

Medicare Technical Assistance

ISSUE BRIEF #85

**UPDATE:
THE MEDICARE ADVANTAGE “WRAP AROUND” PAYMENT FOR
FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)**

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Background

Original Medicare pays federally qualified health centers (“FQHCs”) an all-inclusive per visit payment amount based on 80 percent of reasonable costs as determined through the filing of a Medicare cost report, subject to the Medicare per visit cap or upper payment limits (“UPL”).¹ Section 237 of the Medicare Prescription Drug Improvement and Modernization Act (“MMA”) amended the Social Security Act (“SSA”), providing for supplemental “wrap-around” payments to FQHCs that contract with Medicare Advantage (“MA”) plans. SSA § 1833(a)(3), 42 U.S.C. § 1395l(a)(3). For individuals enrolled in an MA plan, the wrap-around payment increases Medicare reimbursement for FQHCs from 80 percent to 100 percent of reasonable costs (less patient cost-sharing amounts).

Earlier this year, NACHC published an issue brief entitled “Medicare Advantage: Considerations for Contracting with Health Plans”. That Issue Brief described the substantive *contractual* requirements that FQHCs must have in place in order to seek wrap-around payments from Medicare. To review, the MMA establishes three contractual requirements for FQHC wrap-around payments:

- 1) **A written contract.** FQHCs must have a written contract with the MA plan to provide services to Medicare beneficiaries enrolled in the plan.
- 2) **Comparable payment terms.** Under the written contract, the MA plan must pay FQHCs no less than the amount it pays to non-FQHC providers.
- 3) **Payment in full.** Under the written contract, the FQHC must accept the MA payment amount and wrap-around payment “as payment in full for services covered by the agreement” (except for cost-sharing amounts permitted under the terms of the written contract).

Since publication of the earlier Issue Brief, the Centers for Medicare and Medicaid Services (“CMS”) issued a regulation (or rule) on the wrap-around payments. The rule describes how CMS will calculate wrap-around payments and the process that FQHCs should follow to obtain wrap-around payments. 70 Fed. Reg. 70116 (Nov. 21, 2005), appearing at 42 C.F.R. § 405. 2469.

NACHC is publishing this Issue Brief to explain the key components of the new wrap-around payment rule. The Issue Brief describes in detail how Medicare will calculate, process, and issue wrap-around payments. In addition, the Issue Brief identifies strategies and opportunities for FQHCs to maximize potential revenue under the new wrap-around payment rule.

¹ In CY 2005, the UPL is \$109.88 for urban centers and \$94.48 for rural centers.

Key Components of Wrap-Around Payment Rule

This section reviews the key components of the new payment rule and guidance that CMS published in its preamble to the rule.

1) What if the FQHC does not contract *directly* with an MA organization?

- Under the new regulation, wrap-around payments will be made regardless of whether an FQHC has a direct contract with an MA organization or whether it contracts with another entity that has a direct contract with an MA organization. 42 C.F.R. § 405.2469.
 - Example: In the preamble to the new rule, CMS uses an example of an FQHC that contracts with a medical group that, in turn, contracts with an MA organization.
 - Implication: In certain geographic markets, MA plans contract with Independent Practice Associations (IPAs) rather than with individual providers. In these markets, FQHCs that contract with such IPAs *will* be eligible for the wrap-around payments for the services they provide to the enrollees of the MA plan with which the IPA has contracted.

2) How will the FQHC demonstrate to CMS that the MA contract contains comparable payment terms to non-FQHC providers?

- In the preamble to the rule, CMS indicates that it will examine contracts and attendant fee schedules between MA organizations and FQHCs as well as between MA organizations and other providers to ensure that payment levels for FQHCs are comparable to other providers furnishing similar services.
 - Implication: CMS has imposed the burden on itself to ensure that payment levels are comparable to other providers.

3) Will CMS make a wrap-around payment for services provided to enrollees of any type of MA plan (e.g., HMO, PPO, and PFFS²)?

- Yes, CMS clarifies that wrap-around payments are available to FQHCs that contract with any type of MA organization, including Preferred Provider Organizations (“PPOs”).

² A Private Fee-for-Service (PFFS) plan is a type of MA plan that pays providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk and does not restrict the enrollees’ choice of provider so long as the provider agrees to accept the plan’s terms and conditions of payment.

- Example: Contracted Provider: If an FQHC has a written contract with an HMO, PPO or PFFS plan (either directly or indirectly through an IPA), the FQHC may bill Medicare for the wrap-around payment.

4) Is the FQHC entitled to a wrap-around payment if it does not have a written contract with a MA plan (i.e., the FQHC is a non-contracted provider)?

- No. CMS takes the position that when a FQHC does not have a contract with an MA plan, it is a *non-contracted provider* and is therefore *not* entitled to wrap-around payment from CMS.
- CMS payment rules require MA plans to pay non-contract providers whatever the provider would have received under original Medicare, which, for FQHCs, means 80 percent of reasonable costs, subject to the per visit payment cap (less beneficiary cost-sharing). 42 C.F.R. § 422.214.
 - Example: Non-Contracted Provider: If the FQHC does not have a contract with the MA plan (either directly or indirectly through an IPA), the FQHC must accept, as payment in full, the amounts the provider could collect if the beneficiary was enrolled in original Medicare, which is 80 percent of reasonable costs, subject to the per visit payment cap (less beneficiary cost-sharing amounts).

To obtain payment, a FQHC should submit a claim to the MA plan at the time of service for an amount equal to 80% of its all-inclusive rate (subject to the per-visit payment cap) established for that program year. Arguably, if an FQHC's final all-inclusive rate (determined after reconciliation of its actual costs) is higher than the rate paid by the MA plan, then a FQHC could have an additional claim for reimbursement from the MA plan. Similarly, the FQHC could theoretically owe the MA plan money in the event that the rate paid by the MA plan was lower than the FQHC's final per-visit rate. [Note: Should a MA plan refuse to reimburse the FQHC payment equal to 80% of its all-inclusive rate as referenced above, the FQHC should contact its regional CMS office and/or NACHC staff.]

- Implication: As a non-contracted provider, FQHCs are entitled to only 80% of reasonable costs, subject to the per visit payment cap (less beneficiary cost-sharing amounts). However, because the per-visit payment cap restricts the total amount of payment received by an FQHC regardless of whether the FQHC is a contracted or non-contracted provider, the increase in payment from 80% to 100% of reasonable costs will only benefit health centers that currently operate below the payment cap. In other words:

- Non-contracted FQHCs operating at or *above* the payment cap will receive the same level of reimbursement (i.e., the payment cap) as they would as a contracted FQHC.
- Non-contracted FQHCs operating *below* the payment cap will receive 80% of reasonable costs, whereas contracted FQHCs operating below the payment cap will be eligible for wrap-around payments that increase payments to 100% of reasonable costs.

5) What services will CMS cover in its wrap-around payments to FQHCs?

- In the preamble to the rule, CMS states that wrap-around payments only cover services that meet the statutory definition of FQHC services.
 - FQHC Services: Medicare defines FQHC services as physician, physician assistant, nurse practitioner, clinical psychologist, and clinical social worker services, and services incident thereto, as well as preventive primary health services that FQHCs are required to provide under Section 330 of the Public Health Service Act (“PHSA”) (e.g., pneumococcal and influenza vaccines).³ SSA § 1861(aa)(3), 42 U.S.C. § 1395x(aa)(3).
 - Implication 1: CMS will base wrap-around payments on a health center’s costs for providing Medicare FQHC services. Medicare FQHCs services *do not* include certain Part B services such as laboratory and x-ray services and *do not* include pharmacy costs under Medicare’s new Part D prescription drug program. This position is consistent with how CMS currently pays for FQHCs services provided to beneficiaries under original Medicare.
 - Implication 2: Previously, FQHCs have billed Medicare Part B separately for non-FQHC services provided to Medicare beneficiaries. *This is not allowed for beneficiaries enrolled in MA plans.* FQHCs must obtain payment for all non-FQHC Part B services from the MA plan in which the beneficiary is enrolled. In short, if a FQHC agrees to provide services that do not qualify as FQHC services (e.g., laboratory services, dental services), the FQHC should negotiate to receive additional compensation for those services through a separate fee schedule or a separate contract with the MA plan.

³ Section 330 of the Public Health Service Act defines preventive health services as: prenatal and perinatal services; appropriate cancer screening; well-child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear and dental screenings to determine the need for vision and hearing correction and dental care; voluntary family planning services; and preventive dental services. 42 U.S.C. § 254b(b)(1)(A)(i)(III).

6) When will wrap-around payments be made to the FQHC?

- Under the new rule, Medicare will make a wrap-around payment when a face-to-face encounter for a covered service occurs between a Medicare Advantage enrollee and one of the following FQHC core practitioners:
 - physician
 - physician assistant
 - nurse practitioner
 - nurse-midwife visiting nurse
 - qualified clinical psychologist or
 - clinical social worker42 C.F.R. § 405.2463.

- In the preamble to the rule, CMS clarifies that all statutorily-defined Medicare FQHCs services are eligible for wrap-around payments regardless of whether these services alone would trigger a billable FQHC visit. CMS explained that the costs of services incidental to the professional services of a FQHC practitioner would be bundled into the calculation of the wrap-around payment.
 - This policy is the same as CMS's current reimbursement methodology for individuals not enrolled in a MA plan: the center's all-inclusive reasonable cost per visit rate is calculated based on the cost of all Medicare FQHC services, but actual per visit payment ("billable visit") is only triggered by a face-to-face encounter between the patient and one of the health center practitioners listed in the previous paragraph.

6a) When will CMS begin processing wrap-around claims?

- The Medicare fiscal intermediary recently announced that the necessary systems changes to process wrap-around payments are expected to be installed by April 3, 2006. FQHCs will then submit Medicare Advantage claims with a specific type of bill and revenue code that identifies the claims as Medicare Advantage. (Type of bill is 73x and revenue code is 0519.) Until appropriate system changes are made, FQHCs should hold all claims for the new supplemental payment. (See Appendix A)

7) What payment methodology will be used to determine initial Medicare wrap-around?

- In the preamble to the rule, CMS indicates that, for the first two rate years, each FQHC seeking wrap-around payment is required to submit to the Medicare fiscal intermediary (“FI”) an estimate of the average MA payment rate on a per-visit basis for covered FQHC services provided to MA enrollees.⁴
 - Implication: Although FQHCs will ultimately need to convert MA contracted payment amounts to a per-visit basis, CMS does not restrict the type of payment mechanism between the FQHC and MA plan. FQHCs may contract with MA plans under any kind of payment method, including a fee schedule, capitated payment arrangement, or per-visit payment amount.
 - Example: An FQHC contracts with two MA plans. In Plan A, the FQHC contracts on a FFS basis. In Plan B, the FQHC contracts on a capitated basis. The FQHC estimates a total of 250 encounters, with 200 encounters in Plan A and 50 encounters in Plan B. The average MA payment rate is weighted by the number of encounters for each plan. Here, the average MA payment rate is 80% of Plan A’s rate and 20% of Plan B’s rate. This rate is divided by the total number of encounters to obtain an interim per-visit MA rate. (The payment rates include cost-sharing amounts.)

1	2	3	4	5
Annual Total MA Plan Encounters	Annual Plan A FFS Estimated Payments (200)	Annual Plan B Estimated Capitation Payment (50)	Annual Average MA Payment (weighted)	Average MA Per-Visit Payment Rate (weighted)
250	\$7,000	\$4,250	\$6,450	\$25.80

- The FQHC must provide a documented estimate of its average per-visit payment for MA enrollees in *each* MA plan offered by the MA organization and any other information as may be required to enable the FI to accurately establish an interim supplemental payment. The FI will use these expected payments until actual MA revenue and visits collected on the FQHC’s cost report can be used to establish the amount of the wrap-around payment.
 - Practice Pointer: In preparing estimates of MA payments, a FQHC should exclude payment from MA plans for non-FQHC services (e.g., pharmacy, laboratory services) and for financial incentives (e.g., risk pool payments, bonuses, or withholds). If these amounts were included, they would offset the wrap-around payments that the FQHC is entitled to receive, thereby lowering total potential revenue.

⁴ For the wrap-around payment process established by the fiscal intermediary United Government Services, LLC (UGS), see Appendix A.

7a) What fiscal year will be used in calculating the per visit rate?

- CMS advises that FQHCs should base calculations on the FQHC cost report year. For the initial year, if the MA plan’s contract year and the FQHC’s fiscal year do not coincide, the FQHC wrap-around payment calculation should be based on a weighted average of MA payments based on the number of MA visits expected in each respective MA contract year. In subsequent cost report years, actual MA payments and visits will be used to calculate final FQHC supplemental payments as well as the interim supplemental payments for the following year.
 - Example: An FQHC contracts with two MA plans. In Plan A, the FQHC contracts on a FFS basis. In Plan B, the FQHC contracts on a capitated basis. The FQHC estimates a total of 250 encounters, with 200 (80%) in Plan A and 50 (20%) in Plan B. Here, the average interim MA payment rate is 80% of Plan A’s rate and 20% of Plan B’s rate. This rate is divided by the total number of encounters to obtain the rate on a per-visit basis. (The payment rates include cost-sharing amounts.) For each claim submitted to the FI, the difference between the interim Medicare per-visit all-inclusive rate and the interim average MA per-visit rate is the wrap-around payment amount.

1	2	3	4	5	6	7
Annual Total MA Plan Encounters	Annual Plan A FFS Estimated Payments (200)	Annual Plan B Estimated Capitation Payment (50)	Annual Average MA Payment Rate (weighted)	Average MA Per-Visit Payment Rate (weighted)	Interim Medicare Per-Visit Rate	Wrap-Around Per Visit
250	\$7,000	\$4,250	\$6,450	\$25.80	\$109.88	\$84.08

7b) In calculating the FQHC’s per visit rate, will the payments of all MA plans be aggregated or will there be a separate determination for each plan?

- CMS advises that, during reconciliation, it will aggregate payments from all MA plans rather than calculate plan-specific wrap-around payments.
 - Implication: Lower payment rates from one MA plan will offset the higher payments rates of another. Consequently, FQHCs will not be penalized if one MA plan pays less than another.
 - Example: An FQHC contracts with two MA plans. In Plan A, the FQHC contracts on a FFS basis. In Plan B, the FQHC contracts on a capitated basis. The FQHC incurred a total of 250 encounters, with

200 encounters in Plan A and 50 encounters in Plan B. The actual MA payment amounts from each plan are aggregated. (The payment rates include cost-sharing amounts.) The final Medicare wrap-around payment is calculated as the per-visit payment rate multiplied by the number of encounters, less the amount of payments received under the MA contracts. $[(\$109.88 \times 250) - \$11,250] = \$16,220$. Assuming that CMS paid \$21,020 in interim wrap-around payments, then there has been an overpayment in the amount of \$4,800.

1	2	3	4	5	6	7	8
Annual Total MA Plan Encounters	Annual Plan A FFS Payments (actual)	Annual Plan B Capitation Payment (actual)	Annual Total MA Plan Payments (actual)	Medicare Per-Visit Rate	Final Wrap-around Payment Amount	Total Interim Wrap-Around Payments	Amount Due to CMS at Reconciliation
250	\$7,000	\$4,250	\$11,250	\$109.88	\$16,220	\$21,020	\$4,800

8) How will beneficiary cost-sharing amounts be treated in the wrap-around calculation?

- In the preamble to the rule, CMS clarifies that wrap-around payments will be calculated based on what the FQHC could charge as cost sharing, *not* the cost sharing amounts that the FQHC actually collects.
 - Implication: The MA payment rate used to calculate wrap-around payments includes beneficiary cost-sharing amounts. An FQHC’s failure to collect cost-sharing amounts will reduce potential revenue. Thus, an FQHC should view patient cost-sharing amounts as its collection risk on each MA contract it signs.

9) Will the Medicare per visit cap (Upper Payment Limit) apply to wrap-around payments?

- Yes, CMS will apply the Medicare payment cap (also referred to as the upper payment limit (“UPL”)) in determining the wrap-around payment.
 - Implication: In determining wrap-around payments, the Medicare per visit amount cannot exceed the urban or rural (whichever is applicable) per visit payment cap. For FQHCs operating below the FQHC national payment limit, CMS will use their actual per-visit all-inclusive rate to determine the amount of supplemental payment. For FQHCs operating at or above the national payment limit, CMS will use the applicable national FQHC urban or rural upper limit to calculate the FQHC wrap-around payment.

10) Will the FQHC be paid each time it files a claim with CMS?

- Yes. In the preamble, CMS clarifies that *each time* an FQHC submits a claim form to a fiscal intermediary for wrap-around payment the FQHC will report the difference in payment amount between the interim FQHC all-inclusive cost-based rate and the interim average MA rate. CMS explains that it will use an interim rate for MA payments based on estimates from the contracting FQHC until actual MA payments and visits are captured on the FQHC cost report.
 - Practice Pointer: The interim average MA rate, estimated prior to the contract year as described above in Question 5 (“What services will CMS cover in its wrap-around payments to FQHCs?”), may be used throughout the year in the claim forms submitted to the FI for wrap-around payments. CMS has advised NACHC that the claims process for handling wrap-around payments will be operational by April 1, 2006. Prior to that time, CMS will provide additional guidance for submitting claims for wrap-around payments.

11) Is there an appeals process available to the FQHC in the event of claims disagreements between MA Plans and FQHCs?

- Yes. In the preamble to the rule, CMS advises that an FQHC may utilize the MA appeals process at 42 C.F.R. Part 422 subpart M to contest an MA organization’s payment denial. If the MA organization’s denial is overturned, then CMS will make a wrap-around payment to a FQHC.
 - Practice Pointer: To utilize the MA appeals process, FQHCs must first follow the MA plan’s procedures for making a timely appeal of the MA plan’s initial decision. Consequently, in the event that an MA plan denies payment, the FQHC should request the plan’s appeal procedures. If the result of that process is not satisfactory, the FQHC may then appeal to either an outside independent entity or to a CMS administrative law judge.

Summary of Implications from Wrap-Around Payment Rule

- FQHCs that contract with IPAs will be eligible for the wrap-around payments for the services they provide to the enrollees of the MA plan with which the IPA has contracted.
- CMS has imposed the burden on itself to ensure that payment levels to FQHCs are comparable to non-FQHC providers.
- Wrap-around payments will be paid when a FQHC is a *contracted* provider of a Medicare PPO or Private Fee-for-Service Plan (PFFS) (i.e., the FQHC has a written contract with the MA plan). As a *contracted provider*, the FQHC is entitled to 100% of its reasonable cost, subject to the Medicare payment cap (less beneficiary cost-sharing amounts). In contrast, no wrap-around payment will be made if the FQHC is a non-contracted provider.
- As a *non-contracted* provider, the FQHC will receive 80% of its reasonable costs subject to the Medicare payment cap (less beneficiary cost-sharing amounts). Because the per-visit payment cap restricts the total amount of payment received by an FQHC regardless of whether the FQHC is a contracted or non-contracted provider, only health centers that currently operate below the payment cap will lose the increase to 100% of reasonable costs provided by wrap-around payments.
- Previously, FQHCs have billed Part B separately for non-FQHC services provided to Medicare beneficiaries. This is not allowed for beneficiaries enrolled in MA plans. *FQHCs must obtain payment for all services from the MA plan in which the beneficiary is enrolled.* Thus, if an FQHC provides additional services (e.g., laboratory services), the FQHC should negotiate with the MA Plan to receive additional compensation for those services through a separate fee schedule or contract.
- In the absence of a face-to-face encounter, an FQHC will not receive a per-visit payment for Medicare-covered incidental services such as vaccinations. Accordingly, these costs must be included in the Medicare cost report so that their cost may be added into the determination of the centers per visit payment rate.
- Although FQHCs will ultimately need to convert MA contracted payment amounts to a per-visit basis, CMS does not restrict the type of payment mechanism between the FQHC and MA plan. FQHCs may contract with MA plans under any kind of payment method, including a fee schedule, capitated payment arrangement, or per-visit payment amount.

- In preparing estimates of MA payments, an FQHC should exclude payment from MA plans for non-FQHC services (e.g., pharmacy, laboratory services) and for financial incentives (e.g., risk pool payments, bonuses, or withholds). The MMA is clear that these payments are not to be treated as MA plan payments for the purpose of determining the amount of the wrap-around payment. If these payments were included, they would offset the wrap-around payments that the FQHC is entitled to receive, thereby lowering total potential revenue.
- Because CMS will aggregate MA plan payments, lower payment rates from one MA plan will offset the higher payments rates of another. Consequently, FQHCs will not be penalized if one MA plan pays less than another.
- The MA payment rate used to calculate wrap-around payments include beneficiary cost-sharing amounts. As noted in the first Issue Brief on managed care contracting, a FQHC's failure to collect cost-sharing amounts will reduce potential revenue. Thus, an FQHC should view patient cost-sharing amounts as the collection risk on each MA contract it signs.
- In determining wrap-around payments, the Medicare per visit amount cannot exceed the Medicare per visit cap. For FQHCs operating below the FQHC cap, CMS will use their actual per-visit all-inclusive rate to determine the amount of supplemental payment. For FQHCs operating at or above the cap, CMS will use the applicable national FQHC urban or rural upper limit to calculate the FQHC wrap-around payment.
- The interim average MA rate, estimated prior to the contract year, may be used throughout the year in the claim forms submitted to the FI for wrap-around payments. CMS has advised NACHC that the claims process for handling wrap-around payments will be operational by April 1, 2006. Prior to that time, CMS will provide additional guidance for submitting claims for wrap-around payments. (See Appendix A)
- To utilize the MA appeals process, FQHCs must first follow the MA plan's procedures for making a timely appeal of the MA plan's initial decision. In the event an MA plan denies payment, the FQHC should request these appeal procedures. Thereafter, the FQHC may appeal to either an outside independent entity or to a CMS administrative law judge.

Appendix A

UNITED GOVERNMENT SERVICES, LLC (UGS)

Medicare Advantage Wrap-Around Payment Process

- FQHC provider notifies United Government Services, LLC (UGS) that they have a contract with a Medicare Advantage plan(s). With the notification the FQHC submits the necessary information to UGS to identify the per-visit encounter rates. (The information submitted would consist of the actual encounter rate per visit if known or an estimate of the encounter rate per-visit. If an estimate is submitted then supporting documentation would be required on how the estimate was determined.)
- If UGS does not receive information from the FQHC regarding the per visit encounter rate, UGS will send out a letter requesting that the FQHC submit the necessary information for the determination of the per-visit encounter rates for the Medicare Advantage Plans.
- UGS reviews the per-visit encounter rate information that is submitted and determines the interim per visit encounter rate. (This may be a blended per visit amount if the FQHC has a contract with multiple Medicare Advantage plans.)
- UGS will notify the FQHC by letter identifying the Medicare Advantage payment rate and also enters this rate into the Fiscal Intermediary Standard System (FISS).
- FQHC submits Medicare Advantage claims with a specific type of bill and revenue code that identifies the claims as Medicare Advantage. (Type of bill is 73x and revenue code is 0519.) [Note: 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 3, 2006. See Appendix A]
- UGS processes the Medicare Advantage claims and pays the difference between the Medicare per-visit encounter rate and the Medicare Advantage per-visit encounter rate. The payment amount is included on an individual claim basis on the Medicare remittance advices. The PS&R (Provider Statistical & Reimbursement) report will separately identify the Medicare Advantage claims.
- FQHC includes the Medicare Advantage statistical and reimbursement information on the Medicare cost report. UGS will review the cost report to ensure the information is appropriate and make a final settlement on the Medicare Advantage claims.