



Federally Qualified Health Center Version

KEY CONCEPTS OUTLINE

Module 3: Basic Reimbursement Principles for Federally Qualified Health Center Services

- I. Overview of Federally Qualified Health Center Prospective Payment System (FQHC PPS)
 - A. Background
 1. Historically, Medicare reimbursement of FQHCs was based on a cost-based reimbursement system. In 2014, through final rule making, a new methodology and reimbursement rate was established. Effective on the first day of the FQHCs year that began on or after October 1, 2014, FQHCs were transitioned to a prospective payment system for FQHC services under Medicare Part B.
 - B. FQHC PPS Payment Rate
 1. FQHCs are reimbursed a single per-diem rate based on a prospectively set rate for each beneficiary visit for an FQHC covered service. <See 42 C.F.R. § 405.2462 (e)>
 - a. The rate is based on 100 percent of the FQHC's reasonable costs incurred in furnishing care to Medicare beneficiaries for previous cost reporting years.
 - i. The base payment rate is established using historical data through quarter 2, 2022.
 - ii. CMS determines the average per diem cost using the following calculation:
 - (a) Average Per Diem Cost = Total FQHC costs /total FQHC daily encounters

- b. Beginning on January 1, 2017, PPS rates will be increased by the percentage increase in a market basket of FQHC goods and services as established through regulations, or, if not available, the Medicare economic index. < See 42 C.F.R. § 405.2467 (c)(2)>
- 2. From January 1, 2023, through December 31, 2023, the FQHC PPS base payment rate is \$187.19. < See *Medicare Claims Processing Manual Transmittal, 11677*>
 - a. The 2023 base payment rate reflects a 3.9 percent increase from the 2022 base payment rate of \$180.16.

II. Calculation of an FQHC Specific PPS Payment rate

A. The national base payment rate is adjusted by the following:

- 1. Geographic Adjustment Factor
 - a. Takes into consideration the location of where the services are furnished.
 - b. Based on the location (zip code +4) and the date of service it was furnished.
 - i. Note: Payments may differ between FQHCs within the same organization.
- 2. Composite Adjustment Factor
 - a. An adjustment applied once per day, per beneficiary taking into consideration the lengthier and more comprehensive visits.
 - b. The composite adjustment factor is 1.3416 (34.16%) and applies to:
 - i. New patient visit
 - (a) Patient is new to the FQHC and has not been seen at any FQHC locations within the organization.
 - ii. Initial Preventive Physical Examination (IPPE)
 - iii. Initial or subsequent annual wellness visit (AWV). <See 42 C.F.R.2462 (e)>

B. Total FQHC PPS Payment per Visit Calculation

1. FQHC PPS Payment = FQHC base rate X Geographic adjustment factor x Composite Adjustment factor

FQHC PPS Payment Example

Facts: An established patient presents with a complaints of cough, congestion, and fever. Physician performs an evaluation and management service of moderate complexity. Based on the physician's initial assessment antibiotics were prescribed for a sinus infection. The physician reported CPT 99213 for the evaluation and management service. What is the FQHC's reimbursement?

PPS Rate = 160.00

Provider's actual charge for payment code \$150.00

Revenue Code	HCPCS	MOD	DOS	Total Charge	Covered Charge
0519	G0467 FQHC Payment Code		01/22/2023	150.00	150.00
0519	99213 Qualifying Visit		01/22/2023	135.00	135.00
0001				285.00	285.00
PPS Rate	\$225.00				

III. FQHC Supplemental Payments

- A. CMS must provide supplemental payments to FQHCs that contract with Medicare Advantage (MA) organizations to cover the difference between the MA payment and the FQHC PPS payment (per diem amount) that would be made under original Medicare program. < See 42 C.F.R 405.2469; *Medicare Claims Processing Manual*, Chapter 9, §60.4>
1. If the MAC determines the MA payment is less than the FQHC PPS payment made under original Medicare, the MAC will pay the difference to the FQHC. < See 42 C.F.R 405.2469; *Medicare Claims Processing Manual*, Chapter 9, §60.4>
 - a. The supplemental or wraparound payment is based on the PPS rate without comparison to the FQHC's charge.
 2. The supplemental or wraparound payment are not adjusted for coinsurance or preventive services, as the coinsurance or waiver of coinsurance would have been taken into consideration in the MA payment. < *Medicare Claims Processing Manual*, Chapter 9, §60.5>
- B. Per Visit Supplemental Payment
1. Per visit supplemental payments are made when a covered face-to-face encounter or an encounter furnished via two interactive technology or audio only interactions (due to the beneficiary consent or ability) for the purpose of diagnosis, evaluation, or treatment of a mental health disorder between the MA enrollee and the FQHC practitioner. <See 42 C.F.R 405.2469 (d)>
- C. Billing for Supplemental Payments
1. Supplemental payments for an encounter are billed to the MAC, on TOB 077X with revenue code 0519.
 2. The claim must contain the appropriate FQHC payment code and the HCPCS qualifying visit code. Both codes are reported under revenue code 0519.

MA Claim Qualifies for Supplemental Wraparound Payment Example

PPS Rate =225.00

MA Contract Rate = \$200.00

Revenue Code	HCPCS	MOD	DOS	Total Charge	Covered Charge
0519	G0468 FQHC Payment Code		01/22/2023	170.00	170.00
0519	G0439 Qualifying Visit		01/22/2022	150.00	150.00
0001				320.00	320.00
PPS Rate	\$225.00				

Wraparound Payment = PPS Rate- MA Contract Rate

\$225-200 =\$25.00

IV. Sliding Scale

- A. FQHCs, approved by Health Resources and Services Administration (HRSA), are required to establish a sliding fee scale in accordance with statutory and HRSA requirements. . <See *Medicare Benefit Policy Manual*, Chapter 9 § 90.2>
- B. The HRSA approved FQHC must have a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. <See HRA
 - 1. The FQHC must notify patients of the availability of the sliding fee discount.
 - 2. The fee scale/schedule must be based on the most recent Federal poverty level guidelines and be updated on an annual basis.
 - 3. Sliding Fee Discounts Must:
 - a. Provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged);
 - b. Provide varying discounts (slide) for incomes between 100% and 200% of poverty, and incorporate a sliding discount policy based on family size and income; and
 - c. No discounts provided to patients with incomes over 200 % of the Federal poverty guidelines.

V. Calculation of Patient's Deductible and Coinsurance

C. Deductible

- 1. Each calendar year, a single deductible is established for most Medicare Part B services. <See *Medicare Claims Processing Manual*, Chapter 9 § 40.1>
 - a. For CY 2023, the Part B deductible is \$226.00.
 - a. In general, the beneficiary must pay the annual Part B deductible before Medicare begins to pay for the services. However, ***the Part B deductible does not apply to FQHC-covered services*** <See *Medicare Claims Processing Manual*, Chapter 9 § 40.1>

B. Coinsurance

1. FQHC Services

- a. The patient is responsible for a coinsurance amount of 20 percent of the lesser of the FQHC's actual charge for the specific payment code or the adjusted PPS rate <See *Medicare Claims Processing Manual*, Chapter 9 § 40.2>
 - i. Certain preventive services are statutorily waived and are not included in the calculation of coinsurance.
 - ii. For FQHC services paid under the MPFS (i.e., CCM, PCM, BHI, CoCM, VCS, and telehealth originating site fee), the calculation of coinsurance is based on 20% of the MPFS allowed amount.
 - iii. An FQHC may waive coinsurance after a good faith determination that the patient is in financial need. The waivers must not be routinely offered or are advertised.
2. Non-FQHC Services
- a. When an independent FQHC bills the Part B MAC on a 1500 claim form for non-FQHC services, the coinsurance amount is usually based on 20% of the MPFS allowed amount. For more information, see *Medicare Claims Processing Manual*, Chapter 12.
 - b. When a provider-based FQHC (or the parent provider) bills the Part A MAC on the UB-04 claim form for non-FQHC services, the coinsurance amount is based on the rules applicable to the parent provider and type of bill (e.g., TOB 0851 CAH or TOB 131 OPPS). For more information, see the *Medicare Claims Processing Manual*, Chapter 4.
- C. Medicare Reimbursement of FQHC services <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.1; see *Medicare Claims Processing Manual*, Chapter 9 § 40.1; see *CMS Rural Health Clinic Fact Sheet*, May 2019>
- 1. For qualifying medical or mental health visits, Medicare pays independent FQHCs and PB FQHCs, the *lesser* of :
 - a. 80% of the FQHCs actual charge for the specific payment code, **or**
 - b. 80% of the adjusted FQHC PPS rate.
 - 2. For preventive health visits for which coinsurance waived, Medicare reimbursement is the lesser of:
 - a. 100 % of the FQHCs actual charge for the specific payment code, or

- b. 100 % of the adjusted FQHC PPS rate.

V. Cost Reporting

D. An FQHC must submit an annual Medicare cost report to their MAC.

1. The FQHC is paid for the costs of graduate medical education payments, bad debt, influenza and pneumococcal vaccines and administration through the cost report.
 - a. Independent of whether the FQHC has GME costs, bad, debt, or costs associated with influenza and pneumococcal vaccines and their administration, the FQHC must file a cost report.
 - b. An FQHC can claim bad debt for unpaid coinsurance. <See *Medicare Calculation of a Patient's Deductible and Coinsurance*

If an FQHC claims bad debt, it must be able to show that reasonable efforts were made to collect the amounts. Coinsurance that is waived, either due to a statutory waiver or a sliding fee scale, may not be claimed as allowable costs.

The Medicare principles of reimbursement for allowable costs are stated in 42 CFR 413 and in the Medicare Provider Reimbursement Manual, 15-1.

Information on cost report forms and the reporting process can be found in the Medicare Provider Reimbursement Manual, 15-2.

c. Consolidated Cost Reports

- i. FQHCs with more than one site may file consolidated cost reports if approved by the A/B MAC in advance of the reporting period for which the consolidated report is to be used.
 - (a) Once the election to use a consolidated cost report has been made, the FQHC may not revert to individual reporting without first obtaining prior approval of the A/B MAC. <See *Medicare Benefit Policy Manual*, Chapter 13, § 80.2>

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11677	Date: November 4, 2022
	Change Request 12961

SUBJECT: Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2023

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Prospective Payment System (PPS) base payment rate and the Geographic Adjustment Factors (GAFs) for the Federally Qualified Health Center (FQHC) Pricer. This Recurring Update Notification applies to Chapter 9, section 30 of the IOM.

EFFECTIVE DATE: January 1, 2023

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 3, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 11677	Date: November 4, 2022	Change Request: 12961
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SUBJECT: Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2023

EFFECTIVE DATE: January 1, 2023

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 3, 2023

I. GENERAL INFORMATION

A. Background: Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111–148 and Pub. L. 111–152) added Section 1834(o) of the Act to establish a payment system for the costs of Federally Qualified Health Center (FQHC) services under Medicare Part B based on prospectively set rates. In the Prospective Payment System (PPS) for FQHC Final Rule published in the May 2, 2014 Federal Register (79 FR 25436), the Centers for Medicare & Medicaid Services (CMS) implemented a methodology and payment rates for FQHCs under the PPS beginning on October 1, 2014.

B. Policy: Under the FQHC PPS, Medicare pays FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically necessary face-to-face FQHC visit is furnished to a Medicare beneficiary. Section 1834(o)(2)(B)(ii) of the Act requires that the payment for the first year after the implementation year be increased by the percentage increase in the Medicare Economic Index (MEI). In subsequent years, the FQHC PPS base payment rate will be increased by the percentage increase in a market basket of FQHC goods and services, or if such an index is not available, by the percentage increase in the MEI.

Beginning in 2017, the FQHC PPS rate is updated annually by the FQHC market basket. Based on historical data through second quarter 2022, the FQHC market basket for Calendar Year (CY) 2023 is 3.9 percent. From January 1, 2023 through December 31, 2023, the FQHC PPS base payment rate is \$187.19. The 2023 base payment rate reflects a 3.9 percent increase above the 2022 base payment rate of \$180.16.

In accordance with Section 1834(o)(1)(A) of the Act, the FQHC PPS base rate is adjusted for each FQHC by the FQHC Geographic Adjustment Factor (GAF), based on the Geographic Practice Cost Indices (GPCIs) used to adjust payment under the Physician Fee Schedule (PFS). The FQHC GAF is adapted from the work and practice expense GPCIs, and are updated when the work and practice expense GPCIs are updated for the PFS. For CY 2023, the FQHC PPS GAFs have been updated in order to be consistent with the statutory requirements.

Contractors shall load the FQHC Pricer effective January 1, 2023.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC		H H H	D M E M A C	Shared- System Maintainers				Other	
		A	B			F I S S	M C S	V M S	C W F		
12961.1	Contractors shall load the FQHC Pricer effective January 1, 2023.										FQHC Pricer

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC			H H H	D M E M A C	C E D I	I
		A	B					
12961.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X						

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Glenn McGuirk, 410-786-5723 or Glenn.McGuirk@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Version 01/17/2023
Check for Updates