Medicare PPS Implementation: Considerations for FQHCs

CohnReznick is an independent member of Nexia International

Agenda

- Overview of the FQHC Medicare reimbursement system
- “New” FQHC Medicare Prospective Payment System (PPS) – in depth look
- Billing requirements
- Medicare Advantage – Supplemental Payment (“Wraparound”)
- Practical Implementation Guidance
- Implementation Checklist
- FQHC provider experience - Urban Health Plan, Inc.

Background of the New Medicare PPS System

- NACHC has been lobbying to change the FQHC Medicare rate system to eliminate payment caps and productivity screens

- Affordable Care Act required the development and implementation of a Medicare Prospective Payment System (PPS) for FQHCs to account for:
  - Type
  - Intensity
  - Duration

  } of services furnished by FQHCs

- CMS implemented Change Request 7038 effective January 1, 2011 requiring FQHCs to report CPT/HCPCS coding on claims for development of the PPS

- On April 29, 2013, CMS finalized the Medicare PPS, with an implementation date with cost reporting periods beginning on or after October 1, 2014

FQHC Medicare Reimbursement Today

- All-inclusive per encounter rate for Medicare FQHC covered services
  - Cost-based rate based on the annual filing of a Medicare cost report
  - Payment rates held to national payment caps and productivity screens
- No Medicare Deductible for visits to FQHCs
- FQHC Coinsurance - 20% of charges for FQHC services.
  - Preventive services excluded from patient coinsurance liability (per ACA)
  - Sliding fee scale applicability
- 100% Reimbursement for Pneumococcal and Influenza Vaccines and Administration (Calculated Cost)
- Medicare Bad Debt Recovery
- Medicare Part B for non-FQHC services

“New” FQHC Medicare PPS System

- Payment methodology is based on 80% (preventive services 100%) of:

*The **LESSER** of actual charges **OR** the “new” FQHC Medicare PPS rate*

- The “new” FQHC Medicare PPS rate reflects a base rate adjusted for geographic differences in costs by applying geographic adjustment factors (GAFs).
  - A weighted measure used to calculate regional variation of service costs based on national costs.
    - Physicians' work adjustment factor
    - Practice expense adjustment factor
    - Malpractice cost adjustment factor

"New" FQHC Medicare PPS System

Examples of GAF:

Locality Name	2014 FQHC	2015 FQHC
Kentucky	0.925	0.926
New Mexico	0.955	0.954
Manhattan, NY	1.108	1.106
NYC Suburbs/Long I., NY	1.124	1.122
Poughkpsie/N NYC Suburbs, NY	1.039	1.040
Queens, NY	1.123	1.121
Rest of New York	0.966	0.967

"New" FQHC Medicare PPS System

- Base payment for $158.85 from October 1 through December 31, 2015

- PPS base rate will be updated annually
  - 2016 - by the Medicare Economic Index (MEI)
  - 2017 – by the MEI or a FQHC market basket

- FQHCs will transition to the FQHC PPS on the first day of their cost reporting period that begins on or after October 1, 2014

- 34.16% increase in the PPS rate (and no coinsurance) for:
  - New patients
  - Patients receiving an Initial Preventive Physical Examination (IPPE)
  - Patients receiving an Annual Wellness Visit (AWV) (initial or subsequent)

"New" FQHC Medicare PPS System

The FQHC Medicare PPS rates will be calculated as follows:

Face to Face Encounter :

Base payment rate ($158.85) x FQHC **GAF** = PPS rate

New Patient/IPPE:

Base payment rate (158.85) x FQHC **GAF** x 1.3416 = PPS rate

Impact

- The GAF for Chautauqua County ("Rest of New York") 2014 = 0.966
- Therefore, the base rate for Chautauqua will be $158.85 x 0.966 = $153.45
  - Current rate = $129.02 (urban) $111.67 (rural)
  - At 80%: $122.76 PPS vs. $89.34 current (rural) **(↑37%)**
  - PPS preventive (IPPE) = $153.45 × 1.3416 = **$205.87** **(↑84%)**

"New" FQHC Medicare PPS System

Who is a NEW Patient?

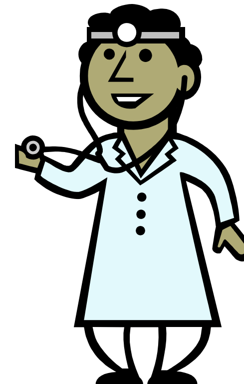
A New patient is someone who has not received any professional medical or mental health services from any site or from any practitioner within the FQHC organization within the past 3 years from the date of service

Examples

- Physician is new to the FQHC and a patient from his/her previous non-FQHC practice comes to the FQHC for the first time
  - NEW FQHC PATIENT, RATE ADJUSTED
- Patient has received FQHC medical services within the past 3 years and has his/her first visit with a mental health practitioner
  - NOT A NEW FQHC PATIENT, RATE NOT ADJUSTED

"New" FQHC Medicare PPS System

- FQHCs can bill for more than one visit per day under the following circumstances:
  - Subsequent illness or injury
  - Mental health visit occurring on the same day as another billable visit



“New” FQHC Medicare PPS System

Coinsurance

- 20% of the lesser of the actual charge or the PPS rate
- No coinsurance charged for preventive services for which the coinsurance is waived
- For claims with a mix of preventive and non-preventive services, coinsurance will be 20% of the full payment amount after the dollar value of the preventive service charges are subtracted

New HCPC Codes - Bundled Services

New Codes for Bundled Services:

- G0466 – FQHC visit, new patient
- G0467 – FQHC visit, established patient
- G0468 – FQHC visit, IPPE or AWV
- G0469 – FQHC visit, mental health, new patient
- G0470 – FQHC visit, mental health established patient

New Billing Protocols:

One of the above G-codes must be reported on claims, when applicable, with an associated charge amount reflective of typical services provided during these visit types

AND

ALL HCPCS codes for services that occurred on the same day must be included on claims as well

New HCPC Codes - Charges

- FQHCs set their charge for the specific payment codes (GO466-GO470) based on
  - their determination of what would be appropriate for the services normally provided and the population served, and
  - the description of services associated with the payment code
- The charge should reflect the sum of the regular rates charged for a typical bundle of services that would be furnished per diem to a Medicare beneficiary
- CMS does not dictate to FQHCs how to set their charges

Setting charges is the KEY TO SUCCESS

New Billing Requirements

- One claim per patient per date of service
  - Multiple claims submitted with the same date of service will be rejected
- FQHC payment codes G0466, G0467, and G0468 must be reported with revenue code 052X or 0519 (for MA claims)
- FQHC payment codes G0469 and G0470 must be reported with revenue code 0900 or 0519 (for MA claims)
- Each FQHC payment code (G0466 – G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit
- Only one G code for a new patient receiving both medical and mental health services on the same day included on the claim

Medicare Advantage Plans

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003:
  - Renamed the Medicare managed care program (formerly Medicare+Choice) to Medicare Advantage
  - Created Medicare prescription drug plans (Part D) effective 1/1/06
  - Created a "new" supplemental" wrap-around payment program for FQHCs who contract with Medicare Advantage (MA) plans
  - Also created Special Needs Plans (SNP) which restrict enrollment to dual eligibles, those residing in institutional settings, or those with multiple chronic conditions

Medicare Advantage Plans

- Health centers with MA plan contracts will be paid based on the contract. In addition, will qualify for a supplemental wrap-around payment when it provides FQHC Services.
- Three contractual requirements between Plans & CMS:
  - Must be written contract between FQHC and MA Plan
  - MA plan must pay FQHCs an amount similar to what it pays other non-FQHC providers
  - FQHC must accept MA payment and wraparound as payment in full
- Covers FQHC services only
  - Does not include certain Part B services such as lab and x-ray
  - Does not include pharmacy costs under Part D

Medicare Advantage Plans – Supplemental Payment

"New" Supplemental "Wraparound" Payment Policy:

- FQHCs that have a written contract with a Medicare Advantage (MA) organization are paid by the MA organization at the rate that is specified in their contract
- If the contracted rate is less than the Medicare PPS rate, Medicare will pay the FQHC the difference, less any cost sharing amounts owed by the beneficiary.
- The PPS rate is subject to the FQHC GAF, and may also be adjusted for a new patient visit or if a IPPE or AWV is furnished.
- The supplemental payment is only paid if the contracted rate is less than the fully adjusted PPS rate.
- All services must be billed with revenue code 0519, a FQHC payment G and HCPCS code must be on the claim *(claims submitted 10/1-11/10/2014 held by MACs for system corrections*

Medicare Advantage Plans – Supplemental Payment

Carrier	Locality	State/County	FQHC GAF
07102	13	Arkansas	0.937

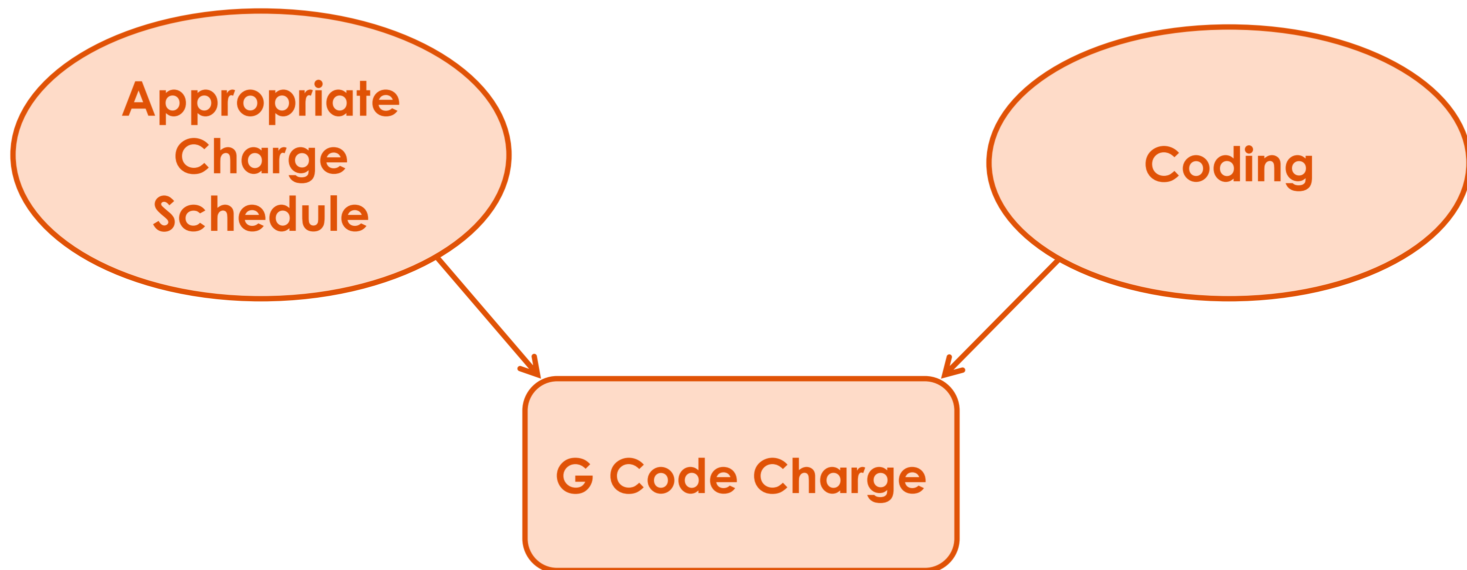
PPS rate is less than the FQHC's charge: $158.85 x 0.937 = $148.84

Supplemental payment = PPS Rate – MA Plan Amount (Including Co-pay)
= $148.84 – $110.00
= $38.84

42 Rev Cd	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	MA Payment	Total Payment	Medicare Payment	Co insurance
0519	FQHC visit, estab pt	G0467	10/01	1	$156.00	---	$38.84	$38.84	---
0519	Office/outpatient visit est	99212	10/01	1	$100.00	$60.00	$0.00	$0.00	$10.00
0519	Hep b vacc adult 3 dose im	90746	10/01	1	$60.00	$30.00	$0.00	$0.00	$0.00
0519	Admin hepatitis b vaccine	G0010	10/01	1	$20.00	$10.00	$0.00	$0.00	$0.00

Practical Implementation Guidance

- In addition to obvious technical adjustments required to bill under the new FQHC Medicare PPS methodology, health centers must construct a charge structure for the new "G" codes
- Framework to construct the new "G" code charge structure -



Practical Implementation Guidance

Charge schedule: Considerations

- HRSA –Requires health centers to prepare a schedule of fees consistent with locally prevailing rates or charges AND designed to cover costs of operations
- Third Party and Commercial Payers – Review contracts and set charge schedule to align with costs mindful of contract reimbursement terms. Review contract language for "Lesser of" payment terms.
- Allow for proper bundling for establishment of G code charges;
  - Visit modeling based on CY CPT utilization by payer and category of service
  - Scope of services, level and intensity of care of population served
  - Effective coding and existing charge capture
  - Multi-site locations (GAF implications)

Practical Implementation Guidance

Charge schedule: Advantages

- Streamlines methods of identifying costs across different departments
- Creates a mechanism to capture chargeable items
- Ensures charges are reasonable and consistent with costs and market prices
- Compliant with HRSA requirements and expectations of maximizing billing and collections to cover cost

Practical Implementation Guidance

Charge schedule: Data Sets

- Drugs and immunization acquisition costs
- Medicare Relative Value Unit measures, Physician and Laboratory Fee Schedules – Locality specific
- Medicaid fee schedules

Practical Implementation Guidance

Cost-Based Charge Schedule Procedures are weighted based on Relative Value Units (RVUs) that are assigned to each procedure (CPT codes)

- The charge for each procedure is calculated based on the following formula:

CPT Weight × Value per RVU = Charge per procedure

- By replacing the "Value per RVU" with a "Cost per RVU", the resulting charge will be equivalent to the cost for the procedure
- The "Cost per RVU" is calculated as follows:

Total Expenses	÷	Total Number of RVUs	=	Cost per RVU
($1,839,135)		(31,925 RVUs)		($57.61)

Practical Implementation Guidance

Charge schedule: G Code bundling

New billing codes - Associate a charge amount reflective of typical services provided during these visit categories

- Identify scope of services, level and intensity of care of population served
- Model visits – Analyze CPT utilization by payer and category of service (e.g. medical, mental health, etc.)
- Determine appropriateness of pricing based on lesser of reimbursement implications
- Factor-in 34% increase in the PPS rate for:
  - New patients
  - Patients receiving an Initial Preventive Physical Examination (IPPE)
  - Patients receiving an Annual Wellness Visit (AWV) (initial or subsequent)
- Set charge in cost based charge schedule

Sample - Cost Based Charge Schedule

CPT Code	Count of CPT	RVU	Description	Total RVU	Cost per CPT	Charge
99201	10	1.25	Office/outpatient visit new	12.50	$72.01	$ 79.21
99202	1,018	2.12	Office/outpatient visit new	2,158.16	$122.13	$ 134.35
99203	1,298	3.04	Office/outpatient visit new	3,945.92	$175.13	$ 192.65
99204	42	4.61	Office/outpatient visit new	193.62	$265.58	$ 292.14
99205	4	5.72	Office/outpatient visit new	22.88	$329.53	$ 362.48
99211	51	0.59	Office/outpatient visit est	30.09	$33.99	$ 37.39
99212	6,754	1.25	Office/outpatient visit est	8,442.50	$72.01	$ 79.21
99213	40,215	2.07	Office/outpatient visit est	83,245.05	$119.25	$ 131.18
99214	1,513	3.04	Office/outpatient visit est	4,599.52	$175.13	$ 192.65
99215	14	4.06	Office/outpatient visit est	56.84	$233.90	$ 257.29

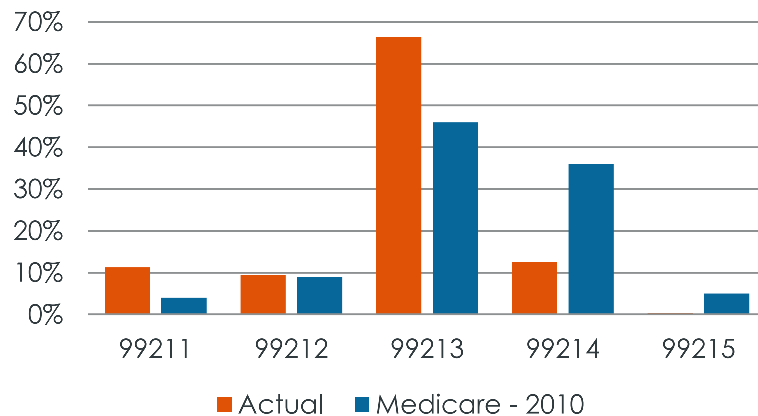
Practical Implementation Guidance

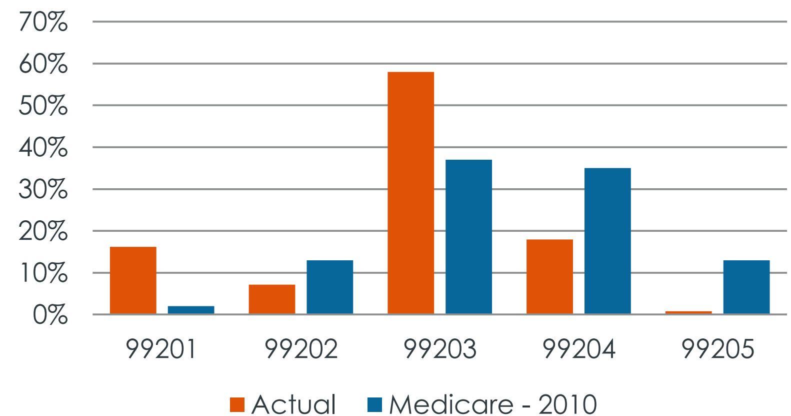
Evaluating your charge schedule: Lessons Learned

- Coding – The good, bad and ugly
  - Provider and coders how effective are they?
- Practice Management System limitations and configuration hurdles
  - EMR templates
  - Practice Management System interfaces
  - EMR template routine maintenance. Who, when, frequency?
- Charge capture – Are all services provided captured AND included on claims?
- Unknown billing "workarounds" – Impact of back-end claim "fix" workarounds
- Improper coding and capture of Initial Preventive Physical Exam (IPPE) & Annual Wellness Visit (AWV) HCPCs

Practical Implementation Guidance

In evaluating the accuracy of the CPT code analysis, centers should also evaluate the appropriateness of its providers coding practices through comparison to industry norms





Practical Implementation Guidance

Before and After:

	Before	After
Average RVU per “G” code (based on bundling of CPT codes)	1.00	2.00
Average charge per RVU	$65.00	$85.00
Projected charge per “G” code	$65.00	$170.00

How does the “G” code charge compare to $158.85 the FQHC Medicare PPS base rate?

Implementation Checklist

- ✓ Create a transition timeline, work plan and selected your team members
  - Implement a DEADLINE : Based on cost reporting period
  - Select your team wisely…
    - Identify key patient account, finance and information technology team members (PMS vendor account manager may be an option in lieu of internal IT staff)
- ✓ Review existing charge schedule – Cost Based or NOT?
  - Incorporate lessons learned from charge schedule analysis
    - Coding, Coding, Coding, PMS system limitations and challenges
    - Charge capture!!
    - Claim Creation
    - Multi-site locations (GAF implications)

    Implement annual review process
- ✓ Develop pricing for new "G" codes
    - Model visits when updating charge schedule considering CPT utilization by calendar year, payer and category of service (e.g. new patients, established patient both medical and mental health)

Implementation Checklist

- ✓ Engage in discussion with Practice Management System vendor
  - Establish ownership and understand the process of update requirements
    - Pricing
    - G codes, payer specific
    - Contractual adjustment of charges to the lesser of the G code charge or PPS rate
      - Expectation - Concurrent or retrospective of creation of claim?
  - Claims
    - Same day patient with multiple service claim requirement
    - Crossover claims - no changes to existing required data elements
    - Transition – All Inclusive Rate v Prospective Payment System billing requirements
      - Expectation – Proper G code assignment based on Center implementation date
- ✓ Engage in discussion with Clearing House vendor
    - Awareness of CMS requirements of new G codes
    - Claims edits

Implementation Checklist

✓ Review pre-billing edits, create testing environment

- Testing environment – Robust and mirror image of production database
- Create variety of test claims
  - Medicare primary (e.g. medical, DSMNT, MNT, mental health, IPPE, AWV)
  - Dual-eligible claims
  - Same day multiple service claims
  - Provider NPI assignment. Consideration and implementation hurdles

TEST, TEST , TEST

✓ Identify and educate key staff

- Patient Access/Registration, Patient Accounts, Information Technology, Finance
  Begin now….do not wait until the 11th hour
  - Involve staff in testing
- Keep Current and share experiences
  - Join CMS & NGS Listservs
  - Subscribe to PMS user groups
  - Share experiences…power in numbers approach with vendors

Implementation Checklist

- ✓ Updated financial reporting - new “G” codes
  - Financial reports, avoid overstated A/R of new G codes
  - Patient Account reports, tracking of G codes
  - Financial models, budget applications used for forecasting revenue
- ✓ Monitor
  - PMS Pre-billing claim edits
  - Vendor Electronic Data Interchange files - rejected and accepted claims reports
  - Electronic Remittance Advice, verify Crossover indicator present
  - Crossover Claim remittances

Helpful Links

FQHC PPS Webpage:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Index.html

FQHC Center Webpage:

http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

Chapter 9, Medicare Claims Processing Manual

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

Chapter 13, Medicare Benefit Policy Manual

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Urban Health Plan, Inc.

Mission

…to continuously improve the health status of underserved communities by providing affordable, comprehensive, and high quality primary and specialty medical care and by assuring the performance and advancement of innovative best practices.

Services

- Primary Care
  - Adolescent Medicine, Adult Medicine, Dentistry, Family Medicine, Family Planning, HIV Primary Care, Internal Medicine, OB/GYN, Pediatrics, Prenatal Services, Primary Care for the Developmentally Disabled, Walk-In Clinics
- Specialty
  - Allergy, Cardiology, Ear, Nose & Throat, Endocrinology, Gastroenterology, Immunology, Infectious Diseases, Nephrology, Neurology, Ophthalmology, Physiatry, Podiatry, Psychiatry, Pulmonary, Rheumotology, Urology
- Ancillary
- Diagnostic
- Support Services

PPS Work Plan, Challenges and Implementation

Evaluated Impact:

- Identify billable visits
  - Percentage of Medicare (inclusive of dual-eligible) claims – 3.45%
- Explore technology and staff limitations
- Determine operational ownership – Clinical v Operations

PPS Work Plan, Challenges and Implementation- Phase I

- Selected team members
  - Working team
  - Advisory team
- Created work plan
  - Determine G code assignment (clinical v operations)
  - Model new G code visits and bundled pricing
  - Identify system requirements and hurdles
    - PMS limitations of AIR and PPS effective dates v billing requirements
    - Update charge master pricing – consider multiple site locations for GAF
- Implement cost based charge structure
- Contacted PMS and Clearing House vendors
  - Multiple same day visit billing requirements
  - New "G" code acceptance/billing edits

PPS Work Plan, Challenges and Implementation- Phase II

- Education : Clinicians
  - NGS guidance, new center patients with prior visits
- Education: Billing, account receivable and finance staff
  - G code workflow, IPPE and AWV
  - Reporting
- Reporting
  - Update financial reporting - account for inflated A/R
  - Custom reports – Identify different billing requirements for all inclusive rate v PPS rate and effective dates
- Perform on-going monitoring of pre-billing claims and electronic remittance advices
- Analyze crossover claims and payments for appropriate co-insurance
- Annual review of charge master
- Continue to work with PMS vendor on automation of multiple same day visits billing requirements

Questions….