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United States Department of Health and Human Services  
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*Submitted via email: [TownHallMeetingsComments@hhs.gov](mailto:TownHallMeetingsComments@hhs.gov)*

**Economic Impact of Health Care Regulation:  
*The Impact of the Medicare Payment Cap on Federally Qualified  
Community Health Centers***

The National Association of Community Health Centers, Inc. (“NACHC”) is pleased to respond to the Health and Human Services' Assistant Secretary for Planning and Evaluation's (HHS/ASPE) request for comment pursuant to the House Appropriations Committee Report 108-636 which calls on HHS and the Office of Management and Budget (OMB) to examine the major federal regulations governing the health care industry. These comments address the economic impact of the Medicare cap for federally qualified health centers and the impact of the Medicare Contractor Reform proposal currently being implemented.

NACHC is the national membership organization for federally supported and federally recognized health centers (hereinafter interchangeably referred to as “health centers” or “FQHCs”) throughout the country, and is an Internal Revenue Code Section 501(c)(3) organization.

**BACKGROUND: FEDERALLY QUALIFIED COMMUNITY HEALTH  
CENTERS**

There are, at present, more than 1000 health center organizations that provide health services through approximately 5000 clinic sites located throughout the country and U.S. territories. Most of these FQHCs receive Federal grants under Section 330 of the Public Health Service Act (42 U.S.C. §254b) from the Bureau of Primary Health Care (“BPHC”), within the Health Resources and Services Administration (“HRSA”) of DHHS.<sup>1</sup> Under this authority, health centers fall into four general categories: (1) those

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<sup>1</sup> In addition to those health centers receiving grant funds pursuant to one or more of the Section 330 funding programs, there are certain entities that are designated by CMS as FQHCs, by virtue of the fact that they meet all of the requirements to receive a Section 330 grant, but do not receiving funding from HRSA

centers serving medically underserved areas (invariably poor communities), (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farm worker populations within similar community or geographic areas, and (4) those serving residents of public housing. Although there are some slight differences in the grant requirements for each of these four program types, for all intents and purposes, the ways in which these health centers operate are identical.

Except for a limited number of public health centers (*i.e.*, health centers operated by local governmental units such as health departments), each health center is a charitable, nonprofit, tax-exempt IRC Section 501(c)(3) corporation formed under the laws of the particular state in which it operates. To qualify as an FQHC, 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 comprised of at least 51% users of the health center, and the health center must offer services to all persons in its catchment area, regardless of their ability to pay or insurance status.

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 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 able to pay or who have insurance, whether public or private, are expected to pay for the services rendered.<sup>2</sup> Approximately 35.7% of the patients served by health centers are Medicaid recipients, approximately 7.5% are Medicare beneficiaries, and approximately 40.1% are uninsured.

Health centers are increasingly becoming important providers of primary care and preventive services – and often providers of on-site dental, pharmaceutical, and mental health and substance abuse services – to the elderly and especially the “near-elderly” (those ages 55-65). Currently, over 1 million health center patients are age 65 and older. For many elderly, health centers may be the only source of care available. For others, the health center may be the only community provider with physicians that speak their language. And for those with Medicare, health centers frequently serve as their medical home. Health centers are thus important providers of care for the elderly, and as such, play an important role in ensuring continuity of care that improves health outcomes while reducing costs.

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(“FQHC look-alike entities”). FQHC look-alike entities are eligible for certain, but not all, FQHC benefits, including, but not limited to, enhanced reimbursement under the Medicare and Medicaid programs. For purposes of this comment, unless otherwise noted, we do not distinguish between grantees and FQHC look-alike entities, collectively referring to both types of organizations as “FQHCs” or “health centers.”

<sup>2</sup> The term “community” in this context refers to either a geographic area or the specific population toward which the program is aimed.

## FQHC MEDICARE PAYMENT CAP

### BACKGROUND:

Medicare FQHC services are paid under a cost-related methodology.<sup>3</sup> In 1992, the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (“CMS”), established a per visit payment cap, based on the statutorily-imposed per visit limit applicable to rural health clinics (RHCs). This payment cap was published in the preamble to HCFA’s FQHC “final rules with comment period.”<sup>4</sup> According the preamble, the cap was to be interim, pending sufficient FQHC cost experience. The 1992 rules were reissued in 1996 substantially unchanged.<sup>5</sup>

CMS first applied the per visit limit to ensure efficiency and economy in the health center program. Today, with 75% of health centers nationwide above the cap, it is clear that the methodology falls far short of this intent.<sup>6</sup> NACHC urges HHS and OMB to review the adverse impact this regulation has on FQHCs particularly since this methodology has not been reviewed since its inception, nearly fifteen years ago.<sup>7</sup>

The current Medicare cap methodology is based on a rate which includes preventive services and the core Rural Health Clinic services. At the time this regulation was implemented, CMS lacked sufficient data on FQHC services. Instead CMS used the RHC baseline as the basis for determining the reasonable costs for FQHC services, thus underestimating the actual scope and costs of FQHC services. CMS now has nearly 15 years of FQHC data to create a limit based on the costs of FQHCs, not RHCs.

Since 1992 Medicare has undergone significant reforms that have broadened coverage in ways that affect FQHCs and their patients, including the addition of several new primary and preventive health benefits (see Table 1). However these services have not been added to the health center benefit package. This means that when a clinic is certified as an FQHC, it will not be reimbursed for providing these services, including:

- Glucose Monitoring
- The technical component of the following specific preventive services (the professional component is an RHC/FQHC service if performed by a RHC/FQHC physician or non-physician practitioner)
  - Screening pap smears and screening pelvic exams;
  - Prostate cancer screening;
  - Colorectal cancer screening tests;

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<sup>3</sup> SSA §1833

<sup>4</sup> 57 Fed. Reg. 24961 (June 12, 1992)

<sup>5</sup> 61 Fed. Reg. 14640 (April 3, 1996)

<sup>6</sup> 57 Fed. Reg. 24961 (June 12, 1992)

<sup>7</sup> NACHC has always questioned and continues to question the legality and propriety of CMS’ establishing a FQHC per visit limit, since Congress specifically mandated such a limit for RHCs and did not to do so for FQHCs. Nonetheless, given CMS’s insistence on establishing some form of FQHC per visit limit, NACHC is confining its comments to the sufficiency of the limits currently in effect.

- Screening mammography;
- Bone mass measurements; and
- Cardiovascular screening blood tests, including: Total Cholesterol Test; Cholesterol Test for High Density Lipoproteins; and Triglycerides Test.
- Glaucoma screening.

There are other Medicare services that have been added to the FQHC service package since the payment cap was created (see Table 1). These services are considered “allowable costs” for the purpose of a Medicare cost report, are factored into the FQHC rate, and are subject to the cap. Yet the cap has not been adjusted to accommodate these changes. For example, in 2006 Congress expanded the FQHC service package to designate diabetes outpatient self-management training services and medical nutrition therapy for diabetics as allowable costs. Thus the impact of these increased costs without an update in the payment methodology will further threaten the financial stability of health centers at or above the cap.

Finally the FQHC Medicare cap is adjusted annually only by the Medicare Economic Index (“MEI”). The MEI is a measure of inflation for physician costs. As suggested by a recent report from the Government Accountability Office, “Health Centers and Rural Clinics: State and Federal Implementation Issues for Medicaid’s new Payment System” (GAO 05-452, June 2005), the MEI does not incorporate the other, more comprehensive services provided by FQHCs, including mental health, nurse-midwifery, and social worker services.

**Table 1. Legislation and Relevant Medicare FQHC Provisions, 1993-2006**

Legislation	Relevant provisions to FQHC payment adequacy due to 1992 Medicare cap
Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66)	Expands definition of nurse midwife services to include all services that are lawful under state law and that are furnished by licensed certified nurse midwives, regardless of whether such services are “related to the management of mothers and babies throughout the maternity cycle.”
Balanced Budget Act of 1997 (105-33)	Added coverage for the following preventive services: <ul style="list-style-type: none"> <li>• screening mammography for women over age 40,</li> <li>• screening pelvic exams,</li> <li>• prostate cancer screening tests,</li> <li>• colorectal screening tests,</li> <li>• diabetes self-management training services, and</li> <li>• bone mass measurements for certain high risk persons.</li> </ul>
Balanced Budget Refinement Act of 1999 (Pub. L. 106-113)	Established minimum payment standards for Pap smears
Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554)	Added/modified coverage for the following preventive services: <ul style="list-style-type: none"> <li>•biennial Pap smears and pelvic exams</li> <li>•annual glaucoma screening for high risk individuals</li> <li>•colorectal screening exams (expanded to all individuals, not just those with known risks)</li> <li>•specified use of the physician fee schedule for screening mammography</li> <li>•medical nutrition therapy services for persons with renal disease or diabetes</li> </ul>
Medicare Modernization Act of 1003 (Pub. L. 108-173)	Added coverage of the following services: <ul style="list-style-type: none"> <li>• an initial preventive physical examination in connection with the preventive testing procedures added through previous amendments;</li> <li>• cardiovascular screening blood tests; and</li> <li>• diabetes screening tests</li> </ul>
Deficit Reduction Act of 2005 (S. 1932)	Expanded the FQHC covered package to include the following services: <ul style="list-style-type: none"> <li>•diabetes self management training</li> <li>• medical nutrition therapy services for diabetics</li> </ul>

**THE CURRENT REGULATORY BURDEN AND HOW IT CAN BE REDUCED**

In 1992, CMS issued a rule that no health center could be reimbursed above a certain amount. During calendar year 2006, the Medicare cap for rural FQHCs is \$97.13 and for urban FQHCs it is \$112.96. A cost report form was developed by CMS to capture the number of Medicare visits, cost per patient, and other data; FQHCs submit it annually to Medicare’s fiscal intermediary. Through a Freedom of Information Act request NACHC obtained the FQHC cost reports from the period June 2002 through May 2003 on which the following analysis is based.<sup>8</sup>

**Economic Burden of the FQHC Medicare Payment Cap Regulation:**

NACHC’s analysis of the 2003 cost report data indicates that the cost per visit at 75% of existing health centers is at or above the Medicare cap. In the aggregate health centers are losing over \$51 million each year, with some of the largest Medicare sites each losing over \$1 million. These financial losses place a significant burden on already strained safety net providers.

- Of 807 health centers, 608 (75.3%) experienced Medicare losses resulting from the FQHC cap totaling over \$51 million.
- Among all health centers, the average loss incurred was nearly \$85,000.
- 5 health centers experienced a loss of over one million.
- The maximum loss was \$1,945,655.
- 587 health centers (72.2%) experienced a loss of at least \$1,000.
- 139 FQHCs experienced a loss of over \$100,000.

<b>Table 2. Summary of Payment Cap Impact on FQHCs, 2003</b>	
<b>Number of Centers</b>	807
<b>Number of Centers Above the Payment Cap</b>	608
<b>Sum of Loss</b>	\$51,211,058
<b>Average Loss</b>	\$84,093
<b>Maximum</b>	\$1,945,655
<b>Number of centers with a loss of more than \$1 million</b>	5
<b>Number of centers with a loss of more than \$100,000</b>	139
<b>Number of centers with a loss of more than \$10,000</b>	477
<b>Number of centers with a loss of more than \$1,000</b>	587

Our analysis demonstrates that the per visit payment cap:

- Adversely affects three-quarters of all health centers.
- Most adversely impacts health centers that provide a broad range of Medicare-covered services, those in higher cost areas, and those with sicker populations that need more health services.
- Rising elderly patient populations at FQHCs will force the centers to incur even more losses under the 15 year old methodology for the per visit payment cap.

<sup>8</sup> The Medicare payment cap for calendar year 2003 was \$88.71 for rural FQHCs and \$103.18 for urban FQHCs.

## **RECOMMENDATION**

In establishing the per visit cap methodology in 1992, CMS stated it would analyze FQHC cost report data to determine if a payment limit adjustment was necessary. The data demonstrates that the cap results in inadequate Medicare funding for FQHCs' Medicare patients and threatens their ability to carry out their statutory mission under the Public Health Services Act of using grant funds to subsidize care for the uninsured. This threat is particularly grave during this period of limited discretionary appropriations.

NACHC recommends that CMS review the data expeditiously and make the necessary changes to the FQHC Medicare payment cap. Based on this analysis we believe it will be possible to develop options that recognize appropriate year-to-year increases in costs, comprehensiveness of Medicare services furnished, improved access for uninsured patients, and involvement in high value undertakings such as quality improvement and health information technology efforts.

# **MEDICARE CONTRACTOR REFORM**

## **BACKGROUND**

The Medicare Modernization Act of 2003 (MMA) directed the Centers for Medicare and Medicaid Services (CMS) to undertake a major reform of the Medicare contracting process. Section 911 of the MMA requires the Secretary for Health & Human Services to replace the current contracting authority to administer the Medicare Part A and Part B fee-for-service programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new Medicare Administrative Contractor Authority. CMS' plan for implementing contractor reform – referred to as Primary Part A and Part B (A/B) Medicare Administrative Contractor (MAC) – would eliminate the single, specialized FQHC Fiscal Intermediary and instead, have FQHC claims handled by the A/B MAC for the region of the country where the FQHC is located. Current plans call for the country to be divided up into 15 A/B MAC regions.

## **ORIGINAL JUSTIFICATION**

Currently Medicare Part A and Part B claims are processed by separate contractors using different claims processing systems. CMS has stated that the A/B MAC proposal is intended to promote competition and flexibility in the administration of the Medicare fee-for-service program; reduce the frustration for beneficiaries and providers; and improve the time it takes to get answers on coverage questions. CMS also has stated that by combining the administration of Part A and Part B, Medicare will be able to deliver more efficient and effective services to beneficiaries and healthcare providers and better meet future programmatic challenges.

## **THE CURRENT REGULATORY BURDEN OF MEDICARE CONTRACTOR REFORM**

Moving from one fiscal intermediary (“FI”) for FQHCs to 15 A/B MACs would represent a serious step backwards in terms of contractor reform for FQHCs. Unlike physicians and hospitals where there is tremendous variability from state-to-state, FQHCs are federally defined entities that adhere to uniform federal standards across all states. Maintaining a single FI system for FQHCs has allowed health centers and the FI to develop very effective communication. That process is working effectively for all parties. For example, FQHCs have benefited by clear and consistent interpretation of Medicare policy by one FI. In addition, under each FI that was contracted with CMS for the FQHC workload, NACHC has had a small handful of people within the organization that it could contact for assistance in addressing complex issues of concern, which has resulted in effective and efficient identification and resolution of Medicare problems involving health centers.

In addition to creating inconsistency in the application and interpretation of CMS policies, provider education can reasonably be expected to become almost non-existent.

Because the single FI structure to date has enabled contractors to have staff that deal only with FQHCs, they have dedicated staff who are typically available and willing to participate in provider education programs organized by health center organizations, including NACHC.

If we are moved to a subcategory of provider type for the A/B MAC we will represent a very small percentage of their business. Realistically, no bidder will win or lose a contract to be an A/B MAC based upon their ability or inability to properly and effectively handle FQHC claims or cost reports. Furthermore, the number of FQHCs in some of the regions will be so small that staffing for these unique provider types within the MAC will be difficult to maintain. As the experts on this issue, we believe that FQHC cost reports and claims processing require specialized staffing. The economies of scale for dividing this work among 15 MACs versus a single FQHC contractor goes against the intent of this initiative to improve services to Medicare beneficiaries and improve efficiency in the Medicare program.

Although NACHC believes that CMS should retain a single FQHC Medicare contractor, these comments should not be interpreted simply as a request to retain the current FI. CMS should know that on numerous occasions the FI decisions have not resulted in favorable reimbursement decisions or requests for FQHCs. Rather the advantage of a single FI is its having or developing reimbursement methodology and its applying policies relating to that methodology consistently.

## **RECOMMENDED REFORM**

Section C.7 in the Statement of Work would allow CMS to maintain a single Medicare contractor for FQHCs.<sup>9</sup> For example, pursuant to this section CMS could create FQHCs as a required option as part of the bid for one of the A/B MAC regions. This would allow CMS to proceed with its current A/B MAC proposal while maintaining a single contractor for all FQHCs. Including the FQHC work in each A/B MAC region is unlikely to result in additional savings for Medicare. Consistent with CMS policy for other specialty providers and beneficiaries, such as home health service providers and beneficiaries, NACHC believes that a single MAC Contractor for all FQHCs will offer greater efficiency and consistency across jurisdictions.

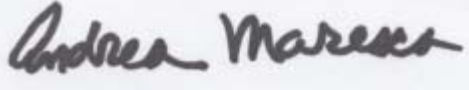
NACHC urges HHS and OMB to work with CMS to consider – at least for this initial implementation cycle of the Medicare contracting reform authority – that it may be more beneficial to HHS, FQHCs and health centers' Medicare patients to maintain specialty contractors to handle the FQHC workload. The FQHC program poses very complex coverage and payment issues, and, unlike most other Part A and Part B benefits, CMS has already consolidated their administration into a single contractor.

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<sup>9</sup> Attachment J-1 of the MAC Contractor Request for Proposal on the Federal Business Opportunities website <http://www.fbo.gov/spg/HHS/HCFA/AGG/CMS%2D2005%2D0016/Attachments.html>

Thank you for the opportunity to submit comments to the Health and Human Services' Assistant Secretary for Planning and Evaluation's (HHS/ASPE) regarding major federal regulations adversely impacting FQHCs. We appreciate your consideration and favorable action on these comments. Please do not hesitate to contact us at (202) 296-0292 if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Andrea Maresca". The signature is written in a cursive style and is placed on a light gray rectangular background.

Andrea Maresca  
Associate Director of Medicare and Medicaid  
Regulatory Affairs  
National Association of Community Health Centers, Inc.