How Health Care Reform Will Impact FQHC Organizations and Their Revenue Cycles

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Now that the celebrations have ended and the confetti has been cleared, it's time to consider how the 2010 Health Care Reform Act will impact reimbursement at Federally Qualified Health Centers (FQHCs).

As one of the most effective federal programs, FQHCs are poised to continue their prominence. Nearly everyone agrees that covering more individuals with health insurance is a positive step forward, as is substantially growing the FQHC program.

But what, if anything, will change in the revenue and/or billing process as a result of the new law? Billing is more than half of the average FQHC's annual revenue, so this question requires a closer look.

Funding

New FQHC grantees will be created under the new law, which will expand the program's reach nationally. In addition to these newly created organizations, existing FQHCs will receive substantial funding increases in the forms of expansion grants. Construction and renovation funds also are available. In a change from previous appropriations, the FQHC program will receive increases tied to those in costs and number of patients served. The overall increases will exceed $11 billion guaranteed over the next five years.

The health care bill delivers the biggest jump in funding since the program began and also allows for continuous appropriation funding. With these new funds, FQHC organizations can apply to expand operating hours and add clinics or programs. This boost in funding marks a continuation of escalating budget allowances since 1990, proving that those in Washington see the FQHC movement is strong and helping those in need.

Medicaid Expansion

With passage of the Health Care Reform Act, Medicaid will expand to include a fair portion of Americans who often fall through the cracks. Members of this group generally could not afford coverage through the commercial market and barely missed eligibility for Medicaid. As a result, they often had no preventive care options and ended up in the emergency room.

This scenario wasn't good for the patient or for the health care system as a whole (with significantly higher costs as the result). The expansion of Medicaid will help this group and others without access to preventative preventive care.

Health Insurance Exchanges

Health care reform has created a new way to purchase health insurance via health insurance exchanges. While the benefits of this provision are too numerous to list here, a few aspects stand out:

- FQHCs are guaranteed reimbursement at their Medicaid Prospective Payment System (PPS) rate.
- Participating plans are required to contract with essential community service providers.
- Plans must include at the very least essential benefits, including preventive care.

Guaranteed reimbursement at PPS rates from members of the exchange is a positive for FQHC organizations nationwide. However, the emergence of health insurance exchanges will force community health center (CHC) organizations to expend significantly more effort (e.g., sending claims to five different organizations) to collect payments that previously came from a single source.

Reduction in Self-Pay and Sliding-Fee Scale Patients

The inverse of adding patients with insurance coverage is the inevitable decrease in self-pay and sliding-fee patients, which is good news. Although this segment of patients certainly will not disappear with health care reform, changes to reimbursement will take place.

While organizations located in states without strong Medicaid programs generated well over 50% of gross charges from these categories, the corresponding collections from these charges often accounted for a small amount. In these cases, the FQHC would report the amounts as uncollectable on their cost report, thereby recouping some funds.

These organizations will see a drastic change in this category as more and more patients enroll in insurance plans of every sort. Staffing in billing departments will need to be bolstered to accommodate the resulting growth in claims volume.

A Multitude of Insurance Plans

Today, FQHC organizations often see much higher Medicaid and Managed Medicaid populations than their for-profit peers. This disparity will soon change as the new members of the health insurance exchange must contract with "essential community providers."

While administrators often would consider commercial plans a small and even insignificant portion of the overall payer mix today, billing and front desk staff and clinicians will need to adapt to a new reality: Coding is important to these plans and hence to the FQHC in the near future.

The Impact on Front Desk Operations

Front desk operations will have a dramatic impact on reimbursement in this new era. Many administrators do not fully understand the important role the front desk plays in the billing process, specifically in demographic denials.

As new payers are introduced into this mix, front desk staff will be ever more important to the FQHC. These cannot be revolving-door positions with limited to no formal training. Now, the positions will require formal training programs, patient check-in process updates and access to real-time eligibility for major payers.

Proposed Medicare PPS Changes

As alluded to earlier, administrators and clinicians alike have claimed "coding isn't important" countless times while discussing their organization's billing and reimbursement processes. This will change soon.

The Health Care Reform Act clearly states that the current Medicare payment system for FQHCs will change. It also stipulates that the new PPS will be one closer to the existing HCPCS coding used by for-profit health care providers. Beginning no later than January 1, 2011, health centers will begin reporting data using HCPCS codes to establish payment rates on a going-forward basis. Coding of encounters by FQHC clinicians is important now — and will be exponentially more so in the future.

Payer Mix

FQHCs have seen a shift (in some cases, a significant shift) in payer mix over the past five years. With the advent in many markets of Managed Medicaid and Medicare Advantage plans, organizations have experienced a marked increase in days in A/R. There also has been a change in the need for qualified and, in some instances, certified billing and coding staff.

With health care reform, FQHC organizations will experience a dramatic change in the number of payers. While the 80/20 rule (80% of revenues will come from the top 20 payers) is in effect now, the emergence of insurance exchanges will dilute this existing set of payers.

Relying on various insurance carriers instead of just, say, Medicaid will be good for the overall health of the organization. However, the FQHC will need to significantly enhance its focus on billing and the revenue cycle by:

- Enhancing staff skills through additional training
- Adding staff members to maintain current volume in claims processing
- Paying more attention to compliance issues and areas of risk from a fraud standpoint

Other issues that will affect the revenue cycle of FQHC organizations include the looming ICD-10 change, 5010 code set and the need for coding training for all providers.

As discussed, the 2010 Health Care Reform Act offers many positives for FQHC organizations. However, it may take some extra effort to collect revenues from an increasing number of payers, meet additional training and staffing needs in the billing department, and diligently manage the intricacies of the revenue cycle. Fortunately for FQHCs, the benefits will far outweigh the negatives.

FQHCs in the post-health care reform world: A great opportunity is waiting to be realized.