

# **The BPHC Newly Funded TA Web Guide Resources for New and Existing Grantees**

## **Developed by:**

The U.S. Department of Health and Human Services (HHS)  
Health Resources and Services Administration (HRSA)  
Bureau of Primary Health Care (BPHC)  
Office of Training and Technical Assistance Coordination (OTTAC)

The BPHC Newly Funded TA Web Guide is a self assessment tool designed to help new BPHC grantees provide high-quality primary health care from the day they open their doors for business. The Guide is a central hub for links to HRSA-approved templates, information pages, and policy documents, and many other resources. The intent of the Web Guide is to help Health Center grantees improve their quality and efficiency, work within Health Center Program Requirements, and access Federal policies, programs and resources intended for the specific needs of Health Centers.

This document is a printable version of a portion of the content available on the Web Guide. It was developed by the BPHC Office of Training and Technical Assistance Coordination and is hosted at:  
<http://bphc.hrsa.gov/technicalassistance/index.html>

## 1b. Medicare/Medicaid/Other Payment

This section provides a brief overview of the steps needed to enable your health center to be reimbursed by Medicare and Medicaid under the FQHC payment system. Detailed information on this topic is available in [PAL 2011-04](#), “Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit.”

**Medicare and Medicaid’s Reimbursement System for FQHCs:** Both Medicare and Medicaid have payment systems that are unique to Federally Qualified Health Centers (FQHCs.) These systems are designed to reflect the relatively higher intensity of health center patients and the broader range of services that health centers provide. Payment is made on a per-visit basis, meaning that FQHCs receive a standardized, predetermined amount for each visit, regardless of which services were actually provided.

Note that being approved for a health center grant through Section 330 or receiving a designation as a Look-Alike is not sufficient for a health center to be reimbursed under the FQHC payment system. Rather, a health center must apply to be enrolled in each program as an FQHC, and this application must be approved, before payment under the FQHC system begins. Under Medicare (and many State Medicaid programs,) payment as an FQHC is not retroactive to services provided prior to the date the application was approved. For these services, health centers may bill Medicare under the name of individual providers, and will be reimbursed based on traditional payment systems (e.g., the physician fee schedule under Medicare.)

### Enrolling and Billing Under Medicare

**How to prepare and submit a Medicare Enrollment Application:** For information on how to prepare and where to submit a Medicare enrollment application, see [PAL 2011-04](#), “Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit.”

**Importance of prompt submission of Medicare enrollment application:** Given that reimbursement under the Medicare FQHC system does not begin until the date the enrollment application is approved, health centers are strongly advised to submit this application as soon as possible and to remain in regular contact with the Medicare contractor about how the review process is progressing. Medicare regulations State that health centers must be operational on the date that they submit the enrollment application. Therefore, health centers are strongly encouraged to have the application ready for submission on the first day the site becomes operational.

**Each permanent and seasonal site must be enrolled individually:** Medicare considers each permanent and seasonal health center site to be a unique FQHC. Therefore, each site must enroll individually and receive a unique Medicare Billing Number.

**Billing under the FQHC per-visit payment system:** Once it has been approved as a FQHC, a health center submits claims to its Medicare contractor using CMS Form UB-04, which must be submitted electronically.

**How Medicare per-visit payment rates are set:** Initially a FQHC will be assigned an “interim per visit rate” by its Medicare contractor, based on an estimate of its costs for caring for Medicare patients. At

the end of the first fiscal year, the FQHC files a “Medicare Cost Report” which reports its actual costs. The Medicare contractor reviews this report and determines a per visit rate. It then adjusts this rate downward if it determines that the individual providers did not meet productivity standards, and/or if the rate exceeds the Upper Payment Limits established by CMS. The Medicare contractor then determines the total amount due based on this final rate, and compares it to the amount actually paid. If the amount paid was less than the amount owed, the Medicare contractor pays the difference to the FQHC; if the amount due is less than the amount already paid, then the FQHC must repay the Medicare contractor. Therefore, new FQHCs are encouraged to closely monitor their costs versus per visit rates throughout their first year, as they could either owe or receive a potentially large amounts based on this adjustment.

Once the first cost report is submitted and accepted, the rate determined based on that report will be used in the following year, with another adjustment being made (if necessary) after the year is over.

**Reimbursement for Medicare Advantage (Managed Care) Patients:** FQHCs are guaranteed to receive their full per-visit rate for their Medicare patients who participate in managed care plans. In these situations, the FQHC negotiates payment rates directly with the Managed Care Organization (MCO), and receives reimbursement directly from the MCO. The FQHC must then bill Medicare for the difference between what the MCO paid and what how much they would have received under the standard per-visit payment system. This amount is called the “wrap-around” payment, and Medicare contractors are required to make these payments not less often than every 3 months.

### **Enrolling and Billing Under Medicaid**

**Enrolling in Medicaid:** Each State Medicaid program establishes its own policies about how health centers are to enroll, and when reimbursement under the FQHC system begins. For example, many States require a health center to be approved by Medicare as an FQHC before it can apply to Medicaid. Also, some States make payments under the FQHC system retroactive to the date the health center applied or became operational, while others make no retroactive adjustments. To determine the policies in your State, contact your [State Medicaid Office](#) or [Primary Care Association](#).

**Billing under the Medicaid FQHC per-visit payment system:** Each State determines how FQHCs are to bill Medicaid. To determine the practices in your State, contact your State Medicaid office or Primary Care Association.

**How Medicaid payment rates are set:** In most States, the per-visit payment rates made to FQHCs under Medicaid are referred to as “Prospective Payment System” (PPS) rates. For a new FQHC, the base rate is set by the Medicaid office, based on the FQHC’s first year costs, the rates in effect for similar FQHCs in the area, or a combination of both. In future years, this base rate is increased annually using CMS’s estimate of health care inflation. It is very important that new FQHCs ensure that the initial PPS rates are set appropriately, as once they are established it is very difficult to change them, other than by the annual inflation update.

State Medicaid programs have the option of using an Alternative Payment Mechanism (APM) instead of a PPS. For an APM to be permissible, it must, 1. result in total payments at least as high as under the PPS, and 2. be approved by the health center. Again, it is important that health centers closely study a proposed APM system before accepting it.

**Reimbursement for patients in managed care:** Similar to Medicare, FQHCs are guaranteed to receive their full per-visit rate for their Medicaid patients who participate in managed care plans. As with Medicare, the FQHC negotiates payment rates directly with the Managed Care Organization (MCO) and the FQHC bills Medicaid for the difference between what the MCO paid and how much it would have received under the standard per-visit payment system. State Medicaid programs are required to issue these “wrap-around payments” at least once every four months.

**For additional information about Medicare and Medicaid,** see the [CMS FQHC](#) website. This site includes additional links to policies, billing/payment, enrollment/recertification, listserv signup, coding, coverage, manuals and a range of other resources.

**Enrolling as a participating provider with commercial and managed care payers active in the area.** Health centers should develop a list of the largest commercial insurance providers in their community, and request enrollment applications from them as soon as possible. To find a list of payers, go to the National Association of Insurance Commissioners web site and click on [your State](#).

Each private insurer – including each MCO operating under either Medicare or Medicaid – will have its own enrollment forms and requirements. New health centers are encouraged to obtain and submit these applications as soon as possible.

### **Insurance, Fees and Billing**

**Contact Your State Compensation Insurance Commission** for worker’s compensation fee schedule and forms. The US Department of Labor has many resources on this topic. Information on worker’s compensation can be found by selecting your State [here](#).

**Develop a Fee Schedule.** It is important to determine reasonable costs or the locally prevailing charges for all services in your approved scope of project (e.g. primary care, dental, mental health, substance abuse, etc.). Your financial auditor, PCA, or NACHC may be able to provide TA. Medicare / Medicaid charges are publicly available information to help you get started in developing your listing of fees for all office visits, procedures, and services. Medicare schedules are found [here](#). Medicaid schedules are found [here](#). The schedule of fees is also the first step in developing the corresponding schedule of discounts (sliding fee discount schedule/sliding fee scale) that must be applied to all services in the approved scope of project for patients without insurance (see Program Requirement 7 for more information on Sliding Fee requirements).

**Develop Accounts Receivable systems and policies.** This should be part of a larger Financial Policies and Procedures Manual. The National Association of Community Health Centers ([NACHC](#)) and/or your [PCA](#) may have additional TA resources on this topic. Order CPT, HCPCS, ICD-9/10 and other coding manuals if you are doing your own billing.

**Complete the EHB Scope Verification Module.** Grantees are allowed up to 120 days following the date of the Notice of Award (NoA) indicating approval for the change in scope to implement the change (e.g. open the site or begin providing a new service) ...” The foundation for this policy is the Bureau of Primary Health Care’s (BPHC) expectation for the timely implementation of change in scope requests (CIS) and/or scope changes occurring via approved applications to add a new service or a new service site. Timely implementation is defined as fully implementing approved scope changes within 120 days from the date of the Notice of Grant Award approving the change. Grantees are now able to **verify**

implementation of these changes within EHB, whereas previously grantees have had to provide verification by way of a paper post award submission (e.g., email, fax or phone conversation). See [PAL 2009-11](#) for more information.