NATIONAL ASSOCIATION OF Community Health Centers

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September 6, 2016

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

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1654-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS 1654-P: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017

Dear Acting Administrator Slavitt:

The National Association of Community Health Centers (NACHC) appreciates the opportunity to comment on CMS' proposed rule on the Physician Fee Schedule and other revisions to Medicare Part B, including several provisions that will impact Federally Qualified Health Centers (FQHCs or "health centers"). 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 9,300 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 and Medicare, please see Attachments A and B.

Background on Medicare and FQHCs

Over two million health center patients are Medicare beneficiaries. Of these, 40 percent 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 health centers, this figure is over 20 percent.

With a few exceptions, FQHC providers are not paid under the PFS. Rather, payment for their services is made directly to the FQHC under a Prospective Payment System (PPS) established by the Affordable Care Act. This PPS provides an all-inclusive, per-encounter rate that health centers receive each time they provide care to a Medicare patient. Nonetheless, the Proposed Rule contains several provisions that will impact FQHCs, and our comments focus on these issues.

Summary of Comments

- **NACHC supports CMS' proposal to revise the requirements that FQHCs must meet to provide Chronic Care Management services to their patients.**
- **NACHC supports the creation of an FQHC specific marketbasket, with some suggested modifications to the proposal.**
    - ***Rebase the FQHC Marketbasket at the earliest opportunity to appropriately capture new Medicare FQHC data***
    - ***Development of Cost Categories and Cost Weights for the Proposed 2013-Based FQHC Market Basket***
    - ***Inclusion of Multi-factor Productivity in the Proposed FQHC Market Basket***
- **NACHC supports the expansion of the Diabetes Prevention Program (DPP) to the Medicare program, but seeks clarification if FQHCs are eligible suppliers under the program.**

Discussion of NACHC Comments

NACHC supports CMS' proposal to revise the requirements that FQHCs must meet to provide Chronic Care Management services to their patients.

As NACHC commented on CMS' proposed rule on the 2016 Physician Fee Schedule, which extended coverage and payment for Chronic Care Management (CCM) services to health centers, we are very supportive of CMS' allowance for FQHCs to provide and be reimbursed for the provision of CCM services. We believe that these services are in line with the health center model to provide comprehensive primary care to their patients and thus we are supportive of the revisions to the requirements set out in this year's proposed rule. These changes will more closely align the CCM requirements to those of other providers and further encourage health centers to provide these critical services to their patients.

We have heard from our members that their Medicare beneficiaries often have difficulty meeting the copayment requirements under CCM and that may be a barrier to health center's adoption of these services under the Medicare benefit. While we understand that it is a statutory requirement to apply the 20 percent copayment for CCM services, we encourage CMS to look into options to ease these requirements to ensure health center patients are able to access these important services.

NACHC supports the creation of an FQHC specific marketbasket, with some modifications to the proposal.

NACHC has long requested that an FQHC specific marketbasket be created to serve as the annual update method for health centers, in both Medicare and Medicaid. We believe that the current update factor, the Medicare Economic Index, is outdated and does not appropriately capture the services that health centers provide and therefore is not an appropriate update factor. In fact, a 2005 GAO study on the

implementation of the Medicaid FQHC PPS noted that *"…the MEI was designed to measure the changing costs for the average physician, which may be different from the costs of FQHCs and RHCs. FQHCs often provide additional services, such as translation, and a significant portion of RHC services may be provided by nonphysician practitioners. Other indexes often used to reflect medical care inflation have a similar shortcoming as they also do not reflect the services typically provided by FQHCs and RHCs."*[1]

Because of this, NACHC supported the Affordable Care Act provision that called for the creation of a market basket and believe that CMS' proposal to create an FQHC specific market basket is an appropriate step toward ensuring fair reimbursement for FQHCs. We support CMS' proposal, while recommending some clarifications and edits to the proposal.

The proposed rule identifies that, for calendar year 2017, CMS will create a "fixed weight" 2013-based FQHC market basket. CMS notes that the market basket is described as a "fixed weight" index because it represents the change in price over time of a constant mix (quantity and intensity) of goods and services needed to furnish FQHC services. Furthermore, CMS notes that only when the index is rebased would changes in the quantity and intensity be captured, with those changes being reflected in the cost weights (the proportion of total costs that each cost category represents). Accordingly, CMS notes that market baskets are periodically rebased so that the cost weights reflect a current mix of goods and services purchased (FQHC inputs) to furnish FQHC services.

- ***Rebase the FQHC Marketbasket at the earliest opportunity to appropriately capture new Medicare data***

The proposed 2013-based FQHC market basket utilizes cost information obtained from the old Medicare FQHC cost report (Form CMS-222-92) required to be submitted by FQHCs for cost reporting periods under Medicare's FQHC reasonable cost-based ("all-inclusive" rate) reimbursement methodology. With implementation of the Medicare FQHC PPS for cost reporting periods beginning on or after October 1, 2014, CMS recently finalized and issued a new Medicare FQHC cost report (Form CMS-224-14) required to be submitted by FQHCs for cost reporting periods under Medicare's PPS reimbursement methodology. With issuance of the new Medicare FQHC cost report, CMS has made adjustments in how costs are reported on Worksheet A so that the new Medicare FQHC cost report will provide higher quality cost reporting data. Among a variety of changes that have been made to Worksheet A, two new cost centers have been created for reporting of "capital related costs" (buildings and fixtures and moveable equipment) and additional lines have been created for improved reporting of pharmacy costs.

Given that the new Medicare FQHC cost report will provide higher quality cost reporting data, NACHC recommends that the 2013-based FQHC market basket be rebased at the earliest opportunity CMS has cost report information available to do so (in this proposed rule, CMS notes that all FQHCs will report

[1] U.S. Government Accountability Office. Health Centers and Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System. GAO-05-4442. Washington, DC, 2005. http://www.gao.gov/assets/250/246758.pdf

costs on the new Medicare FQHC cost report for calendar year 2016 expenses). In addition to an expeditious initial rebasing that utilizes cost information obtained from the new Medicare FQHC cost report, NACHC recommends that CMS implement a routine ongoing rebasing interval of every two years to help ensure FQHCs receive Medicare FQHC reimbursement utilizing a base PPS payment rate that reflects the ever changing nature of FQHC operations and the quantity and intensity of goods and services needed to furnish FQHC services.

- ***Development of Cost Categories and Cost Weights for the Proposed 2013-Based FQHC Market Basket***

The proposed rule provides information regarding the specific lines from Worksheet A of the old Medicare FQHC cost report used for accumulation of FQHC costs by major cost categories (CMS identifies eight major cost categories).

For the "FQHC Practitioner Compensation" cost category, we noted that line 4 of the old Medicare FQHC cost report used to report facility healthcare staff costs for "Visiting Nurse" was excluded from this cost category. Instead, we noted that line 4 was included in the "Other Clinical Compensation" cost category. Given that Chapter 13 of the Medicare Benefit Policy Manual includes "visiting nurse (RN or LPN under certain conditions)" as a type of practitioner that can render a medically necessary FQHC visit, NACHC recommends that the costs for "Visiting Nurse" be included within the "FQHC Practitioner Compensation" cost category and, accordingly, also be removed from the "Other Clinical Compensation" cost category.

In addition, NACHC requests that CMS confirm that compensation costs related to FQHC visit services provided by certified nurse midwives and qualified practitioners of outpatient DSMT and MNT (when the FQHC meets the relevant requirements for provision of these services) are included within the "FQHC Practitioner Compensation" cost category. While there were no specific identified line items on Worksheet A within the old Medicare FQHC cost report for these costs, the new Medicare FQHC cost report includes specific Worksheet A line items for reporting of these costs (lines 29 and 33 within "Direct Care Cost Centers" on the new Medicare FQHC cost report).

In addition to the foregoing, CMS notes that the "All Other (Residual)" cost category includes "nondescript administrative costs (lines 54-56)". Given that lines 54- 56 within Worksheet A of the old Medicare FQHC cost report include costs for certain "costs other than FQHC" versus "administrative costs", we believe the appropriate line numbers that CMS should reference for "nondescript administrative costs" are lines 46-48. NACHC requests that CMS confirm that "nondescript administrative costs" utilized for this cost category were accumulated from the aforementioned lines 46-48 and, if so, revise these line number references.

- ***Inclusion of Multi-factor Productivity in the Proposed FQHC Market Basket***

The proposed rule includes application of a "productivity adjustment" to prevent 'double counting' of the effects of productivity improvements; application of the proposed "productivity adjustment" reduces the proposed unadjusted FQHC Market Basket by .4%. CMS notes that application of this adjustment is similar to the adjustment used to the MEI that applies to self-employed physicians and that, absent this adjustment, physicians would be receiving increased payments resulting from both their ability to increase their individual outputs and from the productivity gains already reflected in the wage proxies used in the MEI. In addition, the proposed rule notes that it is the belief of CMS that the services performed in FQHC facilities are similar to those services provided by self-employed physicians covered by the MEI; accordingly, justifying application of the proposed "productivity adjustment".

While NACHC understands and appreciates the concerns of CMS regarding 'double counting' of the effects of productivity improvements, we believe that, absent further study by CMS of FQHC services, it is premature to apply a "productivity adjustment" in the proposed FQHC Market Basket. FQHC operations are not mirror images of self-employed physician practice operations, and, accordingly, we believe that application of the proposed "productivity adjustment" is not warranted at this time.

NACHC supports the expansion of the Diabetes Prevention Program, seeks clarification on FQHC's ability to participate

NACHC applauds CMS' expansion of the Diabetes Prevention Program (DPP) to the Medicare program. As primary care providers, health centers are very familiar with diabetes, and in 2015 served over 7 million patients with diabetes. Health centers help their patients not only manage their chronic condition but also provide services that can prevent diabetes-related conditions, such as kidney damage, blindness and poor circulation. They also try to improve patient outcomes with innovation and a team approach that helps patients manage their illness through lifestyle changes, nutrition and exercise.

Health centers have demonstrated proven success time and again helping those patients to manage their diabetes. We are very interested in learning more about the Diabetes Prevention Program and request clarification if a health center would be considered an eligible supplier under the Program. If so, would a health center participating in the program be eligible for reimbursement under the Program? We believe that given our mission and focus on patients with chronic conditions, health centers are the perfect fit to become suppliers under this program.

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In closing, NACHC appreciates the opportunity to submit comments on this proposed rule, and both our staff and our member health centers would be happy to provide any further information that would be helpful.

Sincerely,

Colleen P. Meiman, MPPA
Director, Regulatory Affairs
National Association of Community Health Centers
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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

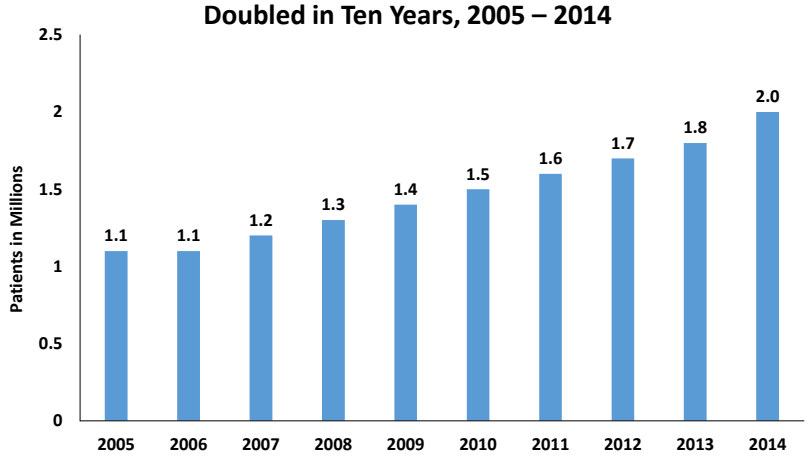
Fact Sheet
May 2016

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]

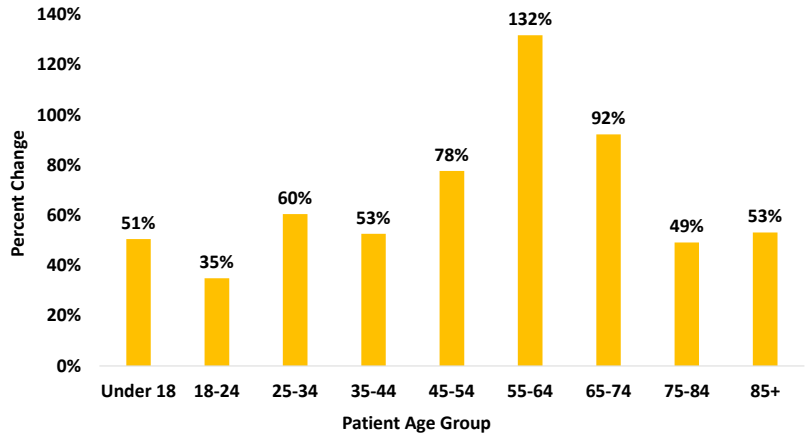
Figure 1
The Number of Health Center Medicare Patients Has Doubled in Ten Years, 2005 – 2014



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.

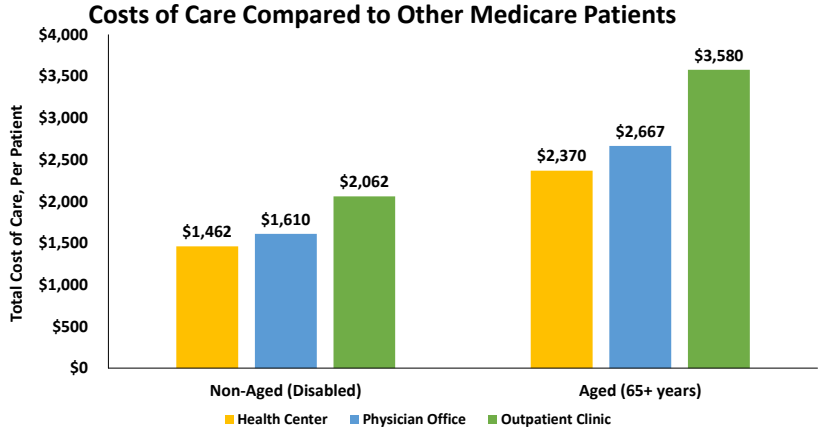
This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number U30CS16089, Technical Assistance to Community and Migrant Health Centers and Homeless for $6,375,000.00 with 0% of the total 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).

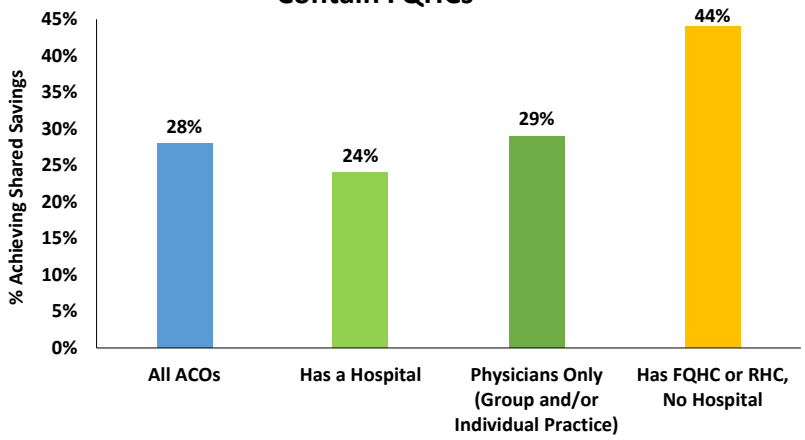
GENERATING SAVINGS FOR MEDICARE

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]

In addition, Medicare Accountable Care Organizations (ACOs) with health centers are nearly twice as likely, on average, to generate shared savings compared to all ACOs (Figure 3).

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/

§ 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.