

Health centers play a unique role in bridging gaps between the health care system and marginalized communities and should be incentivized to do this to the best of their ability. Providers working in health centers face enormous challenges and should be protected and supported. As the economics of the health care system evolve, health centers are equally, if not more, impacted as other major providers. Their reimbursement should also reflect increased costs across care delivery. For example, our centers play a vital role for vaccine outreach and education.

To be prepared for the next pandemic, policymakers must prioritize what makes health centers strong, and what helps health center patients thrive.

FQHCs appreciate the flexibilities of telehealth during the PHE. CMS should understand that even after PHE expires, long COVID patients require high-intensity care to manage unexpected symptoms and emerging social drivers of health. We provide recommendations below.

- Recommendations for CMS policy and program focus areas to address health disparities, including requested waivers/flexibilities to make permanent; any unintended consequences of CMS actions during the PHE; and opportunities for CMS to reduce any health disparities that may have been exacerbated by the PHE.

ACH Response:

In the CY 2023 Physician Fee Schedule Proposed Rule, ACH provided the following feedback for telehealth:

- Allowance for telehealth and telemonitoring (remote therapeutic monitoring), particularly to be furnished in any geographic area and in any originating site setting, including the beneficiary's home 365 days after the PHE ends
- Allowance of certain services to be furnished via audio-only telecommunications systems and adjusting in-person visit requirements 365 days after the PHE ends.
- Revision of the regulations at § 405.2463 such that medical visits, medical nutrition therapy visits, and diabetes outpatient self-management training visits match the definition of FQHC mental health visits in which the visit can also include encounters furnished through interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where beneficiaries are not capable of, or do not consent to, the use of devices that permit a two-way, audio/video interaction for the purposes of diagnosis, evaluation or treatment of a mental health disorder

Additionally, in talking to our members we have heard the following best practices to improve the affordability of care for beneficiaries, particularly during the PHE:

- Care coordination
- Removing and reducing cost-sharing for the beneficiary
- Allowance of different providers, such as licensed marriage counselors, bachelor level social workers, and community health workers
- Include allowance of coding and inclusion of non-clinical facing roles
- Allowing affordable prescription drugs, particularly insulin
- Focusing on social determinants of health, such as transportation services and nutritional services (education and access to healthy foods)
- Flexibility for "outside the 4 walls"
- Allowing wraparound services and same day services for multiple encounters

FQHCs serve some of our most vulnerable communities. ACH recommends that the administration consider our feedback when designing Value-Based Care and implementing CMS regulations. Our frontline workers can speak to barriers and unintended consequences to patients. Communities already know what they need; we just need to listen and remain flexible.

Again, we appreciate the opportunity to provide feedback to the Make Your Voice Heard RFI. For more information, please feel free to contact me at apearskelly@advocatesforcommunityhealth.org.

Sincerely,

Amanda Kelly
Chief Executive Officer
Advocates for Community Health