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Federally Qualified Health Center

RURAL HEALTH SERIES

This publication provides the following information about Medicare-certified Federally Qualified Health Centers (FQHCs):

- ❖ FQHC background;
- ❖ FQHC certification;
- ❖ FQHC services;
- ❖ FQHC visits;
- ❖ FQHC payment;
- ❖ FQHC cost reports; and
- ❖ Lists of helpful websites and Regional Office Rural Health Coordinators.

Note: The information in this publication does not necessarily apply to Grandfathered Tribal FQHCs. For more information about Grandfathered Tribal FQHCs, visit <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Grandfathered-Tribal-FQHCs.html> on the Centers for Medicare & Medicaid Services (CMS) website.



FQHC BACKGROUND

The FQHC benefit under Medicare was added effective October 1, 1991, when Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are safety net providers that primarily engage in providing services typically furnished in an outpatient clinic. FQHCs include community health centers, migrant health centers, health care for the homeless centers, public housing primary care centers, and outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization. The main purpose of the FQHC Program is to enhance the provision of primary care services in medically-underserved urban and rural communities.

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FQHC CERTIFICATION

To be certified as an FQHC, an entity must meet **one** of the following requirements:

- ❖ Is receiving a grant under Section 330 of the Public Health Service (PHS) Act or is receiving funding from such a grant and meets other requirements;
- ❖ Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a “FQHC look-alike”) based on the recommendation of the Health Resources and Services Administration;
- ❖ Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive Federally-funded health center as of January 1, 1990; or
- ❖ Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991.

For certification as an FQHC, the entity must meet all of the following requirements:

- ❖ Provide comprehensive services and have an ongoing quality assurance program;
- ❖ Meet other health and safety requirements; and
- ❖ Not be concurrently approved as a Rural Health Clinic.

FQHCs that receive a Section 330 grant or are determined to be a FQHC look-alike must meet **all** requirements contained in Section 330 of the PHS Act, including:

- ❖ Serve a designated medically-underserved area or medically-underserved population;
- ❖ Offer a sliding fee scale to persons with incomes below 200 percent of the Federal poverty level; and

- ❖ Be governed by a board of directors, of whom a majority of the members receive care at the FQHC.

FQHC SERVICES

FQHC services include:

- ❖ Physician services;
- ❖ Services and supplies incident to the services of physicians;
- ❖ Nurse practitioner (NP), physician assistant (PA), certified nurse-midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;
- ❖ Services and supplies incident to the services of NPs, PAs, CNMs, CPs, and CSWs;
- ❖ Medicare Part B-covered drugs furnished by and incident to services of a FQHC practitioner;
- ❖ Visiting nurse services to the homebound in an area where CMS determined there is a shortage of Home Health Agencies; and
- ❖ Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) for patients with diabetes or renal disease furnished by qualified practitioners of DSMT and MNT.

FQHC VISITS

A FQHC visit is a medically-necessary face-to-face medical or mental health visit or a qualified preventive health visit between the patient and a physician, NP, PA, CNM, CP, or CSW during which time one or more qualified FQHC services are furnished. Transitional Care Management and Advanced Care Planning can also be a FQHC visit. In certain limited situations, a FQHC visit may also include a visit by a registered professional nurse or a licensed practical nurse to a homebound patient.

FQHC visits may take place in **any** of the following locations:

- ❖ The FQHC;
- ❖ The patient's residence (including an assisted living facility);
- ❖ A Medicare-covered Part A Skilled Nursing Facility; and
- ❖ The scene of an accident.

FQHC visits may **not** take place in either of the following locations:

- ❖ An inpatient or outpatient department of a hospital (including a Critical Access Hospital); or
- ❖ A facility that has specific requirements that preclude FQHC visits.

FQHC PAYMENT

Medicare FQHC Prospective Payment System (PPS)

Section 10501(i)(3)(A) of the Affordable Care Act (Public Law 111-148 and 111-152) added Section 1834(o)(2) of the Act to establish the FQHC PPS for cost reporting periods beginning on or after October 1, 2014. FQHCs transitioned to the FQHC PPS between October 1, 2014, and December 31, 2015.

FQHCs must include a FQHC payment code on their claim for payment. They are paid 80 percent of the lesser of their charges based on the FQHC payment codes or the FQHC PPS rate (a national encounter-based rate with geographic and other adjustments). Beginning on January 1, 2016, the FQHC PPS base rate is updated annually based on the Medicare Economic Index or by a FQHC market basket.

Per-Diem Payment and Exceptions

Encounters with more than one FQHC practitioner on the same day, regardless of the length or complexity of the visit or multiple

encounters with the same FQHC practitioner on the same day, constitute a single visit, except when the patient:

- ❖ Suffers an illness or injury requiring additional diagnosis or treatment subsequent to the first encounter (for example, the patient sees the practitioner in the morning for a medical condition and later in the day has a fall and returns to the FQHC); or
- ❖ Has a qualified medical visit and a qualified mental health visit on the same day.

Payment Adjustments

The following adjustments apply to the FQHC PPS payment rate:

- ❖ FQHC Geographic Adjustment Factor;
- ❖ New patient adjustment; and
- ❖ Initial Preventive Physical Examination (IPPE) or Annual Wellness Visit (AWV) adjustment.

Charges and Payment

FQHCs set their own charges for the services they provide and determine which services to include in the bundle of services associated with each FQHC G code. Charges must be uniform for all patients.

To find the specific FQHC payment codes to use when submitting claims under the PPS and a list of billable visits, visit <https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html> on the CMS website.

Payment is for professional services only. Laboratory tests (excluding venipuncture) and the technical component of billable visits are paid separately. Procedures are included in the payment of an otherwise qualified visit and are not separately billable. If a procedure is associated with a qualified visit, include the charges for the procedure on the claim with the visit.

Coinsurance

Coinsurance is 20 percent of the lesser of the FQHC's charge for the specific payment code or the PPS rate, except for certain preventive services. There is no Part B deductible in FQHCs for FQHC-covered services. Patient cost-sharing requirements for most Medicare-covered preventive services are waived, and Medicare pays 100 percent of the costs for these services. No coinsurance is required for the IPPE, AWV, and any covered preventive services recommended with a grade of A or B by the United States Preventive Services Task Force. For a complete list of preventive services and their coinsurance requirements, refer to the ["Federally Qualified Health Center \(FQHC\) Preventive Services Chart"](#) on the CMS website.

Influenza and Pneumococcal Vaccine

FQHCs should report the cost of influenza and pneumococcal vaccine and their administration on a separate worksheet in their cost report. FQHCs receive 100 percent reimbursement for these costs at annual cost settlement. The patient pays no Part B deductible or coinsurance for these services.

If administration of the influenza and/or pneumococcal vaccine are furnished as part of an encounter, include the charges on the claim. If the administration of the vaccine is the only service furnished on that day, do not file a claim.

Hepatitis B Vaccine (HBV)

If a qualifying FQHC visit is furnished on the same day as the HBV, report the charges for the vaccine and related administration on a separate line item to ensure that deductible and coinsurance are not applied. When a FQHC practitioner sees a patient for the sole purpose of administering this vaccination, the FQHC may not bill for a visit; however,

include the costs of the vaccine and its administration on the annual cost report. Charges for the HBV may be included on a claim for a patient's subsequent FQHC visit.

Telehealth Services

FQHCs are authorized to serve as an originating site for telehealth services if the FQHC is located in a qualifying area. An originating site is the location of an eligible Medicare patient at the time the service being furnished via a telecommunications system occurs. FQHCs that serve as an originating site for telehealth services are paid an originating site facility fee.

FQHCs are not authorized to serve as a distant site for telehealth consultations. A distant site is the location of the practitioner at the time the telehealth service is furnished. The cost of a visit may not be billed or included on the cost report.

Chronic Care Management (CCM) Services

Beginning on January 1, 2016, FQHCs may receive an additional payment for the costs of CCM services when a minimum of 20 minutes of qualified CCM services are furnished to a Medicare patient who has two or more chronic conditions:

- ❖ Expected to last at least 12 months or until his or her death; and
- ❖ That place him or her at significant risk of death, acute exacerbation/decompensation, or functional decline.

CCM payment is based on the Medicare Physician Fee Schedule national average non-facility payment rate when Current Procedural Terminology (CPT) code 99490 is billed alone or with other payable services on a FQHC claim. Coinsurance is applied and the FQHC face-to-face requirements are waived for CCM services.

FQHC COST REPORTS

Freestanding FQHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, to identify all incurred costs applicable to furnishing covered FQHC services. To find Form CMS-222-92, refer to Chapter 29 of the “[Provider Reimbursement Manual – Part 2](#)” (Publication 15-2) on the CMS website.

Provider-based FQHCs must complete the appropriate worksheet designated for FQHC services within the parent provider’s cost report. For example, FQHCs based in a hospital complete Worksheet M of Form CMS-2552-96, Hospital and Hospital Complex Cost Report. To find Form CMS-2552-96, refer to Chapter 36 of the “[Provider Reimbursement Manual – Part 2](#)” (Publication 15-2) on the CMS website.

RESOURCES

The chart below provides FQHC resource information.

FQHC Resources

For More Information About...	Resource
FQHCs	https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html on the CMS website Chapter 13 of the “ Medicare Benefit Policy Manual ” (Publication 100-02) on the CMS website Chapter 9 of the “ Medicare Claims Processing Manual ” (Publication 100-04) on the CMS website
FQHC PPS	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS on the CMS website
CCM Services	“ Chronic Care Management (CCM) Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) ” on the CMS website
All Available Medicare Learning Network® (MLN) Products	“ MLN Catalog ” on the CMS website
Provider-Specific Medicare Information	MLN publication titled “ MLN Guided Pathways: Provider Specific Medicare Resources ” on the CMS website
Medicare Information for Patients	https://www.medicare.gov on the CMS website

HELPFUL WEBSITES

American Hospital Association Rural Health Care

<http://www.aha.org/advocacy-issues/rural>

Critical Access Hospitals Center

<https://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html>

Disproportionate Share Hospitals

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html>

Federally Qualified Health Centers Center

<https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>

Health Resources and Services Administration

<http://www.hrsa.gov>

Hospital Center

<https://www.cms.gov/Center/Provider-Type/Hospital-Center.html>

Medicare Learning Network®

<http://go.cms.gov/MLNGenInfo>

National Association of Community Health Centers

<http://www.nachc.org>

National Association of Rural Health Clinics

<http://narhc.org>

National Rural Health Association

<http://www.ruralhealthweb.org>

Rural Health Clinics Center

<https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>

Rural Health Information Hub

<https://www.ruralhealthinfo.org>

Swing Bed Providers

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/SwingBed.html>

Telehealth

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth>

U.S. Census Bureau

<http://www.census.gov>

REGIONAL OFFICE RURAL HEALTH COORDINATORS

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf> on the CMS website.



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