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Washington, DC 20548

July 30, 2010

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United States Senate

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The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Sander M. Levin
Chairman
The Honorable Dave Camp
Ranking Member
Committee on Ways and Means
House of Representatives

Subject: *Medicare Payments to Federally Qualified Health Centers*

To increase access to primary and preventive care services for individuals living in medically underserved communities, Congress authorized federally qualified health centers (FQHC) as a health care facility type and established requirements for Medicare coverage and payment as FQHCs under the Omnibus Budget Reconciliation Act (OBRA) of 1990.[1] FQHCs are typically rural and urban safety net providers that provide primary and preventive care services to individuals regardless of their ability to pay. In general, a health center may qualify as a FQHC if it receives a federal grant under Section 330 of the Public Health Service Act; meets the requirements to receive such a grant; or is an outpatient health program/facility operated by certain tribal or urban Indian organizations.[2] Currently, Medicare reimburses FQHCs for these services with an all-inclusive payment rate—resulting

[1]Medicare is the federal health insurance program for people over age 65, individuals under age 65 with certain disabilities, and individuals diagnosed with end-stage renal disease. Prior to the enactment of OBRA 1990, Medicare paid community health centers for services normally covered under Medicare Part B, which covers physician and other outpatient services on the basis of the lesser of costs or charges.

[2]Section 330 grants are administered by the Department of Health and Human Services' Health Resources and Services Administration (HRSA) and provide funding for programs that support primary health care services to medically underserved populations.

in a payment per visit for all covered services provided during the visit—with certain limits to ensure FQHCs' costs are reasonable for the provision of services. These limits include productivity guidelines and upper payment limits. Productivity guidelines encourage FQHCs to achieve a minimum number of visits each year for certain medical professionals employed by the centers; upper payment limits are a cap on the per visit amount FQHCs are paid by Medicare, updated annually by the Medicare Economic Index (MEI).[3]

The recently enacted health reform legislation requires changes in the way Medicare pays FQHCs. The Patient Protection and Affordable Care Act (PPACA) requires the Secretary of Health and Human Services (HHS) to establish a prospective payment system (PPS) for Medicare payments to FQHCs, which, in effect, will eliminate the Medicare FQHC all-inclusive payment rate, upper payment limits, and productivity guidelines currently in effect and described in this report.[4] Under the new PPS, FQHC payment rates will be based on their estimated reasonable costs for each covered service. Beginning on or after October 1, 2014, the estimated aggregate amount of Medicare FQHC prospective payment rates is to be set at 100 percent of the estimated amount of reasonable costs that would have occurred if the PPS had not been implemented, without the application of the upper payment limit or productivity guidelines. In the first year after implementation, the amount of payment increases is to be determined by the MEI; in subsequent years, the amount of payment increases is to be determined by the MEI or by changes in the costs for a market basket of FQHC goods and services. The PPS is required to include a process for appropriately describing the services furnished by FQHCs and establish payment rates for specific payment codes based on such descriptions of services. In addition, the PPS is required to take into account the type, intensity, and duration of services furnished by FQHCs and may include adjustments—such as geographical adjustments—determined appropriate by the Secretary. PPACA further provides that by January 1, 2011, the Secretary is to require FQHCs to submit information determined necessary to develop and implement the PPS, including Healthcare Common Procedure Coding System (HCPCS) codes.[5] PPACA also expanded the definition of Medicare-covered preventive services provided at FQHCs.

Prior to enactment of PPACA, members of Congress expressed concerns that the Medicare FQHC upper payment limits do not adequately cover the costs of services provided to Medicare beneficiaries. Members of Congress stated in letters to the Secretary of HHS that Congress intended health centers to be paid at a rate that covers the cost of providing services to ensure that health centers do not subsidize Medicare payments with other federal grant dollars. Prompted by letters from Congress, HHS directed the Health Resources and Services Administration (HRSA) and CMS to work together to review the adequacy of these rates. HRSA, in consultation with CMS, hired a consulting firm to analyze the Medicare FQHC upper payment limits. Results from the unpublished report found that 70 percent of FQHCs had costs per visit that exceeded the upper payment limit in 2004, with FQHCs' aggregate

[3]The MEI is a medical inflation index designed to estimate the increase in the total costs for the average physician to operate a medical practice.

[4]Pub. L. No. 111-148, §10501(i), 124 Stat. 119, 997-99 (2010).The Centers for Medicare & Medicaid Services (CMS)—the agency within HHS that administers the Medicare and Medicaid programs—defines a PPS as a method of reimbursement in which payment is made on a predetermined, fixed amount. Congress has established separate prospective payment systems for a variety of facilities, including Medicaid payments to FQHCs. Medicaid is a federal-state program that finances health insurance for certain low-income adults and children.

[5]Healthcare Common Procedure Coding System (HCPCS) is a standard coding system developed to ensure that health care claims are processed in an orderly and consistent manner by Medicare and other health insurance programs.

costs exceeding the maximum Medicare reimbursement under the upper payment limits every year from 1997 to 2004.

The Medicare Improvements for Patients and Providers Act of 2008 required GAO to examine the payment structure that Medicare used to pay FQHCs for services provided to Medicare beneficiaries and to take into consideration the prospective payment methodology used by Medicaid to make payments to FQHCs.[6] This correspondence examines the relationship between Medicare payments and the costs submitted by FQHCs for services provided to Medicare beneficiaries and provides information on how CMS established the Medicare FQHC payment structure. In this correspondence we also describe the preventive services added to or expanded within Medicare since the upper payment methodology was implemented in 1992 (see encl. I) and the key features of the Medicaid PPS (see encl. II). We did not examine the PPACA prospective payment system or the impact it will have on FQHCs.

To determine the extent to which Medicare payments to FQHCs have covered the costs of services furnished to Medicare beneficiaries, we obtained Medicare FQHC cost report data for FQHCs in 44 states, 2 territories, and the District of Columbia from the Medicare fiscal intermediary (FI) responsible for collecting FQHC cost reports from most states in 2007. We obtained the most recent final cost reports submitted in calendar year 2007, reviewed by the Medicare FI, and settled in coordination with the FQHCs.[7] FQHCs identify themselves as either rural or urban on the submitted cost reports and may submit a consolidated cost report if they have multiple clinic locations.[8] For simplicity, we counted each cost report as one FQHC with its population status as rural, urban, or mixed for FQHCs submitting consolidated cost reports with both urban and rural clinics. We included in our analysis cost reports for FQHCs reporting at least 200 Medicare visits, for a total of 922 FQHCs. We analyzed the costs per visit reported by FQHCs, determined the amount of FQHCs' Medicare costs if the upper payment limits had not been applied, and compared the results to FQHCs' Medicare costs with payment limits applied. We examined the difference in FQHCs' Medicare costs when using FQHCs' actual number of visits and when using the minimum number of visits required by the productivity guidelines. CMS officials told us that the agency generally does not audit FQHC cost reports. To determine the reliability of the FQHC cost reports for our purposes, we therefore interviewed the Medicare FI about the policies and procedures for collecting and processing FQHC cost reports and reviewed documentation detailing the FI's Medicare FQHC cost report review procedures and electronic cost report data checks. We examined the reliability of the 2007 Medicare FQHC cost report data used in this report by performing appropriate electronic data checks and checks for obvious errors, such as missing values and values outside of expected ranges. We determined that the FQHC cost report data were sufficiently reliable for purposes of our analysis. We also interviewed officials from CMS and from 3 FQHCs about Medicare payments to FQHCs.

[6]Pub. L. No. 110-275, §151, 122 Stat. 2494, 2550-51.

[7]FQHCs may submit cost reports for any 12-month reporting period; therefore, cost reports submitted in 2007 may include costs and visits from 2006 and 2007.

[8]If a FQHC or a FQHC with multiple sites is located within a metropolitan area, then the urban upper payment limit applies. If a FQHC is not located within a metropolitan area, then the rural upper payment limit applies. If a FQHC has mixed urban-rural sites, the FI applies a weighted upper payment limit based on the percentage of urban and rural visits as the percentage of total site visits.

We conducted our work from May 2009 through July 2010 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objective. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objective and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions in this product.

Results in Brief

Based on GAO analysis of Medicare cost reports submitted by FQHCs in 2007, Medicare payments to most FQHCs were less than FQHCs' submitted costs of services. About 72 percent of FQHCs had costs per visit that exceeded the upper payment limits. However, FQHCs varied greatly in their costs per visit, with FQHCs with the highest costs per visit having relatively fewer Medicare visits than FQHCs with the lowest costs per visit. The application of productivity guidelines reduced Medicare payments to 7 percent of FQHCs, which did not meet the minimum number of visits required by the productivity guidelines and had costs per visit that did not exceed the upper payment limits. Overall, application of the upper payment limits and productivity guidelines reduced FQHCs' submitted costs of services by about $72.8 million from about $504 million to about $431 million—about 14 percent—in 2007. Since Medicare pays 80 percent of the FQHCs' costs (beneficiary coinsurance is 20 percent), the application of these limits reduced Medicare FQHC payments by $58.2 million.

We obtained written comments on a draft of this report from HHS. In its comments, HHS stated that the report provides helpful general background information on the Medicare FQHC program. HHS also raised concerns about the findings of the report because the Medicare cost report data that we analyzed have not been subject to a "comprehensive, full-scope" audit. Because CMS officials previously told us that the agency has not audited the cost reports, we took a number of steps to examine the reliability of the data, and we determined the Medicare FQHC cost report data to be reliable for the purposes of our analysis.

Background

Medicare represented a small proportion of FQHCs' total revenue and patient population in 2007, while Medicaid represented a relatively larger proportion of both. When CMS established the Medicare FQHC payment structure in 1992, the agency modeled it on the rural health clinic (RHC) payment structure, incorporating productivity guidelines and upper payment limits to pay FQHCs an all-inclusive payment rate for services provided to Medicare beneficiaries. Medicare FQHC-covered services include both primary and preventive services furnished by certain physician or nonphysician providers; 13 preventive services have been added to Medicare Part B or expanded, and therefore to FQHC services, since the payment structure was established in 1992.

FQHCs' Insurance and Revenue Sources

In 2008, there were 1,080 Section 330 grantees that served over 17 million patients; 8 percent of these patients were Medicare beneficiaries and 36 percent were Medicaid beneficiaries.[9] (See table 1.) HRSA officials reported a 72 percent increase in the Medicare beneficiary

[9]The 2008 Uniform Data System data reported by HRSA include only FQHCs that receive Section 330 grants.

population at these FQHCs from 2001 to 2008 (from 745,000 beneficiaries to almost 1.3 million beneficiaries). FQHCs depend on a variety of revenue sources to provide services to their patient population. In 2008, Medicaid was the largest source of revenue for FQHCs receiving Section 330 grants, accounting for 37 percent of total revenue, while Medicare was a smaller revenue source at 6 percent.

Table 1: FQHC Patient Population by Insurance Source and Revenue Source, 2008

Source	Percent of patients by insurance source	Percent of total FQHC revenue
Medicare	7.5	6.0
Medicaid	35.8	37.1
Other public insurance	2.8	2.8
Private insurance	15.6	7.5
Self-pay	N/A	6.2
Uninsured	38.3	N/A
Federal grants (including Section 330 grants)	N/A	20.4
Nonfederal grants	N/A	13.9
Other revenue	N/A	6.1
Total	**100.0**	**100.0**

Source: 2008 Uniform Data System data reported by HRSA.

Note: The Uniform Data System data reported include only FQHCs that receive Section 330 grants.

Establishment of Medicare FQHC Payment Structure

CMS established the Medicare FQHC payment structure with a final rule with comment in 1992, followed by a final rule in 1996.[10] CMS based Medicare FQHC payments on its RHC payment structure for simplicity and ease of administration and due to existing similarities between FQHCs and RHCs. CMS established an all-inclusive payment rate for Medicare to pay freestanding FQHCs for the primary and preventive services provided to Medicare beneficiaries, subject to productivity screening guidelines and upper payment limits to ensure the reasonableness of FQHCs' costs.[11] CMS adopted productivity screening guidelines used in the RHC program, which require FQHCs to maintain at least 4,200 visits per year per full-time equivalent (FTE) physician; at least 2,100 visits per year per FTE physician assistant or nurse practitioner; or a combination of those thresholds for FQHCs with various combinations of staff. CMS increased the RHC payment limit to reflect the different practitioner mix and utilization of preventive services at FQHCs, and created separate urban and rural FQHC upper payment limits to recognize the potential for higher operating costs for urban FQHCs. CMS uses the MEI as an inflation adjuster to annually increase the Medicare FQHC upper payment limits, adjusting the limits on the first day of the year (and each subsequent year) by the percentage increase in the MEI applicable to primary care physician services. (See table 2 for the urban and rural upper payment limits for recent years.)

[10]The rules implemented provisions of the Omnibus Budget Reconciliation Act of 1990 regarding Medicare coverage and payment for services provided by FQHCs. *See* Medicare Program; Payment for Federally Qualified Health Center Services, 57 *Fed. Reg.* 24,961 (June 12, 1992) and 61 *Fed. Reg.* 14,640 (Apr. 3, 1996).

[11]Freestanding FQHCs are not affiliated with a hospital, skilled nursing facility, or home health agency participating in Medicare.

Table 2: Medicare FQHC Upper Payment Limits, 2006-2010

Calendar year	Urban upper payment limit	Rural upper payment limit
2006	$112.96	$97.13
2007	$115.33	$99.17
2008	$117.41	$100.96
2009	$119.29	$102.58
2010	$125.72	$108.81

Source: CMS.

Notes: The calendar year 2010 FQHC upper payment limit rates reflect a 1.2 percent increase over the 2009 rates, in accordance with the rate of increase in the MEI, plus an additional $5.00 increase mandated by the Medicare Improvements for Patients and Providers Act of 2008. These upper payment limits reflect the total payments to FQHCs; Medicare pays 80 percent and the beneficiary coinsurance is 20 percent.

Medicare FQHC All-inclusive Payment Rate

The Medicare FQHC all-inclusive payment rate generally includes payment for the professional components (e.g., physicians' or nonphysician providers' work) of certain physician or nonphysician services, and services and supplies incident to the services. The technical components (e.g., the actual performance of tests such as x-rays) of these services and other Medicare services not paid under the FQHC benefit (e.g., certain laboratory tests, durable medical equipment, and ambulance services) generally are billed separately to Medicare Part B.[12] The all-inclusive payment rate is equal to the lesser of a FQHC's cost per visit or the upper payment limit.[13] A FQHC's cost per visit is calculated as total allowable costs divided by total number of visits for the FQHC's reporting period. Allowable costs include the costs of Medicare FQHC services and supplies commonly provided during an office visit as well as overhead costs like FQHC administration. A visit is defined as a face-to-face encounter between a patient and a physician and certain nonphysician providers when a FQHC-covered service is provided.[14]

The Medicare FI applies productivity guidelines and upper payment limits to determine a FQHC's all-inclusive payment rate. The FI compares productivity guidelines to the number of visits reported by the FQHC and uses the greater of the FQHC's actual visits or the guidelines' minimum number of visits as the denominator in the calculation of cost per visit. If a FQHC's actual visits do not meet the minimum, the center must use minimum visits as the denominator, which results in a lower reported cost per visit.[15] To determine the all-inclusive payment rate, the FI applies the lesser of the FQHC's cost per visit or the appropriate upper

[12]There are two exceptions: the technical component of fecal occult blood tests as part of colorectal cancer screening and cholesterol tests as part of cardiovascular disease screening are paid under the all-inclusive payment rate.

[13]Medicare pays FQHCs 80 percent of the all-inclusive payment rate for each visit and beneficiary coinsurance is 20 percent. No deductible applies to Medicare beneficiaries seeking services at FQHCs.

[14]In general, FQHCs can only bill for one visit per beneficiary per day, regardless of whether the patient receives multiple services unless the patient suffers an illness or injury requiring additional diagnosis or treatment. FQHCs can bill for a separate medical visit and mental health visit provided to a patient on the same day and for one-on-one diabetes self-management training and medical nutrition therapy visits. Pneumoccoccal and influenza vaccines and their administration are not included in the all-inclusive rate and are paid at 100 percent of reasonable cost.

[15]When calculating cost per visit, a FQHC whose actual visits are lower than the minimum number of visits from the productivity guidelines must use the minimum number of visits as the denominator to calculate an adjusted cost per visit on its cost report. This results in a lower reported adjusted cost per visit than if the FQHC used the actual number of visits.

payment limit. The FI then pays the FQHC 80 percent of the all-inclusive payment rate multiplied by the total number of Medicare visits (beneficiary coinsurance is 20 percent).

Medicare FQHC-Covered Services

The Medicare FQHC services established in 1992 included primary and preventive services furnished by or under the supervision of a physician, nurse practitioner, physician assistant, clinical psychologist, or clinical social worker. In addition to certain RHC services, the Medicare FQHC services included a number of preventive services (e.g., medical social services, physical exams targeted to risk, blood pressure measurements, nutritional assessments and referrals, and preventive health education). Since 1992, Congress has added or extended Medicare coverage to 13 preventive services—such as initial preventive physical exams, pelvic exams, and prostate cancer screenings—some portion of which are paid under the all-inclusive payment rate. (See encl. I for the list of added preventive services.)

Medicare Payments Were Less than the Costs of Services Submitted by Most FQHCs

Medicare payments to most FQHCs were less than the costs of services that FQHCs submitted to CMS in 2007. About 72 percent of FQHCs had costs per visit that exceeded the upper payment limits; application of the upper payment limits reduced FQHCs' submitted costs of services by $71.7 million. Seven percent of the 922 FQHCs had fewer than the number of visits required by the productivity guidelines, and had costs per visit that did not exceed the upper payment limits; application of the productivity guidelines reduced these FQHCs' submitted costs of services by $1.1 million. Overall, application of the upper payment limits and productivity guidelines reduced FQHCs' submitted costs of services by about $72.8 million from about $504 million to about $431 million—about 14 percent—in 2007. Since Medicare pays 80 percent of the FQHCs' costs (beneficiary coinsurance is 20 percent), the application of these limits reduced Medicare FQHC payments by $58.2 million.

The Upper Payment Limits Limited Medicare Payments for Most FQHCs

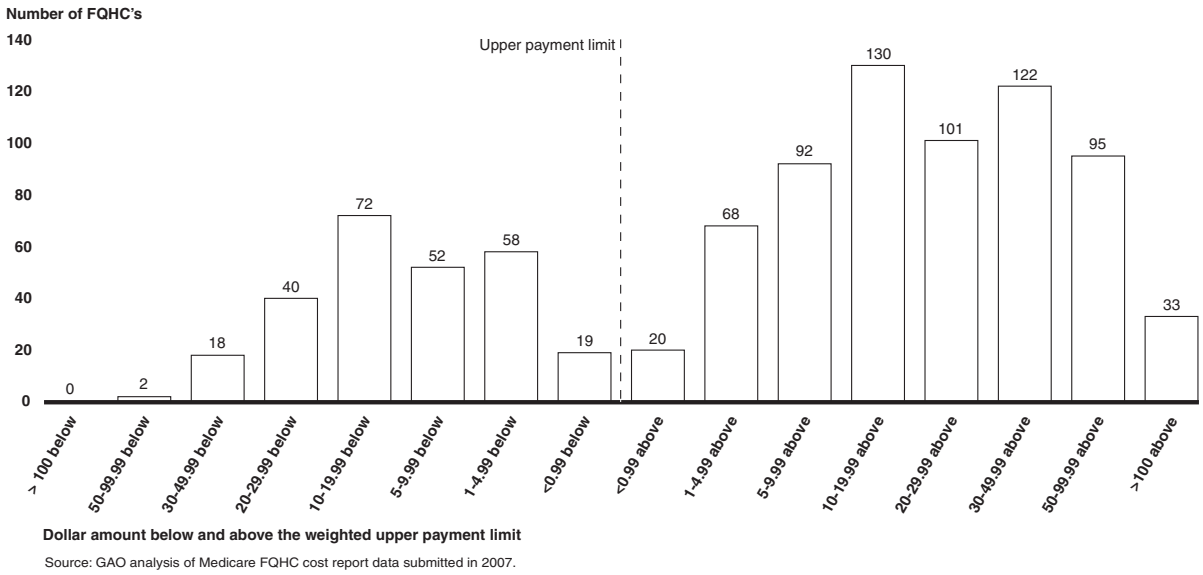
Of the 922 FQHCs used in our analysis, 661 FQHCs (72 percent) had costs per visit that exceeded the upper payment limit in 2007. (See table 3.) Of those 661 FQHCs, more than half had costs per visit that exceeded the upper payment limit by $20 or more. (See fig. 1.) A slightly larger proportion of rural FQHCs (77 percent) had costs per visit that exceeded the upper payment limit, compared to 71 percent of urban FQHCs. The difference between the total Medicare costs as submitted by FQHCs without applying the upper payment limits and FQHCs' total Medicare costs with the upper payment limits applied totaled $71.7 million in aggregate in 2007—on average, a difference of $17 per visit based on 4,155,907 Medicare visits across all FQHCs. Medicare payments based on those costs—given that Medicare pays 80 percent of costs and beneficiary coinsurance is 20 percent—would have been $57.4 million more if FQHCs were paid their cost per visit based on their submitted costs of services instead of the upper payment limit.

Table 3: Upper Payment Limits—FQHCs with Costs Exceeding the Upper Payment Limit, 2007

FQHC status	Percentage of FQHCs that exceeded the upper payment limits	Difference between total Medicare costs applying upper payment limits and total Medicare costs not applying upper payment limits
Mixed rural-urban	58	-$8,379,925
Rural	77	-$19,102,474
Urban	71	-$44,237,135
All	**72**	**-$71,719,534**

Source: GAO analysis of Medicare FQHC cost report data submitted in 2007.

Figure 1: FQHC Distribution of the Difference between Cost per Visit and Upper Payment Limit, 2007



Source: GAO analysis of Medicare FQHC cost report data submitted in 2007.

There was notable variation in costs across FQHCs. More than two-thirds of Medicare visits to FQHCs had costs per visit exceeding the upper payment limit; almost half of Medicare visits had costs per visit that were more than $10 higher than the upper payment limit. Further, some FQHCs with the highest costs per visit had relatively fewer Medicare visits. Conversely, some FQHCs with the lowest costs per visit were well under the payment limit, but reported thousands of Medicare visits. For example, the five FQHCs with the highest costs per visit together reported fewer than 2,900 Medicare visits in 2007, while the five FQHCs with the lowest costs per visit together reported more than 8,700 Medicare visits.

CMS's Productivity Guidelines Lowered Medicare Payments to Some FQHCs in 2007

Applying CMS's productivity guidelines to FQHCs' number of visits resulted in lower costs per visit for purposes of determining Medicare payment for some FQHCs in 2007. Of the 922 FQHCs used in our analysis, 38 percent had fewer visits than the minimum number of visits required by CMS's productivity guidelines. These FQHCs were required to use the minimum number of visits as the denominator in their calculations of costs per visit on their cost report, which resulted in lower reported costs per visit.

Seven percent of the 922 FQHCs had fewer than the number of visits required by the productivity guidelines and also had costs per visit that did not exceed the upper payment limits. As a result, the difference between FQHCs' total Medicare costs based on cost per visit without applying the productivity guidelines and FQHCs' total Medicare costs applying the productivity guidelines was $1.1 million in 2007. (See table 4.) Payments based on those costs would have been $861,965 more than FQHCs were actually paid (Medicare pays 80 percent of costs and beneficiary coinsurance is 20 percent).

Thirty-one percent of the 922 FQHCs did not meet the minimum number of visits required by the productivity guidelines and had costs per visit that exceeded the upper payment limit with productivity guidelines applied. Therefore, the productivity guidelines did not affect the Medicare payments for these FQHCs.

Table 4: Productivity Guidelines—FQHCs That Did Not Meet the Productivity Guidelines' Minimum Number of Visits, 2007

Status	Percentage of FQHCs that did not meet the productivity guidelines' minimum number of visits	Percentage of FQHCs that did not meet the productivity guidelines' minimum number of visits and had costs per visit that did not exceed the upper payment limits	Difference between total Medicare costs using the minimum number of visits required by productivity guidelines (with productivity guidelines applied) and total Medicare costs based on actual number of visits (not applying productivity guidelines)
Mixed rural-urban	27	7	-$165,423
Rural	33	5	-$154,093
Urban	42	7	-$757,940
All	**38**	**7**	**-$1,077,456**

Source: GAO analysis of Medicare FQHC cost report data submitted in 2007.

FQHCs' Total Medicare Costs Without Limits Exceeded Total Medicare Costs with Limits by 17 percent in 2007

Medicare costs of services submitted by FQHCs before applying the productivity guidelines and upper payment limits totaled about $504 million; application of the productivity guidelines and upper payment limits reduced FQHCs' total Medicare costs by $72.8 million to about $431 million. Overall, total Medicare costs submitted by FQHCs without applying the upper payment limits and productivity guidelines were 117 percent of FQHCs' costs subject to these limits. Since Medicare pays 80 percent of the FQHCs' costs (beneficiary coinsurance is 20 percent), the application of the upper payment limits and productivity guidelines reduced Medicare FQHC payments by $58.2 million.

Agency Comments and Our Evaluation

We obtained written comments on a draft of this report from HHS. In its comments, HHS stated that the report provides helpful general background information on the Medicare FQHC program and the establishment of the Medicare FQHC upper payment limits. HHS commented that it would take elements of the report into consideration in developing the prospective payment system for FQHCs that PPACA requires.

HHS also raised concerns about the findings of the report because the Medicare cost report data that we analyzed have not been subject to a "comprehensive, full-scope" audit. Because CMS officials previously told us that the agency has not audited the cost reports, we took a

number of steps to examine the reliability of the data, including an interview with representatives from Medicare FI responsible for compiling and maintaining FQHC cost report data to understand the data quality and verification they do on behalf of CMS. The information conveyed during this interview in conjunction with our electronic testing of the data were the basis of our determination that the FQHC cost report data were sufficiently reliable for the purposes of our analysis, as noted earlier in this correspondence. Nonetheless, for the prospective payment system scheduled to take effect October 1, 2014, the estimated aggregate amount of Medicare FQHC prospective payment rates is to be set at 100 percent of the estimated amount of reasonable costs that would have occurred if the PPS had not been implemented, without the application of the upper payment limit or productivity guidelines. As such, HHS may need to address its concerns about the historical FQHC cost report data if the department uses these data to estimate the amount of FQHCs' reasonable costs for the prospective payment system.

HHS also provided technical comments, which we incorporated where appropriate. HHS's comments are provided in enclosure III.

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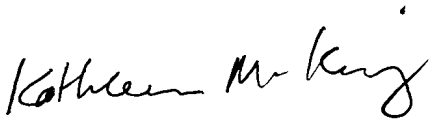
We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in enclosure IV.



Kathleen M. King
Director, Health Care

Enclosures – 4

Enclosure I

Preventive Services Added to Medicare or Expanded Since 1992 That Are Paid Under the Medicare FQHC All-inclusive Rate

Since the Medicare federally qualified health center (FQHC) payment structure was created in 1992, Congress has added or extended Medicare coverage to 13 preventive services—such as initial preventive physical exams, pelvic exams, and prostate cancer screenings—some portion of which are paid under the all-inclusive payment rate.[1] Two of these preventive services, diabetes self-management training and medical nutrition therapy for persons with renal disease or diabetes, were added as separately billable services under the Medicare FQHC all-inclusive payment rate.[2] For the remaining 11 preventive services added since 1992, FQHCs are paid under the all-inclusive payment rate for providing these services to Medicare beneficiaries.[3]

[1]Congress also added Medicare coverage for diabetes screening tests after the Medicare FQHC payment methodology was established in 1992; however, we did not include diabetes screening tests in this table because according to Centers for Medicare & Medicaid Services (CMS) officials, these are laboratory services, which are covered under Medicare Part B and are not paid under the Medicare FQHC all-inclusive rate. Telehealth services were also added to Medicare after 1992, but they are not a FQHC-covered service and are paid under Medicare Part B.

[2]FQHCs that provide one-on-one diabetes self-management training or medical nutrition therapy visits are eligible to bill for these services as separately billable visits if provided to a beneficiary on the same day as another medical or mental health visit; group sessions are not counted as separate visits and are included in the all-inclusive rate.

[3]Technical components—including laboratory tests—of these services are generally not paid under the all-inclusive payment rate, but are billed separately under Medicare Part B. There are two exceptions: the technical components of fecal occult blood tests (a component of colorectal cancer screening tests) and cholesterol tests (a component of cardiovascular disease screening tests) are paid under the Medicare FQHC all-inclusive payment rate.

Table 5: Preventive Services Added to Medicare or Expanded Since 1992 That Are Paid Under the Medicare FQHC All-inclusive Rate

Legislation	Medicare added services and revisions[a]
Balanced Budget Act of 1997 (Pub. L. No. 105-33, §§4101-4106, 111 Stat. 251, 360-68.)	Expansion of annual screening mammography coverage for women over the age of 39, regardless of risk
	Expansion of screening pap smears for high-risk individuals to annual screening[b]
	Screening pelvic exams[b]
	Prostate cancer screening
	Colorectal cancer screening for beneficiaries age 50 and over[c]
	Diabetes self-management training[d]
	Bone mass measurements for certain at-risk individuals
Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. No. 106-554, App. F, §§101-02, 105, 114 Stat. 2763A-463, 467-68, 471-72.)	Annual glaucoma screening coverage for high-risk individuals
	Medical nutrition therapy for persons with renal disease or diabetes[d]
	Initial preventive physical exams including referrals for other preventive services covered by Medicare
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. No. 108-173, §§ 611-12, 117 Stat. 2066, 2303-05.)	Cardiovascular screening blood tests[e]
	Tobacco cessation counseling services
N/A (National Coverage Determination- 2005)	Ultrasound screening for abdominal aortic aneurysms for persons at risk, if referred as part of an initial preventive physical examination
Deficit Reduction Act of 2005 (Pub. L. No. 109-171, §5112, 120 Stat. 4, 43-44 (2006.))	

Source: GAO analysis of legislation, Centers for Medicare & Medicaid Services guidance, and Health Resources and Services Administration documentation.

Table note: The professional components of these services are paid under the all-inclusive payment rate and the technical components are billed separately under Medicare Part B, with some exceptions (e.g., cardiovascular screening blood tests are laboratory tests and do not have professional or technical components).

[a]Some Medicare services—such as the clarification of the scope of nurse midwife services—were originally covered under the Medicare FQHC benefit established in 1992. Diabetes screening tests and telehealth services were also added to Medicare; we did not include these services since they are not paid under the Medicare FQHC all-inclusive rate, but are billed to Medicare Part B.

[b]Prior to the Balanced Budget Act of 1997, pap smears were covered once every 3 years or a shorter period for high-risk individuals as specified by the Department of Health and Human Services. Screening pap smear and screening pelvic exam coverage was expanded to biennial screening pap smears and biennial screening pelvic exams under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

[c]Colorectal cancer screening coverage was extended to average risk individuals under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. Fecal occult blood tests, a component of colorectal cancer screening, were included among the list of preventive primary services paid under the Medicare FQHC all-inclusive payment rate in 1992.

[d]Diabetes self-management training and medical nutrition therapy for persons with diabetes and renal disease were subsequently added as separately billable services under the Medicare FQHC benefit after the Deficit Reduction Act of 2005. FQHCs are eligible to separately bill these services under the all-inclusive payment rate if provided one-on-one to a beneficiary.

[e]Cholesterol tests, a component of cardiovascular screening, were included among the list of preventive primary services paid under the Medicare FQHC all-inclusive payment rate in 1992.

Enclosure II

Key Features of the Medicaid Prospective Payment System

Under the Medicaid federally qualified health center (FQHC) prospective payment system, each FQHC has a specific payment rate based on its own costs. The initial per visit base Medicaid payment rate was based on the average of 2 years of a FQHC's reasonable cost per visit from its fiscal year 1999 and fiscal year 2000 cost report data. In subsequent years, an inflation factor—the Medicare Economic Index (MEI)—was applied to each FQHC's initial base payment rate to account for the increase applied to fees for physician services. Finally, the Medicaid FQHC prospective payment system methodology requires states to adjust the payment rate to take into account any increase or decrease in the scope of services furnished by the health center.

States may choose to use the Medicaid FQHC prospective payment system or choose to construct an alternate payment methodology to reimburse some or all FQHCs if the alternate methodology would result in payments no lower than the prospective payment system payment rate, and if the FQHC agrees to it. In a June 2005 report, GAO reviewed states' implementation of the new Medicaid FQHC payment structure and found that about half of states used the Medicaid FQHC prospective payment system exclusively in 2004; other states used an alternate payment methodology such as cost-based reimbursement.[1] GAO also found that the MEI may not be an appropriate inflation index because it may increase at a slower rate than FQHCs' costs and does not adequately reflect FQHC services. GAO recommended that the Centers for Medicare & Medicaid Services explore the development of an alternative inflation index that better captures FQHCs' costs of services.

[1]See GAO, *Health Centers and Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System*, GAO-05-452 (Washington, D.C.: June 17, 2005).

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUN 25 2010

Kathleen King, Director
Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft correspondence entitled: "Medicare Payments to Federally Qualified Health Centers" (GAO-10-576R).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

Andrea Palm
Acting Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) TO THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT CORRESPONDENCE ENTITLED, "MEDICARE PAYMENTS TO FEDERALLY QUALIFIED HEALTH CENTERS" (GAO-10-576R)

The Department appreciates the opportunity to review and comment on this draft correspondence. Federally Qualified Health Centers (FQHCs) play a vital role in the nation's health care system safety net. We appreciate the GAO's effort in its analysis of Medicare FQHC cost report data. We believe this report provides helpful general background information on the Medicare FQHC program and in particular, a useful informational history regarding establishment of the Medicare FQHC upper payment limits.

We understand that the rationale for this analysis has to some extent been superseded by the requirement in Section 10501 of the Affordable Care Act (ACA) for the Department of Health and Human Services (DHHS) to develop a prospective payment system (PPS) for FQHCs.

Nevertheless, we appreciate the presentation of one possible framework for analysis of Medicare FQHCs and the present payment system in general. While realizing that the focus of this report was an analysis of Medicare FQHC costs, we note the existence of a number of alternative analyses to evaluate Medicare FQHCs and the present payment system. These include comparison of Medicare FQHC payment limits to the Medicare Rural Health Clinic payment limit, comparisons with Medicare fee-for-service payments under the Medicare physician fee schedule, analysis of the growth of Medicare FQHCs, and comparison of Medicare payment to Medicaid payments. We believe that interested parties should explore a wide range of analyses when evaluating the adequacy of the current Medicare FQHC payment system.

While we note that GAO performed a number of data checks on the Medicare FQHC cost report data used in its analysis, *the data are not derived from comprehensive, full-scope, audited Medicare FQHC cost reports.* Accordingly, we are concerned about the findings and conclusions presented in this report.

We note that the existence of the Medicare FQHC upper payment limits reduces the need for detailed audit of FQHC cost data. Reliance upon the FQHC upper payment limits achieves efficiencies in the administration of the Medicare program while maintaining adherence to statutory requirements. We urge caution on the use and evaluation of Medicare FQHC cost data that has not been fully audited.

We appreciate the fact that any review of the Medicare FQHC program, and the upper payment limits in particular, presents difficult and decidedly challenging work in a highly complex area.

We thank the GAO for its hard work on this report and will carefully consider elements of the approach in the development of the PPS for Medicare FQHCs as required by the ACA.

Enclosure IV

GAO Contact and Staff Acknowledgments

GAO Contact

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Acknowledgments

In addition to the contact named above, Martin T. Gahart, Assistant Director; Seta Hovagimian; Drew Long; Ann Tynan; and Jennifer Whitworth made key contributions to this report.

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