

111TH CONGRESS
1ST SESSION

H. R. 1643

To amend title XVIII of the Social Security Act to establish a prospective payment system instead of the reasonable cost-based reimbursement method for Medicare-covered services provided by Federally qualified health centers and to expand the scope of such covered services to account for expansions in the scope of services provided by Federally qualified health centers since the inclusion of such services for coverage under the Medicare Program.

IN THE HOUSE OF REPRESENTATIVES

MARCH 19, 2009

Mr. LEWIS of Georgia (for himself and Mrs. EMERSON) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to establish a prospective payment system instead of the reasonable cost-based reimbursement method for Medicare-covered services provided by Federally qualified health centers and to expand the scope of such covered services to account for expansions in the scope of services provided by Federally qualified health centers since the inclusion of such services for coverage under the Medicare Program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicare Access to
5 Community Health Centers (MATCH) Act of 2009”.

6 **SEC. 2. FINDINGS.**

7 (a) FINDINGS.—Congress makes the following find-
8 ings regarding community health centers:

9 (1) NATIONAL IMPORTANCE.—Community
10 health centers serve as the medical home and family
11 physician to over 16 million people nationally. Their
12 patients represent one in seven low-income persons,
13 one in eight uninsured Americans, one in nine Med-
14 icaid beneficiaries, one in ten minorities, and one in
15 ten rural residents.

16 (2) HEALTH CARE SAFETY NET.—Because Fed-
17 erally qualified health centers (FQHCs) are gen-
18 erally located in medically underserved areas, FQHC
19 patients are disproportionately low income, unin-
20 sured or publicly insured, and minority, and they
21 frequently have poorer health and more complicated,
22 costly medical needs than patients nationally. As a
23 chief component of the health care safety net,
24 FQHCs are required by regulation to serve all pa-

1 tients, regardless of insurance status or ability to
2 pay.

3 (3) MEDICARE BENEFICIARIES.—Medicare
4 beneficiaries are typically less healthy and, therefore,
5 costlier to treat than other FQHC patients. Medi-
6 care beneficiaries tend to have more complex health
7 care needs as—

8 (A) more than half of Medicare patients
9 have at least two chronic conditions;

10 (B) 45 percent take five or more medica-
11 tions; and

12 (C) over half of Medicare beneficiaries
13 have more than one prescribing physician.

14 (4) NEED TO IMPROVE FQHC PAYMENT.—While
15 the Centers for Medicare & Medicaid Services have
16 nearly 15 years' worth of FQHC cost report data,
17 which would equip the agency to develop a new
18 Medicare reimbursement system, the agency has
19 failed to update and improve the Medicare FQHC
20 payment system.

1 **SEC. 3. EXPANSION OF MEDICARE-COVERED PRIMARY AND**
2 **PREVENTIVE SERVICES AT FEDERALLY**
3 **QUALIFIED HEALTH CENTERS.**

4 (a) IN GENERAL.—Section 1861(aa)(3) of the Social
5 Security Act (42 U.S.C. 1395w(aa)(3)) is amended to read
6 as follows:

7 “(3) The term ‘Federally qualified health center serv-
8 ices’ means—

9 “(A) services of the type described in subpara-
10 graphs (A) through (C) of paragraph (1), and such
11 other ambulatory services furnished by a Federally
12 qualified health center for which payment may oth-
13 erwise be made under this title if such services were
14 furnished by a health care provider or health care
15 professional other than a Federally qualified health
16 center; and

17 “(B) preventive primary health services that a
18 center is required to provide under section 330 of
19 the Public Health Service Act,

20 when furnished to an individual as a patient of a Federally
21 qualified health center and such services when provided
22 by a health care provider or health care professional em-
23 ployed by or under contract with a Federally qualified
24 health center and for this purpose, any reference to a rural
25 health clinic or a physician described in paragraph (2)(B)
26 is deemed a reference to a Federally qualified health cen-

1 ter or a physician at the center, respectively. Services de-
2 scribed in the previous sentence shall be treated as billable
3 visits for purposes of payment to the Federally qualified
4 health center.”.

5 (b) CONFORMING AMENDMENT TO PERMIT PAY-
6 MENT FOR HOSPITAL-BASED SERVICES.—Section
7 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is
8 amended by inserting “Federally qualified health center
9 services,” after “qualified psychologist services,”.

10 (c) EFFECTIVE DATES.—The amendments made by
11 subsections (a) and (b) shall apply to services furnished
12 on or after January 1, 2010.

13 **SEC. 4. ESTABLISHMENT OF A MEDICARE PROSPECTIVE**
14 **PAYMENT SYSTEM FOR FEDERALLY QUALI-**
15 **FIED HEALTH CENTER SERVICES.**

16 (a) IN GENERAL.—Paragraph (3) section 1833(a) of
17 the Social Security Act (42 U.S.C. 1395l(a)) is amended
18 to read as follows:

19 “(3)(A) in the case of services described in sec-
20 tion 1832(a)(2)(D)(i) the costs which are reasonable
21 and related to the furnishing of such services or
22 which are based on such other tests of reasonable-
23 ness as the Secretary may prescribe in regulations
24 including those authorized under section
25 1861(v)(1)(A), less the amount a provider may

1 charge as described in clause (ii) of section
2 1866(a)(2)(A) but in no case may the payment for
3 such services (other than for items and services de-
4 scribed in 1861(s)(10)(A)) exceed 80 percent of such
5 costs; and

6 “(B) in the case of services described in section
7 1832(a)(2)(D)(ii) furnished by a Federally qualified
8 health center—

9 “(i) subject to clauses (iii) and (iv), for
10 services furnished on and after January 1,
11 2010, during the center’s fiscal year that ends
12 in 2010, an amount (calculated on a per visit
13 basis) that is equal to 100 percent of the aver-
14 age of the costs of the center of furnishing such
15 services during such center’s fiscal years ending
16 during 2008 and 2009 which are reasonable
17 and related to the cost of furnishing such serv-
18 ices, or which are based on such other tests of
19 reasonableness as the Secretary prescribes in
20 regulations including those authorized under
21 section 1861(v)(1)(A) (except that in calcu-
22 lating such cost in a center’s fiscal years ending
23 during 2008 and 2009 and applying the aver-
24 age of such cost for a center’s fiscal year end-
25 ing during fiscal year 2010, the Secretary shall

1 not apply a per visit payment limit or produc-
2 tivity screen), less the amount a provider may
3 charge as described in clause (ii) of section
4 1866(a)(2)(A), but in no case may the payment
5 for such services (other than for items or serv-
6 ices described in section 1861(s)(10)(A)) exceed
7 80 percent of such average of such costs;

8 “(ii) subject to clauses (iii) and (iv), for
9 services furnished during the center’s fiscal
10 year ending during 2011 or a succeeding fiscal
11 year, an amount (calculated on a per visit basis
12 and without the application of a per visit limit
13 or productivity screen) that is equal to the
14 amount determined under this subparagraph
15 for the center’s preceding fiscal year (without
16 regard to any copayment)—

17 “(I) increased for a center’s fiscal
18 year ending during 2011 by the percentage
19 increase in the MEI (as defined in section
20 1842(i)(3)) applicable to primary care
21 services (as defined in section 1842(i)(4))
22 for 2011 and increased for a center’s fiscal
23 year ending during 2012 or any succeeding
24 fiscal year by the percentage increase for
25 such year of a market basket of Federally

1 qualified health center costs as developed
2 and promulgated through regulations by
3 the Secretary; and

4 “(II) adjusted to take into account
5 any increase or decrease in the scope of
6 services, including a change in the type, in-
7 tensity, duration, or amount of services,
8 furnished by the center during the center’s
9 fiscal year,

10 less the amount a provider may charge as de-
11 scribed in clause (ii) of section 1866(a)(2)(A),
12 but in no case may the payment for such serv-
13 ices (other than for items or services described
14 in section 1861(s)(10)(A)) exceed 80 percent of
15 the amount determined under this clause (with-
16 out regard to any copayment);

17 “(iii) subject to clause (iv), in the case of
18 an entity that first qualifies as a Federally
19 qualified health center in a center’s fiscal year
20 ending after 2009—

21 “(I) for the first such center fiscal
22 year, an amount (calculated on a per visit
23 basis and without the application of a per
24 visit payment limit or productivity screen)
25 that is equal to 100 percent of the costs of

1 furnishing such services during such center
2 fiscal year based on the per visit payment
3 rates established under clause (i) or (ii) for
4 a comparable period for other such centers
5 located in the same or adjacent areas with
6 a similar caseload or, in the absence of
7 such a center, in accordance with the regu-
8 lations and methodology referred to in
9 clause (i) or based on such other tests of
10 reasonableness (without the application of
11 a per visit payment limit or productivity
12 screen) as the Secretary may specify, less
13 the amount a provider may charge as de-
14 scribed in clause (ii) of section 1866
15 (a)(2)(A), but in no case may the payment
16 for such services (other than for items and
17 services described in section
18 1861(s)(10)(A)) exceed 80 percent of such
19 costs; and

20 “(II) for each succeeding center fiscal
21 year, the amount calculated in accordance
22 with clause (ii); and

23 “(iv) with respect to Federally qualified
24 health center services that are furnished to an
25 individual enrolled with a MA plan under part

1 C pursuant to a written agreement described in
2 section 1853(a)(4) (or, in the case of MA pri-
3 vate fee for service plan, without such written
4 agreement) the amount (if any) by which—

5 “(I) the amount of payment that
6 would have otherwise been provided under
7 clauses (i), (ii), or (iii) (calculated as if
8 ‘100 percent’ were substituted for ‘80 per-
9 cent’ in such clauses) for such services if
10 the individual had not been enrolled; ex-
11 ceeds

12 “(II) the amount of the payments re-
13 ceived under such written agreement (or,
14 in the case of MA private fee for service
15 plans, without such written agreement) for
16 such services (not including any financial
17 incentives provided for in such agreement
18 such as risk pool payments, bonuses, or
19 withholds) less the amount the Federally
20 qualified health center may charge as de-
21 scribed in section 1857(e)(3)(B);”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 subsection (a) shall apply to services furnished on or after
24 January 1, 2010.

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