ADVOCATES FOR COMMUNITY HEALTH

January 16, 2026

Dear Members of the Republican and Democratic Doctors Caucuses,

Thank you for your ongoing efforts to support modernization of physician payment reform.

Advocates for Community Health (ACH) is a member organization focused on advocacy initiatives to affect positive change for community health centers (CHCs), the patients they serve, and the entire nation's health care system. Our 45 members represent 23 states, Puerto Rico, and the District of Columbia. On behalf of our member CHCs and the 4 million patients they serve, ACH appreciates the opportunity to contribute to your efforts through responses to your questions below.

1. **What legislative reforms are most needed to ensure future CMMI models deliver real improvements in cost and quality, while also ensuring successful scaling of innovations?**

In its first 15 years, the Centers for Medicare and Medicaid Innovation (CMMI) has focused primarily on the Medicare program. CMMI currently lacks the authority or the existing mechanisms to successfully achieve meaningful payment reform in Medicaid, which limits its ability to test or scale Medicaid-focused models that would benefit safety-net providers like community health centers. Without sufficient authority or flexibility, CMMI has not been able to implement long-term pilots that generate the measurable savings available through chronic disease prevention and management efforts within safety net settings. Through a model that centers best-in-class primary care providers, we can deliver real improvements in cost and quality, while also ensuring successful scaling of innovations.

Congress should give CMMI the authority to circumvent state policy barriers and permit community health centers and other safety-net providers to take on additional risk in value-based payment models. Congress could authorize CMMI to permit eligible entities to obtain insurance licenses and contract directly with the state or permit states to designate primary care entities as eligible to receive a pass through of premium from Medicaid Managed Care Organizations (MCOs) of 90-95%. Under either option, eligible entities would be responsible for the care of a certain set of Medicaid beneficiaries who are attributed under a preponderance model that incorporates quality and cost.

2. If MIPs were to be reformed or replaced entirely, what would a new physician-led quality program look like? How can we ensure a new program reduces administrative burdens and is applicable to all types of clinicians in all settings, while focusing meaningfully on real outcomes.

Across the country, more than 1,400 health centers see about 3.3 million Medicare beneficiaries a year. CHCs and Rural Health Clinics are not paid fee-for-service like other primary care providers; they are paid via a Medicare Prospective Payment System (PPS) for all medically necessary primary health services and qualified preventive health services furnished in a health center visit. Due to the PPS payment structure, CHC services fall outside Medicare's Quality Payment Programs, meaning CHCs do not participate in either MIPS or Advanced APM pathways and therefore cannot receive Medicare quality-based payment incentives, despite their strong focus on quality improvement.

However, CHCs are highly focused on quality improvement, and would welcome a physician-led quality program. Quality measurement in a safety net primary care setting should rely on existing data sets, such as the Uniform Data System (UDS) for community health centers, as well as linkages to public health data collected at the city, county and state levels. In times of public health emergencies or provider closures, community health centers must step up and take care of new patients and work at the community level. Having a strong sense of the trends and themes in their communities in real time will increase capacity, preparedness, and the ability to serve a wide range of health issues.

Many health centers would like to continue this path of quality improvement, build on their existing systems, and take the step of joining a value-based care arrangement. However, they often lack the technology, data infrastructure, and workflow practices needed to do so. Therefore, Congress should enact a six-month, ten percent Temporary Add-On Payment for community health center Medicare PPS to make necessary investments in infrastructure to further encourage investment in quality improvement.

Thank you again for the opportunity to provide comments on this RFI. We appreciate your consideration and partnership. Please contact Stephanie Krenrich, SVP of Policy and Government Affairs, at skrenrich@advocatesforcommunityhealth.org with any questions or to discuss this further.

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