August 8, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6082-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

Re: CMS-6082-NC, Request for Information; Reducing Administrative Burden To Put Patients Over Paperwork

Dear Administrator Verma:

The Community Health Care Association of New York State (CHCANYS) appreciates the opportunity to respond to the Center for Medicare & Medicaid Services' (CMS) Request for Information on Reducing Administrative Burden To Put Patients Over Paperwork.

CHCANYS is a membership organization comprised of New York State's federally-qualified health centers (FQHCs). As such, CHCANYS operates as an advocate and voice for health centers across New York State, with over 800 sites serving 2.3 million patients annually. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral health services, to anyone seeking it. FQHCs are New York's primary care safety net providers - keeping people well in the community and out of higher cost institutional based settings. In total, NY's FQHCs serve about 1,495,000 Medicare, Medicaid, and CHIP beneficiaries each year.

In an effort to best serve their patients and address the growing national substance use disorder and behavioral health crisis (including the opioid crisis), many FQHCs across the State are working to increase their own behavioral health capacity internally. In 2017, nearly 1.2 million visits at FQHCs were behavioral health visits, a number that has been steadily increasing over the past several years. FQHCs recognize the importance of ensuring patients have access to integrated services that address their wide-ranging needs, from primary care to behavioral health and substance abuse services and the necessity of addressing the social determinants of health that can negatively affect their health. FQHCs often seek to partnership with behavioral health organizations to provide comprehensive care to patients on site. However, New York State Department of Health (DOH) has imposed burdensome restrictions on FQHCs' ability to co-locate[1] and share space[2] with other providers, including behavioral health providers, citing CMS Medicare guidance as the grounds for the restrictions.

[1] Co-location is defined as two or more entities that are located at the same address but each with its own distinct physical space.
[2] Shared space is defined as space occupied by one provider, a portion of which is leased to or otherwise used by another provider, or space which is leased or purchased by at least two providers.

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DOH policy states that FQHCs and Rural Health Clinics (RHCs) may not share space with other entities during FQHC/RHC hours of businesses - the same physical premises may be used by the FQHC/RHC only in instances where their usage is temporally distinct.[3] According to NY State Department of Health, CMS advised DOH that a prohibition on simultaneous use of space by FQHCs/RHCs and other provider types is necessary in order to comply with Federal Medicare regulations.

Current CMS Medicare regulations prohibiting shared space arrangements between providers include:

42 C.F.R. §405.2430[4]

(a) Filing procedures. (1) In response to a request from an entity that wishes to participate in the Medicare program, CMS enters into an agreement with an entity when— (iii) The FQHC terminates other provider agreements, unless the FQHC assures CMS that it is not using the same space, staff and resources simultaneously as a physician's office or another type of provider or supplier. A corporate entity may own other provider types as long as the provider types are distinct from the FQHC.

Chapter 13, Section 100 ("Commingling") of CMS Medicare Benefit Policy Manual[5]

Commingling refers to the sharing of RHC or FQHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC or FQHC physician(s) and/or non-physician(s) practitioners…

RHC and FQHC practitioners may not furnish or separately bill for RHC or FQHC-covered professional services as a Part B provider in the RHC or FQHC, or in an area outside of the certified RHC or FQHC space such as a treatment room adjacent to the RHC or FQHC, during RHC or FQHC hours of operation.

On occasion, FQHCs have entered into agreements with behavioral health providers and acquired space that promotes cooperation and coordination between different provider entities, only to be denied approval from the State as a result of the CMS regulations listed above. The restrictions on FQHCs' ability to concurrently share space with other providers and share resources in co-location arrangements severely hamper health centers' ability to participate in integrated care models. The regulations are especially burdensome in rural areas, where often the patient volume does not justify creating an entirely new or separate space for services that could easily be provided in existing facilities. Furthermore, in many urban communities, real estate options for providers may be very limited and the cost of altering or renting a space solely to ensure adequate separation between providers is cost prohibitive.

[3] New York State Department of Health Statewide Guidance on Space Arrangements Between Two or More Providers. (October 18, 2016). https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/2016-09-14_shared_space_guide.htm

[4] https://www.govinfo.gov/content/pkg/CFR-2010-title42-vol2/pdf/CFR-2010-title42-vol2-sec405-2430.pdf

[5] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Providing integrated care supports enhanced access to services, increases care coordination, and has the potential to lower overall healthcare expenditures. For integrated healthcare to succeed, however, there must be true integration of both physical space and the delivery of services. The regulations listed above are needlessly complex. While FQHC practitioners and administrators continue their good faith efforts to partner with other organizations to ensure their patients have access to high quality behavioral health care, the CMS Medicare policies noted are unnecessarily prohibitive.

CHCANYS asks CMS to revise Medicare policy to allow FQHCs to share space with other provider types during clinical hours.

Thank you for the opportunity to provide information to ensure we prioritize patients over paperwork. For more information, or with any questions, please contact Marie Mongeon, Policy Analyst with CHCANYS: mmongeon@chcanys.org.