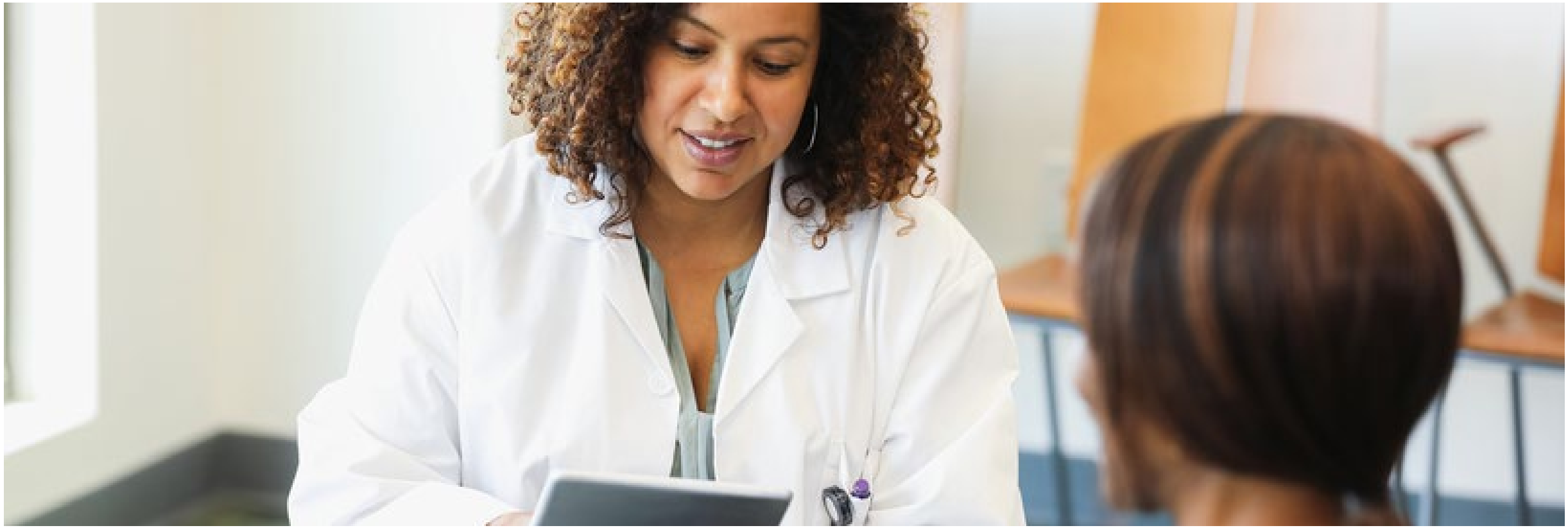

Navigating Medicare Wraparound for Community Health Centers

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Meet Your Presenter

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Agenda

- Medicare Wraparound Definition & Requirements
- Calculation & Submission
- Implementation

Medicare Advantage Wraparound

Medicare Advantage Wraparound

Medicare Advantage Plan

Medicare Part C

Private insurance company contract with Medicare

- Covers Part A (hospital) & Part B (physician)
- Prescription drugs (Part D)
- Vision
- Hearing

Network restrictions (in vs. out of network)

Considered all-in-one alternative to Original Medicare

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Medicare Advantage Wraparound

What is it?

Medicare Advantage (MA) plans are not required to pay PPS methodology; but they may choose/negotiate to pay PPS methodology

Section 237 of the Medicare Modernization Act (MMA) requires CMS to provide supplemental payments to FQHCs that contract with MA organizations to cover the difference, if any, between the payment received by the FQHC for treating Medicare Advantage (MA) enrollees & the payment to which the FQHC would be entitled to receive under the cost-based all-inclusive payment rate as set forth in 42 CFR, Part 405, Subpart X

When the MA contract/average rate is less than the applicable PPS rate that would otherwise have been paid by traditional Medicare, the MAC will pay the difference as a supplemental wrap-around payment, less any patient cost sharing

When the MA contract/average rate is greater than the applicable PPS rate, the MAC will not make any supplemental payment

Medicare Advantage Wraparound

What is it?

Medicare Advantage Contractor (MAC) requires specific information/data to be submitted

- Know your MAC
- May have more than 1 MAC

Wrap rate is set/approved by MAC

Medicare timely filing

- 365-day rolling lookback

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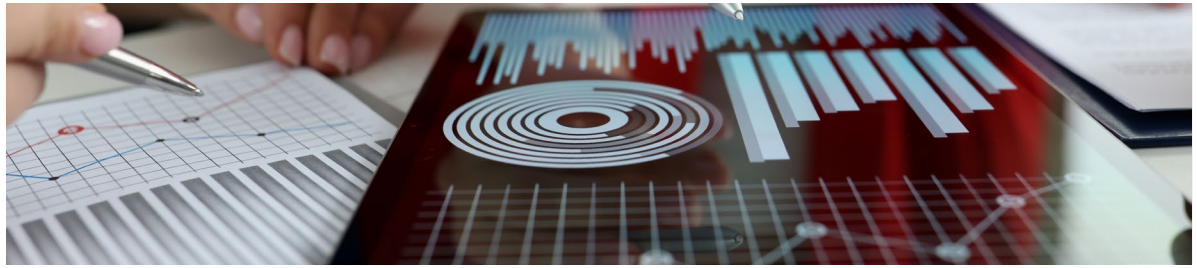
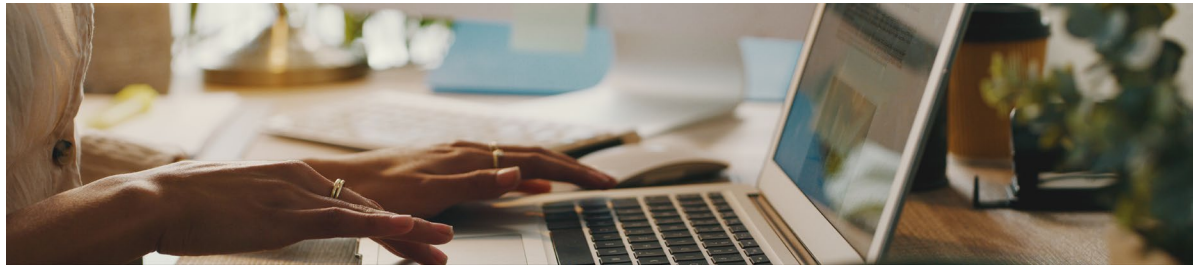
Medicare Advantage Wraparound
Requirements





FQHCs under contract (directly or indirectly) with MA organizations

- CMS has indicated that the supplemental “wrap-around” payment will be based on the applicable PPS rate without comparison to the FQHC’s charge
- Without consideration for secondary payor
- Does not function as a secondary or tertiary payor

Important to successfully navigate the process of establishing appropriate “wrap-around” rate(s)

- Oftentimes health centers do not navigate this process effectively & leave money on the table

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Medicare Advantage Wraparound
Requirements

- Direct contract
  - Written contract between health center & a MA plan
  - Contract terms in alignment with Title 42 CFR Section 422.527
  - Signed by both the FQHC & the MA Plan

§ 422.527 Agreements with Federally qualified health centers.

The contract between the MA organization and CMS must specify that—

(a) The MA organization must pay a Federally qualified health center (FQHC) a similar amount to what it pays other providers for similar services.

(b) Under such a contract, the FQHC must accept this payment as payment in full, except for allowable cost sharing which it may collect.

(c) Financial incentives, such as risk pool payments or bonuses, and financial withholdings are not considered in determining the payments made by CMS under § 422.316(a).

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Medicare Advantage Wraparound Requirements

- Indirect contract
  - Health center is part of a group contract
  - Demonstrate health center is part of group contract
  - Copy of the group contract with required components

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Medicare Advantage Wraparound

Requirements

- Each MA contract needs to include the following information:
  - Signature from health center/group representative
  - Signature from the MA contract representative
  - Payment methodology
    - PPS
    - FFS
    - Capitation
  - Reference to Medicare Advantage line of business

Medicare Advantage Wraparound

Requirements

- Valid Medicare Advantage Contractor number for each contract
  - Each contract can have more than 1 Contract Number
  - Medicare Advantage Plan Contract Number Example:

Legal Entity Name	Organization Marketing Name	Contract Number	Organization Type	Plan Type
HUMANA BENEFIT PLAN OF ILLINOIS, INC.	Humana	H1468	Local CCP	HMO/HMOPOS
HUMANA BENEFIT PLAN OF ILLINOIS, INC.	Humana	H5525	Local CCP	Local PPO

MA Plan Directory | CMS

Medicare Advantage Wraparound

Calculation

- Start by knowing what the eligible PPS rates are
- Eligible PA Medicare 2026 GAF Rate (1.1.26-12.31.26)

CY 2026 FQHC GAF BY STATE AND MEDICARE LOCALITY				
Medicare Administrative Contractor (MAC)	State	Locality Number	Locality Name	2026 FQHC GAF (with 1.0 Floor)
12502	PA	01	METROPOLITAN PHILADELPHIA	1.029
12502	PA	99	REST OF PENNSYLVANIA	0.960

Note: The FQHC GAFs are adapted from the Physician Fee Schedule work and practice expense geographic practice cost indices (GPCIs). The work GPCI floor of 1.0 that was applied in previous updates was extended through January 31, 2026 by Section 6207 of Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 (H.R.5371).

Medicare Advantage Wraparound
Calculation

EXAMPLE:

- Eligible PA Medicare 2026 PPS Rates
  - **Rest of Pennsylvania** 2026 GAF 0.960 (as of 1.1.26)
  - 2026 National PPS Rate $207.72
    - 2026 Established visit $199.41 ($207.72*0.960)
    - 2026 National New/AWV visit Factor 0.3416
    - 2026 New/AWV $267.53 ($199.41*1.3416)
  - **Metro Philly Pennsylvania** 2026 GAF 1.029 (as of 1.1.26)
  - 2026 National PPS Rate $207.72
    - 2026 Established visit $213.74 ($207.72*1.029)
    - 2026 National New/AWV visit Factor 0.3416
    - 2026 New/AWV $286.75 ($213.74*1.3416)

Medicare Advantage Wraparound

Calculation

- **Rate Calculation** include following data fields:
  - Claim/encounter number
  - Date of service (6 months)
  - Clinic location
  - Payor name
  - Procedure codes (CPT/HCPC)
  - Payment amounts
    - Payor payment
    - Patient payment
    - Total payment (if includes both payor & patient)
    - Allowed amount (if available)

Medicare Advantage Wraparound

Calculation

Identify CPT/HCPC codes that are paid as part of the PPS rate (when paid by traditional Medicare)

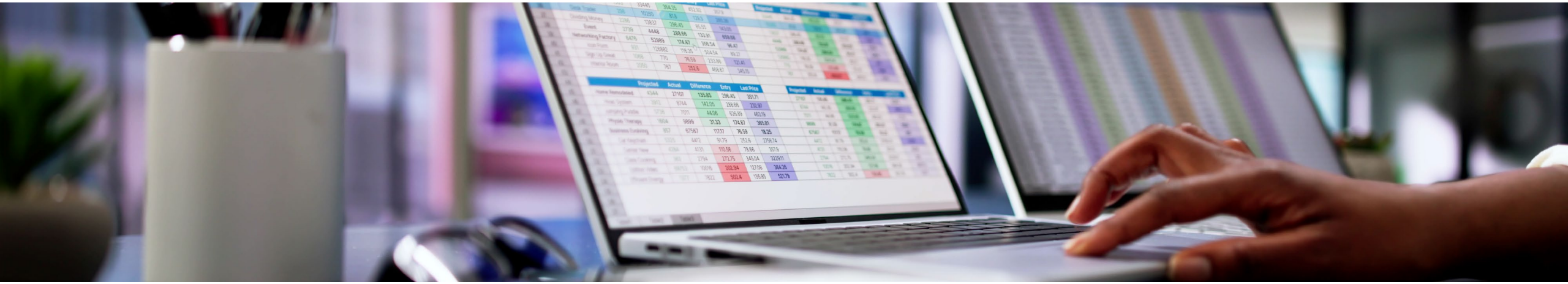
- Refer to Medicare Qualifying Code List
- Procedures (in office)
- Part B pharmaceuticals

Exclude CPT/HCPC for services paid separately

- Flu, Pneumonia, Covid, Hep B
- Labs
- Technical component of diagnostic & preventive services

Medicare Advantage Wraparound

Calculation



- Calculate the average payment per qualifying visit
  - Divide payments by visits
- Adjust visit count for multiple medical services in same encounter
  - If multiple qualifying codes in same encounter, only count as 1 visit
    - *i.e.*, AWV & problem visit
    - Exclude CPT/HCPC codes with zero payment

Medicare Advantage Wraparound

Calculation

- **Example MA Plans paying FFS:**
  - Eligible PPS payment per established visit $199.41
  - Average FFS payment per qualifying visit $100.00 = wrap rate
    - Supplemental Established Visit Payment Amount $99.41 ($199.41-$100)
  - Eligible PPS payment per new/AWV visit $213.74
    - Supplemental New/AWV Visit Payment Amount $113.74 ($213.74-$100)

  - Established patient visits (12 months) 15,000
  - New/AWV patient visits (12 months) 2,000

  - Annual Estimated ROI 15,000 x $99.41 = $1,491,150 Established patient visits
  - Annual Estimated ROI 2,000 x $113.74 = $227,480 New/AWV patient visits
    - Total Annual Estimated ROI $1,718,630

Medicare Advantage Wraparound

Submission to MAC

- Copy of signed contract
- Per visit payment calculation worksheet
- Claims data to support calculation of average payment
- Cover letter
  - Contract ID (could be more than one per payor)
  - Individual clinic address & PTAN (provider transaction access number, aka Medicare Number)
  - Request effective date that aligns with the payor contract effective date
- 50 EOBs
- Email (securely) to MAC
- Yes, this needs to be done for each Medicare Advantage Plan
- Need to submit to individual MAC if you have multiple MACs
- Contact MAC to confirm process & submission requirements
- MAC will provide approval letter with effective date
  - Rolling effective date

Medicare Advantage Wraparound

Implementation

- Get ready to submit claims
  - Historical
    - *i.e.*, effective date 4.1.25
    - If claims submitted 4.15.26, then new effective date is 4.15.25
    - Some MACs are going back several years
  - Practice management system
    - Set up new payor, *i.e.*, MA Wrap Payor
    - Add MA Wrap Payor to patient visit as applicable
      - Historical
      - Future
      - Automate, if possible
- Front Desk staff training
- Billing staff training

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Medicare Advantage Wraparound

Implementation

- Claim submission
- Submit claim to appropriate Medicare MAC for Supplemental Payment:
  - TOB 77x
  - **Revenue code 0519**
  - CPT/HCPCS codes are required
  - G code is required
  - Claim will look like a claim when a patient has traditional Medicare except for the revenue code
  - Claim can be submitted at the same time as the claim is submitted to the MA Plan
  - Claims will return to provider with reason code 37098 when the FQHC PPS supplemental rate is not present for the MA plan

Medicare Advantage Wraparound

Claim Field Examples

FL 42 Rev Code	FL 43 Description	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges
0519	FQHC visit, estab pt	G0467	100114	1	$156.00
0519	Office/outpatient visit est	99212	100114	1	$100.00
0519	Hep b vacc adult 3 dose im	90746	100114	1	$60.00
0519	Admin hepatitis b vaccine	G0010	100114	1	$20.00
0001					$336.00

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Medicare Advantage Wraparound

Implementation

- We are not seeing PS&R Form 778 payments of significance
- Money on the table
- Why is it not being done by community health center?

Confusion on how to get enrolled

Confusion on setting up the payment

Confusion on setting up the practice management system

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Medicare Advantage Wraparound

Common Questions

- What if the contract indicates payment is PPS but the health center is not getting paid PPS?
- What if the contract indicates payment is FFS but the health center is not getting paid FFS?
- What if the contract indicates payment is PPS and the actual payment is PPS but the average per qualifying visit payment is less than PPS (including payment from patient/allowed amount)?
- What if there is no contract in place?
- What if the contract cannot be located?
- What if the contract was recently executed?
- Is there really money available?
- Is there a way to account for payments for established vs. new vs. annual wellness visit?
- Do I need to update/renew annually?

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Medicare Advantage Wraparound

References

- eCFR : 42 CFR 422.527 – Agreements with Federally qualified health centers
- MA Plan Directory | CMS
- Federally Qualified Health Centers (FQHC) Center | CMS

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Contact

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