110TH CONGRESS
1ST SESSION

S. 2188

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 SENATE OF THE UNITED STATES

OCTOBER 17, 2007

Mr. BINGAMAN (for himself, Ms. SNOWE, Mr. SALAZAR, Mr. SMITH, Mr. AKAKA, and Mr. SANDERS) introduced the following bill; which was read twice and referred to the Committee on Finance

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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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Access to Community Health Centers (MATCH) Act of 2007''.

SEC. 2. FINDINGS.

Congress finds that:

(1) NATIONAL IMPORTANCE.—Community health centers serve as the medical home and family physician to over 16,000,000 people nationally. Patients of community health centers represent 1 in 7 low-income persons, 1 in 8 uninsured Americans, 1 in 9 Medicaid beneficiaries, 1 in 10 minorities, and 1 in 10 rural residents.

(2) HEALTH CARE SAFETY NET.—Because Federally qualified health centers (FQHCs) are generally located in medically underserved areas, the patients of Federally qualified health centers are disproportionately low income, uninsured or publicly insured, and minorities, and they frequently have poorer health and more complicated, costly medical needs than patients nationally. As a chief component of the health care safety net, Federally qualified health centers are required by regulation to serve all patients, regardless of insurance status or ability to pay.

(3) MEDICARE BENEFICIARIES.—Medicare beneficiaries are typically less healthy and, therefore,

costlier to treat than other patients of Federally qualified health centers. Medicare beneficiaries tend to have more complex health care needs as—

(A) more than half of Medicare patients have at least 2 chronic conditions;

(B) 45 percent take 5 or more medications; and

(C) over half of Medicare beneficiaries have more than 1 prescribing physician.

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

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

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

''(3) The term 'Federally qualified health center services' means—

''(A) services of the type described in subparagraphs (A) through (C) of paragraph (1), and such other ambulatory services furnished by a Federally qualified health center for which payment may otherwise be made under this title if such services were furnished by a health care provider or health care professional other than a Federally qualified health center; and

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

when furnished to an individual as a patient of a Federally qualified health center and such services when provided by a health care provider or health care professional employed by or under contract with a Federally qualified health center and for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively. Services described in the previous sentence shall be treated as billable visits for purposes of payment to the Federally qualified health center.''.

(b) CONFORMING AMENDMENT TO PERMIT PAYMENT FOR HOSPITAL-BASED SERVICES.—Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is

amended by inserting ''Federally qualified health center services,'' after ''qualified psychologist services,''.

(c) EFFECTIVE DATES.—The amendments made by subsections (a) and (b) shall apply to services furnished on or after January 1, 2008.

SEC. 4. ESTABLISHMENT OF A MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.

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

''(3)(A) in the case of services described in section 1832(a)(2)(D)(i) the costs which are reasonable and related to the furnishing of such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A) but in no case may the payment for such services (other than for items and services described in 1861(s)(10)(A)) exceed 80 percent of such costs; and

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

''(i) subject to clauses (iii) and (iv), for services furnished on and after January 1, 2008, during the center's fiscal year that ends in 2008, an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center of furnishing such services during such center's fiscal years ending during 2006 and 2007 which are reasonable and related to the cost of furnishing such services, or which are based on such other tests of reasonableness as the Secretary prescribes in regulations including those authorized under section 1861(v)(1)(A) (except that in calculating such cost in a center's fiscal years ending during 2006 and 2007 and applying the average of such cost for a center's fiscal year ending during fiscal year 2008, the Secretary shall not apply a per visit payment limit or productivity screen), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items or serv-

ices described in section 1861(s)(10)(A)) exceed 80 percent of such average of such costs;

''(ii) subject to clauses (iii) and (iv), for services furnished during the center's fiscal year ending during 2009 or a succeeding fiscal year, an amount (calculated on a per visit basis and without the application of a per visit limit or productivity screen) that is equal to the amount determined under this subparagraph for the center's preceding fiscal year (without regard to any copayment)—

''(I) increased for a center's fiscal year ending during 2009 by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for 2009 and increased for a center's fiscal year ending during 2010 or any succeeding fiscal year by the percentage increase for such year of a market basket of Federally qualified health center costs as developed and promulgated through regulations by the Secretary; and

''(II) adjusted to take into account any increase or decrease in the scope of

services, including a change in the type, intensity, duration, or amount of services, furnished by the center during the center's fiscal year,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items or services described in section 1861(s)(10)(A)) exceed 80 percent of the amount determined under this clause (without regard to any copayment);

''(iii) subject to clause (iv), in the case of an entity that first qualifies as a Federally qualified health center in a center's fiscal year ending after 2007—

''(I) for the first such center fiscal year, an amount (calculated on a per visit basis and without the application of a per visit payment limit or productivity screen) that is equal to 100 percent of the costs of furnishing such services during such center fiscal year based on the per visit payment rates established under clause (i) or (ii) for a comparable period for other such centers located in the same or adjacent areas with

a similar caseload or, in the absence of such a center, in accordance with the regulations and methodology referred to in clause (i) or based on such other tests of reasonableness (without the application of a per visit payment limit or productivity screen) as the Secretary may specify, less the amount a provider may charge as described in clause (ii) of section 1866 (a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; and

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

''(iv) with respect to Federally qualified health center services that are furnished to an individual enrolled with a MA plan under part C pursuant to a written agreement described in section 1853(a)(4) (or, in the case of MA private fee for service plan, without such written agreement) the amount (if any) by which—

"(I) the amount of payment that would have otherwise been provided under clauses (i), (ii), or (iii) (calculated as if '100 percent' were substituted for '80 percent' in such clauses) for such services if the individual had not been enrolled; exceeds

"(II) the amount of the payments received under such written agreement (or, in the case of MA private fee for service plans, without such written agreement) for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds) less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(B);".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2008.

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