

Rural Health Clinic National Update

Idaho Bureau of Rural Health & Primary Care

November 5, 2014

2:00 p.m.-3:00 p.m.



Jeff Johnson - CPA, Partner
Wipfli Health Care Practice

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Sources of Information

Many of the following slides contains information provided by
Bill Finerfrock, Executive Director
National Association of Rural Health Clinics

If you have not joined the National Association of Rural Health Clinics, organization, I highly recommend you do. They are the only dedicated organization that works exclusively on behalf and for rural health clinics, both independent and hospital-based.

Bill's contact information is:

NARHC

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Congress

- Impact of the Elections.
- Prior to Congressional recess for campaigning, Congress has yet to pass any of the 12 Appropriations bills necessary to fund the federal government.
- Prior to adjourning, Congress adopted a Continuing Resolution effectively extending the current fiscal year through December 11th.
- Congress will reconvene after the election for a Lame Duck session. Lame Duck sessions are notoriously unproductive and there is no reason to believe that this one will be any different than previous Lame Duck sessions.



Post Election (2014)

- Beyond dealing with Appropriations Bills to prevent a government shut-down and potentially dealing with some expiring tax provisions, no substantive legislation is likely to be considered during the November/December Lame Duck session.
- During the Lame Duck, Congress will enact another Continuing Resolution keeping the government open; however, it is not clear how long that CR will last. It could be short-term (1-3 months) or long-term (9 months) or somewhere in between.





Who are the RHCs?

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Ownership of RHCs

Ownership/ Control Category	Frequency	Percent
Government	633	16.67%
Non-Profit	1436	37.81%
Profit	1729	45.52%

Based on 2010 Center for Medicare and Medicaid Provider of Services File



Number of RHC's Per State- Top 10

Missouri	374
Texas	313
California	286
Illinois	221
Kansas	179
Michigan	172
Mississippi	163
Kentucky	147
Florida	143
Iowa	142



RHC's per 100,000 population

North Dakota	8
Montana	7.5
Nebraska	7.3
South Dakota	7
Kansas	6
Minnesota	6
Mississippi	6
Missouri	5.5
Iowa	5
Ohio	5



Comparison

Missouri	374
Texas	313
California	286
Illinois	221
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North Dakota	8
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Kansas	6
Minnesota	6
Mississippi	6
Missouri	5.5
Iowa	5
Ohio	5





RHC National Issues

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Sequester Update

- Beginning in 2013, Sequester mandated a 2% cut in RHC Medicare payments and was then adopted. This applied to ALL providers.
- Beginning April 1, 2013, Medicare RHC payments were reduced from 80% of the approved amount to 78.4% of the approved amount.
- Sequester currently scheduled through 2025



Sequester Update

What will this mean for 2014 and beyond?

- On January 1, 2014, the RHC Cap was set at \$79.80 per visit.
- With the allowable for the RHC in 2014 of \$79.80, then the actual payment from Medicare has been: **\$62.56** per visit ($\$79.80 \times .784$). The calculation of the beneficiary coinsurance (20% of fee schedule amount) is un-changed.



Sequester Update

- We do not expect any NEW sequester related cuts for Medicare HOWEVER, the existing reduction remains in place.
- Absent Congressional action, Medicare will continue the 1.6% reduction in provider payments for the foreseeable future.
- Although the sequester reduction is scheduled to go away in 2025*, providers should anticipate that this reduced amount (78.4% compared to 80%) will remain in place forever!

We expect that Congress will extend the back-end of this cut year-by-year for the foreseeable future.



President's Proposed Changes for RHC's

On March 4, 2014, the Obama Administration released their budget proposal for the FY 2015 (Of course, not enacted)

- Reduce the amount of Bad Debt for RHC's, CAH's and others can claim from 65% to 25% over three years.
 - Note: Currently, in year 2 of 3 year phase down to 65%; 76% in 2014, and 65% in year 2015 (based on cost reports beginning in applicable federal fiscal year
- Not allow CAH status for hospitals that are within 10 miles of one another.
- Reduce CAH payments from 101% of costs to 100% of costs.
- Of these, the most likely candidate for adoption is the Bad Debt proposal. At this time, we see no movement on the other proposals.



RHC Legislative Issues for 2014 and beyond

- Raise the RHC Cap
- Increase flexibility for RHC's
- Remove unnecessary regulatory burdens on RHC's
- Establish a long-term payment methodology that allows all RHC's to recoup costs for care provided to Medicare and Medicaid patients
- Improve EHR incentive payments for RHC's



Raise RHC Cap

- NARHC has been working with key Members of Congress to raise the RHC cap to \$92.00 per visit.
- Based on Wipfli NARHC RHC Benchmark Report, I believe it should be at least \$110 per visit.



RHC Payments

- The Rural Health Clinic all-inclusive payment methodology was the first bundled payment under the Medicare program. But despite the national move to bundled payments, the RHC payment system has come under some criticism of late.
- Establish a long-term payment methodology that allows ALL RHC's to recoup costs for care provided to Medicare and Medicaid patients and incorporates RHC specific quality measures. ORHP has funded an initiative to identify quality measures appropriate for the RHC setting.
- Allow RHC to be the “providers of care” in telemedicine arrangements rather than just the originating site.
- Allow services, such as therapy, diabetes and medical nutrition therapy, to be billable RHC visits rather than just allowable costs.
- Allow RHC's to conduct “group” visits and bill for group visits.



Medicaid EHR incentive Payment Program

- Modify “Needy” Threshold
- Open to ALL PA’s, not just those who “lead” RHC’s.



Other Legislation

- Extend MEDICARE EHR incentive payments to physicians working in RHC's.

Good or Bad for RHC's?



RHC Regulatory Issues

This summer, we had several regulatory victories for RHC's and their patients.

- Eliminated the regulatory requirement for physician on-site availability and instead, defer to applicable state law/state regulatory mechanism.
~New Rule went into effect in early July, 2014.
- Changed the RHC rule from 60% PA/NP staffing to mirror the law 50%.
~New Rule went into effect in early July, 2014.
- Allowed some PA's and NP's to be independent Contractors in the RHC setting rather than "employees"
~New Rule went into effect in early July, 2014.



RHC Regulatory Issues

AND.....

- Allow certain preventive service visits to be billable visits when performed in the RHC setting when delivered as “stand alone” services.

CMS “clarified” their policy in mid-August to allow the following services to be billed when performed as a “stand alone” visit in the RHC.



Service	HCPCS Code	Long Descriptor	Paid at the AIR	Eligible for Same Day Billing	Coinsurance Deductible
Initial Preventive Physical Exam (IPPE)	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment.	Yes	Yes	Waived
Annual Wellness Visit	G0438	Annual wellness visit, including PPS, First visit.	Yes	No	Waived
	G0439	Annual wellness visit, including PPS, Subsequent visit.	Yes	No	Waived
Screening Pelvic Exam	G0101	Cervical or Vaginal cancer screening; pelvic and clinical breast examination.	Yes	No	Waived
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal Examination.	Yes	No	Not Waived
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an Optometrist or Ophthalmologist.	Yes	No	Not Waived
	G0118	Glaucoma screening for high risk patients furnished under the direct supervision of an Optometrist or Ophthalmologist.	Yes	No	Not Waived

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PA Ownership of an RHC?

Earlier this year, CMS announced that they did not believe they could approve an RHC if the clinic was owned 100% by a PA. NARHC intervened, pointed out that CMS was misinterpreting the statute and after a subsequent internal review, agreed that the NARHC interpretation was correct.

PA's CAN own federally certified RHC's.





What lies ahead?

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Final Rule – Medicare PPS for FQHC's

- Affordable Care Act (ACA) authorizes the conversion for Federally Qualified Health Centers (FQHCs) from cost-based reimbursement to prospective payment system methodology.
- On May 2, 2014, CMS released the *Prospective Payment System for Federally Qualified Health Centers; Changes to Contracting Policies for Rural Health Clinics; and Changes to Clinical Laboratory Improvement Amendments of 1988 Enforcement Actions for Proficiency Testing Referral Final Rule*.
- This may be a model that is adopted by CMS for Rural Health Clinics



Final Rule – Medicare PPS for FQHC's

- Establishes a single national base PPS rate with geographic and other adjustments
- Effective for Medicare cost reporting periods beginning on or after October 1, 2014, with all FQHC's phased in by end of 2015
- FQHC PPS rate will be established on a calendar year cycle beginning January 2016
- Medicare payments to FQHC's are expected to increase 32% - however, Medicare currently accounts for only 9% of FQHC claims



Final Rule – Medicare PPS for FQHC's

- Summary of Modifications
 - FQHC's will be paid the lesser of actual charges or the PPS rate with a 20% reduction for coinsurance for all claims except certain preventative services
 - National baseline PPS rate of \$158.85 will be multiplied by a localized geographic adjustment factor (GAF)
 - *Idaho = 0.935 in CY14 = \$148.53*
 - A 34.16% high intensity multiplier will be available for initial preventative physical exams (IPPE) and annual wellness visits (AWV)
 - *\$148.53 * 1.3416 = \$199.27 in CY14*
 - Baseline PPS rate will be updated annually based on either the Medicare Physician Fee Schedule Medicare Economic Index (MEI) or through an FQHC specific market basket index (to be published by CMS)



Final Rule – Medicare PPS for FQHC's

- Summary of Modifications
 - FQHC's will be able to bill for more than one patient visit per day when a patient has an injury or illness subsequent to the first visit that requires additional diagnosis or treatment on the same day
 - FQHC's will be able to bill separately for one mental health visit and one medical visit for the same patient occurring on the same day
 - Coinsurance for certain preventative services is waived in accordance with the Affordable Care Act
 - When both preventative and non-preventative services are provided in the same visit, the FQHC's line-item charge for the preventative service will be the basis for computing the amount of waived coinsurance
 - Confirms the availability of “wrap around” payments for Medicare Advantage plans when the negotiated contract rate is less than the FQHC PPS rate



Final Rule – Medicare PPS for FQHC's

- Summary of Modifications
 - CMS to publish further guidance establishing “G-Codes “ in response to concerns raised about potential understating of charges using Healthcare Common Procedures Coding System (HCPCS) - *A concern because the FQHC will be paid lesser of charges or PPS rate*
 - Allows FQHC to establish charges for bundled services pursuant its own determination of what would be appropriate for the services normally provided
 - Five specific “G-Codes” must be used when submitting claims under PPS
 - G0466 – New patient
 - G0467 – Established patient
 - G0468 – IPPE or AWW
 - G0469 – Mental health, new patient
 - G0470 – Mental health, established patient



Final Rule – Medicare PPS for FQHC's

- Summary of Modifications (continued)
 - FQHC visit will no longer be able to separately bill for qualified practitioners of outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) under the new Medicare PPS methodology.
 - Cost Report submissions will still be required due to other cost settlements included in the FQHC cost report:
 - Graduated Medical Education
 - Flu and Pneumococcal Vaccines





Medicare Physician Fee Schedule Final Rule

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2015 Medicare Physician Fee Schedule Final Rule

Some quick notables:

- Allow physicians bill Medicare \$40.39 per month for each patient with more than one chronic condition to improve care quality. *Currently not applicable to Rural Health Clinics.*
- Expand coverage for telehealth physician visits by requiring Medicare to reimburse physicians for wellness and behavioral health visits.
- Eliminate a "narrative" requirement that requires physicians to submit written descriptions explaining why home health services are necessary.
- CMS also announced in the regulations that it will consider whether to reimburse providers for end-of-life care counseling. The potential payment changes would take effect in 2016 and would apply to voluntary end-of-life care counseling.
- In the rules, CMS noted that providers could see payment cuts around 21% in April 2014 if action is not taken on Medicare's sustainable growth rate formula.



Questions

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Speaker Information

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