CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 794

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 29, 2005

Change Request 3886

***NOTE**: Transmittal 794, dated December 29, 2005, and sent to you via RO 3831 is being **corrected**, not **rescinded**. We inadvertently attached an incorrect Transmittal Sheet to this instruction. The **effective date**, not the implementation date, was changed to January 01, 2006. We have also corrected the new manual subsection which is Section 110.3, entitled "Billing for Supplemental Payments for FQHCS Under Contract with Medicare Advantage (MA) Plans." All other information in the Instruction remains the same. We apologize for the confusion.*

SUBJECT: Announcement of Medicare Supplemental Payments to Federally Qualified Health Centers (FQHCs) Under Contract with Medicare Advantage (MA) Plans

I. SUMMARY OF CHANGES: This instruction provides basic instructions for calculating the supplemental payments to FQHCs under contract with Medicare Advantage (MA) Plans.

NEW/REVISED MATERIAL
EFFECTIVE DATE: January 01, 2006
IMPLEMENTATION DATE: April 03, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	9/Table of Contents
N	9/110/110.3/Billing for Supplemental Payments for FQHCs Under Contract with Medicare Advantage (MA) Plans

III. FUNDING:

Funding for Medicare contractors is available through the regular budget process for costs required for implementation.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-04	Transmittal: 794	Date: December 29, 2005	Change Request 3886

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SUBJECT: Announcement of the Medicare Supplemental Payments to Federally Qualified Health Centers (FQHCs) Under Contract with Medicare Advantage (MA) Plans

I. GENERAL INFORMATION

A. Background:

This One Time Notification provides basic instructions on calculating and billing for the supplemental payments for FQHCs under contract with MA Plans.

Title II of the Medicare Modernization Act (MMA) established the MA program. The MA program replaces the Medicare + Choice (M+C) program established under Part C of the Act. Although the MA program retains many key features of the M+C program, it includes several new features, such as the introduction of regional MA plans that will be organized as preferred provider organizations.

Effective for services furnished on or after January 01, 2006, or contract years beginning on or after such date, Section 237 of the MMA requires CMS to provide supplemental payments to FQHCs that contract with MA organizations to cover the difference, if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive under the cost-based all-inclusive payment rate as set forth in 42 CFR, part 405, subpart X.

This new supplemental payment for covered FQHC services furnished to MA enrollees augments the direct payments made by the MA organization to FQHCs for all covered FQHC services. The Medicare all-inclusive payment, which continues to be made for all covered FQHC services furnished to Medicare beneficiaries participating in the original Medicare program, is based on the FQHC's unique cost-per-visit as calculated by the Medicare Fiscal Intermediary (FI) based on the Medicare cost report. FQHC's seeking payment under Section 237 of the MMA must submit to their FI copies of their contracts under each MA plan.

In order to implement this new supplemental payment provision, CMS must determine if the Medicare cost-based payments that the FQHC would be entitled to exceed the amount of payments received by the FQHC from the MA organization and, if so, pay the difference to the FQHC at least quarterly. In

determining the supplemental payment, the statute also excludes in the calculation of the supplemental payments any financial incentives provided to FQHCs under their MA arrangements, such as risk pool payments, bonuses, or withholds.

B. Policy:

Presented below are the basic instructions for calculating the supplemental payments for FQHCs under contract with MA Plans.

The FQHC supplemental payment shall be based on a per visit calculation subject to an annual reconciliation. The supplemental payments, as required by the MMA, for FQHC covered services rendered to beneficiaries enrolled in MA plans will be calculated by determining the difference between 100 percent of the FQHC's all-inclusive cost-based per visit rate and the average per visit rate received by the FQHC from the MA organization for payment under that MA plan, less the amount the FQHC may charge to MA enrollees permitted under Federal law(i.e., any beneficiary cost sharing allowed under the MA enrollee's plan.) Calculation excludes any financial incentives provided to FQHC's under their MA arrangements.

Each eligible FQHC seeking the supplemental payment is required to submit (for the first two rate years) to the FI an estimate of the average MA payments (on a per visit basis) for covered FQHC services for each MA plan with which they contract. Every eligible FQHC seeking the supplemental payment is required to submit a documented estimate of their average per visit payment for their MA enrollees for each MA plan they contracted with and any other information as may be required to enable the FI to accurately establish an interim supplemental payment. Expected payments from the MA organization would only be used until actual MA revenue and visits collected on the FQHC's cost report can be used to establish the amount of the supplemental payment.

Effective January 01, 2006, eligible FQHCs will report actual MA revenue and visits on their cost reports. At the end of each cost reporting period the FI shall use actual MA revenue and visit data along with the FQHC's final all-inclusive payment rate, to determine the FQHC's final actual supplemental per visit payment. This amount (per visit basis) will serve as an interim rate for the subsequent rate year for that MA plan. Actual aggregated supplemental payments will then be reconciled with aggregated interim supplemental payments, and any underpayment or overpayment thereon will then be accounted for in determining final Medicare FQHC program liability at cost settlement.

An FQHC is only eligible to receive this supplemental payment when FQHC services are provided during a face-to-face encounter between an MA enrollee and one or more of the following FQHC covered core practitioners: physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, or clinical social workers. The supplemental payment is made directly to each qualified FQHC through the FI. Each FQHC seeking the supplemental payment is responsible for submitting a claim for each qualifying visit to the FI on type of bill (TOB) 73x with revenue code 0519 for the amount of the interim supplemental payment. Healthcare Common Procedure Coding System (HCPCS) coding is not required.

Until appropriate system changes are made, FQHCs should hold all claims for the new supplemental payment. The necessary systems changes are expected to be installed by April 03, 2006.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3886.1	CWF shall bypass all previously existing HMO edits if TOB 73x is submitted with revenue code 0519 and the beneficiary is in an MA plan (option codes A, B, or C).								X	
3886.2	FIs shall calculate an interim per visit supplemental payment rate and provide these payments to FQHC’s on a per claim basis.	X								FQHC’s under contract with MA plans.
3886.2.1	FIs shall calculate an interim supplemental payment rate for each MA plan the FQHC has contracted with following business requirements 3886.2.1.1 & 3886.2.1.2.	X								
3886.2.1.1	For services of plan years beginning on or after January 01, 2006 and before an interim supplemental payment rate can be determined by the FI based on cost report data: 100% of the FQHC’s all-inclusive rate minus the sum of the estimated average MA plan payments to the FQHC plus any beneficiary cost sharing. Note: Calculation excludes any financial incentives provided to FQHC’s under their MA arrangements.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3886.2.1.1.1	FISS shall make the necessary changes to house, by plan year, the above mentioned supplemental payment rates for each FQHC per MA plan they contract with. This shall be housed in the provider file for each FQHC.					X				
3886.2.1.2	Once an interim rate is established for a previous plan year based on cost report data, use that interim rate until the FI receives information that changes in service patterns will result in a different interim rate. (This interim rate must reflect any beneficiary cost sharing.)	X								
3886.2.1.2.1	FISS shall make the necessary changes to house, by plan year, the interim supplemental payment rate for each FQHC MA plan they contracted with. This shall be housed in the provider file for each FQHC.					X				
3886.2.1.3	FISS shall make the necessary programming changes to prevent issuance of any negative payments on individual claims.					X				
3886.2.1.3.1	Do not generate a negative payment for an individual claim, if an individual claim has a negative balance, do nothing, for that claim until you can reconcile at cost settlement.	X								
3886.2.2	Do not apply the Medicare deductible in calculating the FQHC interim supplemental payment rate.	X								
3886.2.3	Do not apply the original Medicare co-insurance (20%) to the FQHC all inclusive rate when calculating the FQHC interim supplemental payment rate. Any beneficiary cost sharing under the MA plan is included in the calculation of the FQHC interim	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	supplemental payment rate as specified above in BRs 3886.2.1.1 & 3886.2.1.2.									
3886.2.4	FIs shall submit all claims on TOB 73x with revenue code 0519 to CWF for approval. CWF will verify each beneficiary's enrollment in an MA plan for the line item date of service (LIDOS) on the claim.	X							X	
3886.2.4.1	CWF shall reject all claims for the FQHC interim supplemental payment (TOB 73x with revenue code 0519) for beneficiaries who are not MA enrollees (option codes 1 or 2) on the same date as the LIDOS on the claim. FIs shall RTP such claims to the FQHCs.	X							X	
3886.2.5	CWF shall reject and FIs shall not make payments to any FQHC for the interim supplemental payment (revenue code 0519) and the all-inclusive rate (revenue code 0520 or 0900) for claims with the same LIDOS for the same beneficiary.	X							X	
3886.2.6	FIs shall suppress MSNs for all interim supplemental payment claims (TOB 73X with revenue code 0519). (Beneficiary is never liable for any part of the supplemental payment amount owed the FQHC.)	X								
3886.2.6.1	FISS shall make the necessary program changes to suppress MSNs for all interim supplemental payment claims (TOB 73x with revenue code 0519) so they do not print.					X				
3886.2.7	FIs shall accept TOB 73x with revenue code 0519 and pay the interim supplemental payment rate for each supplemental payment billed for a qualified visit i.e., billable FQHC services.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3886.2.7.1	FISS shall only make this supplemental payment to FQHCs when billed on TOB 73x with revenue code 0519. Revenue codes 0520 and/or 0900 shall not be on the same claim as revenue code 0519. See cross reference in IV. A.					X				
3886.3	FI shall, at cost settlement, determine the FQHC's final supplemental payment.	X								FQHC's under contract with MA plans.

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3886.4	"A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established ""medlearn matters"" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In additions, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	billing and administering the Medicare program correctly."									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3886.1.7.1	Reason code 32956 requires at least one occurrence of revenue code 0520 or 0900 be on the claim. This edit must be revised to require at least one occurrence of 0519, 0520 or 0900 be on the claim. Revenue code 0519 must be accepted when it is the only revenue code on TOB 73x, but only on claims for the FQHC supplemental payment.
3886.1.1.2.1.	FISS must allow 10 iterations of the supplemental rate for each FQHC.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 01, 2006 **Implementation Date:** April 03, 2006 **Pre-Implementation Contact(s):** Roechel Kujawa 410-786-9111 roechel.kujawa@cms.hhs.gov (policy), Gertrude Saunders 410-786-5888 gertrude.saunders@cms.hhs.gov (FI claims processing) **Post-Implementation Contact(s):** David Worgo 410-786-5919 david.worgo@cms.hhs.gov (policy) Gertrude Saunders 410-786-5888 gertrude.saunders@cms.hhs.gov (FI claims processing)	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

110.3 – Billing for Supplemental Payments to FQHCs Under Contract with Medicare Advantage (MA) Plans

(Rev. 794, Issued: 12-29-05; Effective: 01-01-06; Implementation: 04-03-06)

This section provides basic instructions on calculating and billing for the supplemental payments to FQHCs under contract with MA Plans.

Title II of the Medicare Modernization Act (MMA) established the MA program. The MA program replaces the Medicare + Choice (M+C) program established under Part C of the Act. Effective for services furnished on or after January 1, 2006, during contract years beginning on or after such date, Section 237 of the MMA requires CMS to provide supplemental payments to FQHCs that contract with MA organizations to cover the difference, if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive under the cost-based all-inclusive payment rate as set forth in 42 CFR, Part 405, Subpart X.

This new supplemental payment for covered FQHC services furnished to MA enrollees augments the direct payments made by the MA organization to FQHCs for all covered FQHC services. The Medicare all-inclusive payment, which continues to be made for all covered FQHC services furnished to Medicare beneficiaries participating in the original Medicare program, is based on the FQHC's unique cost-per-visit as calculated by the Medicare Fiscal Intermediary (FI) based on the Medicare cost report. FQHC's seeking payment under Section 237 of the MMA must submit to their FI copies of their contracts under each MA plan.

In order to implement this new supplemental payment provision, the FI must determine if the Medicare cost-based payments that the FQHC would be entitled to exceed the amount of payments received by the FQHC from the MA organization and, if so, pay the difference to the FQHC at least quarterly. In determining the supplemental payment, the statute also excludes in the calculation of the supplemental payments any financial incentives provided to FQHCs under their MA arrangements, such as risk pool payments, bonuses, or withholds.

The FQHC supplemental payment shall be based on a per visit calculation subject to an annual reconciliation. The supplemental payments, as required by the MMA, for FQHC covered services rendered to beneficiaries enrolled in MA plans will be calculated by determining the difference between 100 percent of the FQHC's all-inclusive cost-based per visit rate and the average per visit rate received by the FQHC from the MA organization for payment under that MA plan, less the amount the FQHC may charge to MA enrollees permitted under Federal law i.e., any beneficiary cost sharing allowed under the MA enrollee's plan.

Each eligible FQHC seeking the supplemental payment is required to submit (for the first two rate years) to the FI an estimate of the average MA payments (per visit basis) for

covered FQHC services. Every eligible FQHC seeking the supplemental payment is required to submit a documented estimate of their average per visit payment for their MA enrollees, for each MA plan they contract with, and any other information as may be required to enable the FI to accurately establish an interim supplemental payment. Expected payments from the MA organization would only be used until actual MA revenue and visits collected on the FQHC's cost report can be used to establish the amount of the supplemental payment.

Effective January 1, 2006, eligible FQHCs will report actual MA revenue and visits on their cost reports. At the end of each cost reporting period the FI shall use actual MA revenue and visit data along with the FQHC's final all-inclusive payment rate, to determine the FQHC's final actual supplemental per visit payment. Once this amount (per visit basis) is determined it will serve as the interim rate for the next full rate year. Actual aggregated supplemental payments will then be reconciled with aggregated interim supplemental payments, and any underpayment or overpayment thereon will then be accounted for in determining final Medicare FQHC program liability at cost settlement.

An FQHC is only eligible to receive this supplemental payment when FQHC services are provided during a face-to-face encounter between an MA enrollee and one or more of the following FQHC covered core practitioners: physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, or clinical social workers. The supplemental payment is made directly to each qualified FQHC through the FI. Each FQHC seeking the supplemental payment is responsible for submitting a claim for each qualifying visit to the FI on type of bill (TOB) 73x with revenue code 0519 for the amount of the interim supplemental payment rate (FQHC interim all-inclusive rate – estimated average payment from the MA plan plus any beneficiary cost sharing = billed amount > 0). Do not submit revenue codes 0520 and/or 0900 on the same claim as revenue code 0519. Healthcare Common Procedure Coding System (*HCPCS) coding is not required.*

For services of plan years beginning on and after January 1, 2006 and before an interim supplemental rate can be determined by the FI based on cost report data, FIs shall calculate an interim supplemental payment for each MA plan the FQHC has contracted with using the documented estimate provided by the FQHC of their average MA payment (per visit basis) under each MA plan they contract with. Once an interim supplemental rate is determined for a previous plan year based on cost report data, use that interim rate until the FI receives information that changes in service patterns that will result in a different interim rate. FIs shall calculate an interim supplemental payment rate for each MA plan the FQHC has contracted with. Reconcile all interim payments at cost settlement.

Do not apply the Medicare deductible in calculating the FQHC interim supplemental payment. Do not apply the original Medicare co-insurance (20%) to the FQHC all inclusive rate when calculating the FQHC interim supplemental payment. Any beneficiary cost sharing under the MA plan is included in the calculation of the FQHC interim supplemental payment rate.

FIs shall submit all claims to CWF for approval. CWF will verify each beneficiary's enrollment in an MA plan for the line item date of service (LIDOS) on the claim. CWF shall reject all claims for the FQHC interim supplemental payment for beneficiaries who are not MA enrollees on the same date as the LIDOS on the claim. FIs shall RTP such claims to the FQHCs. FIs shall not make payments to an FQHC for the interim supplemental payment and the all-inclusive rate for claims with the same LIDOS for the same beneficiary. The beneficiary is never liable for any part of the supplemental payment amount owed the FQHC. FIs shall accept TOB 73x with revenue code 0519 and pay the interim supplemental payment rate for each qualified visit billed.

FIs shall at cost settlement determine the FQHC's final supplemental payment.