



December 21, 2011

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9070-P
PO Box 8012
Baltimore, MD 21244-1850

RE: Proposed Rule: Medicare and Medicaid Program; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to CMS' proposed rule *Medicare and Medicaid: Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reductions* (76 Fed. Reg 65909 et seq., 10.24.11). NACHC is the national membership organization for federally qualified health centers (hereinafter interchangeably referred to as "FQHCs" or "health centers") throughout the country, and is a non-profit, Section 501(c)(3) tax exempt organization. We are, of course, particularly interested in responding to this proposed rule as it relates to health centers.

Background

There are, at present, more than 1200 health centers with more than 8000 sites serving more than 20 million patients nationwide. The majority of these health centers receive federal grants under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA) of HHS. Under this authority, health centers fall into four general categories (1) those centers serving medically underserved areas, (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farmworker populations within similar community or geographic areas, and (4) those serving residents of public housing. Approximately 100 health centers do not receive a Section 330 Public Health Service Act grant but have been determined by CMS, per recommendation of HRSA, to meet all the requirements that must be met by Section 330 grantees (Sections 1861(aa)(4)(B) and 1905(l)(2)(B)(iii) of the Social Security Act). These health centers are often referred to as "FQHC look-alikes."

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To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center's board of directors must be made up of at least fifty-one percent (51%) users of the health center and the health center must offer services to all persons in its area, regardless of one's ability to pay. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services (such as translation, transportation services, smoking cessation classes, etc) to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients from eligible communities, who are not indigent and are able to pay or who have insurance, whether public or private, are expected to pay for the services rendered. Approximately 35 percent of health center patients are Medicaid recipients, approximately 40 percent are uninsured, and approximately 7.5 percent are Medicare beneficiaries. This 7.5 percent Medicare patient load translates into 1.5 million Medicare beneficiaries receiving services from FQHCs.

Provisions Relating to Health Centers

NACHC will focus its comments on those provisions of the proposed rule which will have the most impact on health centers. Specifically, we will comment on proposed rule 42 CFR §424.540, the deactivation of Medicare billing privileges. NACHC applauds CMS' revision of this regulation, as it will reduce many of the burdens health center providers currently encounter with Medicare billing. An FQHC enrolls in Medicare as an institutional provider ("FQHC") using the CMS 855-A form and health center providers enroll individually using the CMS 855-I form. The FQHC files claims and bills Medicare for the FQHC services (defined in section 1861(aa)(3)) it has provided, and payment is sent to the health center, not the individual health center provider. Because of this arrangement, many health center providers may not bill for Medicare on an individual basis, as the health center itself is billing for their services. However, there are instances where health center providers may enroll in Medicare and also provide services as an individual provider, but these instances may not be as frequent as a typical Medicare provider. Under current regulation, many health center providers are having their Medicare numbers deactivated, not because they had gone "inactive," but because they are providing FQHC services as employees or contractors of at the health center which is billing for these services.

These deactivations are very disruptive to health centers causing many reimbursement issues, including delays in reimbursement and lost productivity trying to get numbers reactivated. In fact, in response to a survey of health centers carried out by the California Primary Care Association, when asked "at what extent does this regulation cause you administrative and financial burden (on a scale of 1 to 10, 1 being the lowest)," the majority of health centers answered 8 or above. This echoes the information we have received from health centers across the country, regardless of size and number of providers. Any type of reimbursement delays are often devastating to health centers, which operate on very small margins and rely on timely payment to ensure they can continue to provide high quality comprehensive care to their community's underserved population.

The revision of this regulation at §424.540(a) to apply only to providers and suppliers who do not submit a CMS form 855-I will remove the burden for health centers and their providers. NACHC appreciates CMS's attention to and revision of this regulation.

We also support and appreciate the proposed revisions at §424.540(a)(3) which would allow for the deactivation instead of revocation of Medicare privileges for those providers or suppliers who fail to furnish complete and accurate information and all supporting documentation within 90 calendar days of receiving notification to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. This too will reduce the burden on health centers and their providers who might inadvertently miss the 90 day deadline.

Thank you again for the opportunity to share our support for these revised regulations. If you have any questions about the comments presented herein, please call me or Susan Sumrell at 202.296.3800 or contract us by email at rschwartz@nachc.org or ssumrell@nachc.org.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Roger Schwartz". The signature is written in a cursive, flowing style.

Roger Schwartz, Esq.
Associate Vice President and Legal Counsel
National Association of Community Health Centers