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September 3, 2015

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

Submitted via www.regulations.gov

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

Bi-State Primary Care Association appreciates the opportunity to comment on the proposed rule on potential revisions to payments policies under the Medicare Physician Fee Schedule (PFS) for Calendar Year 2016 (CMS-1631-P).

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.

Bi-State is focusing its comments primarily on issues that are of particular importance to Health Centers 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 NACHC's permission, our letter uses their template and parallels their comments and concerns.

SUMMARY OF COMMENTS

1. Bi-State strongly supports CMS' proposal to permit FQHCs and Rural Health Clinics to be directly reimbursed for Chronic Care Management (CCM) services effective January 2016 and encourages CMS to finalize this proposal.

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

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

3. With regard to the proposals involving exceptions regarding FQHCs and the Anti-Self-Referral law, Bi-State:
   - Strongly opposes the proposal to allow hospitals to reimburse physicians for the costs of recruiting non-physician providers (NPPs) from outside their geographic area, as we believe it will be used by hospitals to recruit providers away from FQHCs; thereby, exacerbating the primary care workforce shortage for safety-net populations; and
   - Appreciates CMS soliciting input on the definition of "geographical area" in the context of FQHCs and anti-self-referral, and recommends that CMS adopt the definition that permits using non-contiguous zip codes.

DETAILED COMMENTS

1. Paying FQHCs and Rural Health Clinics for Chronic Care Management Services:

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

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

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

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

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

2. Payment for Advance Care Planning:

Bi-State strongly supports CMS' proposal to permit Medicare Administrative Contractors (MACs) to reimburse PFS providers separately for Advance Care Planning (ACP) services. We also support the proposal to include ACP as an optional element of the annual wellness visit (AWV). ACP is an important component of a primary care provider's relationship with his or her patient and recognizing it as reimbursable services, as well as an optional component of the AWV, would help ensure that Medicare beneficiaries have the opportunity to have this important discussion with their clinician on a routine basis (rather than the discussion being delayed until there is a medical emergency). We also urge CMS to clarify that ACP corresponds to the "end-of-life planning" that is an optional component of the initial preventive physical examination, per Social Security Act § 1861(ww)(2).

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

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

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

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

3. Adjustments to Anti-self-referral Provisions Impacting Recruitment and Retention in Underserved Areas:

Bi-State appreciates that CMS's recognition that changes in the delivery system since the implementation of the Affordable Care Act (ACA) have exacerbated an already-severe primary care workforce shortage, and we applaud CMS for thinking about creative solutions to the issue. However, Bi-State thinks that the recruitment proposal in proposed §411.357(x), while well-intentioned, will actually exacerbate the existing safety-net primary care workforce shortage experienced by FQHCs. Therefore, **we strongly oppose the proposal to allow hospitals to reimburse physicians for the costs of recruiting non-physician providers (NPPs) from outside their geographic area, as we believe it will be used by hospitals to recruit providers away from FQHCs; thereby, exacerbating the primary care workforce shortage for safety-net populations.**

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

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

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

CMS now proposes a new exception to the physician self-referral prohibition, which is not explicitly grounded in statute. The proposed § 411.357(x) would allow hospitals or FQHCs to make payments to physicians to assist with the physician's recruitment of NPPs. In practice, this exception does not help FQHCs at all because FQHCs typically recruit by direct employment, rather than contracting arrangements. We believe that the additional exception proposed at §411.357(x) simply allows another vehicle for hospitals to lure practitioners – this time NPPs – from safety net providers. It will further exacerbate challenges that FQHCs are experiencing in retaining their existing primary care workforce by allowing hospitals to recruit NPPs away from FQHCs to serve patients at hospital-affiliated outpatient facilities. In many cases, these outpatient facilities may not serve low-income and uninsured populations, further exacerbating access issues for the vulnerable populations.

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

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

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

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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

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