The New Medicare FQHC PPS

Agenda

- Medicare Basics
- The New Medicare PPS
- FQHC Billing Requirements
- Implementing PPS in your FQHC
Medicare Basics

Medicare covers individuals over 65, individuals with End Stage Renal Disease (ESRD), or individuals receiving Social Security Disability Income (SSDI).

Approximately 8 percent of health center patients nationwide.

Approximately 13.4 percent of South Carolina health center patients.

Medicare Basics (Cont.)

EACH SITE must be certified by CMS, meaning that you must fill out a Medicare 855A application for each site and each site must have its own unique Medicare number.

Organizations can file a consolidated cost report for all grantee sites.

See HRSA PAL 2011-04 for more details.
What does Medicare cover at FQHCs?

- Physician Services
- Nurse Practitioner, Physician Assistant, Clinical Psychologist and Clinical Social Worker services
- Visiting nurse services (where appropriate)
- Preventative primary health services required under the section 330 of the Public Health Service Act; and other Preventative Services, as defined by the US Preventative Task Force with a grade of A or B

How Does Medicare currently pay FQHCs?

- Each health center develops its own per visit rate
- Health centers bill for the face to face encounter between core provider and patient
- Medicare sets “caps” on the per visit rate, also providers productivity screens
- Medicare pays 80 percent of the per visit rate, beneficiary is responsible for the remaining 20 percent
So why do we need a new system?

- Majority of health centers at or above the Medicare payment caps or affected by the productivity screens
- Losing over $50 Million Annually

New Medicare PPS

The Affordable Care Act created a new Medicare payment methodology, the “Medicare PPS”

“The Secretary Shall implement such prospective payment system so that the estimated aggregate amount of prospective payment rates...(determined prior to the application of section 1833(a)(1)(Z)) under this title for Federally qualified health center services in the first year that such system is implemented is equal to 100 percent of the estimated amount of reasonable costs (determined without the application of a per visit payment limit or productivity screen and prior to the application of section 1866(a)(2)(A)(ii) that would have occurred for such services under this title in such year if the system had not been implemented.”
New Medicare PPS

Law required FQHCs to start reporting HCPCS codes January 1, 2011 to provide CMS data to establish new system

CMS issued proposed rule in September 2013, with comment period

CMS issued final rule in May 2014 with comment period

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Implementation

Per ACA, CMS must implement Medicare PPS for cost reporting periods beginning on or after October 1, 2014

Each FQHC will transition to the PPS as of the day of its first cost reporting period beginning on or after October 1, 2014

FQHCs may not change cost reporting periods in order to implement the PPS earlier

All FQHCs will be expected to transition to PPS by January 1, 2016
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Establishing the PPS Base Rate

CMS set a national, all-inclusive, encounter-based PPS rate

CMS set base payment using the most recent health center cost report data

Base PPS payment set at $158.85

Geographic Adjustment

Base PPS payment ($158.85) X GAF (.958) = Health Center PPS rate ($152.18)

South Carolina's GAF = .958
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Adjustments to the Base Rate

High-intensity visits

- New Patients, Patients receiving comprehensive initial Medicare visit (IPPE or AWV), Patients receiving subsequent AWV

  Base PPS payment \times GAF \times \text{multiplier for high intensity visit} = \text{FQHC’s adjusted PPS rate for high intensity services}

  Multiplier is 1.3416 (South Carolina = $204.16)

The PPS rate will be updated annually using the Medicare Economic Index (MEI), starting January 1, 2016

ACA suggests CMS should develop an FQHC specific market basket to serve as the annual inflation update
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Same Day Visits

“All-inclusive” payment rate is intended to reflect all services that an FQHC furnishes in a single day to an individual. FQHC’s currently able to bill for both Medical and mental health visits in the same day, as well as medical and DSMT/MNT services. CMS originally proposed to eliminate ability to bill for same-day visit, but reversed this policy in the final rule, allowing for: mental health visit provided on same day as medical, and multiple visits on same day due to subsequent illness or injury.

New Medicare PPS

The Affordable Care Act created a new Medicare PPS

“Lesser-of” payment provision:

“... with respect to Federally qualified health center services for which payment is made under section 1834(o), the amounts paid [by Medicare] shall be 80 percent of the lesser of the actual charge or the amount determined such section [PPS Rate]
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“Lesser-of” Provision – the Problem

“Actual Charge” undefined in statute and regulations

CMS stated in guidance after proposed rule that “actual charge” for a visit would equal the sum of FQHC charges for individual services/items reflected in each claim

Apples to Oranges Comparison

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“Lesser-of” Provision – the Solution

Final rule implements five “G-Codes” for more “apples to apples” comparison

Each of the five “G-codes” represent a different type of health center visit

Health centers WILL have to continue to report the HCPCS code along with the appropriate G-code to CMS
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The Five 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, established patient

“Lesser-of” Provision – The Solution
FQHCs may need to take steps including:
1. Evaluating schedule of charges – it should list a charge for each service/procedure
2. Evaluating coding practices – clinicians should indicate all relevant services/procedures on each Medicare claim
3. Identifying bundle of services associated with visits in each G-code category
4. Ascertaining “average Charge” per visit for that bundle of services [total charges for all services/number of visits]
5. Determining “Cost-charge ratio” [how costs per visit compare to charges per visit for bundle of services identified in G-codes]
New Medicare PPC

Coinsurance
FQHC will apply G-code charge for relevant visit to determine 20% of “actual charge”
Medicare’s payment + Coinsurance = lesser of PPS or Actual Charge [G-code charge]

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Coinsurance for Preventative Services
ACA waived coinsurance for certain preventative services
If a visit includes only a preventative service, waive the copayment
If a visit includes a preventative service AND other service, follow the formula below:
1. Determine lesser of PPS rate or actual (G-code) charge for visit
2. Subtract coinsurance associated with reported line-item charge for preventative component
3. 20% coinsurance imposed on the difference
**New Medicare PPS**

**Medicare Advantage Wrap Around**
Health centers providing care to Medicare Advantage patients receive a supplemental payment, up to the all inclusive rate (“wrap around payment”)

Do not apply “lesser of” provision when figuring wrap around payment

Medicare Advantage Wrap Around Payment = [adjusted PPS rate] – [payment from plan] – [cost-sharing imposed by plan]

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**New Medicare PPS**

**Cost Reports**
Health centers will continue to submit cost reports

Certain services will continue to be billed separately on cost report
- Influenza and pneumococcal vaccines, Medicare bad Debts

Will also help inform CMS as it works to develop a market basket and inform health centers as they develop their G-codes
FQHC Billing Requirements

- 77X type of bill
- Include all covered FQHC services
  - HCPCS/CPT with the appropriate revenue code and charges
- Applicable revenue codes required
  - All valid revenue codes lines accepted

FQHC Revenue Codes

- 0519 – Supplemental payment for visit by a beneficiary in a contracted Medicare Advantage Plan
- 0521 – Clinic visit by beneficiary to the FQHC
- 0522 – Home visit by the FQHC practitioner
- 0524 – Visit by the FQHC practitioner to a beneficiary in a covered Part A stay at the Skilled Nursing Facility
- 0525 – Visit by FQHC practitioner to a beneficiary in a SNF (not in a covered Part A stay) or Nursing Facility or Intermediate Care Facility for individuals with Mental Retardation (ICF/MR) or other residential facility
- 0527 – FQHC Visiting Nurse Service(s) to a member’s home when in a home health shortage area
- 0528 – Visit by a FQHC practitioner to other non FQHC site (e.g., scene of accident)
- 0900 – Behavioral Health Treatment Services
FQHC Billing Requirements

FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on the FQHC claim if provided as part of an encounter.

- If the only service provided was either of these vaccines, there is no claim to be submitted to Medicare, these services may be reported on the cost report.

Diabetes Self-Management Training (DSMT) and Medical Nutritional therapy (MTN) services should not be reported on the same day.

Under the New PPS – ALL services rendered on the same day must be submitted on one claim, multiple claims submitted with the same DOS will be rejected.

FQHC Billing Requirements

FQHC payment codes G0466, G0467, and G0468 must be reported with revenue code 052X or 0519.

FQHC payment codes G0469 and G0470 must be reported with revenue code 0900 or 0519.

Each FQHC payment code (G0466-G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit.
Implementing PPS in your FQHC

- Charge Setting
- IT System
- Training
- Coding Auditing System

Charge Setting

- Careful setting of the schedule of charges has never been more important.
- Medicare has generally been the benchmark that private payers have used to set their reimbursement rates.
- Data is available that can be extremely helpful in setting fees.
- The Section 300 mandate for the FQHC to “cover its reasonable costs” should be considered to be the minimum level where fees should be set.
Implementing PPS in your FQHC

IT System
- FQHCs use a number of different computer systems, each of which handles fee schedules and billing differently.
- The Vendors should all have provided information and training on the changes necessary to implement PPS Medicare billing.
- Setting up the fee schedules and billing rules are complex tasks requiring a high level of understanding of both billing in general and the software being utilized.
- Because the PPS is being phased in, and claims will need to be processed with dates of service both before and after the effective date, some complex rules are required.

Training
- Training is a crucial element in the implementation process.
- Appropriate training is required for front desk, clinical, and billing staff.
- A detailed set of procedures, reflecting how the organization operates is crucial.
- The HCHCS data generated thus far suggests that there is significant room for improvement in FQHC billing processes.
Implementing PPS in your FQHC

Coding Auditing system

- A system that ensures coding accuracy by providers is crucial.
- Since each G-code can represent a numerous combination of services, the HCPCS codes provided in the claim must accurately reflect the visit being billed.
- The vast amount of data being captured in EHRs, as well as being provided to CMS in the billing makes increased claim audits likely.
- If history is any indication, FQHCs are far more likely to under-code visits than over-code, costing themselves needed and deserved revenues.

QUESTIONS?

William Feagin
Director of Revenue Maximization