

Key Points from PAL 2011-04 Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit

- Program Assistance Letter 2011-04 (PAL 2011-04) consolidates and clarifies existing information about the process through which health center grantees and look-alikes must enroll in Medicare in order to be recognized – and reimbursed – as FQHCs. It does not establish new policy.
- Receiving a grant award or look-alike designation is not enough to enable a health center site to be reimbursed by Medicare as an FQHC; the site must also be enrolled in Medicare as an FQHC, and keep its enrollment information updated.
- In general, a health center become eligible to be paid as an FQHC starting the day its FQHC enrollment application is approved by the Medicare contractor. Payment under the FQHC rate is not retroactive to services provided before this date.
- Health centers must certify that they are operational on the date they submit their enrollment applications. During the period between when a health center becomes operational and the date it becomes eligible to be reimbursed as an FQHC, the health center's providers may bill Medicare individually under Part B. These payments are generally not as high as the FQHC rates.
- Medicare requires that all sites that are considered either “permanent” or “seasonal” under their BPHC scope of project must be enrolled individually in Medicare and have their own CMS certification number (CCN). Thus, from CMS' perspective, a single health center grantee may consist of two or more individually-enrolled FQHCs.
- Health centers whose sites are not appropriately enrolled in Medicare are encouraged to file enrollment applications as soon as possible. Details on how to submit these applications is contained in the PAL.
- All Medicare claims must indicate the CMS billing number for the site where the service was actually provided. It may be considered fraud if a health center site submits a claim using the billing number from a different site – even if both sites are part of the same larger organization. Penalties include, but are not limited to, repaying Medicare all reimbursement received for those services and being expelled from the Medicare program.
- Health centers have 30 days to report a change in their Board membership to CMS, and 90 days to report other changes such as address, licensing information, and adverse legal actions. Failure to report the changes in the required timeframes could cause an FQHC to be denied the right to participate in Medicare.