

525 Clinton Street
Bow, NH 03304
Voice: 603-228-2830
Fax: 603-228-2464



61 Elm Street
Montpelier, VT 05602
Voice: 802-229-0002
Fax: 802-223-2336

www.bistatepca.org

July 3, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

Dear Administrator Brooks-LaSure:

Bi-State Primary Care Association (Bi-State) appreciates the opportunity to provide input on CMS' NPRM: "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P).

Established in 1986, Bi-State is a nonpartisan, nonprofit 501(c)(3) charitable organization promoting access to effective and affordable primary care and preventive services for all, with special emphasis on those most in need in Vermont and New Hampshire. Bi-State's combined Vermont and New Hampshire membership includes 21 Federally Qualified Health Centers, one Look-Alike, Planned Parenthood of Northern New England, Vermont's Free and Referral Clinics, consortia, and networks. Our members provide comprehensive, high quality primary care to over 300,000 individuals in New Hampshire and Vermont serving all counties in these states.

Bi-State supports the goals of this proposed rule, and supports enhanced access and utilization of health care services. We appreciate CMS' intent to better align Medicaid Managed Care and CHIP protections and provisions with other payers.

We welcome the opportunity to comment on this proposed rule and discuss the anticipated implications of these proposed changes on our members and the patients they serve. Our comments are broken down into three sections: I. Network Adequacy Provisions; II. In-Lieu of Services; and III. State-Directed Payments.

I. Network Adequacy Provisions

Appointment Times:

Bi-State appreciates CMS' proposal to implement wait time standards for certain services at §438.68(e), specifically in the categories of substance use disorder/mental health, primary care (adult and pediatric), and OBGYN. We have concerns about the ability of our health centers ability to meet these standards given the significant workforce shortages they are experiencing. Meeting a 15-day appointment time would be a challenge for our health centers as they struggle to maintain and restore workforce lost over the past few years. These workforce challenges can adversely affect patients and their health, as they contribute to longer wait times, decreased hours of operation for health centers, and decreased appointment availability. While there are numerous state and federal programs being developed and implemented, it takes time to build and we anticipate workforce challenges lasting well past 2027. For example 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.¹

In 2021 health centers in New Hampshire provided over 310,000 visits to their patients. Similarly Vermont health centers provided over 615,000 visits in the same time period. ² During the same time, and continuing, we have seen a precipitous decline in available workforce in New Hampshire and Vermont making these numbers seem even more impressive. According to an analysis by BerryDunn on the 2021 UDS data, health centers in New Hampshire and Vermont experienced an average 40% turnover rate – this figure does not include vacancies. Our health centers continue to struggle to retain and recruit workforce. We agree that patients should have access to a wide range of essential services, but are concerned about the ability to maintain the workforce. As has been well documented, the health care sector has been particularly hard hit by employee burnout and shortages. The workforce shortages are throughout our health centers and include all patient facing staff and administrative support staff. For example, one practice noted that while they were successful in recruiting several primary care providers, they found that these providers request fewer in clinic hours than those primary care providers they replaced. This means that more individuals are needed to see the same number of patients. This is compounded by a lack of all members of the clinical support team (some roles like Medical Assistants and nurses are especially challenging to fill).

We are particularly concerned about the availability of behavioral health providers in New Hampshire and Vermont. Prior to the COVID-19 pandemic, these states were experiencing a lack of mental health and substance use providers, which has been mirrored by national research. Unfortunately, the availability of these providers, and individuals who want to enter this field, is still insufficient to meet the need. Compounding this is the unprecedented need for mental health services.

Currently, health centers are prioritizing existing patients and those with higher acuity. We would appreciate it if CMS could clarify the application of wait times regarding new and existing patients as well as routine, urgent, and emergent appoints. It is important that wait time standards take into consideration the varying level of administrative and prep work required to get patients from the waiting room and in with a provider. Health center workflows are based on educating the patient, assessing their financial

¹ <https://www.aamc.org/media/54681/download>

² 2021 UDS data available at <https://data.hrsa.gov> accessed on July 3, 2023.

eligibility, and often screening for social drivers of health. 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 take into consideration the health center patient populations and health care 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.

Credentialing:

We appreciate CMS’ addition of service categories for credentialing. We would recommend that CMS modify §438.214(b) to include additional requirements to ensure credentialing does not impede access to timely services. Credentialing continues to be a perennial problem for our members and we would appreciate it if CMS could work with the States to hold managed care entities more accountable in this process. Credentialing protections can support providers being available to see patients faster.

II. In Lieu of Services or Setting (ILOS)

Bi-State appreciates CMS codifying previous ILOS guidance³ 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 allowing States to extend ILOS to better address health-related social needs (HRSNs).⁴ For years, health centers have been leaders in screening and addressing social drivers of health, connecting patients to essential services. Furthermore, Bi-State 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. Federal and state policy should center on the patient’s choice and right to receive these services at their preferred provider.

At §438.2, CMS proposes granting States more flexibility in determining when and how ILOS can be offered by managed care plans. We appreciate this flexibility offered that would give States 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.”⁵ To avoid unintended consequences, Bi-State recommends that CMS clearly state that this flexibility does not allow States to substitute ILOS for any of

³ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf>

⁴ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf>

⁵ Pg 28162, Managed Care Proposed Rule

the non-ambulatory, Medicare-defined components of the Medicaid FQHC benefit, which State Medicaid programs are required to cover.⁶

Congress early on understood the important 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.⁷ Almost half (48%) of health center's patients have Medicaid coverage,⁸ 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 that offer a full range of primary and preventive services, as well as dental, behavioral health, and vision services. Many services offered 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.

Bi-State recommends CMS further define parameters around scope, duration, and intensity of quality of services within §438.3(e)(2)(i). Bi-State appreciates CMS' 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.”⁹ State Medicaid agencies should have a documented definition of a “change in the 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 approving ILOs will ensure make it easier for CMS to monitor new ILOS' requests.

Bi-State 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 to receive services in accordance with their individual needs. We support 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. Bi-State agrees with CMS' requirement to include enrollee rights and protections¹⁰

⁶ Section 1861(aa)(1)(A)-(C) of the Social Security Act

⁷ <https://www.nachc.org/wp-content/uploads/2018/06/PPS-One-Page-Update.pdf>

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

⁹ the 2001 PPS Guidance: <https://www.nachc.org/wp-content/uploads/2015/11/PPS-Q-As-2001.pdf>

¹⁰ §438.3(e)(2)(ii)

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 as well as States accountable for services offered. Moreover, the proposal to require monitoring and reporting on appeals, grievances, and state fair hearing data will help ensure that 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 clearer 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 lead to inconsistent application of this requirement and negatively impact beneficiaries' health. 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. does We appreciate CMS' directive that States create and make the transition of care policy plan publicly available.

III. State Directed Payments

Bi-State 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.

Bi-State 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 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. 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.

Bi-State 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. We appreciate CMS recognizing the resources required for FQHCs and other safety-net providers to transition in value-based care (VBC). States need the flexibility to determine the best manner to use SDP funds. Given the importance of investments for infrastructure to support FQHCs in VPC, we request 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 intent of these SDPs.

Bi-State recommends CMS better specify patient attribution requirements and processes for value-based care arrangements - specifically population-based and condition-based payments - in SDP contracts¹¹ 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 VBC arrangements¹². We understand that CMS is directing the State to ultimately decide what type of attribution methodology to employ, however, there should be clearer direction from CMS on what types of methodology are acceptable.

Thank you for your consideration of these comments. If you have any questions, please contact me at gmaheras@bistatepca.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'gm', followed by a long horizontal line extending to the right.

Georgia J. Maheras, Esq.
SVP, Policy and Strategy

¹¹ §438.6(c)(5)(iii)(E)

¹² <https://www.soa.org/493462/globalassets/assets/files/resources/research-report/2018/patient-attribution.pdf>