November 18, 2013

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

ATTN: CMS-1443-P (Proposed Rule- Medicare Program: Prospective Payment System for Federally Qualified Health Centers)

To Whom It May Concern:

The Michigan Primary Care Association (MPCA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' proposed rule establishing a prospective payment system (PPS) for Federally Qualified Health Centers (FQHCs).

MPCA is the voice for 39 Health Center organizations in Michigan which provide quality, affordable, comprehensive primary and preventive health care for more than 600,000 patients annually at over 230 sites across the state. Of those 39 organizations, 35 are Health Center Program grantees, 2 are Federally Qualified Health Center Look-Alikes and 2 are both a Health Center Program grantee and an FQHC Look-Alike.

After reviewing the proposed rule in detail, MPCA consulted with national partners and Health Centers across the state. MPCA hosted a webinar on the proposed rule with Michigan's FQHC finance and billing professionals, fielded phone calls with Health Center leadership and facilitated email conversations with FQHC advocates.

MPCA applauds CMS for working with the Health Resources and Services Administration (HRSA) toward implementing a payment methodology that is consistent with Health Centers' unique features, including their comprehensive model of care. MPCA welcomes the introduction of a new payment methodology and is largely supportive of CMS' specific proposal. However, there are some aspects of the proposed rule that could result in continuing the imbalances and convolutions of the current system, in contrast to the proposed rule's intent.

MPCA supports CMS' proposal to offer a bundled PPS rate, reflecting the average costs of providing Medicare FQHC services, with a geographic adjustment factor. We also appreciate CMS' proposal to provide for an upward adjuster for the annual wellness visit and "Welcome to

Medicare" initial visit, which are associated with higher costs than other Medicare FQHC visits. As the new PPS system is implemented MPCA encourages CMS to thoughtfully consider how additional adjusters can be applied to compensate for higher intensity services provided to patients with multiple, complex, chronic conditions. Adjustment factors should take into account the additional provider time consumed, care management services and coordination efforts which are key to better health outcomes for these patients.

MPCA believes CMS should permit Health Centers to bill for multiple visits of different types on the same day and encourages CMS to utilize the existing regulatory provisions on same-day visits for the purposes of the PPS. The existing rules allow Health Centers to bill for more than one visit on the same day when the patient suffers illness or injury requiring additional treatment after the first encounter and when the patient has a medical visit and either a mental health visit, diabetes self-management training (DSMT), or medical nutrition therapy (MNT) service in the same day. MPCA and Michigan's Health Centers are investing significant resources in more strongly integrating care for all patients, including Medicare beneficiaries, and we believe the ability to bill for multiple visits is key to sustaining those efforts. We understand that the data CMS reviewed demonstrated this practice is currently used infrequently, however as FQHCs in Michigan continue to integrate care (there are already integration efforts underway at 130 sites) we know it will increase substantially. In addition, the ability to schedule more than one visit on the same day is crucial to ensuring access to care for elderly and disabled patients, who may have transportation constraints.

MPCA has significant concerns regarding the proposed rule's implementation of Section 1833(a)(1)(Z) of the Social Security Act (the "lesser-of provision"). The draft regulations do not define "charge" or explain how CMS plans to implement the limitation. CMS also appears to have overlooked the lesser-of provision in its regulatory impact analysis. Since the PPS is a bundled payment, the negative impact of the lesser-of provision will be especially acute if CMS contemplates a comparison, for each visit, of the PPS rate to the charges associated with specific procedure codes that the Health Center billed for FQHC services on the day the visit occurred. That type of comparison would be "apples to oranges" – comparing costs of an aggregate bundle to charges associated with a specific day and would routinely result in underpayment. MPCA encourages CMS to implement the provision in a way that ensures parity between the bundled rate and charges compared. For example, the PPS rate could be compared with the health center's average charge per FQHC visit, as determined on an annual basis. That type of approach would mitigate the negative effects of the lesser-of provision by ensuring an "apples to apples" comparison of the PPS rate to charges.

CMS explains in the preamble to the proposed rule that it has excluded from the costs used to set the national PPS rate both the costs of specific FQHCs whose total costs per visit were more than three standard deviations from the geometric mean and the costs associated with individual visits that were more than three standard deviations from the mean. Using these methods, CMS reduced the proposed initial PPS rate significantly. MPCA believes the application of these limitations is inconsistent with the statute, which requires that the aggregate amount of PPS rates be based on "100 percent of the estimated amount of reasonable costs," without the application of caps and screens. MPCA urges CMS, in computing the base PPS rate, to use the costs per visit without exclusion of outliers.

MPCA encourages CMS to develop a specific inflation factor for the market basket of FQHC services, as suggested in the proposed rule. The Government Accountability Office in a 2005

report noted that the Medicare Economic Index (MEI) falls short of the true rate of inflation affecting Health Center services because the MEI takes into account only physicians' service costs, not the broader range of costs affecting Health Center operations.

MPCA urges CMS to allow Health Centers to transition to the PPS effective October 1, 2014. Applying the PPS to cost reporting periods beginning on or after October 1, 2014 will result in almost a yearlong wait for the transition in many Health Centers. MPCA believes CMS should provide an option for Health Centers to file partial cost reports to cover any period between the start of the fiscal year and October 1, 2014 so that Centers wishing to transition can do so as quickly as possible. Given the relatively higher proportion of Medicare beneficiaries served in Michigan's northern and rural Health Centers, we believe many will exercise that option. However, Centers that prefer to wait should be allowed to transition into the PPS system at the start of their new fiscal year as indicated in the proposed rule.

Finally, MPCA encourages CMS to take this opportunity to clarify other important aspects of FQHC Medicare billing. The proposed rule indicated program guidance may be forthcoming on several topics and we encourage CMS to consider the issues below in that guidance.

- The fact that Health Centers currently work with multiple Medicare fiscal intermediaries has propagated confusion as each fiscal intermediary issues different instruction concerning the FQHC benefit and associated billing requirements. Under the Medicare administrative contractor (MAC) system, MPCA encourages CMS to assign one MAC to work with all FQHCs.
- Greater clarity is needed concerning the requirement that health centers bill Medicare for the technical components of FQHC services separately under Part B.
- FQHCs need further guidance on the treatment of services that are included in a bundled encounter but not provided during the billable provider visit. For example, when a patient receives routine allergy injections as part of their ongoing treatment, but does not see a core provider on the day the injections is administered.
- FQHCs continue to experience significant challenges related to the collection of patient deductibles for beneficiaries enrolled in Medicare Advantage plans.
- Health Centers believe comprehensive preventive exams are an essential service for all patients including Medicare beneficiaries and continue to request Medicare coverage for those services as part of the FQHC benefit.

Improving the Medicare payment methodology for FQHCs is critical as Medicare beneficiaries, a group with particularly intensive health care needs, become a more prominent Health Center patient population. Thank you the opportunity to provide feedback on the proposed rule.

Sincerely,

Phillip J. Bergquist
Director of Health Center Operations
Michigan Primary Care Association