NATIONAL ASSOCIATION OF Community Health Centers

Main Office
7501 Wisconsin Ave.
Suite 1100W
Bethesda, MD 20814
301.347.0400 Tel
301.347.0459 Fax

Division of Federal, State and Public Affairs
1400 Eye Street, NW
Suite 910
Washington, DC 20005
202.296.3800 Tel
202.296.3526 FAX

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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-1693-P
P.O. Box 8016
Baltimore, MD 21244-8013

RE: CMS-1693-P: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma,

The National Association of Community Health Centers (NACHC) appreciates the opportunity to comment on CMS' proposed rule on updates to Medicare Physician Fee Schedule and Other Revisions to Part B for CY 2019; the Medicare Shared Savings Program Requirements and Medicare Diabetes Prevention Program. NACHC is the national membership organization for federally qualified health centers (FQHCs or "health centers"). FQHCs serve as the health home for over 28 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 11,000 sites, FQHCs provide affordable, high quality, comprehensive primary care to these individuals, regardless of their insurance status or ability to pay for services. For additional information on FQHCs, please see Attachment A.

Background on Medicare and FQHCs

Over 2 million health center patients are Medicare beneficiaries. Of these, nearly half (41%) are dually eligible for both Medicare and Medicaid. On average, roughly nine percent of an FQHC's patients have Medicare; for close to one in four FQHCs, this figure is at least 15 percent.

With a few exceptions, FQHC providers are not paid via 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. Thus, NACHC will limit our comments to those proposals, and will begin with a summary before providing detailed comments.

Summary of NACHC Comments:

- **NACHC supports the proposed provision to add a new CPT code (994X7, approximately 30 minutes of general care management) to the G code used by FQHCs for Chronic Care Management services.**
- **NACHC supports the proposed provision to create a new G code to reimburse health centers for providing Communication Technology-Based Services and Remote Evaluation to patients that meet the outlined criteria, while encouraging CMS to further investigate its authority to allow FQHCs to serve as distant sites to provide telehealth services.**

Discussion of NACHC Comments

NACHC supports the proposed provision to add a new CPT code (994X7, approximately 30 minutes of general care management) to the G code used by FQHCs for Chronic Care Management services.

NACHC supports CMS' proposal to amend the specific G codes for FQHCs and RHCs to be directly reimbursed for qualifying Chronic Care Management (CCM) services, to include the newest CPT code (994X7), which allows for 30 minutes of Chronic Care Management in a calendar month. NACHC supports the addition of this code to the G code, as it will align the CCM codes FQHCs can use with those allowed by "traditional" Medicare providers paid on the Physician Fee Schedule. As in years past, with the addition of more complex codes for 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. 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.

As with the implementation of any new provision, in order to fully understand the impact, we would like to request clarification in the determination of the fiscal value applied to this new code, which will then be averaged with other to determine the rate. In the event the new code is identified at a rate lower than those already included in the 20 minute CCM encounter rate, this would have an effect of creating a lesser reimbursement for a service that is proposed to be greater (re: 30 minutes, compared to 20 minutes). NACHC and its' member health centers seek clarification from CMS that this methodology will account for the difference in service provision and include within the methodological formula an assurance that the rate for a 30 minute encounter will be no less than that of a 30 minute encounter. While the providers desire full transparency in reporting and validating the increased resources being applied to a particular encounter, the expense of said resources should not be rewarded with a lesser rate of reimbursement. While the proposed rule states that it would be "similar" to other codes, it is requested that this is clarified in some manner to identify and/or recognize the increased level and value of service(s) being provided.

NACHC looks forward to continuing to work with CMS on the implementation of this important provision.

NACHC supports the proposed provision to create a new G code to reimburse health centers for providing Communication Technology-Based Services and Remote Evaluation to patients that meet the outlined criteria.

NACHC strongly supports the creation of a G code for health centers to provide Communication Technology-Based Services and Remote Evaluation services. Health centers are increasingly using technology-based services to provide access to vital primary and preventive care services. As CMS notes

in the preamble, it can be especially helpful where patients have limited access, due to limited transportation or other barriers. Today, nearly 40 percent of health centers use telehealth to deliver needed services to help patients monitor their chronic conditions. In rural communities, that number is even higher, with nearly half of health centers.

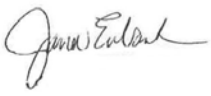
NACHC supports CMS' recognition of health center's role in providing care via communication technology-based services and remote evaluation and we believe that it will be an important step toward allowing health centers to provide more comprehensive care to their patients. However, even with the addition of these services, there are still barriers that prevent health centers from providing their Medicare patients the full spectrum of telehealth services. Unfortunately, in Medicare, only those health centers located in a certain geographic area are able to serve as originating sites, and cannot provide care as a distant site. We believe that the services that CMS is proposing to add are important, but just a portion of services that FQHCs could provide in order to provide the most comprehensive care to their patients and ask CMS to consider investigating its authority to allow health centers to serve as a distant site for the purposes of providing telehealth services to its Medicare beneficiaries.

Specific to this proposal, NACHC supports the methodology CMS created to provide reimbursement for these services. These services were not included in the original calculation of the Medicare FQHC PPS rate, therefore, a separate payment is appropriate. However, NACHC does request that CMS reconsider the reimbursement amount for these new services, as the service requires an FQHC provider specifically, and waives the face to face requirement for these services, therefore, the reimbursement should be on par with that of a traditional FQHC visit. We do not believe that CMS needs to implement any type of frequency limitation, especially in the early years as health centers learn to utilize these services for their patients. At this point, any frequency limitation may have the opposite effect of the provision's intended purpose to encourage innovative ways to provide comprehensive care to Medicare beneficiaries. Should CMS look to include frequency limitations in the future, we would request the opportunity to work with CMS to ensure that the limitations do not have any unintended consequences for the health center patient.

NACHC and its member health centers look forward to working together to implement the provisions specific to health centers, once finalized, to provide their Medicare beneficiaries with the most comprehensive primary and preventive care.

NACHC appreciates the opportunity to submit comments on this important rule, and both our staff and our member health centers would be happy to provide any further information that would be helpful. Please do not hesitate to contact Susan Sumrell on my staff at ssumrell@nachc.org should you have any questions.

Sincerely,



Jana Eubank
Vice President, Public Policy and Research
National Association of Community Health Centers

Attachment A:

OVERVIEW OF FEDERALLY QUALIFIED HEALTH CENTERS

For over 50 years, health centers have provided access to quality and affordable primary and preventive healthcare services to millions of uninsured and medically underserved people nationwide, regardless of their ability to pay. At present there are almost 1,400 health centers with more than 11,000 sites. Together, they serve ***over 28 million patients***, including 8.4 million children and more than 1 in 6 Medicaid beneficiaries.

Health centers provide care to all individuals, regardless of their ability to pay. All health centers provide a full range of primary and preventive services, as well as services that enable patients to access health care appropriately (e.g., translation, health education, transportation). A growing number of Health Centers also provide dental, behavioral health, pharmacy, and other important supplemental services.

To be approved by the Federal government as a Health Center, an organization must meet requirements outlined in Section 330 of the Public Health Service Act. These requirements include, but are not limited to:

- Serve a federally-designated medically underserved area or a medically underserved population. Some Health Centers serve an entire community, while other target specific populations, such as persons experiencing homelessness or migrant farmworkers.
- Offer services to all persons, regardless of the person's ability to pay.
- Charge no more than a nominal fee to patients whose incomes are at or below the Federal Poverty Level (FPL).
- Charge persons whose incomes are between 101% and 200% FPL based on a sliding fee scale.
- Be governed by a board of directors, of whom a majority of members must be patients of the health center.

Most Section 330 health centers receive Federal grants from the Bureau of Primary Health Care (BPHC) within HRSA. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing care to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients who are not indigent or who have insurance, whether public or private, are expected to pay for the services rendered. In 2017, on average, the insurance status of Health Center patients is as follows:

- 49% are Medicaid recipients
- 23% are uninsured
- 18% are privately insured
- 9% are Medicare recipients

No two health centers are identical, but they all share one common purpose: to provide primary health care services that are coordinated, culturally and linguistically competent, and community-directed, to uninsured and medically underserved people.