Summary of CMS Final Rule with Comment on the Development of a

Medicare Prospective Payment System (PPS) for FQHCs

Health Centers and Medicare

Health centers currently serve 1.7 million Medicare beneficiaries and the population is quickly growing. The Medicare FQHC benefit covers primary and preventive care and payment is made directly to the FQHC. The FQHC services benefit includes those primary and preventive care services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, and clinical social worker (and those services incident to the services of these providers). It also includes certain preventive services and preventive primary health services, including diabetes self-management training and medical nutrition therapy.

Section 10501 of the Patient Protection and Affordable Care Act (PPACA) created a new Medicare reimbursement methodology for FQHCs, known as a Prospective Payment System (PPS). CMS issued a proposed rule, outlining the details of this new reimbursement on September 23, 2013 and issued a final rule with additional comment period on May 2, 2014. Below is a summary of the final rule and the provisions of the final rule that CMS has requested further comment on three specific issues: exceptions to the limit of one PPS payment per day, establishment of G codes, and beneficiary copayment for preventive services. The comment deadline is July 1, 2014.

Establishment of FQHC PPS Payment and Health Center Reimbursement

In this final rule, CMS has created a national, all inclusive, encounter-based PPS rate, intended to cover the comprehensive list of services that FQHCs provide to Medicare beneficiaries. There must be a face to face visit between the patient and one of the 6 FQHC provider types listed above in order to trigger a Medicare PPS payment.

Using the most recent health center cost and charge Medicare data, CMS determined an average cost to serve as the base payment for the PPS. **This base rate is currently set at $158.85**. This rate will serve as the base payment for **all health centers** across the country. CMS will use two adjusters, a geographic adjustment and an adjustment for a new patient, Initial Preventive Physical Exam (IPPE), or Annual Wellness Visit (AWV).

> **Geographic Adjustment** – to account for regional variation in cost, CMS will adjust the base rate using a Geographic Adjustment Factor (GAF), the Geographic Price Consumer Index (GPCI). This is the same geographic adjustment factor currently used for the Medicare physician fee schedule. See attachment for your state's specific GAF.
>
> *Base PPS payment x GAF = health center PPS rate*

New patient, Initial Preventive Physical Exam, or Annual Wellness Visit – CMS noted that according to Medicare data, the costs are typically higher for these visits and thus have included an adjustment for a visit with a new patient, an IPPE, initial AWV, or subsequent AWV. For these visits, there will be additional adjustment.

Base PPS payment x GAF x 1.3146 = health center PPS rate for new health center patient, IPPE, or AWV

The PPS rate will be updated annually using the Medicare Economic Index (MEI) and CMS will continue to gather data to establish an FQHC specific marketbasket. The marketbasket will more accurately capture FQHC costs and be a more appropriate inflation update in the future.

The all-inclusive payment is intended to cover all services provided to a patient in a day, with two exceptions. ***CMS is seeking comments on the two exceptions.***

- **Mental Health Visits** – in an effort to promote mental health services, Medicare will allow for a health center to bill for both a medical and mental health visit in the same day. This is a change from the proposed rule.
- **Subsequent Illness or Injury** – in the instance that a patient visits the health center and later that day has a subsequent illness or injury that requires another visit to the health center, the health center can bill Medicare for both of those visits.

Determining Medicare Payment to FQHCs

G Codes & "lesser of" provision

The federal statute specifies that health centers are to be paid "80 percent of the lesser of the actual charge or the [PPS rate]." Social Security Act § 1833(a)(1)(Z). In both the Proposed and Final Rules, CMS implemented this provision almost verbatim, stating that Medicare would pay "80 percent of the lesser of the FQHC's charge or the PPS encounter rate for FQHCs authorized to bill under the PPS."

The text of the Proposed Rule did not define the term "actual charge," but CMS made clear informally that it intended to use the charges associated with the individual CPT codes listed on claims for each day when an FQHC PPS visit occurred. Many commenters, including NACHC, had serious concerns about this proposal, stating that comparing the bundled PPS payment to individual charges would be like comparing apples to oranges and would be an unfair comparison. The final rule proposes a solution to make a more "apples to apples" comparison, by establishing a HCPCS "G code" for the "charges", effectively allowing for comparison of a bundled rate/charge— allowing health centers to describe their charges for "a per diem, encounter-based visit, in accordance with Medicare regulations." According to the final rule, Health centers will set their own "G code," specific to their health center "pursuant to its own determination of what would be appropriate for the services normally provided and the population served at that FQHC, based on the description of services associated with the G code." 79 Fed. Reg. at 25458. It will be up to each health center to set its G code, as CMS does not dictate to providers how to set their charges.

Health centers should carefully consider the CMS and HRSA requirements when setting the G codes to ensure they meet all of the appropriate requirements.

CMS's proposal concerning the G codes is not contained in the final regulations; instead, CMS plans to issue billing procedures for the G codes through informal program instructions. ***CMS is seeking comment on the use of G codes.***

Beneficiary Copayment

As is the case traditionally in Medicare, the patient is responsible for coinsurance, since Medicare only pays 80 percent of the lesser of cost or charges. The final rule states that the patient will be responsible for 20 percent of the lesser of the FQHC charge or PPS rate. However, PPACA also waived the coinsurance for certain preventive services listed in the statute. In the instance that a preventive service is also provided at the same time of another service, the dollar value of the preventive service (as noted on the FQHC's line item charge), will be subtracted from the PPS or FQHC G code charge, whichever is less.

CMS believes this is a more administratively simple method to determine the appropriate copayment than the one set forth in the proposed rule, which required a more burdensome process for health centers to calculate the coinsurance where preventive services were provided. ***CMS is*** seeking ***comment on this provision.***

Vaccine Payment

Under current Medicare FQHC payment, influenza, pneumococcal and hepatitis B vaccines are reimbursed at 100 percent of costs, outside of the all-inclusive rate. This policy remains the same under the final rule.

Medicare Wrap Around Payment

Currently, if a health center has a contract with a Medicare Advantage plan for less than it would receive under traditional Medicare, Medicare will make up the difference between the two rates. This remains the same under the new system in the final rule.

Implementation and Other Details

Health Centers will transition to this new Medicare payment beginning in October 2014. There will be a phased in approach, based on a health center's cost reporting cycle. For example, if a health center's cost report year is October to October, that health center will begin the new payment in October 2014. Or if a health center's cost report year is January to January, that health center will not begin the new payment until January 2015. All health centers will be transitioned by the end of 2015 and beginning in 2016, all will be on a calendar year reporting cycle.

Cost reports

Health centers will still be required to complete cost reports, as CMS will need this information for cost-based payments that are outside the FQHC PPS and to maintain and update their cost estimates.

NACHC anticipates filing comments on the specific issues to which CMS has sought rseponses in the final rule. Should you have comments or questions about the issues discussed in this summary, please contact Susan Sumrell or Roger Schwartz.