ADVOCATES FOR COMMUNITY HEALTH

July 03, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2439-P andCMS-2442-P
Baltimore, MD 21244

RE: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P); and Medicaid Program; Ensuring Access to Medicaid Services (CMS-2442-P)
Sent via electronic transmission at regulations.gov.

Dear Administrator Brooks-LaSure:

ACH is a membership organization 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 two million people and provide high-quality, comprehensive primary health care, mental health services, preventive care, and social services to patients most in need.

ACH appreciates the opportunity to comment on Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P); and Medicaid Program; Ensuring Access to Medicaid Services (CMS-2442-P).

In general, we offer the following comments:

- *Beneficiary Advisory Group*: Support; allow an adequate percentage of patient representation at MAC meetings.
- *Medicaid Managed Care Quality Rating System*: Support.
- *Document Access to Care and Service Payment Rates*: Support but provide further recommendations and FQHC inclusion.
- *Wait times and Secret Shopper Surveys*: Support but seek clarifications and recommend additional guardrails.
- *State Directed Payments*: Support, but seek further clarification to protect FQHCs and value-based care priorities.
- *Medical Loss Ratios*: Support.
- *General comment*: Include FQHCs for any payment protections, guardrails, and primary care regulations. Clarify, when needed, if FQHCs are included or excluded. Allow FQHC information to be available to the public. Patients may not know FQHCs are available as a Medicaid site of service.

For our specific comments, we offer the following recommendations:

FQHC and Patient Voice: Medicaid Advisory Committee and Beneficiary Advisory Group (§ 431.12; CMS-2442-P)

Proposal: Proposes a Medicaid Advisory Committee (MAC) and Beneficiary Advisory Group (BAG) and expanding the scope of discussion beyond medical services but also how to meet social determinants of health (SDOH) and health-related social needs, and topics would be up to the State to meet beneficiary and interested parties' needs. The MAC and BAG would meet separately. States must offer a virtual/telephone option for attendance and make accessible to those with disabilities. Transparency includes reviews and reports published on the website.

ACH Comment: ACH supports these proposals. We appreciate having a wide range of providers for the MAC, and we support specifically calling out representation from "(6) community health, rural health clinic or Federally Qualified Health Center (FQHC) administrators." Additionally, the proposals include other perspectives from reproductive health providers, behavioral health (and SUD) providers, caregivers, community-based organizations and advocacy groups, health plans/ managed care organizations, and those with SDOH experience. FQHCs are already trusted voices in the community.

However, we recommend CMS require at least 25% of BAG at MAC meetings. MAC and BAG can foster collaboration across groups and agencies and allow bi-directional communication. Together, patients and FQHC representatives can voice concerns to states and plans regarding payments, data lag or coordination of care concerns. Most importantly, we support opportunities to amplify patients' voices.

Beneficiary Choice: Medicaid Managed Care Quality Rating System (§§ 438.334 and 457.1240; CMS-2439-P)

Proposal: Proposes a Medicaid and CHIP Quality Rating Service System (QRS) as a state's "one-stop-shop" for their eligibility for Medicaid and CHIP, managed care, and compare plans. As also described in §438.15, CMS will engage with states, beneficiaries, and other parties to propose quality ratings for managed care plans, and as cited throughout the regulations, display user-friendly information on a website.

ACH Comment: We support this proposal that helps patient decision-making. The proposals help patients pick a plan that meets their needs.

Document Access to Care and Service Payment Rates (§447.203 CMS-2442-P; §§ 438.207(b), 457.1230(b) CMS-2439-P)

Proposal: For Access Monitoring Review Plans (AMRPs), states are required to analyze data and supporting information to reach conclusions on sufficient access. States would publish FFS Medicaid

payment rates in a public location on the State website and linked from the State Medicaid agency's website so the public can see what they would pay by 2026. It will also include the date the website was last updated. Additionally, under CMS-2439-P, states will submit an annual payment analysis that compares managed care plans' payment rates for certain services as a proportion of Medicare's payment rate.

ACH Comment: We appreciate the transparency of publicly displaying the payment rate of home health aide services, primary care services, obstetrical and gynecological services, and outpatient behavioral health services. Most importantly, we appreciate providing these rates by provider type such as showing the different payment rates between physicians and nurse practitioners. Additionally, we support disaggregating data by geography and by adult/pediatric population.

However, while it is difficult to disaggregate data for FQHCs, it is not clear what will be publicly available and accessible to the public regarding FQHC payment rates and services. As proposed, the comparative payment rate analysis will include primary care services but excludes FQHCs because Medicare encounter rates are calculated differently. FQHCs are also excluded from analyses that assure workforce capacity.

We strongly encourage CMS to consider FQHC parity for all regulations and payment protections throughout these and all regulations, especially for Medicaid payments and for all types of providers. We recommend including FQHC payment rates by provider type, adult/pediatric populations, and by geographical location on state websites. While FQHC payment may be challenging to display, any analysis or publicly available information is better than no information.

Additionally, under § 447.203(c)(1)(i) we recommend comparing Medicaid payments 100% to Medicare. The FFS Medicaid-to-Medicare Fee Index varies from 0.32 to 1.10 for primary care.[1] It is well established that Medicaid reimbursement often lags significantly to Medicare, and even further compared to commercial rates. Therefore, CMS should require further analysis in states where Medicaid payment is below 100% of Medicare.

Managed Care, Access, and Wait Times (§ 438.68(e) and (f); CMS-2439-P)

Proposal: CMS proposes the state to develop and enforce routine appointment wait time standards for 4 types of services: outpatient mental health and SUD (adult and pediatric within 10 business days); primary care (adult and pediatric within 15 business days); OB/GYN (within 15 business days), and an additional type as determined by the State in addition to the three listed. This would be effective 3 years from the date of the final rule. Managed care plans must achieve 90% compliance with these standards. States must also have a secret shopper survey.

ACH Comment: FQHCs must comply with different wait times across the different MCOs. Therefore, we appreciate and support streamlining all wait times to one standard. However, if FQHCs must uphold these wait times, this can be very difficult. It is difficult to discern if the state, MCO, and/or provider is

[1] https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Primary%20Care%22,%22sort%22:%22asc%22%7D

penalized if these wait times are not met. FQHCs and other practices cannot control the ongoing workforce shortages of primary care and mental health providers, especially in underserved and rural areas. We believe this is a step in the right direction, but FQHCs seek guardrails to ensure these wait times promote its intended goal to increase access in a timely manner and promote health equity. Additionally, these wait times should be established based on clinical evidence and research.

While the regulations establish wait times for routine appointments, we seek clarity of whether these wait times are for new patients or for established patients. This clarification should be used for compliance and the secret shopper survey if finalized.

We appreciate ways that promote person-centered care that provides appropriate care and considers patients' preferences. ACH supports allowing states to use telehealth for appointments if in-person appointments are not available. However, we caution that in some areas, telehealth might be the only option to meet the standards, especially for behavioral health services. Telemental health appointments may be the only option for some patients, especially in rural and underserved areas.

For the secret shopper survey, we caution that these contracts may financially impact states to contract with an independent agency. We agree that states need to evaluate wait times in an unbiased manner. Therefore, if a secret shopper survey is used, we ask that the shopper clarify if they are new or returning patients. Additionally, we recommend the agency consider monitoring wait times and provider directors through existing technology and online platforms that allow booking appointments online.

Value-Based Payments and Delivery System Reform Initiatives and State Directed Payments (§ 438.6; CMS-2439-P)

Proposal: CMS proposes a definition of population-based payment (Example- PCMH) and condition-based payment. As proposed, the population-based payment and condition-based payment must also include at least one performance measure, and the State sets the target. CMS seeks comment on claims run out for attribution purposes. CMS also proposes upper limits for Value-Base Payments to the average commercial rate (ACR) for inpatient and outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers that states include in state-directed payment (SDP) arrangements.

ACH Comment: As proposed, we support the definitions of population-based payments and condition-based payments. In general, we support these proposals as the Agency signals a shift to value-based care and linking quality of care to these payments. These proposals codify existing sub-regulatory guidance. However, we seek further clarification if FQHCs are included in the State Directed Payments, and if FQHCs are subject to these upper limits to payments since our centers serve the most vulnerable populations, and money is reinvested back into patient care.

We also support removing text at 438.6(c)(2)(iii)(D) that prohibits States from recouping unspent funds allocated for State Directed Payments. States can reinvest these unspent funds to further promote innovation and value-based care.

Overall, we support explicitly allowing value-based care under State Directed Payments and removing barriers to allow flexible collaboration and innovation.

For attribution purposes, we caution that 18-24 months of claims run-out is a significantly long time. For Medicare FFS, most claims are submitted by 3 months, and almost all are submitted within 6 months. Medicare Advantage Plans usually submit claims within 12 months.

Additionally, patient attribution can be prospective or retrospective, which also affects payments. Most importantly, FQHCs often do not receive data in a timely manner from MCOs. *Therefore, we recommend CMS consider requiring MCOs to provide FQHCs, providers, and other practices data in a timely manner to best understand and report quality measures and patient outcomes.*

Medical Loss Ratios (MLR) (CMS-2439-P)

Proposal: CMS proposes standardizing MLR regulations to align with Qualified Health Plans. The managed care plan would submit state directed payments as part of MLR reporting to CMS and as separate line items. Overhead and indirect costs cannot be used in the MLR numerator that are not directly related to health care quality improvement.

ACH Comment: We support these MLR changes that put guardrails around MCO profits. These are ways to increase opportunities of person-centered care. Additionally, the additional documentation ensures payments are not used to move funds from Medicaid managed care to a company or inappropriately increase MLR.

Conclusion

ACH thanks CMS for the opportunity to comment on these proposals that ensure Medicaid patients have access to health care services. For more information, please contact me at apearskelly@advocatesforcommunityhealth.org.

Additionally, you may contact Stephanie Krenrich, our Senior Vice President of Policy and Government Affairs, at skrenrich@advocatesforcommunityhealth.org.

Sincerely,

Amanda Pears Kelly
Chief Executive Officer