COMMUNITY HEALTH CARE ASSOCIATION of New York State

August 1, 2022

Judith Steinberg
Senior Advisor to the Assistant Secretary for Health
Office of the Assistant Secretary for Health
Department of Health and Human Services
Washington, D.C. 20201

Submitted via email to OASHPrimaryHealthCare@hhs.gov

RE: Request for Information: 2022 HHS Initiative to Strengthen Primary Care

Dear Ms. Steinberg:

Thank you for the opportunity to provide input on the HHS Initiative to Strengthen Primary Care. I write this letter on behalf of the Community Health Care Association of New York State (CHCANYS). CHCANYS is New York's primary care association representing the state's federally qualified health centers (FQHCs), also known as community health centers (CHCs). CHCs are federally funded nonprofit primary care clinics, providing comprehensive medical care, behavioral health care, and support services to more than 2 million New Yorkers each year at over 800 sites.

1. Successful models or innovations that help achieve the goal state for primary health care

Commitment to the Implementation of Value-Based Payment Models
Unlike most other types of providers, community health centers must meet a host of federal requirements aimed at ensuring they make comprehensive primary care services available to underserved populations regardless of the patient's ability to pay or their insurance coverage. Additionally, CHC patients routinely have higher rates of chronic conditions and require a broader range of community-based services and care coordination than the national average. In NYS, 65% of CHC patients are covered by Medicaid or Medicare. Reimbursement from these two government payers is determined according to a Congressionally mandated federal payment framework, the Prospective Payment System (PPS), which, while different across Medicare and Medicaid, ensures a specific payment methodology that is central to CHCs' continued viability.

Nonetheless, the CHC community across the country is aggressively moving toward stronger value-based payment models through several avenues. Many CHCs are members of Accountable Care Organizations (ACOs) and Independent Practice Associations (IPAs) to engage in a wide range of value-based arrangements in Medicare and Medicaid. CHCANYS has joined efforts with other state primary care associations in a learning collaborative to advance community health center participation in value-based care delivery and contracting. CHCANYS also receives federal funding to support a Health Center Controlled Network (HCCN) which supports data analytics and information technology growth at CHCs; that work is often leveraged in value-based payment.

CHCANYS is currently working with our membership and national experts in the development of a capitated Alternative Payment Model (APM). 42 U.S.C. §1396a (bb)(6) permits a CHC to be paid under an Alternative Payment Methodology (APM) through a Medicaid State Plan Amendment (SPA), with the following conditions:

a) the APM reimbursement is not less than what the community health center would have received under a "traditional" visit-based PPS methodology **and**

b) each community health center individually agrees to participate in the APM.

The traditional visit-based PPS methodology incentivizes volume over value. However, a community health center APM allows State Medicaid programs to adopt a different methodology that can support integrated care, incentivize high-quality comprehensive primary care services, allow flexibility to address patients' social determinants of health, and promote increased access to care. Without the limitation of payment tied to a narrow billable visit, CHCs can adopt innovative care delivery modalities such as telehealth, remote patient monitoring, same-day visits for primary care and behavioral health, and team-based care designed to best suit a given patient's needs. Moreover, an APM will empower CHCs to better coordinate with community partners to provide whole person care, including addressing patients' social needs, which are known to be the root causes of health disparities.

Utilization of 340B Program to Strengthen Primary Care

To support the costs of providing care to medically underserved populations, CHCs rely heavily on the federal 340B Drug Discount Program, which gives CHCs the ability to purchase outpatient medications at reduced costs and provide patients with affordable prescription drugs. The savings that CHCs generate from the 340B program are then directly reinvested into CHC services as required by the federal government. While 340B-supported services vary by CHC, a CHCANYS survey found that many New York CHCs use 340B savings to bolster community outreach programs that expand access, provide free or low-cost medications to low-income patients, subsidize high deductibles for patients who are underinsured, and expand dental and vision service offerings. The 340B program has recently faced a barrage of threats from pharmaceutical manufacturers. The 340B program must be preserved to ensure continuity of vital services.

Utilization of Telehealth to Expand Integrated Care

Community health centers are responding to the ongoing behavioral health crisis in medically underserved communities hard hit by the COVID-19 pandemic. The continued integration of primary and behavioral care is central to this work and the ability of CHCs to provide care via telehealth has been critical to this success. According to a survey conducted by CHCANYS in February 2022, about 60% of CHC behavioral health visits occurred remotely. Among all types of CHC visits, 25% occurred via telehealth. As a result of the various Medicare and Medicaid flexibilities put in place by HHS and Congress, CHCs have proven highly effective at utilizing telehealth to continue providing integrated care and other services to patients. Flexibilities that positively impacted CHCs include policies that remove geographic-related distant and originating site restrictions, permitting delivery of telehealth services via audio-only technologies, and permitting reimbursement at an amount equal to an in-person visit. While the expansions put in place by Congress and HHS have been critical to this success, many flexibilities available to CHC patients on Medicare will expire 151 days after the end of the federal public health emergency (PHE). This will likely result in less access to care for CHC patients. Telehealth flexibilities adopted during the COVID-19 pandemic must be made permanent to ensure access for patients who face barriers to in-person visits and to maintain continuity of care.

2. Barriers to implementing successful models or innovations

Lack of Long-term Stable Funding

Community health centers rely on federal grant funding. Much of that funding is through a mandatory appropriation to the Community Health Center Fund, which periodically expires. These cliffs and static funding levels make it difficult for CHCs to plan for future operations and expansions. Securing longer-term and increased funding as part of the Biden administration's pledge to double the federal investment in CHCs is critical to overcoming barriers to expanding innovative approaches to primary care.

Lack of Investment in Value-Based Care

While value-based arrangements can help CHCs expand access to comprehensive patient care, successful participation requires upfront investment in operational, data, and analytic infrastructure, and long-term sustainability funding. Payers have different value-based payment models that create an unnecessary and additional administrative burden, and thin operating margins at CHCs limit the ability to make the investments needed to harmonize clinical data and metrics using standardized value sets across systems of care.

New York State is currently pursuing a new 1115 waiver focused on advanced VBP arrangements that aim to reduce health disparities, improve population health, and achieve equitable health outcomes among underserved populations. Because CHCs are often the first entry into healthcare and social services for people who experience poverty, racism, and discrimination that inhibits their health and well-being, they are the natural partner for advancing value-based care in underserved communities. Significant investments, through the waiver and long-term sustainable funding, must be made to ensure the success of CHC transition to value-based care delivery.

Health Center Workforce Shortages

A significant barrier to implementation of innovative models and approaches to strengthening primary care most cited by community health center leaders is the ongoing workforce shortage. The pandemic exacerbated what is now an unprecedented amount of workforce attrition affecting operations and patient care. New York CHCs cite nursing staff, behavioral health staff, and dental staff as the hardest to recruit and retain. Community health centers face stiff competition for clinician and non-clinician staff from hospitals and private practices that offer better pay and less challenging work environments.

Lack of Continuity for Needed Telehealth Flexibilities

As outlined previously, telehealth has been a lifeline for CHC patients to continue receiving care during the pandemic. While the expansions put in place by Congress and HHS have been critical to this success, many flexibilities available to health center Medicare patients will expire 151 days after the end of the federal public health emergency (PHE). This will likely result in less access to care for CHC patients.

Prohibitions on Co-location of Primary Care and Behavioral Health Organizations

For years, NYS Department of Health has prohibited co-location and shared space between primary care providers and behavioral health organizations. NYS cites[1] CMS guidance stating that co-location can only occur when each organization has a distinct physical space; the organizations cannot share staff or waiting rooms, for example. This has limited behavioral health and primary care integration and reduced access to care for CHC patients.

3. Successful Strategies to Engage Communities

For a community health center to be formally designated as a Federally Qualified Health Center, it must meet a range of federal requirements outlined in Section 330 of the Public Health Service Act. One of these is that the community health center must be located in or serve a designated Medically Underserved Area or serve a designated Medically Underserved Population. Second, a majority of the CHC's board members must be patients served by the CHC, and even non-patient board members must be representative of the local community. Among CHC patients, 68% are Black, Hispanic, and People of Color, 28% speak limited or no English, 13% are uninsured, and 4% are unhoused. By their very nature, CHCs are federally mandated to provide and strengthen primary care services for underserved communities.

[1] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/2016-01_integrated_care_faqs.htm

4. Proposed HHS Actions

To ensure community health centers can continue to strengthen access to primary care and adopt innovative, cost-effective approaches to care delivery, CHCANYS recommends the following:

- Release a plan with specific goals and funding levels to operationalize President Biden's commitment to double the federal investment in the community health center program.
- Revisit CHC funding for care delivery and rebase PPS given changes in care delivery and need to advance primary care.
- Continue to protect the 340B Program by holding pharmaceutical manufacturers and pharmacy benefit managers accountable for their discriminatory practices and violations of the 340B statute. HHS should continue using its authorities to enforce compliance, including pricing agreements between the department and pharmaceutical manufacturers.
- Permit CHCs to provide remote services by revising the definition of medical CHC visits to include services furnished using interactive, real-time, audio and video telecommunications, or audio-only interactions under defined circumstances and allow reimbursement for medical telehealth visits beyond the Federal Public Health Emergency.
- Continue funding the Affordable Care Act (ACA) Navigator Program, investing in marketing for Health Insurance Marketplaces and Open Enrollment Periods to increase awareness and lengthening enrollment periods.
- Ensure that any CHC value-based care models are sufficiently funded to reflect the diverse needs of large, small, urban, and rural organizations and are flexible and inclusive enough to provide the spectrum of care for underserved, high-needs, and special populations (e.g., homeless, agricultural workers).
- Support policies to expand the list of billable providers on integrated care teams, including licensed marriage and family therapists, peer support workers, community health workers, licensed professional counselors, dental therapists, doulas, midwives, and care coordinators.
- Allow for the co-location of primary care and behavioral health service delivery organizations.
- Expand support for teaching health center planning and development to include resources for community health center accreditation for training other care team roles.
- Expand support for faculty loan repayment and remove or waive requirements for academic affiliation for community health center teaching faculty.
- Expand support for loan repayment programs focused on Behavioral Health staff.
- Expand and modify Nurse Corps to be a tax-exempt program similar to NHSC.
- Provide upfront investment in CHC infrastructure for operational, data and analytic infrastructure and training.

We thank you for your commitment to strengthening primary care. Should you have any questions, please contact Marie Mongeon, Senior Director of Policy, at mmongeon@chcanys.org.

Sincerely,

Rose Duhan
President & CEO
Community Health Care Association of New York State