

## Overview of the Medicare FQHC PPS Proposed Rule

### Background

The Affordable Care Act added Section 1834(o) of the Social Security Act (the "Act") to establish a new system of payment for the costs of federally qualified health center ("FQHC") services under Medicare Part B based on prospectively set rates, effective October 1, 2014. This proposed rule creates a methodology and payment rates for the new FQHC PPS. Separate from its FQHC provisions, the proposed rule would also establish a policy allowing rural health clinics ("RHCs") to contract with non-physician practitioners when certain conditions are met. Finally, the proposed rule would make changes to the Clinical Laboratory Improvement Amendments ("CLIA") regulations regarding enforcement actions for proficiency testing referral.

It is estimated that the methodology in the proposed rule will provide health centers with an approximate 30 percent increase in Medicare payments.

Please note that this is only a summary of the proposed rule and NACHC will be preparing comments on the rule and encouraging health centers and PCAs to do the same. Comments are due November 18, 2013 and can be submitted at [www.regulations.gov](http://www.regulations.gov). Please contact [Susan Sumrell](#) or [Roger Schwartz](#) at NACHC with any questions on this proposed rule.

### Overview of Medicare FQHC PPS

Section 10501 of the Affordable Care Act requires CMS to establish by October 1, 2014 a new payment methodology for FQHCs, without the application of the Medicare payment cap or productivity screens. The law also requires that CMS take into account the type, intensity, and duration of services furnished by FQHCs, and allowed for adjustments deemed appropriate by the Secretary when developing the PPS. The rates must be equal to 100 percent of the estimated amount of reasonable costs (in the aggregate) for the year if the PPS had not been implemented.

#### *Base Rate Calculation*

The proposed rule outlines the new payment methodology, which would consist of a single encounter rate, adjusted appropriately for geographic location and patient type (new patient or initial comprehensive Medicare visit). This encounter rate is determined using the FQHC cost reports, reported HCPCS codes, and claims to determine the total allowable costs and number of visits by developing a cost-to-charge ratio to link individual claims with costs. The encounter rate is then determined by dividing the total allowable costs (excluding pneumococcal and influenza vaccines) by the total number of visits. CMS proposes to exclude from the PPS calculation outlier visits with exceptionally high or low costs. After the exclusion of outliers, CMS determined the average base cost per visit to be \$150.96.

Because the FQHC PPS is to be implemented beginning October 1, 2014, the proposed rule would update the base rate to account for the price inflation through September 30, 2014, using the forecasted MEI update of 1.7 percent for the 15-month period of October 1, 2014, through December 31, 2015, to calculate the first year's base payment amount under the PPS. The proposed rule notes that if more recent data becomes available, CMS would use such data to determine the 15-month FQHC PPS update factor for the final rule.

CMS proposes the base rate be set at \$155.90.

### *Risk Adjustments*

The law allows for adjustments to the PPS rate, as determined necessary by the Secretary. CMS proposes to use two adjustment factors when determining a center's encounter rate, a geographic adjuster and a new patient or initial Medicare visit adjuster. The proposed rule states that CMS considered other adjustment factors, such as demographic, clinical conditions, duration of the encounter, etc. but determined that these factors were not associated with significant variation in costs.

#### Geographic Adjustment Factor

The proposed rule provides for adjustment to the FQHC PPS rate for geographic differences. The rule proposes to make adjustment to the cost of inputs by applying an adaptation of the Geographic Price Cost Indexes (GPCI) used to adjust payment under the Physician Fee Schedule.

$$(base\ payment\ rate) \times (GAF) = PPS\ payment$$

#### New Patient or Initial Medicare Visit

CMS estimated, based on claims data, that cost per encounter was approximately 33 percent higher when a FQHC furnished care to a patient who was new to the FQHC. In response to that finding, the proposed rule will adjust the encounter rate to reflect the 33 percent increase in costs when FQHCs furnish care to new patients or when they furnish a comprehensive initial Medicare visit (initial preventive physical examination or initial annual wellness visit), which could account for the greater intensity and resource use associated with these types of services.

$$(base\ payment\ rate) \times (GAF) \times 1.3333 = PPS\ payment$$

### *Policy Considerations for Developing the FQHC PPS Rates and Adjustments*

#### Multiple Visits on the Same Day

CMS examined Medicare FQHC claims data in order to determine the frequency of FQHCs billing. CMS then analyzed this data for the potential financial impact on FQHCs and the potential impact on access to care. Based on the Medicare claims data provided by FQHCs a very low occurrence of multiple visits billed on the same day (0.5 percent of all claims submitted show a same day visit). The proposed rule would eliminate exceptions for multiple visits on the same day and limit FQHCs to 1 encounter payment per day. CMS believes this proposal would

not significantly impact total payment or access to care, as they found a very low occurrence of same day visits. CMS is seeking further comments that address whether there are factors that it has not considered, particularly in regard to the provision of mental health services.

#### Preventive Laboratory Services and Technical Components of Other Preventive Services

As part of the implementation of the FQHC benefit, CMS used its regulatory authority to enumerate preventive primary services which may be paid for when provided by FQHCs. The preventive services added to the FQHC benefit pursuant to the ACA include laboratory test and diagnostic services, such as screening mammography, diabetes screening tests, and cardiovascular screening blood tests. CMS notes that they are not proposing a change in billing procedures, and do not intend to include payment for these services under the FQHC PPS. CMS further provides that an analysis of FQHC claims indicates that FQHCs are listing some preventive laboratory tests and diagnostic services on their claims. CMS notes that as part of the implementation of the FQHC PPS, CMS plans to clarify the appropriate billing procedures through program instruction.

#### Vaccine Costs

Certain administration and payment of vaccines are not included in the current all-inclusive rate (influenza and pneumococcal vaccines), but paid at 100 percent of reasonable costs via cost report. CMS is not proposing any changes to the current payment structure. CMS would continue to pay for the costs of the certain vaccines and their administration through the cost report, and other Medicare-covered vaccines as part of the encounter rate.

#### Medicare Advantage Organizations and FQHC Wrap Around

The ACA added section 1833(a)(3)(B)(i)(II) to the Act to require that FQHCs that contract with MA organizations be paid at least the same amount they would have received for the same service under the FQHC PPS. If the MA organization contract rate is higher than the amount Medicare would otherwise pay for FQHC services, there is no additional payment from Medicare. CMS proposes to revise § 405.2469 to reflect this provision.

#### Beneficiary Coinsurance

As per the current reasonable cost payment system, beneficiary coinsurance for FQHC services is assessed based on the FQHC's charge, which can be more than coinsurance based on the all-inclusive rate, which is based on costs. Medicare payment under the FQHC PPS should be 80 percent of the lesser of the actual charge or the PPS rate. CMS notes that the statute makes no specific provision to revise the coinsurance. The proposed rule provides that coinsurance would be 20 percent of the lesser of the FQHC's charge or the PPS rate. If finalized, total payment to the FQHC, including both Medicare and beneficiary liability, would not exceed the FQHC's charge or the PPS rate.

### Waiving Coinsurance for Preventive Services

Medicare waives beneficiary coinsurance for eligible preventive services furnished by a FQHC. For FQHC claims that include a mix of preventive and non-preventive services, the proposed rule would use physician office payments under the Medicare Physician Fee Schedule to determine the proportional amount of coinsurance that should be waived. CMS noted that total payment to the FQHC, including both Medicare and beneficiary liability, would not exceed the provider's charge or the PPS rate. Finally, the rule proposed that where preventive services are coded on a claim, to use payments under the Physician Fee Schedule to determine the proportional amount of coinsurance that should be waived for payments based on the PPS encounter rate.

### Cost Reporting

Providers participating in the Medicare FQHC payment system are required to submit information to achieve settlement of costs. In furtherance of submitting such information, CMS indicated that it is considering revisions to the cost reporting forms and instructions. CMS noted that it is exploring whether it has audit resources to include FQHCs in the pool of institutional providers that are subject to periodic cost report audits.

### Medicare Claims Payment

CMS is considering revisions to the claims processing system that would reject claims in which the qualifying visit describes a service that is outside of the FQHC benefit. CMS is further considering revisions that would reject line items for certain technical components which will not be paid as part of the FQHC PPS and would be billed separately to Medicare Part B. Finally, CMS is considering revisions that would allow for the certain informational reporting for vaccines and their administration, while excluding the line item charges. NACHC will provide more information on these matters as it becomes available.

## *Implementation*

### Transition Period and Annual Adjustment

Implementation of the FQHC PPS for FQHCs with cost reporting periods beginning on or after October 1, 2014 is required. The PPS will be "phased in" based on a center's cost reporting period. For example, a center whose cost report period begins on October 1, 2014, will begin the PPS on that date. A center whose cost report period begins on July 1, 2015, will begin the PPS at that time. CMS expects that all FQHCs will be transitioned to the PPS by the end of 2015, or 15 months after the October 1, 2014 implementation date. CMS proposes to transition the PPS to a calendar year update for all FQHCs, beginning January 1, 2016.