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Centers for Medicare & Medicaid Services
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CMS FACT SHEET

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Final Policy and Payment Changes for the New Medicare Prospective Payment System (PPS) for Federally Qualified Health Centers Beginning October 1, 2014

OVERVIEW:

The Centers for Medicare & Medicaid Services (CMS) finalized a new prospective payment system (PPS) for Federally Qualified Health Center (FQHC) services under Medicare Part B that could enable FQHCs to receive as much as a 32 percent increase in their Medicare payments for services furnished to Medicare beneficiaries. The Affordable Care Act directed CMS to develop a PPS for Medicare payments to FQHCs beginning on October 1, 2014.

FQHCs provide comprehensive primary and preventive health services. The majority of FQHCs receive Federal grant funds through Section 330 of the Public Health Service Act. In 2012, FQHCs, accounted for more than 9,000 service sites serving 21 million people throughout the United States. Medicare accounted for approximately 9 percent of their total billing.

BACKGROUND:

AFFORDABLE CARE ACT REQUIREMENTS:

The Affordable Care Act directed CMS to develop a PPS for Medicare payments to FQHCs, to be implemented beginning October 1, 2014. In developing the Medicare FQHC PPS, the statute requires CMS to take into account the type, intensity, and duration of FQHC services and allows other adjustments such as geographic adjustments. Initial payment rates (Medicare and coinsurance) must equal 100 percent of reasonable costs, as determined without application of the current system's per visit payment limits and adjustments that can reduce an FQHC's per visit rate. The law requires that FQHCs be paid the lesser of their actual charge or the PPS amount. In subsequent years, rates must be adjusted by the Medicare Economic Index (MEI) or by a percentage increase in a market basket of FQHC goods and services.

Medicare currently pays FQHCs an all-inclusive rate for the professional component of qualified primary and preventive health services furnished to the same beneficiary on the same day. Under the current reasonable cost-based payment system, an all-inclusive rate is determined annually for each FQHC and is subject to productivity standards and an upper payment limit. The 2014 upper payment limits for rural and urban FQHCs are \$111.67 and \$129.02, respectively. The payment limits are adjusted each year by the MEI. Beneficiaries pay coinsurance based on 20 percent of the FQHC's charges and no deductible applies. In 2011, total Medicare payments to FQHCs were approximately \$500 million.

KEY ASPECTS OF THE NEW PAYMENT SYSTEM

Encounter-Based Per Diem Rate:

To develop a system consistent with the statute that balances the need for appropriate payments to FQHCs, maintains administrative simplicity, and preserves access to care for beneficiaries, FQHCs will be paid based on a single encounter-based per diem rate per Medicare beneficiary, with some exceptions and adjustments. The encounter-based per-diem base rate, which is based on an average cost per encounter, is \$158.85, which includes an MEI adjustment that trends dollars forward through December 31, 2015. The encounter-based per-diem rate will have the following adjustments:

- **Geographic Adjustment:** The encounter-based per diem rate will be adjusted for geographic differences in the cost of services by using the FQHC Geographic Adjustment factor (FQHC GAF), which is adapted from the Geographic Practice Cost Indices used to adjust payment under the physician fee schedule (PFS).
- **New Patient, IPPE, and AWW Adjustment:** The encounter-based per diem rate will be adjusted for greater intensity and resource use when an FQHC furnishes care to a patient that is new to the FQHC or to a beneficiary receiving an initial preventive physical examination (IPPE) or an annual wellness visit (AWV). For such visits, FQHCs will receive a payment that is 34 percent higher than the encounter-based rate.

Beneficiary Coinsurance:

Under the current reasonable cost-based payment system, beneficiary coinsurance for FQHC services is based on the amount the FQHC charges and may be higher than 20 percent of the total payment made to the FQHC. Consistent with the Affordable Care Act's requirement that Medicare payment under the FQHC PPS shall be 80 percent of the lesser of the provider's charge or the PPS encounter rate, coinsurance will be 20 percent of the lesser of the provider's charge or the PPS encounter rate.

Transition Period:

The statute requires implementation of the FQHC PPS for cost reporting periods beginning on or after October 1, 2014. FQHCs will transition into the PPS based on their cost reporting periods. The claims processing system would maintain the current system and the PPS until all FQHCs have transitioned. The FQHC PPS rate is required by statute to be adjusted based on the MEI after the first year of implementation, and either the MEI or a percentage increase in a market basket of FQHC goods and services in subsequent years. The FQHC PPS will be updated on a calendar year basis to match the PFS.

Comments:

Comments are being accepted on how Chronic Care Management policies for physicians billing under the physician fee schedule can be adapted for FQHCs in order to help achieve the goals of furnishing integrated and coordinated services.

CMS is also seeking comments on the proposed "G-Codes" for Medicare payment to FQHCs under the PPS.

In addition, CMS seeks comments on a modification that would simplify the methodology for calculating coinsurance when a preventive and non-preventive service is on the same claim.

CMS will accept comments on these provisions until July 1, 2014.

OTHER CHANGES:

Rural Health Clinics Contracting: This final rule establishes a policy that allows Rural Health Clinics (RHC) to contract with non-physician practitioners when statutory requirements for employment of Nurse Practitioners and Physician Assistants are met, and make other technical and conforming changes to the RHC and FQHC regulations.

Clinical Laboratory Improvement Amendment Proficiency Testing: The Clinical Laboratory Improvement Amendments of 1988 (CLIA) require laboratories to participate in proficiency testing (PT), an important tool to ensure the accuracy and reliability of laboratory test results. Laboratories are required to test PT samples in the same manner as patient specimens, except that they cannot refer these samples to another laboratory for testing for any reason. Historically, the CLIA statute required the revocation of the laboratory's CLIA certificate and a subsequent two-year ban on the owner or operator of the laboratory from owning or operating another CLIA-certified laboratory when a PT referral was substantiated. The two-year ban on the owner or operator was problematic for public health laboratories, large medical systems, and other laboratories that may share a common owner or operator. Additionally, many public health laboratories and large medical systems have multiple laboratories operating under a single CLIA certificate. In these situations, if a PT referral occurred and the laboratory's CLIA certificate was revoked, all laboratories under that certificate were no longer permitted to perform laboratory testing.

The Taking Essential Steps for Testing Act ("TEST Act") (Pub. L. 112-202) was enacted in December 2012. It amended section 353 of the Public Health Service Act (the CLIA statute) to provide the Secretary with discretion as to which sanctions may be applied to cases of intentional PT referral. Such discretion replaces the automatic revocation of the laboratory's CLIA certificate and subsequent imposition of the two-year ban on the laboratory's owner or operator, which would prevent them from owning or operating a CLIA-certified laboratory. This rule fully implements the TEST Act. The rule allows for a better fit between the nature and extent of an intentional PT referral violation and the penalties that are imposed. In this rule, we are finalizing three tiered categories of sanctions for a PT referral (including revocation of the CLIA Certificate and/or alternative sanctions) to be applied under certain specified conditions, based on the severity and extent of the violation. These categories reserve revocations and the most serious sanctions for the most egregious violations while assigning lesser sanctions and civil monetary penalties to cases involving less serious violations.

The final rule will be displayed for public inspection in the *Federal Register* on April 29, 2014. For more information about the FQHC PPS, please see: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html>.

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