COMMUNITY HEALTH CARE ASSOCIATION of New York State

September 6, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements

To Whom It May Concern:

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to comment on the proposed changes to the Medicare Physician Fee Schedule for Calendar Year 2022. CHCANYS is New York State's Primary Care Association for federally qualified health centers (FQHCs). CHCANYS operates as an advocate and voice for FQHCs across New York State, with over 800 sites serving 2.3 million patients annually. FQHCs are non-profit, community-run health centers located in medically underserved areas that provide high-quality, cost-effective primary care, including behavioral and oral health services, to anyone seeking it, regardless of their insurance coverage, immigration status, or ability to pay. Over 270,000 (12%) of our patients are covered by Medicare, including enrollees who are dually eligible for Medicaid.

In the fight against COVID-19, the FQHC mission of advancing equity in the nation's pandemic response is now more critical than ever. FQHCs have been on the ground in force for over two years, fighting the spread of the virus in hard-to-reach communities, including Black, Indigenous, and communities of color and among special populations such as the elderly, people experiencing homelessness, and agricultural workers. They have tested, vaccinated, diverted non-acute cases from overwhelmed hospitals, and connected affected patients to housing, food, and critical services.

As CMS continues to explore new innovative models and expand services for Medicare beneficiaries, it is imperative the agency is intentional about including FQHCs and explicitly amending our reimbursement regulations. CHCANYS is appreciative of the agency's commitment to health equity and value-based care. We request that CMS ensures FQHCs are not stifled by regulatory red tape that limits access to valuable services for the most underserved patients. CHCANYS strongly encourages CMS to consider FQHCs' unique patient population and critical work with underserved communities, when developing solutions to address the growing mental health crisis and health care workforce shortage.

CHCANYS supports comments submitted by the National Association of Community Health Centers (NACHC) and has restated some of those comments below. We appreciate CMS considering the following proposals:

- **CHCANYS urges CMS to use its regulatory authority to permit FQHCs to provide remote services by revising the definition of medical FQHC "visit" to include services furnished using interactive, real-time, audio and video telecommunications, or audio-only interactions under defined circumstances.**
- **CHCANYS strongly encourages CMS to utilize its full regulatory authority to amend the FQHC "incident to" regulations and FQHC mental health visit to include an encounter performed by a LPC and LMFT to generate a billable visit in Medicare to better align with Medicaid.**
- **CHCANYS appreciates CMS' interest in potential Medicare Part B payment for services involving Community Health Workers (CHWs) and support reimbursement models that contribute to the sustainability and success of their workforce at FQHCs.**
- **CHCANYS applauds CMS for recognizing the need to maximize its authority to cover "medically necessary" dental care in Medicare.**
- **CHCANYS appreciates CMS's efforts to provide additional resources necessary for the unique components of chronic care management (CCM) services. We strongly urge CMS to create billing codes that reflect the complexities between FQHC patients and provide variable reimbursement rates that reflect the varying levels of care management services provided.**
- **CHCANYS strongly recommends that CMS increase the Advance Investment Payments (AIPs) to attract more safety-net providers to the MSSP and provide adequate upfront payments to support required infrastructure investments.**
- **CHCANYS supports policies that recognize that the rapid assumption of downside financial risk has prevented many practices and ACOs that serve vulnerable populations from transitioning to value-based payment.**

Telehealth and Remote Access to FQHC Services

CMS has regulatory authority to permit FQHCs to provide remote services by revising the definition of medical FQHC visits to include services furnished using interactive, real-time, audio and video telecommunications, or audio-only interactions under defined circumstances.

For nearly two years, both patients and FQHCs have benefitted immensely from Medicare's public health emergency (PHE) flexibilities. PHE flexibilities have allowed FQHC providers to care for more vulnerable patients and improve their existing patient relationships. The demand for telehealth services has only continued to grow, even as Americans start to transition back to their normal activities. Since February 2022, about 25% of visits at FQHCs occur via telehealth, audio

visual or telephonic. FQHCs' main priority is to provide uninterrupted comprehensive care for their Medicare patients. ***CHCANYS strongly urges CMS to revise the FQHC medical visit definition prior to the end of the PHE to avoid consequential gaps in care for some of the most vulnerable Medicare patients.***

CHCANYS recognizes the agency's hesitation to amend FQHC medical visit regulations based on "temporary provisions" under the PHE. We urge CMS to consider the consequences if Medicare patients cannot receive virtual FQHC medical services due to lapse in coverage and reimbursement. 152 days after the PHE ends, Medicare patients that *choose* to utilize FQHC services will not have access to the same virtual services that other Medicare beneficiaries enjoy due to this lack of regulatory flexibility. FQHC patients and providers should not be stifled by restrictive regulations that prohibit the use of modalities employed by other providers under the PFS. FQHCs cannot continue to carry out their critical role as primary care safety-net providers unless Medicare recognizes patients receiving FQHC services through remote access.

In the past, CMS has stated it lacks statutory discretion to amend the "visit" definition in this manner because FQHCs are not included as "distant site providers" for the purposes of telehealth services in Section 1834(m). As seen by the PFS CY 22, CMS does have the authority to amend the "visit" definition. ***CHCANYS encourages CMS to use its authority, vested by Congress, to broaden the FQHC visit definition to include virtual capabilities for medical visits***. Over 12% of NYS FQHC patients are Medicare beneficiaries, receiving essential preventive and primary care services at their local FQHCs. The same patients who benefit from receiving mental health services through remote access deserve that same access to medical services. Previously, CMS has cited proven benefits of virtual care, including improved access to care for those with physical impairments, increased convenience from not traveling to an office, and increased access to specialists outside of a local area. FQHC patients deserve the same benefits, regardless of if remote access is for medical or mental health FQHC services.

CHCANYS believes CMS has the regulatory authority to revise the regulation at § 405.2463,paragraph (b)(1) to define a medical visit as a face-to-face encounter or encounter where services are furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where beneficiaries are not capable of, or do not consent to, the use of devices that permit a two-way audio/video interaction for the purposes of diagnosis, evaluation or treatment of services under (b)(2). Additionally, CMS should amend cost reporting instructions to ensure the costs associated with services under (b)(2) and (b)(3) are included as "FQHC services" on the cost report.

***Lastly, CHCANYS urges CMS to permanently amend the definition of "direct supervision" to allow supervising professionals to be immediately available through virtual presence using real-time audio/video technology, instead of requiring their physical presence*.** It is critically important that CMS amend the FQHC definition of "direct supervision" to match the PFS definition. In 2022, like many health care facilities, nearly 68% of FQHCs reported losing 5-25% of their workforce in the last six months. However, FQHCs are experiencing unique workforce challenges related to competition with larger health care organizations. Amending the "direct

supervision" definition to include virtual presence will allow FQHCs to utilize providers across multiple sites to meet growing patient demand.

Proposed Revisions to the "Incident to" Physicians' Services Regulation for Behavioral Health Services

CHCANYS strongly encourages CMS to utilize its full regulatory authority to amend the FQHC "incident to" regulations and FQHC mental health visit to include an encounter performed by a LPC and LMFT to generate a billable visit in Medicare to better align with Medicaid.

FQHCs treat patients for a range of behavioral health conditions, including depression and mood disorders, anxiety and PTSD, ADHD, substance use disorder (SUD) and more. Nearly 10 percent of NYS FQHCs' clinical workforce are licensed mental health providers, yet many do not meet the current statutory list of Medicare billable providers.

CHCANYS appreciates CMS's commitment to supporting and strengthening the Medicaid and Medicare workforce. As the agency explores regulatory solutions, it is critical CMS intentionally reviews and amends FQHC regulations in concert with providers paid under the PFS. FQHCs commonly employ licensed professional counselors (LPCs) and Licensed Marriage and Family Therapists (LMFT) to expand their behavioral health services. Currently, FQHCs are permitted to generate a FQHC Medicaid billable visit for LPCs in over 30 states and for LMFTs in about 25 states; New York State does not currently have this critical coverage. ***CHCANYS strongly encourages CMS to utilize its full regulatory authority to amend the FQHC "incident to" regulations and FQHC mental health visit to include an encounter performed by a LPC and LMFT to generate a billable visit in Medicare to better align with Medicaid.***

Under the current regulations, a qualifying FQHC mental health "visit" must be comprised of face-to-face or virtual contact directly with a core provider to trigger a billable service. Auxiliary personnel services, like LPCs and LMFTs, are included in the FQHCs' allowable service costs and would not generate a separate billable encounter for their time. The changes under this proposed rule would not create incentives or meaningfully contribute to reducing the mental health workforce shortage at FQHCs due to the lack of reimbursement. ***CHCANYS strongly urges CMS to amend the FQHC mental health "visit" definition, at 42 CFR 405.2463(b)(3), to include encounters (for HCPCS codes that qualify as mental health per the FQHC Specific Payment Codes) comprised of services performed by auxiliary personnel incident to the services of a physician, NP, PA, CNM, CP, or CSW*.** This amendment to the "visit" definition would recognize encounters that are carried out under the "incident to" authority as billable mental health "visits."

The FQHC PPS statute, (SSA Section 1834(o)), *does not* specify that the unit of payment for FQHC PPS be restricted to face-to-face or virtual interactions directly with a core provider. CHCANYS believes CMS has the authority to recognize encounters that are carried out under the "incident to" authority as billable mental health "visits." All the services carried out would still fall within the statutory FQHC benefit (comprising core practitioners' services and services "incident to" those services, along with certain preventive services).

CHCANYS strongly urges CMS to make the above recommendations to ensure consistency across the PFS and FQHC regulations. FQHCs' ability to provide comprehensive and accessible behavioral health services should not be stifled by regulatory restrictions. This is particularly important for patients that are dually eligible. As safety-net providers, it is important that FQHCs are not penalized for our separate reimbursement structure and can participate and benefit as CMS continues to innovate in the mental health space.

Medicare Part B Payment for Services Involving Community Health Workers

CHCANYS appreciates CMS' interest in potential Medicare Part B payment for services involving Community Health Workers (CHWs) and support reimbursement models that contribute to the sustainability and success of their workforce at FQHCs.

CHWs are often members of the communities in which they work, which makes them uniquely equipped to connect patients to community-based resources and help address barriers patients face in continually accessing the care they need. CHWs may be part of the FQHC multi-disciplinary care team and their responsibilities can include:

- Determining resources available in the community and completing an action plan prior to the patient visit
- Facilitating referrals to community resources based on patient needs
- Case management and follow-up between patient visits
- Health education and translation services

In 2021, FQHCs employed nearly 1900 CHWs and funding to support CHW positions is a constant challenge. CHW services are commonly supported by time-limited grants from private foundations or governmental organizations that help develop and grow capacity at the FQHC, but do not deliver long term sustainability. Over the last few years, we have seen more FQHCs enter contractual agreements with managed care plans that provide reimbursement based on patient size or outcomes. A 2017 Kaiser Family Foundation survey of Medicaid managed care organizations found that 67% of plans used CHWs to address social determinants of health in the previous 12 months. While CHWs have traditionally not been reimbursed by public and private insurers, a growing number of states are using funding mechanisms such as Medicaid State Plan Amendments, Section 1115 Demonstration Waivers, and legislative statutes to reimburse for CHW services.

We observe that existing FFS structures typically do not pay for wraparound patient activities, such as CHWs or care coordination, but these interventions enable family physicians to better address a patient's identified social determinants of health (SDOH). This lack of reimbursement disadvantages patients who require more support and disadvantages the physicians who care for them. In addition to NYS' planned investment in the CHW workforce through a pending 1115 waiver, CHCANYS has been exploring the development of a Medicaid capitated Alternate Payment Methodology to provide the revenue flexibility to fund expanded capabilities to address patients' SDOH, such as investment in the CHW workforce. Such an alternate payment model will

provide adequate, stable financial support and flexibility to deliver the kind of whole person care their patients deserve in new and innovative ways. Adequate reimbursement for CHWs is also needed within the Medicare program. In alignment with NACHC, CHCANYS looks forward to working with CMS to explore ways in which Medicare Part B might better support inclusion of CHWs within primary care settings, including FQHCs.

Proposals on Medicare Part A and B Payments for Dental Services

CHCANYS applauds CMS for recognizing the need to maximize its authority to cover "medically-necessary" dental care in Medicare.

CHCANYS strongly supports the proposed clarification of CMS's authority on "medically-necessary" dental coverage. Medicare's lack of dental coverage not only leaves oral health care unaffordable for millions of Americans, but it also exacerbates underlying racial, geographic, and disability-related health and wealth disparities; improved Medicare coverage for medically necessary dental care would help millions of people get healthy without having to make impossible financial tradeoffs and would mitigate some of these health inequities. Acting to maximize this authority as is being proposed and explored in this proposed rule would help some of the very people who need dental coverage the most.

CMS proposes to clarify and codify the agency's interpretation that certain dental services may not be subject to the Medicare's payment exclusion for dental services under Section 1862 (a)(12) of the Act because they are "inextricably linked to, and substantially related and integral to the clinical success of, a certain covered medical service." This proposal is an important recognition and clarification of CMS's existing authority, which will help to ensure that Medicare beneficiaries can access and afford more of the dental care they need to advance their health. We strongly support the proposed clarification and codification of existing authority, and we encourage CMS to apply this authority in all settings and clinical circumstances where it is appropriate.

Care Management Services in RHC and FQHCs

CHCANYS appreciates CMS's efforts to provide additional resources necessary for the unique components of chronic care management (CCM) services. We strongly urge CMS to create billing codes that reflect the complexities between FQHC patients and provide variable reimbursement rates that reflect the varying levels of care management services provided.

While FQHCs are required to capture the CPT code that represents the level of severity of the patient's condition or time furnishing services and what level of provider furnished them, all CPT codes for the bulk of care management services (CCM, CCCM, PMC, BHI) are required to be billed by FQHCs under G0511. The rate for G0511 is set based upon the average FFS rate for a CMS defined list of services falling under G0511. This means that regardless of the severity of the patient's condition, the time spent treating them, and the level of provider education and training required for treatment, FQHCs will be compensated at the same rate for every patient across all of these existing care management services. Adding General BHI and Chronic Pain Management further dilutes the reimbursement to FQHCs under G0511 and does not account for time spent

or level of provider involved to treat them. It's critical that FQHCs can benefit from and participate in new FFS billing policies and alternative payment models as time progresses. ***CHCANYS urges CMS to evaluate current CCM codes and billing rates to ensure FQHCs are receiving adequate reimbursement to support their workforce and innovation***.

Medicare Shared Savings Program

CHCANYS applauds CMS for prioritizing health equity in the Medicare Shared Savings Program (MSSP) and creating resources to support safety-net providers' transition into value-based care arrangements. FQHCs are well positioned to be leaders in the value-based care space, and help CMS reach their goal to have all traditional Medicare beneficiaries participating in value-based care models by 2030. For decades, FQHCs provided comprehensive primary care by screening for social determinants of health and used this information to build patient-centric models of care.

However, challenges related to restrictive reimbursement models has stifled FQHCs' ability to employ the right workforce and provide the unique services their patient populations need. The transition to alternative payment models must work for diverse providers, serve to improve health equity, and be sustainable for participating providers. Safety-net and small community providers face unique barriers to implementing new value-based payment models. Many of these models require significant up-front investments that safety-net providers may be unable to make. It is important CMS understand the complexities related to FQHC patients, providing care in rural and medically underserved areas, and common barriers for safety-net providers.

Optional Advance Investment Payments to Certain ACOs in Underserved Communities

CHCANYS supports the concept of Advance Investment Payments (AIPs) but has concerns about the amount of funding and allowable uses under MSSP. The $250,000 AIP does not provide enough resources to support the required infrastructure, workforce, and technical assistance FQHCs need to be successful. It is imperative that FQHCs participating in eligible low-revenue ACOs can directly benefit from AIPs to ensure they have the necessary health IT infrastructure and workforce to meet the unique needs of their patients. FQHC patient populations are more complex compared to other patient populations because they have higher rates of chronic conditions and social risk factors associated with poorer health outcomes. An adequate AIP should include funding for the ACO and the safety-net providers participating in that ACO. **CHCANYS strongly recommends that CMS increase the AIPs to attract more safety-net providers to the MSSP and provide adequate upfront payments to support required infrastructure investments.**

Smoothing the Transition to Performance-Based Risk

CHCANYS applauds CMS for recognizing the challenges safety-net providers experience progressing through the MSSP as they transition to performance-based risk models. APMs should also account for the higher costs associated with caring for underserved populations and must not penalize ACOs that spend more to invest in primary care, target historical and ongoing health inequities, and address social determinants of health.

This is even more prominent in the FQHC space, as FQHCs incur unique risks by providing care to all patients regardless of their ability to pay and being strategically placed in medically underserved areas. It is critical that CMS considers FQHCs' "risks" when evaluating how and when they transition into models that assume more downside risk. **CHCANYS supports policies that recognize that the rapid assumption of downside financial risk has prevented many practices and ACOs that serve vulnerable populations from transitioning to value-based payment.** Providing practices with additional opportunities to participate in value-based payment arrangements, including non-ACO models, is an important step in advancing health equity. Additionally, it's imperative CMS considers FQHC-specific challenges with maintaining required attribution rates for safety-net providers.

Benchmarking Methodology Adjustments

CHCANYS encourages CMS to create equity-motivated benchmark adjustments to support additional funding for ACOs that include safety-net providers. As noted by CMS, these adjustments would not only act to correct resource disparities but also establish incentives for ACOs to attract underserved groups with enhanced care.

Quality Measures

CHCANYS appreciate CMS' incorporation of a health equity adjustment and are supportive of adding the low-income subsidy to its calculation. **We recommend that CMS apply the health equity adjustment to ACOs that report via the Web Interface. An ACO's population does not differ based on the reporting mechanism and restricting the adjustment to just ACOs that report via the APP does not align with the intent of the adjustment.** Ensuring all types of practices have opportunities to transition to a more sustainable payment model is critical to promoting a more equitable health system. Without viable opportunities, practices will be left in a payment system that does not provide adequate support and serve as a mechanism to perpetuate inequities.

Thank you for the opportunity to comment on the proposed changes to the Medicare Physician Fee Schedule for Calendar Year 2023. If there are any follow up questions, please contact Bethany Wolfe at bwolfe@CHCANYS.org.