Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

The National Association of Community Health Centers (“NACHC”) appreciates the opportunity to provide comments in response to the U.S. Senate Committee on Finance’s May 22, 2015 letter regarding chronic care management among Medicare patients. NACHC is the national membership organization for federally qualified health centers (hereinafter referred to as “FQHCs” or “health centers”).

For 50 years, health centers have provided access to high quality, affordable primary and preventive healthcare to millions of uninsured and medically underserved patients, regardless of their ability to pay. At present there are almost 1,300 health centers with more than 9,300 sites. Together, they serve over 23 million patients, including approximately 1.9 million Medicare beneficiaries, and 48 percent of health center organizations serve patients in rural areas.\(^1\) Additionally, 93 percent of health center patients have annual incomes below 200 percent of the Federal Poverty Level (FPL).\(^2\) All health centers provide a full range of primary and preventive care, as well as services that enable patients to access health care appropriately (e.g., care management, translation, health education, transportation). A growing number of health centers also provide dental, behavioral health, pharmacy, vision, and other important supplemental services.

Health centers are no strangers to managing chronic conditions, which account for more than 40 percent of health center patient visits. Compared to traditional physician offices, health centers are more likely to treat patients with diabetes, depression, and asthma, and are more likely to provide health education services. Health centers, however, have not only have demonstrated experience with chronic condition but also have demonstrated results. When compared to the low-income and general population in the United States, health center patients with hypertension are more likely to receive and comply with health promotion counseling. Investments in health center chronic care management programs were also followed by significant improvements in process of care measures within one to two years, and improvements in outcomes within two to four years. Moreover, these health center chronic care management efforts have been cost effective, for example lowering lifetime incidence of costly diabetes complications, such as blindness, end stage renal disease, and coronary artery disease.

With these facts in mind, we urge the Committee to consider the significant role health centers continue to play in managing chronic care conditions—especially among the growing Medicare population. While only 8 percent of health center patients are covered by Medicare, the number of Medicare patients served by FQHCs has doubled over ten years. Furthermore, two in five adult Medicare health center patients classify as Medicare-Medicaid dual eligible--double the national rate. Dual eligible patients have a significantly higher likelihood of suffering from multiple chronic conditions such as diabetes, chronic lung disease, and Alzheimer’s. Health centers’ ability to deliver care to such a high proportion of dual eligible adult Medicare patients is just one important example of their continued success in serving hard-to-reach, complex patient populations.

Increasing the number and proportion of Medicare beneficiaries seeking care at health centers in fact represents an opportunity to reduce overall Medicare costs. A review of Medicare claims data from 4.4 million beneficiaries in fourteen states found the total annual cost of care for health center patients was 10-30 percent lower than Medicare beneficiaries receiving their care elsewhere. Moreover, regions with the highest penetration of low-income residents served by health centers had 9.7 percent lower Medicare spending per beneficiary compared to regions with the lowest penetration. High penetration regions also had lower per beneficiary costs in other areas, including post-acute care, hospice, durable medical equipment, and Medicare Part B drugs.

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5 Based on data for adults, aged 18-64, from 2009 BPHC Patient Survey and National Health Interview Survey, 2008
6 Chin, M. Quality improvement implementation and disparities: the case of the health disparities collaborative. Med Care. 2010 Suppl(48(12)): 1050-1056
10 Health Resources and Services Administration, forthcoming research
Health centers play a unique role in the health care system in a variety of ways including: their governance model; sliding fee scale; being open to all regardless of insurance status; and innovative approaches targeted to the community’s needs. Health centers already are integral in treating and improving chronic illness in a cost effective manner. **As you consider new policy approaches, we urge you to continue to incentivize health centers’ role as a key player in meeting these needs.** In many cases, health centers are already serving patients and populations with chronic conditions that are traditionally unserved by the rest of the health care system. Health centers stand ready to continue to provide access to high quality, cost effective care for these and all patients nationwide. **We also ask the Committee to take into consideration the following recommendations when considering reforms to chronic care management in the Medicare program.**

**EXAMPLES AND CONSIDERATIONS FOR COMMITTEE WORK GROUP**

1. **Improvements to Medicare Advantage for patients living with multiple chronic conditions**

Health centers serve few Medicare Advantage patients and so we have chosen to focus our recommendations on other areas raised by the Committee. **However, we believe that many of the ideas suggested throughout this document are cross-cutting and could easily be applied to the Medicare Advantage sphere.**

2. **Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternative payment models (APMs) currently underway at CMA, or by proposing new APM structures**

**Social Determinants of Health**

Broadly speaking, many policies in place across the health care system inhibit improvements in quality of care and health outcomes because they are designed for an acute care model rather than a chronic care model focused on managing health care over time and across organizations. For instance, limitations on visits per day and lack of reimbursement for patient navigation and care coordination are often barriers to quality and improvement of care. Improving health outcomes also frequently requires provision of services that are not traditionally considered clinical in nature, particularly when social determinants of health (SDOH) hinder access to the full range of needed care or otherwise impact how patients respond to care. Research indicates that clinical care makes up only 20 percent of the factors that drive health outcomes, while social, economic, and physical environmental factors make up 50 percent.¹²

Health centers, whose patients are generally at a significant disadvantage with regard to SDOH compared to the general population, already provide a broad array of services such as care management, transportation, food assistance, and housing that enable access to care and promote well-being. In fact, health centers’ unique governance requirement (a 51 percent patient majority board) ensures that each health center provides any such services deemed important and necessary by the community it serves. Unfortunately, in addition to payment barriers surrounding non-clinical services, payment for health care

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¹² County Health Rankings. Available at http://www.countyhealthrankings.org/about-project/rankings-background.
currently does not adequately incentivize the mitigation of SDOH, incentivize population-based partnerships and interventions, or account for the special challenges involved in managing or addressing SDOH.

Preventing the adverse consequences of SDOH can pay off in the form of better health outcomes and care experiences for individuals, improved population health, and lower health care spending – the attributes of the Triple Aim. If the health care system does not account for and support activities that address the SDOH, poor health outcomes will persist and culminate in health and health care disparities--ultimately leading to the perpetuation of otherwise avoidable expensive health care. Given the substantial impact non-clinical factors have on a person’s health and health care outcomes, we ask the Committee to encourage CMS to reimburse for such services that have been demonstrated to improve access to needed care and outcomes directly.

Accountable Care Organizations (ACO)

In an effort to harness the Triple Aim attributes with high quality coordination of care, many health centers have joined forces with Accountable Care Organizations (ACOs). A 2014 study by the Commonwealth Fund found that 28 percent of ACOs contracted with health centers, a clear indication that FQHCs are viewed by ACOs as valuable partners. The study found that ACOs that include health centers have more capability than ACOs without health centers to: 1) have chronic care management processes and programs (41 vs. 26 percent) 2) integrate behavioral health into primary care (23 vs. 8 percent), and 3) involve patients in care decisions and self-management (32 vs. 18 percent) ACOs with health centers and ACOs without health centers have similar Medicare contracts, while ACOs with health centers are more likely to have contracts with Medicaid.

Furthermore, ACOs with health centers reported more experience with reforms such as Patient- Centered Medical Homes (PCMH), public reporting, and risk bearing, where the ACO is held responsible for losses in addition to savings. Many health centers are sought after to strengthen the ACO's delivery model of primary care not only to increase the number of primary care providers but also to amplify primary care expertise. For example, one ACO care coordination team studied one of their participating health center’s care delivery model that decreased hospitalizations among high risk patients. This model was then replicated for high risk patients across the ACO’s practices.

The implications of this study and of increasing FQHC participation in ACOs around the country are significant – not only does FQHC participation in ACOs tend to lead to higher capabilities to achieve the outcomes listed above, but it is an important step toward integration of safety-net providers into the broader system of care. FQHC participation in ACOs should be emphasized and incentivized as the

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Committee Workgroup examines strategies to better manage chronic care and save the system resources.

S. 1456, The Rural ACO Improvement Act of 2015

Given the reliance on non-physician providers at health centers in rural and frontier areas in particular, we support Senators Cantwell and Thune’s efforts to improve the ACO beneficiary assignment process with S. 1456, the Rural ACO Improvement Act of 2015. This legislation would ensure that non-physician provider visits count for the purposes of beneficiary assignment, which is particularly important at PA-led and NP-led health center sites in rural and frontier areas. For example, health centers in Utah are utilizing the experience of PAs and NPs to lead team-based care coordination but are not necessarily reimbursed for their care. The bill would also streamline the need for an attestation process to account for the fact that health centers already are primary care providers and we have provided technical feedback to the bill sponsors on this provision. **We ask the Committee to consider support for S. 1456 (utilizing the feedback we have provided to the bill sponsors) because we believe that these changes to the beneficiary assignment process would streamline and improve chronic care coordination in rural and frontier areas while also keeping health care costs contained.**

3. Reforms to Medicare’s current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions

FQHC reimbursement for providing Chronic Care Management (CCM) services in Medicare

Since January, 2015, Medicare providers who are reimbursed under the Part B Fee Schedule have been eligible to receive separate payment for managing the care of patients with chronic conditions. However, FQHCs (as well as Rural Health Clinics) are ineligible for these payments, since they do not bill under the Fee Schedule. Permitting FQHCs to be reimbursed for these services would promote the integration and coordination of care for these patients who, as described above, are more likely to suffer from common chronic conditions than patients seen in traditional physicians’ offices.

Also, when establishing the requirements that FQHCs must meet in order to be reimbursed for CCM services, it is important to keep in mind the challenges that many health center patients face. For example, one requirement for CCM reimbursement under the fee schedule is the ability to provide patients with secure messages via the Internet. However, many FQHC patients do not have reliable access to the Internet, due to income limitations and/or location. As stated above, 93 percent of health center patients have incomes below 200 percent of the FPL. **Therefore, we ask the Committee to consider adjusting the requirements for receiving CCM payments so that FQHCs are able to bill for services they provide patients facing a variety of unique barriers to care.**

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Increasing FQHC-PACE Alignment

Nationally, a number of PACE (Program of All-Inclusive Care for the Elderly) Programs are operated by FQHCs. In Massachusetts, for example, three of the state’s eight PACE programs are operated by FQHCs. Housing PACE programs within health centers offers increased financial stability for both programs and community benefit through alignment and enhanced access to services. However, significant barriers, both financial and regulatory, exist for communities which would benefit from greater FQHC-PACE integration.

The upfront costs of developing a PACE program are substantial – according to the National PACE Association, it costs approximately $4-6 million to bring a PACE program to market. Investments required include the construction of the PACE center, staffing requirements, and lengthy start-up processes. Each of these is a significant barrier for the typical FQHC, which operates on slim margins. Congress should examine creation of a program of “start-up” grants to community-based organizations, including FQHCs, to cover many of the up-front costs of establishing a PACE Program. These grants could be structured as loans to be repaid over time once the entity’s program is up and running.

The other current barrier to better alignment between FQHCs and PACE programs, including those which are co-located, is the operational inflexibility inherent to current PACE regulations, which limit experimentation with innovative approaches, both within PACE entities and in external partnerships. **We ask the Committee to consider a program of grants, with FQHCs among the eligible entities, to cover many of the up-front costs of developing a PACE program, and to work with CMS to ensure the timely release of a revised PACE regulation that provides the flexibilities needed by PACE organizations to serve more beneficiaries, with greater efficiency.**

4. The effective use, coordination, and cost of prescription drugs

Although Medicare covers prescription drugs for all eligible beneficiaries, this coverage does not always translate into an improvement in health outcomes. Whole patient approaches and care coordination should be considered when addressing patients living with chronic conditions. Though health centers are not reimbursed when their pharmacists counsel patients on medications, health centers are doing everything they can to improve effectiveness. For instance, the Peninsula Community Health Services in Kitsap County, WA increased its blood pressure control rate to 84 percent as of April 2015, well above the Million Hearts target of 70 percent, by integrating clinical pharmacists into the expanded care team. The pharmacists used Electronic Health Record patient blood pressure status and hypertension medications prescribed to tailor education and prescription refill length to improve medication and follow-up care adherence. However, the health center must find unique and innovative ways to fund such advances.17

Another such example is El Rio Community Health Center’s (AZ) Pharmacy-based Diabetes Management Program - a comprehensive approach to control diabetes. As with Peninsula Community Health Services, El Rio’s program incorporates clinical pharmacists into the expanded care team to increase direct service to patients involving intensive and ongoing consultation, integrate treatment of

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17 Million Hearts. Available at http://millionhearts.hhs.gov/aboutmh/htn_champions.html#list
diabetes, high blood pressure and cholesterol, and provide in-depth information and education to empower patients to proactively manage their health.\textsuperscript{18}

**We recommend the Committee consider the benefits of expanding the primary care team to include pharmacists, and to provide appropriate reimbursement for such services, to ensure comprehensive and effective coordination of care, including prescription drugs, for patients living with chronic illnesses.**

5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology

Not only can health centers leverage telehealth to improve care coordination, but also to help address the serious health workforce shortage, especially within rural and frontier areas. Promoting use of telehealth among primary care and behavioral health systems has the potential to increase patient access to care, reduce waiting times and extend a limited provider workforce to areas where the shortages are most acute even if it is not a long-term solution to acute provider shortage.

Roanoke Chowan Community Health Center (RCCHC) in rural Hertford County, NC utilizes in-home blood pressure monitoring systems to remotely monitor patient blood pressure readings without the need for constant clinic visits--reducing costs and unnecessary visits for patients and staff.\textsuperscript{19} With the number of health center Medicare patients on the rise, the need to incorporate telehealth and remote monitoring technologies into health centers chronic care management is ever increasing.

**We urge the Committee to recognize and implement policies supporting new and emerging telehealth and remote patient monitoring technologies and their adoption, which have proven to be highly effective in chronic care coordination. Specifically, we urge you to ensure that Medicare appropriately reimburses for the use of evidence-based telehealth and remote patient monitoring (RPM) services. Currently, Medicare does not reimburse for RPM technologies despite these tools' ability to reduce inpatient care and readmissions, as well as improve care coordination.**

6. Strategies to increase chronic care coordination in rural and frontier areas

While nationally only 8 percent of all health center patients are Medicare beneficiaries, in rural health centers this percentage is higher, with 11 percent of patients covered by Medicare--making considerations of chronic care management for rural Medicare beneficiaries served by health centers ever more significant.\textsuperscript{20} Unlike hospitals, health centers can be led by physician assistants or nurse practitioners increasing access to preventative and primary care services in rural areas with primary care workforce shortages. Many health centers and their satellite sites in rural and frontier areas of Utah have adopted this system, including physician-assistant led Mountainlands Family Health Center-Vernal Clinic in Provo. This clinic has the capacity to add a care coordinator to the non-physician led primary care team to comprehensively improve the health outcomes of patients living with multiple chronic conditions.

\textsuperscript{18} El Rio Community Health Center. “Pharmacy Services.” Available at http://www.elrio.org/patient-services/clinical-pharmacy/
\textsuperscript{19} RCCHC. Telehealth. Available at http://www.rcchc.org/telehealth.html
\textsuperscript{20} 2013 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS
Care coordination services, until recently, were not reimbursed under Medicare (like other to non-physician provider services), which is particularly detrimental in rural and frontier areas. However, we believe S. 1456 will improve health outcomes for patients with chronic illnesses living in hard to reach areas because non-physician providers will not only be able to increase care coordination but also be reimbursed for their necessary and appropriate care. When considering strategies to increase chronic care coordination in rural areas, we urge the Committee to again consider the uniqueness of the health center model in providing vital primary care services to patients in low-resource and low-workforce settings.

As noted in the previous section, telehealth technologies have vastly improved chronic care coordination of health center patients across FQHCs, however, among rural populations, remote technology proves ever more important. Telehealth provides access to a wide variety of services through remote connection to distant specialty sites not readily accessible in rural areas. Medicare does not currently reimburse for remote monitoring systems, such as the one used by Roanoke Chowan Community Health Center to coordinate chronic care for patients served across sparsely populated areas. Moreover, according to CMS, FQHCs are not authorized to bill Medicare for any chronic care management at this time. As rural and frontier health centers serve as important venues for chronic care management in these areas, we encourage the Committee to consider reforming the current reimbursement system for chronic care management, with a special interest in the reimbursement of remote monitoring systems.

7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers

Empowerment plays an integral role when addressing the health needs of chronic care patients. Health care providers and primary care teams can help patients take charge of their conditions by involving both the patient and patient’s family. Each health center takes a tailored approach to meet the unique needs of the people in the community it serves. In doing so, health centers empower community members to manage their health, as well as the community’s health.

Another way health centers are championing primary care and empowerment is by being recognized as a Patient- Centered Medical Home (PCMH). The Bureau of Primary Health Care currently reports that 61 percent of all HRSA-funded health centers qualified for PCMH recognition. With PCMH status, health centers have an increased pool of providers and support services available for beneficiaries. Moreover, health centers are able to improve quality of care through care coordination, comprehensive care, increased access to services, and partnering with patients and their families in their own care. PCMH recently provided a useful framework for the Medicaid Section 2703 health homes program which focuses on the whole patient approach emphasizing education, activation, and empowerment through interpersonal interaction and system level protocols. The next section will provide a more in-depth look at Section 2703 health homes, along with additional recommendations.

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21 HRSA. https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html and http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html
22 National Program Grantee Data, Bureau of Primary Health Care, HRSA, DHHS. Available at http://bphc.hrsa.gov/uds/datacenter.aspx
As discussed in section 4, health centers are including Clinical Pharmacists to the primary care team to offer medication counseling to patients with diabetes, a Medicare listed chronic care condition. The coordination between the pharmacist, patient, and primary care provider makes health centers particularly adept at facilitating proactive patient self-management. In addition, ACOs with health centers have higher patient involvement in self-management (32 percent), than ACOs without health centers (18 percent).\(^{23}\) Also, ACOs with health centers reported more experience with PCMH than ACOs without health centers.\(^{24}\) Health centers continue to involve and educate patients on their chronic illnesses allowing patients to take responsibility for their own health.

Health centers are empowering communities nationwide with their unique role in the health care system and are actively reaching out to untouched patients. However, there continues to be a great need for empowerment within the health care system. **We ask the Committee to consider investment into health promotion and health education programs as well as incentives for health centers to achieve PCMH recognition.**

### 8. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions

**Health Homes**

Under the Affordable Care Act, Section 2703, States have the option to reform their health care delivery systems and adopt The Medicaid Health Homes State Plan Option. The Health Homes State Plan Option provides ways to comprehensively coordinate care for Medicaid beneficiaries living with chronic conditions.\(^{25}\) A whole person approach integrating primary, behavioral, social services, and health information technology is implemented in the context of the individual’s cultural and community needs. This approach empowers not only the patient but also the patient’s family in various health care decisions. While this program is currently used solely for Medicaid beneficiaries, we believe the health homes model could be translated to Medicare with similar financial and health outcomes for patients living with chronic illnesses.

Health centers have been an integral asset since the introduction of Section 2703 Health Homes. As of November 2014, sixteen states including Oregon, Iowa and Ohio, utilize The Medicaid Health Homes State Plan and of those, ten states, including Oregon, Kansas and Idaho, have identified the importance of health centers and have included them as eligible providers. The six states where FQHCs are not participating in the health home program most likely target Medicaid beneficiaries with Serious Mental Illness or Serious Emotional Disturbance. Appropriate care for these populations is not always provided.

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\(^{24}\) Lewis et al.

\(^{25}\) Medicaid. Health Homes. Available at [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html)
at health centers. However in Ohio, health home providers are working with FQHCs to coordinate primary care services.  

In an effort to reduce inappropriate emergency room visits, improve coordination of care, and increase cost effectiveness, the state of Missouri utilized Section 2703 and formed the Primary Care Health Home (PCHH) Initiative. The State Medicaid office worked diligently with four different provider types including twenty-two FQHCs to ensure whole-person approaches to Medicaid beneficiaries with specific chronic conditions. From June 2012 to June 2013, the program displayed a 5.86 percent decrease in hospital admissions per 1000 and a 9.66 percent decrease in emergency room use per 1000. This translated into a net result of saving 70.72 percent of the total per-member-per-month payment of eight million dollars. Furthermore, the PCHH resulted in a total savings to Medicaid of approximately two million dollars. Although health homes are specifically for Medicaid beneficiaries, we ask the Committee to consider the beneficial impacts of health homes with an eye toward replicating the model for Medicare beneficiaries with chronic illnesses.

Non-Physician Led Care Teams

Health centers have already begun incorporating non-physician providers to lead primary care teams. Many utilize the skills of Nurse Practitioners (NPs) and Physician Assistants (PAs) especially at health centers. As discussed earlier, many health center organizations are non-physician led, including Utah’s Kazan Memorial Clinic in the frontier town of Escalante. Hudson Headwaters Health Network’s Health Centers (HHHN) in New York, acknowledges the fact that behavioral health providers are true members of the care team. HHHN estimates that 70-80 percent of their patients have some level of behavioral health need that has an overall impact on their health. In response, they established behavioral health services at most of their centers and are developing workflows and processes to fully integrate. Also, Hudson Headwaters crafted lifestyle coaching services where they identify patients who are at risk for certain diseases, such as diabetes or hypertension, then collaborate with the patient to ward off chronic conditions through healthy lifestyle changes.

S. 1456 changes the beneficiary assignment process allowing non-physicians to improve care coordination while containing health care cost. We ask the Committee to consider the important roles of non-physician providers when addressing patients’ chronic conditions and behavioral health needs.

Reforming chronic care management in the Medicare program will improve health centers’ and other providers’ ability to improve care and outcomes for this vulnerable population. As the Committee’s request for comments explains, the Medicare population is growing along with multiple chronic conditions. Health centers continue to be an essential component when addressing the health needs of communities across the nation because they are cost effective, all-inclusive, and community focused. We

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26 NACHC. Section 2703 Health Homes and Health Centers. Available at http://www.nachc.org/client/Emerging%20Issues%2009_2703%20Health%20Homes%20FINAL.pdf


28 Hudson Headwaters Health Foundation. Available at https://www.hhhn.org/Services/
ask the Committee to take into consideration our recommendations and the importance of health centers. We applaud the Committee for proposing reforms, as we believe that these adjustments are key to a successful Medicare program, and ultimately improving patient care and coordination in health centers.

Thank you again for the opportunity to comment on chronic care reform in the Medicare program. NACHC staff, and our member health centers, would be happy to provide the Committee with additional information. Please contact John Sawyer, Director of Federal Affairs at jsawyer@nachc.org or Heather Foster, Deputy Director of Federal Affairs at hfoster@nachc.org to discuss further.

Sincerely,

Dan Hawkins
Senior Vice President, Public Policy and Research
National Association of Community Health Centers, Inc.

cc: Members of the Senate Finance Committee