September 10, 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-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,

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.

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, a small but steadily growing patient population. Our members 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 center. 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 for that quality take into consideration

other factors impacting healthcare, such as Limited English Proficiency (LEP), access to housing and socioeconomic status.

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 linguistically or culturally appropriate services that AAPCHO members provide. But these services do come at a cost greater than serving beneficiaries who do not need 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.

As health centers are not typically paid according to the Physician Fee Schedule, most of this rule does not apply to AAPCHO's members. However, there are some provisions that do impact health centers and our comments focus on those provisions. Our recommendations are consistent with the comments submitted by the National Association of Community Health Centers (NACHC).

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

AAPCHO supports the addition of this code to the G code, as it will align the CCM codes health centers can use with those allowed by "traditional" Medicare providers paid on the Physician Fee Schedule. AAPCHO strongly support the move to align QHC 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.

For low-income AA&NHOPI Medicare beneficiaries, chronic care management is critical for improved health outcomes, and coordinated services will enhance their health care experience. AAPCHO members provide full access to 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 visit. Our member centers provide culturally and linguistically appropriate care coordination—but this type of service can use more of the centers' resources. We appreciate CMS' continued support for reimbursement for CCM services. In the future, we encourage CMS to evaluate additional costs of providing appropriate CCM services for LEP populations and appropriately adjust payment in future rulemaking.

AAPCHO, in partnership with NACHC, requests clarification in the determination of the fiscal value applied to this new code, which will then be averaged with other to determine the rate and looks forward to continuing to work with CMS on the implementation of these important services.

**AAPCHO 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.**

AAPCHO strongly supports the creation of a G code for health centers to provide Communication Technology-Based Services and Remote Evaluation services. With the addition of this G code, CMS is taking an important step forward in recognizing the role that technology-based services play as part of health centers' delivery of primary and preventive care. AAPCHO believes that the reimbursement of these services outside of (and on top of) the Medicare FQHC PPS rate is appropriate, and we support this methodology. Telehealth and other remote patient monitoring services are new and different from the typical FQHC services, justifying a separate reimbursement.

It is important to note, however, that the addition of this code will not eliminate all the barriers that health centers face in serving patients through telehealth. AAPCHO members use a variety of technology-based services to support their patients including through in-language services, to expand access to health care services, to monitor chronic conditions and to deliver services to rural communities. But 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. To solve this, CMS should 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.

Sincerely,

Jeffrey B. Caballero, MPH
Executive Director