North Carolina Community Health Care Association

Understanding FQHC Medicare & Medicaid Reimbursement

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Curt Degenfelder
curt@degenfelderhealth.com
www.degenfelderhealth.com
310-740-0960

Curt Degenfelder Consulting, Inc.

Health Center Reimbursement

- Medicaid: Cost based rate from Prospective Payment System (PPS) or alternative methodology
- Medicaid managed care: Negotiated rate with PPS wraparound protection. May be paid on a capitated (fixed monthly $ amount per member) or fee-for-service
- Medicare: Cost based rate up to geographically adjusted national average
- Medicare managed care: Negotiated rate with wraparound protection
- Medicare/Medicaid dual eligible: Medicare payment plus crossover payment
- Medicare Advantage/Medicaid dual eligible: Negotiated rate plus PPS wraparound
- Commercial insurance: Negotiated rate
- Self – pay: Based on charges and sliding fee

Federally Qualified Health Center Program

- The FQHC program [enacted under the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) and expanded under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90)] provides for cost-based reimbursement under Medicare and Medicaid for legislatively specified services.

- Congress created the FQHC program to allow specific Medicare and Medicaid payments for CHCs to ensure that grant dollars intended for the uninsured were available for the purpose of serving the uninsured population.

CHC Program – Scope of Project

- The federally approved scope of project defines the five core elements of scope of project, including, approved **service sites**, **services**, **providers**, **service area(s),** and **target population(s)** supported (wholly or in part) under the total section 330 grant-related project budget.

- A grantee's scope of project must be consistent with applicable statutory and regulatory requirements and the mission of the health center.

Medicaid/Medicaid FQHC Scope of Services

- Medicaid is a combined federal/state program. Each state has latitude in designing its Medicaid program
- There is a core set of 15 required Medicaid covered benefits. There are 28 optional Medicaid benefits
- A state may define the services that are included in the Medicaid FQHC rate
- A state may allow health centers to choose whether certain services are included in the FQHC rate
- Medicaid covered benefits that are not included in a health center's FQHC rate are billed against the state's fee schedule. Costs for these services are excluded from the calculation of the center's cost- based rate, usually carved out in an "Other than FQHC/RHC costs" category

Overview of PPS: What Services Are Eligible to Be Paid At PPS Rate?

Services provided by an FQHC or FQHC look-alike (note that CMS recognizes no difference between FQHCs & look-alikes) that:

- Are in-scope
- Are at an approved service site, with an approved 855A
- Are covered services (both the service and the patient are covered)
- Are included in the PPS rate
- Are done by a billable provider (MD, DO, NP, PA, Dentist, Dental Hygienist, Psychiatrist, Psychologist, LCSW). States may designate additional providers to be paid at the PPS rate
- For some states, site needs to be licensed

Overview of PPS

- Rates established using cost data from 1999 & 2000, for health centers existing in 2001
- Rates Adjusted annually by the Medicare Economic Index (MEI)
- New Health Centers (since 2001)
  - Same or similar health centers, or
  - Cost Report
  - Some states may allow Medicare rate on an interim basis until rate can be established using other means
- Change in Scope of Services
- Alternative Methodologies
- PPS Wraparound where managed care exists

North Carolina Medicaid Setting

- PPS Rate
- PPS Rate post-Change In Scope
- Alternative payment methodology – core rate payment with annual cost settlement
- New health center that received rate based on average

PPS Wrap-Around

- States required to make supplemental payments to FQHCs that subcontract (directly or indirectly) with managed care organizations (MCOs) – particularly important in Section 1115 States where managed care is statewide.
- Supplemental payment is the difference between the payment received by the FQHC for treating the MCO enrollee and the payment to which the FQHC is entitled under the PPS.
- Incentive payments, e.g. risk pool payments are excluded from the wraparound calculation.
- Also, whether payments for non-direct medical services such as case management and administration will be figured into the wraparound calculation will also vary on a state-by-state basis.
- FQHCs are entitled to be paid at least as much as any other provider for similar services.

Health centers operating in managed care will receive a quarterly wraparound settlement

Margin Erosion

- MEI: 1% annually
- Physician compensation increases: 5 – 10% a year
- Staff compensation increases: 3 – 5% a year
- CPI: 2.1% annually

Over time, a constant revenue and expense base will experience declining margins.

Fixes to Margin Erosion

- Growth/economies of scale/coverage of fixed cost
- Payor mix improvement
- PPS Change In Scope/Rate Increase
- Increases in provider productivity
- New Access Point 330 funding
- Expanded Service 330 funding
- 340b margin

PPS Change in Scope of Services

<u>"Change in Scope of Services" per CMS Q & A Document:</u>

- A change in scope shall occur if :
  - The center has added or has dropped any service that meets the definition of FQHC/RHC services; and
  - The service is included as a covered Medicaid service under the Medicaid state plan.

- A change in the "scope of services" is defined as a change in the type, intensity, duration and/or amount of services.

- In making such an adjustment, state agencies must add-on the cost of new services even if these services do not require a face-to-face visit with a provider.

- ***A change in scope of services for Medicaid is not the same thing as a 330 change in scope of project!***

Medicaid/Medicaid FQHC Scope of Services

Sites	Sites need to be added to Medicaid scope, sometimes through CON or licensure, can also bill for sites not in Medicaid scope (intermittent, satellite)
Services	Need to distinguish between Medicaid covered services and services included in Medicaid rate
Providers	All FQHC covered providers included. Certain other providers (residents, MSW) may be billable when under supervision
Service area	The borders of the State
Target population	Medicaid eligibles

What Changes Might Qualify You For a PPS Rate Appeal?

- Increase or decrease in overall health center costs
  - Over what period of time?
  - % Threshold for qualification? (i.e., 5%)
- Adding a new site
- If PPS rates are by site, increased cost for particular site?
- Increase or decrease in cost of specific FQHC services
- Addition of a new FQHC service not included in baseline PPS rate
- Amended regulatory requirements or rules.
- Relocating or remodeling a site or service
- Applicable technology and medical practice utilized
- Intensity in services due to serving different types of patients:
  - HIV/AIDS, chronic diseases, homeless, elderly, migrant, etc.

What is the Application Process in Your State?

Note that the CIS processes and results are very different amongst states.

- **Is there a notification requirement?**
  - Prior to the occurrence of the change?
  - Within what period of time?

- **What information is required for submission?**
  - Medicare cost report, or
  - State developed full cost report, or
  - Incremental cost rate adjustment approach?

- **What period of time does the appeal data cover?**
  - Health center's fiscal year?
  - State's fiscal year?
  - Federal fiscal year?
  - Other date

Scope & CHC Cost

- **Medicare cost report**
  - Allowable and other than FQHC/RHC services
- **Medicaid cost report**
  - Allowable and other than FQHC/RHC services
- **Grant allowable costs**
  - In scope
  - Under salary cap
  - Documentation
- **IRS allowable costs**

Sample GL/Cost Report Mapping

Descr	TOTAL	Site Cost Report Line	Home Office Cost Report Line
Expense			
5000-Outreach	31,636	52	36
5015-Equipment	4,592	38	-
5020-Bank Service Charges	94		36
5030-Billing Expenses	75,324	23	36
5040-Board Meeting Expenses	14,292		39
5060-Computer and Internet Exp	15,724		35
5070-Clinic Supplies	130,958	16	-
5090-Continuing Education	9,482	52	-
5100-Fees - Dental	4,072	15	6
5100-Fees - 3440b	5,979	14	-
5110-Dues and Subscriptions	24,474	52	40
5140-Janitorial Expense	6,548	36	-
5150-Laboratory Fees	130,771	17	-
5175-Maintenance	19,283	36	19
5180-Meals and Entertainment	23,124		39
5190-Medical & Drug Supplies Pharmac	139,082	14	-
5190-Medical & Drug Supplies Dental	2,255	15	-
5190-Medical & Drug Supplies Medical	9,246	16	-
5190-Medical & Drug Supplies PT	13	21	-
5201-Interest Expense	14		14
5210-Office Expenses	26,765	52	33

Is It Billable to Medicaid at the PPS Rate?

- General rule of thumb: face to face encounter between Medicaid enrollee and health center billable provider (MD, DO, NP, PA, CNM, Dentist, DH, Psychologist, LCSW)

- There may be multiple other factors:
  - Site of service
  - Licensing
  - Credentialing
  - Supervision
  - Referral and health center pays
  - Telemedicine (and which end of the connection bills)

Is It Billable to Medicaid at the PPS Rate?

- Just because Medicaid is paying a center for the service does not mean that they should be
- Ability to bill Medicaid is one consideration in program design (as is triggering of Medicaid PPS Change in Scope)
- Other payors (e.g. the Medicare diabetes self-management training) may have complex rules and low volume

FQHC Medicare

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FQHC Medicare Program – Scope of Services

- **Parts of Medicare**
  - Part A: Hospitals & Institutions (including FQHCs)
  - Part B: Providers (Part B physician fee schedule based on RBRVS)
  - Part C: Medicare Advantage
  - Part D: Prescription drug

Note: the new Medicare FQHC PPS significantly changes the reimbursement system and rates, but does not impact FQHC Medicare scope

Medicare PPS Payment Rates

- Payment to be determined by the Medicare Administrative Contractor based on the **lesser of the FQHC's charge** for the specific payment code or the PPS rate

- The PPS base rate for 2018 is $166.60. This figure is geographically adjusted for North Carolina by .968, .999 for Atlanta, .953 for the rest of Georgia, and .959 for South Carolina

Medicare PPS Payment Rates

- Rate will be increased 34.16% for:
  - New patient visits. Note that CMS uses CPT definition of new patient as someone not seen by the FQHC (not determined by provider!) in the past 3 years.
  - Patients receiving an Initial Preventive Physical Examination (IPPE)
  - Patient receiving Annual Wellness Visit (initial or subsequent)

Medicare PPS Billing – G Codes

- 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, est. patient

FQHC can bill for mental health visit on same day as another billable visit (must be on the same claim)

CMS Form 855A

- Form requires completing information on health center's identification (locations, address, etc.), legal history (including adverse rulings), ownership interest (sheet per board member with SSN), practice locations, etc.

- Copies of all:
  - Professional/business licenses
  - CLIA licenses
  - Pharmacy licenses
  - Legal Action documents
  - EDI Agreements
  - Articles of Incorporation/Corporate charters
  - IRS Documents
  - Notice of Grant Award

- Don't forget CMS 838

FQHC Medicare Program – Scope of Services

- Core services:
  - Physician services, including required physician supervision of PAs, NPs, and CNMs
  - Services and supplies furnished as incident to physician professional services;
  - Services of PAs, NPs and CNMs
  - Services of clinical psychologists and clinical social workers (when providing diagnosis and treatment of mental illness)
  - Services and supplies furnished as **incident to** professional services provided by PAs, NPs, CNMs, clinical psychologists, and clinical social workers

FQHC Medicare Program – Scope of Services

- Core services (continued):
  - Visiting nurse services on a part time or intermittent basis to homebound patients (limited to areas in which there is a designated shortage of home health agencies).
  - Diabetes Self-Management Training and Medical Nutrition Therapy Services

- These Services cannot be changed. There is no change in scope of services process for FQHC Medicare, and FQHCs cannot “carve out” FQHC Medicare services.

FQHC Medicare Program: Non-FQHC Covered Services

- **Hospital Care** - Medicare excludes hospital inpatient and outpatient services from the list of FQHC covered services (emergency room as well) Medicare does not recognize care provided in hospitals (either inpatient or outpatient) as RHC or FQHC services to be paid for on the basis of cost.

- **Laboratory and Radiology**

- **Other Ambulatory Services covered under Medicaid programs**
  - Services that may qualify as “other ambis” include case management, social services, transportation, pharmacy, dental, and advanced nursing care.

- Where appropriate, these services are billed against Part B or other fee schedules

Dental Services in FQHCs

- Usually paid by Medicaid at the same cost rate as medical, or sometimes on its own individual cost basis (direct + overhead)
- Not a covered service for Medicare
- Could be billed fee-for-service during the cost year and settled to cost at year-end
- Medicaid covered services vary by state for dental
- Dental services use the Current Dental Terminology (CDT), a manual published by the ADA which includes the Code on dental procedures and nomenclature and ADA claim form.

Other Programs

- SCHIP – as of 10/1/09, paid at the PPS rate
- Other state programs – wide variety of reimbursement options. If they are a Medicaid extension, PPS payment rules apply
- Family planning – federal program (Title X) but broad latitude on reimbursement
- Uncompensated care, bad debt, charity care, primary care expansions – oftentimes these programs are billed and paid at a per visit rate, but the health center has an allocated annual maximum payment
- Behavioral health services may have billing limits as to the number of services that can be billed monthly or annually

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