



June 6, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1345-P
P.O. Box 8013
Baltimore, MD 21244-8013

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to the above-cited request for comments from the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS). NACHC is the national membership organization for federally qualified health centers (hereinafter interchangeably referred to as “health centers” or “FQHCs”) throughout the country, and is a non-profit, Section 501(c)(3) tax exempt organization. NACHC is limiting its comments primarily, but not solely, to provisions in the proposed Medicare Accountable Care Organization (ACO) rules that essentially and unnecessarily prohibit FQHCs from any meaningful participation in the Medicare ACO-Shared Savings Program and in doing so, we believe, jeopardize the potential for successfully achieving the goals Congress intended for this program.

I. Background

In the regular course of submitting comments to CMS on proposed rules, NACHC typically begins by providing background explaining the important role that FQHCs play in serving the poor underinsured and underserved in their communities. We will cover this issue in the next section of our comments, however, as it relates to the critical shortcomings of the proposed rule. Instead, we will include as background at this point only that there are, at present, more than 1200 FQHCs with more than 8000 sites serving almost 20 million patients nationwide. Most of these FQHCs receive federal grants under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA) of HHS. Under this authority, health centers fall into four general categories (1) those centers serving medically underserved areas, (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farmworker populations within similar community or geographic areas, and (4) those serving residents of public housing. Approximately 100 FQHCs do not receive a Section 330 Public Health Service Act grant but have been determined by CMS, per recommendation of HRSA, to meet all the requirements that must be met by Section 330 grantees (Sections 1861(aa)(4)(B) and 1905(l)(2)(B)(iii) of the Social Security Act). These FQHCs are often referred to as “FQHC look-alikes.”

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To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center's board of directors must be made up of at least fifty-one percent (51%) users of the health center and the health center must offer services to all persons in its area, regardless of one's ability to pay. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services (such as translation, transportation services, smoking cessation classes, etc) to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients from eligible communities, who are not indigent and are able to pay or who have insurance, whether public or private, are expected to pay for the services rendered. Approximately 35 percent of health center patients are Medicaid recipients, approximately 40 percent are uninsured and approximately 7.5 percent are Medicare beneficiaries. This 7.5 percent Medicare patient load translates into 1.4 million Medicare beneficiaries receiving services from FQHCs.

II. CMS' Proposed Rule Regarding FQHC Participation in the Medicare ACO/Shared Savings Program (MSSP)

Essentially, CMS' proposed ACO/MSSP rule, as we understand it, provides the following with regard to FQHC participation:

1. Health center-formed ACOs cannot participate in the MSSP¹
2. FQHC Medicare patients cannot be included in ACOs for purposes of shared savings²
3. A "one-sided" ACO can be exempt from the 2 percent net savings threshold adjustment, and thereby increase its shared savings, if 50 percent or more of its assigned beneficiaries have at least one encounter with a participating FQHC³; and both "one sided" and "two-sided" ACOs can increase their shared saving by up to 2.5 percentage points and 5 percentage points, respectively, if the ACO includes a FQHC⁴

As we understand it, CMS's explanation for items 1 and 2 above is based on the agency's belief that under 1899(c) and (d) of the Social Security Act (42 USC 1395jjj), as added by Affordable Care Act (ACA), it can only assign a Medicare beneficiary to an ACO based on the beneficiary's utilization of primary care services provided by a "physician" as defined in the Medicare statute. The agency maintains, therefore, that patients treated by an FQHC cannot be assigned to an ACO because prior to January 1, 2011, Medicare claims filed by FQHCs only included revenue codes and did not include HCPCS codes that identify the service provided. CMS appears to conclude that, since it lacks the "requisite data elements" in the claims and payment systems (particularly specific attribution of services to the rendering health care professional), it is not able to assign an FQHC patient to an ACO because it is unable to determine if the service was rendered by a physician. For this same reason, CMS maintains it is unable to establish a

¹ 76 Fed. Reg. 19538-19539 (April 7,2011)

² 76 Fed. Reg. 19538-19539 (April 7,2011)

³ 42 CFR 425.7(c)(4)(iv), as proposed at 76 Fed. Reg.19647.

⁴ 42 CFR 425.7(c)(7), as proposed at 76 Fed. Reg 19647.

three year benchmark as required in Section 1899(d) for Medicare patients treated solely by an FQHC provider. Hence, CMS determined that FQHCs are excluded from participation in the MSSP.

NACHC believes that CMS' conclusions are flawed for a number of reasons and that the law allows the agency to promulgate policies that will allow for full FQHC participation in the MSSP. Before we itemize these proposals, however, we believe it is appropriate to underline the importance of FQHC participation in the ACO/MSSP, as we believe that a system that does not allow for meaningful FQHC involvement undercuts the Congressional intent in establishing the ACO/MSSP program and the broader goal of assuring quality cost efficient health care services to Medicare beneficiaries. Put another way, a proposed program that will be implemented nationwide, with the intent to assure the provision of high quality, coordinated and cost-efficient care and that, appropriately, brings patients into that system based on their receipt of primary care services, cannot possibly be the correct interpretation if it does not include meaningful participation by the largest, most successful, rapidly expanding nationwide system of cost efficient high quality primary care providers that - due to provisions in the same law that provided for the ACO/MSSP - was projected to be serving at least 40 million patients in medically underserved areas by 2015.

III. The Importance of Meaningful FQHC Involvement in the ACO/MSSP

FQHCs are Providers of Cost Efficient, Coordinated, Team-delivered, High Quality Primary and Preventive Care

Rather than going on at length quoting studies and reports that prove that FQHCs are successful providers of high quality, coordinated cost-effective primary and preventive care, NACHC has included below a number of studies and reports that support this premise.⁵ We do think it important to point out, however, that in its preamble to this proposed rule, CMS accepts and underlines this very point. Specifically, the agency states:

FQHCs and RHCs have long delivered comprehensive, high-quality primary health care to patients regardless of their ability to pay, and increase access to health care through innovative models of community-based, comprehensive primary health care that focus on outreach, disease prevention, and patient education activities. FQHCs provide high-quality care to rural and urban populations alike by focusing attention on improving public health through preventive care in addition to direct patient care. Not only do health centers provide critical, high quality primary care in the Nation's neediest areas, but reports have shown that the health center model of care can reduce the use of costlier providers of care, such as emergency departments and hospitals. Currently, more than 1,100 such health centers operate over 7,900 service delivery sites that provide care to nearly 19 million patients in every State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. Despite serving less healthy and more vulnerable populations, research indicates that these health centers have achieved considerable success in

⁵ A comprehensive list of studies and reports can be found at:

<http://www.nachc.com/client/documents/HC%20Quality%20Studies%2004.11.pdf>

<http://www.nachc.com/client/documents/HC%20Cost%20Effectiveness%20Studies%2002.11.pdf>

<http://www.nachc.com/client/documents/HC%20Disparities%20Studies%2004.112.pdf>

<http://www.nachc.com/client/documents/HC%20access%20to%20care%20studies%2004.11.pdf>

increasing access to care, improving health outcomes for patients, reducing health disparities, and containing health care costs. For example, regarding FQHCs, data show health center Medicaid patients were 11 percent less likely to be inappropriately hospitalized and 19 percent less likely to visit the emergency room inappropriately than Medicaid beneficiaries who had another provider as their usual source of care.⁶

Congressional Recognition of the Value of FQHCs and its Intent to Expand FQHC Services

Congress has consistently and frequently recognized and supported the role of health centers in providing critical primary care services in medically underserved communities throughout the country. It has done so by repeatedly passing legislation that has enabled health centers to expand and increase their services, including for example, the provision of discounted drugs to FQHCs through the Section 340B program, the provision of Federal Tort Claims Act coverage for FQHCs and their employees, and most important, provisions in the Social Security Act (SSA) that require fair and adequate reimbursement to FQHCs to cover their costs in treating Medicaid and Medicare (and, recently, CHIP) patients.⁷

The most recent evidence of Congressional support and reliance on health centers' delivery of primary care services can be found in the same legislation in which it provided for the implementation of the ACO/MSSP. In Section 10503 of the Affordable Care Act (ACA) Congress provided for an \$11 billion investment in the expansion of FQHCs over the FY 2011-2015 time period so that they may provide primary health care to a far greater number of rural and urban medically underserved communities and thereby play a major role in the goal of the ACA to assure that those who gain coverage throughout the country in 2014 will have access to a quality cost-effective provider of primary care services in their communities. Thus, for health centers to be essentially excised from participation in the ACO/MSSP undercuts the overall goal of both the ACO/MSSP as well as the health reform direction that is the critical theme of the ACA.

CMS's proposed Rule Takes Medicare's Neediest Patients Out of the ACO/MSSP

In 2009, FQHCs served almost 1.4 million Medicare beneficiaries. The Medicare population treated by FQHCs is a rapidly growing part of the FQHC patient population. According to data from HRSA's Uniform Data Systems (UDS) covering the period 1996-2009, the FQHC Medicare patient population increased by 124%, with most of the growth taking place between 1998-2009. This Medicare patient increase can be attributed to a number of factors including the expansion in the number of health centers.⁸ It seems reasonable to assume that the Medicare beneficiary growth rate at centers will continue to increase in the upcoming years since in the ACA Congress has funded substantial health center expansion. As already noted, the health center funding in the ACA anticipates the overall number of patients that will be treated at health centers to reach 40 million by 2015.

⁶ 76 Fed. Reg., at 19613-19614

⁷ Sections 340B and 233(g)-(n) of the PHS Act and Sections 1902(bb) and 1833(a)(3) of the Social Security Act.

⁸ Rosenbaum and Shin, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Issue Brief No. 23, George Washington University, School of Public Health and Health Services, Department of Health Policy (April 20, 2011) pages 7-8

Equally important, the Medicare patients being treated at FQHCs tend to be an at-risk population. This can be attributed partially to the fact that health centers are located in medically underserved areas which often are low-income areas and, obviously, are areas where patients have had difficulty accessing care. Moreover, health centers treat a large proportion of Medicare patients who are also Medicaid recipients, known as dual eligibles. Dual eligibles are over 1.5 times more likely to experience serious health limitations, more than twice as likely to experience fair to poor health, nearly three times as likely to experience diabetes, and twice as likely to experience asthma.⁹ In short, dual eligibles are significantly more likely to experience worse health arising from conditions whose outcomes can be improved through ambulatory care and are the very patients whose health outcomes might improve through health care furnished in a clinically integrated system such as an ACO.

The proposed rules stress the importance of, and provide incentives for, ACOs bringing dual eligibles into their systems and, in fact, provide that CMS will monitor ACOs to assure that they do not attempt to avoid “at risk” beneficiaries. This concern and admonition only strengthens our initial point, that these proposed regulations are flawed in that they essentially leave out more than 1.4 million mostly high risk and diverse Medicare patients - whose numbers are increasingly being treated by FQHCs - from a Congressionally legislated system of care that is intended to foster high quality and cost savings through a clinically integrated system. Indeed, these proposed rules undercut the agency’s attempt to assure that dual eligibles and other at risk Medicare patients are brought into the ACO system.

Adverse Impact on the Quality Improvement Provisions in the Proposed Rules

Because FQHCs are essentially excluded from participation in an ACO for the reasons noted above, the quality improvement efforts in the rule are adversely affected. Because the proposed rule bases the shared savings on quality and per capita costs, CMS and FQHCs cannot assess their roles in the shared savings calculations or participate easily in ACOs or other CMS supported quality improvement initiatives. In addition, since the benchmarks will be used in the set of quality metrics, FQHCs will not be part of the calculation of these benchmarks, nor will it be easy to assess FQHC performance as a group within the ACO. Lastly, public reporting for providers and suppliers participating in ACOs will be impossible for FQHCs because their performance will not be reflected in the CMS database.

Marginalizing FQHCs from participating in CMS performance measurement and improvement activities may have an adverse effect on other important aspects of the proposed regulations, including, for example, centers participating in ACO quality improvement committees, playing a strong role in clinical integration across health care settings, and participating effectively in other aspects of an ACO’s information infrastructure such as population health assessment and targeting of high risk beneficiaries, coordination of care, and participation in patient experience surveys such as CAHPS. Also of concern is that the proposed rule makes no assurance that FQHCs will be a part of the development of a CMS specified data collection and survey tool using laboratory data. We would request that the final rule specifically state that FQHCs be included in the development of this tool and eligible to use it for laboratory data.

⁹ Id., at page 9

The proposed metrics are not explicit about performance measurement and improvement to reduce health disparities. Addressing health disparities are a persistent theme in Healthy People 2020,¹⁰ the U.S. Department of Health and Human Services (HHS) Action Plan to Eliminate Disparities in Health and Health Care,¹¹ the HHS National Strategy for Quality Improvement in Health Care,¹² and the HHS Strategic Framework for Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions.¹³ NACHC is a member of the National Priorities Partnership which has also identified the reduction of health disparities as a priority that should run through all measurement domains. Currently, the NPP is under contract with DHHS to recommend metrics and priority quality improvement strategies for the National Strategy for Quality Improvement.

Other existing and evidenced based measurement frameworks are available to inform CMS revision of its metrics to reflect the measurement of health disparities. The U.S. Department of Health and Human Services Office of Minority Health's Culturally and Linguistically Appropriate Services Standards,¹⁴ the National Quality Forum's "disparities-sensitive" measures for ambulatory health care quality¹⁵, The annual AHRQ National Health Disparities Report or the National Committee for Quality Assurance (NCQA) Multicultural Health Care distinction program,¹⁶ are all nationally recognized metrics or standards.

At a minimum, the ACOs should collect race, ethnicity, language, disability and other relevant demographic data from beneficiaries served, stratify quality data by those demographics, and develop and implement specific interventions to reduce any identified disparities.¹⁷ This may be done using retrospective population level data, including any data shared with the ACO by CMS.

¹⁰ <http://www.healthypeople.gov/2020/>

¹¹ http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

¹² <http://www.healthcare.gov/center/reports/quality03212011a.html>

¹³ http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf

¹⁴ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15> Resources for physicians are available at <https://www.thinkculturalhealth.hhs.gov/>

¹⁵ http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care—Measuring_Healthcare_Disparities.aspx The National Quality Forum (NQF) is also developing consensus standards on reducing health care disparities and cultural competency.

http://www.qualityforum.org/Projects/h/Healthcare_Disparities_and_Cultural_Competency/Healthcare_Disparities_and_Cultural_Competency.aspx?section=ReviewoftheProposedRoster2011-05-162011-05-30#t=1&s=&p=

As these measures are developed and endorsed by NQF, they should be considered for inclusion in the Medicare Shared Savings Program ACOs.

¹⁶ <http://www.ncqa.org/tabid/1157/Default.aspx> This NCQA distinction program was specifically referenced in the proposed rule. 76 Fed. Reg. at 19550 (April 7, 2011).

¹⁷ Washington DL, et al. "Transforming clinical practice to eliminate racial-ethnic disparities in healthcare." *J Gen Intern Med.* (2008); 23(5):685-691; Beach MC, et al. "Improving health care quality for racial/ethnic minorities: a systematic review of the best evidence regarding provider and organization interventions." *BMC Public Health.* (2006); 6:104; Chin MH, Walters AE, Cook SC, Huang ES. Interventions to reduce racial and ethnic disparities in health care. *Med Care Res Rev.* (2007);64(5 Suppl):7S-28S

Likely Impact of CMS's Proposed Rules on FQHC Participation in Non-Medicare ACOs

One of the reasons why CMS's Medicare ACO/MSSP proposed rules have generated so much attention and are likely to generate a substantial number of comments, is the anticipation and assumption that other payers such as Medicaid, CHIP and private health insurers will follow Medicare's approach and policies in developing their own ACO rules. State Medicaid agencies, particularly, tend to follow Medicare's lead on reimbursement and services. In fact, many of Medicare's payment and services policies relating to FQHCs are reflected in similar policies adopted by State Medicaid agencies. CHIP, in turn, follows Medicaid's lead.

NACHC is concerned that such will be the case with CMS's proposed Medicare ACO/MSSP rules—in fact, we have heard of at least one state that was considering going in that direction and would have left FQHCs out of its Medicaid ACO regulatory scheme. Medicaid patients make up approximately 37 percent of the health center patient population and in some states that percentage is above 40 percent. Thus, it is possible, or more accurately it is likely, that health center-formed ACOs will be excluded from participation in state Medicaid programs and that health center patients will be excluded from Medicaid and private payor shared savings programs. Hence, the implications of CMS excluding FQHCs from the ACO/MSSP system go well beyond the Medicare program.

Finally, the agency's response to the concerns and issues raised in this section may be that FQHCs and their patients have not been left out of the proposed ACO/MSSP system as CMS has built in specific shared savings incentives for ACOs that bring in FQHCs as part of their structure. However, in most instances, FQHC patients are being treated only by physicians and other providers at an FQHC. They are not likely to be treated by a non-FQHC provider as they live in a medically underserved area and the FQHC may be the only primary care provider accessible to them and/or may be their provider of choice. Since FQHC patients are not likely to be seeing or to have been treated by other primary care providers, they will never be assigned to an ACO under CMS's proposed rules. Indeed, the scenario under which the FQHC's Medicare patient would be assigned to an ACO—one in which somehow along the way the patient would be treated by a non-FQHC primary care physician—is contrary to a critical goal of the ACO system and the broader goal of the ACA, i.e. the provision and coordination of care by a team of health care professionals (such as those furnishing services at the FQHC).

IV. CMS' Room for Flexibility

Assigning of FQHC Patients to ACOs

We strongly urge CMS to recognize the purpose of the MSSP when it interprets the assignment provisions under Section 1899(c) and interpret that provision to allow assignment based on the use of primary care services provided by an FQHC since, as discussed below, those services cannot be provided to Medicare patients without the extensive and required involvement of physicians in the delivery of care. In short, we believe a broad interpretation of Section 1899(c) which allows the full participation of FQHCs in ACOs and allows for the ability of FQHCs to form their own ACOs is not only possible but is required by the purpose and goals of the MSSP/ACO legislation.

Specifically, Section 1899(c) provides that:

The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services *provided under this title by an ACO professional* described in subsection (h)(1)(A) [a physician].
(emphasis added)

An “ACO Professional” is defined as a physician or osteopath under Section 1899(h)(1)(A), a physician assistant (“PA”), nurse practitioner (“NP”) or clinical nurse specialist (“CNS”) under Section 1899(h)(1)(B). In the proposed rule, CMS has interpreted the statute’s assignment provision (Section 1899(c)) to require a patient to be assigned to an ACO based solely on that beneficiary’s use of a specific primary care physician or osteopath. As CMS explains in the preamble to the NPRM, CMS does not have data from FQHCs specifying whether a particular patient was seen by a physician or osteopath – as opposed to a PA, NP, or CNS – during his or her office visit. Without this data, according to the NPRM, CMS cannot assign FQHC patients to an ACO because CMS cannot determine that a patient used a particular physician or osteopath. As a result of this interpretation, FQHCs not only cannot independently form their own ACOs, but they also cannot have any their patients assigned to an ACO in which they participate.

We believe this interpretation of Section 1899(c) and particularly the “provided under” language emphasized above is too narrow and frustrates the purpose of the MSSP/ACO provisions of the ACA. Those purposes, as stated in the NPRM, are to create a “new approach to the delivery of health care aimed at (1) better care for individuals; (2) better health for populations; and (3) lower growth in expenditures.”¹⁸ As discussed previously in these comments, health centers were designed precisely to fulfill these aims.¹⁹ CMS recognizes as much in its preamble to the proposed rule, stating, “[d]espite serving less healthy and more vulnerable populations, research indicates that these health centers have achieved considerable success in increasing access to care, improving health outcomes for patients, reducing health disparities, and containing health care costs.”²⁰ This acknowledgement should, at the very least, give CMS pause regarding its current interpretation of the beneficiary assignment provisions of Section 1899(c). More importantly, by excluding the millions of patients served by FQHCs from assignment to ACOs, we believe that CMS’s interpretation clearly frustrates the purposes of Section 1899 as stated above – better care at a lower cost.

We do not believe such a restrictive interpretation of Section 1899(c) is necessary. FQHCs are funded under Section 330 of the Public Health Service Act to provide a wide range of primary and preventive services and, in order to participate in Medicare, those services must be provided under the direction of a physician. For example, in order to receive certification from CMS, an FQHC must be “under the medical direction of a physician” (42 C.F.R. § 491.7(a)(1)), “[t]he clinic or center has a health care staff

¹⁸ 76 FR 19531.

¹⁹ In addition, by virtue of being a participant in Medicare, FQHCs are required to meet and maintain safety and credentialing provisions that other providers are not required to meet. See 42 CFR Part 405, Subpart X, and 42 CFR Part 491 (excluding §491.3).

²⁰ 76 FR 19614.

that includes one or more physicians,” (Id. at § 491.8(a)(1)) and under Section 491.8(b) a physician or physicians must, among other things, have responsibility for overseeing medical policies and reviewing patient records.

Similarly, for a patient visit with a Nurse Practitioner (“NP”), Physician Assistant (“PA”) or Certified Nurse Specialist (“CNS”) (the other categories of ACO professionals identified in Section 1899(h)(1)), to constitute a billable visit under the Medicare program, those services must 1) be services which would be physicians services if furnished by a physician and 2) be provided either under the supervision of a physician in the case of a service provided by a PA or in collaboration with a physician in the case of NPs and CNSs. See Section 1861(s)(2)(K) of the Social Security Act. Again, the certification requirements are consistent with these payment provisions requiring that a physician be “present for sufficient periods of time” to provide “medical direction, medical care services, consultation and supervision” and to be “available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral.” 42 CFR 491.7(b)(2).

CMS’s interpretation ignores other provisions of Section 1899 in which the statute recognizes that current and successful models of delivery fully integrate NPs, PAs, and CNSs in the delivery of primary care. For example, Section 1899(b)(2)(D) states that an ACO must “include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO...” Section 1899(b)(2)(E) requires an ACO to provide “information regarding ACO professionals ...to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements...and the determination of payments for shared savings...” And, of course, the very definition of ACO professional includes physicians, osteopaths, NPs, PAs, and CNSs, as evidenced by the use of the word “and” connecting Sections 1899(h)(1) and (h)(2).

In short, all of the primary care services provided by an FQHC to Medicare patients have the extensive involvement of physicians either through the direct delivery of care, the supervision of that care, collaboration with the providers of that care or oversight in numerous ways of that care. Moreover, the statute itself recognizes this integration of care by using the broad interpretation of “ACO professionals” to determine, for example, that there are sufficient primary care providers to serve the assigned population. These provisions when put in context and when viewed with the purpose of the MSSP/ACO provisions of the ACA argue for a broad, not narrow, reading of 1899(c). We believe it is more than reasonable to –and detrimental to the program’s goals not to—interpret 1899(c) to find that the “provided under” language quoted above means not only services provided by the physician personally but also services provided by additional members of the health care team of an FQHC, with whom physicians supervise and collaborate. A final point: the definition of FQHC services in the Medicare statute encompasses “physician services” (Sections 1861(aa)(1) and (3)(a)) and for almost two decades, Congress has required that CMS Medicare (and Medicaid and recently CHIP) reimburse FQHCs on a per visit basis that reflects the bundle of preventive and primary care services that centers furnish to their low income high risk patients. Given its Congressionally-recognized success in providing high quality cost effective services under that payment methodology, and Congress’ provision in the ACO section of

the ACA that reimbursement payments to providers not be altered by virtue of participation in an ACO,²¹ it defies logic that Congress would sanction a system that prohibits assignment of FQHC patients to an ACO as a result of that same Congressionally-mandated reimbursement methodology. In short, the Secretary has the discretion to determine for purposes of patient assignment that patients who receive care from FQHCs can be treated as patients whose care is furnished by physicians since physician services are an integral part of the FQHC service definition, FQHC practice and FQHC reimbursement.

Establishing a Benchmark for FQHCs

Section 1899(d)(1)(ii) appears to provide CMS further flexibility to bring FQHCs into the ACO/MSSP. This provision requires the Secretary to estimate a benchmark “using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO.” This provision does not appear to require the specific methodology that has been proposed by CMS to determine the benchmark, and certainly does not require a single uniform methodology for all primary care providers. Under the wording of this provision, CMS appears to have the flexibility to apply a methodology to “estimate a benchmark” specifically for FQHCs.

If CMS does not agree that it has this flexibility in 1899(d)(1)(ii), there is no doubt that such flexibility exists in Section 1899(i). This subsection provides CMS options to implement payment models other than Section 1899(d) which is the provision that provides for the 3-year benchmark. Specifically, Section 1899(i) allows for a partial capitation model or “any other payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under” the Medicare program.²² In the next section of our comments, NACHC will propose several alternative methods to bring FQHCs into the ACO/MSSP under Section 1899(i).

V. Proposed Solutions to Allow FQHCs to Fully Participate in the ACO/MSSP

In an earlier section of these comments, NACHC itemized the adverse impact of CMS’ proposed rules to underline the importance of CMS reviewing these proposals with the goal of establishing a system that does not exclude FQHCs and their patients from meaningful participation in the ACCO/MSSP. We submit that in light of these considerations, CMS must approach these proposed rules from the perspective that any ACO/MSSP that essentially excludes FQHCs and its low-income high-risk Medicare patients cannot be consistent with Congressional intent and undermines the goals of such a system and therefore must be revised. Moreover, as explained in the prior section of our comments, we believe there is sufficient flexibility in the relevant provisions of the ACO/MSSP legislation to bring FQHCs and their patients into the program and adequate information and data available to CMS for it to do so. Listed below are several specific proposals as to how it might do so.

Assigning FQHC Patients to ACOs

CMS’ explanation in the proposed rule as to why it cannot assign Medicare FQHC patients to ACOs is that it reads Section 1899(c) of the Medicare law as requiring that beneficiaries be assigned to an ACO

²¹ Section 1899(d)(1)

²² Social Security Act Section 1899(i)(3)(A).

based on their utilization of primary care services furnished prior to January 1, 2011 and that “FQHCs do not include HCPCS codes that identify the specific service provided.” As CMS states, however, since January 1, 2011 health centers’ Medicare claims include relevant HCPCS codes. Since the ACO/MSSP program begins no earlier than January 1, 2012, CMS will have one year’s worth of health center claims with the necessary coding data to assign health center patients to ACOs. As already noted, we believe that the assignment can and should be based on treatment provided by professionals at FQHCs rather than solely physicians. For the same reason, the final CMS rule could and should allow for ACOs that are formed by professionals who are at FQHCs.

Health centers have been filing their claims with CMS for more than 18 years on the UB-04 form which is submitted to CMS for each Medicare encounter. That form contains the patient information, revenue code and “attending physician” information. Because health centers have a limited set of services that are considered “FQHC services” and virtually all FQHC services would be considered primary care services, we believe this information would be sufficient for CMS to establish a reasonable **assignment** process of health center beneficiaries to ACOs.

Establishing a Three-Year Benchmark

CMS’s additional explanation for taking FQHCs out of the ACO/MSSP is that because, prior to January 1, 2011, FQHCs were not providing the requisite data elements in the claims and payment systems, CMS cannot determine expenditures for the 3 year benchmark. There appears to be several approaches CMS could take to get past this barrier. For example:

1. CMS could use the data and claims it will have from FQHCs for 2011 and assume similar and comparable data and claims for the two years prior with some adjustments as appropriate relating to inflation, etc. This approach should provide an accurate benchmark since the proposed rules provide that in setting the three year benchmark the most recent year is weighted 60 percent of the benchmark. Moreover, CMS’ proposed rule would weigh the second year of data at 30 percent and would allow for ACOs starting later than 2012 to use data as of June 1, 2012. FQHC HCPCS codes for claims will be available as of that date, and as weighted under CMS proposed rules, would provide the basis for 75 percent (60 percent and 15 percent (6 months of 2012) of the three year benchmark. CMS could establish a three year benchmark based on non-FQHC patients assigned to the ACO and adjust the benchmark based on the number of FQHC beneficiaries assigned to the ACO per the data provided for 2011.

Notably, CMS described alternative methods in the proposed rule to address gaps in data (*i.e.*, for beneficiaries who were not 68 in their first year assigned to an ACO) in its discussion of establishing an expenditure benchmark²³. Under Option 2 of the discussion, CMS indicated that it could compute a weighted-average (using number of months as the weight) that blends the prior expenditure experience and the average per capita Parts A and B FFS expenditures for all Medicare beneficiaries during the year before the first year they are assigned to the ACO, adjusted for health status. Alternatively, CMS indicated that it could use only those

²³ 76 FR 19605

beneficiaries' prior expenditure experience. Either of these approaches could compensate for the lack of three years' of claims data (if such data is lacking) for beneficiaries served by FQHCs.

2. FQHCs report revenue codes for services provided. CMS could assign members utilizing the 2011 data and recover billing data from the prior two years with use of health center office visit revenue codes to determine the three year benchmark. CMS could gather information as necessary from its Fiscal Intermediaries or Medicare Administrative Contractors.
3. We believe that CMS has encountered a similar assignment issue with FQHC participation in the recent Multi Payor Advanced Practice Primary Care demonstration and recommend that CMS further investigate the methods that are being used to create a work around in that demonstration, and apply a similar work around for the ACO models. We also note (and appreciate) that in its recently published Pioneer ACO Model Request for Application, CMS states: "CMS encourages applications from ACOs led by Federally Qualified Health Centers (FQHCs), CMS would negotiate methods for expenditure baseline and benchmark calculations based on available Medicare data, and methods of patient alignment, with FQHCs that are selected for the Pioneer ACO Model." We ask that CMS apply this same flexibility in its final ACO rule.
4. A number of FQHCs have been recording HCPCS codes for all of their patients and have this information stored in their practice management systems, dating prior to the requirement to report to CMS on January 1, 2011. Those centers that are able to provide CMS with the data it requires to establish the three year benchmark should be allowed to do so. NACHC does not offer this approach in place of the above proposals, but rather suggests that those FQHCs that are currently able to provide the data and claims information that CMS seeks, should be allowed to opt into the system that CMS currently proposes.
5. CMS suggests that in order to allow FQHCs into the ACO/MSSP, it would have to impose, through regulations, reporting requirements that would require a significant change in center operations. The agency maintains that it is reluctant to do so without statutory requirement to do so or "clear support for such a regulatory change from the FQHC [and Rural Health Clinic] community."²⁴ Without commenting on CMS' conclusion as to the additional data that it would require, we reiterate our suggestion in the previous paragraph that there need not be an all or nothing approach. Instead, CMS can allow each health center to choose whether it will provide the requested information.
6. We believe the prior six proposals can be carried out by CMS under section 1899(d). If CMS does not agree that it has that flexibility under that section, **it could implement any one of them under section 1899(i).**

Indeed, Sections 1899(b) (1) (E) and 1899(i) together provide CMS the opportunity to establish essentially a separate track in which FQHCs could be designated as both ACO participants and as

²⁴ 76 Fed Reg., at 19538

ACO leaders, and in which their patients could be assigned and payment arrangements could be fashioned that both recognize and make the maximum utilization of their potential ability to reduce downstream health care costs. In this same vein, CMS could establish a separate benchmark and calculate savings for an FQHC-formed ACO based on hospital emergency room use, hospital admissions, hospital readmissions, post acute care such as extended care facilities use and other related high-cost Medicare expenditures. CMS also could consider reducing the number of quality assurance requirements in this separate FQHC track since the vast majority of FQHCs are Section 330 PHS Act grantees and, by virtue of their receipt of Section 330 PHS Act grant funding, are already highly regulated and provide substantial quality of care data and information to HHS. This model would assure that dual eligibles are part of the ACO/MSSP, since so many of the Medicare eligibles served by FQHCs are also low-income Medicaid recipients. Particularly important, this approach would assure that FQHCs and their patients are part of the mainstream ACO/MSSP which will increase the likelihood of their being brought into Medicaid ACOs, private payer ACOs, etc. The only limitation in 1899(i) is that an alternative model cannot result in more program expenditures than would otherwise be expended for such ACO for such beneficiaries. Based on the track record of FQHCs, as acknowledged by CMS in the preamble to this proposed rule, bringing FQHCs and their patients into the ACO/MSSP will result in lower expenditures, not higher ones.

Precedent from Past CMS Policy

NACHC's various proposals to accommodate the circumstances of FQHCs and, we believe, advance the goals of the ACO/MSSP, are not specifically required in the ACO provisions of the ACA, but we believe are permitted. We think it appropriate to point out there is precedent for CMS developing FQHC policy that it believes to be consistent with Medicare law even though the policy is not specifically spelled out in federal statute. Soon after Congress passed the legislation requiring that CMS Medicare reimburse FQHCs on the basis of reasonable cost, CMS proposed and finalized regulations that, among other things applied both per visit caps and screens to FQHC Medicare payments.²⁵

Nothing in the Medicare FQHC statutory provisions²⁶ provided for a per visit cap and Congress was certainly aware of its option to include such a requirement, as it had done so several years previous in passing similar Rural Health Clinic payment provisions. Nonetheless, CMS established a Medicare FQHC per visit payment limit by starting with the statutorily established RHC per visit limit and adjusting that amount to reflect a different visit mix, **a primary care family practice adjustment** and an urban/rural adjustment.²⁷ In addition, CMS applied productivity screens to the FQHC per visit payment calculation that could result in further reductions of a health center's reimbursement. CMS justified the use of those specific productivity guidelines by noting that they were the same as those used by HRSA in its health center grant review process.²⁸

²⁵ 57 Fed Reg.24961 et seq (June 12, 1992) and 61 Fed. Reg.14640 et seq (April 3, 1996)

²⁶ Section 1833(a)(3))

²⁷ 57 Fed. Reg, at 24970-24972 (June 12, 1992).

²⁸ 61 Fed. Reg.14651, at April 3, 1996

Despite NACHC’s protests as to the propriety of applying a per visit cap, despite the fact that the HRSA productivity guidelines referenced by CMS were no longer being used by HRSA, despite the finding of a GAO Report *Medicare Payments to Federally Qualified Health Centers* that that the actual costs of more than 70 percent of FQHCs exceed this per visit limit²⁹, and despite the availability of 18 years worth of data and claims and cost reports, CMS continues to apply the per visit cap and productivity guidelines it constructed in 1992. In short, there is precedent for CMS to construct—without specific statutory mandate-- a payment cap calculation applicable solely to FQHCs that relies both on Medicare cost principals and HRSA policies, and to apply that methodology for a lengthy period of time. Certainly then CMS should be able to construct a short-term assignment and benchmark process that would allow health centers and their patients to participate meaningfully in a system that is premised on savings resulting from the delivery of primary and preventive care.

VI. Governance

For all of the reasons presented above, NACHC strongly urges CMS to revise its proposed rules regarding FQHC participation in the ACO/MSSP. However, should CMS determine not to do so, we ask CMS to consider and respond to the following concern regarding its proposed governance rule.

Under the proposed regulations, an ACO would be required to have a “mechanism for shared governance,” such as a governing board, consisting of ACO participants and beneficiaries.³⁰ An ACO’s governing board must contain a representative from each of the ACO’s participants. That representative is required to have proportionate control over the ACO’s decision making process.³¹ We support CMS’ efforts to ensure that each ACO participant has a voice in the ACOs decision making process and strongly support CMS’ proposal to require ACOs to describe in their applications how they will partner with community stakeholders.

As we welcome the opportunity CMS has proposed for FQHCs to participate in multiple ACOs, we also urge CMS to consider the potential governance ramifications of this arrangement. FQHCs and other participants permitted to join multiple ACOs (including hospitals and other specialists) will be represented on the governing boards of multiple ACOs. To the extent that those ACOs are within the same geographic area or serve the same populations, issues of competition and conflict of interest arise. As a result, FQHCs may be limited de facto to participate in one ACO, further reducing an FQHC’s ability to participate to the maximum extent possible in the MSSP.

²⁹ GAO-10-576R *Medicare Payments to Federally Qualified Health Centers* July 30, 2010

³⁰ 76 FR 19541.

³¹ 76 FR 19540.

Thank you for the opportunity to comment on CMS' proposed rules on ACOS and the Medicare Shared Savings Program. If you have any questions about the comments presented herein, please call or email me at 202-296-0158 or rschwartz@nachc.com.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Roger Schwartz". The signature is written in a cursive, flowing style.

Roger Schwartz, Esq.
Associate Vice President and Legal Counsel
National Association of Community Health Centers