NATIONAL ASSOCIATION OF Community Health Centers

May 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4207-NC
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: Medicare Program; Request for Information on Medicare Advantage Data (CMS–4207–NC)

Dear Administrator Brooks-LaSure:

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Federally Qualified Health Centers (also known as FQHCs or health centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of an equitable health care system, free from disparities.

Community Health Centers are the best, most diverse, most innovative, and most resilient part of our nation's health system. For nearly sixty years, health centers have provided high-quality, comprehensive, affordable primary and preventive care, dental, behavioral health, pharmacy, vision, and other essential health services to America's most vulnerable, medically underserved patients in urban, rural, suburban, frontier, and island communities. Today, health centers serve 1 in 11 at over 15,000 locations. This includes more than 5 million uninsured people, over 15 million Medicaid patients, over 3 million Medicare patients, and over 1 million patients experiencing homelessness.

In addition to medical services, FQHCs provide dental, behavioral health, pharmacy services, and other "enabling" or support services that facilitate access to care for individuals and families in medically underserved communities, regardless of insurance status or ability to pay. NACHC maintains its role as the national voice for health centers and believes that high-quality primary health care is essential in creating healthy communities. It is the collective mission and mandate of NACHC and the 1,487 health centers around the country to close the primary care gap and provide access to high-quality, cost-effective primary and preventative medical care.

NACHC appreciates CMS' Request for Information (RFI) on Medicare Advantage (MA) to collect stakeholder feedback on what types of data the agency should collect to enhance understanding of how MA impacts its beneficiaries. While we provide desired data collection points, we also highlight the health center perspective on areas in which Medicare Advantage can be improved to benefit health centers entering into MA agreements and the patients utilizing MA coverage. Our comment letter is broken down into four sections: I. Access to Care Issues, including prior authorization and algorithm impact; II. Care and Quality Outcomes/Marketing Tactics; III. Special Populations; IV. Contracting and Reimbursement Challenges for FQHCs with MA Plans.

I. Access to Care Issues, including Prior Authorization and Algorithm Impact

Improving provider directory accuracy for MA patients will enhance access to care and prevent surprise billing. Considering health centers serve some of the nation's most vulnerable patients, it's critical that patients have dependable information on in-network providers. Nearly 70% of health center patients live under 100 percent of the Federal Poverty Level (FPL), and 91% live under 200 percent FPL. MA plans must cover all medically necessary services that Original Medicare covers.[1] Additionally, plans may also offer some extra benefits that Original Medicare does not cover – like certain vision, hearing, and dental services. This is partially why MA enrollment has more than doubled since 2010 and is projected to grow from 54% of the eligible population in 2024 to 60% by the end of this decade.[2] However, health center patients frequently enroll in MA plans without being fully informed about the limitations of their network, made by private insurance companies. If a provider is in-network, the MA plan will cover medically necessary services for a small co-pay, but an out-of-network provider can leave patients with skyrocketing costs, impacting their access to care. This is especially devastating for health center patients who experience several types of social drivers of health (SDOH), such as employment, food security, and transportation issues. Without the appropriate coverage, these patients are met with cost-sharing responsibilities that create detrimental financial challenges.

To help beneficiaries avoid these surprise costs, MA plans are required to publish directories, which enrollees can use to find new doctors or to ensure their existing doctors are covered. However, the accuracy of provider directories has been a problem for some Medicare Advantage plans, sparking major criticism. In fact, a 2018 CMS report found that 52 percent of physician listings in MA provider directories contained at least one inaccuracy.[3] Typical errors include wrong phone numbers, incorrectly listing in-network providers as accepting new patients when they are not and omitting in-network providers from directories.

There have been several cases reported where health center patients enrolled in an MA plan believing their physician was in-network. However, upon attempting to schedule appointments, they were informed by the insurance billing office that their physician was not part of the network.[4] For instance, a health center in California voiced that, for MA plans, when patients look up their provider, the directory will show their provider is in the network, but in fact, they are not. Another health center in North Carolina shared an incident where a patient relied on the MA plan's website to verify their provider's network status. Despite the website indicating the provider was in-network, the patient discovered after enrolling that this was not the case. These instances highlight the critical need for greater transparency and accuracy in MA plan provider networks to prevent patients from facing such misleading and frustrating situations.

While NACHC appreciates CMS conducting an MA Provider Directory Audit to identify inaccuracies, NACHC urges CMS to hold MA plans accountable for provider inaccuracies.

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[1] https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf

[2] https://www.kff.org/medicare/issue-brief/10-reasons-why-medicare-advantage-enrollment-is-growing-and-why-it-matters/

[3] https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf

[4] https://www.pbs.org/newshour/economy/physician-isnt-medicare-advantage-network-can

Unfortunately, it is very difficult, if not impossible, for patients to know ahead of time which plan networks are likely to be inaccurate. Health centers have reported being inaccurately listed in MA provider directories, which impacts their existing patients' access to certain services due to lack of coverage. This can also create a high level of demand for patients seeking care from a limited selection of in-network providers.

MA Organizations rely on various practices to maintain provider directories. These include credentialing services, vendor support, and even provider responses, all of which CMS considers unreliable practices.[5] It is unfair to penalize health center patients who enroll in a MA plan based on false information, but then are expected to pay for the plan's mistake or risk being uninsured altogether. When health center patients discover that their provider is not in their plan's network, providers are left with a choice: send the patient home without care, ask the patient to pay for the service under out-of-network costs, or be prepared to provide the service for free. For example, some health center workers have stated that when a patient is out-of-network, the health center offers either a sliding fee scale or provides the service at no cost. To enhance health equity for all health center patients, NACHC strongly encourages CMS to create guidance to create consistent standards for MA plans directory maintenance processes and technologies.

NACHC recommends CMS revisit current MA network adequacy standards, specifically time and distance standards, at § 422.116 to enhance access to care, especially to specialist providers. A significant difference between Medicare Advantage and Original Medicare is that MA plans have a limited provider network for their enrollees to visit. While we appreciate that CMS recently updated these network adequacy standards in 2023 to try and ensure adequate access, recent feedback from health centers suggests that network adequacy standards are not helping health center patients have sufficient access to providers, especially specialists. Because health centers are required to be located in medically underserved areas, the lack of in-network providers in those areas presents a significant challenge for patient access, especially for older adults who experience chronic conditions, resulting in frequent appointments with specialists.[6] Thus, CMS should exercise increased oversight to improve access to care for older Americans residing in regions facing affordability challenges and accessing comprehensive healthcare services.

Health centers across the country have relayed that there is a general lack of providers in their areas, especially in rural areas. For instance, a health center located in rural northern California relayed that many specialists in their area do not contract with Medicare Advantage plans; while the health center themselves chooses not to contract with MA plans, even if they did, there would be no specialists nearby to send their MA patients to who are in-network. Furthermore, we heard from a health center located in rural Missouri that there is only one in-network primary care provider with the MA plan in the area. Older health center patients may experience mobility issues, making it difficult to travel long distances to seek specialist care. Health centers are strategically placed based on the needs of the community – they must be located in or serve a community with a medically underserved population or a community that has a shortage of healthcare providers.[7] Ensuring adequate access to providers in communities that are already medically underserved is

[5] https://blogs.lexisnexis.com/healthcare/provider-data/provider-directories-still-falling-behind/
[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5486481/
[7] https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers

paramount to promoting health equity, regardless of where patients live. Health centers try to bridge the primary care gap but can be limited when trying to refer their patients to receive specialty care when it comes to MA coverage.

Additionally, we understand that current regulations direct MA plans to "arrange for and cover any medically necessary covered benefit outside of the plan provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet an enrollee's medical needs," per 422.112(a)(1)(iii). However, given the general lack of education MA plans provide to their enrollees about these benefits and their quickness to deny proper prior authorization requests, as detailed further below, better time and distance standards can help alleviate barriers to accessing timely, quality care in MA plans, especially for patients located in rural areas. We urge CMS to adjust MA network adequacy standards, specifically with time and distance requirements, to enhance access to care for patients.

Improving prior authorization processes for MA patients will increase access to medically necessary services for patients and reduce the administrative burden on health center staff. Nearly all Medicare Advantage enrollees are required to obtain prior approval, or authorization, for coverage of some treatments or services — something generally not required in traditional Medicare. A 2022 Office of the Inspector General (OIG) report sheds light on this. It probed coverage denials during one week in June 2019 and found that, among those prior authorization requests that MAOs denied, 13 percent met Medicare coverage rules.[8] The denials were inappropriate because these services likely would have been approved under traditional Medicare rules.[9] Additionally, according to this same report, these denials can delay or prevent beneficiary access to medically necessary care, lead beneficiaries to pay out of pocket for services that are covered by Medicare or create an administrative burden for beneficiaries or their providers who choose to appeal the denial.[10]

For elderly health center patients, prior authorization denials present significant obstacles, compounding the challenges they already face in managing their health. For these patients, timely access to prescribed medications and treatments is crucial for effectively managing their conditions and maintaining their quality of life. However, when prior authorization requests are denied, elderly patients may experience disruptions in their treatment plans, leading to lapses in medication regimens or delays in accessing essential therapies. Such interruptions can exacerbate their chronic conditions, potentially resulting in disease progression, increased symptom severity, and a higher risk of complications. In fact, health center patients are growing increasingly complex, with nearly 32% of health center patients reporting that they suffer from a chronic condition.[11]

With health center patients ages 65 and older being the fastest growing age group served by CHCs, most enrollees are required to receive prior authorization for the highest cost services, such as Part B drugs.[12] Additionally, as the number of older Americans who rely on MA in rural areas continues

[8] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[9] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp
[10] https://oig.hhs.gov/oei/reports/oei-09-18-00260.asp
[11] https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-manual.pdf
[12] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/

to rise, coverage denials increase financial instability for health centers, causing them to make tough decisions about what services they can offer.[13] Notably, a Primary Care Association (PCA) provided information stating that health centers in their state have a hard time getting sufficiently reimbursed for services in rural areas. Even when the plans do pay, they reimburse providers far less than traditional Medicare.[14] Under this circumstance, health centers struggle to satisfy their mission to serve all patients regardless of their ability to pay. Health centers prioritize their patients' needs as they often are one of the few providers in the area.

All health centers, especially rural health centers, depend on adequate reimbursement to meet the needs of their communities. While MA plans repeatedly refuse to reimburse health centers for the services they provide, refusing to provide service is not an option for health centers whose facilities are the only ones operating in their rural area, and health centers provide care to anyone who walks into their facility, regardless of their ability to pay. NACHC urges CMS to address the significant reimbursement disparities faced by health centers for Medicare Advantage services compared to traditional Medicare.

NACHC requests that CMS collect additional data to identify trends in prior authorization denials, approval rates, and reasons for denials. While NACHC appreciates the actions that CMS took to cut down on the cumbersome process of prior authorizations in the Interoperability and Prior Authorization final rule,[15] we urge CMS to gather additional information to increase access to care for MA patients and providers. Specifically, we request that CMS gather information on the frequency and type of MA prior authorizations that health centers are encountering. Understanding the volume of these authorizations is crucial for assessing the workload and administrative burden placed on healthcare providers. Additionally, it is essential to collect data on the average time it takes for a health center to obtain an MA prior authorization. This metric sheds light on the efficiency of the authorization process and can highlight areas where improvements are needed. Accordingly, NACHC requests that CMS identify trends related to these issues, provide feedback to MA plans on improving the PA process, and hold plans accountable for any barriers to care. Additionally, information on the consequences when prior authorizations are not obtained promptly and what happens to patient care when there's not enough staff to fix the issue is critical. Understanding the impact on patient care in such scenarios is vital for identifying systemic challenges and implementing solutions.

NACHC also requests data on the number of MA prior authorization denials that have resulted in peer-to-peer reviews. It would also be helpful to collect data comparing the utilization of MA versus traditional Medicare. Lastly, given the increasing role of algorithms in prior authorization decisions, we urge CMS to examine the effects of algorithms on MA prior authorizations. Collecting data on these matters is essential for promoting transparency and ensuring high-quality care for patients.

NACHC encourages CMS to recommend having a single standard electronic prior authorization system across <u>all insurers</u> to help alleviate some of the burdens stemming from

[13] https://www.nbcnews.com/health/rejecting-claims-medicare-advantage-rural-hospitals-rcna121012
[14] https://www.nbcnews.com/health/rejecting-claims-medicare-advantage-rural-hospitals-rcna121012
[15] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

the process. We appreciate CMS' efforts to streamline prior authorization for MA organizations, state Medicaid and Children's Health Insurance Program (CHIP) Fee-for-Service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs) but hope it can be extended to State-Based Exchanges as well. Prior authorization approvals also impose significant burdens on healthcare providers, particularly when serving MA patients. These requirements demand extensive time and resources from providers, diverting their attention from direct patient care and adding administrative complexity to their workflow. A report from the Medical Group Management Association found that sixty percent of practices surveyed said at least three employees are involved in completing a prior authorization request.[16] Additionally, 77 percent of practices said they have hired or redistributed staff to work on prior authorization to the increase in requests.

Furthermore, the variability in prior authorization requirements across different Medicare Advantage plans further complicates matters for providers and health center workers, requiring them to navigate a maze of varying protocols and documentation criteria. A health center in Louisiana mentioned that it is very difficult to keep up with all of the MA plans – all have a different portal, and it requires time for staff to learn the differences. As a result, health center providers and workers face increased administrative burdens and reduced efficiency, hindering their ability to deliver timely and effective care to MA patients.

Enforcing guidelines to ensure that insurers consider relevant factors for each patient when making coverage decisions through artificial intelligence (AI) will significantly benefit MA patients. While we appreciate that CMS' Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs final rule provides MA patients with certain protections regarding coverage denials based on the use of AI and algorithms, the rule still permits MCOs to use algorithms, AI, and related technologies to assist in making coverage determinations if certain factors are considered for each patient.[17] These include all medical necessity determination requirements[18] and circumstances based on the specific individual, including the patient's medical history, physician recommendations, and clinical notes.

NACHC requests further progress be made to ensure MA patients are not being improperly denied care. As previously mentioned, health center patients ages 65 and older are the fastest-growing age group and are growing increasingly complex, with higher rates of chronic conditions. For this group of health center patients, denials can result in worsening health outcomes, increased pain and discomfort, unnecessary hospitalizations, and decreased quality of life. With nearly two million prior authorization requests for health care services being denied in 2021,[19] it is unclear if these factors were ever taken into consideration or if they will be in the future. For this reason, since MCOs are permitted to use AI algorithms, NACHC requests that CMS take additional steps to ensure insurers consider the relevant patient-specific factors outlined above when making coverage determinations, thereby preventing any bias.

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[16] https://revcycleintelligence.com/news/mgma-medicare-advantage-growth-exacerbates-prior-authorization-burdens
[17] https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf
[18] 42 CFR § 422.101(c)
[19] https://www.kff.org/medicare/press-release/medicare-advantage-plans-denied-2-million-prior-authorization-requests-in-2021-about-6-of-such-requests/

Additionally, navigating the appeals process for denied authorizations can be complex and time-consuming, adding stress and frustration for MA patients. According to a report by the Kaiser Family Foundation, very few Medicare Advantage beneficiaries whose prior authorization requests are denied bother to appeal—just 11%. However, 82% of appealed prior authorization denials are overturned.[20] This alludes to the thought that MA plans are counting on enrollees not appealing to ensure the plan can keep the money for the services not provided. Another mechanism that has payment impacts is "favorable selection," which means that MA plans might disproportionately enroll beneficiaries who are less expensive to treat than predicted by their risk scores.[21] Favorable selection allows plans to bid lower than traditional Medicare spending before producing any efficiencies in care delivery, thus potentially creating overpayments for MA plans. Furthermore, MedPAC recently estimated 11 percentage points of MA favorable selection in 2019.[22]

Prior authorization roadblocks have led some older patients to leave their MA plans. The Commonwealth Fund found that MA plan disenrollments rose from 10% in 2017 to 17% in 2021. Roughly one in five who left cited problems getting the plan to cover medical services.[23] However, a health center in California mentioned that they often experience MA patients being denied Medigap when trying to switch back to traditional Medicare because they are unable to cover the costs.[24] A health center in Louisiana also mentioned that patients feel "stuck" because they do not have the proper assistance to help them switch back to traditional Medicare. Therefore, as MA enrollment continues to grow, we urgently request that CMS closely monitor prior authorization denials and the impact of AI tools used by insurance companies, while also ensuring that there are no policies that interfere with the patient's choice.

II. Care and Quality Outcomes/Marketing Tactics

Health centers provide high-quality, affordable healthcare services to their patients. Health center patients have more chronic conditions than the national average, but our patients experience better health outcomes compared to similar patients who do not use health centers. For example, health centers achieve higher control rates of hypertension and diabetes than the national average despite serving more at-risk patients.[25] However, more granular and stratified data, especially as more patients choose Medicare Advantage plans, is important to better compare patient outcomes served by these plans.

Currently, CMS uses a STAR Ratings system to measure the quality of MA and Part D plans based on member experience, customer service, chronic condition management, and other metrics.[26] This includes certain Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers & Systems (CAHPS) measures, as well as data from the Health Outcomes Survey (HOS). However, CMS should incorporate additional important health equity metrics in its data collection and publicly publish them.

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[20] https://fortune.com/well/2023/04/24/changes-coming-to-medicare-advantage-prior-authorization-rules/
[21] https://www.medpac.gov/wp-content/uploads/2022/07/MA-benchmarks-March-2023-SEC.pdf
[22] https://www.medpac.gov/wp-content/uploads/2022/07/MA-benchmarks-March-2023-SEC.pdf
[23] https://fortune.com/well/2023/04/24/changes-coming-to-medicare-advantage-prior-authorization-rules/
[24] https://www.medicarefaq.com/faqs/can-you-be-denied-a-medicare-supplement-plan/
[25] https://www.nachc.org/wp-content/uploads/2023/07/Community-Health-Center-Chartbook-2023-2021UDS.pdf
[26] https://healthpayerintelligence.com/news/how-hedis-cms-star-ratings-cqms-impact-healthcare-payers

NACHC recommends CMS collect common HEDIS measures, with a focus on stratifying existing Health-Related Social Needs (HRSN) measures. Over 90% of health center patients live at or below 200% of the Federal Poverty Level, making them especially affected by SDOH issues. It is important that existing measures be stratified by HRSN SDOH metrics are compared to regular metrics, and how those outcomes compare to patients with similar SDOH metrics in an MA plan versus being served by an Original Medicare plan. Breaking that down by areas such as age, gender, socio-economic status, drug use, and work environment, for example, could show how exactly these MA plans are serving these more complex patients.

We also request more consistency across the weighting of quality metrics, specifically risk stratification, across plans. For example, there are quality metrics that are 3 or 4 times the weight of other measures, making it inconsistent among plans. Furthermore, it limits or even eliminates financial returns if there is poor performance on that one measure when all other measure performance is 3.8- or 4.0-STAR Ratings. Accordingly, CMS could engage health centers and underserved populations more effectively by harmonizing MA plan measures, increasing focus on unmet HSRNs, adding stratification and appropriate weighting for health equity measures, and enhancing transparency through timely and regular reporting of measure outcomes.

NACHC also supports publishing more timely data around value-based pay programs like the Medicare Shared Savings Program (MSSP) and ACO REACH. Heightening transparency of outcomes related to these projects can help increase health center engagement in some of these innovative models as well as better showcase patient outcomes. However, it is important to note that MA patients cannot partake in the Medicare Shared Savings Program (MSSP) and ACO REACH, only patients covered by Original Medicare can.[27,28] As CMS aims for heightened participation in value-based care (VBC) and having more health center patients engage in these models, not allowing MA participation while MA enrollment outpaces regular Medicare enrollment makes it difficult for sufficient participation in these models. As CMS moves towards more VBC in Medicare, it is crucial that patient attribution is correct when providers are assessed on their patients' quality-of-care outcomes.

We urge CMS to align patient attribution requirements and processes among the same payer and work with other agencies, such as CMMI, to 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 a key component to helping achieve success in value-based care (VBC) arrangements,[29] and CMS has strongly encouraged health care providers, including FQHCs, to increase their participation in these arrangements. In partnership with their state PCAs and Health Center Controlled Networks, health centers across the country have already been actively engaged in Accountable Care Organizations (ACOs) and

[27] https://www.cms.gov/priorities/innovation/innovation-models/aco-reach#:~:text=The%20ACO%20REACH%20Model%20is%20focused%20on,ACO%20through%20voluntary%20alignment%20or%20claims%2Dbased%20alignment.&text=New%20Entrant%20ACOs%20%E2%80%93%20ACOs%20comprised%20of,first%20few%20performance%20years%20of%20model%20participation.
[28] https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/about
[29] https://www.soa.org/493462/globalassets/assets/files/resources/research-report/2018/patient-attribution.pdf

the MSSP. In 2021, 15 states had FQHCs that lead ACOs.[30] Some health centers participating in these VBC arrangements have reported issues with the patient attribution system.

One PCA 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 undue administrative burden on providers who cannot access crucial data for their patients, such as prior authorization data, ultimately hurting the patient's access to care. Furthermore, incorrect attribution can hurt overall care coordination efforts and the health center's ability to maintain VBC arrangements.

We have heard from health centers that it is challenging to track patients given existing limitations to accessing updated MA patient attribution panels. Furthermore, there are many patients automatically attributed to a specific CHC when in fact, their primary care provider is at another facility. This has a negative impact because the CHC is responsible for a patient they are not providing care to, and the system provides the CHC with limited options to remove that patient from their panel. Incorrect attribution does not accurately reflect the care of the patient, and this impacts the CHC's financial success when participating in VBC arrangements. Additionally, incorrect attribution can also make it difficult for CHC to successfully target patients to schedule their Annual Wellness Visits (AWVs).

We request CMS recommend to MA plans that providers, like health centers, have access to updated patient attribution lists via the MA's portal. AWVs are a vital opportunity for patients and their provider to collaboratively discuss preventive strategies, and for the provider to recommend clinical preventive services, leading to the identification of diagnoses.[31] These can help improve patient health as well as establish and develop a deeper, trusted relationship with their provider. Health centers have stressed the need for a timelier way to accurately identify patients on their rosters who are eligible for AWVs. While they are switching to newer technologies in many parts of their practices, health centers currently rely on outdated payor reporting. Having access to an MA portal that allows them to verify the eligibility of the entire attribution list would help improve their efforts of identifying and reaching out to patients to schedule their AWV, a crucial component of overall care. The linkage between patient attribution and provider care necessitates better alignment.

NACHC recommends CMS align Medicare Advantage enrollee protections with requirements in the CY2024 Notice of Benefit and Payment Parameters (NBPP)[32] at §155.220(j)(2)(ii) to require web brokers to submit documentation confirming all enrollment information has been reviewed by and confirmed as accurate by the consumer or their authorized representation. NACHC has heard of deceptive marketing practices used by MA plans and the brokers who sell MA plans as well. We appreciate CMS' intention to address broker compensation, anti-competitive practices, and broader issues within the MA space through the recently finalized Contract Year (CY) 2025 Medicare Advantage and Part D rule. We see further measures CMS can take to increase oversight of broker practices. While some health center

[30] NACHC 2021 PCA Policy Survey Assessment
[31] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8455445/
[32] https://www.federalregister.gov/documents/2024/04/15/2024-07274/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2025

outreach and enrollment staff do help beneficiaries enroll in MA plans, a large amount (one-third) of MA plan enrollees enlist brokers to help them choose their coverage.[33] There needs to be stronger enforcement mechanisms to hold brokers accountable and ensure they provide enrollees with accurate plan information. When a patient finds out they must pay high copays for services or that their doctor is out of network, there is no path for recourse they can take, other than waiting to switch to another plan once open enrollment begins. Health centers try to step in and help make services more affordable for patients in these instances, yet this does not address the larger issue at play: reining in on broker practices. NACHC encourages CMS enhance enrollee protections by implementing similar provisions in the NBPP to ensure that no matter what type of health insurance someone is seeking, they can feel more at ease if they choose to utilize a broker.

By requiring documentation confirming that the entire enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will help protect patients from intentional or unintentional misinformation about their Medicare Advantage insurance. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based or over the phone. As previously mentioned, many patients have expressed confusion and regret about choosing a particular Medicare Advantage plan, whether due to cunning marketing tactics or convincing broker persuasions. Furthermore, this may help decrease instances where patients sign up for Medicare Advantage plans, enticed by the free or low premiums, but are unaware of the copays and end up not being able to afford coverage. Brokers will have to sign paperwork attesting that they have explained the coverage to the patient thoroughly. While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, enhanced oversight, guidance, and enforcement will help protect patients and make them feel more confident when choosing to get assistance from a web broker.

III. Special Populations

Health centers serve many types of special populations, including dually eligible patients and patients with chronic conditions such as chronic kidney disease. To understand how MA plans directly impact these special populations, NACHC requests more specific data on certain outcomes and will provide more granular detail in this section.

In 2022, health centers served 1.28 million dually eligible patients.[34] Dually-eligible individuals traditionally experience more barriers when seeking care, due to the combination of complex chronic conditions and social determinants of health. FQHCs serve higher proportions of dually eligible patients with mental health conditions, substance use disorders, and disabilities than private providers.[35] While we do not know the exact breakdown of health center dually-eligible patients enrolled in Original Medicare versus Medicare Advantage Plans at the health center level, it is nearly an even split at the national level. Over half (51%) have an Original Medicare plan,

[33] https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose
[34] https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2022
[35] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-2847-x

while 49% of the remainder have a Medicare Advantage plan, per 2020 data from KFF.[36] We hope the National Committee for Quality Assurance NCQA can continue to add onto the Social Need (SNS) measures to include more SDOH data, besides food, housing, and transportation unmet needs.[37] Because dually-eligible patients is such a vulnerable population, having the most amount of measures and stratifying those measures by items such as age, race, gender, geographic area and comparing to duals that have Original Medicare can help showcase how similar duals' health outcomes compare.

Health centers also serve patients with chronic conditions, such as chronic kidney disease (CKD), which if left untreated or if it progresses poorly, can lead to End-Stage Renal Disease (ESRD). As mentioned previously, health centers exceed national standards when it comes to controlling diabetes and hypertension, the leading causes of CKD. One of the ways health centers help patients with CKD is through Chronic Care Management (CCM). This includes engaging in care coordination, medication management, creation of a care plan, patient education, resources to support self-management, and more. Health centers also offer outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) from qualified DSMT and MNT practitioners face-to-face visits, one-on-one, to patients with diabetes or renal disease.[38]

These patients have some of the most complex care needs, including needing dialysis, needing to follow a special diet, and subsequently having special health plan needs, and oftentimes needing supplemental plans that help with their over-the-counter drugs. To better understand how health center patients with CKD and ESRD are being served by MA plans, it would be useful to have the existing data CMS collects on these types of patients stratified by race/ethnicity, gender, and geographic region to better analyze disparities in utilization as well as morbidity and mortality. Furthermore, while Medicare Advantage plans do have an out-of-pocket maximum when it comes to Parts A and B, it would be useful to know the frequency/amount of out-of-pocket expenses ESRD patients have due to medically necessary care is out-of-network or prescription drugs are not covered under their plan.

Limiting provider options for referrals in MA Health Maintenance Organization (HMO) plans, especially for patients with chronic conditions, can hinder access to specialized care and potentially compromise the management and treatment of their health conditions. Most people with chronic conditions, such as diabetes, congestive heart failure, asthma, and depression, are managed in primary care settings.[39] However, patients with severe and complex problems are referred to specialists. Specialists play a key role in managing chronic diseases as part of an extended care team and can provide specialist interventions for patients with complex needs.[40] In providing chronic disease care management to health center patients, care teams are doing so with an understanding and sensitivity that many patients face one or more environmental and/or educational barriers.[41]

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[36] https://www.kff.org/medicare/issue-brief/how-do-dual-eligible-individuals-get-their-medicare-coverage/
[37] https://www.ncqa.org/blog/social-need-new-hedis-measure-uses-electronic-data-to-look-at-screening-intervention/
[38] https://www.cms.gov/files/document/mln006397-federally-qualified-health-center.pdf
[39] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC554916/
[40] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC554916/#:~:text=Consultants%20have%20a%20key%20role,bringing%20about%20innovation%20and%20change.
[41] https://www.nachc.org/improving-chronic-disease-care-a-snapshot-of-whats-working-in-health-centers/

However, for MA patients who need to see a specialist for their chronic conditions, obtaining referrals can be challenging due to the restricted network of providers. This is particularly true for MA HMO plans, the most popular type of plan. This is mainly because MA HMO plans typically have lower cost-sharing and out-of-pocket maximums.[42] However, although MA HMO plans keep patients' costs down, network limitations and referral requirements may impede their needed medical care. These plans limit the number of specialists that a patient can see, and to add to their frustration they may require pre-authorization from their insurance company before a treatment or procedure will be covered. While referrals and pre-authorizations can improve the coordination of patient care, they also put some decisions in the hands of the insurance company, rather than the patient's provider.[43] This slows down the treatment process, which can be highly detrimental to the patient's care.

Ongoing high-touch engagements with health center patients about their chronic conditions, including referrals to see a specialist, is a core part of many chronic disease management programs. A health center in Texas expressed similar concerns, stating that when it came to referrals for MA patients, the pool of specialists was limited, and prior authorizations prolonged the process. Due to specialist limitations and prior authorizations, health center patients are put at a higher risk of experiencing adverse health outcomes due to delayed care. Treating chronic illnesses requires an all-hands-on-deck approach, and oftentimes, MA HMO patients suffer. Patients are forced to choose between a plan that limits care for their medical needs or paying additional costs for other MA plans. With nearly 790,000 health center patients experiencing financial strain, these decisions could have detrimental health outcomes.[44] Therefore, we urge CMS to address the issue of limited provider options, particularly within MA HMO plans.

IV. Contracting and Reimbursement Challenges for FQHCs with MA Plans

NACHC encourages CMS to address the challenging issues confronting CHCs by ensuring timely wrap-around payments by Medicare Administrative Contractors (MACs). Per 42 CFR 422.316, FQHCs must be made "whole" by Medicare through supplemental payments to cover the difference if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive under the PPS rate. We have heard anecdotally that there are significant delays in receiving the wrap-around payment from MACs, even though these wrap-around payments to health centers must be made on at least a quarterly basis.[45] The intent behind the statute involving wrap around payments for FQHCs is to ensure that they are paid for services that MA patients are entitled to receive. These complications surrounding timely wrap-around payments further increase existing financial challenges faced by FQHCs, impacting their ability to expand services to meet the healthcare needs of their communities. Therefore, we urge CMS to ensure health centers are receiving timely wraparound payments per the guidelines.

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[42] https://fortune.com/well/2023/08/09/pros-cons-of-medicare-advantage-plans/

[43] https://www.ehealthinsurance.com/medicare/coverage/do-medicare-providers-prefer-medicare-advantage-or-original-medicare/

[44] https://publichealth.gwu.edu/three-out-four-community-health-centers-assess-social-determinants-health-improve-patient-health

[45] 42 U.S.C. §1395w-23(a)(4)(A)

FQHCs lack adequate resources, staffing capacity, and overall negotiating power to enter into fair MA contracts that sufficiently reimburse them. As previously mentioned, under federal law, Medicare must make FQHCs "whole" if they are paid less than the PPS rate through supplemental payments.[46] However, an FQHC who is not contracted with an MA plan is not entitled to that supplemental payment. This can be particularly challenging for FQHCs in rural areas. Although there has been notable growth, MA enrollment in rural areas remains lower than enrollment in more populated areas. This could be the result of fewer investments in marketing and outreach in these areas by MA insurers because financial returns are lower given the smaller population of potential enrollees.[47] Lower enrollment means fewer incentives for MA plans to work to contract with FQHCs. Furthermore, we have heard general issues with receiving timely reimbursement on claims. One PCA stated that they constantly have to threaten legal action in order for the health centers in their state to get paid.

Despite health centers' best efforts to aid MA patients, they often encounter challenges due to having to negotiate separate contracts with each available MA plan. This process can be demanding, especially considering the potential lack of resources, or staffing capacity and expertise needed to secure more favorable contracts. A health center in Iowa expressed that even when they do contract with an MA plan, the reimbursement is not sufficient to cover costs, adding that FQHCs with lower patient populations have a significantly lower reimbursement rate. Another health center in northern California attested to this problem, stating that their health center only gets paid $10 per visit, and other providers in the city (about 30 miles away) decline to take certain MA plans due to the low payments. Rural health centers serve older, sicker, and fewer patients than urban facilities, making their financial situation more fragile.[48] Because many FQHCs do not have the bargaining power to negotiate better MA contracts, it puts them at a financial disadvantage and could impede efforts to address healthcare inequities. Therefore, NACHC encourages CMS to evaluate payments to FQHCs based on geography to ensure better, more equitable payment to FQHCs.

NACHC urges CMS to streamline the complex and varied billing requirements under MA for FQHCs to decrease administrative burden and help promote fair reimbursement for the vital services they provide. Healthcare providers, after having successfully contracted with a MA plan, must next navigate a complex landscape when engaging with MA plans that comply with billing guidelines.[49] Adherence to CMS regulations, understanding reimbursement mechanisms, maintaining effective communication, and prioritizing value-based care are critical for success. However, navigating this landscape is especially challenging for health centers that need to understand various coding systems and documentation standards specific to each MA plan, leading to administrative burdens and potential billing errors. Additionally, health centers must navigate network participation agreements with MA plans to ensure they are included as in-network providers. Failure to participate in a plan's network can result in reduced reimbursement rates or denial of claims, further complicating billing processes.[50]

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[46] https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-faqs.pdf
[47] https://www.kff.org/medicare/issue-brief/medicare-advantage-enrollment-plan-availability-and-premiums-in-rural-areas/
[48] https://www.axios.com/2023/08/21/rural-hospitals-medicare-advantage-financial
[49] https://www.linkedin.com/pulse/deeper-dive-medicare-advantage-plans-comply-billing-neelarathinam-m88nc/
[50] https://www.linkedin.com/pulse/navigating-complexities-medicare-medicaid-billing-vo5re/

A health center in Iowa expressed frustration trying to balance the required paperwork for MA plans and staying up to date with billing requirements. Additionally, a health center in northern California mentioned that if their health center agrees to contract with an MA plan, then they must accept all of their private patients in different products offered by that specific plan. Being forced to take on a large number of patients in a short period of time strains health center resources for the existing underserved community. Furthermore, the health center relayed that for every private insurance patient visit, the health center loses about $200, reiterating that it is a major financial concern for them to take on all those additional patients.

As previously mentioned, health centers often face an unequal playing field in negotiating MA contracts. Health centers typically lack the bargaining power of larger healthcare systems or insurance companies, which puts them at a disadvantage when negotiating reimbursement rates with MA plans.[51] MA plans may also offer health centers contracts with less favorable terms and lower reimbursement rates compared to other providers, making it challenging for them to sustain their operations and provide quality care. Unfortunately, to maintain patient access, health centers are forced to accept these disadvantageous contracts, eventually leading to long-term financial strain.

Moreover, MA reimbursement relies on Hierarchical Condition Category coding, which shows how well providers, like health centers, keep records of patient care and accurately assign diagnostic codes.[52] This is important because it affects how much reimbursement they receive. It is a large responsibility for health centers because they must make sure their records truly show how sick or complicated their patients are. Also, health centers conduct regular check-ups called Medicare Annual Wellness Visits to help prevent health problems but sometimes have trouble recording these visits accurately.[53] The challenge lies in demonstrating how health centers utilize this data effectively, showing the gap between data collection and meaningful document collection. This also further adds to the repeated concerns by health centers discussing the administrative burden of keeping track of payments, plus the added stress of understanding quality metrics from a clinical perspective. As such, addressing these challenges is crucial for streamlining operations and enhancing patient care.

We urge CMS to issue guidance requiring MA plans to pay health centers at least PPS for in-network and out-of-network claims. Additionally, CMS should have more oversight of contractual agreements between providers and MA plans to address inadequate reimbursement terms. MA services provided by an FQHC but not covered under the FQHC benefit are to be paid at the same rate that they would be paid under original Medicare.[54] However, as stated earlier, FQHCs who are not contracted with an MA plan are not entitled to supplemental Medicare payments. For this reason, many FQHCs have expressed ongoing difficulties when

[51]https://www.oregon.gov/oha/OHPB/MtgDocs/8.0%20Community%20Challenges%20presented%20to%20OHPB%20August%207,%202023.pdf
[52] https://www.rcxrules.com/hcc-coding-value-based-reimbursement#:~:text=HCC%20Coding%3A%20A%20Shift%20in,companies%20offering%20Medicare%20Advantage%20plans
[53] https://www.medicareinteractive.org/get-answers/medicare-covered-services/preventive-services/annual-wellness-visit
[54] https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/oonpayments.pdf

handling patients who are not in-network with their existing contracted MA plans. Although health centers will never turn a patient away because of payment issues, it is a continued concern for health centers. As a result, health centers must navigate different ways to fully assist MA patients who are not in-network with the FQHC. For example, health centers in both Iowa and Texas have stated that out-of-network patients are not turned away, but rather put on a sliding fee scale. Uncertainty regarding the proper procedures for health centers to take when providing services to out-of-network MA patients leads to frustration for patients who discover that their provider is not in network and for health centers who ultimately bear the costs.

However, given FQHCs' unique status as a mandatory type of service provider, which includes Medicare service, health centers should be fairly compensated for all services provided to MA patients, regardless of whether the patient's MA plan is contracted with the FQHC. Not adequately compensating FQHCs for essential preventative care services contradicts the intent behind Section 1834(o)(2) of the Social Security Act, which outlines required payments for FQHC services delivered to Medicare beneficiaries. MA patients *are* Medicare patients and thus are entitled to receive FQHC services without being placed on a sliding fee scale. Additionally, as safety net providers serving Medicare patients, FQHCs are entitled to Medicare payments. When FQHCs are not adequately compensated for the services provided, it hurts their ability to provide access to high-quality, cost-effective primary and preventative care, which is the collective mission and mandate of over 1,400 health centers around the country. Therefore, NACHC urges CMS to collect data to support FQHCs in managing reimbursement challenges related to services rendered to MA patients who are not in network with their existing contracted MA plans.

Thank you for your consideration of these comments. We appreciate the opportunity to share our feedback on data points to collect as well as the health center experience to help improve Medicare Advantage for the patients we serve. Given that the Medicare population is the fastest growing patient population for health centers, we are committed to working with CMS to move policies forward that increase access and protect patients.

If you have any questions, please contact Vacheria Keys, Associate Vice President of Policy and Regulatory Affairs, at vkeys@nachc.org.

Sincerely,

Joe Dunn
Senior Vice President, Public Policy and Advocacy