Basics of Federally Qualified Health Center (FQHC) Billing

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Introduction

About S4CH

Since 2007, Solutions 4 Community Health (S4CH) has focused on management solutions to meet the complex needs of our clients in response to the constant changing healthcare landscape. S4CH's expertise is in Strategic Consulting, Practice Transformation, Revenue Cycle Enhancement, Analytics, HEDIS and Risk Contracting Performance Improvements.

S4CH focuses its work primarily federally qualified health centers (FQHCs) and health care organizations that serve predominantly low-income, uninsured, and at risk populations.

S4CH Revenue Cycle Management

We optimize & maximize revenue, ensure accurate billing and coding, and streamline the financial processes within organizations. We utilize the use of automation to help optimize revenue cycle processes. We work hand in hand with our clients to ensure timely and efficient billing practices.

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CHCANYS Billing & Coding Webinar Series in Partnership with S4CH

1.	Basics of FQHC Billing	11/6/2024
2.	Mastering Medicaid Billing in FQHCs	12/4/2024
3.	Navigating Medicare Billing in FQHCs	1/8/2025
4.	Provider Coding and Documentation	2/5/2025
5.	Effective Claim Denial Management	3/5/2025

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Outline - Basics of FQHC Billing

- ✓ FQHC Overview
- ✓ Revenue Cycle Process
  - ✓ Common Medical Billing and Coding Terms
- ✓ Insurance Billing
  - ✓ Insurance Lines of Business
  - ✓ Key Aspects of Credentialing
  - ✓ Reimbursement Types in a FQHC
  - ✓ Threshold Visits
- ✓ Fee Schedules
  - ✓ Sliding Fee Discount Program
  - ✓ Patient Payment Collection
- ✓ Revenue Cycle Oversight
- ✓ Best Practices for Payer Management

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Federally Qualified Health Centers (FQHCs)

- Funded by Health Resources and Services Administration (HRSA) under the 330 grant
- FQHC Types
  - Community Health Centers
  - Healthcare for the Homeless
  - Look-Alike Health Centers
  - Public Housing Primary Care
  - School-Based Health Centers
  - Migrant Health Centers
- FQHC are required to identify their respective “in Scope” services to HRSA

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Scope of Project

- The health center's scope of project includes the health center's service sites, services, providers, service area, and target populations HRSA approves.
  - **Service Sites**
  - **Services**
  - **Providers**
  - **Service Area**
  - **Target Population**
- For more information: https://bphc.hrsa.gov/compliance/scope-project

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HRSA FQHC Billing & Collection Requirements

- The health center must prepare a **schedule of fees** for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation.
- The health center must assure that any **fees or payments required by the center for health care services will be reduced or waived** in order to assure that no patient will be denied such services due to an individual's inability to pay for such services.
- The health center must **establish systems for eligibility determination and for billing and collections** [with respect to third party payors].
- The health center must make every reasonable **effort to enter into contractual or other arrangements to collect reimbursement of its costs.**
- The health center must make and continue to make every reasonable **effort to collect appropriate reimbursement for its costs** on the basis of the full amount of fees and payments for health center services.
- The health center must make and continue to make every reasonable **effort to secure payment for services from patients**, in accordance with health center fee schedules and the corresponding schedule of discounts.

https://bphc.hrsa.gov/compliance/compliance-manual/chapter16

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Benefits of Being an FQHC

- FQHCs share a common mission of reducing health disparities by providing accessible, affordable care.
- Enhanced Reimbursement: Reimbursed full cost from Medicare and Medicaid through the Prospective Payment System (PPS).
- Supplemental Payments/Wrap Around for Medicare, Medicaid and CHP
- 340B drug pricing (Medicare and Commercial only)

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FQHCs in New York

- **Article 28 Facility,** is an accredited medical facility that provides a range of services, including medical, dental, and behavioral health.
  - Article 28 health centers are regulated by the New York State Department of Health (NYSDOH).
- Additional NYS licenses and services delivered at FQHCs
  - **Article 31 Facility**: Focus on behavioral health services regulated by the Office of Mental Health (OMH).
  - **Article 32 Facility (822)**: Specialize in substance use disorder services under the Office of Addiction Services and Supports (OASAS).
  - **Article 16 Facility:** Specialize in providing services for individuals with intellectual or developmental disabilities. Regulated by the Office for People with Developmental Disabilities (OPWDD)

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Poll Question

Does your organization have Article 31 and/or Article 32 facilities?

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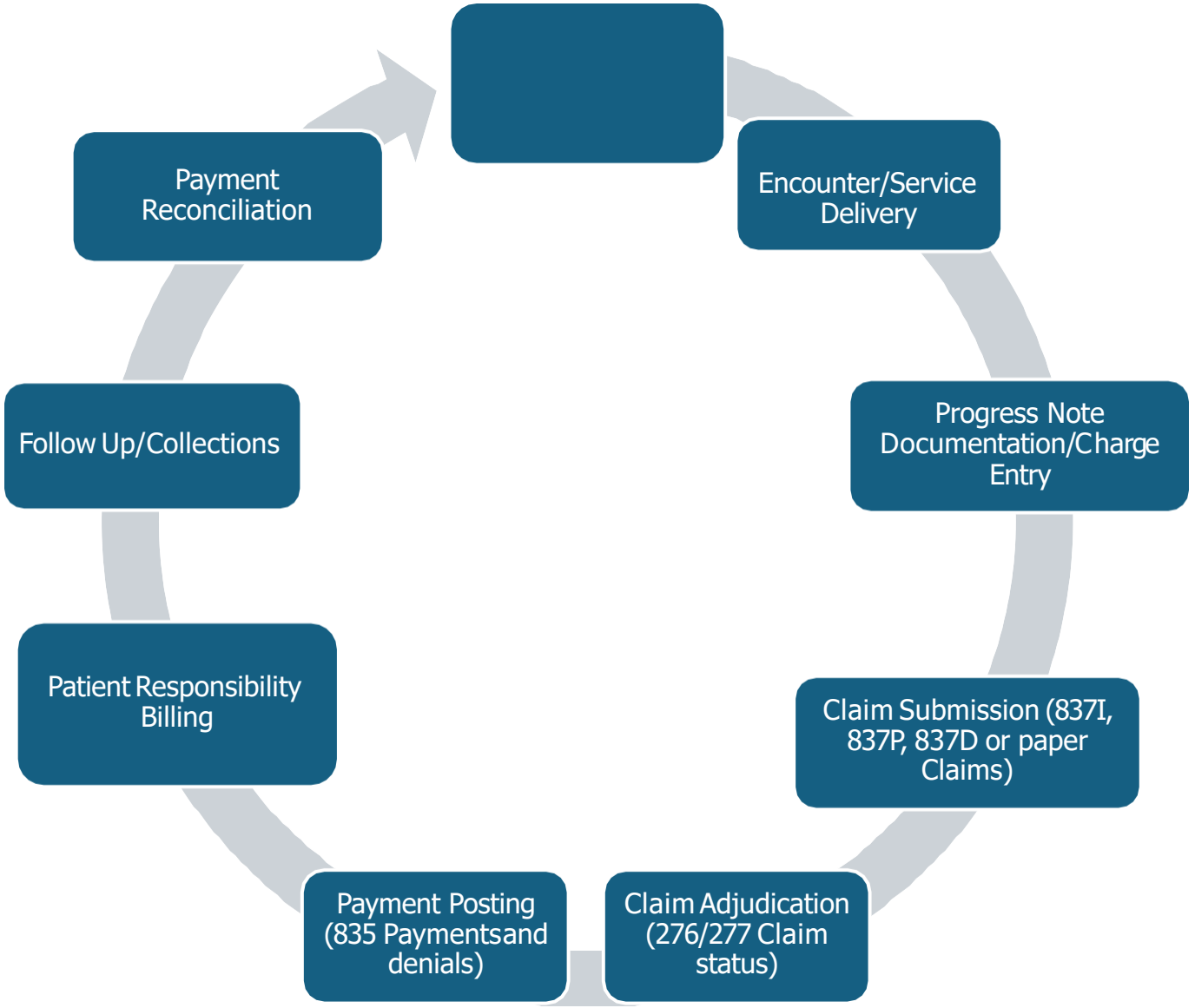
Revenue Cycle Process



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Common Medical Billing Terms

- **Health Insurance Portability and Accountability Act (HIPAA)-** Establishes national standards to protect individuals' medical records and other individually identifiable health information (collectively defined as "protected health information") and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.
- **Authorizations-** A decision by your health insurer or plan that a health care service is medically necessary. Sometimes called prior authorization, prior approval or precertification.
- **Clearinghouse-** Electronically transmits different types of medical claims data to insurance carriers.
- **National Provider Identifier (NPI)-** A unique 10 digit identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA.

- **Incident-To Billing-** Allows a Nonphysician Practitioner (NPP) to provide follow-up services under the direction of a supervising physician and bill under the doctor's national provider identifier (NPI) number, resulting in a greater Medicare reimbursement rate.

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Common Medical Billing Terms

- **Healthcare Effectiveness Data and Information Set (HEDIS)-** A widely used set of performance measures in the healthcare industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
- **Risk Adjustment-** a process that uses the health status of a person to calculate a risk score to predict healthcare costs. The risk score is a number that represents the predicted cost of treating a patient
- **Hierarchical Condition Categories (HCC)-** A list of diagnoses that have been assigned a value for risk adjustment.

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Common FQHC Coding Terms

- ICD-10
- CPT Code
  - 99201-99205, 99213-99215, 99381-99397, 90832-90837
- Category II CPT Codes
  - 3044F, 3046F, 3051F, 3052F
- CDT Code (Dental Codes)
- HCPCS
- Modifier
  - 25, 59, 95, GC, GE, UD
- Revenue Code
  - 0512 (Dental)
  - 0521 (Medical)
  - 0900 (Behavioral Health)
- Medicaid Rate Codes

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Poll Question

Does your organization have certified coders?

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Health Insurance Line of Business/Insurance Class

- Medicare
- Medicare Advantage
- Medicaid
- Medicaid Managed Care
- Child Health Plus (CHP)
- Commercial
- Essential Plans Tier 1-2
- Essential Plans Tier 3-4
- Qualified Health Plan (QHP)
- Dual Eligible Health Plans

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Key Aspects of Credentialing

- Council for Affordable Quality Healthcare (CAQH)
- National Plan and Provider Enumeration System (NPPES)
  - NPPES npi website -https://npiregistry.cms.hhs.gov/search
- Provider Enrollment, Chain, and Ownership System (PECOS)
- eMedNY
- Delegated Credentialing
- Group Contracting or Facility Based Agreement
- Individual Contracting
- Centralized Document Repository and Maintenance
- Recredentialing
- Clearinghouse Enrollment
- Correspondence Addresses
  - EOB, Payments, Denials

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Typical Reimbursement/Contract Types

- Fee for service (FFS)
- Capitation
- Ambulatory Patient Group (APG)
- Prospective Payment System (PPS)
- Supplemental Reimbursement-Wrap Around Payment

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Fee for Service (FFS)

- Reimbursed per procedure and/or service provided.
- Reimbursement is determined by payer provider contract.
- FFS claims are typically billed on a CMS 1500 form
  - The form can be found on the CMS website https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26pdf.pdf
- Common insurances reimbursing at FFS rates:
  - Commercial Insurance
  - Medicare Advantage Plans
  - Essential Plans

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Capitation Contracting

- The provider (typically Primary Care Provider (PCP) or Dentist only) receives a set fee for each enrolled patient, regardless of how often the patient receives care. The fee covers a range of services including preventative care, follow up office visits, diagnostic and treatment.
- Some services can be carved out depending on the contract between the provider and the Managed Care Organization (MCO). The carved-out service is paid FFS and not included in the capitation payment.
- Payments are typically made on a per member per month basis. The provider gets the same capitation payment amount for each month the patient is enrolled on the payer roster. (Payments are not claim based)

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Ambulatory Patient Groups (APG)

- APG is a Medicaid reimbursement classification system utilized for the reimbursement of a facility's cost of outpatient care.
- The Medicaid APG reimbursement methodology classifies and assigns any procedure code submitted for reimbursement. The reimbursement under APG is driven by this classification methodology. Patient diagnosis, symptoms and acuity, are also factors in the reimbursement.
- Main APG Classifications:
  - Significant Procedure
  - Medical Visit
  - Ancillary Procedure
- FQHCs have the option of opting in or out of APG to enroll in the Prospective Payment System (PPS).

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Prospective Payment System (PPS)

- Reimbursement based on revenue or rate codes billed on claims.
- Full PPS payment for threshold visits.
- FQHCs receive a fixed per-visit rate for services provided.
- One PPS payment is made per service date with the following exceptions:
  - *Medicaid*-A behavioral health visit and a medical visit on the same day qualifies for two separate PPS payments as long as two different rate codes are billed.

    *Example-one service in A28 on the same day as A31 or A32.
  - *Medicare*- A behavioral health visit and a medical visit on the same day qualifies for two PPS payment because claims are billed with different revenue codes.

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Typical FQHC Threshold Visits

A FQHC threshold visit refers to a billable encounter where a patient receives comprehensive, face-to-face or telehealth services from a qualified healthcare provider within an FQHC.

Key Elements of a Threshold Visit:

- Face-to-Face Encounter ***or*** Telehealth Encounter.
- Qualifying Providers: The threshold visit must involve a qualified healthcare provider.
- Types of Services Covered: PCP, OB/GYN, Behavioral Health Services, Substance Abuse Services, Dental Services, Physical/Speech Therapy, Podiatry, Optometry, Nutrition.

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Eligible Threshold Provider Types

Article 28	Article 31	Article 32
• Physicians • Physician Assistants (PAs) • Nurse Practitioners (NPs) • Licensed Midwives (LMs) • Licensed Clinical Social Workers (LCSWs) • Licensed Master Social Workers (LMSWs) • Licensed Mental Health Counselors (LMHCs) • Licensed Marriage and Family Therapists (LMFTs) • Dentists/Dental Hygienists • ***excluding Medicare** • Psychologists • Optometrist/Opticians • Physical Therapists (PTs)/Occupational Therapists (OTs)/Speech-Language Pathologists (SLPs) • Podiatrists • Registered Dietitians	• Physicians • Physician Assistants (PAs) • Nurse Practitioners (NPs) • Licensed Clinical Social Workers (LCSWs) • Licensed Master Social Workers (LMSWs) • Licensed Mental Health Counselors (LMHCs) • Licensed Marriage and Family Therapists (LMFTs) • Licensed Clinical Art Therapist (LCAT)	• Physicians • Physician Assistants (PAs) • Nurse Practitioners (NPs) • Licensed Clinical Social Workers (LCSWs) • Licensed Master Social Workers (LMSWs) • Licensed Mental Health Counselors (LMHCs) • Licensed Marriage and Family Therapists (LMFTs) • Licensed Clinical Art Therapist (LCAT) • Credentialed Alcoholism and Substance Abuse Counselor (CASAC) ***excluding Medicare**

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Non-Qualifying Threshold Visits

FQHCs may not submit a threshold claim to NYS Medicaid for reimbursement when the only service rendered to the NYS Medicaid member was a stand alone low-level service.

Low-level services and supplies, include but not limited to:

- Blood draw for labs
- Collecting urine specimens
- Performing laboratory tests
- Taking X-rays
- Filling and dispensing prescriptions
- Giving injections/immunizations
- Tobacco cessation counseling
- Weight or blood pressure checks

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Supplemental FQHC Payments

Medicaid Managed Care

- Medicaid supplemental payments ensure FQHCs are fully reimbursed for their services. If the payments from Medicaid Managed Care plans are less than the PPS rate, Medicaid makes up the difference through supplemental or “wraparound” payments.
- FQHCs are reimbursed their full PPS rate when the Medicaid Managed Care plan does not pay the claim. These claims are submitted to Medicaid with a Court Ordered rate code.
- Medicaid Managed Care secondary eligible for wrap/4028 effective 1/1/2022.
- FQHCs must complete the Managed Care Visit and Revenue (MCVR) report annually.
- Essential Tier 3-4 also qualify for wrap around and court ordered rates.

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Supplemental FQHC Payments

Billing Scenario 1

Medicaid Managed Care pays claim at either contracted rate or under a capitation agreement. An additional claim is submitted to Medicaid with rate code to receive the Medicaid supplemental payment (rate code 1609). In this case scenario the supplemental payment and the MCD Managed Care payment combined should make payment amount whole up to the Medicaid PPS rate.

Billing Scenario 2

Medicaid Managed Care denies claim with no payment. The additional supplemental wrap claim is billed to Medicaid with the court ordered rate code (4028). Medicaid pays the court ordered claim at the full PPS rate.

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Supplemental FQHC Payments cont.

Medicare Advantage

- Like Medicaid Managed Care plans, Medicare pays for supplemental payments when the patient has a Medicare Advantage primary insurance. This is to ensure that payments made to the FQHC are close to if not equal to the Medicare PPS rate.
- FQHCs are required to submit application to Medicare to bill for supplemental payments. These payments are paid at the claim level.

Billing Scenario

Medicare Advantage claim is billed. An additional claim is billed to Medicare. The claim submitted to Medicare is paid at the negotiated contracted Medicare supplemental payment regardless if payment was made on the Medicare Advantage claim.

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Supplemental FQHC Payments cont.

Child Health Plus

- Supplemental payments paid by Department of Health (DOH).
- Health Centers required to submit the Child Health Visit and Revenue (CVR) to receive payment. Payment is not paid at the claim level.

Billing Scenario

A claim is billed to Child Health Plus (CHP). The health center completes a CVR report (typically monthly or quarterly) and sends to Department of Health (DOH). DOH sends a check to health centers. These payments are not paid at the claim level.

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Medicaid PPS and Wrap per Article

Article 28	Article 31	Article 32
PPS	PPS	PPS
Wrap around	NYS requires Medicaid HMOs to reimburse A31 and A32 services at the PPS rate. However, NYS has not loaded any wraparound rates for A31 and A32 services. If you do not receive your PPS payment from the Medicaid HMO, your only current recourse is to argue the matter directly with the Medicaid HMO. There are ongoing discussions with NYS to remedy this problem.	NYS requires Medicaid HMOs to reimburse A31 and A32 services at the PPS rate. However, NYS has not loaded any wraparound rates for A31 and A32 services. If you do not receive your PPS payment from the Medicaid HMO, your only current recourse is to argue the matter directly with the Medicaid HMO. There are ongoing discussions with NYS to remedy this problem.
Court Ordered Rates	Court Ordered Rates	Court Ordered Rates

Poll Question

Do you have a centralized location for all of your insurance contracts?

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Fee Schedule Development

Per HRSA requirements, FQHCs are responsible for creating and maintaining a fee schedule for all services provided in the health centers. The fees should be consistent with local prevailing rates and designed to cover the cost of operation.

https://bphc.hrsa.gov/compliance/compliance-manual/chapter16

- **Useful resources to use to develop fee schedules**
  - Research RVU, Medicare and MCD rates
  - Gather costs for supplies (IUD, Vaccine, injections etc)

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Sliding Fee Discount Program

- Health centers must operate in a way that ensures no patient is denied service because they are unable to pay.
- The health center must offer a sliding fee discount schedule that applies discounts based on the patient's ability to pay.
- In addition, the health center must set up systems to determine eligibility for sliding fee discount
- The health center's schedule of discounts is based on the patient's level within the federal poverty guidelines.
- The sliding fee discount applies to all patients, not just uninsured patients. When determining fees to collect from insured patients with copays or deductibles the patient is charged the lesser of the two.

https://bphc.hrsa.gov/compliance/compliance-manual/chapter9

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Sliding Fee Discount Program cont.

- The health center determines how to document income and family size in health center records.
- The health center determines how and with what frequency to re-assess patient eligibility for the SFDS
- Patient declines/refusal to provide income
  - The health center determines whether to identify individuals who refuse to provide information on income and family size as ineligible for SFDS
- Examples of Proof of Income Documents:
  - Recent Pay Stub
  - W-2 form
  - Disability paperwork
  - Unemployment paperwork

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Patient Payment Collection

1. Pre-Visit:

- Verify insurance and/or determine eligibility for the sliding fee program.
- Inform the patient of their expected financial responsibility.

2. At Check-In:

- Collect copayments or initial sliding fee payments.
- Provide information on payment plans if needed.

3. During the Visit:

- Document any additional services (labs, procedures) that may incur charges.

4. At Check-Out:

- Collect any remaining balance based any additional services performed and documented.

5. Post-Visit:

- Submit insurance claims and follow up on unpaid balances.
- Send regular billing statements

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Oversight of Revenue Cycle Team

- Compliance as per Office of Inspector General (OIG)
- Insurance Aging
- Denial Management
- Payment/Deposit Reconciliation
- Monitoring Data Capture, Registration Errors, Provider Coding etc.
- Billing Staff Productivity
- Use of Analytic Tools

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Best Practices for Payer Management

- Build strong relationship with payer.
- Enable access to payer portals
- Audit payments and compare to contracted rates.
- Review Contracts regularly. Be aware of increased MCR or MCD rates if contracts are based on MCR or MCD rates. Make sure that your managed care contracted rates are updated in your contract.
- Trend denials for specific payers
  - -Payer system edits causing incorrect denials
  - -Understand Claim Adjustment Segments (CAS) codes and Remark codes
- Regularly reconcile credentialing records
- Audit attribution and capitation rosters

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Thank You

Questions

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