September 11, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1676–P
P.O. Box 8016
Baltimore, MD 21244–8013.

*Re: Proposed Rule: 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,

AAPCHO is a national not-for-profit association of 35 community-based health care organizations, mostly federally qualified health centers, dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of medically underserved Asian Americans, Native Hawaiians, and Pacific Islanders (AA&NHPIs) in the U.S., its territories, and its freely associated states. Thank you for the opportunity to comment on this proposed rule. AAPCHO support the provisions of this proposed rule that impact FQHCs, including:

- The provision to create new G codes for Chronic Care Management and psychiatric Collaborative Care Management in FQHCs.
- Implementing a new beneficiary assignment process, taking into account all of the eligible providers that provide primary care to FQHC patients.

AAPCHO also recommends that CMS reconsider its position that FQHCs must participate in the Diabetes Prevention Program under a separate MDPP enrollment.

As health care providers, AAPCHO members focus on providing services that are uniquely appropriate to their patient populations, including: culturally and linguistically appropriate health care services, comprehensive primary medical care, and wrap-around enabling services (ES) for the medically underserved throughout the country. For the approximately 500,000 patients our centers serve annually, AAPCHO advocates that the health care system provide access to comprehensive and linguistically and culturally competent care by our member community health center providers and for our patients.

Medicare beneficiaries, including those dually eligible for Medicare and Medicaid, represent on average, 9.1% of AAPCHO's health center patients rely on Medicare, a small but growing patient population. Our members also have a higher rate of beneficiaries with Limited English Proficiency (LEP) (50% vs. 23%) and a higher rate of beneficiaries at or below 200% of FPL (88%) than other health centers, and thus we provide more enabling services (9,159 vs. 4,875 encounters) given the needs of our patients (HRSA Uniform Data System, 2014). The comprehensive model of care utilized by health centers allows

AAPCHO members to appropriately treat Medicare patients and to ensure that their care is delivered in an effective, efficient and culturally appropriate way. AAPCHO members are on the cutting edge of system delivery and have developed systems of care that reward quality—not just quantity.

As the healthcare delivery system adapts to serve increasing numbers of Medicare patients, AAPCHO continues to urge the Administration to support quality metrics that are obtainable, translatable, and comparable across providers' care AND that reimbursement takes into consideration other factors that impact healthcare, such as Limited English Proficiency (LEP), access to housing and socioeconomic status. AAPCHO has found that addressing such factors through efforts like enabling services breaks down barriers, leading to more effective healthcare.

In addition, AAPCHO supports efforts to ensure that the data collected and reported will be adjusted to reflect patients' Social Determinants of Health (SDOH). Our Medicare patients come from diverse backgrounds and often need our members' linguistically or culturally appropriate services. These services come at a cost greater than serving beneficiaries who do not need such wrap-around services. AAPCHO wishes to emphasize the crucial importance of appropriate risk adjustment to reflect the SDOH affecting providers' patient populations. As decades of research have demonstrated, LEP patients have greater needs and often less access to community resources. This can cause providers who care for them to score lower on measures of quality and resource use because of their limited capacity to serve larger and more complex patient panels.

Our specific comments on the rule follow.

**Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)**

AAPCHO is supportive of the addition of the two new G Codes for 2018:

- GCCC1: General Care Management; and
- GCCC2: Psychiatric CoCM.

We appreciate that these services could be billed alone or in addition to other services furnished during the FQHC visit, recognizing the comprehensive nature of the FQHC model. CMS should continue to more closely align the FQHC services with the Physician Fee Schedule and to support the health center's holistic model of care for Medicare beneficiaries. We also appreciate CMS' work to, 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." CMS has taken care to promote integrated care management services for Medicare beneficiaries who have either or both primary care and behavioral health needs.

AAPCHO supports efforts to promote team-based coordinated care for beneficiaries with chronic conditions and, to that end, support the addition of these G Codes to bolster and support care coordination. This is consistent with the health center model, and AAPCHO members have a long and effective history of providing patient centered care for beneficiaries with multiple chronic conditions. AAPCHO centers also serve many patients with behavioral health needs; across all AAPCHO centers, 12% of the visits were for behavioral health. Many AAPCHO members have co-located or coordinated behavioral health care within the FQHC model.

For low-income AA&NHOPI Medicare beneficiaries, coordinated services enhance their health care experience, such as when AAPCHO members provide culturally competent care, ease the burden of transportation and integrate treatment protocols. Studies have shown that care coordination for patients with socioeconomic challenges or limited English proficiency can lead to more effective care, better health outcomes and fewer emergency department visits. Our member centers provide culturally and linguistically appropriate care coordination—but this type of service can use more of the centers' resources. The additional costs of providing appropriate care for LEP populations should be acknowledged and payments appropriately adjusted in future rulemaking.

AAPCHO shares a concern raised by the National Association of Community Health Centers (NACHC) in their comment letter on this proposed rule. NACHC is concerned about the requirement in the proposed rule that the behavioral health care manager "must be available to contact the patient outside of regular primary care hours as necessary to conduct the behavioral health care manager's duties." AAPCHO, like NACHC, recommends the deletion of this proposed requirement, which will be perceived as a significant and potentially costly barrier to implementation.

**Assignment of Beneficiaries to ACOs That Include RHS and/or FQHCs**

AAPCHO supports the proposal to promote health center participation in ACOs by removing certain attestation requirements and instead treat a service reported on a claim as a primary care service furnished by a primary care physician. Health centers play a key role in coordinating care, providing primary care services, and keeping patients healthy and out of higher cost settings. As such, we strongly support the proposal to allow FQHCs to assign their patients to an ACO if a patient has received care at an FQHC. This will make it easier for FQHCS to participate in ACOs and in turn, leads to more coordinated, less costly care for the system overall.

**Diabetes Prevention Program**

AAPCHO strongly supports the Diabetes Prevention Program and the opportunity to provide care to diabetic patients in the community, using a group setting and trained lifestyle coaches to improve care. AAPCHO's member centers work as diabetes educators, many of whom can serve as trained national DPP lifestyle change program coaches with a specific focus on AA&NHOPI populations and LEP beneficiaries. What's more, research in Chinese-American patients shows that a culturally tailored, linguistically appropriate model for diabetes care employing health coaches improves A1C levels among

patients in FQHCs. This program is aligned with the mission and goals of the health centers and is an important opportunity to reach low-income AA&NHOPI Medicare patients that our centers serve.

AAPCHO encourages CMS to reconsider its position that a health center must participate in the MDPP under a separate supplier enrollment. 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 DPPP lifestyle change program. CMS must revisit this proposal so that FQHCs can 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.

**Conclusion**

We would like to thank you for the opportunity to submit these comments. In providing care to patients with high LEP and low socioeconomic status, AAPCHO's research team and clinics have a great deal of research on the value of addressing the SDOH and the impact of providing linguistically and culturally competent care. We would like to offer to be of assistance as to determine how best to adjust measures and payments to reflect SDOH. AAPCHO, in partnership with NACHC, is currently engaged in an extensive study to create, test, and promote a national standardized patient risk assessment protocol to assess and address patients' social determinants of health.