NATIONAL ASSOCIATION OF Community Health Centers

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February 6, 2015

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1461-P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted via www.regulations.gov

Re: CMS-1461-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations

To Whom It May Concern:

The National Association of Community Health Centers, Inc. ("NACHC") is pleased to respond to the above-referenced Notice of Proposed Rulemaking published by the Centers for Medicare & Medicaid Services ("CMS") on December 8, 2014 (79 Fed. Reg. 72760) ("the NPRM"). NACHC is the national membership organization for federally qualified health centers (hereafter referred to interchangeably as "health centers" or "FQHCs"), and is a Section 501(c)(3) tax-exempt organization.

Health centers play a critical role in the health care system, serving as the health care home to over 23 million people. With over 9,000 sites, they provide affordable, high quality, comprehensive primary care to medically underserved populations, regardless of their insurance status or ability to pay for services. For additional information on health centers, please see the attachment.

Throughout the country, many health centers participate in Accountable Care Organizations (ACOs) operating under the Medicare Shared Savings Program (MSSP.) However, many more health centers have sought to participate, but have been unable to reach the minimum 5,000 assigned beneficiaries due to restrictions in the current system for assigning patients to ACOs. In 2013, 95% of health centers include non-physician practitioners (NPPs) as part of their health care teams[1], a rate that is twice as high as other primary care practices[2]. However, under the current assignment methodology, primary care services provided by NPPs neither qualify a patient to be assigned to an ACO, nor are counted in the assignment process. As a result, health centers that rely on NPPs as part of their team are frequently unable to have their patients assigned to their ACO. This makes it significantly more difficult for health centers to participate in the MSSP, and also leads to health center patients being erroneously assigned to ACOs which do not include their true primary care providers.

[1] NACHC analysis of Bureau of Primary Health Care, HRSA, DHHS, 2013 Uniform Data System (UDS).

[2] Source: Hing, E., Hooker, R., & Ashman, J. (June, 2011). Primary Health Care in Community Health Centers and Comparison with Office-Based Practice. J Community Health, 36(3):406-413

Summary of Comments

1. NACHC strongly supports the proposal to include primary care services furnished by nurse practitioners, physician assistants, and clinical nurse specialists earlier in the beneficiary assignment process.
2. NACHC recommends that CMS enable all FQHC patients who receive primary care services exclusively from NPPs to be assigned to an ACO.
3. NACHC opposes eliminating the current exception opportunity to the Governing Board Rule.

1. Support for proposal to include primary care services provided by certain non-physician practitioners earlier in the beneficiary assignment process (42 C.F.R. § 425.402 and § 425.404)

NACHC commends CMS' proposal to include primary care services provided by certain NPPs in Step One of the beneficiary assignment process, as opposed to Step Two. As acknowledged in the NPRM, NPPs very often serve as a beneficiary's sole primary care provider, especially at FQHCs, which serve areas or populations with a shortage of primary care physicians. As stated above, in 95% of health centers NPPs play a critical role in ensuring that patients have access to timely, high-quality, team-based care. Including their services earlier in the assignment process will make it more likely that FQHC patients will be correctly assigned to ACOs that include their primary care provider, and will also remove a barrier to greater FQHC participation in MSSP ACOs.

2. Recommendation to enable FQHC patients who receive primary care services exclusively from NPPs to be assigned to an ACO

As discussed above, including primary care services provided by NPPs earlier in the assignment process will eliminate one barrier that has both hindered the appropriate assignment of beneficiaries who receive primary care from these providers, and inhibited ACO participation by FQHCs and other providers whose care teams incorporate many NPPs.

However, another significant barrier remains. Under the present methodology, in order for a beneficiary to be assigned to an ACO he or she must receive at least one primary care service from a *physician* participating in an ACO. As a result, patients who receive **all** of their primary care from NPPs can never be assigned to an ACO, even if their NPPs are part of an ACO.

This rule makes it substantially more difficult for providers who rely heavily on NPPs to meet the threshold for beneficiary participation, thereby making it less likely that they will participate in MSSP. As stated above, FQHCs are twice as likely as other primary care practices to use NPPs, with 95% of health centers incorporating nurse practitioners, physician assistants, and certified nurse midwives into their care teams in 2013. This is not surprising, given that all health centers serve communities that have a shortage of primary care professionals, and they all emphasize on providing cost-effective, team-based care. However, it puts them at a strong disadvantage relative to other primary care practices in terms of having their patients assigned to their ACOs.

To avoid placing FQHCs at this disadvantage, CMS should presume that for purposes of the MSSP all primary care services provided by NPPs at an FQHC are furnished by a physician. CMS currently makes this presumption for FQHCs that are not ACO participants, but not for FQHCs who are participating in ACOs. CMS has offered two strong rationales for making this presumption for non-ACO FQHCs: first, it

avoids disrupting established relationships between beneficiaries and their care providers, and second, it avoids inappropriately assigning beneficiaries to ACOs that are not primarily responsible for coordinating their overall care. However, these same protections are not extended to patients of FQHCs who participate in ACOs. Rather, these beneficiaries are either assigned to a different ACO (if they have a single visit to a physician in another ACO) or else are not assigned to an ACO at all.

Fortunately, CMS could eliminate these inconsistencies by extending to all FQHC patients the presumption that primary care services provided by NPPs at an FQHC are furnished by a physician. This can be done in a manner that is consistent with the MSSP statutory requirement that assignment be based on the "utilization of primary care services" furnished by physicians. In defining the term FQHC services, Congress recognized the unique role of NPPs in furnishing primary care services in medically underserved communities. The statutory definition of "FQHC services" explicitly includes services furnished by a nurse practitioner, physician assistant, clinical psychologist, or clinical social worker "as would otherwise be covered if furnished by a physician." 42 U.S.C. § 1395x(aa)(1)(B). That language permits CMS to treat a service furnished by a nurse practitioner or physician assistant as if the service had been furnished by a physician.

In summary, for purposes of the MSSP, NACHC urges CMS to read the requirement to assign only those individuals who received a primary care services from a physicians in tandem with the statutory definition of FQHC services in which NPPs stand in the shoes of physicians in the provision of primary care services. In so doing, CMS can effectuate Congressional intent for both provisions, ensure that all FQHC patients receive equal protections, recognize the unique role of NPPs in furnishing primary care services in medically underserved communities served by FQHCs, and support increased participation of FQHCs in the MSSP.

3. Recommendation to retain current exception opportunity for the Governing Board Rule (42 C.F.R. § 425.106 (c) (3) and (c) (5))

Current regulations require that "at least 75% control of the ACO's governing body must be held by ACO participants." However, they also permit CMS to grant an exception to this rule "in cases in which the composition of the ACO's governing body does not meet the requirements . . . of [the MSSP]." In such cases, the ACO must describe why it seeks to differ from the requirements and how the ACO will involve ACO participants in innovative ways in ACO governance. The NPRM proposes to eliminate this exception authority because CMS has yet to grant an exception or find the requirement difficult for applicants to meet.

NACHC recommends that CMS retain the ability to grant exceptions to the Governing Board rule. As delivery systems continue to evolve, and ACOs expand to more payers, it is difficult to predict how governing boards may need to adapt. Maintaining the exceptions process will give CMS the flexibility to adjust to changing environments.

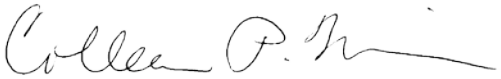
For example, as more states establish ACO program under Medicaid or the Marketplace, ACOs will likely be required to include on their Governing Boards at least one Medicaid beneficiary and/or one consumer with Marketplace coverage. Also, some ACOs intentionally establish a board that represents a broad range of providers, as a tool to help them better coordinate care across multiple settings. In addition, an ACO might discover that one or more specialist physicians on its board no longer constitutes an ACO participant because they furnish a small number of services that are used for attribution by CMS in a different ACO.

By eliminating its authority to make exceptions to the Governing Board role, CMS would unnecessarily reduce its ability to respond flexibly to changes such as those described above. For these reasons, NACHC recommends that CMS retain its authority to grant these exceptions on case-by-case basis.

* * *

Thank you for the opportunity to comment on the NPRM. If you require any clarification on these comments, please contact Ms. Colleen Meiman, NACHC's Director of Regulatory Affairs, at 301-296-0158 or cmeiman@nachc.org.

Sincerely,



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

Attachment:

Background on Health Centers

Health centers play a critical role in the health care system as the health care home to over 23 million people. They provide affordable, high quality, comprehensive primary care to medically underserved populations, regardless of their insurance status or ability to pay for services. A growing number of health centers also provide dental, behavioral health, pharmacy, and other important supplemental services. No two health centers are alike, but they all share one common purpose: to provide primary health care services that are coordinated, culturally and linguistically competent, and community-directed.

There are, at present, almost 1,300 health centers with more than 9,300 sites. Most of these health centers receive Federal grants under Section 330 of the PHS Act, 42 U.S.C. § 254b, from the Bureau of Primary Health Care ("BPHC"), within HRSA. 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.

To qualify as a Section 330 grantee, a health center must be serving a designated medically underserved area or 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 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 39 percent of health center patients are Medicaid recipients, approximately 36 percent are uninsured, and approximately 15 percent are privately insured.