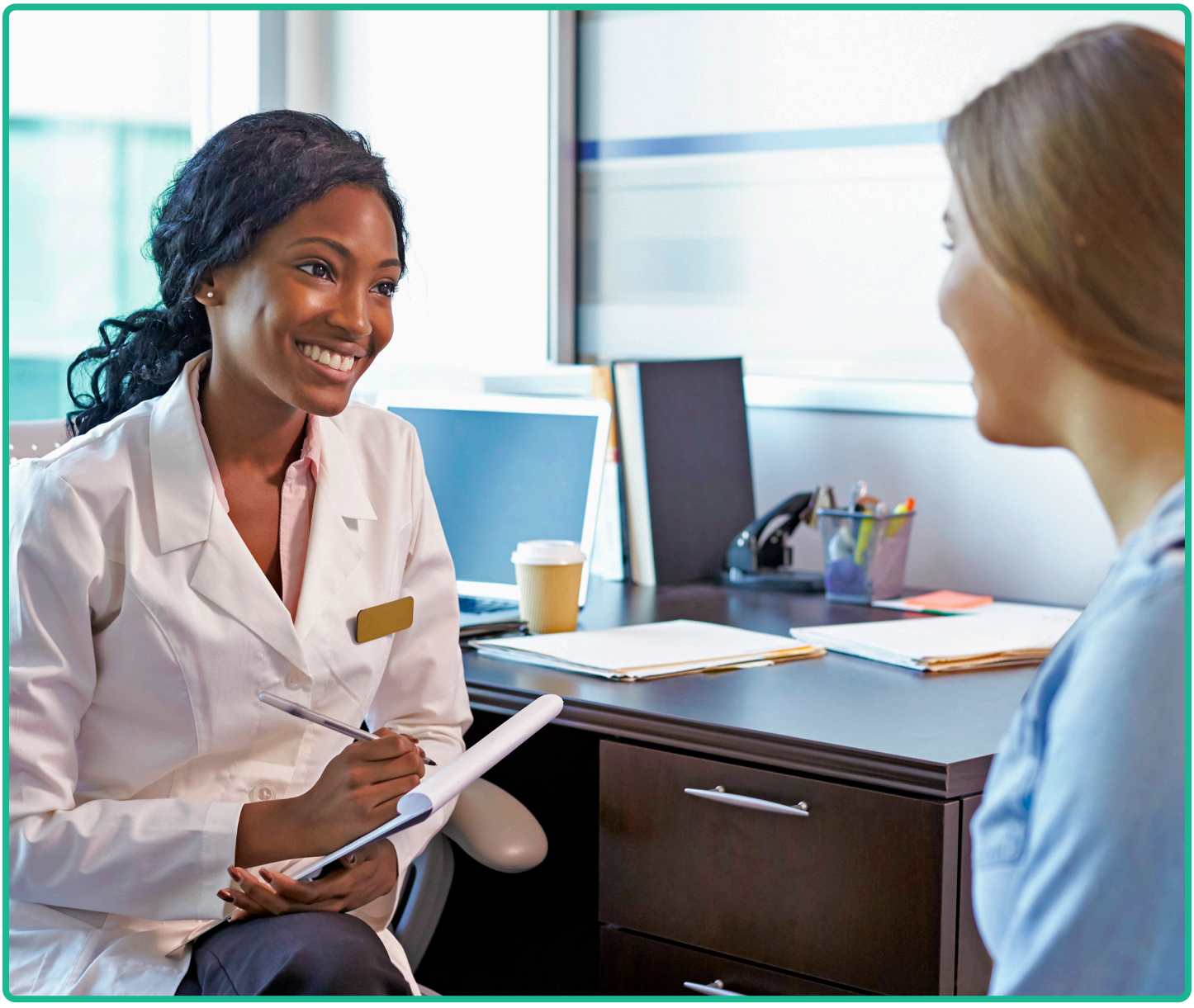
mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

Federally Qualified Health Center



CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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What's Changed?

- Starting January 1, 2022:
  - Federally Qualified Health Centers (FQHCs) get payment for hospice attending physician services when provided by specific providers (pages 5 & 6)
  - We allow mental health services using telecommunications (pages 5 & 12)
  - We allow concurrent billing for chronic care management (CCM) and transitional care management (TCM) services (page 5)
  - We changed G2064 and G0265 to 99424 and 99426, respectively (page 8)
- We added COVID-19 shot and monoclonal antibody therapy administration information (page 9)

You'll find substantive content updates in dark red.

Federally Qualified Health Centers (FQHCs) are safety net providers that give services in an outpatient clinic setting. Section 1861(aa) of the Social Security Act allows additional FQHC Medicare payments.

FQHCs may be located in rural or urban areas and include:

- Community health centers
- Migrant health centers
- Homeless health centers
- Public housing primary care centers
- Health center program "look-alikes"
- Outpatient health programs or facilities a tribe or tribal organization or an urban Indian organization operates

Together we can advance health equity and help eliminate health disparities in rural populations. Find these resources and more from the CMS Office of Minority Health:

- Rural Health
- Data Stratified by Geography (Rural/Urban)
- Health Equity Technical Assistance Program

Note: The information in this publication may not apply to Grandfathered Tribal FQHCs.

Practitioners

You and your staff must comply with all licensure and certification laws and regulations. We pay FQHCs based on the FQHC Prospective Payment System (PPS) for medically necessary primary health services and qualified preventive health services from an FQHC practitioner, including:

- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Certified nurse-midwives (CNMs)
- Clinical psychologists (CPs)
- Clinical social workers (CSWs)

Patient Services

FQHCs provide:

- Physician services.
- Services and supplies incident to physician services like taking blood pressure or administering shots.
- Services and supplies incident to NP, PA, CNM, CP, or CSW services.
- Medicare Part B-covered drugs supplied incident to FQHC practitioner services.
- Medicare patient homebound visiting nurse services when a registered nurse (RN) or licensed practical nurse (LPN) provides them in an area we certify as having a shortage of home health agencies.*

- Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) from qualified DSMT and MNT practitioners in a 1-on-1, face-to-face visit for patients with diabetes or renal disease.
- Certain care management services like transitional care management (TCM), chronic care management (CCM), general behavioral health integration (BHI), principal care management (PCM), and psychiatric collaborative care model (CoCM) services. You can bill TCM services with other care management services (starting January 1, 2022).
- Virtual communication services like communication-based technology and remote evaluation services.
- Mental health services using telecommunications (starting January 1, 2022).
- Hospice attending physician services from an FQHC physician, NP, or PA employed or working under contract for an FQHC, instead of employed by a hospice program (starting January 1, 2022).
- During a hospice election, attending physician services can take place at the patient's home, a Medicare-certified hospice freestanding facility, skilled nursing facility (SNF), or hospital.

*You should check eligibility before providing visiting nurse services to ensure the patient isn't already under a home health plan of care.

Certification

To qualify as an FQHC, you must meet **1** of these requirements:

- Get a grant under Section 330 of the Public Health Service (PHS) Act or be funded by the same grant contracted to the recipient
- Get a grant as an FQHC "look-alike" based on a Health Resources and Services Administration (HRSA) recommendation
- Be treated by the HHS Secretary as a comprehensive federally funded health center since January 1, 1990, for Part B purposes
- Operate as an outpatient health program or tribe or tribal organization facility under the Indian Self-Determination Act or as an urban Indian organization getting funds under Title V of the Indian Health Care Improvement Act

FQHC certification requires you meet **all** these requirements:

- Provide comprehensive services, including an ongoing quality assurance program and annual review
- Meet all health and safety requirements
- Not be approved as a rural health clinic (RHC)
- Meet **al**l Section 330 of the PHS requirements, including:
  - Serve a designated medically underserved area (MUA) or medically underserved population (MUP)
  - Offer people with incomes below 200% of the federal poverty guidelines a sliding fee scale
  - Be governed by a board of directors, where most members get care at the FQHC

Visits

FQHC visits **must:**

- Be medically necessary
- Be face-to-face medical or mental health visits or qualified preventive health visits between the patient and an FQHC where the practitioner provides 1 or more qualified FQHC services
- Include an RN or LPN homebound patient visit (in certain limited situations)
- Meet certain conditions when a qualified practitioner offers outpatient DSMT or MNT services and the FQHC meets the requirements to provide these services

FQHC visits **can** take place at:

- An FQHC
- A patient's home, including an assisted living facility
- A Medicare-covered Part A SNF
- The scene of an accident
- A hospice facility (when an FQHC physician, NP, or PA who's employed or working under contract for an FQHC but isn't employed by a hospice program provides them)

FQHC visits **can't** take place at:

- An inpatient or outpatient hospital department, including a critical access hospital (CAH)
- A facility with specific requirements excluding FQHC visits

Multiple Visits on the Same Day

Visits with more than 1 FQHC practitioner on the same day, or multiple visits with the same FQHC practitioner on the same day, count as a single visit, **except** when a patient:

- Returns to the FQHC to diagnose or treat an injury or illness that happened after the initial visit (for example, a patient sees their practitioner in the morning because they have flu symptoms, then later in the day they cut their finger and return to the FQHC)
- Has a qualified medical and mental health visit on the same day

Payments

- FQHC claims must include an FQHC payment code.
- We pay claims at 80% of the lesser of the FQHC charges or the FQHC PPS rate for the specific payment code (national encounter-based rate with geographic and other adjustments).
- We annually update the FQHC PPS base payment rate using the FQHC market basket.
- Coinsurance is 20% of the lesser of the FQHC charges or the PPS rate for the specific payment code, except for certain preventive services. We waive Part B coinsurance and deductible for certain preventive services, including specific Medicare Wellness Visits.
- Telehealth services are the only services billed on FQHC claims that are subject to the Part B deductible.

Visit the FQHC Center webpage for more information on PPS rates.

Payment Adjustments

These adjustments apply to the FQHC PPS base payment rate:

- FQHC geographic adjustment factor
- New patient adjustment
- Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) adjustment

Charges & Payment

FQHCs set their own service charges and determine which services to include with each FQHC G code. Patient charges must be uniform.

The FQHC Center webpage has more information about submitting claims with FQHC PPS payment codes and lists of billable visits.

We pay for professional services only. We pay lab tests (excluding venipuncture) and the technical component of billable visits separately. We include not separately billable procedures in the payment of an otherwise qualified visit. If a procedure is associated with a qualified visit, include procedure charges on the visit's claim.

Cost Reports

FQHCs must file an annual cost report. Include graduate medical education adjustments, bad debt, flu and pneumococcal shots, and your administration payments. Use FQHC Cost Report Form (CMS-224-14) to determine your payment rate and reconcile interim payments.

The Provider Reimbursement Manual – Part 2 has more cost reports and forms.

Care Management Services

Chronic Care Management or General Behavioral Health Integration Services

- We pay CCM or general BHI services at the **national non-facility Physician Fee Schedule (PFS) average payment rate** for CPT codes 99424, 99426, 99484, 99487, 99490, and 99491 using general care management HCPCS code G0511, which is updated annually based on these codes' PFS amounts
- We update G0511's payment rate annually based on the PFS amounts for these codes
- We adopted (in 2022), CPT codes 99424 and 99426 to replace HCPCS codes G2064 and G2065 in calculating G0511's rate
- You can bill 20% coinsurance of the lesser of submitted charges or G0511's payment rate for care management services
- You can report care management costs in the cost report's non-reimbursable section, and not determine the FQHC PPS rate
- You can bill G0511 once per month per patient when you deliver at least 20 minutes of CCM services, at least 20 minutes of general BHI services, or at least 30 minutes of PCM services, and your services meet all other requirements
  - You can count only FQHC practitioner or auxiliary personnel services within the scope of service elements toward the 20-minute general care management services billing minimum or the 30-minute PCM services minimum
  - **Don't** include administrative activities like transcription or translation services

Psychiatric Collaborative Care Model

- We pay at the **national non-facility PFS payment rate** for CPT code 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services), when HCPCS code G0512 is on an FQHC claim either alone or with other payable services
- You must provide at least 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months of psychiatric CoCM services to bill for this service
- You can bill 20% coinsurance of the lesser of submitted charges or G0512's payment rate for care management services coinsurance
- You can report care management costs in the cost report's non-reimbursable section, and not determine the FQHC PPS rate
- You can bill G0512 once per month per patient when you deliver at least 60 minutes of psychiatric CoCM services and your services meet all other requirements
  - You can count only FQHC practitioner or auxiliary personnel services within the scope of service elements toward the 60-minute psychiatric CoCM billing minimum
  - **Don't** include administrative activities like transcription or translation services

Flu Shots, Pneumococcal Shots, COVID-19 Shots, & COVID-19 Monoclonal Antibody Therapies

We pay for flu, pneumococcal, and COVID-19 shots, and COVID-19 monoclonal antibody products and their administration at 100% of reasonable cost. We include the cost in the cost report so you don't bill a visit. You must include these charges on the claim if they're part of a visit. If you only provide the shot administration on that day, waive the patient coinsurance, and don't file a claim.

Note: We updated the FQHC cost report to reflect costs related to COVID-19 shots, COVID-19 monoclonal antibody products, and their administration.

For Medicare Advantage (MA) patients, submit COVID-19 shot administration claims to the patient's MA plan for dates of service on or after January 1, 2022. Original Medicare stopped paying these claims December 31, 2021.

Hepatitis B Shot Administration & Payment

We include the hepatitis B shot and its administration in the FQHC visit. They aren't separately billable. If you provide a qualifying FQHC visit on the same day as the hepatitis B shot, report the charges for the shot and related administration as a separate line item to ensure we don't apply coinsurance. You can't bill a visit if shot administration is the only service provided.

Telehealth

Telehealth generally involves 2-way, interactive, audio-video technology that permits communication between the practitioner and patient. FQHCs can provide telehealth to extend care when a patient is in a different place.

The originating site refers to the patient's location. FQHCs can be originating sites for telehealth if they're in a qualifying area. FQHCs serving as telehealth originating sites get an originating site facility fee. You may include the originating site facility fee charges on the claim. Although FQHC services aren't subject to a deductible, the facility fee isn't considered an FQHC service. You must apply the deductible when billing the telehealth originating site facility fee.

During the COVID-19 Public Health Emergency (PHE)

FQHCs can provide and get payment for distant site telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE. The distant site refers to the provider's location. FQHCs are only authorized to be a distant site during the COVID-19 PHE.

Practitioners can furnish telehealth services from any distant site location, including their home, during the time they're working for the FQHC, and they can provide any distant site-approved telehealth service under the PFS. You can't bill the visit's cost or include it on the cost report. During the PHE, practitioners can furnish some telehealth services using audio-only technology.

For information on new and expanded FQHC flexibilities during the COVID-19 PHE, refer to MLN Matters® Article SE20016.

Virtual Communication Services

You can also provide virtual communication services. Practitioners bill virtual communication services differently than telehealth services.

Virtual communication services are services where a practitioner meets with a patient for at least 5 minutes to determine if the patient needs a visit. There are 2 ways to provide virtual communication services:

- Through communication-based technology
- With remote evaluation services

During the COVID-19 PHE

During the COVID-19 PHE, payment for virtual communication services includes online digital evaluation and management services. Digital assessment services are non-face-to-face, patient-initiated, digital visits using a secure patient portal.

For information on new and expanded FQHC flexibilities during the COVID-19 PHE, refer to MLN Matters® Article SE20016.

We pay for virtual communication services when an FQHC practitioner meets certain requirements, including:

- Practitioner provides at least 5 minutes of billable FQHC virtual communications, either through communication-based technology or remote evaluation services
- Patient had at least 1 face-to-face billable visit within previous year
- Virtual visit isn't related to services provided within last 7 days
- Virtual visit doesn't lead to in-person FQHC service within the next 24 hours or at next appointment

When the virtual communication HCPCS code G0071 is on an FQHC claim alone or with other payable services, we require FQHCs to submit HCPCS code G2012 (communication technology-based services) or HCPCS code G2010 (remote evaluation services).

When an FQHC practitioner provides virtual communication services, they don't need to meet face-to-face, so the coinsurance doesn't apply.

See Virtual Communication Services FAQs for more information.

Mental Health Visits

In 2022, we revised current regulatory language to allow FQHC and RHC mental health visits using telecommunications. We're allowing payment in the same way as face-to-face services. The changes also allow you to use audio-only technology in cases where patients can't, or don't consent to, using audio-video technology. MLN Matters® Article SE22001 has more information.

Resources

- Care Management Services in RHCs and FQHCs FAQs
- Medicare Benefit Policy Manual, Chapter 13
- Medicare Claims Processing Manual, Chapter 9

Other Helpful Websites

- American Hospital Association Rural Health Services
- National Association of Rural Health Clinics
- National Rural Health Association
- Rural Health Clinics Center
- Rural Health Information Hub

Regional Office Rural Health Coordinators

Get contact information for CMS Regional Office Rural Health Coordinators who offer technical, policy, and operational help on rural health issues.