NATIONAL ASSOCIATION OF Community Health Centers

January 29, 2016

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

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 Senate Committee on Finance's Bipartisan Chronic Care Working Group Policy Options Document released on December 18, 2015. 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 more than 1,300 health centers with more than 9,000 sites. Together, they serve over 24 million patients, including nearly 2 million Medicare beneficiaries. Chronic conditions account for more than 40 percent of health center patient visits.[1] 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.[2] Health centers are integral in treating and improving chronic illness in a cost effective manner.

[1] NACHC. Snapshot: Health centers disproportionately serve patients with costly chronic conditions. Fact Sheet S0514. May 2014. Available at http://www.nachc.com/client/documents/High_Cost_Condition_2014.pdf

[2] Shi, L et al. Characteristics of Ambulatory Care Patients and Services: A Comparison of Community Health Centers and Physicians' Offices. J Health Care Poor Underserved 2010;21(4): 1169-83

We appreciate the Committee's dedication to improving care coordination for individuals with chronic conditions and ask that the Committee continue to consider our recommendations as laid out in NACHC's June 22, 2015 letter to the Committee, as well as those made at our follow-up meeting in September 2015. Additionally we respectfully offer feedback on the following three areas outlined in the Policy Options Document: advancing team based care; expanding innovation and technology; and empowering individuals and caregivers in care delivery.

Advancing Team Based Care

Improving Care Management Services for Individuals with Multiple Chronic Conditions

The recent Centers for Medicare & Medicaid Services (CMS) Medicare Physician Fee Schedule rules providing for a separate chronic care management (CCM) code are an important step forward in incentivizing appropriate team-based coordinated care for beneficiaries with chronic conditions, and we agree with the Committee on the potential to build off of this critical improvement.

We appreciate the Committee's acknowledgment that many patients, including those at health centers, may be dealing with multiple complex chronic conditions and care coordination needs that far exceed the "20 minutes of clinical staff time" per calendar month that the CCM codes are designed to support. As such, **we support the proposal to establish a new high-severity chronic care management code, and urge the Committee to ensure that this new code be applied in a manner similar to how the 2015 proposed CCM code will be implemented. Specifically, FQHCs should be included as eligible providers to bill for the new high-severity chronic care management code.**

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) were originally ineligible for these payments, since they do not bill under the Fee Schedule. CMS acknowledged this problem and addressed it through the CY 2015 Physician Fee Schedule regulation process, proposing a rule to allow both FQHCs and Rural Health Clinics to be reimbursed for these services in the same way that providers on the Physician Fee Schedule are reimbursed starting January 1, 2016. The application of this same method to the proposed high-severity chronic care management code would streamline the process from the beginning, ensuring billing consistency across providers and alignment with the original CCM code, while fully promoting 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.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

NACHC shares the Committee's recognition that behavioral health care is an important component of coordinated care for people with chronic conditions, and supports efforts to improve the

integration of care for individuals who are trying to manage one or more chronic medical illnesses combined with one or more behavioral health disorders.

One approach would be to authorize Medicare reimbursement for consultation services between a primary care provider and a behavioral health provider, including a psychiatrist. This could be accomplished by establishing a behavioral health consultation code in the same vein as the new CCM code, as both would be designed to promote a team-based approach to care coordination.

In health centers across the country, primary care physicians are skillfully managing patients with both chronic care conditions and behavioral health needs, but could be better served with ready access to a psychiatrist or other mental health professional who can consult about a patient's treatment plan on an ongoing basis, even when a separate mental health visit isn't required.

As it stands, many health centers cannot afford to pay for a full time psychiatrist to assist primary care providers in need of such consultation services. The creation of an appropriate reimbursement for consultation between medical and behavioral health providers could incentivize better care coordination, lend behavioral health treatment support to primary care physicians, and would better enable health centers to meet the demands for funding the services of a full time behavioral health provider.

In addition, we greatly appreciate the Committee's acknowledgment of the role of social determinants of health (SDOH) in patient outcomes, and that "for outpatient mental health services Medicare does not cover meals, transportation to or from mental health care services, support groups that bring people together to talk and socialize (though group psychotherapy is covered), or testing or training for job skills that are not part of the beneficiary's mental health treatment."

Improving health outcomes frequently requires provision of services that are not traditionally considered clinical in nature, particularly when 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.[3]

Health center patients are generally at a significant disadvantage with regard to SDOH compared to the general population. Given this, health centers provide a broad array of services such as care management, transportation, food and nutrition assistance and housing – all of which enable access to care and promote well-being by addressing non-clinical determinants of health. In fact, health centers' unique governance requirement (a 51 percent patient-majority board) was designed by Congress to ensure that each health center provides those services deemed important and necessary by the community it serves. Unfortunately, in addition to payment barriers surrounding non-clinical

[3] County Health Rankings. Available at http://www.countyhealthrankings.org/about-project/rankings-background.

services, payment for health care currently does not adequately incentivize the mitigation of SDOH, 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 – or the attributes of the Triple Aim.[4] If the health care system does not account for and support activities that address 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.[5] **Given the substantial impact non-clinical factors have on a person's 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, particularly as they pertain to individuals dealing with chronic care and behavioral health conditions.**

Expanding Innovation and Technology

NACHC agrees with the Committee about the need for better support for telehealth services across the system, including for chronically ill Medicare Advantage enrollees, within Accountable Care Organizations (ACOs), and for the diagnosis and treatment of individuals who have experienced a stroke, as delineated in the Policy Options Document. We urge the Committee to continue to recognize, develop, 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.

Investing in telehealth at ACOs is an important step. In fact, many health centers have taken leading roles in ACOs in an effort to achieve high-quality coordination of care. 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.[6] The study found that ACOs that are centered around primary care and include health centers have more capability than ACOs without health centers to: 1) have chronic care management processes and programs (41% compared to 26%), 2) integrate behavioral health into primary care (23% compared to 8%), and 3) involve patients in care decisions and self-management (32% compared to 18%). Many health centers are sought after to strengthen an ACO's delivery model of primary care, not only to increase the number of primary care providers but also to amplify primary care expertise.

Beyond that, we hope that the Committee will continue to build upon the policy options outlined in this document to improve Medicare reimbursement for telehealth and remote

[4] Labby, D. Achieving the Triple Aim: the simultaneous pursuit of population health, enhanced individual care, and controlled costs. Institute for Healthcare Improvement Oregon Helath Policy Board Presentation, May 2010. Available at: www.oregon.gov/oha/ohpb/meetings/2010/100511-lab.ppt

[5] Wilensky, G., and Satcher, D. Don't forget about the social determinants of health. Health Aff. 2009 Mar-Apr; 28(2): w194 –

[6] V. A. Lewis, C. H. Colla, K. E. Schoenherr et al., "Innovation in the Safety Net: Integrating Community Health Centers Through Accountable Care," Journal of General Internal Medicine, published online July 10, 2014.

patient monitoring services across the heath system, as it is our sincere belief that investments in this area will lead to better care coordination, cost savings, and better outcomes for Medicare patients in a variety of health settings across the country. In addition, telehealth can assist health centers and other safety net providers to overcome challenges posed by 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, reducing waiting times and extending a limited provider workforce to areas where the shortages are most acute. 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, and Medicare reimbursement for remote monitoring systems would dramatically improve the coordination of chronic care for patients served across sparsely populated areas.

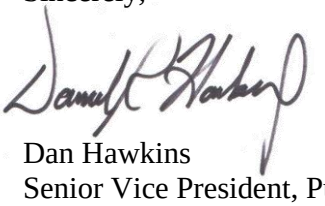
Empowering Individuals and Caregivers in Care Delivery

Encouraging Beneficiary Use of Chronic Care Management Services

We support the Committee's consideration of waiving the beneficiary co-payment associated with the current chronic care management (CCM) code, as well as any future co-payment that would be associated with the establishment of a high-severity CCM code. Ninety-three percent of health center patients have incomes below 200 percent of the federal poverty level (FPL), and thus, additional copayments are often difficult for FQHC patients to pay. Waiving the copayment for chronic care coordination services would both minimize confusion among patients about these charges and reduce financial barriers in accessing care. We also ask the Committee to consider the unique needs and challenges of FQHCs and their patients with regard to the CCM requirements. 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.

Thank you again for the opportunity to comment on your proposals to improve chronic care coordination in the Medicare program. NACHC staff, and our member health centers, remain committed to helping assist you in any way as you continue to work through this process. If you have any questions or to further this discussion, please contact Jennifer Taylor, Deputy Director, Federal Affairs at (202) 296-3410 or jtaylor@nachc.org.

Sincerely,



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