NOVITAS SOLUTIONS

CMS/ITU Medicare Payment Options for Free-standing Tribal Clinics

November 15, 2019

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Today's Presentation

- Agenda:
  - Federally Qualified Health Center (FQHC) Overview
  - FQHC PPS Reimbursement
  - FQHC Billing
  - Cost Reports
  - Credit Balance Report
  - Indian Health Services (IHS) or Tribal Freestanding Clinics (Not Provider-Based) Billing Part B only
- Objectives:
  - Review the FQHC requirements
  - Review FQHC PPS reimbursement and billing
  - Review cost report and credit balance reports
  - Review the Indian Health Services (IHS) or Tribal Freestanding Clinics (Not Provider-Based) Billing Part B only

Acronym List

Acronym	Definition
AWV	Annual Wellness Visit
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
EKG	Electrocardiogram
FAQ	Frequently Asked Questions
FQHC	Federally Qualified Health Center
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
IPPE	Initial Preventative Physical Exam
MAC	Medicare Administrative Contractor

Additional Acronyms

Acronym	Definition
MBI	Medicare Beneficiary Identifier
MLN	Medicare Learning Network
PPS	Prospective Payment System
TOB	Type of Bill
UB-04	Uniform Bill 04

FQHC Overview

How to Become a FQHC

- FQHCs are suppliers reimbursed by the Medicare Part B Trust Fund through the submission of claims filed to the appropriate MAC:
    - Claims filed on UB-04
- There are several ways an FQHC can enroll with Medicare:
    - Received a Public Health Services Act Section 330 grant (administered by The Health Resources Services Administration (HRSA)
    - Contracted with the recipient of such grant and meet grant eligibility
    - Classified by CMS as a federally funded comprehensive health center as of January 1, 1990
    - Categorized as an FQHC “Look-Alike”
    - Classified as an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act

Certification

- For certification as an FQHC, the entity must meet all of the following requirements:
  - Provide comprehensive services and have an ongoing quality assurance program
  - Meet other health and safety requirements
  - Not be concurrently approved as a Rural Health Clinic

Section 330 Grant

- FQHCs that receive a Section 330 grant or are determined to be a FQHC look-alike must meet all requirements contained in Section 330 of the Public Health Services Act:
  - Serve a designated medically-underserved area or medically-underserved population
  - Offer a sliding fee scale to persons with incomes below 200 percent of the Federal poverty level
  - Be governed by a board of directors, of whom a majority of the members receive care at the FQHC

Provider Enrollment

- FQHCs seeking to enroll with Medicare must file an application and other documents with the MAC, rather than go through the State Agency certification process:
  - Applicant files a complete CMS-855A paper or electronic Provider Enrollment, Chain and Ownership System (PECOS) enrollment application and supporting documentation to the MAC:
    - ✓ The MAC will forward to CMS for approval
  - CMS will enter into an agreement with a qualified FQHC when the Health Resources Services Administration (HRSA) documentation is submitted or the applicant is confirmed as a qualifying Tribal or Urban Indian organization outpatient healthcare facility
  - Applicant files a self-attestation that it complies with regulatory requirements at 42 CFR 405 Subpart X and 42 CFR Part 491, except for Section 491.3
  - Entity terminates other Medicare provider agreements:
    - ✓ Hospital contract

Provider Enrollment

- An FQHC cannot have multiple sites or practice locations; each location must be separately enrolled
- Mobile units operated by the FQHC do not require separate enrollment, but are considered part of the permanent FQHC that operates them

Enrolling with Medicare

- New FQHC applicants must submit to MAC the following information:
  - A signed and completed CMS-855A enrollment application
  - Two signed and dated copies of the attestation statement (Exhibit 177):
    - ✓ This will serve as the Medicare FQHC agreement when signed by the Regional Office (RO)
  - CMS-588 Electronic Funds Transfer (EFT) authorization Agreement
  - Clinical Laboratory Improvement Amendments (CLIA) certificate
  - State license (if applicable)
  - A copy of the National Provider Identifier (NPI) notification the applicant received from the National Plan and Provider Enumeration System (NPPES)
- CMS-855B, I and R will need to be submitted in order to bill for Part B
  - Medicare Enrollment Forms
- Part B services on the CMS 1500 claim form not included in the FQHC encounter rate

Enrollment Application Fee and Applications

- Application Fee:
  - Application Fee Requirements Chart
  - 2019 Application Fee of $586.00 must be paid prior to submitting the application dependent on your supplier provider/supplier type:
    - ✓ Fee amounts are subject to change each calendar year
    - ✓ Fee applies to:
      - ➢ IHS hospitals, FQHCs, Grandfathered FQHCs, ambulance, Ambulatory Surgical Center (ASCs) and Durable Medical Equipment(DME) suppliers
- Fee may be applied to certain provider types only:
  - Initial Enrollment
  - Revalidation
  - Addition of Practice Location
  - Fee can be paid using PECOS or Pay.gov
- There are two ways for providers/suppliers to submit or update their application:
  - Internet-based PECOS
  - Paper application:
    - ✓ IHS cover sheet must be completed if submitting paper forms:
  - Novitas Enrollment Center

FQHC Covered Services

- Covered Services are the professional services of a physician, Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNW), visiting nurse, Clinical Psychologist (CP), Clinical Social Worker (CSW), Registered Dietitian (RD)/medical nutrition professional, services and supplies rendered incident to these services (e.g., therapeutic injections):
  - Services of a visiting nurse are only covered for FQHCs located in areas where CMS has determined that there is a shortage of Home Health agencies available to provide services in the home

Requirements for FQHC PPS

- FQHC must establish a payment rate that accounts for the type, intensity, and duration of services furnished by FQHCs:
    - May include adjustments such as a geographic adjustment
    - Must include a process for appropriately describing services and establish payment rates for specific payment codes
    - Initial PPS rate must equal in the aggregate 100% of the estimated amount of reasonable costs that would have occurred for the year if the PPS had not been implemented, and without the application of copayments, per-visit limits, or productivity adjustments
- Medicare payment for FQHC services must be 80 percent of the lesser of the actual charge or the PPS amount

FQHC Encounter

- An FQHC encounter is a face-to-face encounter between a physician, Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNW), visiting nurse, Clinical Psychologist (CP), Clinical Social Worker (CSW), Registered Dietitian (RD)/medical nutrition professional during which an FQHC service is furnished
- An encounter with more than one health professional or multiple encounters with the same health professional, which takes place on the same day and at a single location, constitutes a single encounter

Billing FQHC Services

- Medically necessary lab and technical components of diagnostic tests such as EKGs and X-rays are considered non-FQHC services and are billed to Novitas on the CMS 1500 claim form
- Professional component (interpretation of the test) is part of the FQHC encounter
- Certain screening tests and other preventive services have been added to the Medicare statute by Congress as preventive benefits for all beneficiaries
  - Screening tests and other preventive services are provided at the FQHC, professional component is included as part of the encounter and the technical component is billed to Novitas in the same way as diagnostic tests
- Lab and technical components of diagnostic (or screening) tests are billed on the CMS 1500 claim form
- Enroll with the Part B MAC that serves the FQHC geographic area

FQHC PPS Reimbursement

Update to the FQHC PPS

- MM10990:
  - Effective: January 1, 2019
  - Implementation: January 7, 2019
- Key Points:
  - FQHC PPS Rate:
    - ✓ FQHC market basket for CY 2019 is 1.9 percent
    - ✓ FQHC PPS base payment rate is $169.77:
      - ➢ 2019 base payment rate reflects a 1.9 percent increase

Geographic Adjustment Factors (GAF)

- Calculated by adapting the work and practice expense indices used in the physician fee schedule for the period in which the services are furnished
- Adjusted PPS Rate Calculation:
  - Multiply the base rate times the FQHC GAF
- New patient:
  - One who has not received any professional medical or mental health services from any site or from any practitioner within the FQHC organization within the past three years from the date of service
- Payment adjustments:
  - New patients, AWV and IPPE:
    - ✓ Payment rate will be increased by 1.3416% for new patients, IPPE, initial and subsequent AWVs

FQHC Payment G Codes

- Five G codes:
  - Based on typical bundle of services furnished to a Medicare beneficiary
- Claim (77X TOB) must contain a FQHC specific payment code (G0466, G0467, G0468, G0469, G0470)
- G0466, G0467, G0468 must be reported under Revenue Code 052X or 0519
- G0469 and G0470 must be reported under Revenue Code 0900 or 0519
- FQHCs must continue to report detailed HCPCS coding on the claim to describe all services during the encounter

G Code	Description
G0466	FQHC visit, new patient
G0467	FQHC visit, established patient
G0468	FQHC visit, IPPE or AWV
G0469	FQHC visit, mental health, new patient
G0470	FQHC visit, mental health, established patient

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Multiple Same Day Visits

- All services rendered on the same day must be submitted on one claim or the claim will be rejected
- Allows for additional payment when an illness or injury occurs subsequent to the initial visit (modifier 59), or when a mental health visit is furnished on the same day as a medical visit

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FQHC Mental Health Visits

- When submitting a claim for a mental health visit furnished on the same day as a medical visit, FQHCs must report a specific payment code for a medical visit (G0466, G0467, G0468) and a specific payment code for a mental health visit (G0469, G0470), and each specific payment code must be accompanied by a service line with a qualifying visit
- Revenue Code 090X:
  - Therapeutic Psychiatric or Psychological services subject to Medicare outpatient mental health treatment limitation
  - Used for services of Clinical Psychologist (CP) and Clinical Social Worker (CSW) mental health professionals and other professional staff providing psychiatric therapy services

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FQHC Claim Submission

Encounter Billing

- FQHCs bill with Revenue Codes on the UB-04 or electronic equivalent
- All charges submitted by an FQHC will be on TOB 77X:
  - Third digit of the TOB is the bill frequency and shows the nature or intent of the bill submitted

Medical Visits Billed with Preventive Services

- FQHC services also include preventive primary health services that an FQHC is required to provide, as listed in Section 330 of the Public Health Services Act, unless excluded by law
- SE1039 provides new billing requirements for HCPCS coding with revenue codes
- Preventive services no longer subject to coinsurance must be separately identified on the claim so these charges will not be rolled into those for the rest of the visit for coinsurance calculation
- FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on a FQHC claim; these HCPCS codes will be considered informational only:
  - Reimbursement for the influenza and pneumococcal vaccines will be facilitated through the cost report

FQHC General Billing Guidelines

- Split billing is required for FQHCs:
  - Claims cannot overlap calendar years
  - “From” and “through” dates of the claim must always be in the same calendar year
- Line items on outpatient claims under HIPAA require reporting of a line-item service date for each revenue code
- A single date should be reported on a line item for the date the service was provided, not a range of dates
- Services not included in the Face-to-Face Encounter, need to be added to future billable Encounter visits
- FQHCs use the date of the visit as the single date on the line item

Qualifying Visit Codes

- Qualifying visit, is a HCPCS that describes the visit:
  - List of Qualifying Visit Codes
- FQHC claim must contain the qualifying visit code in conjunction with the G-payment code
- Qualifying visit codes do not receive reimbursement:
  - G0466-G0470

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Cost Reports

FQHC Cost Reports

- FQHCs are required to file a cost report annually:
  - Reimbursed for the costs of Graduate Medical Education (GME), bad debt, and influenza and pneumococcal vaccines and their administration through the cost report
- FQHCs must maintain and provide adequate cost data based on financial and statistical records that can be verified by qualified auditors
- FQHCs are allowed to claim bad debts in accordance with 42 CFR 413.80 for unpaid coinsurance if they can establish that reasonable efforts were made to collect these amounts:
  - Coinsurance or deductibles that are waived, either due to a statutory waiver or a sliding fee scale, may not be claimed

FQHC Cost Report Form

- For cost reporting periods beginning on and after October 1, 2014, freestanding FQHCs, as well as those FQHCs that previously reported as part of a skilled nursing facility or home health agency must use the new form CMS-224-14

Credit Balance Report

What is a Medicare Credit Balance?

- Definition:
  - Improper or excess payment made to a provider as a result of patient billing or claims processing error
- Purpose:
  - Provider determines a credit is due to Medicare for an overpayment
  - Medicare credit balances include money due to the program regardless of its classification in a provider's accounting records
  - Credit balances are reported through the completion of the CMS-838 Form at the end of each quarter
- Examples:
  - Overpayments
  - Duplicate payments
  - Payment received for services not performed
  - Payment received for non-covered services
  - Payment received for outpatient services that should have been bundled to inpatient

Importance of CMS-838 Form and How to Locate

- Provider determines a credit is due to Medicare for an overpayment
- Medicare credit balances include money due to the Medicare program regardless of its classification in a provider's accounting records
- JH Home Page
- Click on the Forms Center:
  - In the Forms Catalog, you will find the Financial & Overpayment /Refund Forms section
  - Scroll down to the form "Medicare Credit Balance Certification (CMS-838)"
- CMS-838 Form

Medicare Credit Balance Report Due Dates

- Must be filed within 30 days after the close of each calendar quarter
- Failure to file the report by the deadline may result in the suspension of Medicare payments

Quarter End	Medicare Credit Balance Report Due	Warning Letter Mailed	Placed on 100% Payment Withhold
March 31	April 30	May 15	June 03
June 30	July 30	August 15	September 03
September 30	October 30	November 15	December 03
December 31	January 30	February 15	March 03

No Medicare Credit Balance to Report

- If your credit balance amount is ZERO at the end of the quarter:
  - Required to sign, date and return the Medicare Credit Balance Report Certification Page
  - Medicare Credit Balance Report Certification Page must be faxed or submitted through Novitasphere:
    - ✓ Fax Number: 410-891-5230

Medicare Credit Balance Status Tool and Resources

- Check the status of your quarterly reports by using the Medicare Credit Balance Status Tool:
  - Allow 2 – 3 days for zero balance certifications
  - Allow up to 2 weeks for credit balance to be added:
  - Credit balance status tool
- FAQs:
- Tips When Filing Quarterly Medicare Credit Balance Reports
- Credit Balance Podcast:
  - An informative interview on the Medicare Credit Balance Report
  - Tutorial on Medicare Credit Balance Reporting

FQHC Fact Sheet

FEDERALLY QUALIFIED HEALTH CENTER

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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 ICN 006397 January 2018

CMS Fact Sheet

Tribal Freestanding Clinics (Not Provider-Based)

Part B Enrollment

- Freestanding clinics and practitioners in facilities owned and operated by tribes and Urban Indian Clinics may choose to enroll with either their local geographic Medicare contractor for the state where they are located or
- May choose to enroll with the Novitas which has the IHS/tribal specialty workload in order to receive special services:
  - Suppression of EOBs
  - Training
- For Medicare Part B (CMS-1500 billing):
  - CMS 855-B (for the group/clinic entity)
  - CMS 855-R (to reassign each individual's billing/payment to 855-B clinic entity)
  - CMS 855-I (for each individual physician and practitioner not already enrolled in Medicare)

Covered Services

- Full range of Part B professional services can be billed in freestanding clinic/office settings on the CMS 1500 form:
  - Physician, Physician Assistance (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Certified Nurse Midwife (CNM),Clinical Psychologist , Clinical Social Worker , Nutrition Professional, Diabetes Self-Management Training (DSMT), incident to (drugs/supplies), Physical Therapist /Occupational Therapist, professional interpretations of diagnostic tests
  - Medicare covered preventive services, lab and technical components of diagnostic tests.
  - Other non-primary care services can also be furnished by tribal suppliers billing Medicare Part B:
    - ✓ Ambulance, Durable Medical Equipment (DME), Ambulatory Surgery Centers, etc., and these suppliers would follow enrollment guidance in Internet Only Manual (IOM) 100-04, Chapter 19 exclusively for Indian Health Services (IHS) providers 100-04, Chapter 19

Payment

- Professional Part B services are paid using the Medicare Physician Fee Schedule for clinic/office settings
- Lab is paid using the Clinical Lab Fee Schedule

Reminders

Medicare Beneficiary Identifier (MBI) is coming! Are you ready?

- Effective January 1, 2020, claims submitted to Medicare will require the beneficiary's MBI number
- Is your office or facility prepared for the MBI transition?
- Use MBI now for all Medicare transactions
- 3 ways to get the MBI:
  - Ask your patient for their card
  - Use your Medicare Administrative Contractor's look up tool:
    - ✓ Sign up for the Portal to use the tool
  - Check the remittance advice:
    - ✓ MBI is returned on the remittance advice if a valid and active Health Insurance Claim Number is submitted
- Get Your New Medicare Card
- Beneficiaries who did not receive their card can:
  - Sign into MyMedicare.gov:
  - Call 1-800-MEDICARE (1-800-633-4227) for assistance
  - TTY users can call 1-877-486-2048

MBI Lookup

- Select the MBI Lookup from the left navigation bar

MBI Lookup

Friday, June 8, 2018 11:53 AM

This tool is to be used only when a Medicare patient doesn't or can't give you his/her Medicare Beneficiary Identifier (MBI). The patient's first name, last name, date of birth, and social security number are required to get a unique match. The MBI is confidential so you'll have to protect it as Personally Identifiable Information and use it only for Medicare-related business.

Note: * Indicates a required field. Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

First Name*	Jane	Last Name*	Doe
Suffix		SSN*	111-22-3333
Date of Birth(MM/DD/YYYY)*	01/01/1937	NPI*	

I'm not a robot

reCAPTCHA
Privacy - Terms

Submit Clear

MBI Lookup Results

MBI Lookup

Thursday, April 26, 2018 9:56 AM

This tool is to be used only when a Medicare patient doesn't or can't give you his/her Medicare Beneficiary Identifier (MBI). The patient's first name, last name, date of birth, and social security number are required to get a unique match. The MBI is confidential so you'll have to protect it as Personally Identifiable Information and use it only for Medicare-related business.

Note: * Indicates a required field. Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

First Name*	Jane	Last Name*	Doe
Suffix		SSN*	111-22-3333
Date of Birth(MM/DD/YYYY)*	01/01/1937	NPI*	123789456

Submit Clear

INQUIRY MBI LOOKUP INFO

MBI Lookup Information

Subscriber First Name	Jane
Subscriber Last Name	Doe
Subscriber MBI Number	1EG4-TE5-MK72

FISS Part A Standard Paper Remittance Advice Example with MBI

- Beginning October 1, 2018 through transition period:
  - MID field will reflect the Medicare identification submitted
  - MBI field will reflect the MBI when a valid and active Medicare number is submitted

FISS Standard Paper Remittance Advice Example

Beginning October 1, 2018, through the transition period:

- The **MID field** (line 32) will show the Medicare ID submitted on the claim
- The **MBI field** (line 66) will show the Medicare Beneficiary Identifier (MBI) when a provider submits a valid and active HICN

```
1 MEDICARE PART A          2 STREET ADDRESS                3 CITY      4 ST 5 999999999          6 VER# 5010
7 CONTACT NAME             8 PHONE: 000-000-0000 9 EXT:    10 FAX:     11 EXT:                   12 EMAIL:
13 NPI#    14 PROVIDER NAME    15 PROVIDER ADDRESS         16 CITY     17 ST 18 999999999        19  PART A
20  PAID DATE: MM/DD/YYYY      21 REMIT#10     22 PAGE
23 PATIENT NAME    24  PATIENT CNTRL NUMBER   25  RC 26 REM27DRG#   28 DRG OUT AMT 29 COINSURANCE 30 PAT REFUND  31 CONTRACT ADJ
32 MID             33 ICN NUMBER              34  RC 35 REM 36 OUTCD   37  NEW TECH/ECT 38 COVD CHGS  39 ESRD NET ADJ 40 PATIENT RESP
41 FROM DT         42 THRU DT  43 HICHG 44TOB  45 RC 46 REM 47 PROF COMP  48 MSP PAYMT  49 NCOVD CHGS 50 INTEREST  51 PROC CD AMT
52 CLM STATUS      53 COST 54 COVDY 55 NCOVDY  56 RC 57 REM 58 DRG AMT   59 DEDUCTIBLES 60 DENIED CHGS 61 PRE PAY ADJ  62 NET REIMB
                                                                  63  SEQUESTRATION
66 MBI                                                            64  PBP REDUCT
                                                                  65  ISLET ADD ON
```

Part B Standard Remittance Advice Example with MBI

- Beginning October 1, 2018, through transition period:
  - MID field will reflect the Medicare identification submitted
  - MBI field will reflect the MBI when a valid and active Medicare number is submitted

```
                PROVIDER NAME                                                        NPI #:              9999999999
                PROVIDER ADDRESS LINE 1                                              PAGE #:           1 OF      1
                PROVIDER ADDRESS LINE 2                                              DATE:          01/11/18
                CITY, ST ZIPCODE                                                     CHECK/EFT #: 99999999999
                                                                                     STATEMENT #: 99999999999

     PERF PROV  SERV DATE    POS NOS    PROC   MODS       BILLED     ALLOWED    DEDUCT  COINS    GRP/RC-AMT        PROV PD
     ____________________________________________________________________________________________________________________
     NAME SMITH, JOHN L           MID 000000000A   ACNT 0000000             ICN YYJJJBBBBSS000   ASG Y  MOA MA67  N793
                                  MBI 1EG4TE5MK72
     1111111111 0919 091917 12  100.0 J7512 KX            18.33        0.90     0.00      0.18 CO-45      17.43        0.71
                                                                                               CO-253      0.01
     1111111111 0919 091917 12    1.0 Q0512               16.00       16.00     0.00      3.20 CO-253      0.26       12.54
     1111111111 0919 091917 12   25.0 J7502 KX           522.69       69.23     0.00     13.85 CO-45     453.46       54.27
                                                                                               CO-253      1.11
     1111111111 0919 091917 12    1.0 Q0511               24.00       24.00     0.00      4.80 CO-253      0.38       18.82
     PT RESP     22.03              CLAIM TOTAL          581.02      110.13     0.00     22.03           472.65       86.34
     ADJ TO TOTALS: PREV PD      162.67      INTEREST      0.00      LATE FILING CHARGE        0.00        NET        76.33-
     ____________________________________________________________________________________________________________________
     TOTALS:   # OF        BILLED      ALLOWED      DEDUCT      COINS       TOTAL       PROV PD     PROV        CHECK
               CLAIMS      AMT         AMT          AMT         AMT         RC-AMT      AMT         ADJ AMT     AMT
                  1        581.02      110.13       0.00        22.03       472.65      86.34       76.33-      0.00

     PROVIDER ADJ DETAILS:   PLB REASON CODE          FCN               CCN               PATIENT CNTL/MID          AMOUNT
```

Join Our Email List Today

- Stay current with Medicare by receiving emails twice a week
- Available email lists (not all-inclusive):
  - Jurisdiction H
  - Part B Electronic Billing
  - Novitasphere Portal
  - ABILITY| PC-ACE
  - Medicare Remit Easy Print (MREP) Users
- JH Providers

Customer Contact Information

- Providers are required to use the IVR unit to obtain:
  - Claim Status
  - Patient Eligibility
  - Check/Earning
  - Remittance inquiries
- Jurisdiction H:
  - Customer Contact Center- 1-855-252-8782
  - Provider Teletypewriter- 1-855-498-2447
- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227)

Summary

- Discussed the overview of FQHC
- Reviewed FQHC reimbursement and billing
- Discussed cost reports and credit balance reports
- Review the Indian Health Services (IHS) or Tribal Freestanding Clinics (Not Provider-Based) Billing Part B only
- Reminders

Thank You

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A TRIBAL PERSPECTIVE

Why become a FQHC

- Enhanced program in Medicare and Medicaid reimbursement
- Up to $650,000 in new start money
- Coverage in medical malpractice through the Federal Tort Claims Act
- Eligible to purchase non-prescription and prescription medications for outpatients through the 340 B Federal Drug Pricing Program
- Access to National Health Service Corps
- Access to the Vaccine for Children program
- Eligible for various other federal programs and grants
- Access to on-site eligibility workers to provide Medicaid and CHIP enrollment services
- Access to National Health Service Corps or NHSC dental, medical, and mental health providers
- Safe Harbor protections

- Enhanced reimbursement for Medicare and or Medicaid

Managed Care Organizations (MCOs) and Wrap-arounds

Section 237 of the Medicare Modernization Act (MMA) requires CMS to provide supplemental payments to FQHCs that contract with MA organizations to cover the difference, if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive under the cost-based all-inclusive payment rate as set forth in 42 CFR, Part 405, Subpart X.

Four Walls

FQHCs have the ability to contract with outside providers and have them treated as in house staff.   FQHC's are not bound by the "four walls.

For example: The health center can take an x-ray and send it out to be read by a radiologist. The contract with the radiologist is for a flat fee per read. The radiologist bills the health center and the health center bundle bills Medicaid for both the technical and professional components.

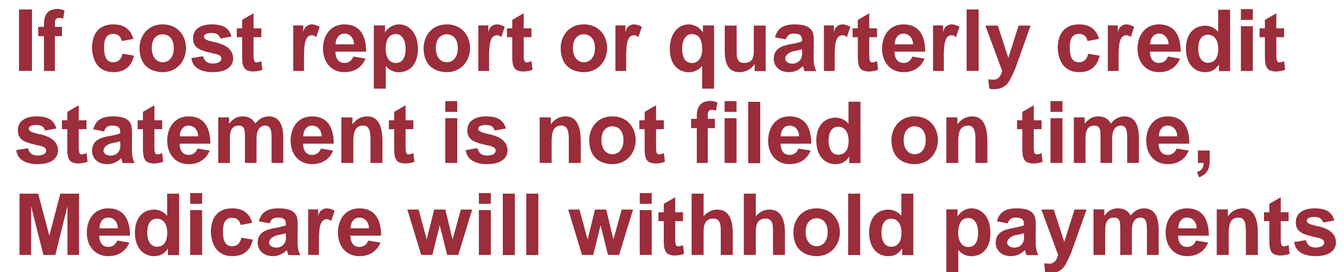
This does not require the use of the SHO letter.

Common Concerns about FQHC

- We have to get certified
- We don’t have the ability to do a cost report
- Will I have to hire additional staff?
- Can we be just Medicare or Medicaid FQHC not both?

FQHC Certification Issues

- Fill out Form CMS-855A
  - Form CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement;
  - Copy of Clinical Laboratory Improvement Act (CLIA) Certification
  - Copy of State License (if applicable)
- 42 CFR Part 491, setting standards for such things as
  - – Compliance with applicable Federal, State and local laws and regulations;
  - – Policies and lines of authority and responsibilities are clearly set forth in writing;
  - – Provision of medical direction to the FQHC by a physician;
  - – Clinical staff and staff responsibilities;
  - – Provision of services and patient care policies;
  - – Patient health records;
  - – Program quality assessment/improvement;
  - – The construction and maintenance of the FQHC ‘s physical plant; and
  - – Handling of non-medical emergencies in the FQHC.



- Cost reports are not that long or complicated
- The instructions are confusing
- Cost reports break your costs into a limited number of large groups by cost center
- Labor cost, medical supplies, pharmaceuticals, utilization data

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FROM:__________ PART I

__________ TO: __________

PART I - FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

		CENTER CCN	Title V	Title XVIII	Title XIX	Other	Total All Patients	
		0	1	2	3	4	5	
1	Medical Visits							1
2	Total Medical Visits							2
3	Mental Health Visits							3
4	Total Mental Health Visits							4
5	Number of Visits Performed by Interns and Residents							5
6	Total Number of Visits Performed by Interns and Residents							6

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FEDERALLY QUALIFIED HEALTH CENTER DATA	CCN: ___________	PERIOD: FROM: __________ TO: ___________	WORKSHEE PART II & III

PART II - FEDERALLY QUALIFIED HEALTH CENTER CONTRACT LABOR AND BENEFIT COST

		Contract Labor	Benefit Cost
		1	2
1	Total facility contract labor and benefit cost		
2	Physician		
3	Physician Assistant		
4	Nurse Practitioner		
5	Visiting Registered Nurse		
6	Visiting Licensed Practical Nurse		
7	Certified Nurse Midwife		
8	Clinical Psychologist		
9	Clinical Social Worker		
10	Laboratory Technician		
11	Reg Dietician/Cert DSMT/MNT Educator		
12	Physical Therapist		
13	Occupational Therapist		
14	Other Allied Health Personnel		
15	Interns & Residents		

PART III - FEDERALLY QUALIFIED HEALTH CENTER EMPLOYEE DATA

Enter the number of hours in your normal work week ________		Number of Employees (Full Time Equivalent)		
		Staff	Contract	Total
		1	2	3
16	Physician			
17	Physician Assistant			
18	Nurse Practitioner			
19	Registered Nurse			
20	Licensed Practical Nurse			
21	Certified Nurse Midwife			
22	Clinical Psychologist			
23	Clinical Social Worker			
24	Laboratory Technician			
25	Reg Dietician/Cert DSMT/MNT Educator			
26	Physical Therapist			
27	Occupational Therapist			
28	Other Allied Health Personnel			
29	Interns & Residents			

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					CCN:	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS
			1	2	3	4
GENERAL SERVICE COST CENTERS						
1	0100	Cap Rel Costs-Bldg and Fix				
2	0200	Cap Rel Costs-Mvble Equip				
3	0300	Employee Benefits				
4	0400	Administrative & General Services				
5	0500	Plant Operation and Maintenance				
6	0600	Janitorial				
7	0700	Medical Records				
8		Subtotal - Administrative Overhead				
9	0900	Pharmacy				
10	1000	Medical Supplies				
11	1100	Transportation				
12	1200	Other General Service (specify)				
13		Subtotal - Total Overhead				
DIRECT CARE COST CENTERS						
23	2300	Physician				
24	2400	Physician Services Under Agreement				
25	2500	Physician Assistant				
26	2600	Nurse Practitioner				
27	2700	Visiting Registered Nurse				
28	2800	Visiting Licensed Practical Nurse				
29	2900	Certified Nurse Midwife				
30	3000	Clinical Psychologist				
31	3100	Clinical Social Worker				
32	3200	Laboratory Technician				
33	3300	Reg Dietician/Cert DSMT/MNT Educator				
34	3400	Physical Therapist				
35	3500	Occupational Therapist				
36	3600	Other Allied Health Personnel				
37		Subtotal - Direct Patient Care Services				

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ADJUSTMENTS TO EXPENSES	CCN: ________	PERIOD: FROM: ________ TO: ________	WORKSHEET A-2

	DESCRIPTION (1)	BASIS/CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED	
				COST CENTER	LINE #
		1	2	3	4
1	Investment income - buildings and fixtures (chapter 2)			Buildings and Fixtures	1
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2
3	Investment income - other (chapter 2)				
4	Trade, quantity, and time discounts (chapter 8)				
5	Refunds and rebates of expenses (chapter 8)				
6	Rental of building or office space to others (chapter 8)				
7	Related organization transactions (chapter 10)	Wkst A-2-1			
8	Sale of drugs to other than patients				
9	Vending machines				
10	Practitioner assigned by Public Health Service				
11	Depreciation - buildings and fixtures			Buildings and Fixtures	1
12	Depreciation - movable equipment			Movable Equipment	2
13	RCE adjustment to teaching physicians' cost			Allowable GME Costs	47
14	Other adjustments (specify) (3)				
50	TOTAL (sum of lines 1 thru 49)				

Do I need to hire more staff

- Maybe but probably not
- Increase in staff requirements are in:
  - Initial certification and setup
  - Filing the annual cost report
  - Education and training are more important

FQHCs provide a great deal of flexibility in providing additional revenue to Health Centers. The initial set up does take time and effort but once done the long term benefits are well worth it.