NATIONAL ASSOCIATION OF Community Health Centers

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August 21, 2017

Submitted electronically via http://www.regulations.gov

Seema Verma
Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS 5522-P: 2018 Updates to the Quality Payment Program

Dear Administrator Verma,

The National Association of Community Health Centers (NACHC) appreciates the opportunity to comment on CMS' proposed rule on 2018 updates to the Medicare Quality Payment Program (QPP).[1] NACHC is the national membership organization for federally qualified health centers (FQHCs or "health centers"). FQHCs serve as the health home for over 24 million medically-underserved people, the majority of whom live below the Federal Poverty Level and face multiple social and environmental factors which impact their need for health care and their ability to access care appropriately. With over 10,000 sites, FQHCs provide affordable, high quality, comprehensive primary care to these individuals, regardless of their insurance status or ability to pay for services. For additional information on FQHCs, please see Attachment A.

Background on Medicare and FQHCs

Nearly two million health center patients are Medicare beneficiaries. Of these, almost half are dually eligible for both Medicare and Medicaid. On average, roughly nine percent of an FQHC's patients have Medicare; for close to one in five FQHCs, this figure is at least 15 percent.

As noted in the preamble of the proposed rule and in last year's rule establishing the QPP, with a few exceptions, FQHC providers are not paid under the Physician Fee Schedule (PFS). Rather, payment for FQHC services is made directly to the FQHC under a Prospective Payment System (PPS). This PPS provides an all-inclusive, per-encounter rate that health centers receive each time they provide care to a Medicare patient. For more information on FQHCs and Medicare, see Attachment B.

[1] 82 *Fed. Reg.* 30010 (June 30, 2017).

While the vast majority of the provisions in the Proposed Rule do not apply to FQHCs, there are some services that health centers provide that would be subject to some of the provisions included in the proposed rule. Thus, NACHC will limit our comments to those proposals and will begin our comments with a summary of those issues then provide detailed comments.

- **NACHC supports an increase in the Low Volume Threshold, which will ensure that health centers are not inadvertently penalized for the limited work that they do billed via the Physician Fee Schedule.**

- **NACHC supports CMS' proposal to permit FQHCs to voluntarily report MIPS data, appropriately adjusted for patients' social determinants of health (SDH),**

- **NACHC encourages CMS to provide more detail on the submission process, allowing FQHCs to submit data as an entity.**

Discussion of NACHC Comments

NACHC supports an increase in the Low Volume Threshold, which will ensure that health centers are not inadvertently penalized for the limited work that they do billed via the Physician Fee Schedule.

As noted earlier, the vast majority of covered FQHC services are reimbursed under the FQHC Medicare PPS. However, there are a few covered services that FQHCs are required to bill under the PFS, using the name of the individual provider. Thus, even "typical" FQHC providers – those who work exclusively at FQHCs providing Medicare-covered primary care services to FQHC patients – receive a small percentage of their total Medicare reimbursement via the PFS.

Current regulations provide a low volume exemption to the QPP for Medicare providers that have equal to or less than $30,000 in allowed Part B charges or see equal to or less than 100 Medicare beneficiaries in a single year. While this exemption captures the large majority of health center providers that bill Medicare Part B for services outside the FQHC Medicare PPS, over the last year, NACHC has found that some health centers with large Medicare populations would be subject to reporting under MIPS. For this reason, NACHC strongly supports CMS's proposal to increase the Low-Volume Threshold. This increase to equal to or less than $90,000 in allowable charges or equal to or less than 200 Medicare beneficiaries during the performance period should ensure that those providers working in a health center with a larger Medicare population are not inadvertently penalized for their work serving Medicare patients.

NACHC supports CMS' proposal to permit FQHCs to voluntarily report MIPS data, and requests that CMS:

- **provide more information on how health centers can voluntarily submit data under MIPS, including allowing FQHCs to submit data as an entity.**
- **adjust FQHCs' data to reflect the social determinants of health (SDH) that disproportionately impact their patients;**
- **permit FQHCs to "opt-in" to Physician Compare**

One of the primary goals of the QPP is to transition providers toward enhanced value-based care delivery and enable the quality and value of care to be compared across providers. NACHC strongly supports this goal, and welcomes the opportunity for FQHCs to voluntarily be included in such comparisons provided that they are based on consistent data and appropriate risk adjustment is conducted.

However, over the last year there has been little information from CMS about how FQHCs are to voluntarily report under MIPS. In fact, NACHC and multiple health centers have asked CMS for more information about how to voluntarily report and were given conflicting responses via the QPP helpdesk at qpp@cms.hhs.gov.

We strongly encourage CMS to provide specific detail to FQHCs on how to voluntarily report under MIPS, should they choose to do so. In addition, as we have previously mentioned, health centers have a unique payment methodology in Medicare and report to CMS as an entity, not as individual providers as the "typical" PFS provider does. Because of this, we strongly encourage CMS to allow the FQHC to report as an entity, not as individual providers. Requiring a health center to report as individual provider is contrary to the way that FQHCs are paid via Medicare and would require the health center to revamp their entire system, which would likely discourage health centers from voluntarily reporting this valuable information.

We also would like to raise the critical importance of appropriate risk adjustment to reflect the SDH affecting providers' patient populations. By both law and mission, FQHCs serve underserved, high-need populations and almost three-quarters of our patients live below the poverty level. They are also disproportionately affected by social and environmental challenges that make it difficult for them to access and utilize health care appropriately (e.g., limited English proficiency, lack of stable housing, low literacy rates, lack of transportation). As research has proven, health center patients have greater needs, which can cause providers who care for them to score lower on measures of quality and resource use.

For these reasons, NACHC's support for FQHCs voluntarily reporting on MIPS is conditioned on the expectation that the data collected will be adjusted to reflect SDH. Without such risk adjustment, it is inevitable that the value and quality of care that FQHCs provide will be understated relative to other providers. If this occurs, the benefits of having a consistent system to measure performance and publicizing this data would be more than outweighed by the fact that the playing field would be uneven for providers, such as FQHCs, who serve the most challenging patients – a clear disadvantage to these providers.

Finally, CMS proposes for that the data voluntarily reported, providers would have an opportunity to opt out of having their data reported on Physician Compare during the 30-day preview period. NACHC believes that this should be an "opt-in" option instead of an "opt-out" option, as for health centers, this reporting is a wholly new experience, and without actively opting-out, their data will be made publically available. An "opt-in" option would allow the health center to clearly make the choice to have their data made publically available.

In closing, NACHC appreciates the extensive work that CMS staff have done to draft this proposed rule. We appreciate the opportunity to submit comments, and both our staff and our member health centers would be happy to provide any further information that would be helpful.

Sincerely,

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Attachment A:

OVERVIEW OF FEDERALLY QUALIFIED HEALTH CENTERS

For 50 years, Health Centers have provided access to quality and affordable primary and preventive healthcare services to millions of uninsured and medically underserved people nationwide, 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 24 million patients***, including nearly seven million children and more than 1 in 6 Medicaid beneficiaries.

Health centers provide care to all individuals, regardless of their ability to pay. All health centers provide a full range of primary and preventive services, as well as services that enable patients to access health care appropriately (e.g., translation, health education, transportation). A growing number of Health Centers also provide dental, behavioral health, pharmacy, and other important supplemental services.

To be approved by the Federal government as a Health Center, an organization must meet requirements outlined in § 330 of the Public Health Service Act. These requirements include, but are not limited to:

- ***Serve a federally-designated medically underserved area or a medically underserved population.*** Some Health Centers serve an entire community, while other target specific populations, such as persons experiencing homelessness or migrant farmworkers.
- Offer services to all persons, regardless of the person's ability to pay.
- Charge no more than a nominal fee to patients whose incomes are at or below the Federal Poverty Level (FPL).
- Charge persons whose incomes are between 101% and 200% FPL based on a sliding fee scale.
- Be ***governed by a board of directors, of whom a majority of members must be patients of the health center.***

Most §330 Health Centers receive Federal grants from the Bureau of Primary Health Care (BPHC) within HRSA. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing care to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients who are not indigent or who have insurance, whether public or private, are expected to pay for the services rendered. In 2014, on average, the insurance status of Health Center patients is as follows:

- 47% are Medicaid recipients
- 28% are uninsured
- 16% are privately insured
- 9% are Medicare recipients

No two health centers are identical, but they all share one common purpose: to provide primary health care services that are coordinated, culturally and linguistically competent, and community-directed, to uninsured and medically underserved people.

NATIONAL ASSOCIATION OF Community Health Centers

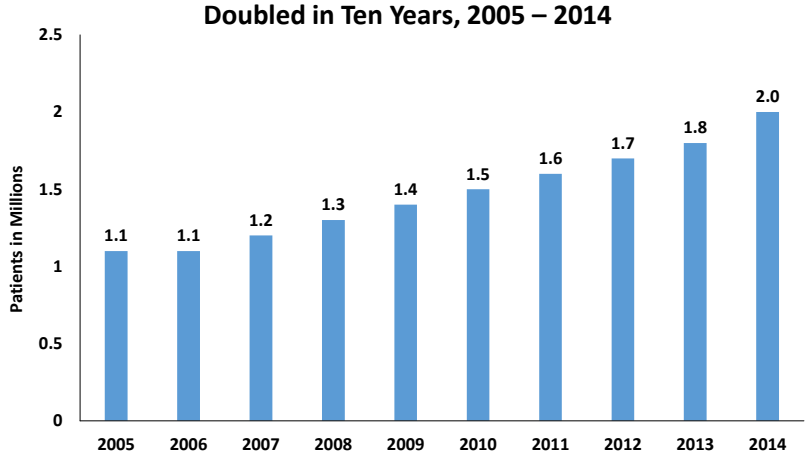
Fact Sheet
May 2016

Health Centers and Medicare: Caring for America's Seniors

Health Center Program Grantees and look-alikes are non-profit, community-directed, primary and preventive care providers serving low-income and medically underserved communities. [§] In the Medicare program, health centers are known as Federally Qualified Health Centers. They, along with Medicare, improve access to crucial health care services. Millions of older adults and persons with disabilities rely on Medicare to help get the care they need, and health centers work to ensure that anyone can access high quality and affordable primary and preventive health services. Health centers are able to do this all while also generating savings for Medicare.

In 2014, **health centers served nearly 2 million Medicare beneficiaries**, many of whom would not otherwise have access to primary care. Medicare patients currently make up 8.6% of all health center patients nationally, and many health center serve far more. In fact, Medicare patients make up at least 15% of total patients at nearly 1 out of every 5 health centers.[1]

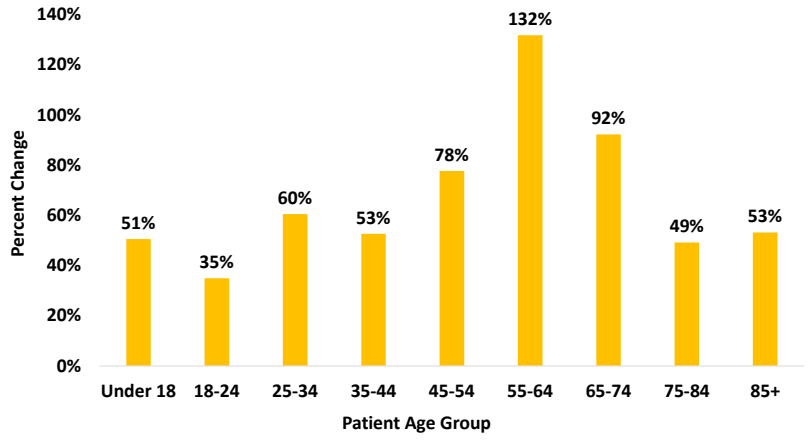
Figure 1
The Number of Health Center Medicare Patients Has Doubled in Ten Years, 2005 – 2014



Source: Federally-funded health centers only. 2005-2014 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

The number of Medicare beneficiaries served by health centers has nearly doubled since 2005 (Figure 1). Their numbers will continue to grow as health centers expand into new communities and as current and new patients reach age 65 and become eligible for the insurance program. Similar to the rest of the U.S. population, the health center population is aging. Between 2005 and 2014, growth in the number of patients nearing Medicare eligibility (ages 55-64) outpaced that of all other age groups, and even exceeded the rate of growth in the total number of health center patients during that time period (Figure 2). Those aged 65-74 represented the second fastest growing age group over the same time. These trends suggest that health centers will see far more Medicare patients in the near future.

Figure 2
The Number of Health Center Patients Ages 55-64 Has Grown Faster than All Other Age Groups, 2005-2014



Source: Federally-funded health centers only. 2005-2014 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

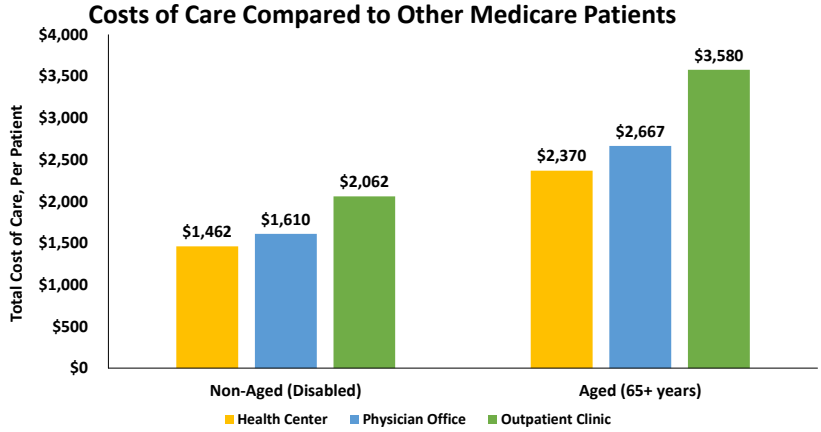
This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number U30CS16089, Technical Assistance to Community and Migrant Health Centers and Homeless for $6,375,000.00 with 0% of the total NCA project financed with non-federal sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

CARING FOR COMPLEX PATIENTS

Health centers serve high numbers of Medicare patients who are also eligible for Medicaid because of their low incomes. These "dual eligibles" have extensive health care needs. They are significantly more likely to suffer from multiple chronic conditions, such as diabetes, chronic lung disease, and Alzheimer's disease.[3] **More than 2 in 5 (42%) adult health center patients with Medicare insurance are dual eligibles** compared to 21% nationally.[4]

Figure 3

Health Center Medicare Patients Have 10-30% Lower Total Costs of Care Compared to Other Medicare Patients



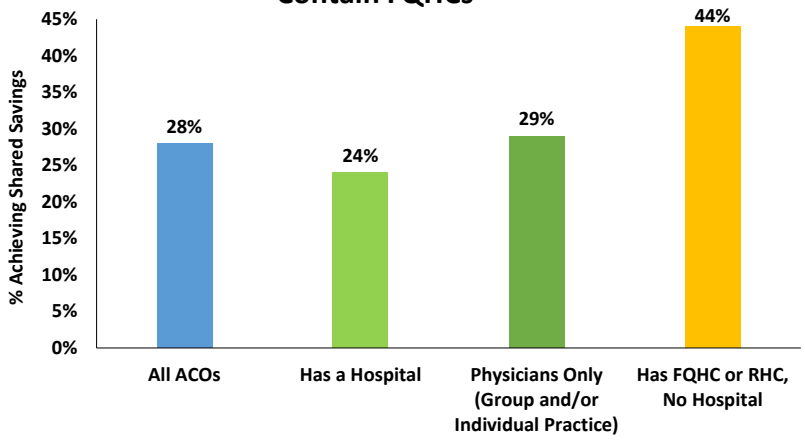
Source: Mukamel, D.B. et al. Comparing the cost of caring for Medicare beneficiaries in federally funded health centers to other care settings. *Health Serv Res.* 2015, July. 26(5).

GENERATING SAVINGS FOR MEDICARE

Despite serving a large number of Medicare beneficiaries with multiple and complex medical conditions, health centers deliver significant savings for the Medicare program. A recent study analyzing Medicare claims data from 14 representative states across the U.S. found that the **total cost of care per patient with Medicare is 10-30% lower for patients using health centers** (Figure 2), compared with patients seeking care at private physician offices and hospital outpatient clinics. This was due primarily to lower non-primary care costs. Other research finds that higher health center penetration in an area is associated with 10% lower Medicare spending without compromising the quality of care.[5]

Figure 4

More Medicare ACOs Generate Shared Savings When They Contain FQHCs



Source: Centers for Medicaid and Medicare Services, DHHS. Medicare Shared Savings Program Webinar: Performance Year 2014 Quality Performance and Financial Reconciliation Results for ACOs with 2012, 2013, and 2014 Start Dates, Slide Deck. September 1, 2015. And Introcaso, D. and Berger, G. MSSP Year Two: Medicare ACOs Show Muted Success. Health Affairs Blog. September 24, 2015. Accessed from http://healthaffairs.org/blog/2015/09/24/mssp-year-two-medicare-acos-show-muted-success/

edicare Accountable Care ACOs) with health centers as likely, on average, to savings compared to all .

§ In this document, unless otherwise noted, the term "health center" is generally used to refer to organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service Act, as amended (referred to as "grantees") and FQHC Look-Alike organizations, which meet all the Health Center Program requirements but do not receive Health Center Program grants.

Sources: 1. 2014 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS. 3. Cassidy, A. "Care for Dual Eligibles." Health Affairs. 2011, June 13, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=70 Meyer, H. "The Coming Experiments in Integrating and Coordinating Care for 'Dual Eligibles'." Health Affairs. 2012, June, http://content.healthaffairs.org/content/31/6/1151.full 4. George Washington University Analysis of 2009 Health Center Patient Survey. BPHC, HRSA, DHHS. And The Henry J. Kaiser Family Foundation. "State Health Facts: Dual Eligibles as a Percent of Total Medicare Beneficiaries." 2010. Access from http://kff.org/medicaid/state-indicator/duals-as-a-of-medicare-beneficiaries/ 5. Sharma, R., Lebrun-Harris,L., and Ngo-Metzger, Q. "Costs and Clinical Quality Among Medicare Beneficiaries: Associations with Health Center Penetration of Low-Income Residents." MMR 4.3 (2014):E1-E17.

 For more information, email research@nachc.com.

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number U30CS16089, Technical Assistance to Community and Migrant Health Centers and Homeless for $6,375,000.00 with 0% of the total NCA project financed with non-federal sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.