Howard Brown Health

September 14, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1848-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Program (CMS-1848-P)

Howard Brown Health is one of the largest community health centers in the Midwest, serving more than 40,000 patients across seven clinic locations in Chicago. Howard Brown serves adults and youth in its diverse health and social service delivery system focused around seven major programmatic divisions: primary medical care, behavioral health, research, HIV/STI prevention, youth services, elder services, and community initiatives. As a federally qualified health center (FQHC), Howard Brown provides services regardless of a patient's ability to pay or insurance status. Almost 30% of Howard Brown's patients are enrolled in Medicaid. We serve vulnerable patients from all over Illinois including rural and low-income areas.

Howard Brown appreciates the recognition of community health centers (CHCs) and our role in providing comprehensive healthcare to over 50 million people across the country. However, this proposed rule by CMS includes a series of provisions and proposed payment reductions that may be harmful to CHCs' ability to provide that vital healthcare.

These proposals come on top of Medicaid cuts and administrative changes that are already placing additional burdens on patients and safety-net healthcare systems. Implementation of Medicaid work requirements, increased eligibility recertification, and new cost-sharing requirements are expected to contribute to significant coverage losses, with millions of individuals potentially losing insurance because of administrative barriers rather than ineligibility. Altogether, these changes to Medicaid on top of these proposed changes to the CY 2027 Payment Policies will further strain healthcare systems and limit patients' access to timely, affordable care. **We therefore urge CMS to ensure it is enacting changes to fee schedules, reimbursement terms, and policies that support community health centers like Howard Brown and prioritize continuity of care for our patients.**

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Separate Payment for Medicare Part B Drugs Administered by CHCs

Howard Brown respectfully requests that CMS use the CY 2027 rulemaking cycle to address the separate payment of Part B drugs, including those administered by injection, in CHCs. The treatment of Medicare Part B drugs under the CHC Prospective Payment System (PPS) illustrates why the underlying payment methodology must keep pace with changes in the services and supplies that CHCs furnish. Since the CHC PPS took effect in 2014, biologics have grown from 30 to 51 percent of total US drug spending, and most biologics are administered by injectable routes.[1] Within Medicare Part B, biologics account for 79 percent of spending and for 89 percent of spending growth since 2008.[2] Total Medicare Part B drug spending similarly increased from approximately $21 billion in 2014 to approximately $65.5 billion in 2024, an increase of more than 210 percent, with biologics representing the majority of the highest-spend Part B products.[3]

The CHC PPS methodology was designed at a time when the injectable products that a primary care practice furnished were generally lower-cost vaccines, contraceptives, corticosteroids, and antibiotics. Under current policy, the cost of administered Part B drugs and their administration is generally included within the CHC PPS payment.[4] With a proposed CY 2027 PPS base rate of just $212.91, the PPS payment cannot adequately account for many Part B drugs with acquisition costs that approach or exceed the PPS payment intended to cover the entire CHC visit. For example, CHCs may administer Invega Sustenna®, a commonly used long-acting injectable for behavioral health conditions, at a 340B acquisition cost exceeding $1,000 per dose.[5] Requiring a CHC to absorb a drug acquisition cost of this magnitude within the PPS payment creates a substantial reimbursement shortfall before accounting for the clinical and administrative resources required to furnish the visit. At Howard Brown, this often creates barriers for patients wanting to access long-acting injectable HIV prevention medications.

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[1] William Blair, Updating FDA Approval Analysis for 2024. Updating FDA Approval Analysis for 2024 Data | William Blair

[2] HHS, Office of the Assistant Secretary for Planning and Evaluation, Medicare Part B Drugs: Trends in Spending and Utilization, 2008–2021, (June 2023) https://aspe.hhs.gov/sites/default/files/documents/06338d34b766b2853741150acaacfd0e/aspe-medicare-part-b-drug-pricing_508c.pdf

[3] MedPAC July 2026 Data Book: Health Care Spending and the Medicare Program, § 10. medpac.gov (July 2026 Data Book)

[4] Medicare Benefit Policy Manual, Pub. 100-02, Ch. 13, § 120 and § 120... https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

[5] https://ndclist.com/ndc/50458-564/package/50458-564-01/price

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Under the current payment structure, CHCs are often substantially underpaid for furnishing Part B injectable drugs or unable to furnish these services because they cannot absorb the acquisition costs. When Medicare reimbursement does not cover the cost of a Medicare-covered drug, CHCs must use other limited resources to make up the difference. Medicare payment policy should not depend on CHC's use of other federal resources to subsidize Medicare-covered services. When CHCs cannot absorb these costs, patients may instead seek treatment at hospital outpatient departments, infusion centers, or other sites of care, potentially creating additional barriers to timely access.

CMS already pays CHCs separately for preventive vaccines and drugs covered as additional preventive services (DCAPS).[6] Therefore we urge CMS to extend these existing reimbursement mechanisms and provide separate payment for Part B drugs, including those administered by injectable routes, when furnished within CHC in-scope services. Specifically, we request that CMS authorize covered Part B drugs or biological products administered by injection in a CHC be paid separately from the CHC PPS per diem rate. The drug should be paid at 100 percent of the Medicare payment amount determined under section 1847A of the Act,[7] and administration should be paid at the geographically adjusted, non-facility PFS amount for the applicable CPT drug administration code.

Separate payment is better suited than rebasing the PPS solely to account for changes in a rapidly evolving pharmaceutical market. Rebasing the PPS per diem rate would not respond as effectively to the pace of change in injectable therapeutics. A product that is a high-cost brand drug today may face generic or biosimilar competition in the future, making a permanent increase to the PPS rate less responsive to changes in the drug's cost. In contrast, separate payment for each drug would more closely track changes in the applicable Medicare payment amount over time.

Allowing CHCs to furnish scheduled, low-acuity injectable medications would expand access to these services in convenient, community-based settings and reduce the need for patients to travel to hospital outpatient departments or other specialty sites. With 94 percent of the population within a thirty-minute drive of a CHC site, CHCs are well positioned to serve as an important access point for injectable administration.[8] Providing

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[6] 42 C.F.R. § 405.2464(c)–(f). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-X/section-405.2464

[7] Centers for Medicare & Medicaid Services. "ASP Regulations & Policy | CMS." *Cms.Gov*, 2021, https://www.cms.gov/medicare/payment/part-b-drugs/asp-regulations-policy.

[8] Han X, et al., Quantifying Population Characteristics Within and Outside a 30-Minute Drive-Time to HRSA-Supported Health Centers, J Ambul Care Manage (2024). https://pubmed.ncbi.nlm.nih.gov/39028274/

these services in CHCs could also help avoid unnecessary inpatient days and skilled nursing placements when patients can safely receive treatment in an outpatient primary care setting. Beyond those covered by Medicare and Medicaid, CHCs could improve access to these medications for uninsured and underinsured individuals. CHCs acquire covered outpatient drugs at 340B prices and, under their sliding fee schedules, pass those discounts through to patients at or below 200 percent of the Federal Poverty Level (FPL). Delivering these services meets the 340B Program's intent, which is to enable covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.[9]

Medicare Part D Claims Data 340B Repository

CHCs are already facing significant administrative and operational burdens associated with the proposed 340B rebate pilot program and manufacturer restrictions. The proposed establishment of a mandatory Medicare Part D Claims Data Repository would add another layer of complexity. Howard Brown's 340B team is already submitting data to the 340B ESP platform to comply with manufacturer restrictions, and, beginning in January, if the proposed rebate model is implemented, we expect to also be submitting claims to Beacon and potentially Kalderos. Each of these systems has its own submission requirements, data elements, processes, and workflows, requiring our staff to spend additional time developing and maintaining separate procedures.

The 340B ESP system has already created significant obstacles for our teams at Howard Brown, with limited communication and support, making it difficult to resolve issues and ensure that submissions are accurate and timely. In addition, these requirements do not account for the Medicaid Transformation Framework (MTF), which pharmacies are using for Maximum Fair Price (MFP) and Inflation Reduction Act drugs. Ideally, CHCs should not be required to manage multiple duplicative systems for submitting claims. A single, neutral repository or system would be the most practical and least burdensome approach.

It is also critical that any such mandated repository system clearly address liability. Under the current 340B ESP process, the liability effectively rests with the covered entity (CE), which must demonstrate that an issue was not our fault or risk losing access to covered drugs. If the proposed mandatory repository places similar liability on CHCs, this concern should be explicitly addressed with established processes to dispute and resolve issues.

[9] Section 340B of the Public Health Service Act, 42 U.S.C. § 256b; H.R. Rep. No. 102-384(II), at 12 (1992)

There are also challenges in accurately identifying Medicare claims. Currently, CEs do not receive complete pharmacy benefit manager (PBM) information, including the bank identification number and processor control number, from all third-party administrators. We would therefore need additional information from some third-party administrators to reliably identify Medicare claims. Even more concerning, Medicare and commercial payer bank identification numbers and processor control numbers can sometimes be identical, making it impossible for CHCs to distinguish between Medicare and commercial claims based solely on this information. CHCs need clearer and more reliable information from PBMs to accurately identify Medicare claims and distinguish them from commercial claims. This issue does not appear to be adequately addressed in this rule, and this should be highlighted, particularly if the responsibility for accurately identifying and reporting claims and the associated liability falls on the covered entity.

For CHCs, we urge that any mandatory repository must reduce, rather than add to, the administrative burden, provide clear and consistent requirements, establish a neutral process, and ensure that covered entities are not held liable for information or distinctions they cannot reasonably collect or verify.

Accounting for ADAP Enrollee 340B Eligibility: A Proposed Modification to the Prescriber-Pharmacy Methodology

The proposed modification to exclude AIDS Drug Assistance Program (ADAP) enrollees from the Prescriber-Pharmacy Methodology is intended to address an administrative data-tracking challenge under the Inflation Reduction Act (IRA), but it could create significant consequences for people living with HIV and the clinics and pharmacies that serve them. The underlying issue is how CMS identifies 340B-eligible drugs and prevents "duplicate discounts." Under the current methodology, a drug is generally identified as 340B-eligible when a prescription can be matched to an approved National Provider Identifier (NPI) and a registered 340B contract pharmacy. Because ADAPs typically operate through complex rebate arrangements rather than upfront discounts, these transactions can be difficult to identify accurately within the existing claims-based system. CMS has therefore proposed excluding all drug units dispensed to ADAP enrollees from Part D inflation rebate adjustments as a way to address these data limitations.

Although the proposed exclusion is intended to simplify administration, it could have significant financial and operational consequences for HIV clinics and other safety-net providers. Ryan White clinics and other 340B providers rely on savings generated through the 340B program to support both clinical care and essential wrap-around services, including housing assistance, case management, nutritional support, and behavioral

health services. If the proposed methodology reduces the savings available to these providers, clinics could face pressure to reduce staffing, shorten operating hours, limit outreach, or otherwise scale back services. These effects could be particularly significant for specialized infectious disease clinics that already operate with limited financial margins.

The proposal could also disrupt pharmacy access and continuity of HIV treatment. Retail and specialty pharmacies may reconsider or withdraw from contract pharmacy arrangements if the administrative requirements associated with ADAP transactions become too burdensome or financially unsustainable. A reduction in participating pharmacies could leave patients with fewer local options and require them to travel farther or rely on mail-order services to obtain their medications. Administrative uncertainty regarding eligibility and claims processing could also contribute to delays in prescription fills. Around 13% of Howard Brown's patients are living with HIV, and for people living with HIV, interruptions in access to antiretroviral therapy can have serious consequences, including loss of viral suppression and an increased risk of treatment resistance. Maintaining reliable, uninterrupted access to medication is therefore essential.

Services Furnished Using Telecommunication Technology

Howard Brown strongly supports CMS' proposal to extend the abeyance of the CHC mental health in-person visit requirements through December 31, 2027. Telehealth is firmly integrated into community-based care delivery, with approximately 98 percent of CHCs utilizing telehealth for primary care.[10] Among seniors, reliance on telehealth and particularly audio-only visits is substantial, reflecting broadband limitations, distance to care, and technology constraints common in rural areas. These challenges are compounded by nationwide provider shortages, especially in rural areas. This extension will provide important continuity for patients and providers and help ensure Medicare beneficiaries do not experience unnecessary disruptions in access to behavioral health care. However, continued reliance on temporary extensions creates uncertainty for CHCs making long-term investments in workforce, technology, and care delivery.

Accordingly, Howard Brown urges CMS to use every available administrative authority to preserve telehealth flexibilities for Medicare beneficiaries receiving care at CHCs and to work with Congress to establish permanent telehealth authority. CHCs serve as the primary care home for 10.5 million rural patients. Telehealth has become an important tool

[10] Tran, Bach. "Audio-Only Telehealth Is Crucial to Patient Health Beyond Pandemic." *Nachc*, 14 July 2021, https://www.nachc.org/audio-only-telehealth-is-crucial-to-patient-health-beyond-pandemic/.

for maintaining access to primary care, chronic condition management, behavioral health services, medication management, and follow-up care, particularly for patients who face geographic, transportation, or workforce-related barriers to in-person care. Permanent policy should preserve access to audio-only services when clinically appropriate and ensure that CHCs are not financially disadvantaged for furnishing care through telehealth rather than in person.

We also urge CMS to make permanent flexibility permitting general supervision through virtual presence for CHCs. CHCs continue to face significant workforce pressures. A survey by the National Association of Community Health Centers (NACHC) found that nearly two-thirds of CHCs experienced staff turnover rates of 5-25 percent in 2022.[11] Allowing virtual supervision for services furnished under general supervision requirements gives CHCs greater flexibility to deploy limited clinical staff, supports team-based care, and reduces unnecessary constraints on providers, particularly in rural and medically underserved communities. As CHCs serve more than 52.3 million patients,[12] preserving this flexibility is an important component in ensuring that limited workforce capacity is used efficiently to maintain patient access.

There also needs to be consideration for an appropriate payment methodology to accompany permanent telehealth authority. CMS and Congress should establish permanent authority for CHCs to furnish Medicare telehealth services, preserve access to audio-only services, and ensure payment parity with in-person CHC services under the PPS. Under current policy, Medicare reimburses CHCs for medical telehealth visits at roughly half the rate of in-person care, resulting in an approximately $205 gap between the reimbursement received and the cost of furnishing a visit.[4] CHCs must maintain the same clinical workforce, care coordination capacity, health information technology, and other infrastructure regardless of whether an individual encounter occurs in person, through audio-video technology, or through audio-only technology. Medicare payment policy should not create a financial disincentive for CHCs to use the modality that best meets a beneficiary's clinical and access needs.

To accomplish these goals, Howard Brown continues to recommend that CMS amend the definition of a CHC “medical visit” to include telehealth encounters expressly. This change

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[11] National Association of Community Health Centers. “Current State of the Health Center Workforce: Pandemic Challenges and Policy Solutions to Strengthen the Workforce of the Future.” *Nachc*, 7 Dec. 2023, https://www.nachc.org/resource/nachc-2022-workforce-survey-full-report-1-2/.

[12] Health Resources and Services Administration. “Health Center Program Uniform Data System (UDS) Data Overview.” *Hrsa.Gov*, 2025, https://data.hrsa.gov/topics/healthcenters/uds/overview.

would create greater consistency between Medicare's treatment of medical and mental health visits and provide a clearer pathway for PPS payment of telehealth services. Specifically, we recommend that CMS update the definition at 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)."

Updating the definition of a medical visit in this manner would provide CHCs with the flexibility to deliver clinically appropriate care through the modality that best meets a beneficiary's needs, while supporting payment parity between medical and behavioral health telehealth services. Taken together, permanent telehealth authority, continued audio-only access, flexibility in virtual supervision, and PPS-equivalent reimbursement would provide CHCs with the stability needed to invest in sustainable telehealth programs while preserving beneficiary access to relationship-based primary care.

Financial and Administrative Stains on CHCs

The financial and administrative structures needed to enact this proposed rule come at a time when CHCs and rural health clinics are already struggling to keep pace with rising costs and administrative stress.

CMS has proposed a CY 2027 CHC base payment rate of $212.91, representing a 2.5 percent increase based on the productivity-adjusted CHC market basket. While any increase provides some additional support, incremental payment updates do not adequately address the broader growth in operating expenses that CHCs are experiencing. Labor costs continue to rise as CHCs and rural clinics compete with hospitals and private practices for physicians, nurses, and other healthcare professionals. At the same time, expenses for medical supplies, technology, pharmaceuticals, facilities, and other essential services continue to increase, placing additional pressure on already constrained operating budgets.

The financial challenges are compounded by the payer mix of safety-net providers. CHCs and rural clinics serve a disproportionate number of Medicare and Medicaid beneficiaries, as well as uninsured and underinsured patients, whose coverage often generates less revenue than commercial insurance or, in some cases, no reimbursement at all. These providers are also obligated to serve patients regardless of their ability to pay, making

uncompensated care a persistent financial burden. For example, Howard Brown has seen a nearly 400% increase in uncompensated care costs from FY 21 to FY 25, and we expect uncompensated care costs to rise even further as more patients lose Medicaid coverage. As a result, modest increases in federal payment rates will not be sufficient to offset rising expenses, lower-reimbursing payer mixes, and uncompensated care.

Structural limitations further constrain the ability of CHCs and rural clinics to absorb these financial costs. Many encounters are reimbursed through bundled or otherwise fixed payment methodologies that may not fully reflect the increasing complexity of treating patients with multiple chronic conditions. In addition, federal grant funding that supports critical safety-net services has not always kept pace with inflation or the growth in demand. Consequently, these organizations must rely heavily on clinical reimbursement to subsidize essential services and maintain access for vulnerable populations. When reimbursement fails to keep pace with costs, the resulting financial strain can ultimately reduce capacity, limit access, and undermine the ability of safety-net providers to deliver comprehensive and continuous care.

Conclusion

CMS must take decisive action to protect the sustainability of community health centers and the underserved populations that depend on us for affordable, high-quality care. In the wake of the significant funding reductions enacted through HR 1, it is more important than ever that CMS ensure fee schedules and reimbursement terms that adequately recognize the vital role of community health centers and preserve the savings and resources intended through the 340B program. Protecting these resources is essential to ensuring that community health centers can continue to serve as a critical safety net for millions of patients. Should you have any questions about our comments, please feel free to contact Timothy Wang, Director of Policy and Advocacy at timothyw@howardbrown.org

Sincerely,
Travis Gayles, MD, PhD
President and CEO