May 5, 2014

CPCA
California Primary Care Association
Health Care Access for All

OVERVIEW AND ANALYSIS OF POLICY AND PAYMENT CHANGES FOR THE NEW MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY QUALIFIED HEALTH CENTERS

On May 2, 2014, The Centers for Medicare and Medicaid Services (CMS) finalized a new prospective payment system (PPS) for FQHCs under Medicare Part B. Per requirements set forth in the Affordable Care Act (ACA), the PPS rate for Medicare payments to FQHCs will begin on October 1, 2014. FQHCs will transition to the new payment system based on their cost reporting period.

Medicare currently pays FQHCs an all-inclusive rate for the professional component of qualified primary care and preventive health services. Under the current system, the all-inclusive rate is determined annually for each FQHC and is subject to productivity standards and an upper payment limit. The 2014 upper payment limit for rural and urban FQHCs are $111.67 and $129.02, respectively. The current all-inclusive rate is being replaced by a new encounter-based per-diem rate (Medicare PPS rate) that will be nationally standardized with some exceptions and adjustments.

The FQHC PPS Rate

The new Medicare PPS base rate, which is based on national average cost per encounter, is $158.85, and will be adjusted annually by the Medicare Economic Index (MEI). This rate may vary per FQHC based upon the FQHC Geographic Adjustment Factor (FQHC GAF) and per the type of service provided. Services subject to adjustment include services provided to a patient new to the FQHC, a beneficiary receiving an initial preventive physical examination (IPPE) or an annual wellness visit (AWV). For these services, FQHCs will receive a payment that is 34% higher than the base Medicare PPS rate.

To calculate your health center's specific new Medicare PPS rate based upon the FQHC GAF, use this formula:

($158.85) x (FQHC GAF for your area)

A list of FQHC GAFs by locality is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html

To calculate your health center's adjusted Medicare PPS rate for new patients, IPPEs, and AWVs, use this formula:

($158.85) x (FQHC GAF for your area) x (1.3416)

"Lesser Of" Provision – What You Will *Actually* Be Paid Under This Rule

Under the "lesser of" provision in the ACA, FQHCs will be *80 percent of the lesser of the actual charge or the Medicare PPS rate*. Beneficiary co-insurance will remain at 20%, so total payment to the FQHC will equal 100% of actual charges or the FQHC PPS rate, whichever is less.

"Actual charges" are defined as "the regular rates for various services that are charged to both beneficiaries and other paying clients who receive the services." For a FQHC, these are the charges for services established under the parameters of the Public Health Service Act (PHSA) and Health Resources and Services Administration (HRSA) guidance, and should reflect charges used when calculating the Sliding Fee Discount Schedule.

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Due to concerns of the California Primary Care Association (CPCA) and other commenters relating to the "lessor of" provision, CMS will determine "actual charges" for Medicare payment by establishing a new set of Healthcare Common Procedure Coding System (HCPCS) G-codes for FQHCs. There will be a separate G-Code to report an established Medicare patient visit, a new patient visit, an IPPE, or an AWV. The G-Codes will represent a bundle of primary and preventive services and their associated charges, and each FQHC will have the flexibility to set the charge for a specific G-code based upon its own determination of what would be appropriate for the services provided and the population served, based upon the description of services associated with the G-code.

The charge for a specific G-code should reflect the sum of regular rates charged to beneficiaries and other paying patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary. FQHCs will be required to use these G-codes when billing Medicare under PPS, though CMS will continue to require detailed HCPCS coding for the purposes of data gathering. Medicare will pay FQHCs based on 80% of the lesser of the G-code rate or the PPS rate on each claim. Beneficiary coinsurance will be 20% the lesser of the charge for the G-code or PPS rate.

Since these new G-codes will describe the FQHC visits as a per diem, encounter-based visit, the charges established for these Medicare G-codes may not directly affect the charges for non-Medicare patients.

Setting Your G-Code Rates

In setting charges for these Medicare FQHC visits, a FQHC would have to comply with cost reporting rules, which require that charges reflect the regular rates for services that are charged to beneficiaries and other paying patients who receive the services. The charges that each FQHC sets for a G-code per diem bundle of services should reflect the sum of regular rates charged to other paying clients. Setting charges in excess of this is subject to section 1128(b)(6) of the Act, codified in section 1001.701.

Because the G-codes concept was not in the proposed rule, but was created in response to CPCA's and others' concerns about the potential impact of the "lesser of" provision, CMS is soliciting comment on this section. CPCA will be providing comment before the July 1, 2014 comment deadline.

Same-Day Visits

The Medicare PPS rate is an all-inclusive payment system designed to reflect costs associated with a single day visit by a Medicare beneficiary. However, under this final rule, there are two exceptions to the one encounter per day policy:

1. A patient comes to the FQHC for a medically-necessary visit and, after leaving the FQHC, has a medical issue that was not present at the visit earlier that day, such as injury or unexpected onset of illness.

2. A mental health and physical health visit occur on the same day.

In these situations, a FQHC can be paid separately for two visits on the same day for the same beneficiary.

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What Is Carved In and Carved Out of the Medicare PPS Rate

Professional services (defined at section 405.2448) and preventive services (defined at section 405.2449) are carved into the Medicare PPS rate. Laboratory and technical components are historically billed separately under Medicare and remain carved out of the FQHC PPS rate under this new rule.

CMS notes that in reviewing claims data in order to determine the Medicare PPS rate, many FQHCs have been billing incorrectly for laboratory and technical services. As a part of the implementation of the FQHC PPS rate, CMS plans to clarify the appropriate billing procedures through program instruction.

Administration and payment of influenza and pneumococcal vaccines are not included in the PPS rate. They are currently paid at 100 percent of reasonable costs through the cost report. CMS will not include these costs in the PPS rate and will instead continue to pay for influenza and pneumococcal vaccinations through the cost report, and all other Medicare vaccines through the PPS rate.

An encounter cannot be billed if an immunization is the only service provided. In order to bill, the vaccine must be furnished as part of an otherwise qualifying encounter.

Beneficiary Co-Insurance

For FQHCs, beneficiary coinsurance for payments under the FQHC PPS will generally be 20% of the lesser of the FQHC's G-Code rate or the PPS rate.

Per the ACA, Medicare waives beneficiary coinsurance for eligible preventive services furnished by a FQHC. Medicare requires detailed HCPCS coding on FQHC claims to ensure that coinsurance is not applied to the line item charges for preventive services. CMS will continue to use the current approach to waiving coinsurance for preventive services, whether payment is based on FQHCs G-code charge or PPS rate, by subtracting the dollar value of the FQHC's reported line-item charge for the preventive services from the full payment amount. Further guidance will be issued through program instruction. CMS invites comments on this approach.

Cost Reporting

The changes under this new rule do not exempt FQHCs from submitting cost reports. Medicare payment for the reasonable costs of the flu and pneumococcal vaccine and their administration, allowable GME costs, and bad debts will continue to be determined and paid through the cost report. CMS is considering revisions to the cost reporting forms and instructions that will improve the quality of the cost estimates and to collect the cost data necessary for the potential development of a FQHC market basket that could be used in base payment updates after the second year of the PPS.

Medicare Advantage

FQHCs that contract with Medicare Advantage (MA) plans must be paid at least the same amount that they would have received for the same service under the FQHC PPS rate. Consistent with current policy, if the MA plan's contracted rate is lower than the amount Medicare would otherwise pay for FQHC services, FQHCs that contract with MA plans will receive a wrap-around payment from Medicare to cover the difference. The wrap will make FQHCs whole to the FQHC PPS rate, not the lesser of actual charges G-code rate.

For questions relating to this rule, contact Meaghan McCamman at mmccamman@cpca.org or (916) 440-8170.