

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Proposed Rule CMS-1443-P: Medicare Prospective Payment System
for Federally Qualified Health Centers

Moderator: Jill Darling
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2:00p.m. EST

Operator: Good afternoon. My name is Stephanie and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Special Open Door Forum. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks, there will be a question and answer session. If you'd like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Ms. Jill Darling in the CMS Office of Communications, you may begin your conference.

Jill Darling: Thank you, Stephanie. My name is Jill Darling in the CMS Office of Communications. Thank you for joining the special open door forum today. I do apologize for the delay in starting.

First, I have a couple of announcements. Starting October 1, 2013, individuals can apply and enroll in health coverage through the health insurance marketplace at healthcare.gov. Health coverage starts as early as January 1, 2014 and the initial open enrollment period for the health insurance marketplace ends on March 31, 2014.

Through the marketplace, individuals can apply, compare all their options and find out if they can get lower cost on monthly premiums or get free or low-cost coverage. Information for consumers, including available plan information and the ability to enroll in a health insurance plan is available on healthcare.gov.

CMS has developed many materials that providers may find useful when answering questions that their patient may ask, including flyers, fact sheets, brochures, talking points, videos and training slides. All of these are available on marketplace.cms.gov.

We will continue to keep you updated on our progress on improving healthcare.gov. As we work to fix the site, we encourage Americans to continue to sign up for quality affordable coverage in four ways. By phone, contacting your local navigator or certified application counselor by calling 1-800-318-2596 or online, by mail and in person.

The Medicare open enrollment period is October 15th through December 7th when all people with Medicare can change their Medicare health plan and prescription drug coverage for 2013. Please advise your patients that information on 2013 plans is now available by calling 1-800-MEDICARE or visiting <http://www.medicare.gov/>.

After evaluating the available information and they are satisfied that their current plan will meet their needs for next year, they don't have to do anything. Your Medicare patients also need to be advised that they should not confuse the health insurance marketplace open enrollment period that runs through March 31, 2014 with Medicare open enrollment period that ends December 7th.

If they miss the December 7th deadline, they will not be able to make a change until next open enrollment period starting October 15, 2014. I will now hand it over to John Rigg.

John Rigg:

Hi, everybody. This is John Rigg. I'm with the Office of Planning, Analysis and Evaluation with the Health Resources and Services Administration. I also happen to be the chairman of the HRSA-CMS low-income access open door forum.

Today is a special open door forum and I welcome all of you and appreciate you for joining in. We're going to discuss only one very important subject and that subject is the Federally Qualified Health Center Prospective Payment

System, which is a proposed rule that was issued by the Centers for Medicare & Medicaid Services approximately 30 days ago – 45 days ago.

My colleague, Corinne Axelrod, who will be presenting most of the information today, can give you further information about how to comment on this important rule. I know that CMS is very interested in receiving your comments.

Here, first, we very much appreciate CMS' engagement on this issue and their very thoughtful approach to the prospective payment system. And we look forward to hearing your questions and answers as colleagues at CMS present the information.

Again, thank you for joining today. And a quick reminder that the CMS low-income access open door forum is a regularly-occurring event, occurring approximately every quarter. You can find out more information, including how to sign up for the low – this low-income access open door forum and other open door forums on the CMS Web site at cms.gov.

And now, without any further ado, I'm going to hand this off to Captain Corinne Axelrod with the Centers for Medicare & Medicaid Services. Corinne?

Corinne Axelrod: Thanks, John. I want to start by thanking you John, and Colleen Meiman, Jim Macrae and others in HRSA for all the assistance that you provided as we developed this regulation. Setting up a new payment system for FQHCs is a big undertaking and there were four of us here in CMS who developed this regulation – Valerie Miller, Esther Markowitz, Sarah Harding and myself.

But I also want to acknowledge our colleagues here in CMS, particularly people in our cost reporting and provider billing divisions, Medicaid office and others throughout CMS and as well as SAMHSA and everyone throughout the department who reviewed many drafts of the proposal and provided valuable assistance throughout the process. So we sincerely thank all of you for your contributions.

Today, I'm going to quickly review the key statutory requirements of the FQHC PPS in the Affordable Care Act. We're going to spend most of our time going over the major provisions of the proposed rule, particularly the payment rate and the adjustments and coinsurance, and walk through some examples, so get your papers and pens ready so you can follow along.

I'll talk briefly about the transition from the current system to the PPS and then we'll take your questions. We have several experts in the room ready to answer your questions to the extent that we can during the comment period.

So before we get started, I want to go over a few caveats and review the process. As John mentioned, today's call is on the proposed PPS for FQHCs. We will not be addressing any other parts of the proposed rule or any other regulations or issues.

The Affordable Care Act authorized the PPS for FQHCs. It did not authorize a PPS for Rural Health Clinics, so this proposed PPS only applies to FQHCs.

This proposed PPS is for Medicare only. It does not change the Medicaid PPS.

The PPS is authorized to begin on October 1, 2014; therefore, it is not in effect yet.

There is no change to the FQHC benefit. If something was covered before, it will still be covered and no additional benefits have been added. This is a payment regulation. It doesn't change the FQHC benefit.

And finally, this is a proposed rule. Nothing is final until it's finalized, which we expect will be early next year.

Let's also review the rulemaking process. The proposed rule went on display at the Federal Register on Wednesday, September 18th. There is a 60-day comment period which ends at 5 pm on Monday, November 18th.

This is the time for you to look at the proposed regulation and provide feedback. If you like something, you can let us know. If you don't like something, you can let us know that too.

We will review all comments and either finalize the rule as it is proposed or make revisions based on the comments received. If you believe there is something we didn't get right or could be improved, or if there are changes that you do like, you need to let us know before the comment period ends on November 18th.

Today's call will provide an overview of the proposed rule and we'll try to answer any questions as best we can. But even if you comment on this call, you will still need to submit a formal comment for it to be in the rulemaking process and considered in the final rule.

OK. Well, let's get started. The short version – and I'm not sure if anyone in Medicare gets to say this very often, but the short version is that most of you will be receiving a significant increase in your Medicare payment and you don't have to do anything.

So I'd like to go over seven of the key statutory requirements pertaining to the FQHC PPS in the Affordable Care Act. First, the FQHC PPS will be effective for cost reporting periods beginning on or after October 1, 2014.

Two, the new PPS must establish a payment rate that takes into account the type, intensity and duration of services furnished by FQHCs and may include any adjustments as appropriate.

Three, the initial estimated aggregate amount of the PPS must be equal to 100 percent of the estimated aggregate amount of reasonable costs that would have occurred for the year if the PPS had not been implemented, and that this be calculated prior to the application of co-payments, per-visit limits, or productivity adjustments.

Four, starting January 1, 2011, FQHCs were required to provide information as required by the Secretary in order to develop and implement the FQHC PPS, including the reporting of services using HCPCS codes.

Five, Medicare payment for FQHC services must be 80 percent of the lesser of the actual charge or the PPS amount.

Six, FQHCs that contract with Medicare Advantage organizations must be paid at least the same amount they would have received for the same service under the FQHC PPS.

And seven, that after the first year of implementation, PPS rates will be increased by the percentage increase in the Medicare Economic Index, known as the MEI. After the second year of implementation, PPS rates will be increased by either the MEI or a market basket of FQHC goods and services.

Those are the key statutory requirements of the Affordable Care Act pertaining to the FQHC PPS. Our job in CMS is to develop regulations to implement the statutory requirements. Our goals were to develop a PPS that accurately pays FQHCs for the cost of furnishing services to Medicare beneficiaries while minimizing additional administrative burden to FQHCs and also to make sure that our policies support access to care for Medicare beneficiaries.

We explored several approaches to developing the PPS, including making separate payment for each coded service and adopting the relative values from the physician fee schedule. Instead, we decided to propose a single and encounter-based rate per beneficiary per day.

We believe that this methodology is administratively simpler and gives FQHCs more flexibility to increase efficiency and reduce over-utilization of services. It's also similar to both the current all-inclusive rate system and the Medicaid payment system.

So let's look at the key provisions of the proposed rule starting with the proposed Medicare rate. As you know the Affordable Care Act required you to include on your claims detailed coding of services furnished along with revenue codes for each FQHC visit.

To develop the PPS, we used Medicare FQHC cost reports from June 30, 2011 to June 30, 2012 and corresponding claims data. Based on in-depth analysis of the claims and cost report data, we estimated the aggregated average cost of services provided in FQHCs without application of productivity standards and without application of the upper payment limit.

Based on the FQHC cost report and claims data, we found that the average cost per daily visit among FQHCs is \$150.96, which we then adjusted to account for the proposed adjustment factors which I'll be describing in more detail.

We increased that number to account for inflation since the data used to calculate the average cost per daily visit are in 2012 dollars. This resulted in a rate of \$155.90, which we refer to as the PPS base payment rate.

I want to emphasize that, until this rule is finalized, this rate is subject to change. Our goal is to establish a rate that is as accurate as possible and we will continue to analyze and update the data until the final rule is published.

Under the current system, each FQHC is paid a rate that is based on its total allowable costs divided by its total number of visits, subject to the productivity standards and upper payment limit. Under the proposed PPS, there would be a single base payment rate for all FQHCs, and adjustments that I'm going to describe in just a moment.

As per the statute, Medicare payment will be 80 percent of the lesser of the PPS-adjusted rate or the FQHC's total charges for the payment in a day. For FQHC patients whose total per diem charges are higher than the PPS adjusted rate, your payment will be based on the PPS adjusted rate.

For FQHC patients whose total per diem charges are below the PPS adjusted rate, your payment will be based on your charges. I will go through some examples in just a few minutes, but let's first talk about the adjustments.

In keeping with the statutory requirements of setting a rate that takes into account the type, intensity and duration of services furnished by FQHCs, we have proposed two payment adjustments. The first adjustment is the GAF, G-

A-F, the geographic adjustment factor, to adjust for geographic variations in the cost of providing services and supplies throughout the country.

We proposed that the payment rate be adjusted by applying an adaptation of the Geographic Practice Cost Index that is used in the physician fee schedule. In the addendum at the end of the proposed rule, there is a list of the 89 proposed GAFs throughout the United States. They range from a factor of 0.808 in Puerto Rico to 1.306 in Alaska.

Let's go through an example of how this would work. Let's say the charges for all services furnished to a patient in a day were \$170 and, let's say, the PPS base payment rate is set at \$155. Again, we won't know the final rate until the final rule is published.

And let's say your FQHC is in Rhode Island, which has a proposed GAF of 1.035. You would multiply the base rate of \$155 times 1.035 which comes out to about \$160. I'm going to round off numbers throughout this call, but, of course, the full amount would be used on your claims.

Since the \$170 charges are higher than the PPS rate of \$160, Medicare would pay 80 percent of \$160. Under the current system, for the same service in the same FQHC, Medicare would pay the FQHC 80 percent of \$128 which is the upper payment limit for an FQHC for an urban area.

Here's another example. Let's say the FQHC is in rural Nebraska which has a proposed GAF of 0.938 and the total charges for services furnished to a patient in a day were \$140. You would multiply the base rate of \$155 times 0.938 which comes out to \$145.39.

Because the statute requires that Medicare payment is the lesser of the actual charge or the PPS amount, Medicare would pay the FQHC 80 percent of \$140. Under the current system for the same service and the same FQHC, Medicare would pay the FQHC 80 percent of \$110.78 which is the upper payment limit for a FQHC in a rural area.

We propose to use the GAFs instead of just rural or urban because we believe that it provides a more accurate estimate of the variation of costs throughout

the country. Please note that the GAF is applied based on where the service is furnished, so it's possible there may be some instances where FQHCs that are part of the same organization might be using a different GAF.

The second adjustment that we proposed is for new or initial patients. This includes patients that are new to the FQHC, patients that are having their initial preventive physical exam, known as the IPPE, and patients that are having their first annual wellness visit.

Based on an analysis of claims data, we found that these visits were approximately 33 percent more costly than the average encounter. So we have proposed an adjustment of 1.3333.

So let's go back to our Rhode Island example. If the services furnished to a patient in a day included a new or initial visit, the PPS rate would be adjusted by 1.3333 to reflect the 33 percent higher of this service than an average encounter.

For this visit, the adjusted PPS rate would be the PPS base rate of \$155, times the GAF of 1.035, times the new initial payment adjustment of 1.3333, for a PPS-adjusted rate of \$214. Because the law requires Medicare to pay 80 percent of the lesser of the PPS rate or the FQHC's charge, if the FQHC charge is \$170 for this visit, Medicare will pay the FQHC 80 percent of \$170 for this visit, since \$170 is less than \$214.

If the FQHC furnishes more costly services and charges \$200 for the day, Medicare will pay the FQHC 80 percent of \$200 for this visit, since \$200 is still less than the adjusted PPS rate of \$214.

One of the disadvantages of doing this call over the phone is that I can't see if you're all nodding along with me or if you're lost in all these numbers. So, just to reassure you, this call is being recorded. There'll be a transcript available, so you'll be able to go back if you missed any of these numbers and read through this again.

Let's go back to our Nebraska example. If the services furnished to a patient in a day included a new or initial visit, the PPS rate would be the \$155 base rate times the GAF of 0.938, times 1.3333, for an adjusted PPS rate of \$194.

Again, since we're required to pay 80 percent of the lesser of either the rate or the charge. If the Nebraska FQHC charged \$140 for this visit, Medicare would pay the FQHC 80 percent of \$140. If instead, the Nebraska FQHC charged \$200, Medicare would pay the FQHC 80 percent of \$194 for this visit.

Note that the comparison is always between the fully-adjusted PPS rate and the provider's charge as billed to Medicare. The provider's charge is not further adjusted by the GAF or the adjustment for new patients and initial visits. Only the PPS rate gets the GAF and new or initial patient adjustment, not the FQHC charges.

These are the two adjustments that we propose based on their impact on FQHC costs. We considered other adjustments such as demographics (age and sex), clinical conditions, duration of the encounter, et cetera, but we found these other adjustments to have little-to-no impact on the estimated cost of services, or the potential added precision of applying these adjustments did not warrant the complexity and additional recordkeeping that would be needed to implement them. There's more information about the adjustments that were considered and not proposed in the research report that is posted on our FQHC PPS Web site.

I do want to talk for a couple of minutes about mental health services because we know that these are services that can be challenging to provide, especially in underserved areas. As you know, under the current payment system, FQHCs can bill for more than one visit per beneficiary on the same day when an illness or injury occurs subsequent to the initial visit or when mental health, diabetes self-management, medical nutrition therapy (DSMT and MNT), or the IPPE are furnished on the same day as the medical visit.

We analyzed the FQHC data to determine if any additional payment should be built into the PPS for these situations, especially for mental health visits that

occur on the same day as a primary care visit. What we found was that billing for more than one visit for these situations is very rarely done and all of these scenarios combined accounted for less than 0.5 percent of all visits.

Based on the FQHC claims data, since Medicare beneficiaries rarely receive mental health services on the same day as another medical visit can in FQHC, removing the option to bill for mental health services that are furnished on the same day as another service would not seem to have a significant impact on access to these services.

We also looked at whether a payment adjustment, like the one that we proposed for the new or initial visit, should be included. However, unlike the new and initial visits, which cost approximately 33 percent more than a regular visit, the cost of providing mental health services in FQHCs is about the same as other primary care services, so an adjustment factor did not seem justified either.

We know that there is a lot of interest in improving both the availability of mental health services and the coordination of mental health with other medical services, so we have made a point of requesting comments on this aspect of the prospect rule.

If you do choose to comment on this and if you believe that the option to bill separately for mental health services should be retained, we would appreciate it if you would address why this option should be continued in lieu of the fact that it is so rarely used, and also why it should be continued when it is not available for other conditions that are treated on the same day by different practitioners (For example, if a patient sees an internist for one issue and then a cardiologist for another issue, the FQHC will be paid one per diem rate, not two payments) and also that the cost of mental health services is not significantly different than other medical services. And if you agree with the proposal not to include this as an option, please let us know that as well.

OK. Well, let's talk about coinsurance. Since Medicare payment under the FQHC PPS must be 80 percent of the lesser of the actual charge or the PPS

rate, we proposed that coinsurance would be 20 percent of the lesser of the actual charge or the PPS rate.

If the FQHC's total charges are less than the PPS rate, like in our Nebraska example, and there were no preventive services on the claim, Medicare would pay 80 percent of the total charge and coinsurance would be 20 percent. If there were both preventive services whose coinsurance is waived and non-preventive services on the claim, we propose to use the line item charges to determine cost sharing, which is how the current claims processing system calculates coinsurance.

Where this gets a little more complicated is where there is a mix of preventive services for which coinsurance is waived and non-preventive services and the FQHC charges are higher than the PPS rate. We looked at many options for accurately calculating the coinsurance in this situation and you can read about the different options we considered and their plusses and minuses in the proposed rule.

What we have proposed to use, again, only when the FQHC charges are higher than the adjusted PPS rate and there is a mix of preventive and non-preventive services, is the physician fee schedule rates for the service listed on the claim in order to determine the proportional amount of the total charge that would not be subject to coinsurance. We are not proposing to use the physician fee schedule amount for payment, only to determine the proportion of the payment that is not subject to coinsurance.

You are already using HCPCS coding on your claims to ensure that coinsurance is not applied to the line item charges for preventive services. Let's go back to our Rhode Island FQHC example where the total charges were \$170 and the PPS adjusted rate is \$160. If there were no preventive services on the claims, Medicare would pay 80 percent of the \$160 and coinsurance would be 20 percent.

Let's modify this example a bit and let's say that it included a regular medical service which was coded as a level three office/outpatient E/M visit, which is

subject to coinsurance, and a medical nutrition therapy service, which is not subject to coinsurance.

The total payment to the FQHC would still be \$160. The question is the cost sharing. How much of the \$160 is subject to coinsurance and how much should be paid by Medicare?

In this example, the physician fee schedule amount for the level three E/M visit is about \$73 and about \$35 for the MNT visit. Total payment for these services if billed separately under the physician fee schedule would be \$108, of which the E/M service accounts for approximately 67 percent of the payment and the MNT service accounts for approximately 33 percent of the payment.

OK. Now that we have the proportionality, let's apply that to our Rhode Island FQHC example where the total payment is \$160. Thirty three percent of \$160 is \$53. This is the amount attributed to the MNT service which is not subject to coinsurance. This will be paid in full by Medicare.

Sixty seven percent of the \$160 is \$107. This is the amount attributed to the E/M service which is subject to coinsurance. Eighty percent of this, which comes out to \$86, will be paid by Medicare.

Medicare's total payment is \$139, which was \$53 for the MNT and \$86 for the E/M visit. The coinsurance is 20 percent of \$170 for a total of \$21. The FQHC gets \$139 from Medicare and \$21 from coinsurance, for a total of \$160.

If there were no waived preventive services furnished, Medicare would pay \$128 and coinsurance would be \$32. Total payment to the FQHC remains the same whether or not there is a preventive service on the claim.

We know this may seem a bit complicated at first, but after you do it a few times, it becomes much easier. There are a limited number of preventive services for which the coinsurance is waived and the physician fee schedule rates are posted on the CMS Web site on the physician fee schedule page.

Let's talk briefly now about the transition from the current system to the new PPS. The Affordable Care Act requires the FQHC PPS to be implemented starting October 1, 2014. You do not need to do anything.

Your MAC, Medicare Administrative Contractor, will transition you to the PPS based on your cost reporting period beginning with those of you whose cost reporting period starts on October 1, 2014, and all FQHCs should be transitioned to the PPS by the end of 2015.

The claims processing system will maintain the current system and the PPS until all FQHCs have transitioned. You will still need to submit cost reports because certain costs, such as the influenza and pneumococcal vaccines and their administration, some graduate medical education costs, and bad debt would continue to be determined and paid through the cost report. We will be updating the cost report forms to eliminate information that is no longer needed and to reflect the new PPS.

We also proposed to transition the PPS to a calendar year update for all FQHCs beginning January 1, 2016 because many of the physician fee schedule files we are proposing to use are updated on a calendar-year basis.

After the final rule is published, we will provide additional information and we will work closely with HRSA and MAC and others to make sure that you all have any information that you need.

I'd like to thank everybody on this call for taking the time out of your busy schedules and I hope that you have found this to be useful. We have several people here with us in Baltimore and on the phone to answer your questions, so here's just one more caveat.

During the comment period of a proposed rule, we are limited in how much information we can discuss beyond what is in the proposed rule. So, in some cases, we may not be able to answer your questions and we'll recommend that you send in a comment.

I also want to remind you that this call is not part of the official rulemaking record. If you want to formally comment on any part of the rule, you will still

need to send in a comment. So now, I'll ask the operator if you could please repeat the instructions for asking questions. Thank you.

Operator: Certainly. As a reminder, ladies and gentlemen, if you would like to ask a question, please press star, then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Please limit your question to one question and one follow-up question to allow other participants time for questions. If you require any further follow up, you may press the star one again to rejoin the queue. We'll pause for just a moment to compile the Q&A roster.

Your first question comes from the line Chrystal Barr. Please state your organization name before asking your question. Your line is open.

Chrystal Barr: Yes. OK. Assurance MD. My question is where could we possibly get the current information for the PPS rates? Does that make sense?

Corinne Axelrod: I'm not sure what you mean. There is information that's from the proposed rule and there is also an additional report that we have on our Web site that goes into a lot of detail about how the rate was developed. Is that report what you...

Chrystal Barr: Well, I'm – no. I'm actually looking for current rate.

Male: So currently, federally-qualified health centers are paid reasonable cost subject to a per-visit limit. So each federally-qualified health center could potential – I mean, if you're subject to the limit...

Chrystal Barr: OK.

Corinne Axelrod: There is a limit for urban FQHC that's about \$128 and there's one for rural FQHCs which I think is \$112¹. Each FQHC has its own rate currently which is based on its total allowable costs and visits, subject to the productivity standards and the upper payment limit.

¹ The 2013 upper payment limit for rural FQHCs is \$110.78

Chrystal Barr: Got you. OK.

Corinne Axelrod: There's information on our Web site - There is an FQHC fact sheet that gives an overview of the current system. There's also our manuals. There's a policy manual and a claims processing manual that goes into a lot of detail about that.

Chrystal Barr: OK. And where – you said on the Web site I can find the – all this information? OK.

Corinne Axelrod: Yes. If you go on the CMS Web site, there is a page dedicated to FQHCs and there are links on there for the fact sheet and for the policy manual which is Chapter 13, and the claims processing manual, which is Chapter nine. And if you have any difficulty finding that, you can certainly send me an e-mail and I'll be happy to send you those links.

Chrystal Barr: OK.

Corinne Axelrod: Do we have any other questions?

Operator: Your next question comes from the line of Jane Spire. Please state your company name before asking your question. Your line is open.

Jane Spire: Hi. My name is Jane Spire and I'm from OCHIN. Since the way that you determine the PPS encounter rate was based on an average of all the charges, would you anticipate then that about 50 percent of the claims coming in would actually be less than the PPS rate?

And so, therefore, my thought is I think that – I realize it's written into the Affordable Care Act. But by limiting payment to the lesser of actual charges or 80 percent of the PPS rate, it appears that what you will encourage is the behavior where FQHCs will increase their fee schedule so that the minimum visit with an FQHC provider is at least the PPS rate and I think that might have an impact on access that I wondered what your comments were on that.

Corinne Axelrod: Yes. Thank you for your comment. CMS does not provide any guidance or directive on the charges that FQHC charges. I don't know if HRSA does have

any limitations or guidance on that - I know that there are some provisions related to the sliding fee schedule, but I just want to be clear that CMS does not dictate, in any way, what an FQHC charges. And, beyond that, I don't think we can really comment on the behavior of what FQHCs will do as a result of this rule.

Jane Spire: OK. (Inaudible).

Corinne Axelrod: OK. Thank you.

Jane Spire: Yes. It's, basically, there is no rulemaking that can occur around whether or not the payment is 80 percent of submitted charges or the rate. It will also be the lesser of because that was written into the Act. Is that correct?

Corinne Axelrod: Yes, that's correct.

Jane Spire: OK.

Corinne Axelrod: Thank you.

Operator: Your next question comes from the line of Nancy Sink from Family HealthCare. Your line is open.

Nancy Sink: OK. Thank you. I see where it starts with cost reporting periods beginning after October 2014. So if we are on an annual cost report from January to December, our PPS would start January of 2015. Is that correct?

Corinne Axelrod: Yes. That is correct.

Nancy Sink: And is there a Web site where you can find the geographic adjustment factor? I've been trying to find one during the call and I can't seem to find it.

Corinne Axelrod: If you look at the proposed rule that was published, there's an addendum in the back which has the list of the geographic adjustment factors. And it's also on our Web site. So, again, if you have difficulty finding either of those, please send me an e-mail and I'll send you those links.

Nancy Sink: OK. Thank you very much.

Operator: Your next question comes from the line of James Luisi from North End Community Health Community. Your line is open.

James Luisi: Hi. Concerning the two visits on one day. If – your comment that it was so small – the number – that you didn't include it - that if they're so small, why not include it for those that it makes a difference?

For instance, my patients live on five – you know have to go up and down five stories, so we try to get all their appointments on the same day, so they don't have to go up and down the stairs and arrange for transportation. I was just wondering if that would make a difference in your decision.

Corinne Axelrod: You may want to send in a comment and just explain in a little more detail about how that impacts on your FQHC.

James Luisi: OK.

Corinne Axelrod: Thank you.

Operator: Your next question comes from the line of Kay Kuhmerker from Community Affiliated Plans. Your line is open.

Kathy Kuhmerker: Thank you. This is Kathy Kuhmerker from the Association for Community Affiliated Plans. I'm wondering if there is any requirement that a Medicare Advantage Plan reflects the Medicare-approved adjustments, both the GAF and the new or initial payment patient adjustment in the rate it negotiates with an FQHC?

Corinne Axelrod: Unfortunately, our Medicare Advantage expert is not here in the room with us today. So if you want to send that question, if we can answer it, we will. If not, then we'd have to do it through the comment process. I don't think any of us here in the room can answer that right now.

Kathy Kuhmerker: And who would I send the question to?

Corinne Axelrod: You can send it...

Jill Darling: So you could send it to Jill Darling – J-I-L-L, dot, darling – D, as in dog, A-L – excuse me, D-A-R-L-I-N-G at cms.hhs.gov and I will forward it along.

Kathy Kuhmerker: Great. Thank you very much.

Jill Darling: You're welcome.

Operator: Your next question comes from the line of Edward Shannon from Hudson Headquarters Health Network. Your line is open.

Edward Shannon: Yes. Thank you. And as she said, it's Hudson Headquarters Health Network. And I apologize, this has already kind of been said, but I (might) also take the opportunity.

First of all, I think CMS did a nice job on this proposal and I think it deserves some credit. But I do see some inconsistency; again, I think it was OCHIN that mentioned it. The rate is really – you've I think very well stated - simplistic, and an average of resources and intensity, but yet, it's going to be applied based on individual charges and resources and intensity.

So I just see a degree of inconsistency there. I understand what – you mentioned about you have a rule you have to live up to, but that just seems inconsistent. Having said that, I could understand why you would want to apply that to the patient side. I guess there's really no question. I just wanted to make that comment. Thank you.

Corinne Axelrod: And thank you for your nice comments about the rule. We tried to do the best we could, so, thank you.

Operator: Your next question comes from the line of John Mengenhausen from Horizon Health Care. Your line is open.

John Mengenhausen: Thank you. My question centers around the GAF percentage. Isn't it a little contradictory to the Affordable Care Act as we take a look at the insurances that are being offered in the marketplace?

The premiums for health insurance in rural community is higher. And the explanation for that furnished by the insurance company is it's more

expensive to provide health care in a rural area than in an urban setting, so that's why they charge more for the premium.

But yet, HRSA and CMS decreased our payments for the rural areas because they feel it's cheaper. I guess I'm just curious why, on one hand, HRSA allows the insurance companies to charge more for premiums because it's more expensive, but yet, you'll reimburse less thinking it's less expensive.

Corinne Axelrod: I think this is something that we could probably have a lovely discussion on and debate and everybody on the call would probably have some thoughtful things to say about it. But I'm not sure it's anything that we can respond to at this time. So if you would like to send in a comment on that, please do.

John Rigg: And this is John Rigg from HRSA. I would be remiss if I did not say that HRSA does not provide remuneration for services furnished in the health centers directly to health centers. We provide grants to health centers. However, the payment is – the payment amounts are calculated by CMS and that's what the subject of the proposed rule is today, so it's CMS.

Operator: Your next question comes from the line of Robert Fisher. Please state your organization name before asking your question. Your line is open.

Robert Fisher: Thank you. Calling from Health Care for the Homeless in Baltimore City. My question is, in reference to eliminating the second payment for a mental health visit after already seeing PCP, if the total charges is less than this new proposed rate for one of the visits, but if you combine both of the visit charges, could we get that full rate or the 80 percent of the new rate?

Corinne Axelrod: So the total charges for the day is what would be looked at. Whatever the services you're providing to the patient in a day would be added. That's your total charges and that's what would be compared to the PPS rate.

Robert Fisher: All right. So we – if we bill – say, the medical visit was \$100 and then the mental health visit was \$100. Each of those visits (inaudible) we'd only get 80 percent of. But, since they're combined, we would actually meet that PPS rate to get the full – the 80 percent of that new rate even though under the new system we get two separate payments.

Corinne Axelrod: Under the current system, you would get two separate payments if a mental health visit was billed on the same day as a primary care visit. Under this proposed rule, you would only get one payment per day, but you would add all your charges together.

So it's a little bit more complicated than just comparing one thing to one thing. You'd add all your charges together; you'd look at that, compare it with the PPS-adjusted rate.

Robert Fisher: OK. I got you. I just – I also wanted to second the thought the one gentleman had about this – the multiple visits and the same day, how eliminating that payment could be hurtful to our clientele as well being homeless. It's more beneficial to have our clients come here and to be seen one day for different specialties. I just wanted to second what he had to say.

Marc Hartstein: Are your clients Medicare patients?

Robert Fisher: About 10 percent.

Marc Hartstein: Right. So keep in mind that this prospective payment system only applies to Medicare patients.

Robert Fisher: Right.

Corinne Axelrod: OK. Thank you.

Operator: Your next question comes from the line of James Chen. Please state your organization name before asking your question. Your line is open.

James Chen: Thank you. I am from the Waianae Coast Comprehensive Health Center in Honolulu, Hawaii. My question is concerning the payment adjustment.

I've gone through the Arbor research paper and I am trying to understand where we have to factor in the intensity of services, it looks like using the (RCC) as the very best way of approximating intensity if that's what it was intended for.

And I would imagine that if we look at FQHC's Medicaid enrollments, which is a good poverty indicator, or you know those working, age, status or something along the line of HCC you know what we (flack) you know the Medicare condition of those Medicare beneficiary. And, so my question is how intensity truly factors into the average cost rate in the rate determination process.

Corinne Axelrod: Thank you for your question. What we did – and I will ask my colleagues to join in if I don't explain this very well – we looked at the cost of services, and the reason that we added in an adjustment for new patients was because of the increased cost of a new patient.

So that's why there is the 1.3333 adjustment for new patient visits which would reflect the intensity of providing these services as opposed to follow-up visits with regular patients. Does anybody here want to add anything to that?

Esther Markowitz: The only thing that I'd add is that we are also adjusting payments for initial Medicare visits and that you're reflecting the increased intensity that would be expected at those sorts of visits. As for suggestions for other options – other ways to approach adjustments to reflect greater intensity, we welcome your comments on this.

There is more information available. I think you mentioned you took a look at the research report online. There is a little more detail in there as to what was examined and what we've found.

And I suggest that you bring up these issues in a formal comment– like I said, we welcome comments on the proposed rule. This is something that we definitely could consider if submitted through the appropriate rulemaking channel.

James Chen: Can I just quick follow up? Obviously you know the initial visit and the annual wellness visit is – they're both you know important to look at. But if you look at the majority of the encounters, they are really truly day to day.

So, I mean, when you look at the demographics that was laid out on the Arbor research datasheet, I mean, obviously – there's certain component like

medical condition I think you folks look into it, but nothing was done regarding that – you know age – you know gender, nothing was done for that.

And so, I think just from a risk-adjustment standpoint, I feel like – that this is an overly-simplistic model that would tend to limit access to those sicker patients and would possibly steer FQHC to try to – as earlier commentator commented - increase their charge which would eventually also hurt access because a lot of us can attest to the fact that the community board members has concern over increasing the charge for FQHC services.

And that's why very often when you do the cost-to-charge ratio analysis, I guess you do get an index higher than one. But that said I'm not sure that's a good indicator of risk adjustment. So it seemed to me that something is missing because, I mean, we've been collecting data since 2011 on HCPCS level.

I mean, we do regression analysis based on the distribution assuming that the level of CPT would be (model distribution) than to the extent that certain health center has higher level three or level four, they would receive some kind of an adjustment. I think that would be a more appropriate way of looking at this.

And it would be similar calculation using the (RCC) just using a different variable which is level of services. And I would imagine that is a better approximator of the intensity of services.

Corinne Axelrod: Thank you for your comment. I'd like to ask Marc Turenne from Arbor Research who's on the line, if there's anything that you can add because I know that the calculations were anything but simple and they were very complex and in-depth. So just wondering if there's anything that you can explain that might at least in part address this gentleman's question.

Marc Turenne: Hi, Corinne, and thank you. Yes. This is Marc Turenne. And we appreciate the attention with Arbor Research and we appreciate the attention and interest in the research report.

As you noted and discussed, there were a number of options considered and factors that we examined as potential predictors of variation and resource use for encounters. And certainly, clinical conditions were among the factors that were considered.

There's a number of options in thinking about how one might account for variation and intensity of services. But, of course, I think as noted by CMS, there are a number of considerations there in terms of the extent of the complexity of the risk adjustment and the requirements to support the system going forward.

We certainly did find some association with certain clinical conditions with resource use and the estimated cost per visit. And, of course, it would be important to be certain that in proposing and applying such adjustments that there's comfort that they reflect valid associations with the intensity of care.

And so, as I mentioned, a number of factors were considered. I think the adjustments for new patients and initial visits were certainly intended as Corinne and Esther both noted to account for variations in intensity.

I think our report does describe other factors that, in some cases, did have an association with resource use and, in some cases have very limited association and actually I would – would note age and sex were among those.

Corinne Axelrod: Thank you, Marc. OK. Well, why don't we move on?

Operator: Your next question comes from the line of Ed Michael. Your line is now open.

Ed Michael Hi, this is Ed Michael from Rural Health. I just have a basic question going back to actual charges. If you just were doing a follow-up visit and then your basic follow-up visit was \$50, are you telling me Medicare is only going to be paying 80 percent of the \$50 and not your old PPS rate?

Corinne Axelrod: Well, if \$50 is your charge and that is, obviously, less than the PPS rate, then, according to the statute, you would be paid 80 percent of your charge. So, yes.

Ed Michael OK. Thanks.

Corinne Axelrod: Welcome.

Operator: Your next question comes from a participant whose information we were unable to gather. Please state your first and last name before asking your question. Your line is open. Participant, please state your first and last name before asking your question. Your line is open.

John Rigg: Operator, this is John Rigg from HRSA. How many more questions do we have in the queue? I see we're running a little low on time. In fact, I think we're – I think we're over time. But if there are still a lot of questions in queue, we can go on for a couple more minutes.

Operator: We currently have three questions in the queue.

John Rigg: OK. Let's take care of the last three questions if the inquirers are still available. And, after that, we'll do a quick wrap up. Thank you.

Operator: Certainly. Your next question comes from the line of Chris Koppen from Avancer Health Policy.

Chris Koppen: Thanks. I – the charge question I think has been answered. The one question I had a follow up to that was how are you all envisioning the max operationalizing that or the FQHC is going to have to send in their list charges in order to make that payment determination or do you have some other mechanism? How do you envision that working?

Marc Hartstein: So the FQHC when it submits its claim, that will be the actual charge. There will also be the fee schedule amount. Medicare will end up paying 80 percent of the lesser of the actual charge or the PPS² amount, so it will be handled through claims processing.

² - Changed from "fee schedule"

Corinne Axelrod: Also, we will be providing additional information after the rule is finalized. So we hope that the transition will go as smoothly as possible, so we're going to give you as much information as we can on that.

Chris Koppen: Thank you.

Corinne Axelrod: Thank you.

Operator: Your next question comes from the line of Jane Spire. Your line is open.

Jane Spire: Hi. I had an additional question. I'm calling from OCHIN. If, in fact, the rule does hold where you're not paying a multiple visit for mental health visit along with a medical visit, I'm wondering if it's possible to stop having the reporting of the 900 revenue code for mental health visits because the limitation on outpatient mental health payment will be removed in 2014. If there's no additional payment for mental health visit, it certainly would be simpler from a claims perspective to just use one revenue code.

Esther Markowitz: Hi. We appreciate the comment. We're still working out how the claims processing would work under the various scenarios which we are proposing. I can't give you additional information at this time. But please feel free to submit this as a comment to the rule and it's something that we could consider.

Jane Spire: Right. Thank you.

John Rigg: All right, operator, I believe this is our final question.

Operator: Certainly. Your last question comes from the line of Michael Holmes from Cook Area Health Services. Your line is open.

Michael Holmes: Hi. My question is in regards to the lesser of actual charge or cost. In looking at the visit coding that goes in where you might generate a daily charge at less than the PPS rate, it seems that this serves as an intensity adjustment because those codes are actually lower-level value visits and whether or not there was some consideration given to an average charge, let's say, as determined on a cost-report basis.

Corinne Axelrod: I guess I'm not totally following your question and we don't provide any direction, as I mentioned earlier, regarding charges. But are you referring instead to sort of a retrospective look at FQHC charges?

Michael Holmes: Whatever – right. Whatever it's looking at is whether or not we – there would be some way of using instead of the actual daily charge, an average charge for an FQHC over the course of a period since the PPS rate was determined based on an average cost without GAFs and (strains).

Corinne Axelrod: No. I don't think we have any information on a FQHC's charge structure beyond what's on the claims and cost report³. So I don't believe that that would actually...

Marc Hartstein: Yes. This is Marc Hartstein. I'm the director of the Hospital and Ambulatory Policy Group. I think this is maybe also a question about what the statute requires.

As Corinne said at the outset, we were charged by the statute to establish a PPS system budget neutral to FQHC costs without the per-visit reasonable cost limitation applied and then pay FQHCs at 80 percent of the lesser of the PPS amount or the charge.

But you can raise that as a comment and we can consider it further as to whether that's something that we have the authority to do. I think what you're saying is that charge in an individual case represents a measure of intensity and the charges will be more or less and given a particular circumstance and that since we're basing it on average cost and some historical period, we should also base from charges from which the 80 percent is determined.

Michael Holmes: Yes.

Marc Hartstein: Why don't you submit that as a public comment? It's something we can consider to the extent that we have the authority to do so.

Michael Holmes: Thank you.

³ Note that cost report data were used to calculate the average cost per visit, and the corresponding charge data from FQHC claims were used to calculate the base rate and adjustments.

John Rigg: OK. Well, this is John Rigg at HRSA. I know you've heard a lot of good information from our colleagues from CMS today. And we do appreciate the time that all of you have spent in joining us today on our special open door forum.

I do want to emphasize that the comment period is still open and will be open until November 18th at 5 pm. Comments can be submitted on regulations.gov where you can search for the federally-qualified health center perspective payment system and it should pull it up. Other instructions were also available on regulations.gov.

As Corinne and others have said online, the comment period is open. And, however, even if you commented in the course of this phone call today I believe that CMS will still need you to submit your comments in writing through the regulation.gov Web site or through the other instructions available on the – on the proposed rule.

Operator, I would ask if you could – if you could provide some instructions about how this call can be listened to in recorded mode. I know that we also have that available on the CMS Web site. Is that something you're able to do?

Operator: Certainly, yes. This call will be available for replay. You can dial 1-800-642-1687 and you will need the conference ID number, 91779151. Again, the dial-in number was 1-800-642-1687 and that dial-in number was 91779151.

John Rigg: Thank you, operator. And again, this is John Rigg from HRSA. I am the chairperson of the low-income health access open door forum. I'm always open to suggestions for future open door forum or special open door contacts or topics. You can send those suggestions to me directly at jrigg – J-R-I-G-G at HRSA – H-R-S-A dot gov – G-O-V.

In addition, if you have any further questions regarding the content presented on today's special low-income access open door forum, please send your e-mails with the question to Jill Darling at J-I-L-L – J-I-L-L dot Darling – D-A-R-L-I-N-G at CMS dot HHS dot Gov. And I think that that concludes today's call.

Operator: This concludes today's conference call. You may now disconnect.

END