



July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P)

The National Association of Community Health Centers (NACHC) is the national membership organization for federally qualified health centers (also known as FQHCs or health centers). Health centers are federally-funded or federally-supported nonprofit, community-directed provider clinics that serve as the health home for over 30 million people, including 1 in 6 Medicaid beneficiaries and over 3 million elderly patients. It is the collective mission and mandate of over 1,400 health centers around the country to provide access to high-quality, cost-effective primary and preventative medical care as well as dental, behavioral health, and pharmacy services and other “enabling” or support services that facilitate access to care to individuals and families located in medically underserved areas, regardless of insurance status or ability to pay.

Health centers serve some of the nation’s most vulnerable patients; nearly 70% of health center patients are under 100 percent of the Federal Poverty Level (FPL), and 90% are under 200 percent FPL. Additionally, 80 percent of health center patients are uninsured or publicly insured.¹ Therefore, access to affordable, timely health care providers and services is crucial to maintaining and advancing their health and well-being. NACHC supports the goals of this proposed rule, which strives to enhance access and utilization of health care and health services and promote opportunities for beneficiaries to be more involved in their care. NACHC appreciates CMS’ intent to better align Medicaid Managed Care and CHIP protections and provisions with other payers. NACHC welcomes the opportunity to comment on this proposed rule and discuss the anticipated implications of these proposed changes on health centers and the patients they serve. Our comments are broken down into four sections: I. Network Adequacy Provisions; II. In-Lieu of Services; III. State-Directed Payments, and IV. Other Recommendations.

I. Network Adequacy Provisions

NACHC appreciates CMS’ proposal to implement wait time standards for certain services at §438.68(e), specifically in substance use disorder/mental health, primary care (adult and pediatric), and OBGYN. Health centers provided over 120 million visits in 2021,² offering a range of essential services to their patients and communities. **While we agree with the spirit of the provision,**

¹ <https://www.nachc.org/wp-content/uploads/2023/04/Community-Health-Center-Chartbook-2023-2021UDS.pdf>

² <https://www.nachc.org/wp-content/uploads/2023/04/Community-Health-Center-Chartbook-2023-2021UDS.pdf>

NACHC is concerned about the continued shortage of workers seen across the healthcare sector, which has negatively impacted health centers particularly hard. A 2022 NACHC survey found that 68% of health centers lost between five and twenty-five percent of their workforce, with a majority citing financial opportunities at a large health care organization as the main reason for departure.³ Nurses represent the highest category of workforce loss, followed by administrative, behavioral health, and dental staff. Workforce challenges can adversely affect patients and their health, contributing to longer wait times, decreased hours of operation for health centers, and reduced appointment availability.

With a shortage of behavioral health staff, meeting the 15-day appointment wait time standard for SUD/mental health would be particularly difficult for health centers. Unfortunately, there are no immediate solutions to address the healthcare workforce shortage, and we anticipate challenges lasting well passed 2027 when these wait time standards will be mandated. A survey conducted by the Association of American Medical Colleges projects that the United States will face a shortage of up to 124,000 physicians by 2034, including 48,000 primary care clinicians.⁴ Besides dealing with the workforce shortage, health centers have dealt with long delays in getting their providers credentialed, further contributing to the appointment wait time issue.

NACHC recommends CMS modify §438.214(b) to include additional requirements to ensure credentialing does not impede access to timely services and reimbursement. We understand and appreciate CMS’ proposal to add categories of services that credentialing must address. However, NACHC suggests CMS support alternative strategies to mitigate the credentialing problem health centers face. Managed care entities have a business motive to prolong the credentialing process, and as a result, providers – including health centers – often have months-long periods of not being able to bill for the services of their whole team of clinicians. Estimates of revenue lost by not being able to bill for an average primary care provider can cost more than \$30,000 a month.⁵

By creating protections to ensure plans cannot stifle a provider’s credentialing process, health centers will have more providers available to see their patients and could be better equipped to meet the proposed wait time standards. To hold plans accountable, CMS could, for example, require managed care entities to establish retrospective credentialing effective dates or to delegate the credentialing function to network providers, like health centers, that have an internal credentialing process.⁶ These creative strategies would help decrease the burden oftentimes faced by health centers while maintaining the integrity of credentialing.

For the proposed appointment wait time standards, NACHC also seeks clarification on which patients this applies to – new versus existing patients – as well as definitions of “routine” versus “urgent” or “emergent” appointments. It is important that wait time standards

³ The National Association of Community Health Centers. (2022, March). Current State of the Health Center Workforce. Pandemic Challenges and Policy Solutions to Strengthen the Workforce of the Future. <https://www.nachc.org/current-state-of-the-health-center-workforce/>

⁴ <https://www.aamc.org/media/54681/download>

⁵ <https://www.beckershospitalreview.com/finance/reclaiming-revenue-a-found-money-trifecta-in-credentialing-privileging-and-enrollment.html>

⁶ <https://www.beckershospitalreview.com/finance/reclaiming-revenue-a-found-money-trifecta-in-credentialing-privileging-and-enrollment.html>

take into consideration the varying level of administrative and prep work required to get patients from the waiting room and in with a provider. Even if the new patient is a walk-in, where the intake process happens in person, health centers need to collect key pieces of information from patients before scheduling their appointment. Health center workflows are based on educating the patient, assessing their financial eligibility, and often screening for social drivers of health. Furthermore, health centers allocate a certain number of daily visits for walk-in patients. To ensure adherence to these proposed wait time standards, it is imperative that CMS defines the types of visits subject to these proposed standards and establishes wait time standards that consider the health center patient populations and healthcare workforce challenges.

Further, the proposed language states that these wait time standards apply to “routine” appointments. We understand CMS’ desire to allow states to develop and provide their own definitions. However, it would be beneficial if CMS provided states with clear guidance on ways to categorize these appointments. It will be easier to compare access standards between states when CMS gathers that data and the same standards apply for all appointments requested by patients, no matter what state they reside in.

NACHC understands that CMS defers to states in deciding what services to cover via telehealth. However, having more states cover telehealth services is a crucial component to help address appointment wait times. **We ask CMS to continue to educate states on the importance of coverage and encourage comprehensive coverage of Medicaid services via telehealth.** NACHC is concerned that the patchwork of Medicaid coverage for telehealth services nationwide creates nationwide inequities based on geography. We encourage CMS to evaluate telehealth parity regulations and adequate reimbursement for primary care services in all states and territories to ensure all beneficiaries have equitable access.

While telehealth does serve as a complete substitute for in-person medical care, the ability of health centers to provide telehealth care has been crucial in bridging gaps to care for patients. In 2021, 99% of health centers nationwide offered telehealth services compared to just 43% in 2019.⁷ As a result of the various Medicaid flexibilities put in place – including permitting delivery of telehealth services via audio-only technologies and permitting reimbursement at an amount equal to an in-person visit – health centers have proven highly effective at utilizing telehealth. Some of these pandemic-era flexibilities have been extended until December 2024. While telehealth flexibilities in Medicaid will not singularly resolve the workforce shortage, it will help connect more patients to care, a key goal of this proposed rule, especially in the proposed wait time standards.

Data shows that medical visits were the most frequent telehealth visit type for health center patients. Fifty-eight percent of telehealth visits were for mental health, 33% for behavioral health services, 7% for enabling services, and 2% for other services.⁸ Overall, health care providers saw increased utilization of mental health services over the course of the pandemic – the percentage of adults who sought out mental health treatment increased from 19.2% in 2019 to 21.6% in 2021.⁹ Given increased utilization, it is important that these services are not only accessible but paid the

⁷<https://www.nachc.org/wp-content/uploads/2023/04/Community-Health-Center-Chartbook-2023-2021UDS.pdf>

⁸<https://www.nachc.org/wp-content/uploads/2023/04/Community-Health-Center-Chartbook-2023-2021UDS.pdf>

⁹[https://www.cdc.gov/nchs/products/databriefs/db444.htm#:~:text=From%202019%20to%202021%2C%20the%20percentage%20of%20adults%20who%20had,21.6%25%20\(Figure%201\).](https://www.cdc.gov/nchs/products/databriefs/db444.htm#:~:text=From%202019%20to%202021%2C%20the%20percentage%20of%20adults%20who%20had,21.6%25%20(Figure%201).)

same rate as in-person services. Also, the availability of providers and if they offer services in person and/or via telehealth is important information for patients to know as they seek care.

NACHC supports CMS' proposal at §438.10 to direct MCOs to keep provider directories up to date. This will alleviate the burden on patients from needing to call multiple providers to inquire if they are accepting new patients or search for an updated phone number for the provider, for example. We also support §438.10(h)(1) to require the managed care entity to mark a provider's availability to provide appointments via telehealth. Some health centers have also cited that the delays of credentialing providers directly impact maintaining accurate, up-to-date provider directories. As previously mentioned, CMS should work with stakeholders to find solutions and improve credentialing to ensure the accuracy of provider directories and mitigate the healthcare workforce shortage.

To ensure compliance with these proposed standards, NACHC supports CMS' proposal at §438.602 that directs states to perform secret shopper surveys of plan compliance with appointment wait times and accuracy of provider directories. We agree that MCOs must meet at least a 90% compliance rate and send directory inaccuracies to the state within three days of discovery. These secret shopper surveys will be a direct test of compliance, helping inform the state about network adequacy across plans and better ensure patients' access to care. NACHC also supports the requirement that states post the results of their secret shopper surveys on their websites. This will enable enrollees, advocates, and providers to track plan performance and hold plans and policymakers accountable to implement remedial measures to address and correct any deficiencies. We encourage CMS to consider compiling these reports and publishing them in one place on its Medicaid.gov website to make it easier to find and compare the reports of different states or to evaluate the performance of an MCO across various states.

NACHC supports CMS' directive for states to create a remedy plan at §438.207(f) in case network adequacy standards are not met but urges CMS to protect providers from adverse reactions from managed care entities. NACHC strongly supports the proposal to require states to promptly submit a remedy plan when CMS identifies areas for improvement for access to services and the requirement that the remedy plan identifies specific steps and timelines to achieve the goals of the remedy plan. This requirement would impose much-needed transparency and accountability to managed care rates. However, we ask CMS to ensure that providers and practices cannot be penalized or excluded from networks for managed care entities to better achieve at least 90% compliance with appointment wait times and provider directory accuracy. The requirements in the proposal will be a plan-wide requirement, but in practice, managed care entities may add more stringent wait time requirements as a standard part of network provider agreements, leaving providers instead of the specific plan being penalized.

NACHC supports developing more protections for providers like FQHCs to ensure managed care entities cannot deliberately exclude certain providers from their networks. Furthermore, we ask CMS to clarify further how they plan to hold states/managed care entities accountable if a 90% compliance rate is not met after state remedy plans. If multiple edited and updated state remedy plans still do not meet set network adequacy standards, we request CMS develop requirements to impose accountability on states and managed care entities to ensure patient access to services is not being hindered. We also recommend that the remedy plans, once approved, be posted on the

state's website and that the state agency be required to share them with the Medicaid Advisory Committee and the Beneficiary Advisory Group.

NACHC supports CMS' proposal at (§§438.66(b) and (c), 457.1230(b) to states on surveying enrollees and utilizing results to better evaluate their plans' networks to assure patient access to services. Having publicly available data regarding access to covered services allows consumers to become better informed when picking plans to ensure they meet their needs and maintain a high quality of care standards. We also appreciate CMS having states separately publish enrollee satisfaction related to telehealth appointments, which will help provide a fuller picture of patient experience with telehealth.

The availability of telehealth is also popular among health center patients. Preliminary results from a new NACHC survey show that almost 90% of patients surveyed agreed that telehealth addressed their needs, was suitable for interaction with their clinician, and that they were generally comfortable and satisfied with care via telehealth. A quarter of the patients surveyed had a visit for behavioral health – 52.55% via audio-only and 65.7% via video (and some were both).¹⁰ This adds to the growing body of research about the strength of telehealth in providing clinically equivalent care¹¹ besides eliciting strong satisfaction from patients.

II. In Lieu of Services or Setting (ILOS)

NACHC appreciates CMS codifying previous ILOS guidance¹² into regulation through this proposed rule and supports creative ways states can utilize ILOS to provide enrollees more choices for health care services. We applaud CMS in codifying their allowance for states to extend ILOS to better address health-related social needs (HRSNs).¹³ For years, health centers have been leaders in screening and addressing social drivers of health, connecting patients to essential services. Furthermore, NACHC supports CMS underscoring that managed care patients will always have the right to choose an ILOS or the state plan service and cannot be required by a managed care plan to use an ILOS. It is imperative policies center the patient's choice and right to receive these services at their FQHC. **However, we ask CMS to grant FQHCs' Prospective Payment System (PPS) protections to ensure the FQHC Medicaid benefit is preserved and cannot be substituted for an ILOS.**

At §438.2, CMS proposes granting states more flexibility in determining when and how ILOS can be offered by managed care plans. States have the authority to identify the services that can be replaced and establish the criteria and conditions for offering alternative services, specifically "...that an ILOS can be used as an immediate or longer-term substitute for a covered service or setting under the state plan, or when the ILOS can be expected to reduce or prevent the future need to utilize state plan-covered service or setting."¹⁴ **NACHC recommends CMS clearly state that this flexibility does not allow states to substitute ILOS for any of the non-ambulatory, Medicare-defined components of the Medicaid FQHC benefit, which state Medicaid**

¹⁰ NACHC Patient Telehealth Satisfaction Assessment 2023, In review.

¹¹ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796668>

¹² <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf>

¹³ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf>

¹⁴ Pg 28162, Managed Care Proposed Rule

programs are required to cover.¹⁵ Congress early on understood the critical role health center’s play in providing high-quality, affordable care to Medicaid patients. Congress created the unique PPS methodology to ensure predictability and stability for health centers while protecting other federal investments.¹⁶ Almost half (48%) of health center’s patients have Medicaid coverage,¹⁷ making it crucial they receive adequate payments. Adequate Medicaid reimbursement enables health centers to stretch federal 330 grant funding to serve uninsured and underinsured patients. Furthermore, Congress saw health centers operating as a one-stop shop offering a full range of primary and preventive services, and dental, behavioral health, and vision services. Many services provided by health centers are often not covered by fee-for-service Medicaid, such as case management, translation, transportation, and some dental and mental health services. Congress created the FQHC Medicaid benefit – a statutory right – to ensure patients could always access high-quality, comprehensive services. Given health centers’ unique care coordination and patient-centered model of care, allowing states to not cover specific FQHC services could interrupt the continuum of care health centers provide and could negatively impact the patient. While we understand that patients would still be allowed to choose which service they want, NACHC is concerned about the unintended consequences to our payment model if states substitute services.

NACHC also wants to ensure that a state’s ability to substitute an ILOS for another covered service does not result in a reduction of PPS/APM payment for these FQHC services or otherwise reduce payment by other means, such as restricting the definition of a billable encounter. If this results in altering the billable encounter scheme, states should report these changes to CMS and provide a justification. NACHC requests CMS require states to demonstrate the parameters for billable ILOS visits compared to current visits without ILOS coverage. Having a written determination that explains how the ILOS does or does not impact the PPS/APM rate will help health centers better understand what services are covered under the FQHC benefit for their patients. Health centers are required to serve all patients, regardless of their ability to pay. When specific services are no longer covered at the FQHC, the health centers’ already scarce resources are further impacted. This will enhance transparency for FQHCs to see the potential impact of ILOS changes on PPS/APM payments. NACHC also requests that payment below PPS cannot occur when the state calculates capitation rates.

NACHC recommends CMS further define parameters around scope, duration, and intensity of quality of services within §438.3(e)(2)(i). NACHC appreciates CMS’s intent to ensure managed care plans demonstrate that ILOS being offered are equivalent in scope, duration, and quality to the services specified in the Medicaid State Plan. Plans must show that the alternative services meet the same needs and achieve the same outcomes as the original services. However, not every State Plan has the same definitions around these terms (scope, duration, and intensity). Having common definitions for these terms will enhance protections for health center patients if they receive an ILOS, and set common expectations around quality of services, regardless of the state a health center patient lives in. Changes in the scope of FQHC services are also defined by similar parameters, specifically as “a change in the type, intensity, duration and/ or amount of services.”¹⁸ State Medicaid agencies should have a documented definition of a “change in the

¹⁵ Section 1861(aa)(1)((A)-(C) of the Social Security Act

¹⁶ <https://www.nachc.org/wp-content/uploads/2018/06/PPS-One-Pager-Update.pdf>

¹⁷ <https://www.nachc.org/wp-content/uploads/2023/04/Community-Health-Center-Chartbook-2023-2021UDS.pdf>

¹⁸ the 2001 PPS Guidance: <https://www.nachc.org/wp-content/uploads/2015/11/PPS-Q-As-2001.pdf>

scope of services” and define parameters for duration and intensity as well. These definitions could be similar for FQHCs and ILOS to ensure consistency. The definition should, at minimum, include the four types of changes listed in the 2001 CMS issuance: changes in type, intensity, duration, and intensity (amount) of services. Furthermore, setting a standard for states when submitting ILOSs requests will make it easier for CMS in comparing and approving new ILOS requests.

NACHC supports CMS’ proposals at (§§438.16(e) and 457.1201(e)) to include beneficiary protections when it comes to ILOS. Managed care plans must ensure that beneficiaries receive appropriate notice and information about the alternative services, including any potential differences or limitations. We appreciate that beneficiaries will also always have the right to choose among available service options and receive services per their individual needs. NACHC supports the details that CMS included in the termination plan (§438.16(e)(2)(iii)(A) – (D) States need to institute, in the event of terminating an ILOS. NACHC agrees with CMS’ requirement to include enrollee rights and protections¹⁹ be included in enrollee handbooks in the event a managed care plan’s contract adds ILOSs. To assure ILOSs are being used reasonably, appropriately, and overall, effectively by states, it is paramount that managed care enrollees can be active participants in making decisions regarding their health care. Furthermore, enrollees need to have their voices heard, so access to avenues, including an appeals process related to adverse benefit determinations and grievances, will help hold managed care entities and states accountable for services offered. Moreover, the proposal requiring monitoring and reporting on appeals, grievance, and state fair hearing data will help ensure enrollees receiving ILOS retain their rights and protections. We agree with CMS that this will better safeguard enrollees’ experience with ILOSs “is not inconsistent or inequitable compared to the provision of State plan services and settings.”

However, we urge CMS to outline a better timeline/set of parameters related to notifying a beneficiary about the termination of an ILOS. The proposed language directs states to “[n]otify enrollees that the ILOS they are currently receiving will be terminated as expeditiously as the enrollee’s health condition requires.” A lack of a clear definition/timeline for expeditiously, or how the severity of the enrollee's health condition affects the notification timeline of termination of ILOS could negatively impact health center patients. Health center patients have higher rates of chronic conditions than in previous years and whose needs are uniquely complex,²⁰ making timely notification imperative to ensure continuity of care is not interrupted. Furthermore, terminating these services will create a void for patients in trying to find another provider or coverage for those services. This can create health inequities as the gap in care will negatively impact health outcomes. Clearer language will help better guide states when notifying enrollees of termination of an ILOS. NACHC does appreciate CMS’ directive that states create and make the transition of care policy plan publicly available.

III. State Directed Payments

NACHC appreciates and supports CMS’ intention to increase transparency around State Directed Payments (SDPs) while creating regulatory flexibilities to enhance states’ ability to utilize them, especially for value-based care arrangements. **However, NACHC requests CMS clarify that FQHCs can take advantage of both incentive and value-based payment arrangements as an**

¹⁹ §438.3(e)(2)(ii)

²⁰ <https://www.nachc.org/wp-content/uploads/2023/04/Community-Health-Center-Chartbook-2023-2021UDS.pdf>

SDP and that these amounts should be excluded from the FQHC supplemental payment calculation.

Federal law addressing the Medicaid FQHC PPS contains special provisions regarding payments to FQHCs for services rendered under contract with an MCO. By statute, states are required to make payments to FQHCs to cover the difference between amounts paid to the FQHC by an MCO and the FQHC's PPS rate (if the latter is higher).²¹ These supplemental payments, which are made directly from the state to the FQHC, are sometimes referred to as "wraparound" payments. By statute, value-based and incentive payments must be excluded from the calculation of supplemental payments.²² Any other type of SDP would be considered payment for specific services provided and thus would be incorporated into the supplemental payment calculation. **NACHC recommends CMS codify language in its 2000 State Medicaid Director Letter describing this exclusion.**²³ Furthermore, similar language is also repeated with respect to Medicare Advantage wraparound.²⁴ By excluding SDPs from supplemental payment calculations, this would ensure health centers can fully utilize SDPs for their intended purpose: helping states better achieve "their overall objectives for delivery system and payment reform."²⁵

As mentioned previously, states are required to make payments to FQHCs to cover the difference between amounts paid to the FQHC by a Medicaid managed care organization (MCO) and the FQHC's PPS rate (if the latter is higher).²⁶ With 72% of Medicaid beneficiaries enrolled in an MCO,²⁷ many states are seeking to avoid FQHC wraparound payments as a separate payment obligation, and instead, to delegate the responsibility to the MCO to pay FQHCs their full PPS rates. Because the Medicaid statute requires direct wraparound payments from the state to the FQHC, states may delegate PPS payments to MCOs only through a CMS-approved APM documented in the Medicaid State plan. CMS made clear that states "*would remain responsible for ensuring that FQHCs and RHCs receive at least the full PPS reimbursement rate. States must continue their reconciliation and oversight processes to ensure that the managed care payments comply with the statutory requirements of the APM.*"²⁸ To preserve their role as critical safety net providers in a Medicaid landscape increasingly dominated by managed care, health centers need to receive their full PPS rate for services furnished to managed care enrollees. **NACHC requests that CMS have more oversight over prompt delegated wrap payments.**

Timely and full payment of delegated wraparound is a concern for FQHCs in many states. The law requires states to make supplemental payments to FQHCs "in no case less frequently than every 4 months."²⁹ The 2001 PPS Guidance also requires states to conduct an annual reconciliation to ensure that managed care supplemental payments are fully compensatory as required by the law. In some instances, states do not provide a fully compensatory supplemental payment to the FQHC

²¹ SSA § 1902(bb)(5)

²² 42 CFR 438.6(c)(1)(i)

²³ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd092700.pdf>

²⁴ 42 CFR 405.2469(c)

²⁵ <https://www.federalregister.gov/d/2016-09581>

²⁶ SSA § 1902(bb)(5).

²⁷ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>

²⁸ State Health Official Letter # 16-006, from Vikki Wachino, Director, Center for Medicaid & CHIP Services, CMS (Apr. 26, 2016), re: FQHC and RHC Supplemental Payment Requirements, pp. 2-3

²⁹ SSA Section 1902(bb)(5)(B)

within the 4-month timeframe for wraparound payments. Such delays are widespread in states that use APMs that provide cost-based reimbursement. Under such a methodology, FQHCs file annual Medicaid cost reports. Per-visit payments are typically made on a provisional basis, pending settlement of the cost report.

For states using retrospective cost-based APMs, managed care supplemental payments typically form part of the cost report settlement. Managed care wraparound payments may lag for years if the cost report settlement process is delayed. States are obligated to reconcile those supplemental payments regularly to the full PPS or APM rate in a timely manner (at least annually). Like SDPs, delegated wraparound payments are crucial in ensuring provider reimbursement. The health centers' central role in Medicaid is jeopardized when states delegate the PPS payment obligation to MCOs, and the MCOs do not follow the payment requirements. **NACHC requests that CMS extend the same SDP protections to the delegated wrap because of the unique nature of FQHC PPS.**

Based on CMS' definition of an SDP,³⁰ a delegated wraparound arrangement would fall under a type of SDP, specifically related to the "minimum fee schedule" type. **If this is true, we ask CMS to clarify in the text of the regulation that delegated wrap is considered a form of an SDP.** If a wraparound payment is considered an SDP, **NACHC requests that the same special protections of providers and federal/state funds for SDPs should then, by default, be extended for delegated wrap arrangements as well.**

However, if CMS decides delegated wrap arrangements are not considered an SDP and thus not subject to the scrutiny/federal protections described in 438.6(c), then NACHC recommends CMS implement clearer protections for a delegated wrap. CMS should reaffirm its statements in the 2016 SHO letter to include the following protections:

- The delegated wrap payment be included in an APM.³¹ Many states have delegated the wrap without putting an APM in the state plan. We have heard from FQHCs whose CMS regional offices have approved managed care entity contracts containing these delegations without verifying first whether the state had an approved APM, which could lead to FQHCs getting paid less than the Medicaid PPS rate.

States should maintain the same reconciliation and oversight processes used under traditional supplemental payments. Because CMS is instituting more scrutiny over SDPs to better hold managed care entities and the providers who receive these payments accountable, this recommendation falls in line with CMS' actions in this proposed rule.

- Furthermore, states must ensure that amounts added to capitation payments are actuarially sufficient for managed care entities to comply with cost-related payment requirements. Failure by the state to pay actuarially-sound rates to MCOs could jeopardize reimbursement rates to FQHCs in their network as well.
- CMS should also clearly state its expectations as to which provisions states would need to include in its contracts with managed care entities, similar to what is included in this NPRM.³²

³⁰ 438.6(a)

³¹ 1902(bb)(6)

³² 438.6(c)(5)

NACHC supports CMS' proposal to require states to report on provider-specific payment amounts of SDPs by submitting data to T-MSIS. We urge CMS to make aggregated data publicly available to facilitate the evaluation of access and equity for these SDPs. Furthermore, we request this data to be aggregated by 1905(a) benefit categories, with FQHCs/RHCs as one category. Given the current opaqueness of SDPs, having this reporting mechanism will allow us to see how many FQHCs/RHCs providers are receiving SDPs and can help further enhance FQHC participation in receiving SDPs. Furthermore, this data empowers FQHCs to better hold their states accountable for these SDPs.

NACHC appreciates CMS' proposed change to §438.6(c)(2)(iii)(C) and (D) that will allow states to set the amount or frequency of the plan's expenditures and allow the state to recoup unspent funds allocated for these SDPs. NACHC appreciates CMS recognizing the resources required for FQHCs and other safety-net providers to transition in VBP. States need the flexibility to determine the best manner to use SDP funds. Given the importance of investments for infrastructure to support FQHCs in VBP, NACHC requests CMS clarify that states reinvest any extra funds back into health care to support safety-net providers and their patients. In the text, it does assume that the state would invest these funds into VBC-activity. However, it does not clearly direct states on how to utilize these unspent funds. If not clarified, states may utilize these unspent SDPs to offset other parts of their budget, which goes against the spirit and intent of these SDPs.

NACHC recommends CMS better specify patient attribution requirements and processes for value-based care arrangements - specifically population-based and condition-based payments - in SDP contracts³³ and see where patient attribution strategies can be better streamlined across payers. Patient attribution helps identify the health care relationship between the patient and provider. Successful patient attribution is crucial to success in value-based care (VBC) arrangements,³⁴ and CMS has strongly encouraged health care providers, including FQHCs, to increase their participation in these arrangements. We understand that CMS is directing the state to ultimately decide what type of attribution methodology to employ. However, there should be more precise directions from CMS on what types of methods are acceptable.

If health centers are allocated these VBC arrangement SDPs, accuracy in patient attribution for providers is crucial to measuring the success of SDPs in achieving their stated value-based care goals. Some health centers participating in VBC arrangements, such as the Medicare Shared Savings Program and Accountable Care Organizations, have reported issues with the patient attribution system. While these arrangements differ, they showcase providers' ongoing issues in accurate patient attribution.

One state Primary Care Association stated that of their health centers participating in VBC arrangements, between 20% to 40% of patients that have been attributed are established with their health center, depending on the payer. If not correctly attributed, this could place an undue administrative burden on all parties involved in SDPs – not just the providers, but MCOs and the state. It can also inaccurately depict how SDPs in value-based care arrangements affect provider performance and patient health outcomes. Furthermore, incorrect attribution can hurt overall care

³³ §438.6(c)(5)(iii)(E)

³⁴ <https://www.soa.org/493462/globalassets/assets/files/resources/research-report/2018/patient-attribution.pdf>

coordination efforts. The linkage between patient attribution and provider care necessitates better alignment; NACHC encourages CMS to align patient attribution requirements and processes among the same payer to decrease provider burden.

IV. Other Recommendations

Health centers strive to be good partners with MCOs to increase patient access to quality health care services. Because this proposed rule looks to extend flexibilities and protections in different aspects of managed care, NACHC requests CMS implement more guardrails to ensure health centers have adequate protections. We understand CMS' rationale to carve out health centers from mandated reporting of payment-related data, due to the unique nature of the Prospective Payment System (PPS), or FQHCs/RHCs payment arrangements. Congress established the PPS rate to ensure stability and predictability for health centers, given the critical role of health centers and their services in serving the Medicaid population. FQHCs offer a full range of primary and preventive services, and dental, behavioral, and vision services. Also, many services offered by FQHCs are often not covered by fee-for-service Medicaid, such as case management, translation, transportation, and some dental and mental health services. FQHC PPS ensures health centers are not forced to divert their Federal Section 330 grant funds, which support operations and care to the uninsured, to subsidize low Medicaid payments.³⁵ The following recommendations outline some of NACHC's ideas on how CMS could do this for FQHCs' PPS rate and contracting with FQHCs.

NACHC recommends that CMS reinstate time and distance wait time standards from the 2016 managed care rule for network adequacy. Appointment wait times, while a valid way to measure network adequacy, is not the only factor that should measure patient access to care. Given that the 2020 CMS Medicaid managed care final rule removed the state requirement of using time and distance standards,³⁶ states currently calculate provider network adequacy quantitatively. Many health center patients face geographic and distance barriers accessing timely care, as well as myriad social drivers of health barriers. Reinstating time and distance standards will more accurately measure patient access to services. NACHC is also concerned about the new proposed standards placing more pressure on the providers instead of the managed care entities to ensure that services are available in the network. If MCOs are not contracting with enough providers to ensure appointment availability, it places the onus on existing providers to try and bridge the gap in care. To combat this, CMS should create a standard for MCOs to contract with a sufficient number of providers, including FQHCs.

NACHC requests that CMS institute a policy similar to the Essential Community Providers (ECP) provision of the Affordable Care Act³⁷ to ensure that MCOs are contracting with an adequate amount of health centers. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients live healthier lives and increase their overall

³⁵ <https://www.nachc.org/wp-content/uploads/2018/06/PPS-One-Pager-Update.pdf>

³⁶ <https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicare-and-childrens-health-insurance-program-chip-managed-care>

³⁷ § 156.235

well-being. Congress designed the ECP provision of the Affordable Care Act (ACA)³⁸ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. A similar provision for Medicaid could be developed to have a minimum number of FQHCs an MCO would need to contract with.

NACHC is concerned that not all beneficiaries within an MCO's catchment area have access to mandatory FQHC services, especially because FQHCs are always located in HRSA-designated Health Professional Shortage Areas (HPSAs) or Medically-Underserved Areas (MUAs). Given CMS' stated priority to better align standards across payers and coverage lines, creating a similar provision to ECP through guidance to ensure MCOs are contracting with enough FQHCs in their catchment areas is in line with the Centers' goals. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

We also request CMS engage more in oversight to ensure that FQHCs are reimbursed at least their PPS rate in contracts with their MCOs. CMS should create a tracking system to show timeliness on interim and annual reconciliation payments, and how many months after the end of the year these payments are made. Health centers operate on razor-thin margins, and the timeliness of payments from MCOs is crucial to continuing operations to provide care for health center patients.

If a state chooses to contract with managed care organizations (MCOs) to provide services to its Medicaid recipients, the state is responsible for ensuring that health centers receive no less in reimbursement in treating their Medicaid managed care enrollees than they would receive under the PPS methodology. This responsibility also extends to the reconciliation and oversight processes to ensure that the managed care payments comply with the statutory requirements of the APM.³⁹ Under the Medicaid statute, the state must ensure in contracting with MCOs that FQHC services are accessible to Medicaid beneficiaries to the same extent as such services are accessible under fee-for-service.⁴⁰ When the total MCO payment to a health center is less than what the health center would receive under PPS or an APM, the state Medicaid agency must pay the difference to the FQHC.⁴¹ As mentioned previously, this difference is referred to as a supplemental, or wraparound, payment.

As of 2021, about 22 states are responsible for the wraparound payment. However, states also have the option to delegate the supplemental payments to MCOs, but only if they use a CMS-approved APM. When the state "delegates" the wraparound payment responsibility to the MCO, it remains ultimately responsible for ensuring that FQHCs receive their full PPS or APM reimbursement in managed care arrangements. As of 2021, 16 states direct managed care organizations to participate in this arrangement. Given the number of states that delegate power to the MCO to pay the FQHC

³⁸ Section 1311(c)(1)(C)

³⁹ SHO #16-006: FQHC and RHC Supplemental Payment Requirements and FQHC, RHC, and FBC Network Sufficiency under Medicaid and CHIP Managed Care

⁴⁰ § 1903(m)(1)(A)(i)

⁴¹ § 1902(bb)(5)

their full PPS/APM rate, tracking this type of information is in line with enhancing accountability and transparency in the managed care system while ensuring FQHCs receive adequate and statutorily required payments.

Thank you for your consideration of these comments. We appreciate CMS' initiative to further strengthen the Medicaid program, advance innovation in payment methodologies and benefit strategies, and enhance access to health care services for all enrollees. NACHC looks forward to continuing to partner with CMS on advancing these Medicaid Managed Care initiatives. If you have any questions, please contact Vacheria Keys, Director of Policy and Regulatory Affairs, at vkeys@nachc.org.

Sincerely,

A handwritten signature in black ink that reads "Joe Dunn". The signature is written in a cursive, flowing style.

Joe Dunn
Senior Vice President, Public Policy and Research
National Association of Community Health Centers