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HEALTH LAW NEWS

SEPTEMBER 30, 2013

CMS ISSUES PROPOSED RULE ESTABLISHING MEDICARE FQHC PROSPECTIVE PAYMENT SYSTEM

EXECUTIVE SUMMARY

On September 23, 2013, the Centers for Medicare & Medicaid Services ("CMS") published a proposed rule ("Proposed Rule") enumerating the details of the pending prospective payment system ("PPS") for Federally Qualified Health Centers ("FQHCs"). This Proposed Rule was developed in response to a mandate established in the Patient Protection and Affordable Care Act of 2010 ("ACA"). The FQHC PPS is set to become effective for cost reporting periods beginning on or after October 1, 2014.

The ACA requires that the FQHC PPS take into account the type, intensity and duration of FQHC services. After considering those factors, CMS is proposing to adopt an encounter-based payment methodology. This would be implemented as an initial base rate per patient visit of $155.90 times i) a geographic adjustment factor ("GAF"); and ii) if applicable, a high-intensity initial visit multiplier. As proposed, FQHCs can bill only one visit per patient per day. The proposed encounter-based payment methodology is similar to the current Medicaid payment methodology for FQHCs in many states. This shift to a PPS system is significant since, even though services to Medicare beneficiaries only represent approximately 9% of total FQHC billing,[1] CMS anticipates the new FQHC PPS will increase Medicare payments to FQHCs by approximately 30%. Key components of the Proposed Rule are summarized below.

ANALYSIS AND DISCUSSION

Encounter-Based Per Diem Rate. The Proposed Rule represents a notable departure from Medicare's current reasonable cost-based methodology, through which FQHCs are paid a per encounter, all-inclusive rate ("AIR"). This AIR includes costs associated with medically-necessary professional services furnished in person at an FQHC, as well as services and supplies furnished incident to those professional services. Because FQHCs are accustomed to billing Medicare based on per encounter AIR-based methodology, CMS opted to maintain the per encounter payment rate approach as the basis for the FQHC PPS.

The current AIR is calculated by dividing the total allowable costs (including, but not limited to, certain practitioner compensation, overhead, equipment, supplies and personnel costs) by the total number of visits, subject to a productivity threshold. While current allowable costs are subject to tests of reasonableness, productivity standards and a maximum per-visit rate, the Proposed Rule eliminates those tests, standards and limits. Instead, the Proposed Rule arrives at a predetermined national per diem rate ("Per-Visit Rate") by estimating total national FQHC costs based on claims data received by CMS, subject to certain outlier adjustments, and dividing that number by the total number of daily visits to arrive at an average cost per visit.

The ACA requires that the Per-Visit Rate be equal to 100% of the estimated reasonable costs that would have occurred absent the FQHC PPS, without applying the current tests of reasonableness, productivity standards and payment limits. The base Per-Visit Rate noted in the Proposed Rule is $155.90, which includes an estimated Medicare Economic Index ("MEI") adjustment trended forward to December 31, 2015. In subsequent years, the base Per-Visit Rate will be adjusted by the MEI or by a percentage increase in a market basket of FQHC goods and services to be developed by CMS.

The ACA further requires Medicare payments to any particular FQHC under the PPS to be the lesser of 80% of that FQHC's actual charge, or 80% of the Per-Visit Rate. For example, if an FQHC's charges were $145.00, Medicare would pay the FQHC $116.00, instead of the $124.72 that Medicare would pay under the Per-Visit Rate (before adjustments). Except where Medicare waives beneficiary copayments for certain preventative services, the remaining 20% of the FQHC's actual charge or Per-Visit Rate, whichever is less, would be paid by the beneficiary as a copayment. In the example above, the beneficiary copayment would be $23.20 instead of the $24.94 the beneficiary would pay under the Per-Visit Rate. In either case, total payment to the FQHC would be greater than the current rural and urban FQHC upper payment limits ($128.00 per visit for urban FQHCs and $110.78 for rural FQHCs).

Adjustments to the Base Per-Visit Rate. CMS anticipates the following adjustments will be made to the base Per-Visit Rate.

1. *Geographic Adjustment*. Under the Proposed Rule, CMS intends to use Geographic Practice Cost Indices to adjust the Per-Visit Rate for

geographic differences in the cost of services. For example, an FQHC providing services in Chicago, Illinois would be paid a Per-Visit Rate of $160.89, calculated as follows: the base Per-Visit Rate of $155.90 multiplied by a GAF of 1.032. An FQHC providing services in Wisconsin would be paid a Per-Visit Rate of $151.53, calculated as follows: the base Per-Visit Rate of $155.90 multiplied by a GAF of 0.972. The list of proposed GAFs can be accessed here.

2. *New Patient or Initial Medicare Visit*. CMS acknowledged in the Proposed Rule that new patient visits and Medicare beneficiaries receiving a comprehensive initial Medicare visit require greater FQHC resources. CMS is proposing to increase the Per-Visit Rate for those visits by 33%. In the examples above, an FQHC located in Chicago would be paid $214.51 ($160.89 x 1.3333) for a new patient visit, and an FQHC located in Wisconsin would be paid $202.03 ($151.53 x 1.3333).

Elimination of One Visit Per Day Exception. CMS is proposing to eliminate the existing FQHC exception to the single encounter payment per day rule. According to CMS, the exception is used very infrequently (0.5% of all visits), and removal of that exception would simplify the PPS billing and payment procedures. Additionally, CMS noted the Per-Visit Rate is slightly higher than payment FQHCs would otherwise receive, were multiple encounters on the same day to be permitted.

Waivers of Beneficiary Coinsurance. Consistent with the treatment of coinsurance in certain other Medicare settings, CMS is proposing that beneficiary coinsurance under the FQHC PPS would be 20% of the FQHC's actual charge or 20% of the Per-Visit Rate, whichever is less. However, Medicare began waiving beneficiary coinsurance for certain eligible preventative services as of January 1, 2011. In the Proposed Rule, CMS indicated that it is considering several approaches to implement a coinsurance waiver for payments based on the Per-Visit Rate when both preventative services and non-preventative services are provided. The options considered include the unbundling of services and coinsurance payments based on proportionality of preventative services to aggregate encounter services. CMS is currently leaning toward using a proportionality approach, where preventative services are coded on a claim, and CMS would use charges under the Physician Fee Schedule to determine what portion of the beneficiary's coinsurance would be waived.

Medicare Advantage Organizations. For FQHCs contracting with Medicare Advantage ("MA") organizations, the ACA requires FQHCs be paid at least the same amount they would have received for the same service under the FQHC PPS. Consistent with current policy, FQHCs receiving a lower contract rate with an MA organization would receive a wrap-around payment from Medicare to cover the difference.

Transition Period. All FQHCs will transition to the FQHC PPS for cost reporting periods beginning on or after October 1, 2014. The current reasonable cost methodology will apply until all FQHCs have transitioned to the PPS. CMS also expects that the PPS will eventually transition to a calendar year basis. CMS has tentatively proposed January 1, 2016 as the date for the calendar year transition.

Effect of Proposed Rule on Other FQHC Billing and Reporting Requirements. Other FQHC billing practices and reporting requirements are unaffected by the Proposed Rule. Specifically, FQHCs will still be required to file cost reports, even though such cost reports will not be used to reconcile Medicare payments for professional services with FQHC costs. Also, Medicare payments for the reasonable costs of influenza and pneumococcal vaccines and their administration, allowable graduate medical education costs and bad debts will continue to be determined and paid through cost reports. Finally, FQHCs will continue to bill Medicare Part B separately for technical components associated with professional services.

PRACTICAL TAKEAWAYS

The deadline for submitting comments on the Proposed Rule is November 18, 2013. FQHCs may wish to coordinate in preparing and submitting comments. Comments have specifically been sought by CMS on the following items:

- Removal of the exception allowing billing for more than one patient visit per day. Also, to the extent multiple encounters in a day for a patient occur more frequently than the data suggests, reasons for underreporting.
- How the proposed approach to waiving beneficiary coinsurance for preventative services would impact the FQHC's administrative procedures and billing practices.

Should your organization require assistance in evaluating the Proposed Rule or would like assistance in preparing comments, please contact Todd Nova at (414) 721-0464 or tnova@hallrender.com, Megan L. Snow at (414) 721-0457 or msnow@hallrender.com or your regular Hall Render attorney.

Please visit the Hall Render Blog at http://blogs.hallrender.com/ for more information on topics related to health care law.

[1]According to data from the U.S. Health Resources and Services Administration, the patient mix of FQHCs nationally is as follows: approximately 8% of patients are Medicare beneficiaries, 41% are Medicaid beneficiaries, 36% are uninsured and the remaining 15% are privately insured or had other public insurance.