

CMS FACT SHEET

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CMS Proposes New Medicare Prospective Payment System (PPS) for Federally-Qualified Health Centers Beginning October 1, 2014

OVERVIEW: On September 18, 2013, the Centers for Medicare & Medicaid Services (CMS) will issue a proposed rule that would establish methodology and payment rates for a prospective payment system (PPS) for Federally Qualified Health Center (FQHC) services under Medicare Part B. 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, are generally required to treat all patients regardless of their ability to pay, and offer a sliding fee scale to persons with incomes below 200 percent of the Federal Poverty Line. The majority of FQHCs receive Federal grant funds through Section 330 of the Public Health Service Act. In 2012, these FQHCs, accounted for 8,900 service sites serving 21 million people throughout the United States. Medicare accounted for approximately 9 percent of their total billing. We estimate that the proposed payment system would increase Medicare payments to FQHCs by approximately 30 percent for services furnished to Medicare beneficiaries.

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 payments (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. 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 2013 upper payment limits for rural and urban FQHCs are \$110.78 and \$128, 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 PROPOSED 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, CMS is proposing payment to FQHCs based on a single encounter-based per diem rate per Medicare beneficiary. The encounter-based per-diem base rate would be calculated based on an average cost per encounter. It is estimated to be \$155.90, which includes an MEI adjustment that trends dollars forward through December 31, 2015. This amount may be changed in the final rule based on more current data. The encounter-based per-diem rate would have the following adjustments:

Geographic Adjustment: CMS proposes that the encounter-based per diem rate be adjusted for geographic differences in the cost of services by adopting the Geographic Practice Cost Indices (GPCI) used to adjust payment under the physician fee schedule (PFS).

New Patient or Initial Medicare Visit: CMS proposes that the encounter-based per diem rate 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 a comprehensive initial Medicare visit (i.e., an initial preventive physical examination or an initial annual wellness visit). For such visits, CMS proposed to increase the encounter-based rate by approximately 33 percent.

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, CMS is proposing that coinsurance would be 20 percent of the provider's charge or the PPS encounter rate, whichever is less. This is consistent with how coinsurance is calculated under other Medicare payment systems.

Transition Period:

The statute requires implementation of the FQHC PPS for cost reporting periods beginning on or after October 1, 2014. CMS is proposing that FQHCs would 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. CMS is also proposing to transition the PPS to a calendar year update to match the PFS that is also updated on a calendar year basis.

OTHER PROPOSED CHANGES:

Rural Health Clinics Contracting: This proposed rule would establish a policy that would allow 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 CLIA certificate and a subsequent two-year ban for the owner or operator of the laboratory from owning or operating another CLIA-certified laboratory when PT referral has been substantiated. The two-year ban for the owner and operator is 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 PT referral occurred and the CLIA certificate was revoked, all laboratories under that certificate were no longer permitted to perform laboratory testing.

The Taking Essential Steps for Testing Act or “TEST Act” (Pub. L. 112-202), was enacted in December 2012. It amended section 353 of the Public Health Service Act to provide the Secretary with discretion as to which sanctions may be applied to cases of intentional PT referral. This would be in lieu of the automatic revocation of the CLIA certificate and subsequent imposition of the two-year ban on the laboratory’s owner or operator preventing them from owning or operating a CLIA-certified laboratory. The purpose of this rule is to propose amendments to the CLIA regulations to align them with the statutory changes and to propose the regulatory provisions needed to fully

implement the TEST Act. If finalized, the proposals would allow for a better fit between the nature and extent of the intentional PT referral incident(s) and the type and extent of corrective actions that are imposed. In this rule, we are proposing three tiered categories of sanctions for PT referral (including revocation and/or alternative sanctions) to be applied under certain specified conditions and based on the severity and extent of the violation(s). These categories would 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 proposed rule will be displayed in the *Federal Register* on September 18, 2013. CMS will accept comments on the proposed rule until November 18, 2013.

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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