



**New York State Health Equity Reform 1115 Waiver Amendment
Community Health Care Association of New York State Comments
October 19, 2022**

Background

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to comment on the 1115 waiver amendment, New York Health Equity Reform (NYHER): Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic. CHCANYS is the primary care association of more than 70 NYS federally qualified health centers (FQHCs), also known as community health centers (CHCs), that serve approximately 2.1 million New Yorkers each year at over 800 sites in medically underserved communities. FQHCs are non-profit, community run clinics that provide high-quality, cost-effective primary care as well as behavioral health, dental care, and social support services to everyone, regardless of their insurance coverage, immigration status, or ability to pay.

The majority of FQHC patients are extremely low-income; 90% live below 200% of the Federal poverty level. FQHCs serve populations that the traditional healthcare system has historically failed: 68% are Black, Indigenous, or People of Color (BIPOC), 28% speak limited or no English, 13% are uninsured, and 4% are unhoused. Nearly 60% of our FQHCs' patients are enrolled in Medicaid, CHIP, or are dually enrolled in Medicare and Medicaid. FQHCs are a crucial safety-net for New York's residents of both rural and urban areas and are often the first entry into healthcare and social services for people who experience poverty, racism, and discrimination that inhibits their health and well-being. As safety-net providers who have built trust and relationships in medically underserved communities, FQHCs have long worked to address health disparities and advance health equity. The waiver must prioritize and invest in primary and preventive care to further the goals of improving health outcomes and advancing health equity.

FQHC Alternate Payment Methodology (APM)

Capitated APM

CHCANYS is pleased to see reference in the waiver amendment to a FQHC-specific alternative payment methodology (APM), which we believe is necessary to align care delivery models with the goals of advanced value-based payment. Federal law mandates that State Medicaid programs reimburse FQHCs using a visit-based bundled payment methodology, known as the prospective payment system (PPS), regardless of contractual agreements between FQHCs and Medicaid managed care plans. However, 42 U.S.C. §1396a (bb)(6) permits an FQHC to be paid under an Alternative Payment Methodology (APM) through a State Plan Amendment (SPA), with the following conditions:

- a) the APM reimbursement is not less than what the FQHC would have received under a "traditional" visit-based PPS methodology **and**
- b) each health center individually agrees to participate in the APM.

The traditional visit-based PPS methodology incentivizes volume over value. However, a FQHC APM allows State Medicaid programs to adopt a different methodology that can support integrated care,



incentivize high-quality comprehensive primary care services, allow flexibility to address patients' social determinants of health, and promote increased access to care. Without the limitation of payment tied to a narrow billable visit, FQHCs can adopt innovative care delivery modalities such as telehealth, remote patient monitoring, same-day visits for primary care and behavioral health, and team-based care designed to best suit a given patients' needs. Moreover, an APM will empower FQHCs to better coordinate with community partners to provide whole person care, including addressing patients' social needs, which are known to be the root causes of health disparities.

CHCANYS appreciates the inclusion of a value-based FQHC capitated APM in the waiver amendment and welcomes the opportunity to work with DOH to submit a State Plan Amendment (SPA) for a capitated APM.

Directed Payment APM

In July 2020, the Department of Health issued guidance directing MCOs to reimburse FQHCs at the PPS rate for FQHC services licensed under the State Office of Mental Health and Office of Addiction Services and Support. The Department of Health has shared its plan with CHCANYS to direct MCOs to pay FQHCs their full PPS payment for all FQHC services in the coming months. We welcome the opportunity to move to a less administratively burdensome payment methodology. As we have noted, per CMS SHO #16-006, DOH is required to secure CMS approval of a State Plan Amendment (SPA) for this alternate payment methodology. While the directed PPS is not part of the waiver amendment, we believe the process for implementation of this initiative has potential accountability and transparency impacts for the capitated APM included in the waiver. We look forward to working with DOH to develop a SPA to gain CMS approval for this APM as a basis for an additional capitated APM that moves FQHCs to value-based payment.

\$1 Billion Investment in Community-Based, Integrated Primary Care

As safety-net providers who have built trust and relationships in medically underserved communities, FQHCs have always addressed social determinants of health and are well-positioned to be key partners in advancing the waiver goals. FQHCs are safety-net providers located in the communities that have been most adversely impacted throughout the pandemic, and were at the forefront of public health efforts, including standing up mass testing sites and vaccination efforts statewide. To advance the prevention and population health goals of the waiver, targeted investment will expand interventions focused on health equity and population health improvement for the large proportion of the Medicaid population served by FQHCs.

CHCANYS has requested a \$1 billion investment in FQHCs and FQHC-led IPAs, through upfront investments and long-term FQHC rate reform to ensure sustainability beyond the life of the waiver.

Investment in FQHCs

Upfront, targeted investments in FQHCs are needed for capacity building and COVID-19 recovery. Specifically, an upfront investment would support:

- Development of technical infrastructure, including telehealth capabilities;
- Expansion of data analytics that promote interoperability resulting in actionable information to improve clinical outcomes;



- FQHC solvency requirements to successfully participate in risk-sharing VBP arrangements;
- Integrated care initiatives, such as development of community partnerships that enhance FQHCs' ability to address social determinants of health, regulatory waivers to allow a co-location pilot, and integrated care team transformation;
- Workforce recruitment, retention, and resiliency;
- Innovations to improve patient satisfaction and retention; and
- Readiness for a FQHC capitated Alternative Payment Methodology (APM) to align care delivery models with value-based payment and health equity goals. An APM provides greater flexibility for meeting patient care needs, helps reduce the unnecessary utilization of services, and has the potential to improve the patient experience.

Investment in FQHC-led IPAs

CHCANYS requests a targeted investment for capacity building at existing FQHC-led IPAs to strengthen FQHC engagement in VBP contracting. Many FQHCs have formed or joined Independent Practice Associations (IPAs) in partnership with other FQHCs, primary care providers, behavioral health agencies, and Community-Based Organizations (CBOs). IPAs are the primary vehicle through which FQHCs participate in advanced VBP arrangements. IPAs enable FQHCs to better address population health and coordinate with behavioral health organizations and social services agencies. IPAs identify high-risk FQHC patients and connect them to the appropriate level of care. However, FQHC-led IPAs remain self-funded and challenged to develop needed infrastructure. The State must make investments in FQHC-led IPAs to support the technical infrastructure and data analytic capabilities needed to effectively manage population health, drive improved outcomes, ensure connectivity with social care needs providers, and be high performers in value-based contracts.

FQHC Rate Reform

FQHCs are the primary care safety-net for millions of impoverished New Yorkers and are often the provider of choice in medically underserved communities. For many years, FQHCs have been facing rising operating costs that far exceed reimbursement, most recently including astronomical increases in workforce costs. Federal COVID funding provided temporary relief that allowed FQHCs to continue providing essential care during the pandemic and forestalled catastrophic operating losses. FQHCs are now preparing for the end of this enhanced federal funding and face new pressures on operating costs. FQHC reimbursement rates must be reformed to sustain FQHC operations and support the sustainability of innovations in the health delivery system implemented by the 1115 waiver.

Innovation in FQHC rate reform must reflect:

- Comprehensive analysis of operating costs, including workforce recruitment/retention needs;
- The full spectrum of FQHC services, including many social care services that FQHCs provide directly;
- Sustainability of waiver initiatives, such as expanded interventions focused on health equity and population health improvement for the large proportion of the Medicaid population served by FQHCs; and
- A commitment from the State to increase the percentage of healthcare spending allocated to community-based primary care to promote preventive care and improve



health outcomes.

FQHC Participation in Advanced Value-Based Arrangements

Improve Transparency Between Providers & Plans

Providers and health plans do not have equal footing when negotiating and implementing VBP contracts. Due to plans' proprietary risk stratification methodologies, it is difficult for FQHCs and independent practice associations (IPAs) to understand exactly how their patient populations' health and social risk is being measured by the plan. Additionally, medical loss ratio and avoidable hospitalization calculations are not always explicit. Providers often do not receive timely information around patient attribution and patient utilization that occurs outside of the FQHC. For a provider to ensure success in VBP, the State must define and enforce minimum intervals for "timely" sharing of data from MCOs to VBP contractors. CHCANYS applauds the State's intent to establish a statewide data store supported by the existing infrastructure of the SHIN-NY to provide near real-time insights into waiver activities such as screenings, referrals, and service outcomes. VBP contractors must also have access to the full range of plan data on a regular basis: monthly claims, risk score calculation, timely care gap data, and patient rosters.

Require MCOs to Contract with FQHC-Led IPAs

Currently, the State sets minimum goals for dollars captured in arrangements by Level 1 and Level 2 or higher as defined in the State's Value Based Payment Roadmap. However, these goals do not consider provider types in each Level of VBP contracting and leaves full discretion to MCOs on whether to enter into VBP arrangements with certain providers. This has restricted willing and capable community-based primary care providers from participating in VBP arrangements with certain MCOs, if the MCO believes they have sufficiently met VBP contracting targets with other provider types. CHCANYS requests that the State set requirements for MCOs to enter into VBP arrangements, through a lead contractor such as a FQHC-led IPA, with FQHCs who meet a minimum percentage of the provider's patients covered by the MCO.

Primary Care Attribution Methodology

Currently, the discrepancies between MCO attribution, consumer utilization, and VBP contractor rosters make it challenging for FQHCs to effectively manage patient health outcomes. For example, a FQHC is currently held accountable for patients who are auto assigned to the FQHC as their primary care provider, but receive primary care elsewhere, and for whom MCOs cannot provide current contact information. A primary care attribution methodology must include the ability to add patients who receive most of their care at the FQHC and remove patients who receive the majority of care from other providers. Additionally, the attribution methodology should stipulate that patients with serious mental illness be attributed to behavioral health providers. CHCANYS requests the state to set minimum required standards for primary care-centered attribution, as opposed to the current non-binding guidelines. These required standards should include periodic (i.e., quarterly) reconciliation to actual utilization.



Health Equity Measures and Improvement-Based Targets

CHCANYS is supportive of the establishment of a statewide measure set through Clinical Advisory Groups (CAGs). A statewide menu of quality metrics will allow HEROs to adopt measures best suited for their region's population, will standardize measures across plans, and will enable contractors to better meet quality targets. In each region, all VBP contracts should include the same or similar measures, as defined by the HERO, to reduce provider burden. Additionally, the state should set and enforce a maximum total number of quality measures that can be included in a VBP contract.

Improvement-based targets require that a provider show improvement on a specific metric compared to that same population at baseline, over time. Improvement-based targets avoid penalizing providers who treat individuals with greater social needs or experiencing wider disparities, as is the case for many within the FQHC population. In cases where measures are stratified by relevant characteristic (e.g. race, ethnicity, language, etc.), improvement based targets with pay for performance rewards the achievement of equity-related goals without penalizing safety-net providers.

Workforce

CHCANYS is supportive of the waiver's expanded scope of workforce initiatives to provide a wide range of training, recruitment, and retention initiatives across the care continuum. In addition to investments through Workforce Investment Organizations (WIOs), the waiver should invest in other workforce development partners, such as Area Health Education Centers (AHECs) and community colleges, who have existing capacity to train in expertise specific to primary care.

CHCANYS is supportive of the waiver's initiative to expand the Community Health Worker (CHW) workforce. To bolster these efforts, CHCANYS recommends that the State empower a governing body to standardize certification, training standards, and core competencies for CHWs. The State must also establish a long-term funding sustainability mechanism for Community Health Workers after the waiver period ends. While this initiative will improve care and expand career pathways, the waiver should also invest in development of career pathways and care delivery improvement through other health care titles as well, such as dental support staff, nationally certified Medical Assistants, health educators, and care managers.

The ability to provide visits remotely has enhanced FQHCs' ability to attract behavioral health providers, as well as other needed health professionals. However, telehealth reimbursement disparity for FQHCs remains a barrier. FQHCs continue to incur fixed personnel costs along with operation and maintenance of their physical sites and telehealth infrastructure regardless of provider and patient locations. A recent survey of CHCANYS members found that among all telehealth (audio-only and audio visual) visits, about 17% occur with both the patient and the provider offsite. That same survey of CHCANYS members found that nearly 60% of behavioral health visits are occurring remotely, and 16% of those are occurring with both the patient and the provider located offsite. Given the increased need for behavioral health services since the beginning of the pandemic, recruitment for behavioral health providers is extremely competitive and nearly impossible when searching for multi-lingual providers. Full telehealth payment parity is needed regardless of provider and patient location to ensure that FQHCs have the flexibility to recruit and retain providers and to meet patients' care needs.



In addition to the workforce challenges listed above, New York State is experiencing a workforce shortage of dental providers, including dentists, dental assistants, and dental support staff. FQHCs have built robust oral health programs. However, improving oral health outcomes will require that many kinds of providers offer oral health services and that effective approaches embed oral health services across community institutions. Benefits already accrue from initiatives to provide oral health services in the places where people gather or go: Head Start programs, schools, pediatricians' offices, and FQHCs. Additional investment and attention are needed to expand the dental health workforce and increase access to high quality dental care.

Governance

Given their patient attribution and ability to advance primary care and prevention, FQHCs must be represented in HERO governance and must be meaningful partners in HERO and SDHN networks and have representation on Clinical Advisory Groups. FQHC-led IPAs, who serve as the VBP contractor for many FQHCs, and School Based Health Centers (SBHCs), who provide medical, mental health and social services to meet the needs of their students and families, must also be incorporated into HERO and SDHN governance to leverage their existing work and to avoid duplication of resources and effort.

Contact

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