Issue Brief

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Medicare Revises its Payment System for Federally Qualified Health Centers, Makes Minor Change to Rural Health Center Policy

Background
Section 10501(i)(3)(A) of the Affordable Care Act (ACA) requires that the Centers for Medicare and Medicaid Services (CMS) establish a new reimbursement methodology for Medicare payments to Federally Qualified Health Centers (FQHCs). On May 2, 2014, CMS published a final regulation implementing the new "prospective payment system" (PPS) methodology. Payment under the FQHC PPS will apply beginning to services rendered on or after October 1, 2014.

FQHCs are facilities that furnish services that are typically furnished in an outpatient clinic setting. According to HRSA, approximately 8 percent of FQHC patients were Medicare beneficiaries, 41 percent were Medicaid recipients, and 36 percent were uninsured in 2012. The remaining 15 percent were privately insured or had other public assistance. Medicare accounts for approximately 9 percent of FQHC's total billing in dollars. The PPS created under this final rule only impacts payment for FQHC services rendered to Medicare beneficiaries.

FQHC services and supplies covered by Medicare include those provided by physicians, NPs, PAs, CNMs, clinical psychologists and clinical social workers, as well as services incident to those of these providers.

Under the existing Medicare payment methodology, each FQHCs is paid an "all inclusive rate" (AIR) per visit for qualified primary and preventive health care services furnished to Medicare beneficiaries. Technical components such as x-rays, lab tests and durable medical equipment are not part of the AIR and are paid for under separately applicable Medicare payment methodologies.

FQHCs are required to file annual reports with CMS, providing extensive data on their incurred costs. The AIR for each FQHC is calculated by dividing total allowed costs by the total number of visits.

At the beginning of a FQHC's fiscal year, the Medicare administrative contractor (MAC) calculates an interim AIR. Payments through the year are based on this interim AIR with reconciliation at the end of the year based on actual figures.

When calculating allowed costs FQHCs must meet certain productivity standards. Specifically, each year there must be at least 4,200 visits per full-time equivalent physician and 2,100 visits per NP, PA or CNM. If the FQHC has furnished fewer visits,

when calculating the AIR, the productivity standards would be substituted instead of the actual number of visits. Thus, FQHCs that cannot meet the productivity standard would be negatively impacted financially.

In addition, FQHCs are subject to a payment limit, depending on whether they are located in an urban or rural area. If the AIR exceeds the payment limit then the payment limit would be substituted for the AIR. The 2014 payment limit per visit for urban and rural FQHCs is $129.02 and $111.67 respectively.

A Government Accountability Office (GAO) study in 2010 found that about 72 percent of FQHCs had average costs per visit that exceeded the payment limit and that the application of the productivity standards reduced Medicare payments for approximately 7 percent of FQHCs.

Content of the New PPS

Under the new FQHC PPS individual FQHCs will not have their own AIR. Instead, a single base payment rate will be applied to all FQHCs, adjusted for geographic variations in costs. The base rate will be calculated by aggregating data from all FQHCs and dividing their costs by the number of total visits during a specified time period. This rate is calculated without using either the productivity standard or the upper payment limit. The final base payment rate for visits in FY 2014 is $158.85.

FQHCs report their costs on an annual basis, but not all report on the same time cycle. CMS will implement the FQHC PPS beginning on or after October 1, 2014, as the FQHCs reach their annual cost reporting deadlines. The agency will ultimately transition all FQHCs to an annual calendar year process, with payment updates taking effect January 1 of each year.

After the first year of its implementation, the PPS payment rates will be increased by the percentage increase in the Medicare Economic Index. In subsequent years, the PPS rates will be updated by the percent increase in a market basket of FQHC goods and services established through regulation.

CMS will geographically adjust payments, to take into account variation in costs across the country. The FQHC "geographic adjustment factor" (GAF) will be based on the "geographic practice cost indices" (GPCIs) used to adjust physician payments. CMS has posted a table on its website listing the FQHC GAFs.

In developing the payment methodology, CMS discovered that costs associated with services to new patients, the Initial Preventive Physical Exam (IPPE) and an initial or subsequent Annual Wellness Visit (AWV) are significantly higher than average. To address this situation, payment for new patient visits, the IPPE and AWV visits will be increased. The adjustment factor for 2014 for these specific visits will be 34.16%.

In the proposed rule, CMS had indicated there would be no allowance for billing second visits during a single day for a single beneficiary. However, in response to comments,

in the final rule CMS has allowed FQHCs to bill a second visit on the same day for the same patient when that visit is for mental health services, or when the beneficiary suffers an illness or injury subsequent to the first visit that requires additional diagnoses or treatment on the same day.

Medicare will pay the lesser of 80 percent of the PPS payment rate or the FQHC's actual billed charges. Cost sharing for beneficiaries will be 20 percent. Services that are not subject to cost sharing, including a range of preventive and screening services, will be paid at 100 percent by Medicare.

Concrete Example
If an established patient visits an FQHC in Arizona, where the GAF is 0.985, the payment would be:

$158.85 x 0.985 = $156.47

If the visit were for a new patient, an IPPE or AWV, then it would be further modified thus:

$156.47 x 1.3416 = $209.92

Impact
CMS estimates that the PPS payment methodology will result in a 32 percent increase in payments to FQHCs. Given that Medicare accounts for 9 percent of FQHC billed charges, a reasonable assumption would be that the new payment system will increase FQHC income by approximately 3 percent. The precise impact will of course vary by FQHC, based on the applicable GAF and the patient and service mix of the particular FQHC.

Rural Health Center Changes
This final regulation also made a small change to policy related to rural health centers (RHCs). Under policy that has been in place to this point, RHCs are not paid for the services of contracted individuals other than contracted physicians. The change in policy would allow RHCs to be paid for the services of contracted individuals who are <u>not</u> physicians. This includes CNMs.