NATIONAL ASSOCIATION OF Community Health Centers

September 12, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: (CMS-1832-P)
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program (CMS-1832-P)

To Whom It May Concern:

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Community Health Centers (CHCs) (also known as Federally Qualified Health Centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of the primary health care system in the United States.

For 60 years, CHCs have provided high-quality, affordable, comprehensive care – including primary, preventive, dental, behavioral health, pharmacy, vision, and other essential health services to nearly 34 million patients annually at over 17,000 locations across rural and non-rural communities. This includes over 10 million rural residents (at least 1 in 5), more than 20 million (at least 1 in 3) in poverty, and more than 6 million (at least 1 in 5) uninsured people. CHCs serve at least 1 in 10 Americans and up to 1 in 7[1] yet account for only 1% of total U.S. healthcare spending, saving Medicaid and Medicare billions annually by reducing costly emergency, inpatient, and specialty care.[2] Research shows that every dollar invested in primary care yields a 13-to-1 return in overall health system savings.[3]

In addition to medical services, CHCs provide dental, behavioral health, pharmacy services, and other "enabling" or support services that facilitate access to care for individuals and families in medically underserved communities, regardless of insurance status or ability to pay. NACHC maintains its role as the national voice for Community health centers and believes that high-quality primary health care is essential in creating healthy communities. The collective mission and mandate of NACHC and the 1,512 community health centers around the country is to close the primary care gap and provide access to high-quality, cost-effective primary and preventative medical care.

The number of CHC Medicare patients has increased significantly over the past ten years, from 1.5 million in 2010 to over 3.6 million in 2024. Medicare patients currently make up 11% of the patients community health centers serve.[4] Community health centers play an integral role in helping lower Medicare patients' out-of-pocket costs. Costs for community health center Medicare patients ($2,370) are 10% lower than

[1] https://www.weitzmaninstitute.org/the-hidden-patient-base/
[2] Volerman A, Carlson B, Wan W, Murugesan M, Asfour N, Bolton J, Chin MH, Sripipatana A, Nocon RS. Utilization, quality, and spending for pediatric Medicaid enrollees with primary care in health centers vs non-health centers. BMC Pediatr. 2024 Feb 8;24(1):100. doi: 10.1186/s12887-024-04547-y. PMID: 38331758; PMCID: PMC10851548. https://pubmed.ncbi.nlm.nih.gov/38331758/
[3] https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf
[4] National Health Center Program Uniform Data System (UDS) Awardee Data (hrsa.gov)

those for physician office patients ($2,667) and 30% lower than those for outpatient clinics.[5] This could be attributed to the community health center model of care that strives to provide Medicare patients with affordable and high-quality care.

NACHC supports the agency's proposals to expand coverage and billing of Medicare services to better serve our patients and appreciates the intentional approach to proactively include CHCs in innovative proposals to address ongoing challenges for safety-net providers and underserved patients.

NACHC welcomes the opportunity to provide comments on this proposed rule. In brief, we appreciate CMS considering the following proposals below:

- **NACHC appreciates the unbundling of G0071 to better showcase the virtual communication services community health centers are providing and believes this will increase CHC utilization of the code. However, we urge CMS to increase the payment rate for the Advanced Primary Care Management (APCM) coding bundle to better account for patient care costs and the loss of concurrent billing with G0071.**
- **NACHC supports the expansion of the telehealth service list but encourages the agency to reconsider adding telemedicine Evaluation and Management (E/M)**.
- **NACHC recommends CMS reconsider the removal of HCPCS code G0136, the telehealth code for Social Determinants of Health Risk Assessment.**
- **NACHC applauds the proposal to amend regulations § 405.2401(b) to define direct supervision as either physical presence or continuous real-time virtual interaction.**
- **NACHC praises CMS for the rural exception of virtual resident supervision but is concerned about curtailing the option of virtual supervision of residents in non-rural settings.**
- **While NACHC appreciates CMS' continued allowance for community health centers to bill for non-behavioral health visits, we recommend a revised definition of a medical visit to ensure adequate payment for these telehealth visits.**
- **While we appreciate the agency's deference to physician discretion, NACHC remains concerned about the October 1 deadline for the implementation of the in-person requirement for telehealth mental health services.**
- **NACHC supports CMS' proposal to designate care management services established and paid under the PFS as care coordination services.**
- **NACHC supports CMS' efforts to remove time-based requirements for existing behavioral health integration (BHI) services and the Psychiatric Collaborative Care Model (CoCM) to reduce documentation requirements for billing.**
- **NACHC requests CMS ensure adequate reimbursement for BHI and CoCM in the event the agency moves forward with establishing these as add-on codes to APCM.**
- **NACHC appreciates the recognition to allow CHCs and RHCs to bill both APCM and behavioral health services and recommends that CMS not create add-on codes for behavioral health services in CHCs within APCM.**
- **Furthermore, NACHC recommends that CMS not include the Annual Wellness Visit (AWV), depression screening, or other preventive services in the APCM bundle, as this would also not align with the CHC integration model.**
- **NACHC recommends eliminating cost-sharing for APCM and behavioral health codes by categorizing these components as preventive services.**

[5] National Health Center Program Uniform Data System (UDS) Awardee Data (hrsa.gov)

- **NACHC encourages CMS to revise the definition of a behavioral health visit for CHCs and RHCs to broaden the types of HCPCS codes that can be billed to meet the definition of a qualifying visit.**
- **NACHC has strongly supported CMS' efforts to add mental health counselors (MHC) and marriage and family therapists (MFT) as Part B Medicare practitioners, as well as adding those clinicians' services to the Medicare and Medicaid mandatory CHC benefits.**
- **NACHC strongly recommends that Health Behavior Assessment and Intervention (HBAI) services, along with their corresponding CPT codes, be included on the service list for CHCs.**
- **NACHC supports the use of the term "upstream driver(s)" to include a variety of factors that can impact the health of Medicare beneficiaries.**
- **NACHC supports the proposed updates to the Medicare Diabetes Prevention Program (MDPP) and applauds CMS for allowing suppliers to offer MDPP services virtually through December 31, 2029.**
- **NACHC also urges CMS to set a clear goal of transitioning DPP into a permanently covered Medicare benefit.**
- **NACHC recommends CMS reconsider its proposal to reduce the time ACOs in the BASIC track can remain in a one-sided risk arrangement from seven years to five years.**
- **NACHC recommends CMS exempt the ACOs already participating in Level A of the BASIC Track from its proposal to reduce the time ACOs in the BASIC track can remain in a one-sided risk arrangement.**
- **NACHC supports the proposal to amend § 425.110(a)(2) to allow ACOs applying for a new agreement period to reach at least 5,000 assigned beneficiaries in the ACO's BY3 but could have fewer than 5,000 assigned beneficiaries in BY1, BY2, or both.**
- **NACHC requests CMS reconsider its proposal at § 425.605(i) to exclude ACOs that fall below 5,000 assigned beneficiaries in any BY from being eligible to leverage existing policies that provide certain low-revenue ACOs participating in the BASIC track with increased opportunities to share in savings.**
- **NACHC highly recommends that CMS reconsider the removal of two critical MIPS quality measures for the 2026 performance period: *Screening for Social Drivers of Health* and *Connection to Community Service Provider*.**
- **NACHC supports the inclusion of an oral health risk assessment and referral as a quality improvement activity in MIPS because it promotes a more integrated and holistic approach to patient care.**
- **NACHC would encourage CMS to reconsider its decision on the utilization of the proposed estimation percentage based on PVP data and the Medicaid Drug Rebate Program (MDRP) of Average Manufacturer Price (AMP) unit sales, as detailed in the draft version of the CY 2025 PFS.**
- **NACHC recommends that CMS use its own data as part of the estimation.**
- **Furthermore, NACHC recommends manufacturers submit data on 340B retail sales volume for direct sales and AIDS Drug Assistance Programs (ADAP) to either the 340B Prime Vendor Program or CMS.**
- **NACHC strongly supports the proposed voluntary 340B repository.**
- **Beyond those already noted by CMS, NACHC would like to outline our concerns that both methodologies will lead to significant overestimation of the 340B units as a portion of the Part D rebatable drug calculations, resulting in underpayments by manufacturers when charged inflationary penalties.**
- **Because of the significant concerns of 340B unit overestimation resulting from both the Prescriber-Pharmacy and Beneficiary-Pharmacy Methodologies, NACHC encourages CMS**

to pursue a refined version of the 340B percentage methodology, such as the proposed CY25 estimation methodology, with a few changes, until able to transition to the 340B claims repository.

- **NACHC would like to reiterate our concern that the mechanism for setting a fair professional dispensing fee (PDF) has not been described in statute, regulation, or guidance.**
- **NACHC supports the proposal to extend the application of HCPCS code G2211 to home and resident E/M visits and requests that CMS extend this opportunity to community health centers that perform home visits.**
- **NACHC requests that CMS develop and provide additional educational materials for CHCs to improve uptake and utilization of this important benefit.**
- **NACHC requests clarity from CMS on whether CHCs can use the 837D/837I instead of CMS-1500 for payment of dental services regarding the coordination of dual eligible patient care.**
- **NACHC supports reducing the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning in CY 2026.**

Payment for CTBS and Remote Evaluation Services

NACHC appreciates the unbundling of G0071 to better showcase the virtual communication services community health centers are providing and believes this will increase CHC utilization of the code. However, we urge CMS to increase the payment rate for the Advanced Primary Care Management (APCM) coding bundle to better account for patient care costs and the loss of concurrent billing with G0071. NACHC was supportive of the creation of the APCM services code, as it encompasses several services that are fundamental to the CHC model. Community health center patients are more likely to have been diagnosed with diabetes mellitus, asthma, high cholesterol, or hypertension as compared to the U.S. population. APCM services are more advanced than some of the general care management services community health centers already provide. However, due to their higher intensity, including provider coordination, the use of technology-based communication services, and additional documentation requirements compared to other general care management services, NACHC believes APCM services should have a higher reimbursement rate.

We have concerns about community health centers being unable to bill G0071 with APCM service codes, given that the low reimbursement rate does not accurately reflect the complexity of care or the administrative burden placed on community health centers. Community health centers provide high-quality, comprehensive services while operating on razor-thin financial margins. The ability to concurrently bill G0071 with APCM service codes was a crucial component in CHC utilization of APCM services, as it provided reimbursement reflective of the complexity of care CHCs are providing. Furthermore, many other care management services cannot be billed with APCM, which, coupled with the coding billing requirements, makes APCM quite complicated for community health centers to understand and implement. We urge CMS to adjust the APCM payment rate to reflect the quality care community health centers are providing.

Telecommunications

NACHC supports CMS' expansion of the telehealth service list but encourages the agency to reconsider adding telemedicine Evaluation and Management (E/M). As CHC providers spend time ensuring that all patients' needs are met, services such as reviewing tests, coordinating care, and documentation should be adequately compensated for, whether they are provided in person or virtually. The American Medical Association (AMA) recognized the value of telehealth when they created the new telemedicine-specific E/M codes starting in 2025 (98000–98007 for video, 98008–98015 for audio-only,

and 98016 for brief check-ins).[6] This move demonstrates how the field regards telehealth as a distinct, clinically valid mode of care rather than merely an extension of in-person visits.

Telehealth has also been crucial in addressing care gaps for CHC patients. In 2024, nearly 99% of community health centers nationwide offered telehealth services, up from just 43% in 2019.[7] By providing telehealth for both medical and behavioral healthcare, community health centers can increase access to comprehensive care and better serve Medicare beneficiaries facing socioeconomic challenges. Telehealth is also popular among CHC patients. A NACHC survey shows that nearly 90% of respondents believe telehealth meets their needs, is suitable for interacting with their clinician, and that they are generally comfortable and satisfied with telehealth care.[8] About a quarter of the surveyed patients had a behavioral health visit—52.55% via audio-only and 65.7% via video (with some using both). This adds to the growing body of evidence[9] supporting telehealth's ability to deliver clinically equivalent care while achieving high patient satisfaction. Continued growth of telehealth through the expansion of the telehealth service list helps connect more providers to patients and addresses barriers to access.

NACHC recommends CMS reconsider the removal of HCPCS code G0136, the telehealth code for Social Determinants of Health Risk Assessment. Community health centers have long been at the forefront of screening for upstream risk factors and connecting patients to vital resources. Community health centers specialize in providing comprehensive primary care services through whole-person care, treating patients and uncovering the barriers patients they face in accessing basic health care services. With their team approach to care, community health centers understand the need to document and track these services to ensure that any provider treating the patient can fully understand their needs.

One tool that community health centers use to do this is the Protocol for Responding and Assessing Patients' Assets, Risks and Experiences (PRAPARE) tool.[10] NACHC helped create this tool to enable community health centers and other providers to collect the data they need to better understand and address their patients' risk factors and needs. PRAPARE is widely used, with 70% of CHCs that screen for upstream risk factors using the tool in 2023 and 2024.[11]

CHCs ability to use G0136 to screen patients for these risk factors through telehealth is especially crucial for patients in rural areas who face barriers such as transportation or time constraints. Although we recognize that these services may sometimes be encompassed under existing codes, we believe it remains essential to maintain G0136 to improve access, address the underlying causes of poor health outcomes, and adequately document all the services that CHCs provide to their patients. We strongly encourage CMS to continue allowing CHCs to bill for non-clinical factors of health screening delivered via telehealth.

NACHC applauds CMS' proposal to amend regulations § 405.2401(b) to define direct supervision as either physical presence or continuous real-time virtual interaction. Making virtual supervision permanent will help community health centers better optimize staff, enhance communication, and reduce provider burden, ultimately benefiting patient care. In a NACHC survey, data revealed that community health centers are facing a severe workforce crisis, with nearly two-thirds experiencing staff turnover rates of 5-25% in 2022. [12] Virtual supervision offers needed relief to providers while also helping enhance healthcare access, especially in medically underserved, rural areas where many community health centers are located. Community health centers provide care to nearly 10 million rural patients, who make up 1 in 5

[6] Proposed changes to federal student loans could worsen the doctor shortage | AAMC
[7] 2024 UDS Data
[8] https://www.nachc.org/resource/assessing-patient-satisfaction-with-telehealth-at-community-health-centers-a-policy-brief/
[9] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796668
[10] https://prapare.org/
[11] Internal NACHC data
[12] NACHC-2022-Workforce-Survey-Full-Report-1.pdf

rural residents.[13] NACHC strongly supports these advancements, which enable community health centers to expand access to care for the nearly 34 million patients they currently serve and address critical workforce challenges.

NACHC praises CMS for the rural exception for virtual resident supervision but is concerned about curtailing the option of virtual supervision of residents in non-rural settings. With an estimated shortage of 87,150 full-time equivalent (FTE) primary care physicians by 2037,[14] there has been a growing emphasis on strengthening the pipeline of residents into primary and community-based care. While the 90 Teaching health centers (THCs), serving over 1,200 residents in 26 states, and Washington, D.C.[15] can help address this shortage, many community health centers also partner with teaching hospitals to serve as a rotation for a resident. Preserving opportunities for more residents to be trained in community-based organizations in rural, urban, island, frontier, and tribal areas with limited access to care is crucial. Training physicians in these settings is the strongest predictor of continued practice in such communities in subsequent years.

As previously mentioned, virtual supervision offers relief to an overburdened physician workforce. NACHC is concerned that CMS' decision to no longer allow flexibility for virtual supervision of residents will negatively impact unique partnerships that allow community health centers to serve their communities in ways that work for them. Specifically, many psychiatry programs use remote preceptors due to significant faculty shortages across the nation. For example, a psychiatry program at a CHC in central Wisconsin has long used tele-precepting with faculty as far away as Georgia to address the lack of available local faculty. However, the program is not considered rural by CMS despite being in a geographically isolated community that meets other federal rural definitions. Since at least 2006, the rules for supervising teaching physicians billing under the Physicians at Teaching Hospitals (PATH) program have included a special provision for psychiatry residency programs that allows for non in-person supervision (e.g., via a "one-way mirror or video equipment"). CMS should consider maintaining tele-supervision flexibility includes all residents, including psychiatry residents, so that CHCs can continue improving access to care in underserved communities amid a health workforce crisis. CMS could request reporting of data to ensure quality of training and patient safety are maintained while virtually supervising residents in all geographies. NACHC also encourages CMS to evaluate options for enhancing residency training in CHCs by reducing barriers to braiding GME funding available through federal, state, and private grants with Medicare and Medicaid dollars.

While NACHC appreciates CMS' continued allowance for community health centers to bill for non-behavioral health visits, we recommend a revised definition of a medical visit to ensure adequate payment for these telehealth visits. Currently, community health centers are receiving around $94 for non-behavioral telehealth services via the Physician Fee Schedule. Being able to bill the Prospective Payment System (PPS) rate for medical visits ($195.99) will bolster financial stability, improve cash flow, and ensure fairer compensation for telehealth services. By simplifying the billing process and increasing revenue, community health centers can expand telehealth access to more patients. NACHC continues to advocate for amending the definition of a medical visit, which would help provide more congruent payment for telehealth visits, regardless of whether they are medical or behavioral health visits.

Amending the definition of a "medical visit" creates parity with the revised definition of mental health visits, defined at § 405.2463 b(3). We also support ensuring the definition of a medical visit allows for audio-only capabilities and suggest CMS use the below definition for§ 405.2463, paragraph (b)(1) to define a medical visit:

[13] FlyIn_RuralCHCDataSheet_V7.pdf
[14] State of the Primary Care Workforce
[15] Home | Bureau of Health Workforce

as a face-to-face encounter or encounter where services are furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where beneficiaries are not capable of or do not consent to, the use of devices that permit a two-way audio/video interaction for the purposes of diagnosis, evaluation or treatment of services under (b)(2).

Changing the definition of a medical visit to include virtual encounters allows the CHC to provide patients with services through the modality of their choice and to best address their medical needs. Community health centers strive to meet patients where they are and enhance access to care; telehealth helps community health centers fulfill their purpose of providing high-quality, affordable, and accessible care to all their patients.

While we appreciate CMS' deference to physician discretion, NACHC remains concerned about the October 1 deadline for implementing in-person requirement for telehealth mental health services. We appreciate the continued delay of the in-person mental health visit requirement for telehealth mental health services furnished to Medicare beneficiaries via telehealth by RHCs and CHCs in the previous PFS. With a looming deadline less than two months away, however, we fear that continuity of care will be disrupted if this proposal is enacted as written. In-person visit requirements strain an already thin health care workforce, with an expected shortage of between 20,200 and 40,400 primary care physicians by 2036.[16] Physician shortages disrupt care and lead to longer wait times, especially for patients who want to see a physician in person. Postponing in-person visit requirements for telehealth mental health visits will enable community health centers to continue providing essential mental health care to patients in rural and underserved areas, ensuring continuity of care and preventing disruptions in treatment for underserved populations.

Community health centers are a critical access point for mental health and substance use disorder care. In 2024, community health centers provided care to over 3 million patients with behavioral health needs, including depression, anxiety, Post-Traumatic Stress Disorder (PTSD), Attention-Deficit / Hyperactivity Disorder (ADHD), and substance use disorders.[17] Upstream risk factors that contribute to health outcomes, including poverty and limited access to transportation, which can significantly hinder individuals from seeking necessary mental health support and make it difficult to meet the in-person requirement.

Aligning with the Physician Fee Schedule for Care Coordination

NACHC supports CMS' proposal to designate care management services established and paid under the PFS as care coordination services. Distinguishing these care coordination services as separately payable versus services included in a visit will enhance transparency and increase clarity for community health centers submitting care coordination claims. We appreciate this shift, as it aligns with the previous PFS in the unbundling of G0511, a previous code that encompassed general care management services. As the U.S. population ages, CHCs will serve a growing number of Medicare patients who often have complex care needs. Community health centers strategically leverage care models, including team-based care, that provide proactive support that often extends beyond the exam room. These care coordination opportunities, which are separately reimbursable and can often be led by auxiliary staff, enable real-world interventions that make a difference in patients' lives. This approach helps community health centers stay financially strong and allows CHC staff to work within their scope and licensure.

Enhanced Care Management

- Integrating Behavioral Health into Advanced Primary Care Management (APCM)

[16] 2024 UDS Data
[17] 2024 UDS Data

- Behavioral Health Integration Add-On Codes for APCM (HCPCS Codes GPCM1, GPCM2, GPCM3)

CHCs have long been at the forefront of addressing mental and behavioral health needs in America, as they are accessible, community-based, and comprehensive. In 2024, community health centers provided over 18.3 million visits for mental health services to more than 3.1 million patients and over 1.8 million visits for substance use disorder services to over 325,000 patients.[18] The integration of whole-person services such as behavioral health and primary care is at the core of the CHC program.

CHCs offer a wide range of integrated mental and behavioral health services for children and adults, such as comprehensive individual or group counseling, intensive outpatient services, addiction and recovery services, Medication-Assisted Treatment (MAT), school-based therapy, and crisis services. These services are patient-centered and determined by the needs of the community the CHC serves. Community health centers utilize interdisciplinary teams to coordinate care and offer case management to diagnose, treat, and care for individuals with trauma, sleep disorders, domestic abuse, depression, anxiety, or alcohol or drug use, among other mental health conditions.

NACHC supports CMS' efforts to remove time-based requirements for existing behavioral health integration (BHI) services and the Psychiatric Collaborative Care Model (CoCM) to reduce documentation requirements for billing. Patients seeking care at community health centers often manage multiple chronic conditions such as asthma, chronic lower respiratory diseases, diabetes, heart disease, and hypertension, as the most common conditions. Efficiencies in documentation and billing for medically complex patients can help reduce administrative burden. Additionally, this change would support and advance community health centers' ability to fully integrate behavioral health services with primary care settings.

NACHC requests CMS ensure adequate reimbursement for BHI and CoCM in the event the agency moves forward with establishing these as add-on codes to APCM. However, if CMS decides to include BHI and CoCM as add-on codes to CMS, how the agency values these codes for CHCs and RHCs to determine the specific payment amounts will also impact utilization. If these payments are less than the standalone codes for BHI and CoCM codes, it is unlikely to increase utilization. NACHC urges CMS to ensure community health centers receive adequate reimbursement for these add-on codes, if this proposal is finalized.

Request for Information Related to APCM and Prevention

How should we account for cost sharing if APCM includes both preventive services and other Part B services? Should CMS consider including the Annual Wellness Visit, depression screening, or other preventative services in the APCM bundle, and if so, which services and why?

NACHC appreciates the recognition to allow CHCs and RHCs to bill both APCM and behavioral health services and recommends that CMS not create add-on codes for behavioral health services in CHCs within APCM. As CHCs have varying levels of integration, which include coordination and co-location of primary care and behavioral health facilities and services, add-on codes for APCM will be difficult for CHCs to operationalize and would not encourage increased utilization, as behavioral health is already integrated into a community health center's primary care practice. For example, the CoCM model and APCM services are delivered by providers within different specialties. APCM may be delivered by a physician, a nurse practitioner (NP), a physician assistant (PA), or a clinical nurse specialist (CNS) within primary care specialties, like general internal medicine, family medicine, geriatric medicine, or pediatrics.

[18] 2024 UDS Data

The CoCM model requires Primary Care Providers (PCPs) to work with embedded Behavioral Health Care Managers (BHCM) to provide evidence-based medication or treatments. Then, treatment plans are constantly monitored and adjusted regularly by a board-certified psychiatrist or a psychiatric nurse practitioner.

Whereas for BHI services, a physician or non-physician practitioner, such as a PA (Physician Assistant), NP (Nurse Practitioner), CNS (Clinical Nurse Specialist), or CNM (Certified Nurse-Midwife) in primary care or another specialty, may deliver general BHI entirely or under their direction via incident-to services. Different from the CoCM model, community health centers often employ Licensed Clinical Social Workers (LCSWs) to deliver care coordination rather than an outside psychiatric consultant. While we appreciate CMS' intention behind creating add-on codes, CMS needs to be aware that the operational and care team structure within community health centers is distinct from other Medicare providers, making add-on codes for APCM not feasible. Furthermore, NACHC seeks that CMS clarify if add-on codes are finalized, how these add-ons will be valued, and if overall reimbursement will be lower than if the CHC independently provided BHI or CoCM in addition to APCM.

CMS must also consider how community health centers and other integrated primary care settings utilize separate electronic health records (EHRs) for medical and behavioral health care. This is due to different information collected during patient visits, referrals, or intake, often requiring behavioral health staff to record and retrieve information differently when compared to medical documentation. When a patient has an overlapping medical condition with a substance use disorder, the Code of Federal Regulation (CFR) Title 42 Part 2 adds different privacy protections for mental health conditions. Privacy concerns are a current challenge for integrated community health centers, and CMS should consider this as well when deciding whether behavioral health add-on codes for APCM are practical for community health centers.

Furthermore, NACHC recommends that CMS not include the Annual Wellness Visit (AWV), depression screening, or other preventive services in the APCM bundle, as this would also not align with the CHC integration model. Community health centers need the flexibility to perform these screenings on an ad hoc basis, as not all community health centers bill for APCM. Continuing to be able to bill for these annual screenings will ensure adequate reimbursement and showcase all the preventive services provided by community health centers. The AWV is not meant to be a physical exam, but rather an update to a personalized prevention plan that includes medical history, vaccines, health risk assessment, functional ability, advanced care planning, among other medical and lifestyle factors. Clinicians must be trained on how to provide the AWV, as opposed to an annual physical. This is similar to Medicare's depression screening, where there are a series of required components using a standardized tool, documentation, and follow-up that must occur. CMS has noted that a Medicare annual depression screening is distinct from the AWV and cannot currently be billed on the same day. Lastly, the AWV and depression screening do not have any deductible or coinsurance responsibilities to beneficiaries, while the APCM does have cost-sharing associated with its services. NACHC suggests the AWV, depression screening, and other preventative services remain separately billable from the APCM bundle. If CMS chooses to include these in said bundle, we ask the agency to clarify how these preventive services would interact with APCM and if beneficiaries would incur cost-sharing when receiving these services.

NACHC recommends eliminating cost-sharing for APCM and behavioral health codes by categorizing these components as preventive services. In addition to administrative burdens like time-based documentation mentioned above, the other largest barrier to increasing patient access to behavioral health services is related to patient cost-sharing requirements. Currently, Medicare will pay 80% of the lesser of the CHC's actual charges or the geographically adjusted PPS rates. Then, patients are expected to pay the 20% coinsurance based upon the lesser of the submitted charges of the local PPS payment rates for G0469 (PPS qualifying mental health visit, new patient) and G0470 (PPS qualifying mental health visit, established patient). Under CoCM services, HCPCS codes G0511 and G0512 are subject to coinsurance

and deductibles on RHC claims. For CHCs, only coinsurance applies. While community health centers strive to make services affordable, CHC patients are often financially unstable, and the monthly cost for some of these recurring services deters them from receiving these services. Categorizing components of APCM and behavioral health codes as preventive services would eliminate the cost-sharing barrier for underserved CHC patients.

NACHC encourages CMS to revise the definition of a behavioral health visit for CHCs and RHCs to broaden the types of HCPCS codes that can be billed to meet the definition of a qualifying visit. The Prospective Payment System (PPS) requires that to be considered a qualifying "visit", [19] two conditions must be met: an encounter has to meet the regulatory "visit" criteria, and it must include a service with a code included on a list of HCPCS codes, included within one of CMS' "visit" G codes. These "visit" G codes are identified within informal guidance. For CHCs and RHCs, a mental health visit is a medically necessary mental health encounter between a patient (established or new) and a qualified practitioner. To qualify as a CHC mental health visit, the encounter must include a qualified mental health service, such as a psychiatric diagnostic evaluation or psychotherapy. If a new patient is receiving both a medical and mental health visit on the same day, the patient is considered "new" for only one of these visits. As of January 1, 2022, a CHC mental health visit is defined as a face-to-face encounter or an encounter furnished using interactive, real-time audio and video telecommunications technology or, in certain cases, audio-only technology. The codes covered under the guidance, as mentioned above, are limited to a narrow set of diagnostic evaluation, psychotherapy, and psychoanalysis codes. While the 90792 code within the mental visits does refer to a psychiatric evaluation including medical services, overall, "medication management" for psychiatric patients, which is usually assigned an E/M code, is classified as a medical, rather than mental health, visit for CHCs. Additionally, while practitioner groups may use a wider range of workforce as "auxiliary personnel" who are paid for on an "incident to" basis under the Physician Fee Schedule, CHCs do not benefit from this flexibility since CHC visits must include direct involvement by the billable CHC clinician. We encourage CMS to revisit the types of HCPCS codes that can be utilized to bill and meet the definition of a qualifying behavioral visit.

Template Letter RFI Questions to Address When Possible

- *Should CMS consider other changes to APCM or additional coding to further recognize the work of **advanced primary care practices in preventing and managing chronic disease?***
- *Should CMS consider other updates to APCM payments or Shared Savings Program policies that **would drive increased participation of primary care practitioners in ACOs?***
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<u>Community Health Integration and Principal Illness Navigation for Behavioral Health</u>

NACHC has strongly supported CMS' efforts to add mental health counselors (MHC) and marriage and family therapists (MFT) as Part B Medicare practitioners, as well as adding those clinicians' services to the Medicare and Medicaid mandatory CHC benefits. We appreciate the clarification to include these providers under the PFS for Community Health Integration (CHI) Services and Principal Illness Navigation (PIN) services as direct or auxiliary personnel under general supervision in the absence of additional state-level requirements. This will further expand the types of care these practitioners can provide and share valuable insights with CMS on the types of services LMHCs and LMFTs can provide to their patients.

NACHC strongly recommends that the Health Behavior Assessment and Intervention (HBAI) services, and corresponding CPT codes, qualify on the service list for CHCs.[20] Currently, HBAI is not on the qualifying visit list for initiating care coordination. For a CHC, the initiating visit for care coordination services would need to be a distinct CHC qualifying visit, which, as previously mentioned, is

[19] CMS refers to language within SSA 1834(o) for these "specific payment codes"
[20] https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf

a medically necessary medical, mental health, or qualifying preventative health visit. Due to the payment structure for CHCs, a qualifying visit must take place to receive the CHC Prospective Payment System reimbursement. Updates to the qualifying visit list are strongly needed to reflect the full scope of services provided by CHCs to the nearly 34 million people served in 2024.[21]

Technical Refinements to Revise Terminology for Services Related to Upstream Drivers of Health
NACHC supports the use of the term "upstream driver(s)" to include a variety of factors that can impact the health of Medicare beneficiaries. As the largest source of primary and preventive care for the nation's underserved, many of whom are at elevated risk for poor health outcomes and health disparities, patients come to community health centers with a host of complex health and other social risk factors. NACHC supports a range of priorities to improve efforts to address and minimize the root causes of many chronic conditions and other medical conditions.

Non-Clinical Factors of Health Risk (SDOH) Assessment
As mentioned in the telecommunications section, NACHC recommends CMS retain the SDOH Risk Assessment code. CHCs were screening for upstream risk factors as part of the Annual Wellness Visit (AWV) despite being unable to bill separately for the risk assessment, except in the instance of its delivery via telehealth. Incorporating this assessment during the AWV aligns with the goal of the visit – to improve patient outcomes – by detecting potential health risks early on, enhancing care coordination, and identifying and closing care gaps. Over two-thirds of community health centers screened over 6 million patients for upstream drivers of health, with 3 million patients screening positive for addressing these upstream drivers.[22] While community health centers will continue to conduct this assessment to address patients' complex care needs, we urge CMS to keep this code and allow community health centers to be able to bill for this.

Medicare Diabetes Prevention Program (MDPP)
NACHC supports the proposed updates to the Medicare Diabetes Prevention Program (MDPP) and applauds CMS for allowing suppliers to offer MDPP services virtually through December 31, 2029. Twenty-one percent of community health center patients have diabetes, compared to 11% of the general U.S. population. Yet, CHCs are able to achieve higher rates of diabetes control compared to the national average, with thirty-two percent of community health center patients having their diabetes under control, compared to 19% of the general U.S. population with diabetes.[23] With their focus on primary, preventative, and public health education services, community health centers are strategically designed to help patients with diabetes effectively manage their condition.

NACHC supports extending the virtual flexibilities to bridge care gaps for patients and improve uptake of the program:

- **We support the updated weight collection requirements in sections § 410.79 (c)(1)(ii) and § 410.79 (e)(3)(iii)(C)** to allow participants the option to submit weight collection as part of a medical record or self-reporting weight for MDPP sessions from a home or reasonable location.
- **NACHC supports extending the flexibilities in section § 410.79(b)** that allow MDPP suppliers to continue providing virtual sessions and self-reporting weight through December 31, 2029. We appreciate CMS clarifying in section § 410.79 (f)(2) that suppliers are not required to maintain in-person delivery capabilities through December 31, 2029. We believe this will allow for more rural Medicare beneficiaries to participate in the program.

[21] 2024 UDS Data
[22] https://www.nachc.org/wp-content/uploads/2025/05/2025-UDS-Chartbook_Final-05.13.25.pdf
[23] https://www.nachc.org/community-health-center-chartbook-2023/

- **We support the added coverage for asynchronous, online delivery of MDPP through December 31, 2029, in section § 410.79 (f).** We are also supportive of the added G-code in section § 414.84 (c)(3) to indicate payment for online delivery of MDPP.

NACHC also urges CMS to set a clear goal of transitioning DPP into a permanently covered Medicare benefit. This transition would strengthen participation in and access to the MDPP, encourage more National DPP suppliers to apply as MDPP providers, and motivate new suppliers to develop diabetes prevention programs, seek CDC recognition, and apply to be MDPP suppliers.

Medicare Shared Savings Program

NACHC recommends CMS reconsider its proposal to reduce the time ACOs in the BASIC track can remain in a one-sided risk arrangement from seven years to five years. In partnership with their state Primary Care Associations (PCAs) and Community health center Controlled Networks (HCCNs), CHCs nationwide have been actively engaged in Accountable Care Organizations (ACOs) and the Medicare Shared Savings Program (MSSP). In 2024, 62 percent of CHCs reported that their largest site is part of an ACO,[24] In 2025, over 7,000 CHC service sites participated in the Medicare Shared Savings Program (MSSP), which is 18 percent more CHCs than in 2024.[25]

We understand CMS' belief that ACOs bearing more risk – transitioning to two-sided risk more quickly – could help enhance value-based care and elicit more meaningful changes for providers. **However, the proposed change could have significant implications for community health center-led ACOs already participating in the program or impact community health centers interested in participating in MSSP in the future.** We believe that pushing community health center-led ACOs to take on more risk faster than they are ready could reduce participation in MSSP. Community health centers see patients regardless of income level or ability to pay, operating on razor-thin margins. More than half of CHCs operate with margins below 5%, and 11 million patients were served by community health centers operating with negative margins in 2022. Moreover, community health center-led ACOs, compared to other ACOs, often lack significant reserves to enable them to take on risk and do not typically have investors willing to contribute capital to fund the ACO's reserves.

Amending this proposal could entice more community health centers to participate in MSSP and look further into adopting VBC models. With more CHCs participating in ACOs, patient outcomes are more likely to improve. A 2024 study showed that ACOs with CHCs served more beneficiaries with lower incomes, those with disabilities, or those with racial differences, while simultaneously increasing several quality measure outcomes related to the delivery of preventive care, compared to ACOs without CHC participation.[26]

NACHC recommends CMS exempt the ACOs already participating in Level A of the BASIC Track from its proposal to reduce the time ACOs in the BASIC track can remain in a one-sided risk arrangement. This proposal would impact around 57 ACOs currently participating in Level A of the BASIC track (7 2022 starters, 7 2023 starters, 26 2024 starters, and 17 2025 starters), per CMS' calculations. An exemption would preserve the option of participating in a one-sided model for all seven performance years, which these ACOs were informed of and relied upon when they entered their first agreement period. Furthermore, CMS acknowledges that, based on trends in program participation, at least some of the ACOs currently participating under Level A of the BASIC track may elect to transition to a two-sided

[24] https://www.commonwealthfund.org/publications/issue-briefs/2025/aug/advancing-accountable-care-community-health-centers

[25] Centers for Medicare and Medicaid Services, "Shared Savings Program Fast Facts," Jan. 2025; and Centers for Medicare and Medicaid Services, "Shared Savings Program Fast Facts," Jan. 2024.

[26] https://www.commonwealthfund.org/publications/issue-briefs/2025/aug/advancing-accountable-care-community-health-centers

model level of the BASIC track during the remaining performance years of their current agreement period or would transition to a two-sided risk model at the beginning of their next agreement period notwithstanding the proposed change. Consequently, CMS could achieve the Shared Savings Program's goals by applying the proposed change to new ACOs enrolling in their first enrollment period on or after January 1, 2027, without changing the rules on ACOs currently participating in the program.

NACHC supports the proposal to amend § 425.110(a)(2) to allow ACOs applying for a new agreement period to reach at least 5,000 assigned beneficiaries in the ACO's BY3 but could have fewer than 5,000 assigned beneficiaries in BY1, BY2, or both. Community health centers are eager to continue to enter into value-based agreements, and this proposal will open the door to allow more to embark on this endeavor. Given the increasing number of CHC patients aging into Medicare, this change should help ACOs led by CHCs meet the requirement of having 5,000 assigned beneficiaries. We appreciate CMS' thinking in this proposal to decrease one barrier to entry for CHCs that operate on slim margins.

NACHC requests CMS reconsider its proposal at § 425.605(i) to exclude ACOs that fall below 5,000 assigned beneficiaries in any BY from being eligible to leverage existing policies that provide certain low-revenue ACOs participating in the BASIC track with increased opportunities to share in savings. While this proposed change does not exclude these low-revenue ACOs from participating in the MSSP overall, it does preclude them from receiving shared savings that they would otherwise have been eligible for because of meeting the quality performance standard but not the Minimum Savings Rate (MSR).

This proposal by CMS seems inconsistent with the previous proposal of allowing ACOs with less than 5,000 assigned beneficiaries in benchmark years 1 and 2, but at least 5,000 assigned beneficiaries in benchmark year 3, to participate in the MSSP. If 5,000 assigned beneficiaries in benchmark year 3 is permissible for participation in the MSSP, it is unclear to us why it is necessary for these low-revenue ACOs to have at least 5,000 assigned beneficiaries in all three benchmark years to receive these opportunities for shared savings. Furthermore, current rules still require these ACOs to have at least 5,000 assigned beneficiaries for the performance year to be eligible for the shared savings opportunity. As a result, this proposed change denies certain low-revenue ACOs that have been accepted into the MSSP program from receiving the same benefits as similarly situated ACOs without a reasonable basis for doing so. We urge CMS to reconsider this proposal.

Merit-based Incentive Payment System (MIPS) Proposed Changes

NACHC highly recommends CMS reconsider the removal of two critical MIPS quality measures for the 2026 performance period: *Screening for Social Drivers of Health* and *Connection to Community Service Provider*. For community health centers, which have for decades been at the forefront of addressing health-related social needs (HRSN), this proposal will have substantial downstream impacts. The removal of these measures will have significant negative consequences for patient care, data infrastructure development, and supporting patients who have difficulty accessing healthcare due to barriers, thereby increasing the health burden on patients and straining our healthcare systems (such as emergency rooms and hospital inpatient services) even further.

- **Impacting Data-Driven Care for Vulnerable Populations:** CHCs have been leaders in systematically screening for and addressing social needs. As previously mentioned, many community health centers use a tool called PRAPARE to help screen for non-health related social risk factors. This tool is widely used; 70 percent of CHCs that screen for upstream risk factors used the tool in 2023 and 2024.[27] Most CHCs are already engaged in Health-Related Social Needs (HRSN) activities, recognizing that factors like food insecurity, housing instability, and transportation are not peripheral but central to health outcomes. The MIPS measures, while imperfect process indicators, provided a standardized, albeit

[27] Internal NACHC Data

initial, incentive for the structured collection of this data within electronic health records (EHRs). Removing them disincentivizes the very data collection that is essential for understanding and addressing the needs of complex patient populations.

- **Affecting Critical Clinical Workflows:** NACHC believes that while these are categorized as "process" measures, screening for non-clinical factors of health is a clinical intervention. It requires sophisticated and sensitive clinical workflows, integration of validated screening tools (like PRAPARE) into the EHR, and staff training to have difficult conversations with patients.[28] Similarly, connecting a patient to a community service provider is a complex care coordination activity that relies on robust health IT infrastructure, including interoperable referral platforms and closed-loop communication systems.[29] Keeping these measures will show CMS the value of the essential, non-billable work that is foundational to whole-person care, as championed by the MAHA movement. This work ultimately drives better outcomes and lower costs.

- **Hindering Community health centers' Ability to Address Non-Clinical Social Needs:** The widespread adoption of these measures has initiated the creation of a national-level dataset on social needs, which is invaluable for population health management, resource allocation, and policy development. This standardized data collection is the necessary first step toward developing more sophisticated outcome measures and predictive analytics that can identify at-risk populations and tailor interventions. Removing these measures will mean that critical non-clinical needs that patients need will slip through the cracks if proper investments are not made to collect this data.

We urge CMS to reconsider the removal of these measures. Instead, CMS should work with stakeholders to evolve these process measures into more robust outcome-focused measures. This could include measures that track the resolution of identified social needs or the impact of interventions on health outcomes and costs.

Oral Health Risk Assessment and Referral

NACHC supports the inclusion of an oral health risk assessment and referral as a quality improvement activity in MIPS because it promotes a more integrated and holistic approach to patient care. In 2024, CHCs provided dental care to over 6.9 million patients annually in over 22 million dental visits.[30] Research has increasingly shown the strong link between oral health and systemic conditions, including diabetes, cardiovascular disease, and adverse pregnancy outcomes. The underserved and vulnerable populations served by community health centers often lack access to dental care, and medical providers are often their first and only point of contact with the healthcare system. While many community health centers are already integrating dental care into primary care and/or behavioral health services, given the significant impact of oral health outcomes on overall health, primary care providers serve as an important touchpoint for the initial assessment of oral health.

By integrating oral health risk assessments into routine medical visits, providers can play a pivotal role in closing gaps in care and ensuring patients receive appropriate referrals. This approach supports the goals of MIPS by advancing care coordination and reducing costs. Supporting this improvement activity helps elevate the role of medical professionals in addressing oral health, fosters stronger interprofessional collaboration, and ultimately leads to better patient outcomes. We also request that CMS collaborate closely with the American Dental Association to enhance medical-dental interoperability for electronic health records, which will significantly aid providers in this endeavor and reduce administrative burdens.

[28] https://archive.thepcc.org/sites/default/files/resources/PCC_Oral_Health_Primary_Care_Integration.pdf
[29] https://www.mchoralhealth.org/PDFs/IntegratingOralHealthCare-ResourceGuide.pdf
[30] https://www.nachc.org/wp-content/uploads/2025/05/2025-UDS-Chartbook_Final-05.13.25.pdf

Inflation Reduction Act (IRA)

For over 30 years, the 340B program has been crucial to helping safety net providers, like community health centers, purchase outpatient medications at significantly reduced costs, enabling them to provide affordable, discounted, or free medications to uninsured and underinsured patients. By law and policy, community health centers are required to invest every penny of 340B savings into activities that expand access to care for their patients. The 340B program generates savings that are reinvested in community health centers to meet the unique needs of their communities, including dental care, behavioral health services, specialty care, translation services, food banks, housing support, and copay assistance programs. Community health centers heavily rely on 340B pharmacies to expand their community reach by providing their patients with affordable, accessible medications. Additionally, community health centers operate on razor-thin margins and cannot afford to lose access to 340B-priced medications. NACHC and CHCs support the intent of the Inflation Reduction Act (IRA) as it lowers drug prices. We seek to provide constructive feedback on the effectuation of the Medicare Inflation Rebate Program to ensure community health centers' opportunities for participation in the 340B program remain intact and do not unduly burden our pharmacies, including contract pharmacies.

Community health centers strive to make medications affordable for all their patients. Because patients aged 65+ are the fastest growing population for community health centers, we applaud CMS as it implements the IRA provisions to help decrease financial barriers for Medicare patients for prescription drugs and seek to continue partnering with the agency. NACHC appreciates CMS' efforts to engage all stakeholders as they work to develop methodologies to exclude 340B units from Part D rebatable drug calculations beginning in 2026, as required by Section 1860D-14B(b)(1)(B) of the Inflation Reduction Act.

NACHC would encourage CMS to reconsider its decision on the utilization of the proposed estimation percentage based on PVP data and the Medicaid Drug Rebate Program (MDRP) of Average Manufacturer Price (AMP) unit sales, as detailed in the draft version of the CY 2025 PFS. CMS proposed an estimation percentage for 340B units, based on data from the Health Resources and Services Administration's (HRSA) 340B Prime Vendor Program (PVP) and manufacturer reporting under the MDRP of Average Manufacturer Price (AMP) unit sales. Based on comments submitted, this 340B repository was well received by stakeholders across the industry, highlighting a rare instance of a 340B policy proposal being universally accepted. While CMS acknowledged in the final CY25 PFS rule that certain limitations exist with PVP data-based methodology and elected not to move forward with this, this methodology would better calculate the 340B units to exclude from the Part D rebatable drug calculations beginning in 2026.

NACHC recommends that CMS use its own data as part of the estimation. CMS has both Part B and D claims for a given NDC; therefore is able to determine what percentage of the market is Part D. Then, that market percentage can be applied to the Prime Vendor Program (PVP) purchase data to estimate how much of that overall 340B spend for a particular NDC went to retail class of trade versus clinic-administered drug claims. This number could then be used as the marketplace 340B retail purchases that could then go back into CMS' original calculation.

Furthermore, NACHC recommends manufacturers submit data on 340B retail sales volume for direct sales and AIDS Drug Assistance Programs (ADAP) to either the 340B Prime Vendor Program or CMS. This will be used in the calculation and will address the concern of unknown 340B sales volume to these parties and prevent underestimation of the 340B sales volume. If quarterly data submissions present a challenge, historical data could also be helpful here as a reflection of the percentage in the market of this currently unknown factor. These simple refinements to the 340B percentage calculation would streamline the calculation methodology and allow for a reasonable and accurate estimation of 340B units until the 340B repository is able to serve as the final calculation data source.

NACHC strongly supports the proposed voluntary 340B repository. We appreciate the time CMS is giving CHCs to begin participating in data submissions voluntarily. The five data elements requested (1) Date of Service; (2) Prescription or Service Reference Number; (3) Fill Number; (4) Dispensing Pharmacy NPI; and (5) NDC-11 are appropriate for the nature of the request, do not present overly burdensome requirements, or protected health information risks. We also appreciate the proposed quarterly timeframes and opportunities for data correction and resubmission. Our members report that they find the 340B repository proposal manageable operationally. We thank CMS for their diligence in designing a workable model for excluding 340B units from Part D rebatable drug calculations in the future. Until the 340B repository can serve as the method for identifying 340B units for exclusion from the Part D rebatable drug calculation, NACHC harbors significant concerns with the use of both the Prescriber-Pharmacy Methodology and the Beneficiary-Pharmacy Methodology described in the proposed CY 2026 PFS.

In the proposed rule, CMS already highlighted a few limitations of the Prescriber-Pharmacy Methodology and Beneficiary-Pharmacy Methodology, including:

- The model does not include data for entity-owned pharmacies or ADAPs
- The model may overestimate 340B accumulations that cannot be replenished in certain scenarios, such as:
    - Manufacturer restrictions on the contract pharmacy
    - National Drug Code (NDC) dispensed on the claim was discontinued, in shortage, or unavailable from the pharmaceutical wholesaler
    - Did not accumulate enough units to replenish a full bottle of the drug
    - Prescription resulted from care provided outside of a 340B covered entity
- Not all covered entities have a Medicare Provider Number (MPN) or report their MPN in the 340B OPAIS database, which may result in an inability for CMS to designate claims affiliated with such covered entities.
    - Only hospitals are required to report their MPNs.

Beyond those already noted by CMS, NACHC would like to outline our concerns that both methodologies will lead to significant overestimation of the 340B units as a portion of the Part D rebatable drug calculations, resulting in underpayments by manufacturers when charged inflationary penalties.

<u>Manufacturer Restrictions: (Anticipated Overestimation)</u>
Manufacturers are restricting access to a single contract pharmacy per covered entity (CE) parent site, if they do not have an entity-owned pharmacy, which could lead to overestimation. Members are experiencing at least an 80-90% reduction in prescription access due to manufacturer restrictions. Based on the proposed CMS Prescriber-Pharmacy Methodology calculation, they will grossly overestimate eligible prescriptions. Additionally, there are general limitations on contract pharmacies that could inadvertently impact the estimation. 340B contracts are designed to protect the CEs from financial harm. As a result, even in situations of unrestricted access to 340B pricing, on average, fewer than 50% of potential prescriptions written by CE prescribers are included in the 340B program. Not all contract pharmacy arrangements are actively participating, although they are active in the Office of Pharmacy Affairs Information System (OPAIS). This is a smaller limitation and can be time sensitive in most instances due to time constraints to bring programs live.

<u>Entity-Owned Pharmacy Limitations: (Anticipated Underestimation)</u>
Limitations exist in this methodology related to entity-owned pharmacies, which we anticipate will lead to an underestimation of 340B units. Due to contract pharmacy restrictions, which began in 2020, covered entities, including community health centers, have increased utilization of entity-owned (in-house) pharmacies. Specifically, CHCs have increased to more than 50% having entity-owned pharmacies (EOPs).

Because of this, a significant portion of 340B Medicare claims will be missed by not including EOPs in the calculation methodologies.

340B OPAIS Utilization: (Mixed, Anticipated Overestimation)
Based on the estimation methodology, NACHC also anticipates that 340B OPAIS Utilization will be overestimated. For context, 340B OPAIS Medicaid and Medicaid Exclusion File (MEF) designations are designed for Fee-For-Service Medicaid billing elections only. The NPIs listed on OPAIS are limited to serve this purpose and are not comprehensive of all CE billing information. Additionally, not all locations or services within many covered entities are considered 340B eligible. For instance, there are non-reimbursable "below the line" clinics for hospitals, out-of-scope services that community health centers provide (services that are funded outside of their 330 grant), and PrEP & PEP services from Ryan White Clinics, which can be dually-certified as RWCs and CHCs. Finally, not all prescriptions written by 340B eligible providers are deemed 340B eligible by CEs. For example, refills on prescriptions for patients who have not been seen within the CEs patient definition window, typically 12-24 months.

Another instance is prescriptions not documented in the medical record, such as handwritten prescriptions. While community health centers are largely relying on technology to document prescriptions, there are times when community health centers prescribe clinic-administered drugs, and those are logged on paper. Lastly, prescriptions for controlled substances are frequently excluded from 340B programs because of the complexity of procuring and managing these medications. There is complexity in procuring and managing these medications, specifically around strict regulations, tracking requirements, and potential diversion risks.[31]

Beneficiary-Pharmacy Methodology Specific Limitations:
Based on the model, the patient definition appears to be limited to one year. This contrasts with the Bureau of Primary Health Care's definition, which defines community health center patients as being seen in the past 24 months,[32] underestimating patient eligibility. 340B covered entities do not generally consider all prescriptions written as 340B eligible, overestimating patient eligibility. Additionally, eligibility is tied to the 1996 patient definition.[33] This presents a conundrum about patient definition and what would be included in this methodology based on contrary definitions.

Most importantly, the article by Nikpay et al.[34] used as the basis for Prescriber-Pharmacy and Beneficiary-Pharmacy Methodologies has not been validated as a means of quantifying 340B purchase volume in the retail space. In comparison to the Office of Pharmacy Affairs 340B Prime Vendor Program data, which serves as the national standard of 340B sales volume and can be categorized into retail sales for CMS inflationary penalty calculation, the proposed Nikpay et al. model-based methodologies present the potential for substantially lower calculation accuracy. **Because of the significant concerns of 340B unit overestimation resulting from both the Prescriber-Pharmacy and Beneficiary-Pharmacy Methodologies, NACHC encourages CMS to pursue a refined version of the 340B percentage methodology, such as the proposed CY25 estimation methodology, with a few changes, until it is able to transition to the 340B claims repository.**

Finally, while not addressed in the CY2026 Physician Fee Schedule, NACHC would like to reiterate our concern that the mechanism for setting a fair professional dispensing fee (PDF) has not been

[31] https://www.proxsysrx.com/2022/01/03/what-drugs-are-not-eligible-for-340b-savings/#:~:text=Onsite%20Specialty%20Pharmacy-,General%20exceptions%20to%20340B%20drug%20eligibility,costs%20exceed%20the%20savings%20generated?
[32] https://bphc.hrsa.gov/compliance/compliance-manual/chapter20
[33] https://www.hrsa.gov/sites/default/files/hrsa/opa/patient-entity-eligibility-10-24-96.pdf
[34] Nikpay, S., Bruno, J. P., & Carey, C. (2024). "Recent court ruling could increase the size and administrative complexity of the 340B program." Health Affairs Scholar, 2(12), qxae157. https://doi.org/10.1093/haschl/qxae157

described in statute, regulation, or guidance. The average Medicare Part D dispensing fee was $0.65 in 2022,[35] falling well below the 2023 national cost of $13.67 for an independent pharmacy to dispense a prescription.[36] We have significant concerns about the detrimental economic impact that the failure to define the Maximum Fair Price (MFP) professional dispensing fees will have on all independent pharmacies, particularly those within community health centers. We encourage CMS to consider a similar PDF methodology to that used with the Medicaid billing requirement when passing on the 340B ceiling price to Fee-For-Service Medicaid. By using a metric that considers the accurate cost of dispensing when determining professional dispensing fees, CMS will ensure that independent pharmacies are compensated fairly for the cost of dispensing the negotiated drugs. This will be of the utmost importance considering the lost profit margins on the growing number of these medications in the future. If unchanged, independent pharmacies will not only lose their current profit margin on negotiated drugs but could also stand to lose an additional $13.00 per Medicare Part D prescription (at present rates), which will be financially unsustainable in years to come.

Since the submission of our previous comments on this topic, members have reported receiving contract amendments from Medicare Part D Plan Sponsors, confirming our expressed fears. On average, these amendments alerted the dispensers that the "fair" dispensing fee being provided would be $0.50, well below the actual cost of dispensing an MFP prescription. Community health centers already anticipate a 13% overall loss of margin at their retail pharmacies due to the transition to MFP pricing methodology. Add to this that each MFP prescription will be filled at a loss, and we fear the economics will have significant unintended destabilizing effects across the nation and reduce access to affordable medications for our most vulnerable patients. NACHC again respectfully requests that CMS proactively create regulations setting fair professional dispensing fees, reflecting the cost of dispensing, or create a formal mechanism for dispensers to file grievances related to unfairly low PDFs.

Evaluation and Management (E/M) Complexity Add-on

NACHC supports the proposal to extend applications of HCPCS code G2211 to home and resident E/M visits and requests that CMS extend this opportunity to community health centers performing home visits. We strongly agree with CMS' reasoning that building relationships between patients and providers is key to the success of home visit interventions. Data from the 2024 Uniform Data Set indicates that patients aged 65 plus are the fastest-growing patient population, and more than 11% of community health center patients are Medicare beneficiaries.[37] The number of Medicare patients seeking care at CHCs is growing, and approximately two-thirds (68%) of adult patients have reported utilizing support services, such as health education services, and transportation, among others.[38] We anticipate the number of home-bound Medicare beneficiaries will continue to grow as the population ages, and community health centers will need to address the necessity of home-based care.

Currently, CHCs can perform a visit between a home-bound patient and a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under certain conditions. According to a 2022 survey, about 3% of community health center patients participated in a home care visit.[39] CHCs are also eligible to bill for the home or residence evaluation and management visits code family (CPT codes 99341, 99342, 99344, 99345), which would be included with the add-on code on the claim.[6] CHCs have a strong track record of providing high-quality, patient-centered, comprehensive care tailored to the patient's care needs. This add-on code would greatly help community health centers, which are already operating on slim financial margins, meet patients where they are without compromising quality. To continue improving access to rural and

[35] Medicare Part D Dispensing Fees (PY2022) https://milligram-health.com/insights/2022-02-medicare-part-d-dispensing-fees
[36] 2024 Nation Community Pharmacy Association (NCPA) Digest, https://pharmacybookshelf.cardinalhealth.com/view/491779965/
[37] https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=4&year=2024
[38] https://www.kff.org/medicaid/issue-brief/community-health-center-patients-financing-and-services/
[39] https://www.kff.org/medicaid/issue-brief/community-health-center-patients-financing-and-services/

underserved patients, NACHC believes community health centers should be eligible to bill for this add-on code to allow for financial assuagement from the complexity of home visits.

Medicare Parts A&B Payment for Dental Services

NACHC requests that CMS develop and provide additional educational materials for CHCs to improve uptake and utilization of this important benefit. Providing critical dental care to over 6.9 million patients annually, CHCs are leaders in medical-dental integration for underserved communities. In 2024, community health centers provided over 22 million dental visits, demonstrating their significant contribution to oral healthcare.[40] We applaud CMS for ensuring community health centers can bill for the dental policies in the final rules for CY23 and CY24 and updating the CHC qualifying visit list as appropriate in CY25. The expanded Medicare coverage of dental services aligns with that of other Medicare providers and helps alleviate the financial burden on community health centers, allowing them to continue providing whole-person, comprehensive care.

CHCs serve as a safety net for millions of low-income and uninsured individuals, many of whom have complex dental needs. However, NACHC has heard from many community health centers and various stakeholders that more education and buy-in are needed to effectively operationalize this benefit. NACHC requests additional educational materials, such as resources on the standalone Medicare dental page,[41] informational webinars, and FAQs, to better educate community health centers on best practices and the covered services under this benefit to improve utilization.

Additionally, NACHC requests clarity from CMS on whether CHCs can use the 837D/837I instead of CMS-1500 for payment of dental services regarding the coordination of dual eligible patient care. We believe this will significantly improve the claims rejection process, enabling CHCs to immediately forward the claim to Medicaid once it is rejected by Medicare. Currently, CHCs must complete CMS-1500, wait to receive a denial, then fill out another claim form (837D) and send the rejected CMS-1500 as a claim attachment. Additional educational materials clarity on this billing discrepancy will streamline operations for community health centers and potentially improve uptake of the benefit for dual clarity on this billing discrepancy will streamline operations for community health centers and potentially improve uptake of the benefit for dual eligible patients.

Re-Evaluation Strategy Feedback

NACHC supports reducing the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning in CY 2026. The proposed site of service differential would provide an immediate revenue boost to independent practices, making them more viable and begin to address rising health care prices associated with growing hospital ownership of primary care.[42] These additional resources are urgently needed in community-based practices. On the current trajectory of stagnating reimbursement and increasing administrative burdens, primary care physicians and those in small or solo practices are exiting Medicare at a higher rate than other specialties and larger groups.[43]

At the same time, it is crucial that CMS's policy achieves its objective while avoiding unintended consequences. Amidst an overall shortage of primary care clinicians and other members of the primary care team including behavioral health providers, policymakers should explore ways to mitigate impacts on

[40] 2025 and 2024 Health Center Program UDS Data (hrsa.gov)
[41] https://www.cms.gov/medicare/coverage/dental
[42] Yashaswini Singh et al., "Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications," JAMA Health Forum 6, no. 1 (January 17, 2025): e244935, https://doi.org/10.1001/jamahealthforum.2024.4935.
[43] Hannah T. Neprash and Michael E. Chernew, "Trends in Physician Exit From Fee-for-Service Medicare," JAMA Health Forum 6, no. 7 (July 18, 2025): e252267, https://doi.org/10.1001/jamahealthforum.2025.2267.

clinicians currently practicing in facility-based settings.[44] We note, further, that many primary care medical residencies, PA training sites and advance nursing education and behavioral health programs currently operate in facility-affiliated clinics. Without additional policy steps to mitigate impacts, the reductions in non-facility payment could have the unintended effect of undermining the viability of these training programs and further constrict the pipeline of primary care clinicians. Going forward, the valuation of and payment for physician practice expenses could be made more accurate through more robust data collection and support. We encourage CMS to explore data sources and processes for PE valuation that allow for more regular and more precise adjustments over time.

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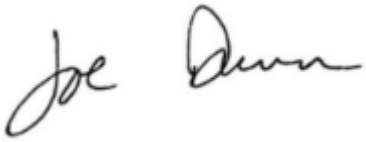
Thank you for considering these comments on the community health center portion of the CY26 Medicare Physician Fee Schedule and areas in which we hope community health centers can participate. If you have any questions, please contact Elizabeth Linderbaum, Deputy Director of Regulatory Affairs, at elinderbaum@nachc.org.

Sincerely,



Joe Dunn
Chief Policy Officer

[44] Alison Huffstetler et al., "Health Is Primary: Charting a Path to Equity and Sustainability," 2023, https://thepcc.org/sites/default/files/resources/pcc-evidence-report-2023.pdf?utm_source=bitly&utm_medium=link&utm_campaign=2023_evidence.