

110TH CONGRESS  
1ST SESSION

# H. R. 2897

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.

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 28, 2007

Mr. LEWIS of Georgia (for himself, Mr. WELLER of Illinois, Mr. BISHOP of Georgia, Mrs. EMERSON, Ms. JACKSON-LEE of Texas, Mr. McDERMOTT, Mr. McNULTY, and Mr. HINOJOSA) 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

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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.

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 2007”.

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 Medi-  
14    caid 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 patients, regardless of insurance status or ability to  
2 pay.

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

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

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

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, 2008.

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 2008, during the center’s fiscal year that ends  
12 in 2008, 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 2006 and 2007 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 2006 and 2007 and applying the aver-  
24 age of such cost for a center’s fiscal year end-  
25 ing during fiscal year 2008, 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 2009 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 2009 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 2009 and increased for a center’s fiscal  
23 year ending during 2010 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

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 2007—

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

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 withhold) 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, 2008.

