ADVOCATES FOR COMMUNITY HEALTH

June 14, 2024

The Honorable Ron Wyden
Chair, Senate Finance Committee
221 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member, Senate Finance Committee
239 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Comment to the Bolstering Chronic Care through Physician Payment White Paper

Dear Chair Wyden and Ranking Member Mike Crapo,

On behalf of our member community health centers (CHCs) and the over 3 million patients they serve, Advocates for Community Health thanks you for your Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B White Paper, which outlines strategies to enhance physician compensation in a way that best serves their patients' needs.

Advocates for Community Health (ACH) is a member organization focused on advocacy initiatives to affect positive change for CHCs, the patients they serve, and the entire nation's health care system. Our members spearhead forward-thinking federal policies and drive change to advance and achieve health equity through comprehensive, integrated primary care. While Medicare is not a large payer for many health centers, our members represent those health centers most likely to bill Medicare, due to a large rural service area or sophisticated programming, such as operating their own Medicare Advantage Plans. Therefore, we are especially eager to work with you on this effort.

Below we provide recommendations to improve physician payment reform and chronic disease management and coordination. Our responses are focused on questions on pages 19 and 20.

1. *What other policies, if any, would appropriately encourage improvement in quality of care delivered by clinicians under FFS Medicare?*

   In total, the over 1,400 health centers across the country see about 3.3 million Medicare beneficiaries a year. As you know, CHCs and Rural Health Clinics are not paid fee-for-service like other primary care providers. Instead, federally qualified health centers (FQHCs) are paid via a Medicare Perspective Payment System (PPS) for all medically necessary primary health services and qualified preventive health services furnished in an FQHC visit. This rate also acknowledges CHCs' provision of enabling services as required under Section 330(b)(1)(A)(iv) of the Public Health Service Act, or non-clinical services that often improve health outcomes and quality of life. This includes case management, transportation, insurance enrollment assistance, and health education. As research shows, these enabling services address social drivers of health, remove barriers to accessing primary care, improve chronic disease management, and increase patient satisfaction. Recognizing the staff time associated with managing more complex patients, FQHCs are permitted to bill a few codes outside of the PPS, including Chronic Care

Management, Behavioral Health Integration, and the newly created Community Health Integration codes.

Our mission is to serve patients regardless of their insurance status or ability to pay. To that mission, we bring a strong focus on quality improvement: CHCs improved in 12 out of 18 clinical quality measures in 2022. Of note, health centers improved the percentage of patients with controlled hypertension and with uncontrolled diabetes (inverse measure), outperforming the national Healthcare Effectiveness Data and Information Set (HEDIS) benchmarks. 78% of FQHCs were recognized as a patient-centered medical home (PCMH) in 2022, meaning that the center improves patient-centered coordination of care, better manages chronic conditions, and achieves ongoing quality improvement.

Many health centers would like to continue this path of quality improvement and take the step of joining a value-based care arrangement. However, they often lack the technology, data infrastructure, and workflow practices to create a strong foundation from which to do so. Therefore, to further encourage investment in quality improvement, many health centers could benefit from support for foundational infrastructure. We propose a six-month, ten percent Temporary Add-On Payment for FQHC Medicare PPS to make necessary investments in infrastructure.

2. *In a hybrid PBPM payment model under FFS, which services should be paid through FFS versus the PBPM? Are there services beyond primary care that would benefit from this type of payment model as well?*

   As noted, health centers are paid through a different mechanism for clinical and other enabling services. However, the current PPS rate does not account for all necessary patient investments, nor provides the flexibility necessary to iterate with a constantly changing set of patient needs. We strongly support the ability of health centers to participate in PBPM payment models in Medicare for the following reasons:
   a. **Ability to address HRSNs**: Health centers and other providers need flexible spending for Health-Related Social Needs (HRSNs). A flexible PBPM can supply beneficiaries with refrigerators for food and medicine, socks to prevent foot ulcers, and vacuums to mitigate asthma-related triggers. Flexible spending can also fund additional supports like community health workers who can help beneficiaries navigate the health system and coordinate care.
   b. **Investing in other providers**: FQHCs can bill the Medicare PPS when the patient sees a Physician, Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Visiting Nurse, Clinical Psychologist (CP) or Clinical Social Worker (CSW). However, a clinical pharmacist is increasingly an essential part of the care team, and a patient might visit the FQHC simply to see the pharmacist and receive medication therapy management (MTM) or other counseling services, especially for patients on multiple specialty drugs. Including a broader range of providers under a PBPM arrangement would be a huge asset for health centers and their patients.

3. *Should a hybrid model design include a hybrid-specific risk adjustor for primary care? How can such a policy account for quality?*

   We advocate for federal policies that will ensure a health care system focused on equity and

access for marginalized communities. ACH recommends developing, testing, and using health equity measurement tools and adjustments. Health centers are national leaders in health equity and should be compensated for the structural and community-led work to achieve it. ACO REACH includes a Health Equity Benchmark Adjustment based on the characteristics of the beneficiaries the ACO serves. We support piloting ways to adjust for the communities our health centers serve.

4. *What other benefit-related policies should the Committee consider to improve chronic care in Medicare FFS?*

a) Increasing the Use of Chronic Care Management

About 4 in 10 Americans have 2 or more chronic conditions, which costs the health care system over $3.6 trillion. Studies increasingly show the connection between chronic disease and socioeconomic factors (CDC). Therefore, we offer two recommendations regarding chronic care management (CCM).

First, we urge allowing FQHCs to waive cost sharing for CCM codes. FQHCs in large part have been able to balance the enrollment and paperwork requirements because of the large number of patients interested in, and able to benefit from, CCM services. However, patients will drop out or disenroll because of the cost-sharing burden. Permitting FQHCs to waive co-pays matches their usual practice of adjusting and sliding fees based on income, as set by HRSA 330 grants.

Second, we recommend permitting FQHCs to bill alongside Psychiatric Collaborative Care Management service codes (CoCM) (99492, 99493,99494). Although the Behavioral Health Integration (BHI) codes can be billed in the same month as Chronic Care Management (CCM) for the same patient, this only works if there is advance consent for both services and all other reporting requirements are met. Additionally, time and effort can't be double counted. However, needing to document cost sharing and get advance consent for each service means that billing for both services together rarely happens, even if it would benefit the patient. FQHCs should be permitted to bill both codes in a month, without cost-sharing.

b) Improve FQHCs' ability to leverage Medicare to serve patients by including them in all payment reform efforts

We urge Congress and CMS to consider FQHC input when designing flexibilities to ensure primary care waivers can also integrate FQHCs. Health centers require parity. As we commented in our response to the CY 2023 Medicare Physician Fee Schedule's proposed rule, allowing licensed professional counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) to bill "incident to" physicians or non-physicians for behavioral health services had not been extended to FQHCs, despite that the proposal is intended to increase access to behavioral health and advance health equity as part of the CMS Behavioral Health Strategy. Unfortunately, health centers had to wait for CY 2024 proposals to correct this inequity. This is just one example where CHCs needed to wait additional time to allow them the same flexibilities offered to other primary care settings.

Conclusion
We appreciate the opportunity to provide feedback on these critical issues and look forward to working with the Committee as you pursue policy options for bolstering the provision of chronic care. For more information, please contact me at apearskelly@advocatesforcommunityhealth.org and/or Stephanie Krenrich, our Senior Vice President of Policy and Government Affairs, at skrenrich@advocatesforcommunityhealth.org.

Sincerely,

Amanda Pears Kelly
Chief Executive Officer
Advocates for Community Health