NATIONAL ASSOCIATION OF Community Health Centers

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*Submitted via www.regulations.gov*

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2328-NC
Mail Stop C4–26–05
Baltimore, MD 21244-8016

**Re: Request for Information (RFI)—Data Metrics and Alternative Processes for Access to Care in the Medicaid Program**

Dear Acting Administrator Slavitt:

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to the above-referenced Request for Information (RFI) published by the Centers for Medicare & Medicaid Services (CMS) on November 2, 2015.

NACHC is the national membership organization for federally qualified health centers (FQHCs or "health centers"). With over 9,200 sites nationwide, FQHCs provide affordable, comprehensive primary care to over 22 million medically-underserved individuals. Our members include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Grantees, and Public Housing Primary Care Grantees, all of whom strive to meet the health care needs of uninsured and underserved populations. In 2014, these health centers served almost 11 million Medicaid beneficiaries, which is more than 1 in 7 Medicaid recipients nationwide. In addition, FQHCs provide a stable, accessible medical home to individuals who churn between Medicaid, the Marketplace, and being uninsured. A fundamental characteristic of FQHCs is their commitment to serve all individuals, regardless of their insurance status or ability to pay. FQHCs also provide a wide range of "enabling services" – meaning services which enable underserved populations to access medical services appropriately. This includes services such as: transportation, translation/ interpretation services, and health education. Due to these core characteristics, FQHCs provide a consistent, accessible, affordable primary care home for vulnerable individuals who cycle on and off of Medicaid. For more information on FQHCs, please see Attachment 1. In brief, our comments on the RFI are as follows:

1. NACHC strongly supports CMS' efforts to develop and implement appropriate, uniform national mechanisms for monitoring access for Medicaid patients, in both fee-for-service and managed care.

2. NACHC recommends that the core set of mandatory metrics include an analysis of access to FQHC services, as FQHCs differ from typical primary care practices due to their commitment to:
    - provide a consistent, accessible medical home for people who churn on and off of Medicaid, and
    - provide "enabling services" to help individuals overcome barriers to accessing care.

3. NACHC recommends that access measures reflect the number of Medicaid patients – including new patients – that participating providers are willing to accept. Each of these comments is discussed in detail below.

**1. NACHC strongly supports CMS' efforts to develop and implement appropriate, uniform national mechanisms for monitoring access for Medicaid patients, in both fee-for-service and managed care environments.**

As you are aware, the recent Supreme Court decision in *Armstrong vs. Exception Child Center* highlighted the critical role that CMS must play in ensuring that Medicaid patients have access to providers consistent with the requirement at section 1902(a)(30)(A) of the Social Security Act. In addition, our experience of current state efforts to monitor access is consistent with the description contained in the RFI – that these efforts are "generally inconsistent and in many cases did not adequately document access." For these reasons, NACHC thinks it is critical that CMS establish a core set of access measures and threshold, and require all states to monitor and publicly report on their performance on each appropriate measure. Such a system will ensure a uniform, national, data-driven approach for regularly monitoring access, including the impact of specific policy changes.

In addition, we support CMS' proposal to establish a process to enable beneficiaries experiencing access issues to raise and seek resolution of their concerns. At present, beneficiaries have limited mechanisms for raising concerns and having them addressed, so this process should significantly increase awareness of, and efforts to address, access issues.

**2. NACHC recommends that the core set of mandatory metrics include an analysis of access to FQHC services, as FQHCs differ from typical primary care practices due to their commitment to:**

- **provide a consistent, accessible medical home for people who churn on and off of Medicaid, and**
- **provide "enabling services" to help individuals overcome barriers to accessing care.**

NACHC strongly encourages CMS to include a measure of access to primary care providers in its core set of metrics. In addition, we recommend that a separate metric be included to measure access to FQHC services. As discussed above, FQHCs differ from standard primary care practices in two key ways:

- FQHCs accept all patients regardless of ability to pay, and charge them using a sliding fee scale based on income. Thus, they serve as an accessible, consistent, affordable source of care for individuals as they churn on and off of Medicaid.

- FQHCs provide a wide range of "enabling services" – meaning services which enable underserved populations to access medical services appropriately. Examples of enabling services include transportation, translation/ interpretation services, and health education. Thus, FQHCs ensure that individual patients who face specific barriers (e.g., language, transportation) are able to access services appropriately.

Because of these important benefits offered by FQHCs, NACHC encourages CMS to include access to an FQHC in the core set of metrics. Due to issues involved with provider/ patient ratios and time-distance standards (as will be discussed below) we encourage that this metric measure wait time for an appointment, specifically for new patients.

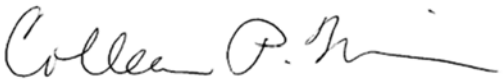
**3. NACHC recommends that access measures reflect the number of Medicaid patients – including new patients – that participating providers are willing to accept.**

Standard access measures such as patient/provider ratios and time-and-distance standards share a key limitation that overstates the actual level of access. As you are aware, many providers participate in Medicaid, but limit the number of Medicaid patients they will accept, resulting in new patients being unable to get appointments with them. Unfortunately, standard patient/provider ratios and time-and-distance measures typically consider all providers equally, so a provider with a "closed" Medicaid panel (i.e., those not accepting new patients) is counted the same as a provider with an "open" Medicaid panel. This results in real access being overstated, as providers who are not accepting new Medicaid patients are considered as "accessible" as those who are not.

In addition, panel sizes can vary enormously among individual providers, with some limiting their panels to just a few patients. Therefore, even among participating providers who are accepting new Medicaid patients, the actual degree of "access" can vary significantly (e.g., one provider may be willing to accept 30 new Medicaid patients, while another may be willing to accept only 3 more.) Due to these significant variations, NACHC recommends that access measures reflect the actual panel size of each participating provider, as opposed to counting each provider equally.

In closing, we thank you for the opportunity to provide comments on this important issue. If you require any clarification on our comments, please contact Ms. Colleen Meiman, NACHC's Director of Regulatory Affairs, at 202-296-0158 or cmeiman@nachc.org.

Sincerely,



Colleen P. Meiman, MPPA
Director of Regulatory Affairs
National Association of Community Health Centers

**ATTACHMENT ONE**

**Overview of Federally Qualified Health Centers**

For 50 years, Health Centers have provided access to quality and affordable primary and preventive healthcare services to millions of uninsured and medically underserved people nationwide, regardless of their ability to pay. At present there are over 1,300 health centers with more than 9,300 sites. Together, they serve ***over 24 million patients***, including almost 11 million Medicaid patients (more than 1 in 7 Medicaid patients).

***Health centers provide care to all individuals, regardless of their ability to pay***. All health centers provide a full range of primary and preventive services, as well as services that enable patients to access health care appropriately (e.g., translation, health education, transportation). A growing number of Health Centers also provide dental, behavioral health, pharmacy, and other important supplemental services.

To be approved by the Federal government as a Health Center, an organization must meet requirements outlined in Section 330 of the Public Health Service Act. These requirements include, but are not limited to:

- ***Serve a federally-designated medically underserved area or a medically underserved population.*** Some Health Centers serve an entire community, while other target specific populations, such as persons experiencing homelessness or migrant farmworkers.
- Offer services to all persons, regardless of the person's ability to pay.
- Charge no more than a nominal fee to patients whose incomes are at or below the Federal Poverty Level (FPL)
- Charge persons whose incomes are between 101% and 200% FPL based on a sliding fee scale
- Be ***governed by a board of directors, of whom a majority of members must be patients of the health center.***

Most Section 330 Health Centers receive Federal grants from the Bureau of Primary Health Care (BPHC) within HRSA. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing care to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients who are not indigent or who have insurance, whether public or private, are expected to pay for the services rendered. In 2014, on average, the insurance status of Health Center patients is as follows:

- 47% are Medicaid recipients
- 28% are uninsured
- 16% are privately insured
- 9% are Medicare recipients

No two health centers are alike, but they all share one common purpose: to provide primary health care services that are coordinated, culturally and linguistically competent, and community-directed care to uninsured and medically underserved people.