PACHC Memo 11-08
Please share with:
Senior management
Billing manager
Compliance officer

June 3, 2011

TO: Pennsylvania Association of Community Health Center Members
FROM: Cheri Rinehart, President & CEO
SUBJECT: Important Changes Relative to FQHC Participation in Medicare

Issue: Several significant changes have been made to the process for health center enrollment and revalidation in the Medicare program. Perhaps even more significantly, the Centers for Medicare & Medicaid Services (CMS) is validating compliance with the requirements for Community Health Centers FQHC enrolled in the Medicare program and is significantly ramping up the consequences of non-compliance. It is critical that both FQHCs and FQHC Look-Alikes ensure compliance to avoid financial jeopardy.

Background: For many years, CMS has required that Community Health Centers FQHC enroll each site separately and bill Medicare encounters under the unique CMS certification number (CCN) for the site where the care was provided, not by using a single FQHC CCN number. Although the requirement has been in place for many years, it has not been enforced. That is no longer the case.

On March 8, 2011, the Health Resources & Services Administration (HRSA) released a new Program Assistance Letter, (PAL) 2011-04, Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit. As outlined in PAL 2011-04, *CMS counts every seasonal and permanent site of an FQHC as a separate organization.* That is, a health center with five locations is considered five organizations for Medicare purposes. CMS requires the FQHC claim to reflect the unique CCN of the site where the care was delivered. Failure to bill accordingly can be interpreted as fraud and, according to HRSA, CMS is increasing the penalties for failure to comply. The penalties can now be as significant as being asked to repay all Medicare payments plus interest as well as disenrollment from the Medicare program. .

In addition, health centers that fail to comply with the notification timelines required by CMS also risk disenrollment from the Medicare program and other penalties. These reporting requirements, outlined completely in PAL 2011-04, include notifying CMS within 30 days of changes in board composition and within 90 days of other reportable events.

An additional CMS change affects new health center sites. This change was shared by HRSA last week during our cooperative agreement call and is not reflected in PAL 2011-04. In the past, health center New Access Points (NAPs) were encouraged to apply for Medicare as soon as word was received of approval as an FQHC. According to HRSA, CMS is now prohibiting new

sites from submitting an application to enroll in Medicare *until the day the site becomes operational.*

Effective March 23, 2011, the Affordable Care Act requires CMS to charge a fee for any enrollment or revalidation application for participation in the Medicare program. For FQHCs, the current fee is $505 which the statute requires be adjusted annually for inflation. The fee must be paid through www.pay.gov. It should be noted that health centers may apply to CMS for hardship waiver of this enrollment fee, however, PACHC urges caution and weighing the pros and cons of doing so. If a health center applies for a waiver of the fee, CMS has 60 days to review the waiver application, so a fee waiver request can result in a significant delay in Medicare site approval.

Member Action:

1- **Review PAL 2011-04 and ensure that your health center's billing manager, corporate compliance officer and other relevant members of your team are familiar with its requirements**.

2- **Review your health center's CMS site-specific information for accuracy to avoid the risk of improper and potentially fraudulent billing.**
   Does each and every seasonal and permanent site of your health center have a separate Medicare number?
   Is that unique CCN being used to submit Medicare claims for that site and that site only?
   Are the site addresses accurate?
   Does CMS have an accurate listing of your Board of Directors?
   CMS requires revalidation of FQHC 855A applications every five years—have your sites' information been revalidated within the past five years?

3- **Review your health center's process and procedures for notification of reportable events to CMS.**
   Do they incorporate all reportable events?
   Are they effective?
   Do they include a double-check mechanism to avoid errors or omissions?
   Do they incorporate routine review for accuracy and completeness?

4- **Conduct a random billing audit.**
   Are encounters billed accurately to the appropriate site CCN?

5- **Make any necessary corrections.**
   Each Medicare 855A application for initial enrollment in Medicare and change or update of information requires supporting documentation. To properly prepare a Medicare Enrollment for an FQHC, please refer to Medicare Publication 100-07, State Operations Manual, Exhibit 179. Please Note: ***FQHC applicants are not eligible to use the internet-based PECOS, and must submit paper copies of all required enrollment application documents to the appropriate Medicare contractor***, i.e. Medicare Administrative Contractor (MAC) or "legacy" Fiscal Intermediary (FI).

6- **Additional considerations.**

- When you enroll a new site or revalidate an existing site, be sure to print the confirmation receipt from www.pay.gov for your records and include it with the paper application you submit to your Medicare contractor to avoid application rejection and billing revocation. Note that payment can only be processed for one application at a time.
- Since the timeframe for the hardship waiver or fee waiver determination is 60 days, health centers are permitted to submit both the fee and the hardship waiver at the same time to minimize delays in processing of the application. If the hardship waiver is subsequently approved, the application fee will be refunded to the health center.
- Although your FQHC 855A applications must be mailed, all fees MUST be paid through Pay.gov, which is a web-based application operated by the U.S. Department of the Treasury that allows you to make online payments to government agencies by electronic check, credit card, or debit from your checking or savings account. Pay.gov accepts Visa, MasterCard, American Express, and Discover. ***Do not mail application fee payments. Pay.gov cannot accept payments by mail or phone. Please note that all fees must be paid via Pay.gov and that paper checks will not be accepted.***

PACHC Action: PACHC will continue to monitor CMS action relative to health center billing and notification requirements and share any updates via *News CHCs Can Use.*

For More Information: Questions on any information in this memo may be directed to Cindi Christ at cindi@pachc.com or (717) 761-6443, ext. 204.