NATIONAL ASSOCIATION OF Community Health Centers

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September 8, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2333-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via www.regulations.gov

RE: CMS-1631-PM Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

The National Association of Community Health Centers (NACHC) appreciates the opportunity to comment on this proposed rule on potential revisions to payments policies under the Medicare Physician Fee Schedule for CY 2016 (CMS-1631-P).

NACHC is the national membership organization for federally qualified health centers (FQHCs). FQHCs play a critical role in the health care system, serving as the health home to over 24 million people, the majority of whom live below the Federal Poverty Level. In 2014, over 2 million FQHC patients were Medicare beneficiaries. With over 9,300 sites, FQHCs provide affordable, high quality, comprehensive primary care to medically underserved individuals, regardless of their insurance status or ability to pay for services. For additional information on FQHCs, please see the attachment.

We begin by summarizing our comments, and then discuss each one in order.

SUMMARY OF COMMENTS

1. NACHC strongly supports CMS' proposal to permit FQHCs and RHCs to be directly reimbursed for Chronic Care Management (CCM) services, effective January 2016, and encourages CMS to finalize this proposal.

2. With regards to Advance Care Planning (ACP), NACHC:
   - strongly supports CMS' proposal to permit Medicare Administrative Contractors (MACs) to reimburse PFS providers for ACP services;
   - supports the proposal to include ACP as a component of the annual wellness visit;
   - encourages CMS to establish a consistent national policy permitting payment for ACP services to PFS providers, regardless of what MAC jurisdiction they are in; and

- encourages CMS to ensure that all Medicare Administrative Contractors are aware that a standalone ACP counseling session with an FQHC billable provider qualifies as a "billable visit" under Medicare's Prospective Payment System for FQHCs.

3. With regard to the proposals involving exceptions regarding FQHCs and the Anti-Self-Referral law, NACHC:

- strongly opposes the proposal to allow hospitals to reimburse physicians for the costs of recruiting non-physician providers (NPPs) from outside their geographic area, as we believe it will be used by hospitals to recruit providers away from FQHCs, thereby exacerbating the primary care workforce shortage for safety-net populations; and
- appreciates CMS soliciting input on the definition of "geographical area" in the context of FQHCs and anti-self-referral, and recommends that CMS adopt the definition that permits using non-contiguous zip codes.

DISCUSSION OF COMMENTS

1. Paying FQHCs and RHCs for Chronic Care Management (CCM) services.

NACHC strongly supports CMS' proposal to permit FQHCs and RHCs to be directly reimbursed for qualifying Chronic Care Management (CCM) services, effective January 1, 2016. NACHC appreciates CMS' recognition, as stated in the preamble, that:

> "the type of structured care management services that are now payable under the PFS for patients with multiple chronic conditions, particularly for those who are transitioning from a hospital or SNF back into their communities, are not included in the RHC or FQHC payment."

NACHC agrees with CMS that it is appropriate that the requirements for FQHCS and RHCs to bill for CCM services – in terms of both the patient's condition and the provider's capacities – should be identical to those applied to practitioners who traditionally bill under the PFS.

NACHC also appreciates CMS' acknowledgement that CCM services are part of the RHC/FQHC benefit. 80 FR 41795. Accordingly, FQHCs should not be required to exclude any activities relating to CCM from their Medicare cost reports.

Finally, NACHC appreciates CMS soliciting comment on this issue as part of the CY 2015 Physician Fee Schedule regulation process, and the careful consideration that was given to the comments received. We look forward to partnering with CMS in using CCM as a tool for improving health outcomes, enhancing the patient experience, and reducing expenditures.

2. Payment for Advance Care Planning (ACP):

NACHC strongly supports CMS' proposal to permit Medicare Administrative Contractors (MACs) to reimburse PFS providers separately for ACP services. We also support the proposal to include ACP as an optional element of the annual wellness visit (AWV). ACP is an important component of a primary care provider's relationship with his or her patient, and recognizing it as reimbursable services, as well as an optional component of the AWV, would help ensure that Medicare beneficiaries have the opportunity to have this important discussion with their

clinician on a routine basis (rather than the discussion being delayed until there is a medical emergency). We also urge CMS to clarify that ACP corresponds to the "end-of-life planning" that is an optional component of the initial preventive physical examination, per Social Security Act § 1861(ww)(2).

In addition, we have two requests regarding the ACP proposal:

- **Establish a consistent national policy permitting payment separate payment for ACP services for PFS providers, across all MAC jurisdictions.** Under the current proposal, in 2016 there will not be a consistent national policy about payment for ACP; rather, the policies will vary according the local coverage determination (LCD) made by the local MAC. Therefore, patients' access to ACP services, and PFS providers' ability to receive payment for them, will vary based upon where they live. NACHC thinks this outcome is both inequitable and inappropriate, particularly given the value and widespread need for ACP services across the country. Therefore, NACHC encourage CMS to make a national coverage determination (NCD) to pay PFS providers separately for ACP services.

- **Ensure that all Medicare Administrative Contractors are aware that ACP services qualify as a standalone "billable visit" under Medicare's Prospective Payment System for FQHCs.** As CMS acknowledges in the preamble to the NPRM, ACP is a component of "physicians' services," and physicians' services are included in the statutory FQHC and RHC benefits. *See* Social Security Act § 1861(aa). In addition, 42 C.F.R. § 405.2463 defines a "visit" under the FQHC and RHC payment systems as "as face-to-face encounter between an RHC *[or FQHC]* patient" and one of several types of providers (e.g., physician, PA, NP, LCSW.) Given this definition, ACP services also qualify as a "visit" under the FQHC and RHC payment systems, as long as the service was provided by one of the provider types listed. As a result, if a patient sees an appropriate FQHC or RHC provider for ACP services, this qualifies as a separately billable visit, regardless of which other services are provided.

  Due to the unique nature of Medicare's payment systems for FQHCs and RHCs, MACs frequently are confused about how changes in payment rules affect them. Therefore, NACHC requests that CMS proactively inform all MACs that a standalone ACP counseling session (CPT code 99497) counts as a "billable visit" when provided by an appropriate provider in an FQHC or RHC, and therefore should result in the appropriate per-visit payment (PPS for FQHCs, AIR for RHCs) being made to the provider. CMS should also consider stating this explicitly in the preamble to the Final Rule.

3. Adjustments to anti-self-referral provisions impacting recruitment and retention in underserved areas

a. NACHC appreciates that CMS's recognition that changes in the delivery system since the implementation of the ACA have exacerbated an already-severe primary care workforce shortage, and we applaud CMS for thinking about creative solutions to the issue. However, NACHC thinks that the recruitment proposal in proposed §411.357(x), while well-intentioned, will actually exacerbate the existing safety-net primary care workforce shortage experienced by FQHCs. Therefore, **we strongly oppose the proposal to allow hospitals to reimburse physicians**

for the costs of recruiting non-physician providers (NPPs) from outside their geographic area, as we believe it will be used by hospitals to recruit providers away from FQHCs, thereby exacerbating the primary care workforce shortage for safety-net populations.

a. As CMS has noted, the shortage in primary care providers has led to extreme competition between facilities seeking to hire them. Safety net providers such as FQHCs and RHCs are particularly impacted by this competition, as they are generally unable to pay providers the high salaries and large signing bonuses offered by hospitals, integrated health systems, medical groups, and other non-safety net organizations. Rather than supporting other providers in hiring primary care non-physician practitioners, FQHCs themselves need support to hire providers and fill exam rooms that are now sitting idle due to the lack of primary care provider capacity. Currently, FQHCs are being plundered for their primary care providers, and we believe this proposal will exacerbate issues that are causing a major disruption in care for Medicaid enrollees throughout the country.

Current statute permits hospitals to make payments directly to physicians to recruit other physicians from different geographic areas and to retain physicians who have an offer of employment in a different geographic area. Hospitals, medical groups, and integrated delivery systems are already using these exceptions to justify aggressive recruitment strategies to lure primary care providers away from FQHCs. In fact, in many instances private hospital recruiters are soliciting providers at the FQHC itself, sending recruitment teams into FQHCs and offering huge salary increases and signing bonuses to the FQHCs' primary care providers as an incentive to relocate and work for the non-safety-net organization. FQHCs are losing providers every day to hospitals and health systems able to pay salaries that are far out of reach for safety-net organizations. We recognize that CMS' past rulemakings sought to place FQHCs on an even footing with hospitals by extending these statutory exceptions to FQHCs, and we appreciate that CMS has undertaken in the present rulemaking to revise the definition of "geographical area" to create greater clarity for FQHCs seeking to make incentive payments to physicians. In practice, however, these exceptions are benefiting only hospitals, rather than health centers, which due to budget limitations are often unable to make such incentive payments.

FQHC-trained providers are particularly valued because of their cultural competency and their ability to serve populations with limited health literacy and a wide variety of medical, social, and behavioral health conditions. FQHCs spend considerable resources to provide up-front training programs in order to ensure a robust, culturally competent primary care workforce. Those costs are real dollars, and represent an investment from the FQHC that is then aggressively and unfairly recruited away by these large and well-financed hospitals, medical groups, and integrated delivery systems.

CMS now proposes a new exception to the physician self-referral prohibition, which is not explicitly grounded in statute. The proposed § 411.357(x) would allow hospitals or FQHCs to make payments to physicians to assist with the physician's recruitment of non-physician practitioners (NPPs). In practice, this exception does not help FQHCs at all, because FQHCs typically recruit by direct employment, rather than contracting arrangements. We believe that the additional exception proposed at §411.357(x) simply allows another vehicle for hospitals to lure practitioners – this time NPPs – from safety net providers. It will further exacerbate challenges that FQHCs are experiencing in retaining their existing primary care

workforce by allowing hospitals to recruit NPPs away from FQHCs to serve patients at hospital-affiliated outpatient facilities. In many cases, these outpatient facilities may not serve low-income and uninsured populations, further exacerbating access issues for the vulnerable populations.

b. In addition, CMS sought feedback on proposed changes to the definition of "geographical area," as used in the exception to the physician self-referral rule relating to physician and NPP incentive payments (subsections e and x.) We appreciate CMS' acknowledgement that in the existing regulation (42 CFR 411.357(e)), the definition of "geographical area" is confusing because it is the same definition that applies to hospital recruitment payments, and it relies on concepts (particularly hospital inpatient volume) that do not apply to FQHCs. The lack of clarity on this point may have deterred FQHCs from making this type of incentive payments to attract physicians to underserved areas. CMS' proposed changes appear to be motivated by the current primary care provider shortage in underserved areas, and NACHC appreciates CMS' acknowledgement that health centers play a critical role in solving this problem.

   CMS offered two alternative versions of the definition of "geographic area." One definition, which appears in the text of the proposed regulations, would consider at the outset only contiguous zip codes in determining the area from which the FQHC draws at least 90 percent of its patients. The alternative definition would consider the various zip codes from which the patients are drawn without factoring in contiguity. **NACHC recommends that CMS use the definition that does not use contiguity as a factor**. Health centers across the country operate in vastly different communities which share the characteristic of being medically underserved. This broader definition will help ensure that the exception applies as broadly as possible and accommodates all communities and all health centers.

c. Finally, NACHC appreciates that CMS specifically sought comment from FQHCs and RHCs on "whether the physician recruitment exception at § 411.357(e)) for physician recruitment is useful to such entities and any barriers to its use that they perceive." As discussed above, in practice, the exception at subsection (e) is of limited utility to FQHCs, because as safety net providers, FQHCs struggle be able to pay market salaries to attract clinicians. Incentive payments are often financially infeasible for FQHCs. The experience of our field is that unfortunately, the physician recruitment exception to the Stark prohibition at subsection (e) is more often invoked by hospitals that offer incentive payments seeking to lure clinicians away from FQHCs. NACHC values CMS' concern about this issue.

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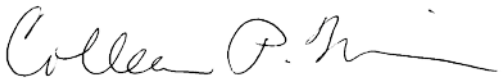
Thank you for the opportunity to comment on this Notice of Proposed Rulemaking. NACHC staff, and our member FQHCs, would be happy to provide CMS with any further information that would be beneficial. To initiate a discussion, please contact me at 202-296-0158 or cmeiman@nachc.org.

Sincerely,



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

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 22 million patients***, including nearly seven million children and more than 1 in 7 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 Section 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 Section 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 2013, on average, the insurance status of Health Center patients is as follows:

- 41% are Medicaid recipients
- 35% are uninsured
- 14% are privately insured
- 8% are Medicare recipients

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 care to uninsured and medically underserved people.