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BI-STATE PRIMARY CARE ASSOCIATION
SERVING VERMONT & NEW HAMPSHIRE
Improving Access to Health Care for 30 Years
bistatepca.org

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January 1, 2018

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-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Comments on CMS 5522-P: 2018 Updates to the Quality Payment Program

Dear Administrator Verma,

Bi-State Primary Care Association appreciates the opportunity to comment on CMS' final rule on 2018 updates to the Medicare Quality Payment Program (QPP).[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 New Hampshire and Vermont. Bi-State's combined NH and VT membership includes 28 Community Health Centers (CHCs), delivering primary care at 120 locations for over 300,000 patients, the majority of whom live at or below 200% of the federal poverty level and face multiple social and economic factors impacting their need for health care and their ability to access care appropriately.[2]

Approximately 20% of our NH and VT FQHC patients are Medicare beneficiaries, and the exact percentage varies for each FQHC.[3] While payments for FQHC services to Medicare beneficiaries are generally covered under the Medicare Prospective Payment System (PPS), and many of the final rule's provisions do not apply to our member FQHCs, there are services that would be subject to some of the provisions. Accordingly, Bi-State will only comment on the sections of the final rule that impact our FQHCs.

- Bi-State supports an increase in the Low-Volume Threshold, which will ensure that health centers are not inadvertently penalized for the limited work they do billed via the Physician Fee Schedule (PFS). While there are many services that are incorporated within the payment under PPS, there are some covered services that FQHCs are required to bill under the PFS using the name of the individual provider. Thus, even providers working exclusively at a FQHC receive a small percentage of their total Medicare reimbursement via the PFS. Current regulations provide a low volume exemption to the

[1] 82 Fed. Reg. 20010 (June 30, 2017).
[2] For a family of 3, 200% of the federal poverty level is approximately $40,840 per year. *See* FPL Guidelines: https://aspe.hhs.gov/poverty-guidelines.
[3] For example, 36% of patients are Medicare enrollees at Indian Stream Health Center in Colebrook, NH. (2015 UDS data.)

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QPP for Medicare provider;[4] and while the exemption captures a large majority of centers billing Medicare Part B for services outside of the Medicare PPS, some centers with large Medicare populations would be subject to reporting under MIPS. For this reason, Bi-State strongly supports the final rule's language increasing the Low-Volume Threshold, as the change will ensure that providers working in FQHCs with large Medicare populations are not inadvertently penalized for their work serving Medicare patients.

- Bi-State supports allowing FQHCs to voluntarily report MIPS data appropriately adjusted for patients' social determinants of health (SDH), and we request the FQHCs be allowed to submit data as an entity. FQHCs are required to report to CMS as an entity, not as individual providers. Requiring health centers to report as individual providers is contrary to the way the FQHCs are paid via Medicare and would require FQHCs to revamp their entire systems, which would likely serve to discourage health centers from voluntarily reporting the information. Also an appropriate risk adjustment is needed to reflect the SDH affecting the center's patients. FQHCs are required to serve underserved, high-need populations whom are disproportionately affected by social and environmental challenges that make it difficult for them to access and utilize health care appropriately. FQHC patients have greater needs, which can cause providers who care for them to score lower on measures of quality and resource use. Accordingly, FQHCs who voluntarily submit the data should have it adjusted to reflect SDH; and without such a risk adjustment, it is inevitable that the value and quality of care that FQHCs provide will be understated relative to other providers. If that occurs, the benefits of having a consistent system to measure performance would be outweighed by the fact that the playing field would be uneven for FQHC providers who serve the most underserved patients.

In closing, Bi-State appreciates the opportunity to submit comments on this important issue, and both our staff and member FQHCs and Rural Health Clinics would be happy to provide 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 Kuenning

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

[4] The current low-volume threshold is for providers that have equal to or less than $30,000 in allowed Part B charges or provide care to 100 or less Medicare beneficiaries.