



Federally Qualified Health Center



THE **FEDERALLY QUALIFIED HEALTH CENTER (FQHC)** benefit under Medicare was added effective October 1, 1991 when Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are “safety net” providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities.

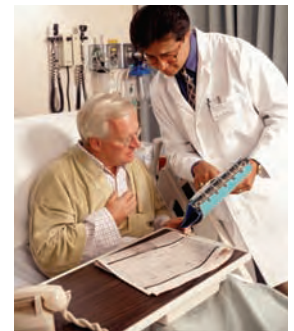
Federally Qualified Health Center Designation

An entity may qualify as an FQHC if it:

- Is receiving a grant under Section 330 of the Public Health Service (PHS) Act;
- Is receiving funding from such grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act;
- Is not receiving a grant under Section 330 of the PHS Act but determined by the Secretary of the Department of Health and Human Services (HHS) to meet the requirements for receiving such a grant (i.e., qualifies as a FQHC look-alike) based on the recommendation of the Health Resources and Services Administration;
- Was treated by the Secretary of the Department of HHS for purposes of Medicare Part B as a comprehensive Federally funded health center as of January 1, 1990; or
- Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Covered Federally Qualified Health Center Services

Payments are made directly to the FQHC for covered services furnished to Medicare beneficiaries. Services are covered when furnished to a beneficiary at the FQHC, the beneficiary’s place of residence, or elsewhere (e.g., at the scene of an accident). A FQHC generally furnishes the following services:



- Physician services;
- Services and supplies incident to the services of physicians;
- Nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;
- Services and supplies incident to the services of NPs, PAs, CNMs, CPs, and CSWs;
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has determined that there is a shortage of Home Health Agencies;
- Otherwise covered drugs that are furnished by, and incident to, services of a FQHC provider; and

- Outpatient diabetes self-management training and medical nutrition therapy for beneficiaries with diabetes or renal disease (effective for services furnished on or after January 1, 2006).

FQHCs also furnish preventive primary health services when furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, or CSW. The following preventive primary health services are covered when furnished by FQHCs to Medicare beneficiaries:

- Medical social services;
- Nutritional assessment and referral;
- Preventive health education;
- Children’s eye and ear examinations;
- Well child care including periodic screening;
- Immunizations including tetanus-diphtheria booster and influenza vaccine;
- Voluntary family planning services;
- Taking patient history;
- Blood pressure measurement;
- Weight measurement;
- Physical examination targeted to risk;
- Visual acuity screening;
- Hearing screening;
- Cholesterol screening;
- Stool testing for occult blood;
- Tuberculosis testing for high risk beneficiaries;
- Dipstick urinalysis; and
- Risk assessment and initial counseling regarding risks.

For women only:

- Prenatal and post-partum care;
- Prenatal services;
- Clinical breast examination;
- Referral for mammography; and
- Thyroid function test.

Federally Qualified Health Center Preventive Primary Services that are NOT Covered

FQHC preventive primary services that are NOT covered include:

- Group or mass information programs, health education classes, or group education activities

including media productions and publications; and

- Eyeglasses, hearing aids, and preventive dental services.

Items or services that are covered under Part B, but are NOT FQHC services include:

- Certain laboratory services;
- Durable medical equipment, whether rented or sold, including crutches, hospital beds, and wheelchairs used in the beneficiary’s place of residence;
- Ambulance services;
- The technical component of diagnostic tests such as x-rays and electrocardiograms;
- The technical component of the following preventive services:
 - Screening pap smears;
 - Prostate cancer screening;
 - Colorectal cancer screening tests;
 - Screening mammography; and
 - Bone mass measurements;
- Prosthetic devices that replace all or part of an internal body organ including colostomy bags, supplies directly related to colostomy care, and the replacement of such devices; and
- Leg, arm, back, and neck braces and artificial legs, arms, and eyes including replacements (if required because of a change in the beneficiary’s physical condition).

Federally Qualified Health Center Payments

Generally, Medicare pays FQHCs (which are considered suppliers of Medicare services) an all-inclusive per visit



payment amount based on reasonable costs as reported on its annual cost report. The beneficiary pays no Part B deductible for FQHC services but is responsible for paying the coinsurance with the exception of FQHC-supplied influenza and pneumococcal vaccines, which are paid at 100 percent. The coinsurance for FQHC services is 20 percent of the clinic's reasonable and customary billed charges except for mental health treatment services, which are subject to the 62.5 percent outpatient mental health treatment limitation. The application of the outpatient mental health treatment limitation increases the beneficiary's copayment to 50 percent of the clinic's reasonable and customary billed charges. This limit does not apply to diagnostic services. With enactment of the Medicare Improvements for Patients and Providers Act of 2008, the amount of this limitation will be reduced incrementally over the next five years beginning with services provided on or after January 1, 2010.

The FQHC all-inclusive visit rate is calculated, in general, by dividing the FQHC's total allowable cost by the total number of visits for all FQHC patients. The FQHC payment methodology includes two national per-visit upper payment limits—one for urban FQHCs and one for rural FQHCs. The two national FQHC per-visit upper payment limits are increased annually by the Medicare Economic Index applicable to primary care physician services. A FQHC is designated as an urban or rural entity based on definitions in Section 1886(d)(2)(D) of the Act. If a FQHC is not located within a Metropolitan Statistical Area (now generally known as a Core Based Statistical Area) or New England County Metropolitan Area, it is considered rural and the rural limit applies. Rural FQHCs cannot be reclassified into an urban area for FQHC payment limit purposes.

Freestanding FQHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, in order to identify all incurred costs applicable to furnishing covered FQHC services. Form CMS-222-92 can be found in the **Provider Reimbursement Manual**—Part 2 (Pub. 15-2), Chapter 29, located at <http://www.cms.hhs.gov/Manuals/PBM/list.asp> on the CMS website.

Provider-based FQHCs must complete the appropriate worksheet designated for FQHC services within the parent provider's cost report. For example, FQHCs based in a hospital complete Worksheet M of Form CMS-2552-96, Hospital and Hospital Complex Cost

Report. At the beginning of the FQHC's fiscal year, the Fiscal Intermediary or A/B Medicare Administrative Contractor calculates an interim all-inclusive visit rate based on either estimated allowable costs and visits from the FQHC (if it is new to the FQHC Program) or on actual costs and visits from the previous cost reporting period (for existing FQHCs). The FQHC's interim all-inclusive visit rate is reconciled to actual reasonable costs at the end of the cost reporting period. Form CMS-2552-96 can be found in the **Provider Reimbursement Manual**—Part 2 (Pub. 15-2), Chapter 36, located at <http://www.cms.hhs.gov/Manuals/PBM/list.asp> on the CMS website.

Influenza and Pneumococcal Vaccine Administration and Payment

The cost of the influenza and pneumococcal vaccines and related administration are separately reimbursed at annual cost settlement. There is a separate worksheet on the cost report to report the cost of these vaccines and related administration. These costs should not be reported on a FQHC claim when billing for FQHC services. The beneficiary pays no Part B deductible or coinsurance for these services. When a FQHC practitioner (e.g., a physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering these vaccinations, the FQHC may not bill for a visit; however, the costs of the vaccine and its administration are included on the annual cost report and reimbursed at cost settlement.

Hepatitis B Vaccine Administration and Payment

The cost of the Hepatitis B vaccine and related administration are covered under the FQHC's all-inclusive rate. If other services that constitute a qualifying FQHC visit are furnished at the same time as the Hepatitis B vaccination, the charges for the vaccine and related administration can be included in the charges for the visit when billing and in calculating the coinsurance. When a FQHC practitioner (e.g., a physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering a Hepatitis B vaccination, the FQHC may not bill for a visit; however, the costs of the vaccine and its administration are included on the annual cost report. Charges for the Hepatitis B vaccine may be included on a claim for the beneficiary's subsequent FQHC visit and used in calculating the coinsurance.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Provisions that Impact Federally Qualified Health Centers

Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that professional services furnished on or after January 1, 2005 by physicians, NPs, PAs, and CPs who are affiliated with FQHCs are excluded from the Skilled

Nursing Facility Prospective Payment System, in the same manner as such services would be excluded if furnished by individuals not affiliated with FQHCs.

To find additional information about FQHCs, see Chapter 9 of the *Medicare Claims Processing Manual* (Pub. 100-4) and Chapter 13 of the *Medicare Benefit Policy Manual* (Pub. 100-2) at <http://www.cms.hhs.gov/Manuals> and the Federally Qualified Health Centers Center at <http://www.cms.hhs.gov/center/fqhc.asp> on the CMS website.

HELPFUL WEBSITES

American Hospital Association Section for Small or Rural Hospitals

http://www.aha.org/aha/key_issues/rural/index.html

Critical Access Hospital Center

<http://www.cms.hhs.gov/center/cah.asp>

Federally Qualified Health Centers Center

<http://www.cms.hhs.gov/center/fqhc.asp>

Health Resources and Services Administration

<http://www.hrsa.gov>

Hospital Center

<http://www.cms.hhs.gov/center/hospital.asp>

HPSA/PSA (Physician Bonuses)

http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp

Medicare Learning Network

<http://www.cms.hhs.gov/MLNGenInfo>

National Association of Community Health Centers

<http://www.nachc.org>

National Association of Rural Health Clinics

<http://www.narhc.org>

National Rural Health Association

<http://www.nrharural.org>

Rural Health Center

<http://www.cms.hhs.gov/center/rural.asp>

Rural Assistance Center

<http://www.raconline.org>

Telehealth

<http://www.cms.hhs.gov/Telehealth>

U.S. Census Bureau

<http://www.Census.gov>

REGIONAL OFFICE RURAL HEALTH COORDINATORS

Below is a list of contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues.

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The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNGenInfo/> on the CMS website.

Medicare Contracting Reform (MCR) Update

In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at <http://www.cms.hhs.gov/MedicareContractingReform> on the CMS website.