



August 23, 2010

Donald M. Berwick, MD, MPP, FRCP
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1503-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY2010

Dear Administrator Berwick,

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to the above-cited solicitation from the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) for comments on the rules related to the **Medicare Program and Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY2010**. 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 501(c)(3) organization.

BACKGROUND

There are, at present, approximately 1200 FQHCs serving nearly 20 million patients nationwide. Most 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 farm worker populations within similar community or geographic areas, and (4) those serving residents of public housing.

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 users of the health center and the health center must offer services to all persons in its area, regardless of his or her 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 to uninsured and

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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 (public or private) are expected to pay for the services rendered. Approximately 35 percent of health center patients are Medicaid recipients, approximately 7.5 percent are Medicare beneficiaries, and approximately 40 percent are uninsured.

COMMENTS ON THE PROPOSED RULE

NACHC appreciates the opportunity to respond to the proposed rule on the Medicare Physician Fee Schedule and other provisions relating to Part B. We would like to thank CMS for their work on this proposed rule, as it contains two important provisions relating to health centers and the implementation of the Affordable Care Act, which will enable health centers to provide more comprehensive, affordable care to their Medicare beneficiaries in need. NACHC will limit its comments to these specific provisions, as noted below.

Addition of Preventive Services to FQHC Services (42 CFR §405.2449)

The proposed rule creates a new section, 42 CFR §405.2449, which will allow for the addition of a number of preventive services to the list of FQHC services. The addition of these preventive services will allow for health centers to provide more comprehensive preventive care to their patients, while also guaranteeing proper reimbursement of these services. Since the inception of FQHCs in 1992, Medicare has added 13 new services to its coverage, yet those services have not been included as FQHC services, except for diabetes self management training and medical nutrition therapy, which were added in the Deficit Reduction Act. Prior to the enactment of the Affordable Care Act, many health centers provided these services to their patients as part of the primary and preventive care offered at the center, yet when provided to Medicare beneficiaries, they received no additional reimbursement. The addition of these services, which include an initial preventive physical examination and personalized prevention services, and the methodology that we understand CMS to be proposing to reimburse centers for these services, will alleviate the financial restrictions faced by health centers in providing these critical services and, thereby, will improve patient care to Medicare beneficiaries at health centers.

Currently, FQHCs are reimbursed using an all-inclusive per visit rate, determined by dividing the total allowable costs by the number of allowable visits. They also are subject to upper payment limits and productivity screens that CMS has imposed and which CMS maintains serve as "tests of reasonableness." A recent GAO study noted that over 72 percent of health centers were negatively impacted by these "tests of reasonableness." Additionally, there are seven providers (physician, physicians' assistant, nurse practitioner, clinical psychologist, clinical social worker, Diabetes Self Management Training provider and Medical Nutrition Therapy provider) that are can perform a "face to face" visit, thus triggering an all-inclusive per visit payment. If a provider other than one of these seven providers performs a service, those costs are included in the centers allowable costs, but do not trigger a

per visit rate. It is likely that many of these preventive services will fall into the latter category, thus not generating a per visit payment.

In the preamble, CMS states that given Section 4104(b)(1) of the Affordable Care Act, which waives the coinsurance for preventive services that are recommended with a US Preventive Services Task Force (USPSTF) Grade A or B, it will apply this provision to health centers as well, allowing for 100 percent reimbursement for these preventive services. NACHC agrees with and supports what it understands to be CMS' proposed application of the law; however we request further clarification on this issue. According to Section 1861(s)(10)(A) of the Social Security Act, health centers are reimbursed 100 percent of their costs for the provision of influenza, pneumococcal, and Hepatitis B vaccinations. This reimbursement is done separately and outside the upper payment limit and is noted as such on the health centers' annual cost reports. Given that an overwhelming majority of health centers are negatively impacted by the upper payment limit, NACHC requests that CMS provide further clarification on the reimbursement for these new preventive services in the final rule, and encourages CMS to use a similar method to determine the reimbursement for these new FQHC services. Indeed, we read CMS's preamble and proposed rule to provide that these preventive services will be reimbursed to FQHCs at 100 percent of their costs and that these amounts would be regardless of whether the health center's per visit payment is at the FQHC per visit payment limit. Because the list of new preventive services includes the provision of influenza, pneumococcal and Hepatitis B vaccinations, CMS must ensure that health centers do not lose their current reimbursement structure for these services, and with the addition of these new services, using a similar method to determine reimbursement would be in the best interest of CMS, health centers, and their patients. Additionally, NACHC encourages CMS to clarify these questions within in Section 405.2449 of the final rule, not just in the preamble, in order to ensure health centers receive the proper reimbursement for the provision of these services.

Data Collection (42 CFR §405.2470)

The proposed rule adds a new section, 42 CFR §405.2470, which takes the first step in the shift from the current Medicare FQHC payment structure to a new Prospective Payment System (PPS), as called for in Section 10501(i)(3) of the Affordable Care Act. The statute allows for the Secretary to begin collecting the data necessary to develop a PPS, and the proposed rule creates a new section which calls for health centers to begin reporting Healthcare Common Procedure Coding System (HCPCS) codes for the services they provide to their Medicare beneficiaries. NACHC supports the provisions in the proposed rule and simply requests that CMS ensure that their systems are appropriately updated and health centers are given adequate time to learn the new reporting requirements. We would also suggest that the data collection begin with a representative sample of health centers, and that it generally be phased in across the nation, in order to ensure that CMS not penalize health centers that may have difficulties adjusting to the new requirements and continue to work with those centers that might need additional assistance. This data collection is critically important to both CMS and health centers as it will provide the foundation for the development of the new PPS. In as much, since this is a new requirement for health centers, we request that there be adequate time and assistance to ensure the reporting is being done properly.

As the reporting of HCPCS codes is the first step in the development of the PPS, NACHC would also like to request that CMS review the lessons learned from the recent GAO report "Medicare Payments to Federally Qualified Health Centers" published on July 30, 2010. The report found that nearly 73 percent of health centers are negatively impacted by the upper payment limit or productivity screen. The GAO did a thorough analysis of the current payment structure, which NACHC believes can be helpful to CMS as it begins the development of a new payment structure.

NACHC looks forward to continuing to work with CMS on the implementation of the new Medicare PPS and other important provisions from the Accountable Care Act.

We appreciate the opportunity to comment on these proposed regulations and would welcome the opportunity to further discuss these concerns. If you have questions please contact Roger Schwartz or Susan Sumrell at 202.296.3800.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Roger Schwartz". The signature is fluid and cursive, with the first name "Roger" and last name "Schwartz" clearly distinguishable.

Roger Schwartz, Esq.
Associate Vice President and Legal Counsel