FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC PAYMENT SYSTEMS

*payment***basics**

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Federally qualified health centers (FQHCs) and rural health clinics (RHCs) furnish services typically provided in outpatient clinic settings. While most clinician services furnished to Medicare beneficiaries are billed under the fee schedule for physicians and other health professionals, the Congress established special payment rules for FQHCs and RHCs to improve access to primary care services in rural and underserved areas. (For information about the fee schedule for physicians and other health professionals, see MedPAC's *Medicare Payment Basics: Physician and Other Health Professional Payment System*.)

FQHCs can be located in both urban and rural areas and must serve a medically underserved area (MUA) or a medically underserved population, such as migrant farmworkers or homeless individuals.[1] FQHCs must also meet a number of other requirements, including governance as a non-profit or public agency and offering free or reduced-cost care to low-income individuals.

RHCs must initially be located in a non-urbanized area that qualifies as a primary care health professional shortage area (HPSA), MUA, or governor-designated shortage area.[2] RHCs are not subject to many of the requirements applicable to FQHCs, such as offering free or reduced-cost care, but must meet other standards. For example, RHCs must employ a nurse practitioner or physician assistant and have a nurse practitioner, physician assistant, or certified nurse midwife working at the clinic at least 50 percent of the time.

In 2019, about 6,500 FQHCs provided services to 2.0 million Medicare fee-for-service (FFS) beneficiaries; Medicare spending for these services totaled $1.4 billion. FQHCs also receive substantial grants from the federal government to help cover the cost of providing free and reduced-cost care to their patients. In 2019, FQHCs each received an average of $3.7 million in health center grant funding from the federal government. In the same year, about 4,100 RHCs provided services to 2.2 million Medicare FFS beneficiaries; Medicare spending for RHC services totaled $1.6 billion.[3] Unlike FQHCs, RHCs do not receive grant funding.

Defining the product that Medicare buys

FQHC and RHC services are medically necessary medical visits, mental health visits, or qualified preventive health visits. The visit must be a face-to-face (one-on-one) encounter between the patient and an eligible clinician. FQHCs and RHCs predominantly furnish primary care, and most of their services are evaluation and management services, such as office visits or visits to beneficiaries in nursing homes.

Both the FQHC and RHC payment systems generally bundle all professional services furnished in a single day into one payment, with limited exceptions (e.g., a qualified medical visit and a qualified mental health visit on the same day). The FQHC and RHC payment bundles cover professional services but exclude other services commonly furnished in conjunction with a visit, such as laboratory tests and technical components of imaging services. Clinicians who practice at FQHCs and RHCs may still perform such services, but Medicare pays for them separately under different payment systems, such as the clinical laboratory fee schedule or fee schedule for physicians and other health professionals.

Setting the payment rate

In 2014, Medicare began paying FQHCs using a prospective payment system (PPS). Under the PPS, Medicare established a

The policies discussed in this document were current as of October 15, 2021, and reflect any relevant changes implemented in response to the COVID-19 public health emergency as of that date. This document does not reflect proposed legislation or regulatory actions.

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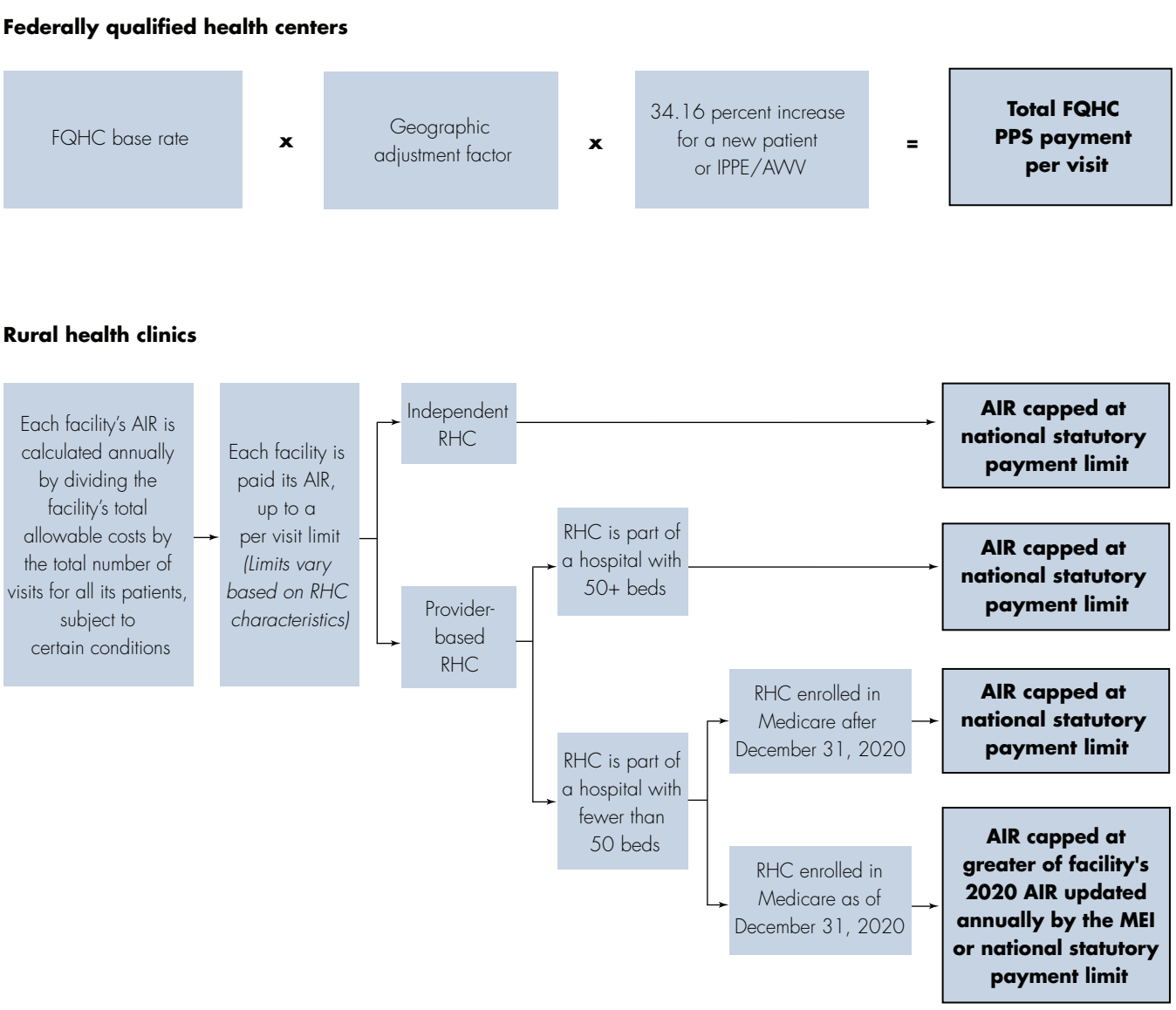
Figure 1 FQHC and RHC payment systems for 2021



Note: FQHC (federally qualified health center), IPPE (initial preventive physical exam), AWV (annual wellness visit), PPS (prospective payment system), AIR (all-inclusive rate), RHC (rural health clinic), MEI (Medicare Economic Index). In order to qualify for the AIR-based payment limit, an RHC must have been enrolled in Medicare as of December 31, 2020, or submitted an application for enrollment that was received no later than December 31, 2020.

single, national per visit base rate. The rate was based on 100 percent of FQHCs' reasonable costs incurred in furnishing care to Medicare beneficiaries for cost reporting years ending between June 30, 2011, and June 30, 2013. In 2021, the FQHC PPS base rate is $176.45. The FQHC base rate is adjusted to reflect differences in practice costs across geographic areas using the FQHC geographic adjustment factor.[4] The adjusted base rate is increased by 34.16 percent when a patient is new to the FQHC or receives an initial preventive

physical exam (IPPE) or annual wellness visit (AWV) (Figure 1). Medicare pays 80 percent of the lesser of an FQHC's charges or the PPS rate, and beneficiaries are responsible for the remaining 20 percent of the applicable amount. The Part B deductible does not apply to FQHC services.

Medicare pays RHCs a facility-specific all-inclusive rate (AIR) for each visit. A facility's AIR is calculated annually by dividing the facility's total allowable costs by the total number of visits for all its patients, subject to certain conditions.[5] The AIR is subject to limits, which vary based on whether a clinic is independent or provider-based, whether a provider-based RHC is part of a hospital with fewer than 50 beds, and when the RHC enrolled in Medicare. These limits were substantially revised in the Consolidated Appropriations Act, 2021.

The AIR for independent RHCs and for provider-based RHCs that are part of a hospital with 50 or more beds is subject to a national statutory payment limit, which is $100 as of April 2021. New RHCs of any type that enrolled in Medicare after December 31, 2020, are also subject to the national statutory payment limit. Historically, provider-based RHCs that were part of a hospital with fewer than 50 beds were not subject to the national statutory payment limit. As of 2018, Medicare's payment rate for these RHCs averaged about $200 per visit. However, beginning April 1, 2021, the payment limit per visit for these RHCs is equal to the greater of their 2020 payment rate increased by the Medicare Economic Index (MEI) or the national statutory payment limit (Figure 1). Because their payment limits are based on each individual facility's 2020 payment rate, the limits are higher than the national statutory payment limit and may vary substantially (e.g., one facility might have a payment limit of $200 per visit while another might have a limit of $300 per visit).

Medicare pays 80 percent of the AIR, subject to the per visit payment limits. Beneficiaries are responsible for 20 percent of RHC charges. RHC services are subject to the annual Part B deductible. As a result of RHC visits being subject to the Part B deductible and coinsurance being based on provider charges (instead of the lesser of provider charges or the payment rate, as is the case for FQHCs), beneficiaries generally face higher cost sharing at RHCs compared with FQHCs.

Other services billed by FQHCs and RHCs

While most FQHC and RHC services are paid using the PPS and AIR methodologies, a few services have special payment rules. For example:

- Influenza, pneumococcal, and COVID-19 vaccines and their administration are paid at 100 percent of reasonable costs.
- Virtual communication services, chronic care management services, and certain other services are paid rates similar to those paid under the fee schedule for physicians and other health professionals.

In addition, during the COVID-19 public health emergency, FQHCs and RHCs are allowed to bill for telehealth services (as the distant site) and are paid a rate that is similar to the payment rates for comparable telehealth services billed under the fee schedule for physicians and other health professionals.

Updating payments

The FQHC PPS base rate is annually updated for inflation using the FQHC market basket.

At the beginning of 2021, the national statutory payment limit for RHCs was $87.52 and was set to increase annually based on the MEI. However, the Consolidated Appropriations Act, 2021, instituted large increases in the statutory payment limit. Beginning in April 2021, the national statutory payment limit increased to $100 and will increase

incrementally until it reaches $190 in 2028. In subsequent years, the payment limit will increase annually based on the MEI.[6]

For 2022 and beyond, the payment limits for provider-based RHCs that are part of a hospital with fewer than 50 beds and that were enrolled in Medicare as of December 31, 2020, will be set at an amount equal to the greater of the payment limit per visit established for the previous year, increased by MEI, or the national statutory payment limit. ■

1 MUAs are areas designated by the Health Resources and Services Administration (HRSA) as having a combination of too few primary care physicians, high infant mortality, high poverty, and a large elderly population.

2 RHCs must meet these criteria when they are first certified as an RHC. However, Medicare does not require RHCs to meet these criteria on an ongoing basis. Primary care HPSAs are designated by HRSA as having shortages of primary medical care providers. Geographic or population HPSAs may be used to qualify a facility as an RHC.

3 The total number of FQHCs and RHCs is calculated as the number of unique provider numbers that billed Medicare in 2019. Spending figures do not include services paid on a cost basis (such as certain vaccines) and services paid under other payment systems (such as the technical component of imaging services and tests billed under the clinical laboratory fee schedule).

4 The FQHC geographic adjustment factor is an adaptation of the geographic practice cost indices used for the fee schedule for physicians and other health professionals.

5 For example, RHCs are subject to productivity standards. Current productivity standards require 4,200 visits per physician and 2,100 visits per nurse practitioner, physician assistant, or certified nurse midwife per year. If an RHC's clinicians furnished fewer than the applicable minimum standards, then Medicare substitutes the minimum standards for the actual number of visits when calculating the AIR, effectively lowering the AIR.

6 The FQHC market basket update and MEI are both reduced to account for multifactor productivity growth before being used to update payment rates or limits.