THOUGHTWARE®

RHC Regulatory and Reimbursement Update

Glenn Grigsby, CPA
Managing Director
Louisville| 502.581.0435
ggrigsby@bkd.com

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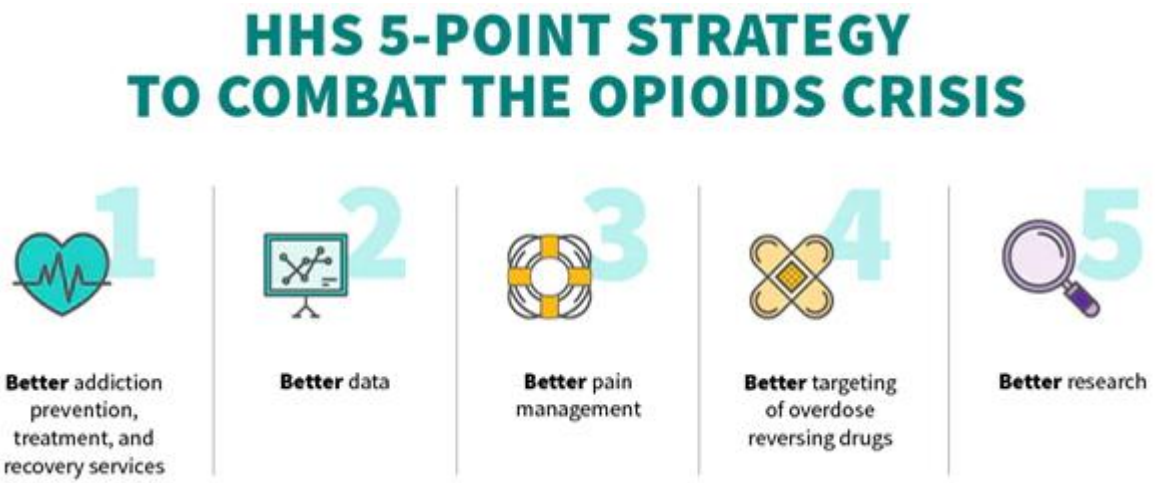
Current Environment

- **Rural Health Clinics continue to provide basic services in underserved areas**
  - **Currently over 4,500 RHCs nationwide**
  - **Many RHCs are expanding services to combat the opioid epidemic**
    - RCORP-Medication-Assisted Treatment Expansion awards
    - Up to $725,000 for 3 year period to expand MAT
  - **RHCs begin to add care management and virtual communication services**
    - **CCM rate increased to $67.03 (G0511)**
  - **RHCs and FQHCs expanding into school-based health services**

Current Environment

- **Health Centers identified to be on the front line to help combat the opioid crisis**
  - September, 2018 - HHS awards over $1 billion to support Five-Point Opioid Strategy



Current Environment - Medicare

- **CMS continues to explore and expand payment for telehealth and virtual communication services**
  - Virtual Communications (HCPCS code G0071)
  - Included in 2019 MPFS Final Rule (effective 1/1/19)
  - Brief discussion to determine if visit is necessary
    - Does not replace a face to face visit
    - Not to be confused with telehealth
  - At least 5 minutes of communication (telephone, secured text, email, etc)
  - Patient must have had a billable visit in the past year
  - Not billable if patient was seen within 7 days prior to discussion or leads to a visit within 24 hours
  - Paid at $13.69 subject to coinsurance
  - Billing is tricky
  - Goal – Concern for patients health outside of the visit

Current Environment - Medicaid

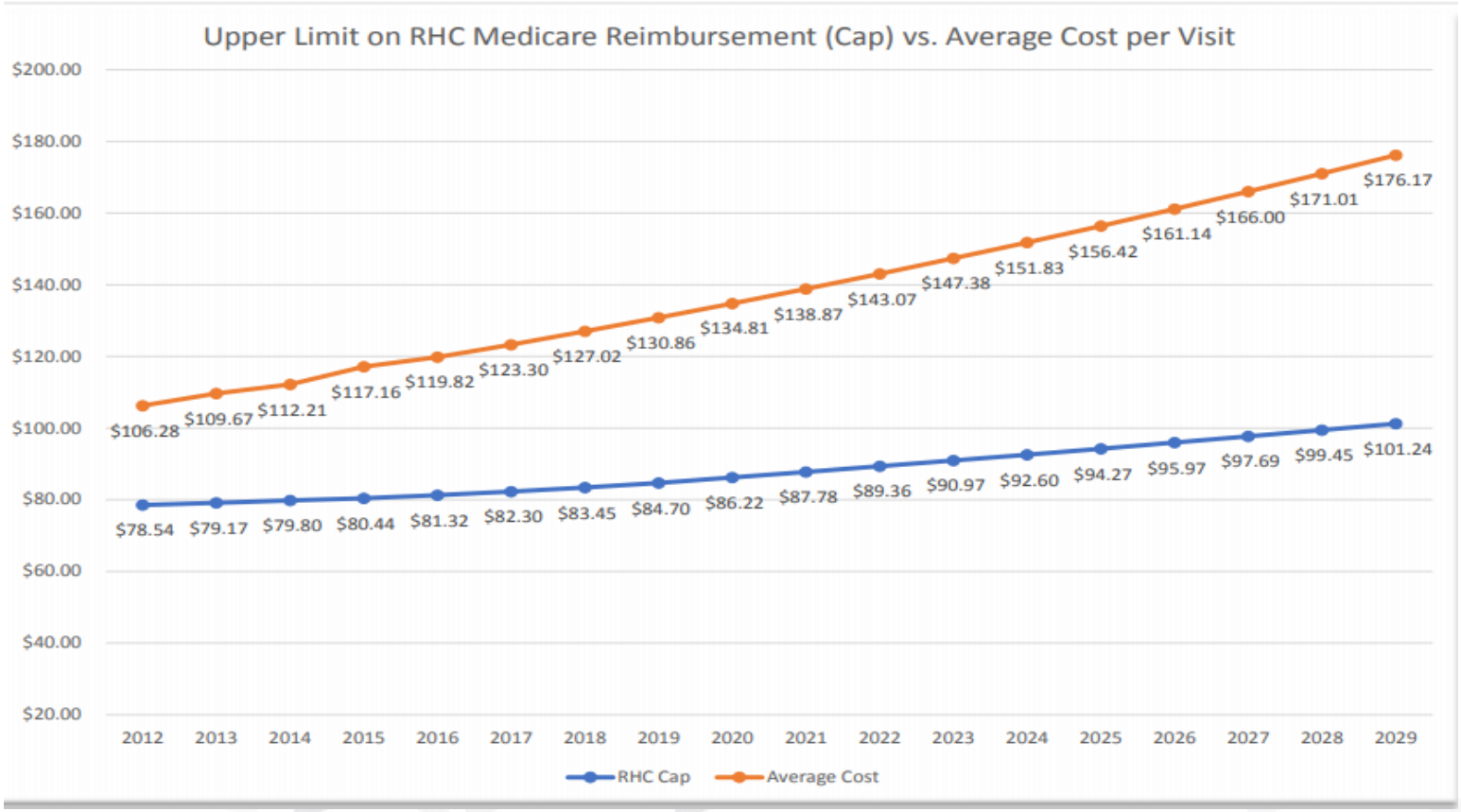
- **Kentucky is seeking permission from CMS to amend state plan to expand school-based health services**
  - School districts receive federal Medicaid funding to provide increased access such as mental health, screenings, and asthma management
  - RHC and FQHC continue to find solutions to partner with school districts

Current Environment - Medicare

- **S.1037 - Rural Health Clinic Modernization Act of 2019**
  - **Introduced in Senate April 4, 2019**
  - **Raises Medicare cap to $105 per visit beginning in CY 2020**
    - **Currently $84.70 for CY 2019**
  - **Aligns federal physician supervision requirements to state scope of practice**
  - **Allows RHCs to move certain lab services offsite**
  - **Removes employed NP or PA requirement**
  - **Allows RHCs to be distant site for telehealth services**
  - **Creates state option for rural designation**

Current Environment - Medicare

NARHC NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS



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Medicare Cost Report 222-17

- **Medicare issued new cost report form 222-17 replacing the old 222-92**
  - Effective for cost reporting periods ending on or after 9/30/18
  - Followed the FQHC which created their own form 224-14 cost report
  - Eliminated CMS 339 Questionnaire
  - Expanded visit category by including Title V and Title XIX visit counts
  - Renamed worksheets to be consistent with other cost report forms
  - Reorganized and expanded cost centers on Worksheet A
    - Flu and pneumo vaccine cost
  - Added new lines for CCM and Telehealth (not paid under AIR)
  - Estimated time to complete increased from 50 to 55 hours

Medicare Cost Report 222-17

- **Takeaways for those responsible for gathering cost report data**
  - Must enter date requested and approved for consolidated sites
  - Malpractice premium reporting requirements
  - Must be able to report visits by Medicare, Medicaid and Other
  - Influenza and pneumococcal vaccine cost are now reported in their own cost center on Worksheet A, lines 30 and 31
    - Previously reported directly on WS B-1
    - Will more than likely require a reclass on Worksheet A-6

Medicare Cost Report 222-17

- **Takeaways for those responsible for gathering cost report data**
  - Frequently request PS&R summaries to keep login current
  - Financial data should be reported on accrual (not cash) basis
  - Keep vaccine logs current
  - Keep vaccine invoices handy
    - Prevnar 13 vs pneumovax
  - Track Medicare bad debts
    - Paid at 65%

Medicare Cost Report 222-17

EXHIBIT 1
LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

RHC Name _____
RHC CCN _____
FYE _____

Prepared By _____
Date Prepared _____

Patient Name	MBI. No.	Dates of Service		Indigency& Medicaid Beneficiary (Check if applicable)		Date First Bill Sent to Beneficiary	Date Collection Efforts Ceased	Medicare Remittance Advice Dates	Co-Insurance/ Total Medicare Bad Debts*
		From	To	Yes	Medicaid Number				
1	2	3	4	5	6	7	8	9	10

*These amounts must not be claimed unless the RHC bills for these services with the intention of receiving payment. See instructions for columns 5 and 6 - Indigency/Medicaid Beneficiary, for possible exception. These amounts must not be claimed if they were included on a previous Medicare bad debt listing or cost report.

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Medicare Cost Report 222-17

- **Takeaways for those responsible for gathering cost report data**
  - Some of the Medicare contractors (Palmetto) are now paying lump sum payments and adjusting rates in the interim
    - Send any MAC correspondence to your cost report preparer
  - New RHCs
    - Typically paid an interim rate of $50 unless projected cost reports are submitted to the MAC
    - Must request approval to consolidate
    - Must bill under the correct PTAN

Medicaid Reminders

- RHCs paid a PPS rate
  - Based on first full fiscal year after the effective enrollment date (survey date)
    - Must reach maximum hours per day, days per week and weeks per year of intended operation
  - Paid on an interim rate until a cost report is filed and audited
    - Based on PPS rates of entities with similar caseloads
    - Track actual vs interim at a minimum quarterly
  - If final rate is lower than Alternative Payment Methodology, the APM can be requested
    - $99.75
    - Not adjusted for inflation

Medicaid Reminders

- RHCs paid a PPS rate
  - Cost reports are subject to audit by Myers & Stauffer
  - Review provider compensation and productivity
  - Review any related part costs
- Consider possible rate increases due to change in scope
  - OB/GYN
  - MAT/SUD
  - Behavioral Health

Threats

- Potential Cuts to 340B program (provider-based RHCs)
- Future of Medicaid PPS
  - Shift from volume to value
- Staffing shortages
- Medicaid expansion

Questions?