

January 30, 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: Request for Information; Essential Health Benefits (CMS-9898-NC)

I am writing on behalf of Howard Brown Health, a federally-qualified health center located in Chicago, IL. Howard Brown is the largest LGBTQ+ health center in the Midwest, serving more than 30,000 patients across eleven clinic locations in Chicago. Howard Brown serves adults and youth in its diverse health and social service delivery system focused around seven major programmatic divisions: primary medical care, behavioral health, research, HIV/STI prevention, youth services, elder services, and community initiatives. As a federally qualified health center, Howard Brown provides services regardless of a patient's ability to pay or insurance status.

The Essential Health Benefits (EHB), included in the passage of the Affordable Care Act, drastically changed health insurance in America for the better. Their mandated inclusion in the benefit design of QHPs on the Marketplace and for people receiving coverage through Medicaid expansion has led to more comprehensive coverage for millions of people. EHB helps over 20% of health center patients who have private insurance and many of the 46% of patients who receive Medicaid coverage through Medicaid expansion. Prior to the ACA, many Americans were underinsured; 62% of individual market plans did not offer maternity care coverage, 34% substance use disorder coverage, 18% mental health services, and 9% prescription drug coverage.¹ Given that EHB has not been reviewed since it went into effect in 2014, we welcome the opportunity to provide feedback. Our comments focus on the most important aspects of EHB that affect community health center patients: I. Barriers of Accessing Services Due to Coverage or Cost and II. Addressing Gaps in Coverage

I. Barriers of Accessing Services Due to Coverage or Cost

Howard Brown recommends CMS ensure that patients can continue to access EHB via telehealth, even after the pandemic. The ability for health centers to provide services

¹ <https://aspe.hhs.gov/sites/default/files/private/pdf/76356/ib.pdf>

through telehealth has been a lifeline for patients to continue receiving care during the pandemic. In 2021, nearly all health centers provided telehealth services. Data shows that mental health visits were the most frequent telehealth visit type for health center patients. Fifty-four percent of telehealth visits were for mental health, 31% for substance use disorder, 27% for enabling services and 18% for medical visits. 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 2021.²

At Howard Brown, we've seen similar increased uptake and continuity of care for behavioral health services administered via telehealth. From July 2020 to June 2021, we provided 34,655 telehealth visits over 989 unique zip codes, with 91% of behavioral health, 99.7% of substance use treatment services and 47.8% of primary care services conducted via telehealth. We have seen higher initiation and retention in hormone replacement therapy for transgender and nonbinary (TNB) patients receiving telehealth services. TNB patients were able to receive integrated telehealth options to accelerate clinical care consultations related to gender-affirming hormone therapy, primary care, and pre-surgical clinical consultations. Efforts to increase access to affirming care, including through the use of telehealth, are especially important now that anti-LGBTQ+ and anti-transgender legislation is on the rise across the country. These laws foster hostility toward LGBTQ+ people and, in some cases, make it illegal to seek in-person gender affirming care. The Biden Administration has made it clear that the federal government is committed to advancing LGBTQ+ health equity and protecting transgender people from discriminatory laws.

Telehealth serves an important role by expanding health care access to patients, helping them overcome geographic, economic, transportation, and linguistic barriers. CMS should maintain telehealth flexibilities to ensure patients' access is not hindered.

Howard Brown recommends CMS ensure mental health payment parity, which is critical in the post PHE landscape and for Medicaid reimbursement, especially related to Quality Health Plans. Despite the parity requirement in both Federal and state laws for coverage of mental and physical health services, cost and reimbursement rates differ vastly. "Mental health services are more than 5 times as likely to be charged out of network and in-network provider reimbursement rates are 20% higher for primary health care versus mental health visits."³ Our patients experience the additional barrier of lacking

² [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).)

³ <https://www.whitehouse.gov/briefing-room/statements-releases/2021/10/19/fact-sheet-improving-access-and-care-for-youth-mental-health-and-substance-use-conditions/>

LGBTQ+ competent and affirming providers in network. Payment parity for mental health services is crucial for the continued financial viability of health centers, who commit to serving all regardless of their ability to pay.

The issue of payment also affects patients because having insurance does not automatically equate to affordable coverage; one survey found that around half of insured adults consider their plans to offer adequate mental health coverage.⁴ Health centers strive to provide affordable care to all their patients, regardless of insurance status. One of those ways is through a sliding fee discount program, which reduces or waives the amount that the patient pays, based on the patient's income relative to the federal poverty level and the patient's family size. Under this statutory requirement, health centers must charge individuals whose income is above 200% of the federal poverty level pay full price for services, while individuals whose incomes are at, or below, 100% of the federal poverty level pay only nominal fees. In 2021, 17% of our patients at Howard Brown qualified for use of sliding fee scale discounts. The fee schedule is intended to have patients be monetarily invested in their care but also minimize cost-related barriers to care. Even with insurance coverage, health center patients still need discount pricing to have access to comprehensive medical care and the sliding fee scale can help patients better afford mental health coverage no matter their health insurance plan.

Howard Brown urges CMS to promote policies and strategies to enhance the health care work force, so that patient needs related to EHB can best be met. A recent NACHC survey found that 68% of health centers lost between 5 and 25% of their workforce in the last six months, with a majority citing financial opportunities at a large health care organization as the reason for departure.⁵ At Howard Brown, we recently were forced to implement a workforce reduction of about 16%, largely impacting our administrative and behavioral health teams. This workforce reduction was brought on by financial challenges stemming from reduced 340B pharmacy revenue as well as loss of federal COVID-19 funding.

These workforce losses could be mitigated by interstate licensure compacts. Howard Brown supports state efforts to expand the use of interstate medical licensure compacts that simplify cross-state licensure processes and supports expansion of federal policies and incentives for improvement in ease of practice across state lines, and recommend CMS use their regulatory authority to create incentives for states to maintain this flexibility created

⁴ <https://www.apa.org/monitor/2014/07-08/upfront-health-parity#:~:text=While%20the%20APA%20survey%20found,limits%20for%20mental%20health%20care.>

⁵ 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/>

in the pandemic. This approach minimized barriers for providers and strengthens the workforce in areas with significant shortages of providers, like in rural America. This is especially impactful for our patients given the lack of LGBTQ+ affirming care, and specifically gender affirming care, across the country. According to the 2015 US Transgender Survey, only 45% of participants reported receiving gender-affirming/transition-related care within 10 miles of their home, and respondents were three times more likely to have to travel more than 50 miles for transgender-related care than for routine health care.⁶ Expanding the use of interstate medical compacts would help mitigate these access issues, especially for more vulnerable patients that health centers serve.

II. Addressing Gaps in Coverage

Howard Brown recommends CMS add FQHCs as an essential health benefit. Health centers serve 30 million patients and provide care to anyone, regardless of their ability to pay. They have served on the frontline during the COVID-19 pandemic, administering vaccines, and responded to adverse weather events in their states or neighboring states. Health centers are highly valued because of their strong community ties as well as their ability to provide affordable, accessible care. FQHCs provide high-quality, affordable, and accessible primary care, along with other required services as outlined in the Section 330 Statute.⁷ Adding FQHCs as an EHB will ensure that MCOs and states will contract with FQHCs, enhancing patient choice and access to health care services. FQHC services are already included within Medicaid as a required service and made available to patients. Including FQHCs as an EHB falls in line with Medicaid benefits and would allow more health insurance enrollees to have access to similar benefits. This also would ease contracting opportunities between FQHCs with Medicaid MCOs or the State, and ensure proper payment is being given to FQHCs to allow them to continue offering accessible health care services to their patients.

To better address coverage gaps, Howard Brown also strongly urges CMS to add case management and care coordination into EHBs offered by QHPs on the Marketplace. Per the Section 330 Statute, health centers are required to provide a number of primary care health services, which includes patient case management services and enabling services.⁸ As the largest source of primary and preventive care for the nation's underserved, many of whom are at elevated risk for poor health outcomes and health

⁶ James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality, page 99, available at <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>.

⁷ Within the Public Health Service Act

⁸ <https://www.nachc.org/wp-content/uploads/2018/05/Section-330-statute-as-of-March-2018-Clean.pdf>

disparities, patients come to health centers with a host of complex health and other social risk factors. These two services allow the health center to address patient SDOH needs, such as gaining access to programs that deal with social, housing, educational, or financial services as well as outreach and enrollment and transportation, for example.

At Howard Brown, case management and care coordination are critical in helping our patients access care address barriers to care and improve whole-person health with a focus on SDOH needs. For example, our Broadway Youth Center provides primary care, behavioral healthcare, and sexual and reproductive care to LGBTQ+ street-based youth. Our case managers also help youth access food, housing, clothing, and other basic needs. They also help to provide assistance in accessing government assistance, health insurance, education, and job placement. Case management and care coordination are critical to ensuring that the youth that we serve not only access healthcare that they need, but are also set up to succeed and to thrive outside of our healthcare center. We recommend that CMS amend EHB to incorporate case management and care coordination to better address SDOH needs experienced by patients to lead to better outcomes.

Including case management and care coordination, which both help better address SDOH experienced by patients, can create savings for the overall health care system. Further, health centers help reduce emergency room utilization by better addressing patient care needs through offering primary care and addressing SDOH.⁹ These two points are crucial to consider, given that U.S. health care expenditures continue to grow. In 2021, it reached \$4.3 trillion, or \$12,914 per person and accounts for 18.3% of the U.S.'s total Gross Domestic Product.¹⁰ Investing in SDOH pays off; a 2018 study showed that when a health plan focused on SDOH and connected patients to services to address SDOH needs, spending decreased around 11% within a year.¹¹ There are countless other studies that show a clear connection between addressing SDOH needs and improved patient outcomes as well as lower costs – adding case management and care coordination as EHBs will ensure SDOH are adequately addressed.

To help ensure more comprehensive access to EHB, Howard Brown recommends CMS find creative ways to incentive the remaining 11 states to take up Medicaid expansion. The Affordable Care Act requires that state Medicaid plans offered to people who gained access through Medicaid expansion cover the essential health benefits for this

⁹ https://www.nachc.org/wp-content/uploads/2015/06/ED_FS_20151.pdf

¹⁰ <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical#:~:text=U.S.%20health%20care%20spending%20grew,For%20additional%20information%2C%20see%20below.>

¹¹ <https://www.liebertpub.com/doi/10.1089/pop.2017.0199>

population.¹² Currently, 39 states and the District of Columbia have expanded Medicaid. States that have taken up Medicaid expansion report improved quality of care, enhanced access to care, and reduced health care costs,¹³ all of which greatly benefit health center patients. For health centers, expansion led to increased financial stability and the number of patients served. Health centers in expansion states served about 25% more patients and provide nearly 50% more patient visits.¹⁴ Also, plans offered to people receiving coverage through Medicaid expansion also have to cover EHB¹⁵, modified for the Medicaid population.¹⁶ With 91% of health center patients in or near poverty,¹⁷ Medicaid expansion ensures that coverage reaches those that were previously stuck in the coverage gap.

Medicaid expansion has been particularly beneficial for LGBTQ+ communities. According to the Center for American Progress, just 8% of LGBTQ+ people are uninsured in states with Medicaid expansion, compared to 20% uninsured in states that have not yet expanded Medicaid. Expanding access to insurance coverage is a critical issue for LGBTQ+ people as anti-LGBTQ+ discrimination is still common in healthcare and in insurance, and we are seeing a resurgence of legislative attacks across the country particularly around restricting coverage for gender affirming care. Medicaid expansion has also been especially beneficial for people living with HIV. According to the Kaiser Family Foundation, 20% of people living with HIV in non-expansion states were uninsured, compared to just 6% in expansion states.

Unfortunately, in the 11 non-expansion states, the choice not to expand Medicaid has left many without affordable access to coverage and worsened health disparities. A strong Medicaid program is critical for health centers to serve patients effectively. NACHC strongly supports all efforts for expansion in the remaining states and recommend CMS continue to do all it can to incentivize states to take advantage of expansion.

Howard Brown also recommends making the enhancement to APTC, found in Section 9661 of the American Rescue Plan (ARP), permanent. The ARP increased the number of households eligible for the subsidies as well as the monetary amount of subsidies

¹² [https://www.medicaid.gov/medicaid/benefits/alternative-benefit-plan-coverage/index.html#:~:text=Alternative%20Benefit%20Plan%20Final%20Rule&text=Alternative%20Benefit%20Plans%20\(ABP\)%20must,any%20other%20groups%20of%20individuals](https://www.medicaid.gov/medicaid/benefits/alternative-benefit-plan-coverage/index.html#:~:text=Alternative%20Benefit%20Plan%20Final%20Rule&text=Alternative%20Benefit%20Plans%20(ABP)%20must,any%20other%20groups%20of%20individuals)

¹³ <https://www.nlm.nih.gov/news-events/research-spotlights/medicaid-expansion-benefits-young-adults.html#:~:text=The%20researchers%20concluded%20that%20the,that%20chose%20to%20broaden%20eligibility>.

¹⁴ Kaiser Family Foundation: [Community Health Centers: Recent Growth and the Role of the ACA](#).

¹⁵ Per the ACA

¹⁶ [https://www.medicaid.gov/medicaid/benefits/alternative-benefit-plan-coverage/index.html#:~:text=Alternative%20Benefit%20Plan%20Final%20Rule&text=Alternative%20Benefit%20Plans%20\(ABP\)%20must,any%20other%20groups%20of%20individuals](https://www.medicaid.gov/medicaid/benefits/alternative-benefit-plan-coverage/index.html#:~:text=Alternative%20Benefit%20Plan%20Final%20Rule&text=Alternative%20Benefit%20Plans%20(ABP)%20must,any%20other%20groups%20of%20individuals)

¹⁷ <chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.nachc.org/wp-content/uploads/2022/03/Chartbook-Final-2022-Version-2.pdf>

themselves.¹⁸ Patients are more likely to get and keep their insurance, taking advantage of EHBS, when they can afford their insurance. This means having a household income that qualifies them for APTCs that help lower their monthly premiums. NACHC is glad that the Inflation Reduction Act extended APTCs, which were set to expire at the beginning of this year, for three more years,¹⁹ and urges to make those expansions permanent. APTCs help health insurance patients that fall short of qualifying for Medicaid and make health insurance more affordable. Before the passage of the American Rescue Plan Act—which originally extended APTCs during the pandemic—an estimated 18.1 million people were eligible for a Marketplace premium subsidy, both people insured and those who were uninsured. After the passage of ARPA, the eligible number of people increased around 20%, reaching 21.8 million people. These subsidies not only helped lower premiums for people newly eligible for APTCs—households with incomes over 400% FPL, but increased financial assistance to those already eligible.²⁰ APTCs are crucial in extending access to EHB and break down gaps in coverage.

A comprehensive review of the essential health benefits will help ensure patients continue to receive accessible, affordable health care services and has the chance to positively impact health equity, in line with the Administration’s stated goals. We greatly appreciate the opportunity to submit comments on this CMS request for information regarding Essential Health Benefits. Should you have any questions about our comments, please feel free to contact Tim Wang, Director of Policy and Advocacy, at timothyw@howardbrown.org.

Sincerely,

David Ernesto Munar
President and CEO

¹⁸ <https://www.congress.gov/bill/117th-congress/house-bill/1319/text>

¹⁹ <https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/19/fact-sheet-the-inflation-reduction-act-supports-workers-and-families/>

²⁰ <https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/>