Understanding Your Rural Health Clinic Medicare Reimbursement

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Objectives

- Better understanding of RHC reimbursement
- Better understanding of RHC cost report "risk areas"
- Improved data gathering for annual RHC cost report
- Provide examples of "best practices" for cost report strategies

Agenda

Today's Agenda

- Designation Criteria
- Medicare Reimbursement
- Ancillary Services
- Visits
- Productivity Standards
- FTEs
- Vaccinations
- Medicare Bad Debts
- Other Opportunities

Rural Health Clinics

Applicable Regulations

CMS Pub 100-02, Chapter 13
CMS Pub 100-04, Chapter 9
PRM 15-1
PRM 15-2, Chapter 29 (Form 222)
PRM 15-2, Chapter 40, 4010 and 4066-4070 (Worksheet S-8 and M-Series) (Form 2552)

Designation Criteria

Location Requirements – RHC must be located in:

1. A non-urbanized area, as determined by the U.S. Census Bureau, and

2. An area designated or certified within the previous 4 years in any one of the four types of shortage designation areas:
   - Geographic Primary Care HPSA;
   - Population-group Primary Care HPSA;
   - MUA (does not include the population group MUP designation);
   - Governor-Designated and Secretary-Certified Shortage Area (does not include Governor's MUP designation).

Designation Criteria

Staffing Requirements – In addition to the location requirements, a RHC must:

- Employ an NP or PA; and (island exception)

- Have an NP, PA or CNM working at the clinic at least 50 percent of the time the clinic is operating as a RHC.

- May request a temporary staffing waiver
  - Make good effort to recruit in the 90 days prior to the waiver request
  - Staffing waiver good for 1 year
  - Subsequent waivers cannot be granted until a minimum of 6 months have elapsed since the prior waiver expired.

Designation Criteria

Staffing Requirements (continued)

- RHC Practitioner
  - Physician
  - NP
  - PA
  - CNM
  - CP
  - CSW
- At least one of these practitioners must be present in the RHC and available to furnish patient care at all times the RHC is in operation.

Medicare Reimbursement

Medicare Cost Report

- Cost Per Visit (All-Inclusive Rate)
- Pneumococcal and Influenza Vaccinations
- Medicare Bad Debts

Medicare Reimbursement

Medicare Cost Report

- Accrual basis of accounting
- Based upon books/records of RHC
- Encompasses information from fiscal year
- Due – five months after fiscal year end

Medicare Reimbursement

Medicare Reimbursement of RHCs

- Paid cost per visit by Medicare
  - All-inclusive Rate (AIR)
- Cost per visit/AIR is determined through the RHC cost report which determines final payment
  - Freestanding = separate cost report
  - Provider-based RHCs = M series of hospital cost report

Medicare Reimbursement

Cost per visit limitation

- Freestanding RHCs
- Provider-based RHCs to hospitals in excess of 50 beds
- 2017 per visit limit = $82.30

Provider-based RHCs to hospitals less than 50 beds do not have a cost per visit limitation.

Medicare Reimbursement

Exception Provider-based RHCs to hospitals with 50 beds or more:
(Conflicting Info)

Benefit Policy Manual (100-02, Chapter 13, Section 70.2)

- Average daily census does not exceed 40 and meets both of the following additional requirements:
  - Sole community hospital (42 CFR 412.92) or EACH (412.109(a))
  - Located in a level 9 or 10 Rural-Urban Commuting Area (RUCA).

Medicare Reimbursement

Exception Provider-based RHCs to hospitals with 50 beds or more:
(Conflicting Info)

Claims Processing Manual (100-04, Chapter 9, Section 20.6.3)

- Average daily census does not exceed 40 and meets the following conditions:
  - Sole community hospital, and
  - Located in an 8-level or 9-level nonmetropolitan county using urban influence codes as defined by the U.S. Department of Agriculture.

Medicare Reimbursement

- Change Request 8981 issued December 12, 2014 with Effective Date January 1, 2015 updated 100-04, Chapter 13 eliminating the conflict with 100-02, Chapter 9.
  - Eliminates the exception for those RHCs whose exception was based on being located in an 8-level or 9-level nonmetropolitan county using urban influence codes

Medicare Reimbursement

Opportunities

- Provider-based RHC(s) hospital over 50 beds
  - Provider-based to rural hospital less than 50 beds?
  - Establish provider-based RHCs anyway for 340b benefit (qualifying hospital)?
    - Reimbursement due diligence must be done

Medicare Reimbursement

Initial Rate per Visit – New RHC

<u>Medicare</u>

- Independent/Freestanding RHC
  - Typically set and paid at cost per visit limit
- Provider-based RHC
  - Typically set at cost per visit limit in lieu of actual data
  - Recommend submit estimate, discuss with MAC

Medicare Reimbursement

Initial Rate per Visit – New RHC

Medicaid

- State specific
- Usually,
  - Statewide average rate for first year or two
  - Facility specific prospective rate based upon average of first two years cost reports or some variation of this

Medicare Reimbursement

What are allowable expenses under the all-inclusive rate?

- RHC physician wages & benefits/contracted expense
- RHC advanced practice providers (Midlevel) wages & benefits and contracted amounts also
- Clinical psychologist
- Clinical social worker
- Nursing personnel
- Medical supplies
- **Pharmacy**
- Building and space costs
- Equipment costs
- Office salaries & supplies

Medicare Reimbursement

What are some non-allowable expenses?

- Technical portion of Radiology services/EKGs
- Laboratory services
- **Services provided by RHC practitioner elsewhere (Non-RHC time) (i.e. - hospital, emergency room)**
- Prosthetic devices
- Non-allowable advertising
- Revenue received from non-patient care

Structure general ledger appropriately to capture costs separately.

Medicare Reimbursement

Non-RHC Services

Costs associated with non-RHC services must be offset or reclassified (provider-based) on the cost report.

- Hospital patients – offset
- Hospital administrative – reclassified
- Emergency Room Call – reclassified

Recommend time records versus per visit estimates

Medicare Reimbursement

Emergency Room Availability

- Very difficult to address
- Recommend compensation separately identified in contract

If not addressed in contract, based upon time spent.

Could be beneficial depending upon Medicare utilization ER versus RHC.

Ancillary Services

Pharmacy

- Cost of pharmacy is part of cost per visit
- Must be reported as part of RHC cost center
- Do not report as part of non-RHC pharmacy costs

Ancillary Services

Separately billable to Medicare A/B

- Technical portion of radiology services/EKGs
- Laboratory services

Must carve out time/space out of RHC cost report for this.

Hospital-based RHC – costs and charges should be included in hospital ancillary departments.

Visits

RHC Visits

- Medically necessary face-to-face encounter between a physician, nurse practitioner, physician assistant, certified nurse midwife, clinic psychologist or clinical social worker
- Transitional Care Management services can also be RHC visits.
- If approved visiting nurse program, home-bound visits by RN or LPN may also qualify.

Visits

Visits can take place at the following locations:

- Rural Health Clinic
- Patient's home
- Assisted Living
- Medicare covered Part A SNF (nursing home or swingbed)
- Scene of an accident

Visits

Cost Reporting – Visits

- Need to track/identify visits for each practitioner "type" separately
  - Physicians
  - Physician Assistant
  - Nurse Practitioner
  - Visiting Nurse
  - Clinic Psychologist
  - Clinic Social Worker
  - Physicians services under agreements

Visits

Tracking of visits

- Can be either a manual or electronic process
- Best if done by someone in clinic setting
- Document and record on monthly basis
- If electronic, consider auditing face-to-face encounters
- Recommend tracking for each practitioner separately

Remember – do not include nurse only visits in total visits for cost reporting.

Visits

Example

Provider Visits						
	NON-RHC VISITS			RHC VISITS		
Discipline	Inpatient/Outpatient	ER Visits During RHC Hours	ER Visit After RHC Hours	Nursing Home and Swing bed Billed as RHC	Rural Health Clinic	Total Visits
Physician #1						
Physician #2						
Physician Assistant #1						
Nurse Practitioner #1						
Nurse Practitioner #2						
Contracted Physicians (*)						
Locum Tenens (*)						
Clinical Social Worker						

** Contracted physicians include regularly scheduled physician staff the facility contracts with for services. Locum Tenens include only those physicians contracted or employed for the coverage of vacations, short term coverage due to lost physicians, etc.*

Productivity Standards

Productivity Standard

- 4,200 visits per 1.0 FTE Physician
- 2,100 visits per 1.0 FTE PA, NP or CNM
- No standard
  - Visiting nurse
  - Clinical psychologist
  - Clinical social worker
  - Physician services under agreements
- Frequently overstated
  - Higher calculated standard
  - Lower reimbursement

Productivity Standards

Exception to productivity standards:

- Request to MAC (Medicare Administrative Contractor)
- Granted by the MAC
- Demonstrated reasonable justification for not meeting standard
- Request new "standard" for your clinic for that period

Reasonable justification (examples):

- Loss of clinic use
- Provider turnover
- Economic conditions

FTEs

Key is the FTE!

- What time is NOT included in FTE calculation?
  - Hospital patients
  - Hospital administrative
  - PTO
  - Emergency Room Availability
- Essentially divide the hours worked in clinic (time spent seeing patients or scheduled to see patients) by, typically 2,080 hours.

FTEs

Opportunities

- Track specific time practitioner at clinic/SNF/Home for RHC services.
- Improve midlevel time in RHC as compared to physicians
- Adjust hours clinic is open for patients to be seen

FTEs

Example – FTE Effect (Provider-based RHC)

- 1.30 Physician FTEs
  - Actual visits = 3,550
  - Productivity standard = 5,460
- 1.50 Physician Assistant FTEs
  - Actual visits = 3,900
  - Productivity standard = 3,150
- Total visits = 7,450
- Prod standard visits = 8,610

FTEs

Example – FTE effect (Provider-based RHC)

Total cost of services = $1,825,000

Cost per visit (PS) = $211.96

Medicare visits = 2,500

Medicare recognized cost = $423,920 *($529,900 x .80)*

FTEs

Example – FTE effect (Provider-based RHC)

- FTE overstated, properly exclude hospital time
  - Physician = 1.15
  - PA = 1.38
- Revised productivity standard visits = 7,728
- Revised cost per visit = $236.15
- Revised Medicare cost = $472,300 *($590,375 x .80)*
- Difference of $48,380

Vaccinations

Influenza and Pneumococcal

- Do not bill separately or through the Hospital!
- Reimbursed through the cost report, vaccine and administration
- No billable RHC visit if sole purpose is vaccination(s)

Vaccinations

Information needed (separately for influenza and pneumococcal):

- Total vaccinations
- Medicare vaccinations
- Staff expense per vaccination - wage per vaccination
- Supply expense per vaccination - invoices

- Medicare and Non-Medicare
  - Patient Name and date of services
  - HIC number

Medicare Bad Debts

Amount allowable:

- Beginning on/after 10/1/14 – 65%

Coinsurance and Deductible

- Medically Indigent
- Attempted to collect bad debts
- Medicare Crossover

Other Opportunities

Chronic Care Management (CCM)

- Separately paid under the MPFS, not included in RHC AIR
- Should identify time/cost associated and show as "Other than RHC cost" on cost report (both practitioners and other clinical staff)

Other Opportunities

Consolidated Cost Reports/Worksheets

- Hospitals with multiple RHCs can elect to file consolidated M-series
- Election made to MAC before filing the Medicare Cost Report (varies among MACs)
- Benefits include combining visits for comparison to productivity standards

Other Opportunities

Consolidated RHC cost report example:

	RHC I	RHC II	Total
Productivity Standard	7,050	1,700	
Actual Visits	7,700	700	8,400
Medicare Visits	3,200	200	3,400
Total Costs	$1,600,000	$ 250,000	$ 1,850,000
Cost Per Visit	$ 207.79	$ 147.06	
Medicare Cost	$ 664,935	$ 29,412	$ 694,347
Combined Productivity Standard			8,520
Combined Cost Per Visit			$ 217.14
Medicare Cost			$ 738,263
Difference			$ 43,916

Other Opportunities

Provider-based RHCs Cost Reports

- Avoid double allocation of costs on hospital cost report
  - Common errors:
    - Business Office
    - Housekeeping
    - Plant
    - Medical Records

Other Opportunities

RHC Charge Structure

Factors to consider

- What are reimbursement terms of other payers?
  - Fee schedule
  - Percentage of Charge
- Medicare co-insurance is 20% of charge.

Other Opportunities

Setting of Clinic Charge

- Mostly fee schedule
  - Set clinic charges 10-20% above highest paying commercial fee schedule
  - Market consideration can factor in
    - If increasing charge, 20% coinsurance on Medicare patient
    - Covers calculated 20% of cost reduction on cost report

Other Opportunities

Commingling (Risk)

Commingling is prohibited to prevent:

- Duplicate Medicare or Medicaid reimbursement
- Selectively choosing a higher or lowe
  for the services

Other Opportunities

Commingling (cont.)

Rural Health Clinic (RHC) rules do indicate that commingling of space is allowable in the RHC if specific requirements are met for reporting on the Medicare cost report

- RHCs that share resources (e.g., waiting room, telephones, receptionist, etc.)
- Must have appropriate allocation of resources between RHC and non-RHC usage

Other Opportunities

Commingling (cont.)

- Do not recommend commingling even if can carve out cost.
  - Have received indication from individuals at CMS Central Office that the provider based rules in 42 CFR 413.65 also apply which would eliminate that opportunity
    - Free standing RHCs could have commingled space
  - Confirming opinions from some legal counsel

Other Opportunities

Commingling (cont.)

Possible Solutions

- Separate and Distinct Space
- PSA (Professional Services Agreement)
- Freestanding Clinic (really not a viable solution, depends upon reimbursement implications)

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Questions?