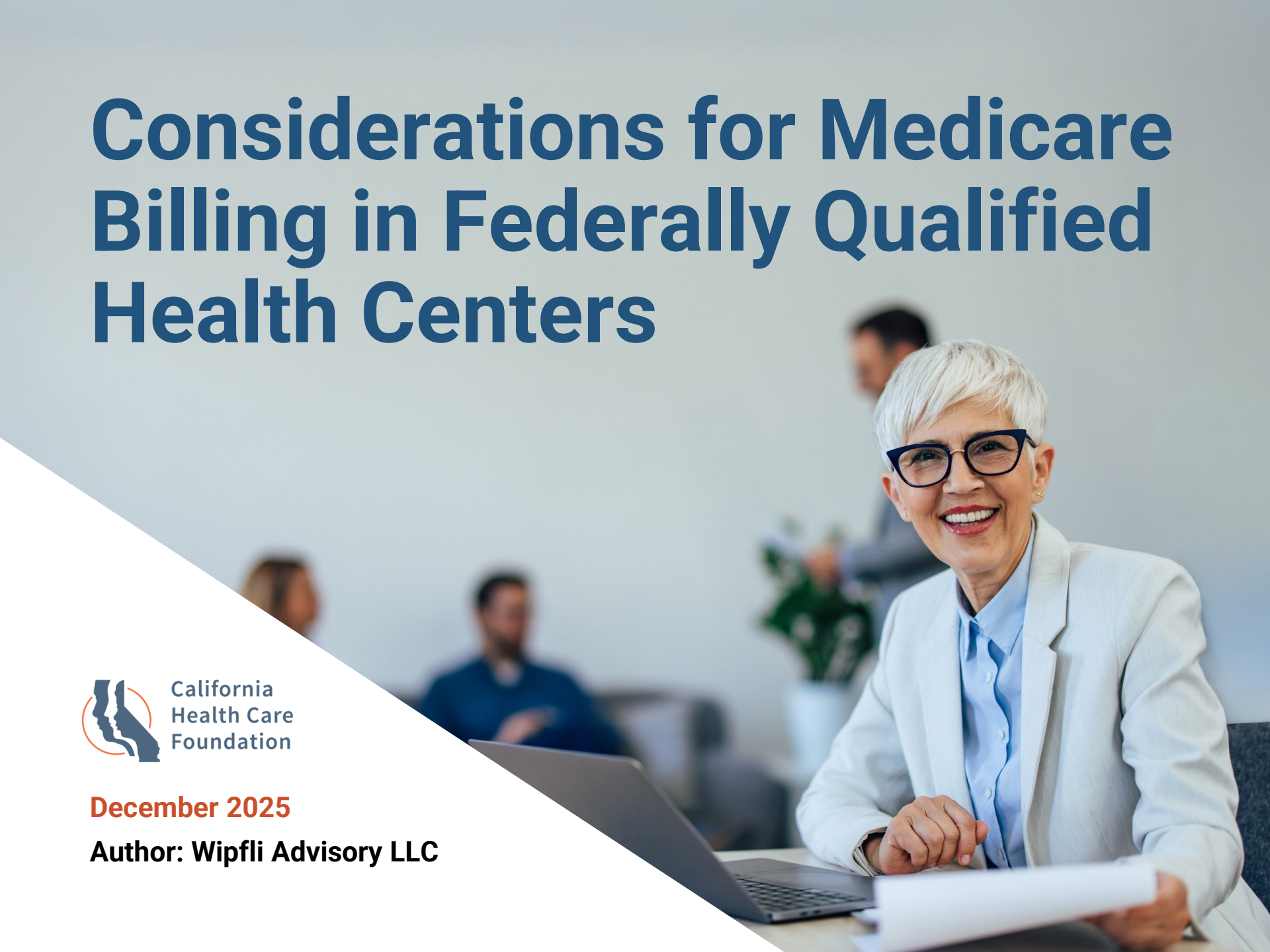
Considerations for Medicare Billing in Federally Qualified Health Centers



California Health Care Foundation

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Overview

Introduction

California's aging population means more Medicare patients are turning to Federally Qualified Health Centers (FQHCs) for care. This includes people with both Medicare and Medi-Cal coverage (“dually eligible enrollees”) as well as those with Medicare only.

Since Medicare pays FQHCs differently than Medi-Cal, health centers that understand Medicare's requirements and improve their contracting, operations, and billing can increase revenues and improve the financial sustainability of caring for this population’s complex needs.

This overview document has been developed to support FQHCs seeking reimbursement for care provided to Medicare enrollees. Select related documents from the Centers for Medicare & Medicaid Services and the California Department of Health Care Services are listed in the “Appendix: Related Resources” section at the end of the document.

Overview of Considerations for Medicare Billing in FQHCs

DUALLY ELIGIBLE ENROLLEES

Original Medicare and Medi-Cal

FQHC billing steps:

1. Bill Medicare a geographically adjusted Medicare PPS rate; if applicable, bill for "special visit types" (see below).
2. If applicable, bill for any Medicare "add-ons" (e.g., Medicare Chronic Care Management, Remote Patient Monitoring).
3. Bill Medi-Cal MCP for secondary coverage.
4. Bill DHCS using a Medicare crossover billing code set.

FQHC Medicare PPS "special visit types" (e.g., New Patient, Annual Wellness Visit, Welcome to Medicare) have higher rates, but these are still typically lower than FQHC Medi-Cal PPS rates and thus still follow the above billing steps.

Revenue from Medicare "add-ons" (e.g., Chronic Care Management, Remote Patient Monitoring) is generally retained by FQHCs.

Detailed description

Special considerations for ACO

Medicare Advantage (MA), Including D-SNP, and Medi-Cal

An FQHC can apply for a 519 wrap rate with their Medicare Administrative Contractor (MAC) for each of its sites that have MA contracts to bring reimbursement for MA patient visits up to its geographically adjusted Medicare PPS rate. If an FQHC does not establish 519 rates for each of its sites covered by an MA/D-SNP contract, it is leaving money on the table.

FQHC billing steps:

1. Bill MA plan/D-SNP based on negotiated rates defined in contract.
2. Bill MAC for visit site's 519 wrap rate if one has been established.
3. Bill Medi-Cal MCP for secondary coverage (this may be internally coordinated by MA/D-SNP if they are the same carrier as the Medi-Cal MCP).
4. Bill DHCS using a Medicare crossover billing code set.

DHCS Medi-Cal PPS reconciliation assumes the FQHC has received its maximum Medicare reimbursement via prior billing steps.

Original Medicare "special visit types" and "add-ons" cannot be billed unless FQHCs specifically negotiate contract terms with MA plan/D-SNP to be reimbursed for these services.

Detailed description

Special considerations for D-SNP

MEDICARE ONLY

Original Medicare

FQHC billing steps:

1. Bill Medicare a geographically adjusted Medicare PPS rate; if applicable, bill for "special visit types" (see below).
2. If applicable, bill for any Medicare "add-ons" (e.g., Medicare Chronic Care Management, Remote Patient Monitoring).

FQHC Medicare PPS "special visit types" (e.g., New Patient, Annual Wellness Visit, Welcome to Medicare) have significantly higher maximum allowable Medicare reimbursement rates. An FQHC is leaving money on the table if it does not implement these visits for Original Medicare-only patients.

Detailed description

Special considerations for ACO

Medicare Advantage (MA)

An FQHC can apply for a 519 wrap rate with their Medicare Administrative Contractor (MAC) for each of its sites that have MA contracts to bring reimbursement for MA patient visits up to its geographically adjusted Medicare PPS rate. FQHCs that contract with MA plans but do not apply for 519 rate(s) are leaving money on the table.

FQHC billing steps:

1. Bill MA plan based on negotiated rates defined in the contract.
2. Bill MAC for visit site's 519 wrap rate if one has been established.

Original Medicare "special visit types" and "add-ons" cannot be billed unless FQHCs specifically negotiate contract terms with MA plans to be reimbursed for these services.

Detailed description

Source: Author analysis of sources noted in Appendix.

Notes: *ACO* is Accountable Care Organization; *D-SNP* is Dual Eligible Special Needs Plan; *DHCS* is California Department of Health Care Services; *FQHC* is Federally Qualified Health Center; *MCP* is Medi-Cal managed care plan; *PPS* is prospective payment system.

Medicare Coverage and FQHC Payment Basics

FQHCs that take the time to understand Medicare complexity and optimize their Medicare contracting, clinical operations, visit coding, and billing practices can increase their Medicare revenue significantly.

Medicare FQHC reimbursement is different from Medi-Cal FQHC reimbursement.

- Medicare has its own formula for FQHC PPS rates that differs from Medi-Cal. (As with Medi-Cal, Medicare PPS rates are adjusted annually by the Medicare Economic Index.)
- Medicare has enhanced FQHC reimbursement for specific types of preventive visits that do not require 20% patient co-insurance (e.g., New Patient, Annual Wellness Visit, Welcome to Medicare).
- Medicare has “add-on” visit types (e.g., Medicare Chronic Care Management, Remote Patient Monitoring) that can be billed separately from FQHC PPS as long as all requirements are met.

In addition to Original Medicare, FQHCs can contract with Medicare Advantage (MA) plans to become in-network providers.

- Reimbursement and patient out-of-pocket expenses vary by MA plan.
- MA plan contracted rates are typically lower than Medicare PPS rates.
  - To fully realize their Medicare PPS rate for MA patient visits, FQHCs must establish 519 rates with Medicare Administrative Contractors (MACs) to supplement MA contracted rates.

Dually Eligible Enrollees with Original Medicare and Medi-Cal

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Billing Overview

STEP 1

Bill a geographically adjusted Medicare Prospective Payment System (PPS) rate (CY25 base rate = $202.65). (FQHCs do not use the Medicare Physician Fee Schedule (PFS) for Evaluation & Management (E&M) CPT codes.)

To adjust PPS rates based on geographic cost of business differences, Medicare publishes Geographic Adjustment Factors (GAFs) for various regions within each state.

- Medicare Geographically Adjusted PPS Rate Charge Formula:
  Medicare PPS Base Rate x GAF = FQHC-specific PPS rate charged to Medicare
  - If an FQHC charges Medicare less than this geographically adjusted PPS rate, it will not receive the full Medicare PPS reimbursement to which it is entitled.
- In CA, the CY25 GAF range is from 1.051 to 1.257.

Original Medicare is an 80/20 co-insurance plan.

- Medi-Cal covers the 20% co-insurance fee for dually eligible patients.

Outpatient services in Original Medicare are covered under Medicare Part B, but FQHCs actually bill Medicare PPS services to Part A because Medicare considers FQHCs to be “institutions.”

The Medicare PPS base rate is annually adjusted by the Medicare Economic Index (MEI).

Billing Overview

IMPORTANT: Medicare will pay 80% of the lesser of the geographically adjusted Medicare PPS rate and the health center's actual charge, so it is critical that each FQHC's Medicare fee schedule is updated to charge the Geographically Adjusted PPS rate or a greater amount.

Example

In the lowest cost areas of CA, FQHCs should bill Medicare PPS Base of $202.65 x 1.051 GAF = ~$212.98 and Medicare will pay 80% (~$170.38).

- However, if an FQHC bills Medicare $100, Medicare will only pay 80% of that charge ($80).

STEP 2

Bill the patient's Medi-Cal managed care plan (MCP) for secondary coverage.

STEP 3

Bill the California Department of Health Care Services (DHCS) via Medicare crossover billing code sets to make up the difference between maximum Medicare reimbursement (80% of geographically adjusted Medicare PPS rate) and Medi-Cal PPS rate

- Medicare crossover payments will be reconciled annually during Medi-Cal PPS reconciliation, and DHCS will presume FQHCs received maximum allowable Medicare reimbursement.

PPS Special Visit Types

New Patient visits, Annual Wellness Visits (AWVs), and Welcome to Medicare (aka Initial Preventive Physical Examination or IPPE) visits are billed to Medicare Part A and can be billed at a rate that is currently 34.16% greater than the FQHC Medicare PPS rate.

These are considered preventive services and Medicare will pay 100% of the maximum charge instead of 80%.

Charge Formula: Medicare PPS Base Rate x GAF x 1.3416

Example

- In the lowest cost areas of the state, FQHCs can bill Medicare $202.65 x 1.051 x 1.3416 = $285.74, and Medicare will pay 100% of that charge.
- In the highest cost area of the state, FQHCs can bill Medicare $202.65 x 1.257 x 1.3416 = $341.75 and Medicare will pay 100% of that charge.

Bill a Medi-Cal Managed Care Plan (MCP) as secondary coverage.

Bill DHCS as tertiary coverage via Medicare crossover billing code sets if the maximum allowable Medicare payment is less than the site's Medi-Cal PPS rate.

Medicare Add-Ons

"Add-ons" may also be billed to Medicare if all relevant criteria are met.

Add-ons are services offered in addition to and outside standard primary care visits.

Unlike E&M CPT codes, add-ons are reimbursed separately from Medicare PPS according to the Medicare Physician Fee Schedule (PFS).

Examples of add-ons include:

- Chronic Care Management (CCM)
- Remote Patient Monitoring (RPM)
- Behavioral Health Integration (BHI)

Add-ons are important because they enhance patient care and health outcomes while promoting health center financial sustainability.

Add-ons are **not** billed to Medi-Cal MCPs or to DHCS.

- Add-on payments for dually eligible patients are generally retained by FQHCs after Medi-Cal PPS reconciliation.

Effective January 1, 2025, FQHCs can bill the individual CPT codes for add-ons.

- When done correctly, this leads to higher reimbursement.

Accountable Care Organization (ACO) Considerations

- Some FQHCs may be members of ACOs participating in the Medicare Shared Savings Program (MSSP).
- Only people with Original Medicare can be attributed to an ACO.
- ACO membership does not change how FQHCs bill Original Medicare and Medi-Cal.
- If shared savings (or losses) take place, they accrue to the ACO, which credits (or debits) participating organizations based on ACO contract provisions.
- ACO participation does not affect billing staff processes but may affect clinical providers, as accurate Hierarchical Condition Category (HCC) documentation is critical to realize and optimize savings.

Dually Eligible Enrollees with Medicare Advantage (MA), including D-SNP, and Medi-Cal

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Billing Overview

STEP 1

Bill MA plan (not Medicare) as the primary payor.

Payment is based on negotiated rates defined in contract.

- Fee-for-service (FFS) is typically reimbursed at a percentage of the Medicare fee schedule.
- MA FFS payments tend to be significantly less than 80% of an FQHC's geographically adjusted Medicare Prospective Payment System (PPS) rate paid by Original Medicare.

Capitation – per member per month – is most often negotiated by Independent Practice Associations (IPAs).

- Utilization drives whether per-visit revenue is above or below Medicare PPS rate (lower utilization leads to higher payment per visit calculation).

While FQHCs can attempt to bill MA plans for visits as out-of-network providers if a contract is not in place, claims may be denied or require payment to be collected from the patient.

Prior authorizations for referrals may be required depending on the contract with the MA plan and/or IPA and if the organization is the patient's assigned primary care provider (PCP).

Note: D-SNP is Dual Eligible Special Needs Plan

Billing Overview

STEP 2

Bill Medicare Administrative Contractor (MAC) for visit site's 519 wrap rate if one has been approved by the MAC.

This 519 wrap rate is intended to increase reimbursement for Medicare Advantage visits up to an FQHC's Medicare PPS rate.

FQHCs must apply for 519 rates with each of their MACs.

- In California, the MACs are National Government Services (NGS) and Noridian.
- Health centers must apply for rates each time a new site location is opened or when they enter into a new MA agreement.
- MACs allow for retroactive billing, meaning visits that occurred prior to establishing 519 rates are still eligible for reimbursement

How far back retroactive billing is allowed varies by MAC.

- With Noridian, it is the effective date of the contract and/or when the provider number was approved.
- With NGS, it is one year from the date of 519 approval.

Medicare does not reconcile the sum of MA payments and 519 payments to see if they are above or below the geographically adjusted Medicare PPS rate.

Billing Overview

STEP 3

Bill the patient's Medi-Cal managed care plan (MCP) for secondary coverage. (This may be internally coordinated by MA/D-SNP if they are the same carrier as the Medi-Cal MCP.)

STEP 4

Bill the California Department of Health Care Services (DHCS) via a Medicare crossover billing code set.

Medicare Special Visit Types and Add-Ons

Medicare “special visit types” (e.g., New Patient visits, Annual Wellness Visits (AWVs), Welcome to Medicare (aka Initial Preventive Physical Examination or IPPE) visits, and most “add-ons” (e.g., Medicare Chronic Care Management, Remote Patient Monitoring)) cannot be billed directly to Medicare; FQHCs can attempt to negotiate terms with MA/D-SNP plans to provide these services.

MA plan enrollees are entitled to Chronic Care Management (CCM) services, but MA plans have some flexibility in how to furnish these services.

- Therefore, FQHCs may have more success in contracting with MA plans for CCM add-on services than other add-ons, but will need to negotiate the rate.

Special Considerations for D-SNP

For Exclusively Aligned Enrollment (EAE) D-SNPs, Medicare and Medi-Cal benefits are provided by the same entity.

- Beneficiary enrollment is operated by the same parent organization for improved care coordination and integration.

Non-Aligned D-SNPs still exist but may not enroll new beneficiaries.

- Non-Aligned D-SNPs are only responsible for Medicare coverage and services but must coordinate with Medi-Cal MCPs (and DHCS for Medi-Cal benefits carved out of MCPs).

D-SNP enrollees do not qualify for Enhanced Care Management (ECM) services under CalAIM (California Advancing and Innovating Medi-Cal).

- Instead, D-SNPs are required to coordinate CA Integrated Care Management (CICM) services (which are similar to ECM) for specific populations, like ECM populations of focus.
  - DHCS recommends that D-SNPs contract with community-based organizations that serve CICM populations to augment D-SNP plan-based care management and leverage existing relationships with Medi-Cal providers to do so.
  - Therefore, FQHCs may have opportunities to negotiate CICM rates or fees with D-SNP plans and contract for CICM services.

Original Medicare Only

Billing Overview

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- In CA, the CY25 GAF range is from 1.051 to 1.257.

Original Medicare is an 80/20 co-insurance plan. Patients (or other supplemental plans) are responsible for paying the 20% of costs not covered by Medicare.

Outpatient services in Original Medicare are covered under Medicare Part B, but FQHCs actually bill Medicare PPS services to Part A because Medicare considers FQHCs to be “institutions.”

The Medicare PPS base rate is annually adjusted by the Medicare Economic Index (MEI).

Billing Overview

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Medicare Advantage (MA) Plan Only

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Billing Overview

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About the Authors and Related Resources

California Health Care Foundation

About the Authors

About the Authors

Benjamin Leroi, MPA; Nathan Smith, MPH; and Mila Duenas, CBCS, are consultants at Wipfli Advisory LLC, a national consulting firm providing professional services to Federally Qualified Health Centers and other organizations in the health care industry.

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Appendix: Related Resources

Centers for Medicare & Medicaid Services

Federally Qualified Health Centers (FQHC) Center – Medicare Claims Processing Manual: Chapter 9 – Rural Health Clinics/Federally Qualified Health Centers (PDF), June 2025.

Medicare Learning Network (MLN) Booklet: Federally Qualified Health Center (MLN006397) (PDF), April 2025.

California Department of Health Care Services

Crossover Billing Toolkit for Medicare Providers Serving People with Both Medicare and Medi-Cal (PDF), August 2024.

Medicare/Medi-Cal Crossover Claims: Outpatient Services (PDF), August 2020. (FQHC information can be found on page 12.)

Cost Report Forms and Documents Reconciliation Request section, October 2024.

National Association of Community Health Centers

FQHC Payment Guide (PDF), July 2025.