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June 30, 2014

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1443-FC  
P.O. Box 8013  
Baltimore, Maryland 21244-1850

**RE: Solicitation of Comments on Final Rule with Comment Period, Medicare Program;  
Prospective Payment System (PPS) for Federally Qualified Health Centers (CMS-1443-FC)**

Submitted Electronically: <http://www.regulations.gov>

To Whom It May Concern:

Bi-State Primary Care Association (Bi-State) is pleased to respond to the above-referenced Final Rule with Comment Period (CMS-1443-FC) published by the Centers for Medicare and Medicaid Services (CMS) in the May 2, 2014 issue of the Federal Register, 79 Fed. Reg. 25,436. The final rule establishes a methodology and payment rates for Federally Qualified Health Center (FQHC) services under Medicare Part B.

Bi-State is a 501(c)(3) nonprofit, nonpartisan charitable organization. Bi-State works with federal, state, and regional health policy organizations and policymakers, foundations, and payers to develop strategies, policies, and programs that promote and sustain community-based, primary health care services in New Hampshire and Vermont. Bi-State provides advocacy, technical assistance, education and training, networking opportunities, and resource and information services.

Bi-State and the FQHCs in New Hampshire and Vermont are appreciative of the collaborative effort between CMS and the Health Resources and Services Administration (HRSA) to develop a Medicare payment methodology that is fair and consistent with FQHCs' unique features, and is reflective of Congress' intent in establishing a Medicare payment methodology as part of the Affordable Care Act (ACA). In addition, we commend CMS for considering and revising several key aspects of the proposed PPS methodology set forth in the September 23, 2013, Notice of Proposed Rule Making (78 Fed. Reg. 58,396). Specifically, CMS' willingness to allow FQHCs to bill for a medical visit and behavioral health visit on the same day is applauded, as is the decision to revise the provision that would have based patient co-insurance on the lesser of the FQHC charge or the PPS rate.

## **Comments on Section II.B.1 - Same-Day Visits**

As noted previously, Bi-State supports CMS' decision to continue to allow FQHCs to bill Medicare for a medical visit and mental health visit on the same day. This will assist our FQHCs as they continue efforts to expand access to mental health services and to better integrate those services with primary care. However, Bi-State recommends that CMS enhance its decision by completely restoring the existing same-day billing rules to allow for same-day billing for medical visits, diabetes self-management training (DSMT) visits, and medical nutrition therapy (MNT) visits. DSMT and MNT are important primary care services provided by the FQHCs and are critical components to cost-effective prevention strategies for diabetes and chronic diseases related to obesity. Not allowing same-day billing for DSMT and MNT visits in addition to a medical visit may act as a deterrent to the provision of these services and should be reconsidered.

## **Comments on Section II.E.2 – Establishment of G-Codes**

In addition, Bi-State appreciates CMS' careful consideration of comments related to the Medicare claims payment process and its introduction of G-code charges to allow for a fair comparison of the average per-visit cost of bundled services with actual charges. This solution solves the "comparing apples to oranges" problem which would have resulted in the consistent underpayment of FQHCs for services rendered.

While the use of G-codes is a positive solution, the FQHCs in New Hampshire and Vermont do have concerns related to the development and implementation of these codes. Specifically, the process for developing charges for typical bundles of services is complex and will be a challenge for the FQHCs. While the FQHCs appreciate the flexibility of determining their individual average charges, they want to ensure these charges are correct and will not be questioned by CMS at a later date. The FQHCs would appreciate further clarification in writing regarding the ability to determine average charges and make adjustments where these charges may have been understated.

There is also a concern among the FQHCs that the use of G-codes will artificially increase Accounts Receivable (AR). The duplicative nature of the G-codes could potentially overstate AR on a rolling short-term basis. In the long-term (once the FQHC receives payment) the AR balance will be resolved, but Gross Charges and Total Adjustments will be overstated. The short-term overstatement will cause FQHC auditors to require a higher overall uncollectable reserve because the adjustments will be so high. One FQHC in New Hampshire estimated that the overstatement will amount to a 25-30% increase in total charges per year. The use of G-codes could also confuse patients when receiving their Explanation of Benefits (EOB) as there will be additional charges, beyond what they typically see, for the same type of visit. This will likely create additional administrative burden on the FQHCs as they explain the changes to the patients.

To minimize the artificially inflated financial impact on the FQHC's financial statements, Bi-State recommends allowing the FQHC's to use zero dollar charges for the non G-code CPT's. This will allow for an "average" charge to be submitted with the G-code and Medicare to calculate their lesser of, but it should have minimal impact on the health center financial statements because it is an average charge. This should also simplify the answers to patients that are questioning the EOB.

There are additional questions regarding the logistics of coding and concerns regarding additional administrative burden. For example, should the clinical staff be adding G-codes to the invoice via the chart, or should the billing staff be adding them to the invoice after the fact? Either way, this is likely to create additional administrative burden to the coding and billing staff within the FQHCs.

Given the complexities and uncertainties of the development and implementation of G-codes, Bi-State requests CMS work with HRSA to ensure FQHCs receive the technical assistance necessary to meet the significant challenges associated with this change. Continued technical assistance and written clarification in the areas noted above would help to ease the level of concern at the FQHCs. Bi-State also requests CMS work with HRSA to better understand the effect of the use of G-codes on AR and seek solutions to lessen the impact to the FQHCs and its patients.

#### **Comments on Section II.E.4 – Waiving Coinsurance for Preventive Services**

Similar to the comments above, Bi-State is pleased by the CMS' efforts to simplify the methodology in the Proposed Rule for determining which portion of the patient's visit would be subject to coinsurance. While the proposed changes are certainly a step in the right direction, Bi-State believes it is still too complex to accurately determine patient coinsurance at the time of service. Our concern, and the concerns of our FQHCs, is that they will likely default to a policy of waiving the coinsurance where preventive services are provided in order to avoid overcharging the patient at the time of service. While they could then invoice the patient for the coinsurance once remittance advice is received, it is still likely to result in increased bad debt due to potential collection issues. In addition, this would result in total payments to the FQHCs that do not ultimately add up to the rate (the lesser of PPS or the appropriate charge) intended by Congress.

As a result of the potential negative financial implication to the FQHCs, Bi-State respectfully requests CMS consider instituting a policy whereby coinsurance is fully waived for any visit involving a mix of preventive and non-preventive services. This would be the most straightforward methodology, and would be least likely to have a negative impact on the FQHCs and their patients.

Thank you again for the opportunity to respond to the solicitation for comments on the Final Rule with Comment Period. Bi-State and the FQHCs in New Hampshire and Vermont appreciate CMS' careful consideration of comments on the Proposed Rule and willingness to adapt the Final Rule in response to stakeholder comments. Please do not hesitate to contact me at [tkuennig@bistatepca.org](mailto:tkuennig@bistatepca.org) directly should you have any questions or require clarification on any of the above comments.

Sincerely,



Tess Stack Kuenning, CNS, MS, RN  
President and Chief Executive Officer