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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
New Medicare Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs)
MLN Connects National Provider Call
Moderator: Nicole Cooney
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Nicole Cooney. Thank you, you may begin.

Announcements and Introduction

Nicole Cooney: Thank you, Victoria. I'm Nicole Cooney from the Provider Communications Group here at CMS and I will be your moderator today. I'd like to welcome you to this MLN Connects National Provider Call on the Review of the New Medicare PPS for Federally Qualified Health Centers. MLN Connects Calls are part of the Medicare Learning Network. During this call CMS subject matter experts will provide information on the review of the new Medicare PPS for Federally Qualified Health Centers.

As required by Section 10501 of the Affordable Care Act, Federally Qualified Health Centers, or FQHCs, will transition to a Prospective Payment System, or PPS, beginning on October 1st, 2014. Today's presentations will include information on the final policies for the new Medicare PPS. A question-and- answer session will follow the presentation.

Before we get started, I have a few announcements. You should have received a link to the slide presentation for today's call in previous registrant emails. There is also a related MLN Matters article, MM8743, that was posted with the presentation yesterday.

If you have not already done so, please view or download these materials from the following URL: www.cms.gov/npc. Again, that's www.cms.gov/npc. At the left side of the webpage select National Provider Calls and Events and then select the date of today's call from the list. Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these are available.

And last, for this call registrants were given the opportunity to submit questions. We thank everyone who submitted questions, and our speakers today have tried to incorporate some of the most frequently asked questions as part of their remarks on today's slides. We will also post supplemental information addressing many of the frequently asked topics within a few business days. Once this information is posted, registrants will be notified via email.

At this time, I'd like to turn the call over to Dr. Chris Smith-Ritter, Deputy Director of the Hospital and Ambulatory Policy Group here at CMS.

Presentation

Dr. Chris Smith-Ritter: Welcome, everyone. I'm Chris Smith-Ritter, and I'm the Deputy Director in the Hospital and Ambulatory Policy Group, which is the area of Medicare payment policy that handles kind of non-post acute. We have the physician payment and

hospital payment, and most importantly today, for Medicare, payments for Federally Qualified Health Centers. And we're really excited to be here at this point, after the Affordable Care Act and the requirements for the new Prospective Payment System.

We've been working diligently, and we've been working towards this point to be able to get the payment system up and running. I guess we're going to turn it over to the subject matter experts, but we just want to acknowledge all of the wonderful input that we've had over this process. It has been a great public dialogue for us, and we continue to welcome that input. And I also want to make sure that I note the great contributions from both HRSA and SAMHSA, who have really worked with us to try and bring this up.

And so I hope today's call is really helpful, and I am going to look forward to hearing more about it as well. Thanks so much.

Corinne Axelrod: Hi, this is Corinne Axelrod. I also want to thank everybody for joining us on the call today and thank people for submitting questions in advance as part of the registration process. I will be going through the slides that were posted on the page when you registered for the call. And as Nicole said, if you haven't already downloaded them, you can do so and it will probably make it a little bit easier for you to follow along, although I will be adding quite a bit of information to the slides as we go through them.

I will also incorporate answers to the questions we received to the extent possible. For those questions not answered or for additional questions, we have a roomful of experts here and some on the phone who are ready to answer your questions as well.

On today's call, we're going to go over the key requirements for the FQHC PPS from the Affordable Care Act, review the FQHC PPS timeline. We're going to talk about the payment rate and adjustments, including the geographic adjustment, the new patient IPPE AWV adjustment, the use of the G-codes, the annual rate update. We'll also talk about multiple same day visits, coinsurance and preventative services, the Medicare Advantage wrap-around payment, the transition from the current system to the PPS, and also some additional information.

There's a lot of material and we have already blocked out time for a followup call in about a month that will get into even more detail on some aspects of billing and claims processing and we'll tell you more about that a little bit later. But first, a few reminders about today's call – this FQHC PPS is for Medicare only. It does not change the Medicaid PPS and it does not apply to rural health clinics. FQHCs are still being paid under the current all-inclusive rate system. The new Medicare PPS is not in effect yet. And finally, this call is on policies and related information for the new FQHC PPS payment system. We will not be discussing any other programs or issues today.

Key Requirements of the Affordable Care Act

OK, we have lots to talk about, so let's get started. The Affordable Care Act – the key requirements – we wanted to review them with you so that you'll have a better understanding of why we built the system the way we did. And you can see where the

statue is very specific and other places where we have more flexibility and where some things are dictated by law and other things are regulatory.

So the key requirements, and this is page – I think slide 6. The system must establish a payment rate that accounts for the type, intensity, and duration of services furnished by FQHCs. May include adjustments such as a geographic adjustment. Medicare payment for FQHC services must be 80 percent of the lesser of the actual charge or the PPS amount.

This system must include a process for appropriately describing services and establish payment rates for specific payment codes. The initial PPS rate must equal in the aggregate 100 percent of the estimated amount of reasonable costs that would have occurred for the year if the PPS had not been implemented and without the application of copayments, per visit limits, or productivity adjustments. After the first year of implementation, the PPS rates must be increased by the percentage increase in the Medicare economic index, known as the MEI. And after the second year of implementation, PPS rates must be increased by either the MEI or a market basket of FQHC goods and services.

So to summarize, the Affordable Care Act requires that under the new system, payment is based on either the PPS rate or your charges, whichever is less. The statutory – this statutory requirement differs from the current system, where your charges are not a factor in your Medicare payment rate. The PPS rate reflects the average cost of FQHC services without productivity screens, copayments, or payment limits.

Under the current all-inclusive rate system, there is a FQHC- specific rate based on the center's previous year allowable cost divided by total visits. Under the new PPS, there's one national rate based on average national cost. Under the current system, there is a rural and urban payment limit. Under the new PPS, there is a geographic adjustment to the PPS rate. Instead of just two categories – urban and rural –there are 89 localities.

Timeline for Adopting the Medicare PPS

Let's review the PPS timeline. The Affordable Care Act was signed into law on March 23rd, 2010, and requires the development and implementation of a Medicare PPS for FQHCs. On January 1st –FQHCs – of 2011, FQHCs were required to use HCPCS coding on claims for use in the development of the PPS. So FQHCs have been required to use detailed HCPCS coding now for 3½ years, so you should all be very familiar with them by now.

September 23rd, 2013, we published a proposed rule for the Medicare PPS for FQHCs. Comments were accepted on this until November 18th. On May 2nd, 2014, we published the final rule for the Medicare PPS for FQHCs. On October 1st of 2014, FQHCs will begin transitioning to the new Medicare PPS. On December 31st of 2015, all FQHCs are expected to be transitioned to the new Medicare PPS.

One other note on the timeline, in the final rule, we invited comments on three topics:

- A Chronic Care Management Program for FQHCs,
- The FQHC G-codes, and
- The process for waiving coinsurance for preventive services.

These comments are due July 1st, and we'll talk more about that when we get to those topics.

FQHC PPS Payment Rate

Let's talk now about the FQHC PPS payment rate. And this – now we're on slide 12. The proposed rule proposed that FQHCs would be paid an encounter-based payment, based on an average cost per encounter, estimated to be $155.90, subject to change in the final rule, based on more current data. The final PPS rate is $158.85. Again, this is a national PPS rate, it's applicable to all FQHCs.

There is a geographic adjustment. The proposed rule proposed that the PPS rate would be adjusted for geographic differences in the cost of services by using an adaptation of the geographic practice cost indices used to adjust payment under the physician fee schedule. We refer to this as the FQHC PPS geographic adjustment factor or GAF, G-A-F, GAF. The FQHC GAFs are calculated by adapting the work and practice expense indices used in the physician fee schedule for the period in which the services are furnished.

This was finalized as proposed with updated values. Please note that the values in these tables are subject to change due to the recent enactment of Public Law 113-93, Protecting Access to Medicare Act of 2014, known as PAMA, P-A-M-A. The values will actually be slightly higher for certain areas of the country, especially rural areas. To determine your adjusted PPS rate, you would multiply the base rate of $158.85 times the FQHC GAF, geographic adjustment factor, for the area where the services were furnished. The FQHC GAF values are included in the final rule and are posted on our website. And the new values as a result of PAMA will be posted soon.

So let's look at a couple of examples. If you are a FQHC in Tennessee, the FQHC GAF for services furnished in 2014 is 0.937. So we know this because it is published in the final rule and it's on our website. And we also know that this value will change when the new values are published and you will need to check our website for the current values. To determine the adjusted PPS rate, you would take the base payment rate of $158.85, multiply that times 0.937 – again, this is for Tennessee, which results in a PPS rate of $148.84.

Let's look at another example. Let's say you are furnishing services in Minnesota. You would take the national PPS rate of $158.85 and multiply it times the 2014 FQHC GAF for Minnesota, which is 1.005, and the rate would be $159.64. Again, this is very straightforward – find the FQHC GAF value for the area where the service is furnished, multiply the base PPS rate times the GAF. Your payment will be the lesser of this adjusted rate or your charges.

The FQHC GAFs are adapted from the values used from the physician fee schedule and are updated annually. They could be updated more frequently if Congress makes changes to this. So we will always have a current list posted on our website.

A couple of important notes on this – the FQHC GAF is only applied to the PPS rate, not to the PPS – not to the FQHC charges. It applies to the rate, not to your charges. And since the FQHC GAF is based on where the services are furnished, it is possible that the payment rates may vary among FQHC sites within the same organization.

OK, let's move on to the new or initial patient adjustment. This is slide 14. The proposed rule proposed that the rate would be increased by approximately 33 percent for greater intensity and resource use when an FQHC furnishes care to a patient that is new to the FQHC or to a beneficiary receiving an initial preventive physical examination, known as an IPPE, or an initial annual wellness visit, known as an AWV. The final adjustment is 34 percent for new patients, IPPEs, initial and subsequent AWV visits. So please note that the proposed rule only had the adjustment for the initial AWV, but based on the comments we received and on our subsequent analysis of the costs of the AWV, we expanded the adjustments to include both initial and subsequent AWVs. So the new and initial patient adjustment – 34 percent for new patients, IPPE, initial and subsequent AWVs.

We have been asked to clarify what is a new patient. So a new patient is one who has not received any professional medical or mental health services from any site or from any practitioner within the FQHC organization within the past 3 years from the date of service. This is similar, it is not identical, but it's similar to the guidelines used in the physician fee schedule, which makes the determination of new versus established payment at the physician or physician group practice level. For these patients, the MACs, the Medicare Administrative Contractors, will increase the base payment by a factor of 1.3416.

So let's look at an example for a new or an initial patient adjustment. You would start with the base payment rate, $158.85,multiple that times the FQHC GAF for the area where the service was furnished, and multiply that number times 1.3416.

So we can go back to our examples. Tennessee – the PPS rate is $158.85, we multiplied that times 0.937, which is the FQHC GAF for Tennessee, and we got $148.84. We then multiply $148.84 times 1.3416, which is the IPPE AWV adjustment, and we get $199.68.

If we look at Minnesota – again we start with $158.85, we multiply that times the FQHC GAF for Minnesota, which was 1.005, and we got a total of $159.64. We would then multiply $159.64 by 1.3416, which is the IPPE AWV adjustment, for a total of $214.17.

So again, this is fairly straightforward. You start with a PPS rate of $158.85, multiply that times your FQHC GAF, and if you have a new patient or a patient receiving an IPPE or an AWV, you multiply that number times 1.3416.

Now I'm going to stop and ask my colleague Esther Markowitz to talk about the G-codes. Esther.

Use of G-Codes

Esther Markowitz: Thank you so much, Corinne. Good afternoon, this is Esther Markowitz of the Hospital Ambulatory Policy Group with CMS, where I work on FQHC payment policy. Continuing with today's presentation and moving on to slide 16. As Corinne mentioned, one of the statutory requirements of the FQHC PPS is that Medicare payments for FQHC services must be 80 percent of the lesser of the actual charge or the PPS amount.

We received a number of comments on the proposed rule which identified this lesser of provision as the most significant concern with implementation of the FQHC PPS. So in response to commenters' concerns, we established specific payment codes to report an FQHC visit under the PPS.

FQHCs will be required to use these new payment codes, or G-codes, to bill for an FQHC visit. And they would bill to these specific payment codes using a charge that reflects the sum of the regular rates charged for a typical bundle of services that would be furnished per diem to a Medicare beneficiary. The payment would then be determined by the MAC based on the lesser of FQHCs charge for these payment codes or for the applicable PPS rate. And by using these specific payment codes, the comparison of the provider's reported charge and the PPS rate would be based on a bundle of services furnished per diem.

The CMS is establishing five specific payment codes to be used by FQHCs submitting claims under the PPS. On slide 16, we list short descriptors for these new codes. These codes will describe an FQHC visit for a new patient, an FQHC visit for an established patient, an FQHC visit that includes an IPPE or AWV, an FQHC visit for mental health services for a new patient, and an FQHC visit to mental health services for an established patient.

So under the PPS, the FQHCs would bill Medicare using these specific payment codes that correspond to the type of FQHC visit that qualifies the encounter for Medicare payment according to all of the Medicare-appropriate regulations. The full descriptors of these specific payment codes also include the typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving each one of these type of FQHC visits. Each of these specific payment codes will also correspond to the appropriate PPS rates.

So as noted on the previous slide, an FQHC would record a charge for one of these FQHC specific payment codes that would reflect the sum of regular rates for a typical bundle of services that would be furnished per diem for a particular type of FQHC visit. We want to emphasize that in addition to reporting these specific payment codes, the FQHCs must continue to report detailed HCPCS coding on the claim to describe all the

services that occurred during this particular FQHC encounter. All these service lines must be reported with their associated charges

Additional Resources

As Nicole mentioned, we issued MLN article MM8743, "Implementation of Prospective Payment Systems for Federally Qualified Health Centers." You can access that particular MLN article from the Call Details Page. You can also access that particular MLN article from FQHC Center Page, a link of which is included on slide 26 of this presentation. This particular article includes a lot more details about the changes to the FQHC billing requirements, changes to claim processing, and the use of these specific payment codes. We have plans in the works as we mentioned for a future national provider call to review the billing claims processing issues and those plans will be posted on the FQHC Center Page as they are available.

Because we did not propose the establishment of the G-codes in the proposed rule, and we also didn't receive any public comments that specifically requested that we establish these types of codes, we invite public comments on the establishment of these G-codes for FQHCs to report and bill FQHC business to Medicare under the FQHC PPS. As I mentioned, some of this complexity involved in the billing and the use of these codes is addressed in the MLN article, and I strongly urge you to take a look at that and we will be addressing it further in one of our future calls. Back to you Corinne.

The FQHC PPS Payment Rate — Annual Rate Update

Corinne Axelrod: Thank you Esther. OK, let us look at slide 17, the FQHC PPS payment rate, the annual rate update. The base rate of $158.85 will be effective from October 1st, 2014, through December 31st of 2015. In 2016, the rate will be increased by the MEI, the Medicare Economic Index, as required by the statue. In 2017, it will be increased either by the MEI or a market basket developed for FQHCs. Updates to the FQHC base payment rate would be made through program instructions.

Commenters requested that we develop an FQHC market basket for annual payment rate adjustments instead of using the MEI. We are exploring developing an FQHC market basket, but no decision has been made at this time.

Multiple Same Day Visits

OK. The next topic is multiple same day visits. Under the current system, we allow an exception to the single payment per day when an illness or an injury occurs subsequent to a visit. For instance, a patient has a billable visit in the morning, and in the afternoon they fall and go back to the FQHC to have their injury treated. In this situation the FQHC can bill for two visits for the same patient on the same day. We also allow separate billing when a mental health, IPPE, or DSMT or MNT visit occurs on the same day as another visit – that's under the current system.

We proposed in the proposed rule not to allow exceptions to the single payment per day for subsequent illness or injury, mental health, IPPE, and DSMT/MNT. We received a lot of comments on this, especially in regards to separate billing for mental health services

that occur on the same day as a medical visit. There is an extensive discussion in the final rule on the comments that we received and on our analysis.

So although we didn't receive any information that showed a direct link between multiple billing on the same day and increasing access to care, we decided to allow separate billing under two circumstances. The first is for subsequent illness or injury, because this is a unique situation that cannot be planned or anticipated. And the FQHC would not benefit from any economies of scale that can be realized when multiple conditions are addressed on the same day.

The second circumstance for which we will allow multiple billing on the same day is when a mental health visit occurs on the same day as another billable visit. We believe that allowing separate billing for mental health on the same day as another visit has the potential to increase access to care. So for mental health services furnished by an FQHC practitioner on the same day as another billable visit, the FQHC will be able to bill for two visits.

We noted in the final rule our interest in supporting ways to promote the coordination, integration of services, and specifically mentioned the Chronic Care Management Program that will be implemented for physicians billing under the physician fee schedule, starting in 2015. As I mentioned earlier, we are seeking comments on three topics in the final rule, and this is one of them.

There has been a lot of material published in the physician fee schedule, beginning with the 2012 physician fee schedule proposed rule and through the 2015 proposed rule. And we encourage you to take a look at those documents and submit comments to us on how the Chronic Care Management Program can be adapted for FQHCs. We think this will be very helpful to FQHCs and would like to get any suggestions from you as we consider developing a CCM, Chronic Care Management, Program for FQHCs.

Comments on this are due on July 1st. Now Esther is going to talk about coinsurance and preventive services and the Medicare Advantage wrap-around payment, Esther.

Coinsurance and Preventive Services

Esther Markowitz: Thank you Corinne. As we previously mentioned, the total payment amount for an FQHC visit will be the lesser of FQHC's reported charge for the FQHC payment code or the fully adjusted PPS rate for that specific payment code. Under the FQHC PPS, the MACs will generally pay 80 percent of this total payment amount; and coinsurance will generally be 20 percent of the total payment amount. Medicare waives coinsurance for certain preventative services and this is applicable to FQHC.

So FQHC claims that consist solely of preventative services that are exempt from beneficiary coinsurance, the MACs will pay 100 percent of the total payment amount. Meaning for an FQHC visit consisting solely of these types of preventive services for which coinsurance is waived, the MAC would pay 100 percent of the lesser of the

provider's charge for the FQHC payment code or the FQHC PPS rate. And no beneficiary coinsurance would be assessed in that particular situation.

However, there may be FQHC visits that consist of both preventive and nonpreventive services. Because payments under the FQHC PPS will be based on a bundle of services, we needed to consider how to assess coinsurance for nonpreventive services while waiving coinsurance for certain preventive services when they are furnished during the same FQHC visit. So as we discuss on slide 21, the proposed rule proposed a fairly complex methodology for calculating coinsurance when preventive and nonpreventive services are on the same claim.

Our proposal discussed using the proportionality of physician fee schedule payments to determine the coinsurance waiver. We received a lot of feedback on this. And in response to commenters that requested that CMS re-think this calculation to simplify how coinsurance will be assessed for these types of claims, we reconsidered whether the current approach to waiving coinsurance for preventive services could be adapted to the FQHC PPS. In the final rule we presented a simpler methodology, based on the current system for determining coinsurance that subtracts the dollar value of a line item charge for the preventive service from the full payment amount.

What this means is, as in all payments under the PPS, the MAC will use the lesser of the provider's charge for the specific FQHC payment code or the corresponding FQHC PPS rate to determine the total payment amount for the FQHC visit. So when an FQHC visit includes a mix of preventive and nonpreventive services, to determine the amount of Medicare payments and the amount of beneficiary coinsurance that should be waived, the MACs will use the FQHCs reported line item charges and subtract the dollar value of the FQHCs reported line item charge for the preventive services from the full payment amount for that visit.

This method of using the provider's line item charge to determine the coinsurance waiver would be used whether the total payment amount is based on provider's charge or the PPS rate. More details of how this calculation would work is available in the MLN Matters article 8743, which we've referenced previously, which also links to some detailed examples of this calculation. Because we did not propose this revised methodology in the proposed rule, nor did we receive any public comments specifically requesting that we adapt the current methodology for waiving coinsurance for preventive services, we invite comments on this revised methodology for accepting coinsurance when preventive and nonpreventive services are furnished during the same encounter.

Medicare Advantage Wrap-around

Moving on to our next topic, Medicare Advantage wrap-around payment. And if you received a written contract from an MA organization, Medicare Advantage organization, that furnishes care to beneficiaries covered by the MA plan are paid by the MA organization at the rate that's specified in the contract. If the MA contract rate is less than the Medicare PPS rate, Medicare will pay the FQHC the difference, less any coinsurance

amounts owed by the beneficiary, which is an amount referred to as the MA supplemental payment or wrap-around payment.

When we discussed this in the proposed rule, the commenters requested clarification that the wrap-around payment is based on the PPS rate and not the charges, meaning that the wrap-around payment will be based on the PPS rate without applying the lesser of comparison. As we note on slide 23, in the final rule, we confirm that the wrap-around payment is based on the difference between the PPS rates and the MA contracted rates. There is no comparison that occurs in terms of the lesser of the PPS rate or the charge when calculating the supplemental payment.

So it is important to note the supplemental payment is only paid if the contracted rate is less than the fully adjusted PPS rate. Keep in mind that the PPS rate is subject to the geographic adjustment factor, the FQHC GAF, and it might also be adjusted for new patient visits or if an IPPE or an AWV was furnished during the FQHC visit. So to support accurate payment, claims for any supplemental payments under the FQHC PPS must include the specific payment codes, the G-codes that we mentioned, that correspond to the appropriate PPS rates and the detailed HCPCS coding required for all FQHC PPS claims.

More information on how to bill the supplemental payments and how the supplemental payments will be calculated is available in MLN Matters article MM8743, which also links to examples of the calculation for supplemental payment. Back to you Corinne, thank you.

Transition to the New PPS

Corinne Axelrod: OK thank you, Esther. OK, let's talk a little bit about the transition. The proposed rule proposed that FQHCs would be transitioned to the new PPS based on their cost reporting period. This has been finalized as proposed. Changes will be effective on Wednesday, October 1st, 2014, regardless of where you are located or which MAC processes your claim. Some things are not changing, and I want to point these out.

This is not an all-inclusive list, but the FQHC benefit is not changing. If something was covered before, it will still be covered, and no additional benefits have been added. It is still a Part B benefit and will still be processed by Part A MACs. You will continue to submit claims to the Part A MAC on a 77x type of bill for FQHC services. Labs and the technical component of a service will continue to be billed separately. The CCN, a CMS Certification Number, CCN, is still required to bill for FQHC services. You will still need to file a Medicare Cost Report at the end of the year. The reasons for this is that the statute did not exempt FQHCs from filing a cost report and the cost report is still necessary for payment of the influenza and pneumococcal vaccines and their administration, graduate medical education costs, and bad debts.

Additional Information

So additional information. We will be having, as I mentioned earlier, another National Provider Call to review billing and claims processing. That call is scheduled for June

25th from 1:30 to 3 o'clock eastern time. And on that call we're going to walk through the billing requirements and provide more details regarding revenue codes, G-codes, and detailed HCPCS coding, and more information on qualifying visits. We are setting up a resource box so that you can submit questions on the FQHC PPS, but unfortunately, we don't have that email address yet.

As soon as we get that email address, Nicole will be sending out an email to everybody that registered for this call letting them know the email address in case you have additional questions to submit. In the meantime, please check our websites, which are listed here and for additional information and updates. There is the FQHC Center Page and the FQHC PPS Page. And the web addresses are in the handout. So I'd like to thank all of you again for taking the time of your busy schedules to be on this call today.

And now we'll move into our question-and-answer session.

Nicole Cooney: Thank you, Corinne. This is Nicole and just to add to what Corinne mentioned about the upcoming call on June 25th, please save the date. We do not have registration open yet for this call. Once registration is open, we will send out information to all the registrants for today's call so that you can join us again next time if you wish.

At this time, we will be pausing for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note that there will be a few moments of silence while we calculate the results. Victoria, we're ready to start the polling.

Keypad Polling

Operator: CMS appreciates that you minimize the government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight or you listening, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you. I would now like to turn the call back over to Nicole Cooney.

Question-and-Answer Session

Nicole Cooney: Thank you Victoria. All right, we're ready to start our question-and-answer session. Our subject matter experts will now take your questions about the new Medicare PPS for FQHCs. But before we begin, I'd like to remind everyone that this call

is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your questions to just one.

If you'd like to ask a followup question, or have more than one question, you may press star 1 to get back into the queue and we'll address additional questions as the time permits. All right Victoria, we're ready to take our first question.

Operator: To ask a question, press star, followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to ensure clarity.

Please note your line will remain open during the time that you are asking your question, so anything you say or any background noise will heard into the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Patty Telgener.

Patty Telgener: Hi, this is Patty Telgener, a consultant to the American Association of Diabetes Educators. My question – just to confirm on the multiple encounters being paid separately, did I hear you correctly, that a visit for diabetes self-management training or MNT is not a separately payable, only mental health and new injury?

Corinne Axelrod: Yes, thank you for your question. Yes, that is correct. Under the current system, we allow a separate payment for DSMT and MNT. Under the new system we are not allowing that. And the reason for that is that we – there is a couple of reasons. We consider diabetes management and MNT – DSMT and MNT – to be really part of the primary care visit that should be included in the all-inclusive bundle. And we looked at the cost of this service and the cost was actually far lower than a typical visit. So there didn't seem to be really the justification for including that as a separately billable visit.

The PPS is a per diem type of payment. It bundles all services together, so when a patient comes in, if they see a physician, a nurse practitioner, a PA for whatever conditions, they get paid one payment. So we viewed the DSMT and MNT as part of that visit and didn't really see the reason to allow for separate billing for that, especially when the costs were not comparable with the average cost of a visit.

Patty Telgener: And is it something that you would take under consideration if comments were provided?

Corinne Axelrod: Well the comment period has come and gone on that. We discussed that in the proposed rule. We did not get very many comments on that. But we're always willing to consider whatever people want to bring to our attention and discuss it and see what we can do.

Patty Telgener: Thank you.

Corinne Axelrod: Thank you.

Operator: Your next question comes from the line of Jennifer Youngberg.

Jennifer Youngberg: This is Jennifer Youngberg from North Country Healthcare. And our question is regarding clinical pharmacists and if they are eligible providers to be doing the annual wellness visits.

Corinne Axelrod: Thank you, this is Corinne again. And the FQHC practitioners include a physician, nurse practitioner, physician assistant, certified nurse mid-wife, clinical psychologist, clinical social worker, and in some cases DSMT providers. So clinical pharmacists are not FQHC practitioners and cannot bill for a visit. Whether they are able to provide an annual wellness visit as part of their scope of practice would be another issue, but they are not FQHC providers.

Operator: Your next question comes from the line of Janice Payment

Janice Payment: Hi, my name is Janice Payment, I work for County of Santa Barbara Public Health Department. My question is in regards to your new patient guideline. CPQ states that a new patient is one who has not received any services, specialist services, in the past 3 years by specialty. And from my understanding, your guideline of a new patient is by group practice. So if a patient went to see someone, say in internal medicine, and then they were referred to ophthalmology and has never seen someone in ophthalmology before, that would not be considered a new patient for the ophthalmologist?

Corinne Axelrod: Thank you for your question, again this is Corinne. In an FQHC, the practitioner is not billing, it's the FQHC that is billing. So what we look at is whether the patient is new to the FQHC. And that would include any practitioner in the FQHC, whether it's an ophthalmologist or cardiologist or primary care practitioner or mental health practitioner. So it's a little bit different than in the fee schedule world, but in an FQHC it's the entity that we're looking at not the individual practitioner.

Operator: Your next question comes from the line of Michelle Songer.

Michelle Songer: Hi, this is Michelle – this is Michelle Songer from Sumter Family Health Center, can you hear me?

Nicole Cooney: Yes, we can.

Michelle Songer: Thank you. My question was based again around that new patient ruling. That's going to place a burden on the billers to identify patients who are typically an AMA new patient but not a center-based new patient, to change the coding that the providers are using based off of AMA guidelines.

Corinne Axelrod: So that might be something if you could email us, we'll take another look at, because I am not familiar with that and I am looking around the room – does anybody here have any comments? No? So why don't you send that to us and we will be happy to take a closer look at that.

Nicole Cooney: And again, this is Nicole, I will be sharing the resource box that you can send your questions to. As soon as we have it available we will send it out to the registrants for today's call. So please send that one into us. Thank you for your question.

Operator: Your next question comes from the line of Sarah Houston.

Brittany Lovejoy-Haines: Hello, this is Brittany Lovejoy-Haines, I'm calling from Briggs Community Health Center. I just wanted a clarification as far as the use of the new G-codes. Are we looking at just getting a total of the line item charges for the FQHC charges and replacing that with the – that total charge amount with the G-code?

Esther Markowitz: This is Esther Markowitz speaking. No. What we are – what we're asking FQHCs to do is to establish a charge for each of these different G-codes based on a typical bundle of services that you would furnish for that type of visit. So it would not necessarily be the total of the actual line items that were furnished, the actual services that were furnished for that specific beneficiary on that specific day in that specific visit.

So no, it's not – the total for the G-code does not necessarily equal the sum of all those pieces.

Brittany Lovejoy-Haines: OK

Nicole Cooney: Good question.

Corinne Axelrod: I would like to add something that we will go into this in a little bit more detail on the call next month. Thank you.

Operator: Your next question comes from the line of Sandra Pogones.

Sandra Pogones: Yes, hello, this is Sandy Pogones with Primaris. I am wondering if any of these changes will in any way affect requirements for providers in an FQHC to participate in PQRS for value-based modifiers?

Corinne Axelrod: This is Corinne. We're not aware of anything in this PPS that would impact on that in any way. So if there's any specific concern you have, please let us know.

Sandra Pogones: OK, thank you.

Corinne Axelrod: Thank you.

Operator: Your next question comes from the line of Dawn Briggs.

Dawn Briggs: My question was just, is this presentation going to happen again, because we were unable to log in and missed over three-quarters of it?

Nicole Cooney: Hi, this is Nicole Cooney. We will be posting the audio recording from this presentation as well as the written transcript. We have to post those two items together, so it usually takes us 7 to 9 business days to do that. But we'll be posting those materials on the Call Detail Page and announcements will go out about that.

Dawn Briggs: OK, thank you.

Nicole Cooney: Thank you.

Operator: Your next question comes from the line of Linda Braswell.

Linda Braswell: Hi, this is Linda Braswell with East Georgia Healthcare Center, and my question is about the new G-codes also. Are we going to report an E/M HCPCS in addition to the G-code or is the G-code the E/M portion of the visit?

Esther Markowitz: Hi, this is Esther Markowitz speaking. We'll be addressing some more about that in the future call, but to give you the short answer, the G-code would be describing the totality of the visit. The individual HCPCS code that would describe the type of visit that qualifies this for Medicare payment would still be required as detailed line item billing.

In the meantime, I do want to refer you again to the MLN Matters article. I don't know if everyone online has had an opportunity to take a look at it. It does have a lot of information that you will find useful and we will be addressing some more of the detail in a future call. Thank you.

Operator: Your next question comes from the line of Anola Small.

Anola Small: Hi, I'm curious about the wrap-around rates and how that works. We usually refer to that as our Medi Cal FQHC rate. Are you saying that we take the capitated rate from our MACs plan and then bill Medicare for an additional rate?

Corinne Axelrod: Hi this is Corinne. We have a Medicare Advantage subject matter expert joining us at 1:30, so – which is in about 5minutes. So if you don't mind waiting about 5 minutes and then calling back in, then he'll be on the line and he would be the best person to answer that. So sorry about that delay, but he wasn't able to attend until 1:30.

Anola Small: I don't have a problem with that, but what's the – the same phone number, or what's the phone number I call back on?

Nicole Cooney: No, no. You do not need to call back. We have this expert – unfortunately, he was not able to join us prior to 1:30, so he'll be on the line to help us address questions on this line at 1 ....

Anola Small: Oh, OK. So just wait or get back in the queue?

Corinne Axelrod : Get back in the queue.

Nicole Cooney: Yes, if you could get back in the queue and – but when we get to you, he should be with us.

Anola Small: So to get back in the queue is star 1?

Nicole Cooney: Star 1.

Anola Small: OK, thanks.

Nicole Cooney: Thank you.

Operator: Your next question comes from the line of Sandra DuBois.

Sandra DuBois: Yes, hello, my name is – hello, hello, can you hear me?

Nicole Cooney: Yes, we can.

Sandra DuBois: Oh, I'm sorry, my name is Sandra DuBois. I am calling from Little Traverse Bay Bands of Odawa Indians. And again, I guess the G-codes are a hot topic. When are those particular codes going to be effective and when are we supposed to start using them – those G-codes?

Corinne Axelrod: Your clinic will transition to the new PPS based on your cost reporting period. So clinics whose cost reporting periods are October 1st – will begin October 1st of this year. If your cost reporting period is later, you will transition to the new PPS on that date. So once you're transitioned to the new PPS is when that you'll start using the G-codes.

Sandra DuBois: And how would I find out when our transition date is, I mean, who would I contact?

Corinne Axelrod: Do you know when your cost reporting period begins? Is it in October 1? January 1?

Sandra DuBois: No, as far as I know they are every – it's just every quarter. So I'm going to assume that it is January.

Esther Markowitz: Hi, it's Esther Markowitz speaking. If you're not sure what your cost reporting date is, I would suggest that you talk with your MAC about this. They'd be able to help you out about that, thank you.

Sandra DuBois: OK, great. Thank you so much.

Operator: Your next question comes from Deena Bayhardt.

Deena Bayhardt: Hello?

Operator: Yes, your line is open.

Deena Bayhardt: Hello, this is Deena Bayhardt from Yakima Valley Farm Workers Clinic. And my question was answered earlier, it was about how to tag an associated fee to the G-codes. So, you discussed it in an earlier question, so I'm OK now.

Nicole Cooney: OK, thank you.

Operator: Your next question comes from the line of Pat Mack.

Pat Mack: Hi, good morning. I have a quick question. Could you repeat the MLN for the Medicare Advantage wrap-around payment?

Esther Markowitz: The MLN is MM8743. That MLN article refers to a bunch of changes related to FQHC PPS, including information on the Medicare Advantage Supplemental Payment. There is more information on claims processing manual about MA supplemental payments as they currently function, but this particular MLN article is about specific changes related to FQHC PPS, including information on those MA payments. You'll find it …

Pat Mack: Thank you very much.

Esther Markowitz: I'm sorry, you'll find it posted as a link to the Call Details Page on today's call. You'll also find it posted on the FQHC Center Page, and the link for the FQHC Center Page is on slide 26 of today's presentation.

Pat Mack: Thank you.

Operator: Your next question comes from the line of Shelby Massey.

Shelby Massey Hi, Shelby Massey with the Texas Association of Community Health Centers. My question is related to beneficiary coinsurance calculation for –not for preventive services. Can you clarify whether the FQHC should be calculating the coinsurance based on 20 percent of the lesser of the PPS or the G-code charge amount or the lesser of the PPS or the actual charges for the services provided that day.

Esther Markowitz: The charge for the specific payment code, which we're referring to often in this call as the G-code, is the actual charge for the service. The total payment amount would be the lesser of the actual provider's charge for the G-code or the PPS rate that would be corresponding to that G-code. Therefore, the coinsurance would be based on 20 percent of the total payment amount. So putting it a little bit differently, the coinsurance would be based on 20 percent of the lesser of the charge associated or reported by a provider of the G-code or 20 percent of the PPS rate.

Shelby Massey: OK, thank you.

Esther Markowitz: Sure.

Operator: Your next question comes from the line of Tammy Greenwell.

Tammy Greenwell: Hi, my name is Tammy Greenwell, I'm with Blueridge Community Health Services in North Carolina. And my question is in regards to the new patient definition. And my question is specifically, as an FQHC we are expanding and part of what we are looking at right now is the possible acquisition of some private practices in our area.

And my question is, if we acquire a practice and there are Medicare patients in that practice that start you know are not the practice but the provider becomes an FQHC-employed provider and they were not previously. And so the FQHC is now billing for those patients, and if they're Medicare beneficiaries, are they considered new patients? Because previously they weren't billed under the FQHC model.

Corinne Axelrod: Hi, this is Corinne. They would be considered new patients because they would be new to the FQHC.

Tammy Greenwell: OK, thank you.

Corinne Axelrod: Thank you.

Operator: Your next question comes from the line of Julius Talley.

Julius Talley: Oh, hello, this is Julius Talley from Family Christian Health Center in Harvey, Illinois. I think my question is really answered, it was the logistics of how we get the wrap – the difference between the MA and the PPS rate in the wrap-around calculation. And that is going to be done in conjunction with the cost report – or how do we get that difference if there is a difference? Is it on a per visit basis or is it going to be, again, through the cost reporting process?

Esther Markowitz: So with respect to the MA supplemental payment, because the…

Julius Talley: Yes

Esther Markowitz: It's Esther Markowitz speaking, I'm sorry I didn't introduce myself. Because the payments – supplemental payments is based on the difference between what Medicare would otherwise pay, it would be based on what's sitting on that particular claim. So the comparison of the fully adjusted PPS rate for that claim and what the MA contract rate would be that the MA is paying the FQHC for treating or furnishing care to that beneficiary. And that would be done on a claims-related basis.

The MACs will have the information about the MA contract plan rate and the MACs will also be able to calculate the PPS rate that would otherwise be applicable. Again, the fully adjusted PPS rate, reflecting the GAF and the IPPE or AWV new patient adjustment is applicable. And that is how the difference would be calculated. It would not be something that would be done through the cost report.

Julius Talley: OK, alright, thank you.

Operator: Your next question comes from the line of Debra Walford.

Debra Walford: Good afternoon. My question is in regards to mental health visits. Currently we are all using with psychiatric codes series 290 diagnosis code, 3310. If it is a medical visit, we put medical on the narrative. If it is for drug management, we put drug on the narrative. I'm curious as to with the new G-codes, how we will be paid – not for a mental health visit for counseling, but when a patient comes in and sees the psychiatric provider for drug management?

Corinne Axelrod: Hi, this is Corinne. Just in general, FQHCs can bill for a visit – for a medically necessary visit with an FQHC provider. So generally, if a visit is a medically necessary visit, that would be billable. But in terms of the specifics, I'm kind of looking around the room and I'm not personally familiar with the specific codes, so that might be one that we'd have to get back to you on.

Debra Walford: OK.

Tracey Mackey: This is Tracey Mackey with the Provider Communications Group I'll also add, the mental health visit, you would bill that with the G-code for mental health and under a Revenue Code Center of 900. A medical visit would be billed under Revenue Code Center 52X. And that distinguishes the difference between medical and mental.

Debra Walford: Correct, and that's currently how we do it. So I guess what I am really asking is, when the G-codes go into effect, then the payment based on the psychiatric codes will go away. Because if I was to bill it out with a psychiatric code, they would process it at a behavioral health rate right now if I didn't identify it as a medical or a drug encounter.

Dr. Chris Smith-Ritter: So your question is, this is Chris Smith-Ritter. Is the CPT code – if you put the CPT code down on the claim, will it process as a mental health visit or do you need to put down the new G-code for mental health?

Debra Walford: For nonmental health, but being seen by a psychiatrist for their drug management only. It's not actually – it's not a counseling session, it's a drug management visit for psychogenic medications.

Dr. Chris Smith-Ritter: OK, so the question really has to do with whether the drug management visit is considered mental health services or not – is that –that is the question?

Debra Walford: I guess, with the new G-codes, I guess, I guess that's what it's going to boil down to, yes.

Corinne Axelrod: OK, so I think that is one that we will have to go back and discuss so that we give you the correct answer.

Debra Walford: OK.

Corinne Axelrod: So if you don't mind, we will have to get back to you on that.

Debra Walford: OK, thank you very much.

Operator: Your next question comes from the line of Cindy Szczypiorski.

Cindy Szczypiorski: Hi, I'm Cindy Szczypiorski. I'm calling from Health Choice Network. My question has to do with – I was searching for the MLN Matters, sorry, slide 21, and we're talking about the preventive services and subtracting them from the total payment – that didn't quite make sense to me, if you could re-explain that to me I'd appreciate it.

Esther Markowitz: Hi, it's Esther Markowitz, I'm the one who went through that particular slide. I'm going to refer you to take a closer look at the MLN Matters article. It does go through some of the detail on this. There's also additional detail in the change request that links to this MLN Matters article. The change request has the contractor instructions but also includes attachments that have some samples of how the payment is going to be working.

Just in general to go over it, what's going to happen is, is that the MAC is going to determine what the total payment amount is based on what is lower – is the PPS rate lower or is the provider's charge for the specific G-code lower? That would become your total payment amount.

When there's a mix of preventive and nonpreventive services on the claim, we would then take a look at the total payment amount, reduce it by the line item charge for the preventive service before assessing coinsurance on the total payment amount. So it would actually be assessing 20 percent of coinsurance on the net of the total payment amount after subtracting out the line item charge for the preventive service.

Cindy Szczypiorski: But the total payment amount is not affected? It sounds like the total payment is being reduced. That's why I got confused.

Esther Markowitz: OK, so the terminology that I'm using – total payment amount – is referring to both the amount that the MAC is going to pay and the amount that would be the beneficiary coinsurance. So I just want to make sure we're clear on that terminology. So using that terminology, how much is the total that the FQHC would get between what the MAC pays and what the beneficiary coinsurance would be assessed at? That particular amount, in order to figure out the amount of coinsurance when you've got this mix, that amount is going to be reduced by the line item charge for the preventive service.

When you've got a situation where the preventive charges are the only things that are on the claim, and that the entire FQHC visit is composed of preventive services, in that situation, the MAC would pay 100 percent, Medicare would be responsible for 100 percent of FQHC visit, and there would not be any beneficiary coinsurance.

Cindy Szczypiorski: OK.

Esther Markowitz: A lot of the walkthrough on this, we're going to be doing more in the next call. A lot of it's very detailed. I don't have slides prepared for today to discuss this. It will be addressed on the next call. In the meantime, please do take a look both at the MLN Matters article and the underlying change requests, including the attachments, which do walk through some of these examples. And I thank you very much for your question.

Cindy Szczypiorski: And that was MM 8743, correct?

Corinne Axelrod: Hi, this is Corinne. I believe that our subject matter expert on Medicare Advantage is on the line, Marty, is that correct, are you…?

Marty Abeln: Yes, I am.

Corinne Axelrod: So for the people that have been holding their Medicare Advantage questions, please get back in the queue. Also, some people have asked questions that we're not able to answer, and as I mentioned earlier, we don't have our resource box set up yet. So in the meantime, my email address is Corinne corinne.axelrod@cms.hhs.gov and we'll repeat that at the end. But in the meantime feel free to send those emails to me and I'll make sure that somebody here will get back to you. So anyway, please continue with the questions.

Operator: Your next question comes from the line of Pamela Salinas.

Pamela Salinas: Hi, my name is Pam and I'm calling from Eric Chandler Health Center. And I would just like to know about the G-codes. How would we determine the amount billed, the charge amount?

Esther Markowitz: Hi, this is Esther speaking. So one thing that I'm not sure if we emphasized enough when we were discussing this previously is that Medicare is not going to dictate how you set up your charge structure. What our expectation is though is that you would set the charge for the G-code based on the typical bundle of services that you would furnish per diem for this type of visit. So if you were going ahead and setting up your charge for the FQHC visit for an established patient, it would include both the qualifying face-to-face medically necessary visit that would qualify this for Medicare payment and the other type of services that your particular FQHC would furnish to somebody per diem, any other ancillaries, any other services that would typically be furnished during that type of FQHC visit.

Again, we're not dictating the way that you set up your charges, but that is our expectation of how those charges for those visits would be established. There is additional information about this in the MLN Matters article. We strongly urge all participants who want more information about billing, to please take a look at that article. Please take a look at the underlying CR, especially the supplemental pages, the attachments, and please do stay tuned and participate in our call on June 25th. We're going to do more of a walkthrough on how the billing works on this. Thank you.

Operator: Your next question comes from the line of Deborah Ait Alla.

Deborah Ait Alla: Hello, my name is Deborah Ait Alla and I'm with Family Practice and Counseling Network. And my question is more on what our obligations are as far as providing our patients with the Advanced Beneficiary Notice for any services that may not be covered. Will there be a new list published for us to follow?

Corinne Axelrod: And so if anybody – hi, this is Corinne. I'm not sure that there is anybody in the room here that can speak directly to any changes in the ABN, but there are no changes in the ABN procedures as a result of the new PPS. So whatever has been required before will continue to be required. So we're certainly not aware of anything that has changed in that regard.

Deborah Ait Alla: OK, thank you so much.

Corinne Axelrod: Thank you.

Operator: Your next question comes from the line of Tracy Douglas-Wheeler.

Tracy Douglas-Wheeler: Yes, thank you. I'm calling from the MidAtlantic Association of Community Health Centers. A question for you regarding the billing of telehealth for telemedicine. I didn't see any – any information on that, is that something that is going to come at a later time?

Tracey Mackey: Hi, this is Tracey Mackey. FQHCs can continue to bill their originating site fees on their 77x bill type under 23014. There's no change to the current billing status.

Tracy Douglas-Wheeler: Great, thank you.

Corinne Axelrod: So as Tracey says, FQHCs are authorized to be originating sites for telehealth. They are not authorized to be distance site providers of telehealth and that has not changed as the result of the PPS. Thank you.

Operator: Your next question comes from the line of Miami Beach Community.

Mark Rabinowitz: Good afternoon, this is Mark Rabinowitz from Miami Beach Community Health Center. Thank you for taking our question. Right now our providers drop CPT codes and associated charges with those codes while they're using the Electronic Medical Record. How is the G-code going to impact that? Will the providers have to also drop a G-code now?

Corinne Axelrod: Drop? Drop? I'm not sure that we understand what you mean by "drop". Can you elaborate on that?

Mark Rabinowitz: Yes, by drop I mean create the bill.

Crosstalk at CMS: What do you mean?

Mark Rabinowitz: When we do our medical records in Electronic Health Records, we post the charges to the encounter that takes place between the doctor and the patient. So the charges show up on the encounter based on the CPT code that was chosen and the ICD-9 code that was chosen to document the service provided during that business, during that encounter. And that's – that CPT code and ICD-9 code is associated with a charge that then becomes associated with that encounter.

And right now we don't have G-codes in our Electronic Health Record. And I don't know if the providers will be responsible for placing the G-code in the record or if that is going to be delegated to a billing service that's being used. What's the recommendation?

Tracey Mackey: This is Tracey Mackey. We'll try to – this is a great question. We will try to address it. Going forward with the PPS, providers will be responsible for reporting the G-code for the encounter visit with a qualifying HCPCS CPT code. So I'm not sure if in your process who will need to drop it, but the 77x bill type submitted to your MAC will need to contain the G-code and a qualifying visit for payment consideration.

Esther Markowitz: But I think internally, however your organization internally handles translating the medical record into the – into billing, that's an organizational determination. For Medicare's purposes, we're going to need to see the G-code and the associated charges in order for us to make a payment to the FQHC.

Operator: Your next question comes from the line of Donna Myers.

Donna Myers: My name is Donna Myers from Family Healthcare Clinic. My question is –goes back to the – what was it, the rate where it starts over around your cost report time. My cost report is due June the 3rd of 2014. Does that mean I need to start the new rate then or do I wait to next year? Hello?

Nicole Cooney: Just 1 second, give us 1 second.

Corinne Axelrod: The green light wasn't on. Hi, thank you for your question. So again, you will transition to the new PPS based on your cost-reporting year. So if your cost-reporting year begins July 1st, that's when you would transition to the new PPS. No?

Tracey Mackey: No, no, you would transition beginning October 1.

Corinne Axelrod: Oh, right, right, OK.

Tracey Mackey: No, no, no.

Corinne Axelrod: No, let me pass this to our experts over here.

Marty Abeln : Performance date that begins on or after after 10-1

Tracey Mackey: Right, so they would actually not begin their PPS until '15

Marty Abeln: Yes.

Esther Markowitz: Right, this is Esther

Julie Stankivic: OK, well I just want to be clear on something here, before we take this further.

Female: Say who you are.

Julie Stankivic: You are indicating that your report is due on June 30th. Is that your end date or is that the date that it's due to your intermediary?

Donna Myers: If I'm correct, it is the day that it is due to the intermediary.

Julie Stankivic : OK, well you want to also make sure that that is also your cost-reporting period that you selected for purposes of Medicare reimbursement, if in fact it is. Then of course, June 30 – that means you have a July 1 begin date for your cost-reporting period. You would begin FQHC PPS on July 1, of 2015.

Esther Markowitz: And this is Esther Markowitz speaking. I just want to follow up on what Julie, our cost-reporting expert, contributed to this. Please do check in with your

MAC if you are not sure that that is your cost- reporting period. Because if your cost-reporting period for the new year has already begun before October 1, 2014, you're not going to start the PPS on October 1, 2014. You're going to start the PPS for the first cost-reporting period that begins on or after October 1, 2014.

So any FQHCs out that that have cost-reporting periods that go from October 1 through September 30th, they're going to go straight into FQHC PPS as of October 1, 2014. If you are a calendar year cost-reporting period and you go from January 1st through December 31st, you're going to start being paid on an FQHC PPS from January 1st, 2015. This means that there will be certain FQHCs out there that are going to continue to be paid under the current all-inclusive rate system. And we're expecting everyone to transition into the PPS by the end of 2015.

So I thank you very much for your question. If you need further confirmation, please feel free to send us an email. And again, do touch base with your MAC if you're not sure about your cost reporting period.

Operator: And you have a question from the line of Anola Small.

Anola Small: Hi, this is Anola from Native American Health Center. I have a question on how to bill the Medicare Advantage plan wrap rate. Is that billed to Medicare based on the fact that your patient is enrolled in a Medicare Advantage Plan HMO?

Corinne Axelrod: So Marty, I believe that you're on the line. Did you want to respond to that?

Marty Abeln: Yes. Are you are talking about when you are getting paid?

Anola Small: I'm talking about billing the wrap-around rate that was referred to in the presentation we just had. We currently do bill a wrap-around rate to our Medi Cal FQHC for Medical Advantage Plan members. This suggests that we actually bill Medicare FQHC for a Medicare Advantage Plan member.

Marty Abeln: I am not sure if I completely understand your question, but, I mean, if you are dealing with an MA plan on noncontract plan basis, then you would pay them exactly as, you know, you would pay them as original Medicare would pay.

Anola Small: No, I'm talking about, you could – the presenter said that there is now a Medicare Advantage Plan wrap rate. How do we as a clinic bill that Medicare Advantage Plan wrap rate?

Marty Abeln: Well, if I understand the wrap rate, what that is, is you know if you are – if you have a contract with an MA plan, and that MA plan is paying you less than what you would have received under original Medicare, the payment rate you negotiated with them, then you're entitled to an additional payment which may be what they're referring

to as the wrap rate for Medicare to make up that difference. Is that what you're asking about?

Anola Small: Yes, that is what I am asking.

Marty Abeln: You know I do not know exactly the logistics of how you get the wrap rate, I can look into that, but that's not something I do. So certainly if you send me that question, I can give you specifics on it or find the person that can.

Anola Small: How do I …

Esther Markowitz: And Marty, thank you so much for addressing it from the Medicare Advantage perspective.

There – you are welcome to send in your question to us if you need further information. What I will say is that if you're dealing with an MA plan and the contract rate is the same or more than you were getting for the FHQC patients under original Medicare, then there was a supplemental payment until now. And the concept of the supplemental payment for MA beneficiaries is not a new one, it exists under the current all-inclusive rate system. There are instructions for billing it under the current system in Chapter 9 of pub 100-04, which talks about how to do it. And it's done with an 0509 revenue code.

If you take a look at the MLN Matters article 8743, we do address how it will change under the PPS. The key aspects of the changes under the PPS are that the comparison being done on the contractor side. The comparison being done by the MAC is going to be between the PPS rate, the fully adjusted PPS rate, and the MA contract, right, as opposed to the air and the contract rate.

Another major difference that's going to happen on the FQHS PPS is that we would start requiring detailed HCPCS coding on the claim so it's crystal clear how much the fully adjusted PPS rate would have been for that particular beneficiary. So again, you would still be working with the MA plan that is paying for the beneficiary when you furnish service to a beneficiary who's covered under an MA plan, and that's where you would get your contract payment from when you have a written contract from them. If you would qualify for supplemental payment because of the contracted rate is less than the fully adjusted payment rate, that is something that will be submitted to the Part A MAC.

Please do take a look at the MLN Matters article for some more information about that. We'll be doing a little bit more walkthrough in the June 25th call and if you have questions in the meantime, please do feel free to submit them. Thank you.

Operator: Your next question comes from the line of Laurie Wilson.

Laurie Wilson: Hi, this is Laurie. I'm calling from North Penn Comprehensive Health Services. Hello, hello.

Nicole Cooney: We're here.

Laurie Wilson: Hi, This is Laurie, I'm calling from North Penn in Pennsylvania, and I had another question on the diabetes education. I know that you said that we cannot bill it on the same date as an office visit with another provider. Can we bill it if it's done on a separate day or is that still considered inclusive in a previous visit?

Corinne Axelrod: Hi, this is Corinne. So a DSMT visit that meets the requirements for payment does quality as a visit. So if it's done on a day when there is no other service provided then it would be a billable visit. If it's done on the day that another service is provided, then only one visit would be billed.

Laurie Wilson: OK, thank you.

Corinne Axelrod: Thank you.

Nicole Cooney: Victoria, we have time for one final question.

Operator: Your final question comes from the line of Pam Flint

Pam Flint: Hi, this is Pam from Muskegon Family Care. And our question is –are these new G-codes replacing …

Nicole Cooney: I'm sorry, you broke up a little bit, could you repeat your question?

Operator: Miss Flint, please press star 1

Pam Flint: The old G-codes – can you hear me?

Nicole Cooney: We lost you there for a minute. Can you please repeat your question?

Pam Flint: Yes, Are the G-codes replacing the old G-codes that we used and are we still using the Welcome to Medicare code?

Corinne Axelrod: Hi, this is Corinne. You – currently, FQHCs are not using G-codes, but again, I would encourage you to join our call next month where we'll be going into detail on the use of the G-codes in FQHCs and as well as the revenue codes. Did you want to add something else?

Esther Markowitz: Yes, I did want to add, this is Esther Markowitz speaking. I just want to make sure that we're clear on the specific payment codes. As a shorthand during this call and sometimes during our discussions, we refer to them as FQHC G-codes. But just to clarify, we're referring to the FQHC specific payment codes that were newly created in order to implement the FQHC PPS. And those specific payment codes are in the range of G-0466 to G-0470. And those will be used exclusively for the billing of FQHC visits as

part of how we discussed in this call and as detailed a little bit more in the MLN Matters article.

But the concept of the G-code for CMS is a much broader concept and I think I heard the caller referring to, would we still use the G-codes to describe, I'm not sure if he said the IPPEs or the AWVs. That would still be included as a line item detail because the G-code for the most part just means it's a HCPCS code developed for use in Medicare payments.

So G-code is really a broader concept. Again, in the FQHC discussion that we're having now, we've been using G-codes as a shorthand for these specific payment codes in the ranges G-0466 through G-0470. If your qualifying visit for line item detail – any of the services furnished during the visit– are described by a HCPCS code that happens to be a G-code, you would also include that in the detail line. I hope that's clear. Does that answer your question?

Pam Flint: Yes, thanks. That helps a lot.

Esther Markowitz: Thank you very much for your question.

Additional Information

Nicole Cooney: OK, unfortunately, that's all the time that we have for questions today. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 28 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. And we hope that you will take a few minutes to evaluate your MLN Connects Call experience.

Again, my name is Nicole Cooney and I'd like to thank our presenters and also thank all of you for participating in today's MLN Connects Call on the new Medicare PPS for Federally Qualified Health Centers. Have a great day.

Operator: This concludes today's call. Presenters, please hold.

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This document has been edited for spelling and punctuation errors.

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