DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR BENEFICIARY CHOICES

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From: Abby Block
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To: Medicare Advantage Organizations Offering PFFS Plans

Subject: Payment of Rural Health Clinics and Federally Qualified Health Centers

Medicare Advantage Organizations (MAOs) operating PFFS plans exclusively through deemed providers are legally responsible for paying providers not less then the payment rates established under Medicare when they reimburse deemed and non-contracting providers. See sections 1852(a)(2)(A), 1852(d)(4)(A) and 1852(k)(2)(B) of the Act. We continue to receive anecdotal reports that PFFS plans are paying some providers (in combined plan payment and member cost sharing) less then the amount that would have been received by the provider in Original Medicare payment and beneficiary cost sharing. In particular, we have received complaints from Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs). In our online "MA Payment Guide for Out-of-Network Payments" we outline MAO claims payment responsibilities to non-contracting and deemed providers. The "Guide" can be found at: http://cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf.

In some cases, Original Medicare reimbursement calculations are complex. Note particularly that RHCs and FQHCs are sometimes paid more by Original Medicare than the "all inclusive rate" or the national per-visit limit. In such situations, MAOs offering PFFS plans must also pay more.

In addition, when a provider disputes a PFFS plan payment amount an MAO must follow a meaningful process to resolve the dispute that includes a method for the provider to submit evidence supporting a higher payment amount. Although the law permits PFFS plans to rely on deemed providers to establish network adequacy, it does so only on the basis that the plan's payment rates are not less than what original Medicare would pay. If such a PFFS plan's payment rate is in fact less than the Medicare rate, it may be subject to sanction by CMS on the basis that it is not meeting Medicare access requirements.

MAOs offering PFFS plans must ensure that they are meeting their responsibility to pay providers at least what they would have received under original Medicare and that there is a system in place through which a deemed provider can dispute payment amounts and receive higher payments when they are due. If you have any questions, please contact Sabrina Ahmed on (410) 786-7499.

Background on RHCs and FQHCs

The RHC Program was established in 1977 to address an inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. For RHC purposes, any area that is not defined as urbanized is considered non-urbanized. The U.S. Census Bureau defines an urbanized city as a central city of 50,000 or more and its adjacent suburbs. Medicare payments are made on a cost-related basis for outpatient physician and certain non-physician services.

The Federally Qualified Health Center (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, such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC program is to enhance the provision of primary care services in underserved urban and rural communities. Medicare pays FQHCs, which are considered suppliers of Medicare services, an all-inclusive per visit amount based on reasonable costs.

For additional information on RHCs and FQHCs please review the Medicare Guide to Rural Health Services Information for Providers, Suppliers and Physicians. http://www.cms.hhs.gov/MLNProducts/downloads/MedicareRuralHealthGuide.pdf.