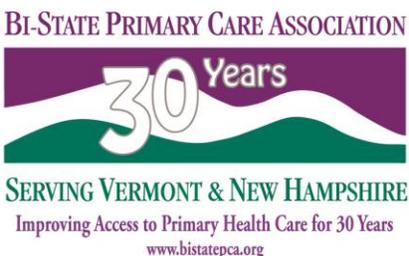


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June 23, 2016

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-5517-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS 5517-P: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models

Dear Acting Administrator Slavitt:

Bi-State Primary Care Association is extremely active and engaged in payment reform efforts in both Vermont and New Hampshire. Bi-State works closely with both states and with the safety net primary care providers in their local communities on the changing health care systems and financing to meet the Triple Aim. Changes to the Medicare payment system, which affects safety net providers caring for our most vulnerable populations, is of great interest to our organization. Bi-State has always taken a population-based approach to our work to assure access to care for the medically disenfranchised. Bi-State appreciates the opportunity to comment on CMS' proposed rule establishing the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentives under the Physician Fee Schedule (PFS) (also referred to as the "Proposed Rule").¹

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.

Nationally, 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. In Vermont and New Hampshire, FQHCs are part of the essential primary care fabric and health care ecosystem. Collectively, our member FQHCs serve over 236,000 patients in underserved communities across our two states. Bi-State is focusing its comments primarily on issues that are of particular importance to Health Centers and the patients they serve.

In addition to our comments, we fully endorse the National Association of Community Health Center's letter that will be submitted before the deadline, and our letter parallels their comments and concerns.

¹ 81 Fed. Reg. 28162 (May 9, 2016).

Bi-State Primary Care Association

Comments on CMS 5517-P: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models

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National Background on Medicare and FQHCs

Nearly two million Health Center patients are Medicare beneficiaries. Of these, almost half are dually eligible for both Medicare and Medicaid. On average, roughly 9% of an FQHC's patients have Medicare; for close to 1 in 5 FQHCs, this figure is at least 15%. In Vermont, 20% of the FQHCs' patients served have Medicare (1 in 4 Vermont Medicare enrollments); while in New Hampshire, it's nearly 20%. In both states, some of our rural providers see as high as 35% Medicare at their practice. As two rural states, our FQHCs and Rural Health Clinics serve a disproportionate number of Medicare patients than our urban counterparts.

As noted in the preamble, with a few exceptions, FQHC providers are not paid under the PFS. 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.

Because of their unique payment structure, FQHCs and their providers are ineligible for many of CMS' quality payment initiatives, including the Physician Quality Reporting System (PQRS) and Value-Based Payment Modifier Program (VBPM). These programs are designed for providers who are paid under the PFS and rely heavily on data collected directly from PFS claims, making FQHCs ineligible. Many of our FQHCs in Vermont and New Hampshire are, however, enrolled in an Accountable Care Organization with Medicare Share Savings Programs, working toward the Triple Aim. Because the FQHCs and Rural Health Clinics are strong community partners with their hospitals, any national change that would alter a payment system to a state or community is of interest to our work.

Similarly, FQHCs' unique payment system means that many key elements of the Quality Payment Program (QPP) do not apply to them directly. Nonetheless, the proposed rule contains a handful of provisions that will impact FQHCs, and our comments focus on these issues. Therefore, we offer the following thoughts on the proposed rule:

- Bi-State supports CMS' proposal to permit FQHCs to voluntarily report MIPS data, appropriately adjusted for patients' social determinants of health (SDH), as these efforts will make it more feasible to compare quality and value across FQHCs and PFS providers.
- Bi-State encourages CMS and HRSA to align the quality measurement sections of MIPS and the Uniform Data System (UDS), such that FQHCs will be able to submit one set of quality data one time for both UDS and MIPS purposes.
- Bi-State supports giving FQHCs who voluntarily submit data under MIPS, appropriately adjusted for patients' SDH, the option to have this data published on Physician Compare.
- Bi-State supports permitting FQHCs to voluntarily report on MIPS and be listed on Physician Compare so long as the data collected and reported will be adjusted to reflect patients' SDH.
- Bi-State requests that CMS ensure that FQHC providers are not subject to MIPS for the limited number of FQHC-related claims that they submit under the PFS.

In closing, we appreciate the work that CMS staff have done to draft this proposed rule under a very tight timeframe. We appreciate the opportunity to submit comments, and both our staff and our member FQHCs and Rural Health Clinics would be happy to provide any further information that would be helpful. Please do not hesitate to contact me at (603) 228-2830 extension 112 or via e-mail at tkuenning@bistatepca.org if you would like additional information or require clarification on the comments presented above.

Sincerely,



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