

**Statement of Work
For
Medicare Administrative Contractor**

**Comments Submitted by the
National Association of Community Health Centers
January 6, 2006**

NACHC has reviewed the Statement of Work as requested by CMS and respectfully submits the following comments and recommendations. We appreciate your consideration and look forward to your response to our comments.

<i>C.1.1.</i>	<p>Page 1, second paragraph: This appears to reference the fact that separate regional Contractors would be utilized versus a national Contractor for FQHC, and references the requirements in the Medicare manuals. NACHC wishes to restate our position in support of a single national Contractor for FQHCs. NACHC believes significant improvements in service to Medicare beneficiaries and FQHCs can be achieved by updating the RHC/FQHC Medicare Manual to provide more specific, consistent guidance to the Contractor(s) on a number of topics. [See General discussion at the end]</p> <p>Page 1, second paragraph: NACHC recognizes that Appendix A lists the covered MAC entities. NACHC recommends strengthening the SOW by providing examples of “institutional providers.” For example, NACHC recommends a reference that institutional providers include FQHCs, hospitals, home health agencies, etc. and noting in the appropriate sections that billing for such providers are distinctly different.</p>
<i>C.1.4.2.</i>	<p>Page 4, first paragraph: Since FQHCs are listed in this Appendix A as both a professional and institutional provider as covered under the MAC Contract, NACHC requests that CMS ensure the SOW, Provider Communications Manual, Medicare Contractor Provider Satisfaction Survey and other relevant documents appropriately reference these designations.</p>
<i>C.2.1.2.</i>	<p>Page 6: NACHC requests CMS add the ability to process “wraparound” payments to FQHCs for Medicare Advantage beneficiaries as well as compile reconciliation data since this is a new aspect of Medicare that the Contractors should be aware of.</p>
<i>C.2.3.</i>	<p>Page 7: Appendix K provides a list of Manual citations. NACHC was unable to identify a reference to FQHCs in this appendix and requests that CMS include the appropriate citations.</p>
<i>C.4.1</i>	<p>Page 8: NACHC requests that CMS insert language requiring the contractor to maintain a high level of understanding of the specific intricacies and individual provider issues relevant to FQHCs.</p>
<i>C.5</i>	<p>Page 10: This section generally deals with transition and implementation issues. NACHC requests that CMS have or require Contractors to have a “back-up” plan</p>

	for reimbursing health centers. FQHCs are familiar with some of the challenges that can occur during a transition of contractors, for example with the transition from Aetna Life Insurance to United Government Services, LLC. NACHC believes that it is imperative that there be a protection plan for FQHCs should the Contractor(s) have trouble processing claims. For example, if the Contractor(s) fail to process claims for 30 days, there must be an emergency cash flow system for FQHCs to pursue to adjudicate claims so as to avoid cash flow problems and we believe a precedent for this may already have been set by other provider types.
C.5.1.1.8	Page 13: NACHC requests that CMS make clear that contractors are expected to involve NACHC, the State/Regional Primary Care Associations (PCAs), other health center related organizations, and individual health centers in its implementation communication initiatives.
C.5.1.1.9	Page 13: NACHC requests that CMS make clear that contractors are expected to involve NACHC, the State/Regional Primary Care Associations (PCAs), other health center related organizations, and individual health centers in its implementation meetings.
C.5.1.2.	Page 14: When the health center program converted from FFHC to FQHC, there were a myriad of errors in the communication of visit and payment data between the old and new intermediaries. These issues created all kinds of problems when it came to performing the cost report reconciliation for the period that included claims paid by the 2 intermediaries. NACHC requests that CMS add language here to ensure that visit and claim payment data is exchanged from the old Contractor to the new Contractor, for a certain period of time prior to the transition date, so that the cost report reconciliation process is not affected.
C.5.3.4.4	Page 31: NACHC requests that CMS further clarify and develop its standard to consider evaluation of contractor's "timeliness" for conducting its internal education and assessing its performance. NACHC requests that CMS provide for a mechanism for approving the specific information distributed by the contractor to ensure that there is uniformity across contractors regarding FQHC specific materials. As previously discussed, without this "check," it will not be feasible to ensure consistency across information and determinations being made.
C.5.3.7.1	Page 32: NACHC request clarification from CMS as to whether the bulleted items would include Contractor participation in NACHC sponsored conferences. In the past, at least one representative from the Medicare fiscal intermediary has attended and presented at NACHC's two annual meetings.
C.5.3.7.2	Page 33: As in Section C.5.3.7.1, NACHC requests clarification from CMS as to whether the Contractor will be required to attend and participate in NACHC's two annual conferences. In addition, NACHC recommends that as part of its regularly scheduled calls or other initiatives, CMS identify a method for communicating with all contractors and FQHCs to ensure consistency of determinations and education materials.
C.5.3.8.1	Page 35: Throughout the SOW NACHC urges CMS to consider that contractors need to be sensitive to specific provider responses. This section specifically points to the need to do so. For example most providers may be satisfied with a CR but FQHCs may not be. In general, NACHC urges CMS to issue new CRs, etc specific to specialized provider groups and professional providers such as

	FQHCs.
C.5.4.2.	<p>Page 47: NACHC is concerned that this language is very general, thereby creating very limited standards for evaluating services to Medicare beneficiaries and providers, particularly with respect to health center patients and FQHCs. In the area of claims processing, the standards are general as follows:</p> <ul style="list-style-type: none"> • Standard 1 – Claims processing is successful when Claims are paid with acceptable accuracy as evidenced by a contractor-specific Comprehensive Error Rate Testing (CERT) error rate not to exceed 5.4% by 2007 and 4.7% by 2008. • Standard 2 – Clean claims are processed timely when 95% of the claims are processed within the claims payment floor and ceiling specified in IOM Pub. 100-4, Chapter 1, sections 80.2.1.1 and 80.2.1.2. <p>One concern is raised in the context of how a MAC will audit and review claims for accuracy utilizing the CERT testing or other approved mechanisms. FQHC claims on the UB-92 claim form, as of April 1, 2005, no longer required the use of HCPCS/CPT codes in Field Locator 44. This is referenced in IOM 100-04 Chapter 9, section 100.B.</p> <p>This data field is important in gathering visit data utilized by auditing entities. For example, all other institution billing requires a HCPCS/CPT code in this data field but FQHCs do not. This leaves the revenue code (520), unit amount, dollar amount and ICD-9 diagnosis code to retrieve data from. This disables an auditing entity to track and monitor visit codes by service type such as a preventive CPT code, ranging from 99381-99397), sick visits (99211-99215) or any other CPT procedures represented by the CPT coding system from the American Medical Association, performed within the context of a provider visit.</p> <p>While the IOM Completing Claims Processing UB-92 Data Set Manual is referenced within the SOW, NACHC notes that RHC/FQHC entities are held out as the only other provider claim types that are not reported synonymously as other institutional claims.</p> <p>Without the appropriate training provided to a MAC and/or auditing agency, FQHCs may be inaccurately included in audit results or potential denials of payment due to specific billing requirements on the UB-92 billing claim form. Fiscal Intermediaries at this time are accustomed to specific field locator information required to be present on a claim. This is one example of the billing intricacies faced in this SOW transition.</p>
C.5.4.2.6.	Page 49: NACHC requests that CMS add a section here under <i>Handling of Medicare Advantage Claims</i> on the processing of “wraparound” payments to FQHCs since this will be a new payment type for the Medicare system.
C.5.4.4.	Page 50: NACHC requests that CMS add a section here to state that Contractor systems need to maintain/compile the visit and payment data needed for cost report settlement calculations, based on individual provider fiscal year ends. Also, this should include the ability to compile the visit and payment data needed

	to reconcile the new Medicare “wraparound” provisions for FQHCs for Medicare Advantage beneficiaries.
C.5.6	Page 55: NACHC requests that CMS insert language addressing FQHC appeal rights and processes.
C.5.7.3.1.	Page 64, 4 th paragraph: NACHC requests clarification on whether this paragraph means that each Contractor will have separate cost reporting software for the same provider type. Also, instead of the Contractor “monitoring” consistency between their cost reporting software and cost reporting instructions, NACHC believes this section could be strengthened by requiring the Contractors to “prove” to CMS that their cost reporting software is consistent with the instructions within a specific period of time.
C.5.7.3.2.6.	Page 66: One of the current problems with cost report settlements is how late they are performed after submission. As such, NACHC suggests that the desk review be completed within 30-60 days of acceptance.
C.5.7.3.2.10.	Page 67: Another common challenge experienced by FQHCs is that, currently, UGS provides “proposed” audit adjustments to FQHCs before issuing the Final Settlement, but allowing an unusually short period of time for the FQHC to review and comment on the proposed adjustments. NACHC recommends that CMS add language that states the Contractor must provide “proposed” cost report adjustments to the provider at least 30 days prior to the issuance of the NPR to allow the providers adequate time to research and discuss the adjustments with the Contractor.
C.5.7.3.2.13	Page 68: NACHC requests clarification as to whether this section and the referenced IOM affords FQHCs the ability to change to a different MAC Contractor for good business reason. NACHC believes such protection is necessary should any Contractor fail to commit to understand health centers as well as they need to, particularly as this relates to slowing or otherwise impeding reimbursement for health centers.
C.5.7.3.3.4	Page 72: CMS makes reference to the payment cap for hospice providers. NACHC requests that CMS insert language requiring the Contractor to update limits on the payment cap for RHCs/FQHCs as the MEI changes, so long as this payment cap is applied to these providers.
C.5.7.3.3.12.	<p>Page 74: The first sentence references the ability to review interim payment rates on a quarterly basis. However, the common experience for FQHCs is for this review to be done on an annual basis after review of the cost report. As such NACHC requests clarification of this process.</p> <p>Page 74: NACHC also requests that CMS add some additional language that the Contractor must be able to compile visit and payment data for the new Medicare “wraparound” protection for Medicare Advantage patients, to allow it to perform the required reconciliation and rate-setting process.</p> <p>This and previous sections (pages 64-74) make general references to the Medicare cost report guidelines. Currently FQHCs have been granted leeway by CMS in the penalty they experience if they fail to submit cost reports by the due date. CMS permits a 50% disallowance rather than 100% in such situations; however</p>

	NACHC has not identified any reference to this in the SOW or associated documents. We would request that CMS insert the appropriate language to make the Contractor aware of this policy.
C.5.10.	<p>Page 84: NACHC requests that CMS include the 855 A Short Form among those listed. The 855A Short Form addresses the site-by-site certification issue (see attached document for an example of this form). It was created through a collaboration between CMS, NACHC and UGS to expedite the process of certification for health centers that establish new service sites. It is NACHC’s understanding that the 855A Short form was approved by CMS and, as such, CMS should ensure that all MACs are aware of and properly utilize this form.</p> <ul style="list-style-type: none"> ▪ <i>NOTE: The 855A Short Form was created based on problems identified by FQHCs, the Intermediary and the national association. These entities worked together to develop a process that met the needs of health centers. As such we encourage CMS to ensure that this process remains in place should the agency move forward with FQHCs as part of the MAC reform proposal.</i>
C.5.11.1.5.1	Page 89: The discussion of electronic claims submission in this section does not appear to reference the FQHC specific timelines and processes for transition and NACHC requests that CMS insert the appropriate language and/or references.
C.7.	Page 119: Throughout 2005, NACHC discussed with CMS alternatives to including FQHCs in the MAC Contract. Pursuant to this section, NACHC again requests that CMS consider maintaining a single Medicare contractor for FQHCs. As noted in our previous communication with CMS, FQHCs are a “special” provider and we maintain that keeping a single Contractor for FQHC work is in the best interest of all stakeholders.
General	<p>Based on health centers’ recent experiences observations of the past history with UGS, there are a number of issues that NACHC wishes to raise a number of outstanding issues that could be addressed in conjunction with the MAC Reform initiative:</p> <ul style="list-style-type: none"> • What are the definitions of allowable FQHC costs and definitions of FQHC covered costs, even when they are not billable visits, i.e., medical assistants, case managers. • What is the definition of an FQHC covered service, that can be billed under the FQHC program or billed separately under Regular Part B (e.g. physical therapy, other Medicare benefits not specifically delineated in FQHC – telemedicine) • Recently imposed “reasonableness” parameters on allowable staff time for pneumococcal/influenza vaccines and increased documentation for recovery of Medicare bad debt. <p>Regardless of whether FQHCs have one national Contractor or various regional Contractors, these issues will still remain. NACHC believes significant improvements in service to Medicare beneficiaries and FQHCs can be achieved by updating the RHC/FQHC Medicare Manual to provide more specific, consistent guidance to the Contractor(s).</p> <p>In addition NACHC believes that in conjunction with the changes that must be</p>

	<p>made to the cost report form to account for the January 1, 2006 implementation of the Medicare Advantage supplemental payment for FQHCs and prior to any changes in the Contractor for FQHCs, CMS should further update the Medicare cost report form and take into consideration that the form does not allow for some of the unique billing/claims situations from FHQCs.</p>
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