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# The New Medicare PPS For FQHCS

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# Health Centers Medicare Program

- While the Medicare program constitutes a small percentage of the overall Health Center patient related revenues, it is however an important 3<sup>rd</sup> party payer of services.
  - Medicare is the second best 3rd party payer after state Medicaid
- Based on CMS data –
  - Medicare population is expected to grow from a current 15% to an average of approximately 21% -25% in the next 2 years.
  - 70% of Medicare population is enrolled in traditional Medicare
  - 30% of Medicare population is enrolled in Medicare Managed Care
  - Medicare is therefore a revenue source that Health Centers should ensure compliance with due to potential increased revenues

# New Payment System

- Health Care Reform Legislation mandated a transition from the current Medicare FQHC cost based reimbursement system to a prospective payment system (PPS) where payment is based on a national rate
- In May 2014, CMS published a final rule that establishes a new methodology and reimbursement rate schedule for the prospective payment system for FQHC services under Medicare Part B.
  - Final rule notes that if the FQHCs charge structures remain the same, approximately 65% of FQHCs would be paid less under the new PPS rate methodology than they are currently paid
- FQHCs are required to transition to the new rate effective on the first day of the FQHC's year end that begins on or after October 1, 2014

# Medicare PPS Rate

- Single encounter-based prospective payment rate per beneficiary per day, with some adjustments
  - From 10/1/2014 to 12/31/2015, base rate is \$158.85
  - As of 1/1/2016, PPS base rate will increase by the % increase in the Medicare Economic Index (MEI)
  - As of 1/1/2017, PPS base rate will increase either by the % increase in the FQHC market basket index or the MEI
- Base rate was determined by CMS using FQHCs cost reports with periods ending between 6/30/2011 and 6/30/2013
- Rate was determined by dividing total allowable costs by total visits

# Medicare PPS Rate Adjustments

- Base PPS rate will be adjusted for 2 factors:

Geographic Adjustment Factor (GAF) – takes into consideration the location of where the services are furnished

- FQHC GAF for Metropolitan Boston – 1.082 (2014) & 1.085 (2015)
- FQHC GAF for Rest of MA – 1.038 (2014) & 1.040 (2015)
- GAF is always based on the location (zip+4) and the date of where and when the service is furnished
- Payment can be different for each FQHC site within the same organization as a whole

Multiply Base PPS Payment X GAF = Individual Health Center PPS Rate

# Medicare PPS Rate Adjustments(cont.)

- Base PPS rate will be adjusted for 2 factors:

Composite Adjustment Factor – 34.16% increase in PPS rate, applied once per day per beneficiary, to account for lengthier and more comprehensive types of visits such as:

- New patient visit – new patient to FQHC (not seen at any of FQHC sites within the last 3 years)
- Patient receiving an Initial Preventive Physical Examination (IPPE)
- Patient receiving an Annual Wellness Visit (AWV) whether initial or subsequent

Multiply Base PPS Payment X GAF X 34.16% = Individual Health Center PPS Rate

# Medicare PPS Payment

- **Payment is 80% of the lesser of the FQHC's actual charge for the payment code or the adjusted PPS rate**
- **To qualify for payment, a medically-necessary, face-to-face FQHC visit must be furnished to a Medicare beneficiary in order for FQHC to be paid**
  - IPPE and AWW – FQHC visits
  - Diabetes Self Management Training services (DSMT)
  - Medical Nutrition Therapy services (MNT)
  - Transitional Care Management services (TCM)
  - If above services are done on same day as another billable visit, only one visit is paid.
- **An additional payment is allowed if –**
  - An illness or injury occurs subsequent to the initial visit
  - A mental health visit is furnished on the same day as a medical visit
  - Needs to be billed on same claim

# Coinsurance

- 20% of the lesser of the FQHC's actual charge for the payment code or the fully adjusted PPS rate
  - Potential increase in patient coinsurance if FQHC increases its charges
- Preventive services – coinsurance waived, paid at 100%
- FQHC visit with a mix of preventive and non-preventive services – coinsurance is 20% of payment amount after the charges of the preventive services are subtracted



# Definition of New Patient

- A new patient is a person who has not received any professional medical or mental health services from any sites within the FQHC organization in the past 3 years
- If a new patient is also receiving a mental health visit on the same day, the patient is considered new for only one of those visits and not both

# G-Codes

CMS established 5 payment codes known as "G-codes" to be used by FQHC when submitting a claim to Medicare under FQHC PPS based on the services provided.

- G0466 – FQHC visit, new patient
- G0467 – FQHC visit, established patient
- G0468 – FQHC visit, IPPE or AWW
- G0469 – FQHC visit, mental health, new patient
- G0470 – FQHC visit, mental health, established patient

The G-codes describe the type of patients and not the services provided.

- Acuity of patient - irrelevant
- Greater intensity of resource use & lengthier visits - relevant

# G-Codes (continued)

Establishment of G-codes charges:

- no magic way of determining
  - requires thought and analysis
- 
- Final rule states references to charge setting requirements in section 330(k)(3)(G) of the Public Health Services Act and HRSA guidance
    - Consider actual and reasonable costs
    - Consider “locally prevailing charges”
    - Consider Section VI (Fee Schedule) of HRSA’s PIN 2014-02 dated 9/22/2014 Sliding Fee Discount and Related Billing and Collections Program Requirements

Various methodologies can be used to establish the G-code charge structure:

- Encounter based
- RVU
- CPT

# G-Codes (continued)

Consider the following when establishing the G-code charges:

- Establish charge for each FQHC G-code by determining the “typical bundle of services” that is normally furnished to a Medicare beneficiary during an encounter
- Review your current fee structure to determine if change is needed (most likely)
- Charge for each G-code should be uniform amongst all patients and all payors
- Understand “new patient” definition – intensity of resources used
- Coding accuracy is important: IPPE and AWV
- Changes to the G-code charge occurs when a change takes place in the charges of the bundled services
- G-code charge does not have to equal or exceed PPS rates
- Maintain written documentation of what constitutes “typical bundle of services”, date G-code charge was established, subsequent date changes and reasons for change
- Review G-code charge every 6 months to ensure reasonableness

# G-Codes (continued)

Payments will be made for qualifying visits only -

## HCPSC Qualifying Visits for G0466

92002 Eye exam new patient	99341 Home visit new patient
92004 Eye exam new patient	99342 Home visit new patient
97802 Medical nutrition indiv	99343 Home visit new patient
99201 Office/outpatient visit new	99344 Home visit new patient
99202 Office/outpatient visit new	99345 Home visit new patient
99203 Office/outpatient visit new	G0101 and G0102
99204 Office/outpatient visit new	G0108
99205 Office/outpatient visit new	G0117 and G0118
99324 Domicil/r-home visit new pat	G0442 to G0447
99325 Domicil/r-home visit new pat	G0436 and G0437
99326 Domicil/r-home visit new pat	Q0091
99327 Domicil/r-home visit new pat	
99328 Domicil/r-home visit new pat	

# G-Codes (continued)

**Payments will be made for qualifying visits only –**

## **HCPCS Qualifying Visits for G0467**

92012 Eye exam establish patient	99334 Domicil/r-home visit est pat
92014 Eye exam&tx estab pt 1/>vst	99335 Domicil/r-home visit est pat
97802 Medical nutrition indiv in	99336 Domicil/r-home visit est pat
97803 Med nutrition indiv subseq	99337 Domicil/r-home visit est pat
99211 Office/outpatient visit est	99347 Home visit est patient
99212 Office/outpatient visit est	99348 Home visit est patient
99213 Office/outpatient visit est	99349 Home visit est patient
99214 Office/outpatient visit est	99350 Home visit est patient
99215 Office/outpatient visit est	99495 Trans care mgmt 14 day disch
99304 Nursing facility care init	99496 Trans care mgmt 7 day disch
99305 Nursing facility care init	G0108 Diab manage trn per indiv
99306 Nursing facility care init	G0270 Mnt subs tx for change dx
99307 Nursing fac care subseq	G0101 and G0102
99308 Nursing fac care subseq	G0117 and G0118
99309 Nursing fac care subseq	G0442 to G0447
99310 Nursing fac care subseq	G0436 and G0437
99315 Nursing fac discharge day	Q0091
99316 Nursing fac discharge day	
99318 Annual nursing fac assessmnt	

# G-Codes (continued)

**Payments will be made for qualifying visits only –**

## **HCPCS Qualifying Visits for G0468**

- G0402 Initial preventive exam
- G0438 Ppps, initial visit
- G0439 Ppps, subsequent visit

# G-Codes (continued)

**Payments will be made for qualifying visits only –**

## **HCPCS Qualifying Visits for G0469**

- 90791 Psych diagnostic evaluation
- 90792 Psych diag eval w/med services
- 90832 Psytx pt&/family 30 minutes
- 90834 Psytx pt&/family 45 minutes
- 90837 Psytx pt&/family 60 minutes
- 90839 Psytx crisis initial 60 min
- 90845 Psychoanalysis



# G-Codes (continued)

**Payments will be made for qualifying visits only –**

## **HCPCS Qualifying Visits for G0470**

- 90791 Psych diagnostic evaluation
- 90792 Psych diag eval w/med services
- 90832 Psytx pt&/family 30 minutes
- 90834 Psytx pt&/family 45 minutes
- 90837 Psytx pt&/family 60 minutes
- 90839 Psytx crisis initial 60 min
- 90845 Psychoanalysis

# EXAMPLES

## Example - 1

- An established patient comes to the FQHC for a routine medical visit-

Rev Code	Description	HCPCS /Rates	Date of Service	Service Units	Total Charges
0521	FQHC visit, estab patient	GO467	10/01	1	\$160.00
0521	Office/Outpatient visit est	99213	10/01	1	\$135.00
0300	Routine Venipuncture	36415	10/01	1	\$ 15.00
0001					\$310.00

## Example - 1 (continued)

PPS Rate = \$158.85

PPS Adjusted Rate = \$158.85 x 1.085 (FQHC GAF) = \$172.35

Payment is based on the lesser of the FQHC 's charge for payment code or the adjusted PPS rate.

FQHC's charge is \$160 which is less than the PPS Adjusted Rate of \$172.35

Medicare payment is 80% of \$160 = \$128.00

Coinsurance payment is 20% of \$160 = \$32.00

## Example - 2

- A new FQHC patient comes to the FQHC for a routine medical visit-

Rev Code	Description	HCPCS /Rates	Date of Service	Service Units	Total Charges
0521	FQHC visit, new patient	GO466	10/01	1	\$200.00
0521	Office/Outpatient visit new	99201	10/01	1	\$150.00
0300	Routine Venipuncture	36415	10/01	1	\$ 15.00
0001					\$365.00

## Example - 2 (continued)

PPS Rate = \$158.85

PPS Adjusted Rate =

$\$158.85 \times 1.085 \text{ (FQHC GAF)} \times 1.3416 \text{ (composite factor)} = \$231.23$

Payment is based on the lesser of the FQHC 's charge for payment code or the adjusted PPS rate.

FQHC's charge is \$200 which is less than the PPS Adjusted Rate of \$231.23

Medicare payment is 80% of \$200 = \$160.00

Coinsurance payment is 20% of \$200 = \$40.00

## Example - 3

- A new FQHC patient comes to the FQHC for a mental health visit-

Rev Code	Description	HCPCS /Rates	Date of Service	Service Units	Total Charges
0900	FQHC visit, MH new patient	GO469	10/01	1	\$250.00
0900	Psych diagnostic evaluation	90791	10/01	1	\$200.00
0001					\$450.00

## Example - 3 (continued)

PPS Rate = \$158.85

PPS Adjusted Rate =

$\$158.85 \times 1.085$  (FQHC GAF) = \$172.35

Adjustment for new patient =  $\$172.35 \times 1.3416$  = \$231.23

Payment is based on the lesser of the FQHC 's charge for payment code or the adjusted PPS rate.

FQHC's charge is \$250 which is higher than the PPS Adjusted Rate of \$231.23

Medicare payment is 80% of \$231.23 = \$184.98

Coinsurance payment is 20% of \$231.23 = \$46.25



## Example - 4

- An established FQHC patient comes to the FQHC for a medical and mental health visit on the same day -

Rev Code	Description	HCPCS /Rates	Date of Service	Service Units	Total Charges
0521	FQHC visit, estab patient	GO467	10/01	1	\$160.00
0521	Office/Outpatient visit est	99213	10/01	1	\$135.00
0900	FQHC visit, MH estab patient	GO470	10/01	1	\$200.00
0900	Psych diagnostic evaluation	90791	10/01	1	\$175.00
0001					\$670.00

## Example - 4 (continued)

PPS Rate = \$158.85

PPS Adjusted Rate = \$158.85 x 1.085 (FQHC GAF) = \$172.35

Payment is based on the lesser of the FQHC 's charge for payment code or the adjusted PPS rate.

For medical visit, FQHC's charge is \$160 which is less than the PPS Adjusted Rate of \$172.35

Medicare payment is 80% of \$160 = \$128

Coinsurance payment is 20% of \$160 = \$32

For mental health visit, FQHC's charge is \$200 which is higher than the PPS Adjusted Rate of \$172.35

Medicare payment is 80% of \$172.35 = \$137.88

Coinsurance payment is 20% of \$171.88 = \$34.47

## Example - 5

- An established FQHC patient comes to the FQHC for a medical visit in the morning and later in the day suffers a subsequent illness or injury -

Rev Code	Description	HCPCS/ Rates	Date of Service	Serv. Units	Total Charges
0521	FQHC visit, estab patient	GO467	10/01	1	\$160.00
0521	Office/Outpatient visit est	99214	10/01	1	\$135.00
0521	FQHC visit, estab patient	GO467 59	10/01	1	\$160.00
0521	Office/Outpatient visit est	99213	10/01	1	\$135.00
0001					\$590.00

## Example - 5 (continued)

PPS Rate = \$158.85

PPS Adjusted Rate = \$158.85 x 1.085 (FQHC GAF) = \$172.35

Payment is based on the lesser of the FQHC 's charge for payment code or the adjusted PPS rate.

For both visits, FQHC's charge is \$160 which is less than the PPS Adjusted Rate of \$172.35

Medicare payment is 80% of \$160 = \$128

Coinsurance payment is 20% of \$160 = \$32

## Example - 6

- An established FQHC patient comes to the FQHC for a medical visit and receives preventive services -

Rev Code	Description	HCPCS/ Rates	Date of Service	Serv. Units	Total Charges
0521	FQHC visit, estab patient	GO467	10/01	1	\$160.00
0521	Office/Outpatient visit est	99212	10/01	1	\$135.00
0636	Hep b vacc adult 3 dose im	90476	10/01	1	\$ 60.00
0521	Admin hepatitis b vaccine	G0010	10/01	1	\$ 20.00
0001					\$375.00

## Example - 6 (continued)

For claims that include a mix of preventive and non-preventive services, MACs will pay 100% of the FQHC charge for the preventive services. The Mac will subtract the charge for the preventive services from the payment before assessing coinsurance.

PPS Rate = \$158.85

PPS Adjusted Rate = \$158.85 x 1.085 (FQHC GAF) = \$172.35

In this example, the Mac will pay 100% of preventive services \$80.00

Payment is based on the lesser of the FQHC 's charge for payment code or the adjusted PPS rate for the non-preventive services.

FQHC's charge is \$160 which is less than the PPS Adjusted Rate of \$172.35

Medicare payment is (100% of \$80) + [80% of (\$160-\$80)] = \$144

Coinsurance payment is 20% of (\$160-\$80) = \$16

# Implementation Steps

- Understand changes and how they will impact the FQHC
  - Effective Date
  - Population affected –established, new, mental health patients
  - Typical bundle of services furnished during an encounter- what services are normally covered under Medicare
  - Fee structure and charge – in order to determine G-code charge
- Educate staff as follows:
  - Scheduling/Reception Staff –
    - to properly define type of patient, established vs. new when scheduling
    - to identify IPPE and AWW visits (subsequent AWW)
    - to properly schedule visits on various day (ie medical visit, Diabetes Self Mgmt or Medical Nutrition Therapy, etc.) to maximize reimbursement
    - to be prepared to answer patients questions regarding increase in co-insurance payments
  - Clinical/Provider Staff –
    - to properly code as it ties directly to reimbursement (IPPE and AWW)
    - to complete paperwork timely in order for all services be listed on one claim
    - to ensure that patient medical record supports services received and billed

# Implementation Steps (continued)

- Billing Staff to ensure that:
  - Proper reporting of all services rendered on same day must be submitted on one claim otherwise rejected
  - FQHC payment codes G0466, G0467 and G0468 are reported with revenue codes 052X or 0519
  - FQHC payment codes G0469 and G0470 are reported with revenue codes 0900 or 0519
  - All 5 payment codes (G-codes) are reported with a corresponding service line with a HCPCS code that describes the visit
  - Second visit for a subsequent illness or injury is submitted with modifier 59
  - Properly understand the calculation of PPS reimbursement to verify accuracy of payments received
  - Prepare for challenges with secondary payors – NACHC reached out to CMS who has issued this email for questions/help  
(FQHC-PPS@cms.hhs.gov)
  - Denials are followed up timely



# Implementation Steps (continued)

- Finance Staff to ensure that:
  - Proper and adequate charges are established for each HCPCS G-code
  - Charges are reasonable and cover cost but not exceed it –
    - Avoid payback / review prior year's filed cost report
  - Charges are in line with local prevailing rates
  - Practice Management System (PMS) has instituted all required changes – avoid system configuration issues
    - Accuracy of claim templates to show G-codes and HCPCS charges
    - Coding file updates for proper revenue codes and HCPCS codes
    - Accuracy of Reporting data
    - Testing

# Implementation Steps (continued)

- Finance Staff to ensure that (cont.):
  - Payments received from Medicare for dates of service on or after 10/1/2014 (or the new PPS effective date per FQHC) are not over or understated - review remittances
  - Gross Patient Charges properly recorded in the general ledger -
    - Avoid Overstatement
    - What charges are being recorded?
    - Is there an Automatic Medicare Contractual Allowance?
  - Accounts Receivable, Reserve and Bad Debt –
    - Avoid overstatement until claim is paid
    - Adequacy of reserve
    - Increases in Bad Debt due to higher coinsurances?
    - Increases in Bad Debt due to improper recording of AR & Gross Charges?

# Medicare FQHC Cost Report

## Cost Report Myths –

- Medicare FQHC cost report will no longer be required
- Medicare FQHC cost report will not have relevance in the PPS environment
- Medicare FQHC cost report will be used for informational purposes only, accuracy of preparation is not relevant

# Medicare FQHC Cost Report (continued)

Originally, in the final rule, CMS' comments were as follows:

- FQHCs must continue to file cost reports however CMS is considering revisions to the current cost report forms.
- Complete and accurate filing is a must – data submitted will impact future rates
- Current version of FQHC cost report will continue to be filed for cost reporting periods ending thru 8/31/2015.
- “For services included in the FQHC per diem rate, Medicare cost report will not be used to reconcile Medicare payments with FQHC costs”.
- Certain charges will continue to be paid through the cost report:
  - Influenza and pneumococcal vaccines - paid at 100% of reasonable costs
  - Bad Debt - reimbursed at 65%
  - Allowable graduate medical education costs

# Medicare FQHC Cost Report (continued)

- CMS published a “notice” in the Federal Register regarding the New Cost Report Form
  - Notice dated 12/19/2014
  - Notice included public comment period thru 2/17/2015
  - Notice not well publicized
  - Form CMS-224-14 (new)
  - NACHC was able to comment just in time
  - NACHC still awaiting response, CMS can ignore

# Form CMS-224-14

## Federally Qualified Health Center Cost Report Form –

- Form is significantly altered from CMS-222-92 and very problematic
- Inconsistencies in the calculation of the FQHC's total cost-per-visit
- Requires a significant amount of data to be collected and reported on
- Requires additional worksheets to be completed
- Effective on a retroactive vs prospective basis
- Anticipates 20% additional hours for completion

# Medicare Advantage Plans

- FQHCs who are contracted with Medicare Advantage organizations will be reimbursed at the rate listed in contract.
- If contracted rate is less than adjusted PPS rate (includes GAF, new patient and new to Medicare visit), Medicare will pay the difference.
- Lesser of provision rule is not applied.

# Questions & Comments



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# Thank You!

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