September 11, 2017

Submitted electronically via http://www.regulations.gov

Seema Verma, Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1676-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-1676-P: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Dear Administrator Verma,

Bi-State Primary Care Association (Bi-State) appreciates the opportunity to comment on CMS’ proposed rule on 2018 updates to Medicare Physician Fee Schedule and Other Revisions to Part B for CY 2018; the Medicare Shared Savings Program Requirements and Medicare Diabetes Prevention Program.

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’s combined Vermont and New Hampshire membership includes 22 Federally Qualified Health Centers (FQHCs) delivering primary care at over 80 sites and serving over 261,000 people.

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 one in five FQHCs, this figure is at least 15%. In New Hampshire, the percentage of Medicare clients served is 19% and in Vermont it is nearly 22%.

With a few exceptions, FQHC providers are not paid under the Physician Fee Schedule (PFS). Rather, payment for FQHC services is made directly to the FQHC under a Prospective Payment System (PPS). This PPS provides an all-inclusive, per-encounter rate that Health Centers receive each time they provide care to a Medicare patient.

While the vast majority of the provisions in the Proposed Rule do not apply to FQHCs, there are some provisions that will have a direct impact on FQHCs, Rural Health Clinics (RHCs) and the patients they serve. Thus, Bi-State will limit comments to those proposals, and will begin with a summary before providing 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.
BI-STATE PRIMARY CARE ASSOCIATION
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Summary of Bi-State’s Comments

- Bi-State supports the proposed provision to create new G codes for FQHCs and RHCs to provide Chronic Care Management to ensure access to these important services.
- Bi-State supports the proposed provision to create a new G code for FQHCs to provide psychiatric Collaborative Care Management, allowing for more integration of primary care and psychiatric care.
- Bi-State supports the proposed provision implementing a new beneficiary assignment process, taking into account all of the eligible providers that provide primary care to FQHC patients.
- Bi-State recommends that CMS reconsider its position that FQHCs must participate in the Diabetes Prevention Program under a separate MDPP enrollment.

Discussion of Bi-State Comments

Bi-State supports the proposed provision to create new G codes for FQHCs and RHCs to provide Chronic Care Management to ensure access to these important services.

Bi-State strongly supports CMS’ proposal to create specific G codes for FQHCs and RHCs to be directly reimbursed for qualifying Chronic Care Management (CCM) services, effective January 1, 2018. With the addition of more complex codes for those providers paid on the Physician Fee Schedule, we appreciate CMS’ work to more closely align the FQHC and RHC services with the codes of other providers. Bi-State also appreciates CMS’ work, as stated in the preamble, “…to develop a methodology that would support the provision of care management services without creating additional reporting burdens, while promoting beneficiary access to comprehensive CCM and BHI services furnished by RHCs and FQHCs.” Bi-State agrees that the proposed methodology for reimbursing FQHCs and RHCs is the most administratively simple methodology, as it closely aligns with the current FQHC payment methodology. Allowing FQHCs to provide, and be appropriately reimbursed for, CCM services only improves a Health Center’s ability to provide comprehensive primary care to their Medicare patients. Bi-State looks forward to continuing to work with CMS on the implementation of this important provision.

Bi-State supports the proposed provision to create a new G code for FQHCs and RHCs to provide psychiatric Collaborative Care Management, allowing for more integration of primary care and psychiatric care.

Bi-State supports CMS’ proposal to create a specific G code for FQHCs and RHCs to bill for Collaborative Care Management (CoCM) services. CoCM services have been proven to enhance primary care, improving the quality, patient satisfaction of care and reducing the total health care expenditures over time. CoCM can also be used to treat opioid addiction and other substance abuse concerns and Health Centers are often on the front lines addressing these issues. As such, we believe allowing FQHCs to be appropriately reimbursed for, these important services will enhance their ability to provide comprehensive care to these patients. As with CCM, we also support the methodology CMS proposes to reimburse for these services, again, developed in a manner that closely aligns with the CCM and current FQHC payment methodology. Bi-State looks forward to continuing to work with CMS on the implementation of this important provision.

Bi-State supports the proposed provision implementing a new beneficiary assignment process, taking into account all of the eligible providers that provide primary care to FQHC patients.

Bi-State strongly supports CMS’ proposal to implement the provision in the 21st Century Cures Act to allow FQHCs to assign their patients to an ACO if a patient has received care at an FQHC. This proposal will dramatically simplify the cumbersome two-step assignment process currently in place and allows for consideration of the eligible providers at an FQHC, not just physicians, as the statute previously allowed. As CMS noted in the preamble, many Health Centers are often led by non-physician providers, especially in rural areas. This provision will make it easier for FQHCs to participate in ACOs, particularly in those rural areas and places where the primary
care team is led by a non-physician provider. This in turn will lead to increases in system efficiency and will incentivize better, more coordinated care for Medicare beneficiaries accessing care at FQHCs.

**Bi-State recommends that CMS reconsider its position that FQHCs must participate in the Diabetes Prevention Program under a separate MDPP enrollment.**

The Diabetes Prevention Program (DPP) is an exciting opportunity to provide care to diabetic patients in unique settings, using a group setting and trained lifestyle coaches to improve care. As providers that pride themselves on representing the needs of their communities, Bi-State believes this is an important program; Health Centers across the country are involved in the Centers for Disease Control and Prevention’s (CDC) development of this program and continue to participate in the National DPP lifestyle change today. Additionally, Health Centers across the country currently employ diabetes educators, many of whom can serve as trained national DPP lifestyle change program coaches.

While we appreciate CMS’ careful consideration on whether or not it is appropriate for FQHCs to participate in this program as an FQHC, given our unique nature in the Medicare program, we believe that this program aligns well with both the Health Center model and mission. We encourage CMS to reconsider its position that a Health Center must participate in the MDPP under a separate supplier enrollment. We recognize that services under the MDPP are not typically provided by an FQHC provider eligible for Medicare reimbursement, but Health Centers often employ community health workers or other individuals that could serve as trained lifestyle coaches and many of these individuals already have experience with the CDC’s National DPP lifestyle change program. Bi-State would like to work with CMS to explore potential opportunities for FQHCs to become further involved in this important program without the burden of having to operate as two separate entities and producing two cost reports. Being able to seamlessly provide and receive financial incentive or reimbursement will allow Health Centers to sustain and build upon this program.

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In closing, Bi-State appreciates the opportunity to submit comments on this important rule, and both our staff and our member FQHCs and RHCs 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 email 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