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September 2, 2016

Submitted via www.regulations.gov

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

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

Dear Acting Administrator Slavitt:

Bi-State Primary Care Association appreciates the opportunity to comment on CMS' proposed rule on the Physician Fee Schedule and other revisions to Medicare Part B, including several provisions that will impact Federally Qualified Health Centers and Rural Health Clinics.

Established in 1986, Bi-State is a nonpartisan, nonprofit 501(c)(3) charitable organization that promotes access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations in Vermont and New Hampshire. Bi-State works with federal, state and regional health policy organizations, foundations and payers to develop strategies, policies and programs that provide and support community-based primary health care services in medically-underserved areas. Our members include Community Health Centers, which include Federally Qualified Health Centers (hereafter interchangeably referred to as Health Centers or FQHCs); Rural Health Clinics; private and hospital-supported primary care practices; Community Action Programs; Health Care for the Homeless programs; Area Health Education Centers; Clinics for the Uninsured; and social service agencies.

Nationwide, FQHCs serve as the health home for over 24 million medically-underserved people, the majority of whom live below the Federal Poverty Level and face multiple social and environmental factors which impact their need for health care and their ability to access care appropriately. With over 9,300 sites, FQHCs provide affordable, high quality, comprehensive primary care to these individuals, regardless of their insurance status or ability to pay for services. Over two million Health Center patients are Medicare beneficiaries. Of these, 40% are dually eligible for both Medicare and Medicaid. On average, roughly 9% of an FQHCs' patients have Medicare; for close to one in five Health Centers, this figure is over 20%.

In Vermont and New Hampshire, FQHCs and Rural Health Clinics are part of the essential primary care fabric and health care ecosystem. Collectively, our member FQHCs serve over 242,000 patients in underserved communities across our two states (nearly 310,000 patients when including all our member Health Centers). Of those 242,000 patients, 4.4% are dually eligible for both Medicare and Medicaid in each state. In Vermont, 21% of the Health Center patient population has Medicare; and nearly 19% in New Hampshire.

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

Bi-State is focusing its comments primarily on issues that are of particular importance to FQHCs, Rural Health Clinics and the patients they serve. Bi-State's comments begin by summarizing our comments and then we provide more detailed comments. In addition to our comments, we fully endorse the National Association of Community Health Center's (NACHC) letter that will be submitted before the deadline. With NACHCs permission, our letter uses their template and parallels their comments and concerns.

SUMMARY OF COMMENTS:

Bi-State Primary Care Association supports:

- CMS' proposal to revise the requirements that FQHCs and Rural Health Clinics must meet to provide Chronic Care Management services to their patients.
- Creation of an FQHC specific market basket with some modifications to the proposal.
- Expansion of the Diabetes Prevention Program to the Medicare program; however, Bi-State seeks clarification on FQHCs' and Rural Health Clinics' ability to participate.

SPECIFIC COMMENTS:

CMS' proposal to revise the requirements that FQHCs and Rural Health Clinics must meet to provide Chronic Care Management services to their patients:
As both Bi-State and NACHC commented on last year's proposed rule on the Physician Fee Schedule, which extended coverage and payment for Chronic Care Management (CCM) services to Health Centers, we are very supportive of CMS' allowance for FQHCs and Rural Health Clinics to provide and be reimbursed for the provision of CCM services. We believe that these services are in line with the Health Center model to provide comprehensive primary care to their patients and, thus, we are supportive of the revisions to the requirements set out in this year's proposed rule. These changes will more closely align the CCM requirements to those of other providers and further encourage Health Centers to provide these critical services to their patients.

Creation of an FQHC specific market basket with some modifications to the proposal:
Health Centers have long requested that an FQHC specific market basket be created to serve as the annual update method for Health Centers, in both Medicare and Medicaid. We believe that the current update factor (Medicare Economic Index) is outdated and does not appropriately capture the services that Health Centers provide and, therefore, is not an appropriate update factor. In fact, a 2005 Government Accountability Office study on the implementation of the Medicaid FQHC PPS noted that *"…the MEI was designed to measure the changing costs for the average physician, which may be different from the costs of FQHCs and RHCs (Rural Health Clinics). FQHCs often provide additional services, such as translation, and a significant portion of RHC services may be provided by non-physician practitioners. Other indexes often used to reflect medical care inflation have a similar shortcoming as they also do not reflect the services typically provided by FQHCs and RHCs."*[1]

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

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

proposal, which are outlined in detail in the comments from NACHC on this proposed rule. NACHC looks forward to working with CMS on this implementation.

Expansion of the Diabetes Prevention Program; however, Bi-State seeks clarification on FQHCs' and Rural Health Clinics' ability to participate:
Bi-State and NACHC applaud CMS' expansion of the Diabetes Prevention Program to the Medicare program. As primary care providers, Health Centers are very familiar with diabetes and in 2015 served over 7 million patients with diabetes. Health Centers help their patients not only manage their chronic condition but also provide services that can prevent diabetes-related conditions, such as kidney damage, blindness and poor circulation. They also try to improve patient outcomes with innovation and a team approach that helps patients manage their illness through lifestyle changes, nutrition and exercise.

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

* * *

Thank you for the opportunity to comment on this proposed rule. Please do not hesitate to contact me at (603) 228-2830 extension 112 or via e-mail at tkuenning@bistatepca.org if you require clarification on the comments presented above.

Sincerely,

Tess Kuenning

Tess Stack Kuenning, CNS, MS, RN
President and Chief Executive Officer
Bi-State Primary Care Association