ADVOCATES FOR COMMUNITY HEALTH

October 5, 2023

The Honorable Jason Smith
Chairman, Committee on Ways and Means
United States House of Representatives
1139 Longworth House Office Building
Washington, D.C. 20515

RE: Improving Access to Health Care in Rural and Underserved Areas Request for Information (RFI)
Submitted electronically to WMAccessRFI@mail.house.gov

Dear Chairman Smith,

Advocates for Community Health (ACH) is a national membership organization comprised of leading federally qualified community health centers (CHCs) focused on health equity and innovation to drive health care systems, policies, and health programs. Our members serve over 2.3 million people in 15 states, including Missouri, and provide high-quality, comprehensive primary health care, mental health services, preventive care, and social services to patients most in need.

As I emphasized in my testimony for the Senate HELP Committee hearing, *Community Health Centers: Saving Lives, Saving Money,* on March 2, 2023, CHCs are required to provide services to everyone, regardless of ability to pay, and play an essential role in health care for rural areas. According to the 2022 Uniform Data System (UDS) Statistics, CHCs serve over 30.5 million patients in the United States, of which 90 percent of patients live below 200 percent of the poverty line, and 1 in 9 patients are children under 18. CHCs served over 9.6 million residents of rural areas in 2022, as well as 1 million agricultural workers.

CHCs have responded to the growing health care access crisis in rural areas. Between 2010 and 2021, 136 rural hospitals closed.[1] Nineteen of these closures occurred in 2020, when the COVID pandemic hit the United States. Research shows that there is a higher probability of new community health centers service delivery sites post-closure in areas previously served by a rural hospital.[2] Over time, most rural areas are seeing an increase in access to community health centers,[3] and health centers add to economic growth in those communities.

Further, recent research has shown that, every $1 invested in primary care services like those provided at health centers, saves $13 in downstream costs.[4] Medicare costs for health center patients are 10 percent lower than for physician office patients and 30 percent lower than for

[1] "Rural Hospital Closures Threaten Access: Solutions to Preserve Care in Local Communities" (American Hospital Association, September 2022), https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf.
[2] Katherine E. M. Miller et al., "Access to Outpatient Services in Rural Communities Changes after Hospital Closure," Health Services Research 56, no. 5 (October 2021): 788–801, https://doi.org/10.1111/1475-6773.13694.
[3] Nathaniel Bell et al., "Changes in Access to Community Health Services among Rural Areas Affected and Unaffected by Hospital Closures between 2006 and 2018: A Comparative Interrupted Time Series Study," The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association 39, no. 1 (January 2023): 291–301, https://doi.org/10.1111/jrh.12691.
[4] Sherril Gelmon et al., "Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Finding" (Oregon Health Authority, September 2016), https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf."

outpatient clinic patients.[5] Community health centers were estimated to save a total of $25.3 billion for the Medicaid and Medicare programs in 2021.[6]

We appreciate the opportunity to comment on the Ways and Means Rural Access to Health Care in Rural and Underserved Areas RFI. Thank you for your consideration of our recommendations.

Geographic Payment Differences
The Committee is requesting comments on policies to improve existing payment methodologies to end the perpetuation of historical payment inequities and to reduce opportunities for abuse. This includes a review of the area wage index and the geographic practice cost index. Comments should address proposals that ensure adequate payments to health care facilities while avoiding harmful cliffs and perverse incentives. Feedback is also requested on how best to ensure adequate payments to providers without creating unjustified disparities.

It is important to consider the differences between different types of health care settings when discussing geographic payment differences. Federally qualified health centers (FQHCs) serve the most vulnerable patients who tend to have the most complex care needs. For example, in urban settings, the Medicare payment rate may be lower than that of a rural area to account for a higher density of patients, but these patients are often among the most vulnerable and the most complex, and therefore the most costly. The way that geographic differences are accounted for in Medicare payment do not always accurately reflect the complexity of the communities FQHCs serve, and it may make sense to consider a new adjuster.

ACH and our members are happy to work with the Committee on methodologies that would more accurately reflect the needs of providers with more vulnerable, complex patient populations.

Sustainable Provider and Facility Financing
The Committee is requesting comments on policies that support the long-term health of medical providers and facilities to ensure access to care for patients in rural and underserved areas. This includes proposals to simplify and streamline Medicare's outdated patchwork of rural hospital adjustments and designations while ensuring adequate payments for safety net hospitals. Comments should describe improvements needed to Medicare payment systems and structure to incentivize providers to operate in rural and underserved areas. Feedback is also requested on regulatory or financing changes needed to ensure facilities in rural areas maintain critical inpatient services while promoting access to specialized services, such as maternity care.

FQHCs are often stuck between the value-based care world and the fee-for-service world. While many want to invest in models that promote wellness, they find themselves needing to focus on sickness by virtue of the payment methodologies, regulations, and differing quality measures across payers that they must adhere to. What is feasible for other types of providers may not be feasible for health centers.

[5] Mukamel, D. B., White, L. M., Nocon, R. S., Huang, E. S., Sharma, R., Shi, L., & Ngo-Metzger, Q. (2016). Comparing the Cost of Caring for Medicare Beneficiaries in Federally Funded Health Centers to Other Care Settings. Health services research, 51(2), 625–644. https://doi.org/10.1111/1475-6773.12339
[6] Robert Nocon (Kaiser Permanente Bernard J. Tyson School of Medicine). "Testimony on Community Health Centers: Saving Lives, Saving Money before the United States Senate Committee on Health, Education, Labor and Pensions Committee." (March 02, 2023).

As such, we encourage the Committee to consider approaches that improve the ability of providers like FQHCs to participate in advanced alternative payment models. Often, models such as accountable care organizations benefit large hospital systems but not entities like FQHCs, which are not always ready for the downside risk inherent in the model. One way to help health centers in this instance is to ensure the availability of explicit guidance on these policies so that health centers can better determine their ability to participate.

While we understand that Medicaid is not under the Ways and Means Committee's jurisdiction, we would also recommend that the Committee work with their colleagues on the Energy and Commerce Committee to consider Medicaid patients, not just Medicare beneficiaries, in considering how best to address alternative payment models. As Georgetown University points out, Medicaid's role in rural areas has grown. We urge the Committee to consider Medicaid and Medicare alignment when possible. Additionally, please consider multi-payers, Program of All-Inclusive Care for the Elderly (PACE) programs, Medicaid plans, and managed care organizations in your discussion of provider and facility financing.

The Committee should also consider how to best integrate care for dually eligible beneficiaries (another issue of shared jurisdiction). As Senate HELP Committee Ranking Member Bill Cassidy, M.D. (R-LA) noted recently in *JAMA*, this population often lacks care coordination as Medicare and Medicaid often wait for the other program to pay for services. Dr. Cassidy notes that one solution may be the PACE program, which completely integrates all types of care, avoids nursing home admissions, and improves health outcomes.[7] Many of ACH's health centers currently have successful PACE programs, and we recommend expanding the capacity and geographic reach of PACE to other vulnerable populations and to all states. PACE program infrastructure is expensive, but we suggest reinvesting Medicare savings into expanding PACE and general primary care.

Aligning Sites of Service

The Committee is requesting comments on policies to lower patient costs for patients by equalizing payments for identical care provided at different settings of care. Comments should address how Congress should approach equalized payment policies that lower costs while preserving access to care and discouraging health care consolidation. Feedback is also requested on how Congress should reinvest savings into Medicare to correct reimbursement disparities and improve patient access to care in rural and underserved areas.

ACH recommends instituting a parity principle to apply the same regulations that apply to primary care services to FQHCs. Often in regulations, FQHCs are not provided with the same flexibilities that primary care providers are given. Flexibilities given to FQHCs often lag 2-3 years behind when they are given to other providers, despite the fact health centers provide the same primary care services as other sites.

One notable and recent example is the CY2023 Medicare Physician Fee Schedule Final Rule (CMS-1770-F). FQHCs were not included in the proposal for changes to the level of supervision for "incident to" behavioral health services for Licensed Professional Counselors and licensed Marriage and Family Therapists. As such, CMS had to address the discrepancy in the CY2024 Medicare Physician Fee Schedule proposed rule to change regulations for FQHCs and rural health centers. This greatly affects access to care for our patients. As UDS data shows, health centers experienced a substantial increase in patients seeking behavioral health services

[7] Cassidy B, Letchuman S. A Prescription for Americans Dually Eligible for Medicare and Medicaid. JAMA. 2023;330(13):1221–1222. doi:10.1001/jama.2023.16686

between 2021 and 2022. 54 percent and 31 percent of health center virtual visits in 2022 were mental health and substance use disorder related, respectively.[8] While we understand the legal and logical outgrowth issues involved in rulemaking, ACH recommends agencies consider FQHCs when issuing relevant regulations and stands ready to work with the Administration and the Committee to ensure parity.

Lastly, ACH strongly recommends permanently allowing telehealth and telemonitoring (remote therapeutic monitoring) to be furnished in any geographic area and any originating site setting, including the beneficiary's home. We further recommend allowing mental and behavioral health services to be furnished via audio-only telecommunications systems and adjusting in-person visit requirements. For example, community health workers should be able to support rural patients via phone and telehealth, not just in person.

Health Care Workforce

The Committee is requesting comments on policies to revitalize the health care workforce across the country to improve patient access to care, especially in rural and underserved areas. This includes policies that develop new providers and specialties in areas of the country where shortages are most acute, encourage providers to spend more time on patient care than paperwork, and ensure independent practice remains a viable option in a highly consolidated health marketplace. Comments should address existing barriers that prevent health care professionals at all levels from best providing health care services for patients. Feedback is also requested on how policies like nursing home staffing mandates at the state or federal level impact the health care workforce availability in other settings of care and the adequacy of how graduate medical education (GME) slots are being distributed in rural America.

CHCs are the training ground for our country's integrated, interdisciplinary primary care workforce. CHCs have workforce programs and policies to help train and retain providers who are most likely to continue serving those communities after training. They also provide career ladders for staff and students interested in healthcare. Much of the health center workforce comes from the communities they serve. For five decades, CHCs have fostered a culture of continuous learning and growth at every level in their organizations. But a great deal more needs to be done to address the current workforce challenges and severe shortages we face as a nation, and particularly in underserved communities.

ACH supports ensuring Medicare coverage of services furnished by Community Health Workers and for community-based organizations to act as community health worker suppliers to broaden access to services.

We also recommend that the Committee address health care workforce burnout and support efforts to build resilience. Turnover in the primary care physician workforce costs the United States $979 million annually; $260 million (27%) is attributable to burnout.[9] Providers have been on the frontlines of COVID-19 and experienced severe added stress due to the worsening workforce shortages. As a result, they are suffering mental health effects. ACH supports funding for evidence-based interventions at community health centers to ensure that providers are connected to behavioral health resources and peer support. ACH strongly supports the new $25 million program proposed in the President's FY24 budget for Supporting the Mental Health of

[8] https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-2022-trends-webinar-slides.pdf

9 Christine A. Sinsky et al., "Health Care Expenditures Attributable to Primary Care Physician Overall and Burnout-Related Turnover: A Cross-Sectional Analysis," *Mayo Clinic Proceedings* 97, no. 4 (April 1, 2022): 693–702, https://doi.org/10.1016/j.mayocp.2021.09.013.

the Health Professions Workforce. This program will support the development of a culture of wellness for community health centers.

ACH also recommends the following actions, which are not under Ways and Means Committee jurisdiction but would meaningfully support the community health center workforce.

- Reduce barriers and expand opportunities for provider loan forgiveness. CHCs are understaffed, especially in rural areas, and loan forgiveness programs should be better utilized. Adequately funding and reducing barriers to participation in the National Health Service Corps (NHSC) and other loan repayment programs could have a significant impact.

- Enact the *Restoring America's Health Care Workforce and Readiness Act,* sponsored by Senators Dick Durbin (D-IL) and Marco Rubio (R-FL), that significantly increases mandatory funding for the NHSC over the next several years.

- Provide guaranteed loan forgiveness eligibility for providers working in CHCs, and/or provide allotments to CHCs through grants for clinicians and other eligible staff.

- Invest in the successful Teaching Health Center (THC) model. CHCs are exceptional training facilities for providers given the range of clinical and social conditions among the patient population. Yet, many health centers do not participate due to lack of start-up funds and an unclear pathway to sustainability. We recommend increasing funding for the Teaching Health Center program as well as providing funds to interested CHCs to cover start-up costs and provide funds sustainably beyond the number of residents.

- Improve and expand the workforce pipeline for CHCs. CHCs often struggle to find qualified staff for a range of positions, which impacts their ability to grow and innovate. We support increasing funding for top programs at the Department of Labor and Department of Education that specifically support CHC workforce development, including community college partnerships and apprenticeship programs. We also suggest integrating leadership training into these pipelines and investing in clinical mentors for such partnerships.

- Create a new Health Care Workforce Innovation Program, as proposed in President Biden's FY24 budget. This ACH-championed idea aims to address growing concerns around healthcare workforce shortages and would stimulate and develop innovative approaches to recruiting, supporting, and training new providers, with an emphasis on meeting the needs of underserved communities.

Innovative Models and Technology

The Committee is requesting comments on policies to advance innovative care models and technology, especially those that improve access to care in rural and underserved areas. This includes examples of successful models or technology which improve patient outcomes in rural and underserved areas. Comments should address proposals that can be replicated at the federal level while ensuring providers with limited resources can participate. Feedback is also requested on how recent Medicare flexibilities may have bolstered access to care. Thought should be given to addressing how these policies can maintain and not diminish quality of care or increase overall costs to taxpayers.

ACH advocates for innovative investments that increase access to care, quality of care, and patient outcomes. Innovation can make clinical care more patient-centric, from the process of scheduling appointments to accessing care via telehealth to receiving regular reminders of timely care. Innovation can also streamline a patient's access to medicines, through mail order and central fill pharmacies.

CHCs often act as hyper-local hubs that provide consumer driven, comprehensive care, screening for social risk factors and working to improve clinical care and quality of life for their communities. Health centers can lead the way in addressing barriers to equitable health care by caring for their patients with a whole person approach and by convening the many stakeholders and supports to address the complex needs of their patients. As we all know, many of these barriers go far beyond the walls of a patient treatment room.

We highly recommend investing in strategies that address social determinants of health (SDOH), especially for the rural population, who often experience challenges related to transportation, broadband access, and other issues. Medical care is estimated to account for only 10-20 percent of the contributors to healthy outcomes for a population. The other 80 to 90 percent are SDOH.[10] Addressing the social determinants of health like access to reliable transportation, quality education, health literacy, and healthy food among others is key to ensuring a healthier community.

As such, ACH recommends implementing frameworks that integrate SDOH screening and follow-up, especially for tracking purposes in electronic health records. As mentioned above, rural areas benefit from coverage of innovative technology like remote monitoring, digital tools, and devices. Remote technology like Continuous Glucose Monitors and blood pressure machines allow clinicians to track a patient's health status from a distance, avoiding or delaying complications. Additionally, we support software and training that promote patient-centered and culturally and linguistically appropriate care.

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We appreciate the Committee's work to address the needs of rural and underserved areas and the opportunity to provide our recommendations. We look forward to working with the Committee on these important issues.

For more information or to discuss this further, please contact me at apearskelly@advocatesforcommunityhealth.org and Stephanie Krenrich, our Senior Vice President Policy and Government Affairs, at skrenrich@advocatesforcommunityhealth.org.

Sincerely,

Amanda Pears Kelly
Chief Executive Officer
Advocates for Community Health

[10] Magnan S. Social determinants of health 101 for health care: five plus five. NAM Perspectives. Washington, DC: National Academy of Medicine; 2017. https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five