AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Summary of new prospective payment system for Federally Qualified Health Centers

The Centers for Medicare & Medicaid Services (CMS), on April 29, published the "Medicare Program; Prospective Payment System for Federally Qualified Health Centers; Changes to Contracting Policies for Rural Health Clinics; and Changes to Clinical Laboratory Improvement Amendments of 1988 Enforcement Actions for Proficiency Testing Referral" final rule. When the regulation was released, CMS issued a related press release and fact sheet.

This final rule implements methodology and payment rates for a prospective payment system (PPS) for Medicare Part B services at a federally qualified health center (FQHC) beginning on October 1, 2014. According to CMS, the new PPS could enable FQHCs to receive as much as a 32-percent increase in Medicare payments for services furnished to Medicare beneficiaries.

The final rule is effective on October 1, 2014, with several exceptions. CMS is accepting comments until July 1, 2014, on those sections of the rule regarding:

- Developing the FQHC PPS rate for multiple visits on the same day
- Establishing G-codes for FQHCs to bill Medicare and integrating chronic care management into FQHC claims payment
- Waiving coinsurance for FQHC patients for preventive services.

Federally Qualified Health Center (FQHC) prospective payment system

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 total FQHC billing. According to AAFP member data, 8.1 percent of AAFP members' primary patient care location is in a FQHC.

Until this rule goes into effect on October 1, 2014, Medicare will continue to pay 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 this payment system based on "reasonable costs," 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.

The *Affordable Care Act* (ACA) requires CMS to develop a PPS that takes into account the type, intensity, and duration of FQHC services and allows other adjustments such as those for geographic variations. Initial payment rates (by 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.

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Under the new FQHC PPS system, FQHCs will be paid a per diem based on each encounter with a Medicare beneficiary with some exceptions and adjustments. To develop this new system, CMS is attempting to balance statutory requirements with administrative simplicity and the need to preserve access for beneficiaries. CMS established the encounter-based per-diem base rate of $158.85 and pegged it to the average cost of an encounter. CMS will also make the following adjustments to the rate:

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

Under outgoing FQHC payment policy, beneficiary coinsurance for FQHC services had been based on the amount the FQHC charges and could be higher than 20 percent of the total payment. Consistent with the ACA 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.

The ACA 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.

CMS seeks further comments on how the Chronic Care Management (CCM) policies for physicians billing under the physician fee schedule can be adapted for FQHCs to help achieve the goals of furnishing integrated and coordinated services. CMS also seeks comments on proposed G-codes for Medicare payment to FQHCs under the PPS. Finally, CMS seeks comments on a modification that would simplify the methodology for calculating coinsurance when a preventive service and non-preventive service are on the same claim.

Rural Health Center contracting changes

The rule also finalizes allowing rural health centers (RHCs) to contract with non-physician practitioners, consistent with statutory requirements that require at least one nurse practitioner or physician assistant be employed by the RHC. In a regulatory comment letter sent March 8, 2013, the AAFP concurred with this approach.

CMS discretion to sanction intentional violations on proficiency testing

The *Clinical Laboratory Improvement Amendments* (CLIA) requires laboratories to participate in proficiency testing (PT) 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. The final rule implements the *Taking Essential Steps for Testing* (TEST) *Act* that provides discretionary authority to CMS as to which sanctions may be applied to cases of intentional violation of the prohibition on PT referrals. CMS asserts the rule allows a better fit between the nature and extent of an intentional PT referral violation and the penalties that are imposed. CMS finalizes three tiered categories of sanctions for a PT referral to be applied under certain specified conditions, based on the severity and extent of the violation. The AAFP supported the proposed changes in the same March 8, 2013 letter.