U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

Program Assistance Letter

DOCUMENT NUMBER: 2011-04

DATE: March 8, 2011

DOCUMENT TITLE: Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit

TO: Health Center Program Grantees
Federally Qualified Health Center Look-Alikes
Primary Care Associations
Primary Care Offices
National Cooperative Agreements

I. Purpose

The purpose of this Program Assistance Letter (PAL) is to highlight the steps that health centers must take in order to initiate and maintain reimbursement by Medicare under the Federally Qualified Health Center (FQHC) benefit. It expands on information provided in the standard program term on Notices of Grant Awards for New Access Points (NAPs) and approved change in scope requests to add a site under the Health Center Program. This PAL also builds on information in Policy Information Notice (PIN) 2008-01: Defining Scope of Project and Policy for Requesting Changes, Section VI.C. Scope of Project and Medicare FQHC Cost-Based Reimbursement.

This PAL is applicable to Look-Alike health centers and to grantees funded under the Health Center Program authorized in section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended, which includes:

- Community Health Centers (CHC) funded under section 330(e);
- Migrant Health Centers (MHC) funded under section 330(g);
- Health Care for the Homeless (HCH) Centers, funded under section 330(h); and
- Public Housing Primary Care (PHPC) Centers, funded under section 330(i).

II. Background: How Medicare Defines and Reimburses FQHCS

A. How Medicare Defines FQHCs

The term FQHC is defined in Section 1861(aa)(4) of the Social Security Act, which states that to be an FQHC, an entity must fall under at least ***one*** of the following categories:

- Be receiving a grant under section 330 of the PHS Act; or
- Be receiving funding under a written agreement with the recipient of a section 330 grant, and meet the requirements to receive a grant under section 330 of the PHS Act; or
- Based on the recommendation of the Health Resources and Services Administration (HRSA), has been determined by the Centers for Medicare and Medicaid Services (CMS) to meet the requirements for receiving a section 330 grant, even though it is not actually receiving such a grant (a Look-Alike); or
- Have been treated by CMS as a comprehensive federally-funded health center as of January 1, 1990; or
- Is 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.

The term "FQHC" is used by CMS to indicate eligibility for reimbursement by Medicare, Medicaid, and CHIP using specific payment methodologies. An entity that meets the above definition of an FQHC is ***eligible*** to be paid under the Medicare FQHC benefit. However, ***simply meeting this statutory definition is not sufficient***. The entity must also meet the enrollment and update requirements discussed below in Section III.A.[1]

It is important to note that ***a single health center organization can consist of more than one FQHC*** as defined by CMS. For example, CMS considers a health center that receives a grant under section 330 with two permanent sites within its scope of project to constitute two FQHCs (assuming they have each met the enrollment and update requirements.) See Section IV.A. below, for a discussion of which organizational units are required to enroll separately as FQHCs, how to prepare the application, and where to submit it. Likewise, FQHC status applies only to those activities that are included in the health center's approved scope of project. For information on how scope of project is defined, see PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes.

B. How Medicare Currently Reimburses FQHCs

Entities that have been approved by CMS as FQHCs are eligible to be reimbursed under a methodology referred to as the Medicare FQHC benefit. Reimbursement rates under this methodology are intended to reflect the broad range of services and complexity of care that FQHCs provide to low-income and vulnerable populations. The FQHC Medicare benefit is

[1] These entities are also eligible for special reimbursement methodologies under Medicaid, provided that they meet the appropriate enrollment and other requirements; see Section VI.

structured differently for beneficiaries enrolled in traditional fee-for-service (FFS) versus Medicare Advantage (managed care).[2]

Under FFS Medicare, FQHCs receive an all-inclusive amount for each covered visit, regardless of the specific services that were provided. Services covered under this all-inclusive per-visit amount include a range of primary care services, and services incident thereto, including physician, physician assistant, nurse practitioner, and certain other non-physician practitioner services such as clinical social worker and clinical psychologist services. They also include a range of preventive services as well as pneumococcal and influenza vaccines. The FFS Medicare reimbursement amount is currently calculated as the lower of:

- the FQHC's reasonable costs, as determined through its Medicare cost report, or
- an upper payment limit (UPL).[3]

Under Medicare Advantage plans, FQHCs receive a wrap-around payment equal to the difference between what the Medicare Advantage plan pays the FQHC, and the all-inclusive per-visit amount the FQHC otherwise would receive under Medicare FFS.

In addition to the services reimbursed under the all-inclusive rate, there are a few additional services for which Medicare will reimburse FQHCs separately. For these services, the health center must submit separate bills to Medicare. Examples include the technical components of many preventive services, such as pap smears and prostate cancer screenings.

III. Requirements and Effective Date for Being Enrolled in and Reimbursed by Medicare as an FQHC

A. Requirements for Being Reimbursed under the FQHC Benefit

To enroll in Medicare as an FQHC and be reimbursed under the Medicare FQHC benefit, an entity must meet ***all*** of the following requirements:

1. Meet one of the statutory definitions listed in Section II.A above; and
2. Have submitted a complete enrollment application, including all supporting documents, to the appropriate Medicare administrative contractor for each organizational unit for which separate enrollment is required; and
3. Have received from the appropriate CMS Regional Office (RO):
   - a CMS Certification Number (CCN); and
   - a signed Medicare agreement (which takes the form of the applicant's Attestation Statement, countersigned by the RO); and
   - an effective date, which is indicated on the Medicare agreement; and

[2] The Affordable Care Act of 2010 has mandated that the current FFS FQHC payment system be replaced with a Prospective Payment System starting in 2014.
[3] There are separate UPLs for urban and rural areas.

4. Have submitted updates to the enrollment application as required by regulation within the appropriate timeframes. See Section V for more information.

B. Effective Date for Being Reimbursed under FQHC Benefit

An entity is eligible to be reimbursed under the FQHC benefit starting on ***the effective date*** indicated on its Medicare agreement, which ***is the date on which all Medicare requirements have been met. Generally this will be the date that the Medicare administrative contractor recommended to the RO approval of the application for enrollment***.[4] Services provided to Medicare beneficiaries ***on or after that date*** are eligible for reimbursement under the FQHC benefit. Any services provided to Medicare beneficiaries ***prior*** to this date are ***not*** eligible for reimbursement under the FQHC benefit.[5]

Receiving section 330 grant funding, Look-Alike designation, or approval of a change in scope (CIS) to add a site establishes eligibility to enroll in Medicare as an FQHC; however, it does not initiate the Medicare FQHC enrollment application. Rather, it is the responsibility of each health center to prepare, submit, and monitor the progress of each of its Medicare Enrollment Applications and to ensure that it has received the appropriate approvals prior to billing under the FQHC benefit. To expedite this enrollment application process – and thereby the effective date on which a health center starts being reimbursed under the FQHC benefit – health centers are encouraged to begin the enrollment process as soon as possible.

IV. Process for Enrolling in Medicare as an FQHC

This section discusses the process of preparing and submitting an initial enrollment application to be reimbursed under the Medicare FQHC benefit.

A. Which Organizational Units Must Enroll Separately in Medicare

The Medicare regulations at 42 CFR 491.5(a)(3)(iii) state:

> "If clinic or center services are furnished at permanent units in more than one location, each unit is independently considered for approval as… an FQHC."

CMS provides information on this and related FQHC regulations in Medicare Publication 100-07, State Operations Manual, Exhibit 179 (available at http://www.cms.gov/manuals/downloads/som107_exhibit_179.pdf), which states:

> "In accordance with 42 CFR 491.5(a)(3)(iii), each permanent site at which an FQHC offers services requires a separate agreement with Medicare.
>
> – This means that an FQHC that operates several health centers at different sites but under one management must have each site separately enrolled in Medicare

[4] In the event that the RO identifies issues when reviewing the attestation or other application documents, the effective date will not be earlier than the date on which the problems are corrected.

[5] However, a health center's providers that are individually enrolled in Medicare may bill Medicare Part B directly, and assign payment to the health center, for services that they provided on behalf of the health center prior to the FQHC effective date.

as an FQHC. While this requirement for a separate agreement with CMS for each permanent site does not prevent an FQHC which has several permanent sites from consolidating Medicare claims and cost report data, it would be a violation of Medicare regulations for the FQHC to submit claims for services provided at a site for which there is no specific Medicare agreement.

- Mobile units of an FQHC are not required to be separately enrolled in Medicare, but are treated as part of the FQHC. Mobile units must also comply with the Medicare health and safety standards."

Thus, health centers are required to submit a separate Medicare enrollment application for each "permanent unit" at which they provide services. This includes units considered both "permanent sites" and "seasonal sites" under their HRSA scope of project. (For the definition of permanent and seasonal sites under the scope of project, see Section III of PIN 2008-01: at http://bphc.hrsa.gov/policy/pin0801/definingscope.htm.)[6] ***Therefore, as discussed in Section II.A., for Medicare reimbursement purposes a single health center organization may consist of two or more FQHCs, each billing under its unique CCN.***

Consistent with the definition referenced above, each of the following events should trigger a health center to submit a separate Medicare enrollment application for each of its permanent and seasonal sites:

1. Receiving initial section 330 grant funding (i.e., a "new start");
2. Receiving supplemental section 330 grant funding to add a new permanent or seasonal satellite site as a new access point;
3. Receiving a initial designation as a Look-Alike; or
4. Receiving approval to add a new permanent or seasonal site to the existing scope via a Change in Scope request.

As discussed in Section III.B, a health center must receive a separate Medicare agreement and effective date for each of its permanent and seasonal sites ***before*** submitting claims under the FQHC benefit for services provided at that site. Medicare regulations require that each claim that is submitted include the CCN associated with the location where the services were provided. In cases where a claim is submitted with the incorrect CCN, it may not be paid, or, if payment is made, it may later be considered improper and retracted by Medicare. ***Penalties, including but not limited to recovery of overpayments and/ or revocation of Medicare billing privileges, may apply if a health center submits bills using an inappropriate CCN. Therefore, to avoid the risk of improper and potentially fraudulent***

[6] Seasonal sites provide care at a fixed location on a scheduled, recurrent basis which is less than 12 months of the year. Note that a site that ceases operations – as opposed to taking a scheduled break with a plan to resume services at the end of the break – is not considered a seasonal site. Such a site is considered to have voluntarily terminated it Medicare agreement, and if it resumes operations at a later date, it is required to re-enroll in Medicare.

billing, it is imperative that health centers ensure that each of their permanent and seasonal sites is enrolled separately in Medicare and that all services are billed using the appropriate CCN.

Even when a health center organization bills under more than one NPI, it is permitted to submit a single consolidated cost report and to receive the same all-inclusive per-visit payment rate for all of its organizational units.

B. How to Prepare a Medicare Enrollment Application

Detailed information on how to prepare a Medicare Enrollment Application for an FQHC is contained in Medicare Publication 100-07, State Operations Manual, Exhibit 179. This Exhibit, entitled "Information on Medicare Participation for FQHCs," is accessible at http://www.cms.gov/manuals/downloads/som107_exhibit_179.pdf.

In brief, each Medicare enrollment application package must include all of the following items:

- A signed and completed Form CMS-855A, Medicare Enrollment Application, accessible at http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf; this form includes instructions regarding where to submit the application.
- Two copies of the Attestation Statement for FQHCs (Exhibit 177), each with an original signature and date. Since FQHCs must sign an agreement stipulating that they will comply with section 1861(aa)(4) of the Social Security Act and all applicable regulations, this statement serves as the Medicare FQHC agreement when countersigned by the CMS RO. Exhibit 177 is accessible at http://www.cms.gov/manuals/downloads/som107_exhibit_177.pdf;[7]
- A copy of the HRSA NGA or Look-Alike Designation Memo from CMS;
- A copy of HRSA Form 5 - Part B, Service Sites, in order to verify that the site is included in the approved scope of project;
- Form CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement;
- Clinical Laboratory Improvement Amendments of 1988 (CLIA) Certificate (if applicable);
- State License (if applicable);
- Other documents as indicated in the application instructions.

C. Where to Mail the Enrollment Application(s)

Many types of providers may now submit their Medicare enrollment applications using CMS's internet-based Provider Enrollment Chain and Ownership System (PECOS). However, as of December 2010, FQHC applicants are not eligible to use the internet-based PECOS, and must submit paper copies of all required enrollment application documents.

[7] For FQHCs, this Attestation Statement takes the place of the initial certification survey by the State Survey Agency or by a CMS-recognized accreditation organization that is referred to on page 3 of the From CMS-855A. Since FQHCs do not undergo a certification survey, they are not – and do not need to be – "certified" by Medicare.

The FQHC enrollment application package must be mailed to the appropriate Medicare contractor (either a Medicare Administrative Contractor (MAC) or "legacy" Fiscal Intermediary (FI)) serving the State in which the applicant is located. (See Section VII for a discussion of how FQHCs are currently assigned to contractors.) To identify the name of the appropriate MAC or FI, and the address where the package should be mailed, please refer to http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf. The appropriate Medicare contractor is listed next to "Fiscal Intermediary." Health centers are encouraged to retain a copy of their application and all pertinent records regarding when and where the application was submitted.

Prior to April 27, 2009, all health center Medicare enrollment applications were submitted to National Government Services (NGS). Due to changes in Medicare contracting rules, NGS ceased accepting new enrollment applications as of that date. Failure to submit the application to the correct MAC or FI will result in a delay in processing the application and, more importantly, in the effective date for eligibility for payment under the FQHC benefit.

For a further discussion of recent changes to Medicare administrative contracting, see Section VII.

D. Application Fee Scheduled to Start March 2011

Section 6401 of the Affordable Care Act requires the Secretary of Health and Human Services to charge an application fee for each enrollment application submitted to Medicare on or after March 23, 2011. For FQHC enrollment applications, this fee was set at $505 starting on March 25, 2011 and it will be increased annually to reflect inflation.

E. What to Expect after the Application has been Submitted

Once the Medicare enrollment application package is received by the appropriate MAC or FI:

- The MAC/FI begins its review of the application package and may request that additional or clarifying information be submitted. ***Health centers are encouraged to monitor the progress of their application and to respond promptly to requests for information.***
- If the MAC/FI recommends approval of the application, the recommendation will be sent to the appropriate CMS RO.
- Upon receipt of the recommendation for approval, the RO verifies that the application package is complete and satisfies all of the enrollment requirements. If it does, the RO:
  - countersigns the applicant's Attestation Statement for FQHCs, which becomes the Medicare FQHC agreement;
  - dates it using the date on the MAC/FI's recommendation letter; and
  - assigns the applicant a unique CCN.

If the RO finds identifies issues with the application, it will seek clarification from the FQHC and will not issue an agreement until the issues are resolved. The effective date of the agreement cannot be earlier than the date when the RO determines that all requirements have been met.

Please note that the requirement on page 3 of the Form CMS-855A indicating that most providers that participate with Medicare must undergo a State survey does not apply to FQHCs.

As stated earlier in Section III.B., the date placed by the RO on the Attestation Statement is the effective date of the applicant's agreement with CMS. This date is critical as services provided to Medicare beneficiaries on or after that date are eligible for reimbursement under the Medicare FQHC benefit. Conversely, any services provided to Medicare beneficiaries ***prior*** to this date are ***not*** eligible for reimbursement under the FQHC benefit.

V. Requirements to Update Medicare Enrollment Information within 30 or 90 Days of Change

In accordance with 42 CFR 424.516(e),[8] FQHCs must promptly report to their Medicare contractor any change to the information furnished in the initial enrollment application. These changes include, but are not limited to:

- Board members;
- Organization's legal business name;
- Practice location;
- Licensing information;
- Adverse legal actions affecting the organization, board members, or managing employees; and/or
- Billing agency (if applicable).

It is imperative that health centers implement processes to ensure they act on these reporting and updating requirements in a timely manner. Specifically, FQHCs have 30 days to report a change in Board membership to their appropriate MAC or FI; for most other information, FQHCs have 90 days. ***Failure to report these changes within the required time frame may result in the deactivation or revocation of Medicare billing privileges.***

VI. Enrolling as an FQHC in Medicaid

Successful enrollment in Medicare as an FQHC does ***not*** automatically qualify a health center for payment as an FQHC under its State Medicaid program. Health centers should contact their State Medicaid office directly to determine the process and timeline for becoming eligible for payment as an FQHC under Medicaid.[9]

[8] Available at http://edocket.access.gpo.gov/cfr_2010/octqtr/42cfr424.516.htm.

[9] While Medicaid programs are required to offer FQHC services to their enrollees, Children's Health Insurance Programs (CHIP) are not, unless they are structured as Medicaid expansions. CHIP plans structured as Medicaid expansions follow the same enrollment processes as the Medicaid plan on which they are based.

Unlike Medicare, State Medicaid programs have the discretion to reimburse a health center as an FQHC retroactively to the date it received grant funding under Section 330, received a designation as a Look-Alike, or received approval to add a site to a health center's approved scope of project. Health centers should contact their State Medicaid agency directly for more information.

VII. Medicare Contracting Changes Affecting Newly-Enrolling FQHCs

Medicare uses a national network of private contractors for processing enrollment applications, reviewing cost reports, and reimbursing claims. Until recently, contractors for Medicare Part A (which includes FQHCs) were referred to as FIs. A single national FI, National Government Services (NGS), managed all aspects involving the Medicare FQHC benefit for all organizations across the United States.

The 2003 Medicare Modernization Act (MMA) required CMS to phase out its existing network of Medicare FIs and replace it with a system of 15 (eventually 10) regionally-based Medicare Administrative Contractors (MACs). With a few exceptions, each MAC will be responsible for receiving and processing claims submitted by ***all*** types of providers and suppliers in its geographic region, including section 330 grantees and Look-Alikes. Thus, when the new system is fully implemented, each FQHC will work with the MAC assigned to its region, and the role currently filled by NGS will be divided among the 10 regional MACs.

CMS is transitioning ***all currently-enrolled FQHCs*** from NGS to the regional MACs over a series of years. For example, all FQHCs in the States of Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming were transitioned to their regional MAC in April 2007. All other currently-enrolled FQHCs that work with NGS will continue with NGS until a time when CMS systems can accommodate moving those "out-of-jurisdiction" FQHCs to their appropriate MAC jurisdictional workload. The timing of this migration date has yet to be determined.

All health centers enrolling new organizational units (i.e., permanent and seasonal sites) in Medicare as FQHCs are now required to work with the MAC or legacy FI assigned to their region, rather than NGS. [10] Under this "geographic assignment rule," the regional MACs/legacy FIs are now responsible for reviewing and processing ***all new FQHC enrollments*** (as opposed to updates of existing applications) for applicants located in their geographic area. After the enrollment process is complete, these newly-enrolled FQHCs will continue to work with their MAC/legacy FI for all Medicare services, including cost report review, claims processing, and updating information on the enrollment application. Thus, new FQHCs who seek to enroll in the Medicare program should file their enrollment applications with the MAC or legacy FI that covers the State where the FQHC is located.

[10] In regions where the MAC is not yet operational, health centers are required to work with the "legacy" FI currently serving their region for new FQHC enrollments; they will later be transferred to their regional MAC once it becomes operational.

Existing health centers that enroll new organizational units as separate FQHCs will be required to work with two Medicare contractors until the nationwide migration date. During this period, the health center will continue to work with the single national FI for all Medicare enrollment updates, claims processing, etc., for its previously-enrolled units, while working with their regional MAC/legacy FI for its newly-enrolled units. However, health centers may continue to file joint cost reports that cover all of their separately-enrolled FQHCs, and the data will be shared between the single national FI and the appropriate regional MAC.

For additional information about the mandatory assignment of newly-enrolling FQHC units to their regional MAC, please refer to http://www.cms.hhs.gov/transmittals/downloads/R1707CP.pdf.

VIII. For Further Information

Questions and comments pertaining to this PAL should be referred to BPHC's Office of Policy and Program Development at OPPDCMS@hrsa.gov or 301-594-4300.

James Macrae
Associate Administrator for Primary Care