RURAL HEALTH CLINIC

August 23, 2019

Health Financial Systems

DISCOVERY
Healthcare Consulting Group

Background

- The Rural Health Clinic Services Act passed in 1977 to help meet the primary and emergency health needs of rural communities.
- Viewed as safety net providers that must be located in rural areas designated as underserved.
- CMS proposed to challenge rural and underserved designations. No final ruling.

Rural Health Clinic (RHC)
What is it?

- The Rural Health Clinic certification is a designation for clinics providing primary care in certain rural, underserved areas obtained from the Centers for Medicare and Medicaid Services (CMS), which provides an alternative, cost-based reimbursement system for treating Medicare and Medicaid beneficiaries.

- RHC's paid at an all-inclusive rate.

Qualifications

- RHC must be rural or non-urbanized AND one of the following:
  - A medically underserved area
  - A geographic Health Professional Shortage Area
  - A population group HPSA

Enrollment/Credentialing of RHC

- Whether provider-based or Freestanding, the certification process is the same.
- An initial application CMS 855A is required.
- Upon completion of the MAC review, recommendation letter is sent to the State.
- A survey is conducted to determine Conditions of Participation are met.
- Provider based RHCs are obligated to satisfy all requirements for provider-based status established under 42 CFR 413.65.
- CMS makes the final determination regarding the Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

Certifications

- RHC may be housed in a permanent or mobile structure.
- RHC may be freestanding or provider-based.
  - Provider based attestation for under 50 beds required as cost reimbursed.
- RHC must provide:
  - One Midlevel practitioner employed 50 percent of the time
  - Provide routine diagnostic and laboratory services.
  - Be able to provide first response emergency care including drugs.
  - Physician supervision

RHC Services

- RHCs can provide the following:
  - Services and supplies incident to services of physicians.
  - Services of nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers.
  - Visiting nurse services to the homebound.
  - Registered dieticians or nutritional diabetes training
  - Covered drugs and vaccines

Covered Services

- Covered RHC Services
  - Reasonable and Necessary

- Medicare Payment – Computed rate per covered visit at the lower of actual cost or a limit.

  - RHC clinic based to small rural hospitals with less than 50 beds are not subject to the CMS limits.

- Rate can increase every year

Covered Services

- A visit is defined as a face-to face encounter between the patient and a physician
- Same Day visits for same service– not Encounters
- A vaccine injection is not a visit
- Checking Blood Pressure is not a visit

Definition of an RHC visit per Section 40 of Chapter 13 of the Medicare Benefits Policy Manual

An RHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit mist be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one of more RHC services are rendered. A Transitional Care Management (TCM) service can also be an RHC visit. Services furnished must be within the practitioner's state scope of practice, and only services that require the skill level of the RHC or practitioner are considered RHC visits.

Practitioner defined

- Physician
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Certified Nurse Mid-wife (CNM)
- Clinical Psychologist (CP)
- Clinical Social Worker (CSW)
- Visiting Nurse - homebound patients (RN, LVN, or LPN)

Not Practitioner in RHC

- Lab Technician
- Other health care staff- example of radiology tech, EKG tech, or Ultrasound technician, Dietician
- CRNA
- Sonographer
- Licensed Professional Counselor (LPC)

RHC Patient defined

- Individuals who receive services at the RHC
- Individuals who receive services at a location other than the RHC for which the RHC bills the service or is financially responsible for the provision of service.
- Individuals whose cost of care is included in the cost report of the RHC

Covered Services – RHC visit

- An RHC service:
  - Primary Care Diagnosis
    - 992xx CPT codes
      - Office or other outpatient visit for the E & M….
    - 993xx CPT codes
      - Nursing facility care services
  - Services and supplies incident to the practitioner services
  - Nursing Home Visit for primary care diagnosis
  - Transitional Care Management Service (30 day TCM period)
  - Qualified Preventable Health Services
    - Initial Preventable Physical Exam (IPPE)
    - Annual Wellness Visit (AWV)
  - Expanded Services for RHC after Oct 2016 – covers many urgent care type visits

RHC Billing

RHC Revenue Codes - Effective July 1, 2006:

- 0521 Clinic visit at RHC
- 0522 Home visit by RHC
- 0524 Visit by RHC practitioner in Part A stay SNF
- 0525 Visit by RHC practitioner in a NF or ICF or residential facility
- 0527 RHC visiting nurse (must have special designation)
- 0528 RHC visit other locations (i.e., scene of an accident)
- 0780 Telehealth services (Note: not an RHC service – Facility Fee only)
- 0900 Mental health visits
  Sometimes referred to as place of service with respect to RHC/FQHCs

RHC Payments Forms vs. Urgent Care Clinic (UCC)

- RHC Payment – Encounter Rate
- Overall Clinic Cost $ 3,324,577
- Less Cost of Vaccines 16,885
- Total Allow Cost 3,307,692
- Total Visits 17,810

- Cost per visit $ 185.72

- Payment per encounter for primary Care (E & M code)
- Unpaid deductible and Co-pay for Medicare patients are reimbursable through the cost report (65%).

- No additional payment for treatment of diagnosis / procedure CPT codes for Medicare.
- Payment for RHC made under an all-inclusive rate

RHC Payments Forms vs. Urgent Care Clinic (UCC)

- Urgent Care Center – Primary Care Payment Model
- CPT code 29085 – Level I Cast Application – Wrist or Hand

• National Payment Rate	$	125.15
• Labor Rate – 60%		75.09
• Non-Labor Rate - 40%		50.06
• Wage Adjusted (.7816)		108.75
• Professional Component		
• Facility Total (Hosp. Based)		66.59
• Total Reimb under Hospital OP	$	175.34

- UCC could bill technical component and professional component
- Can now bill under RHC as an encounter rate under Medicare

RHC Services

RHCs can provide the following:

- Physician and mid-level primary care OP clinic services.
- Services and supplies incident to services of physicians.
- Services of nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers.
- Visiting nurse services to the homebound.
- Registered dieticians or nutritional diabetes training.
- Covered drugs and vaccines.
- Initial Preventive Physical Exam – after 1/1/2016.
- Mental Health visits –after 2/1/2016.
- Expanded services after 10/2016 – New Qualifying Visits.

RHC Services

RHCs can provide the following (continued):

- Preventive services
- Influenza, Pneumonia, Hepatitis B vaccines
- Initial Preventive Physical Exam (IPPE) -1/1/2016
- Annual Wellness Visits (G0438 or G0439 HCPCS code)
- Medicare covered preventive services as recommended by the US Preventive Service Task Force –grade of A or B (ex).
  - High blood pressure
  - Cancer screenings
- All RHC services are subject to Reasonable and Necessary provisions

RHC Services – Special Billing – Wellness Visit

- G0438/G0439 are paid under the RHC all-inclusive rate. (January 1, 2011 addition to RHC billing – MLN Matters SE 1039)
- G0438 (initial visit) is a once-in-a-lifetime benefit; cannot be billed within 12 months after effective date of Medicare coverage (should be preceded by Initial Preventive Physical Exam - IPPE).
- G0438 cannot be submitted within 12 months of IPPE (Welcome to Medicare Visit, G0402) or G0439 (AWV, subsequent visit).
- Total Coinsurance and Deductible are waived for qualified preventive services through RHC.

Covered Services

- Same day - Second encounter may be counted as encounters for multiple diagnosis
- Encounters must be reported for Medicare and non-Medicare visits
- Virtual communication services in RHCs (HCPCS G0071). This can be billed either along or on the same claim as a billable visit.
- Virtual communication services are not billable if an RHC visit was furnished within the previous 7 days or the next 24 hours or soonest available appointment.

Covered Services – RHC visit

Chronic Care Management Services

- Established January 1, 2016
- Minimum of 20 minutes of qualifying CCM services during a calendar year
- Patient with multiple chronic conditions expected to last at least 12 months
- CPT code 99490
- Payment is based on MPFS national average non-facility payment rate
- Coinsurance does apply
- Face to face requirement is waived

RHC Required Services

Required Lab Services That Must be Available as an RHC

- Chemical examinations of urine (CPT 81002)
- Hemoglobin (CPT 83026)
- Blood sugar (CPT 82962)
- Examination of stool specimens (CPT 82270)
- Pregnancy tests (CPT 81025)
- Primary culturing for transmittal to a certified laboratory

➢ *Clinic must have the ability to perform these basic [CLIA waived] tests; however, they are billed as non-RHC services. These services should be billed under the hospital lab services on a UB for hospital based RHC's (not the RHC number). (MLN Matters Number MM8504, November 22, 2013)*

RHC Services

RHCs can provide the following (continued):

- Qualifying codes for RHC –after October 2016
  - CMS is primarily expanding the services of a RHC
  - Many of the treatment of diagnosis codes not allowable as Medicare visits are included.
    - Skin and lesion treatment codes
    - Closure of wounds
    - Foreign bodies removal
    - Setting of fractures
    - OB exams
    - Sonograms
  - There are a few codes that are no longer considered a stand-alone billing visits for an RHC, but many more are added than removed from the allowable billing codes.

RHC Billing

Mental Health Visit – Revenue Code 900

- Reduction in Mental Health Limitation - Mental health limitation is phased out effective 1/1/2010 per a memorandum dated 10/30/2009:

- 2011 68.75% (Medicare pays 55%, patient pays 45%)
- 2012 75.00% (Medicare pays 60%, patient pays 40%)
- 2013 81.25% (Medicare pays 65%, patient pays 35%)
- 2014 100% (Medicare pays 80%, patient pays 20%)

RHC Billing

Home Health Visits

- The Affordable Care Act (ACA) mandates that prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she or an allowed NPP has had a face-to-face encounter with the patient.

- Must occur within 30 days of start of care unless seen within 90 days.
- Documentation must be present with starts of care on or after 1/01/11.
- Certifying physician can "hand off" care.
- Face-to-face encounter could be through telehealth in approved sites.

- (Refer to MLN Matters SE1038 for more details.)

RHC Billing

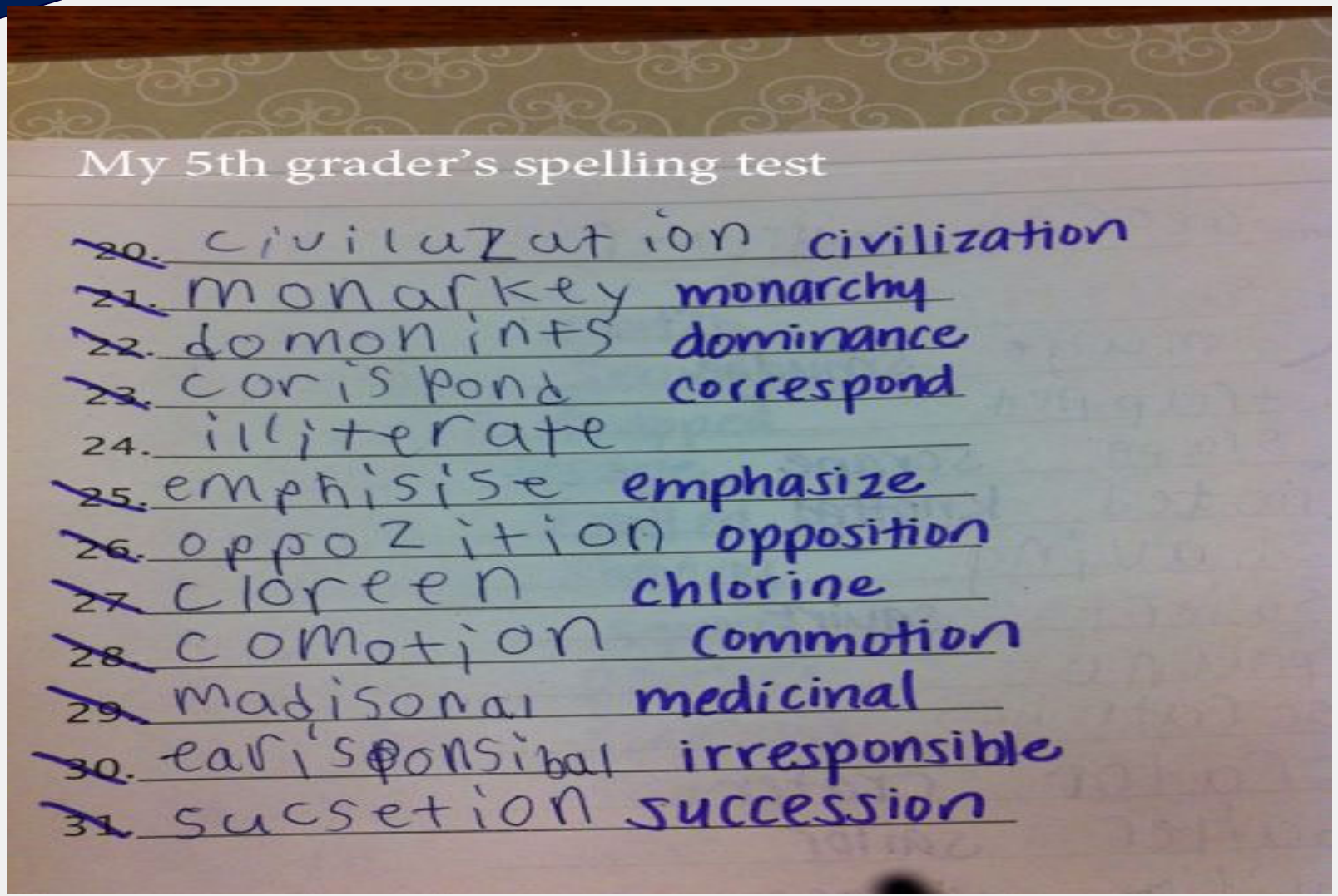
Special Billing - Telehealth Services

- Telehealth services (originating site) are non-RHC services. Originating site will receive separate payment. Coinsurance and deductible apply.

- RHC (originating site fee):

- This is the only service that may be included on an RHC bill (bill type 71X) with another RHC service (e.g., Rev. Code 521)
- Bill Telehealth service under Rev. Code 0780 with HCPCS Q3014
- Requires HCPCS code Q3014 (Reimbursement ~ $27.00)

- Medicare only Billing – Commercial insurance will not pay the Originating site fee.


My 5th grader's spelling test
30. civilaZation civilization
31. monarkey monarchy
32. domonints dominance
33. corispond correspond
24. illiterate
35. emphisise emphasize
36. oppozition opposition
37. cloreen chlorine
38. comotion commotion
39. madisonal medicinal
30. earisponsibal irresponsible
31. sucsetion succession

RHC Services Not Covered

Services not covered as RHC clinic services, but may be covered under other Medicare benefits include:

- Durable medical equipment
- Ambulance services
- Prosthetic devices
- Contract Therapist services
- Screening mammography
- Technical components of diagnostic tests
- Contracted non-physician diagnostic or therapeutic services
- Physician and mid level services provided in hospital setting or E.R.

RHC Services Not Covered

Example:

- If RHC has an agreement to obtain specialized laboratory or therapy services from an outside agency or individual not employed by the RHC, the service must be billed by the outside agency or individual to its own carrier. The service cannot be billed through the RHC.

Reimbursement Methodology

- The reimbursement rate for newly certified RHC is established at 75 percent of the CMS limit.

- This rate remains in effect until the provider submits financial data OR until the cost report is submitted.

- The cost report can be completed, containing, at a minimum, three months of actual data or the MAC will also accept budget data.

Reimbursement Methodology

- RHC payment is subject to the Part B cash deductible.
- After the deductible has been satisfied, RHC is reimbursed at 80 percent. The patient is responsible for a coinsurance amount which can be claimed as Medicare bad debt not subject to 65% reduction.
- The RHC receives interim payments during the cost reporting period based on claims submitted.

Reimbursement Methodology

- Actual reimbursement is computed via the annual Medicare cost report. Thus the RHC must settle up with Medicare at the end of the cost reporting period.
- If certified as rural hospital based RHC, the hospital available bed count should be less than 50 beds to receive cost reimbursement not subject to the CMS limit.
- RHC is subject to the CMS cost limit for 2019 is $84.70.
- Pay particular attention to the Medicare Managed Care (Medicare Advantage) Contract rates for the RHC.

Medicaid Reimbursement Methodology

- Medicaid RHC reimbursement varies by state and initial rate is set by the state where RHC is located.
- Most states follow similar or same methodology in reimbursement as Medicare for RHC's.
- Medicaid initial rate setting is higher, in most states, than initial rate set by Medicare. This may lead to an initial over-payment in relation to actual cost supported through first cost report.
- Medicaid rate does not always update to the most recently filed cost report. Medicaid may require a "Change of Scope / Rate" calculation to support rate revision.
- Pay particular attention to the Medicaid managed Care Contract rates for the RHC.

New Information Requirements

Independent RHCs will have to provide new information for their annual cost report submissions this year. The Centers for Medicare and Medicaid Services (CMS) has replaced the CMS 222-92 form with the new CMS 222-17 and replaced Chapter 29 of the Provider Reimbursement manual with Chapter 46. Instructions and forms were provided by CMS in Transmittal 1 on May 18, 2018, and the new cost report forms are required for cost report submissions ending on or after September 30, 2018.

Alternatively, provider-based RHCs in a hospital healthcare complex, will continue to use Form 2552-10 instead.

Below is a link to the new cost report forms and instructions.

https://www.com.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R1P246.pdf

Sources – RHC Cost Reports

Description	Link
Chapter 46, RHC Instructions and Forms, May 18, 2018. (95 page PDF)	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R1P246.pdf
Medicare Cost Report E-Filing (MCReF) MLN Matters Number: MM10611 revised November 2, 2018	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10611.pdf
MCReF FAQs (5-page PDF)	https://www.cms.gov/Medicare/Compliance-and-Audits/Part-A-Cost-Report-Audit-and-Reimbursement/Downloads/MCReF-FAQ.pdf

Cost Report Filing Requirement

- Freestanding RHC is required to file CMS Form 222-17 while provider based RHC must file the supplemental Worksheet M and S-8 of the parent cost report. For hospital based RHC it is the 2552-10 CMS Form.

- Cost report is due last day of the fifth month following the cost report year end or 37 days from the date of the CMS letter notifying cost report is due. Can Amend initial cost report prior to scoping, best to do it before tentative.

Crosswalk of Forms between Provider-based & Independent RHCs

Purpose of Form	Independent	Provider-based
Provider Name, Location, CCN Number, Signature	S Parts I, II & III	S-2/S-8
Malpractice Information, Hours of Operation	S-1 Part I & II	NA
Replaces the 339 Questionnaire	S-2	NA
Payer Mix and mental health visits	S-3	NA
Expense information (Trial Balance of total expenses)	A	A/M-1
Reclassifications (Salaries to the proper cost center)	A-6	A-6
Adjustments (remove non-allowable expenses, straight-line depreciation on assets, value of services)	A-8	A-8
Related Party Transaction (adjust RPTs to actual cost)	A-8-1	A-8-1
Allocation of Overhead (Hospital or Parent)	NA	B Part I, B-1

10

Why Change?

The reason for the changes to the independent RHC cost report are as follows:

1. To incorporate electronic filing of the cost report using the MCReF system. The following link has the information on how MCReF works: https:///www.cmc.gov/Medicare/Compliance-And-Audits/Part-ACost - Report-Audit-and-Reimbursement/MCReF.html
2. To eliminate unnecessary FQHC information due to the Form 224-14 used by FQHCs
3. To incorporate information previously submitted on the Form 339 Questionnaire (no longer required)

New Cost Centers – Independent RHCs

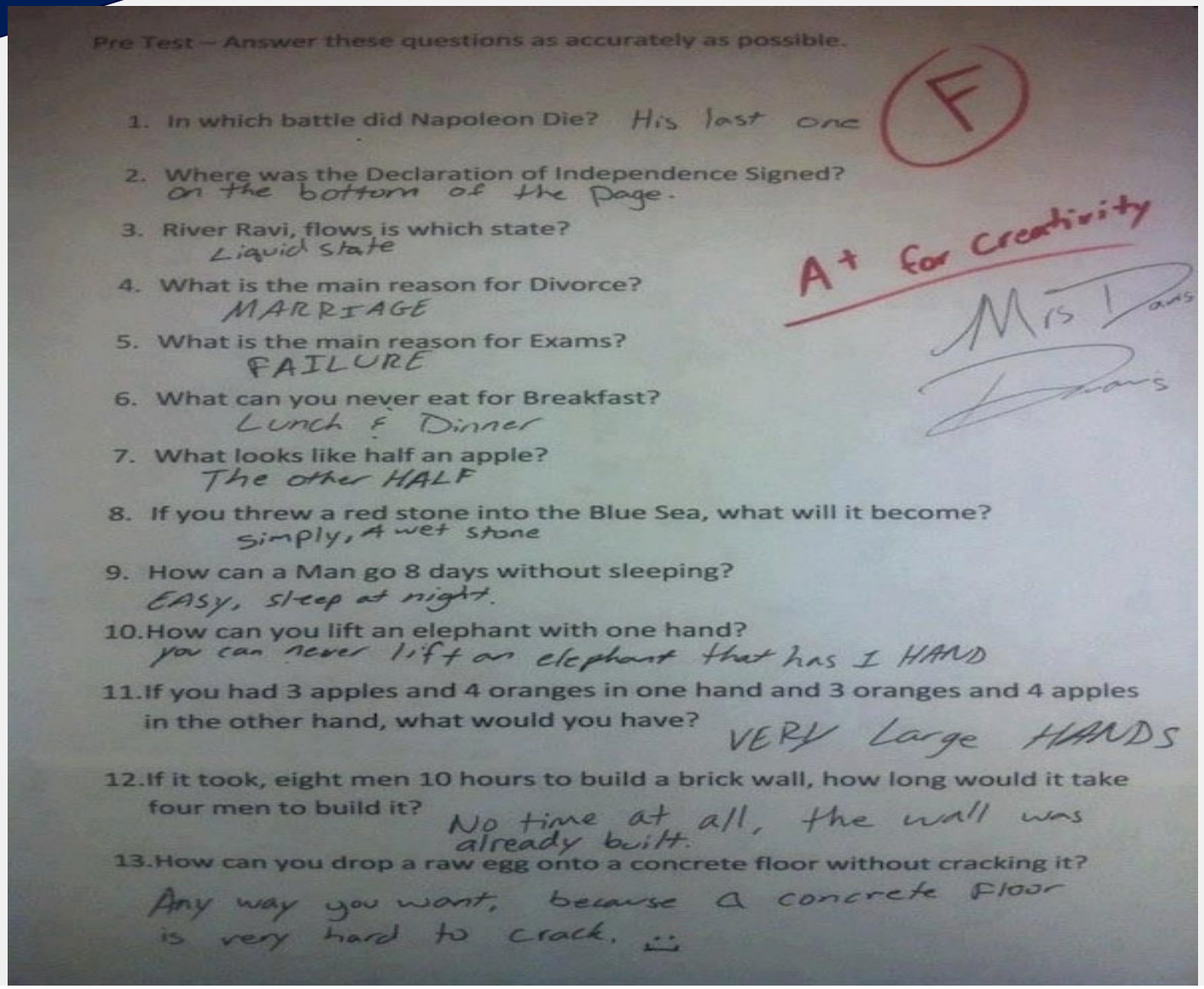
The new Form CMS 222-17 expands the number of cost center and add specific cost such as:

a) Pneumococcal vaccines (CR 30) must be entered here or will not get paid.

b) Influenza vaccines (CR 31) same here.

c) Telehealth (CR 79)

d) Chronic Care Management (CR 80)



Pre Test – Answer these questions as accurately as possible.

1. In which battle did Napoleon Die? His last one
2. Where was the Declaration of Independence Signed? on the bottom of the Page.
3. River Ravi, flows is which state? Liquid state
4. What is the main reason for Divorce? MARRIAGE
5. What is the main reason for Exams? FAILURE
6. What can you never eat for Breakfast? Lunch & Dinner
7. What looks like half an apple? The other HALF
8. If you threw a red stone into the Blue Sea, what will it become? Simply, A wet stone
9. How can a Man go 8 days without sleeping? EASY, sleep at night.
10. How can you lift an elephant with one hand? you can never lift an elephant that has 1 HAND
11. If you had 3 apples and 4 oranges in one hand and 3 oranges and 4 apples in the other hand, what would you have? VERY Large HANDS
12. If it took, eight men 10 hours to build a brick wall, how long would it take four men to build it? No time at all, the wall was already built.
13. How can you drop a raw egg onto a concrete floor without cracking it? Any way you want, because a concrete floor is very hard to crack. :)

F

A+ for Creativity

Mrs Davis

Cost Report Filing Requirement

- Low or no utilization cost report filing requires no electronic cost report , but written request to MAC within 150 days of year end for no utilization; within 1 month prior to filing due date for low utilization. Interim payments must be under $15,000 and Medicare utilization less than 15%.
- If terminating from the Medicare Program than a terminating cost report is required.
- Can file consolidated cost report if own more than one RHC.
- Reopening cost report within 3 years after NPR, but must be deemed new material not available at time of filing or audit. MAC does not automatically accept reopenings.

Cost Reporting Principles

- Hours of operation as RHC should be as RHC. If other than RHC services provided during the same RHC hours then COP issue.

- Must remove non RHC services for the cost report if operates services not during RHC hours.

- Track physician supervisory hours and billing number.

Cost Reporting Principles

- If rural hospital available bed size exceeds 50, RHC will lose cost reimbursement for RHC.
- CMS productivity standard exemption if approved by MAC. Must document case and meet CMS screening guidelines.
- Productivity Standards are cumulatively applied on the Cost Report, so if cumulative total number of visits exceed prod. Standard, than actual visits are used in calculation of cost per visit.

Cost Reporting Principles

Identify in general ledger OR profit/loss statement RHC salary or contract expense for each healthcare staff:

- Physician
- Physician Assistant
- Nurse Practitioner
- Visiting Nurse
- Clinical Psychologist
- Clinical Social Worker
- Laboratory Technician
- Nursing Staff
- Other health care staff- example of Radiologist, EKG or Ultrasound technician, Dietician

Cost Reporting Principles

Identify in the general ledger or profit/loss other health care costs such as:

- Medical supplies
- Vaccines for influenza and pneumococcal
- Professional liability insurance
- Continuing education by level of staff
- Depreciation for medical equipment based on Medicare AHA Chart of Useful Lives and S/L
- Transportation for health care staff

Cost Reporting Principles

Identify in the general ledger or profit/loss the facility overhead expense:

- Rent
- Related party expense with utilization and actual expense from related party records.
- Insurance
- Interest on building and office equipment
- Utilities
- Depreciation expense for Building or Building equipment using the AHA Chart of Useful Lives and Straight Line
- Housekeeping ,maintenance, grounds, security
- Property Tax
- Uniform Expense, Disposal expense
- Any other type of expense associated with the facility cost

Cost Reporting Principles

Identify expense in general ledger or profit/loss for facility administrative cost:

- Office salary or contract expense
- Office supplies
- Legal and accounting services
- Insurance
- Telephone
- Fringe benefits and payroll taxes
- Miscellaneous expense- dues, postage
- Advertising
- Marketing or public relations

Cost Reporting Principles

Identify in general ledger or profit/loss expense that is other than RHC:

- Retail pharmacy
- Dental
- Optometry
- Private Practice
- Diet Clinic
- Rented space for non RHC services

- These services impact the allocation of the RHC overhead which is part of the cost per visit and vaccine administration reimbursement.

Cost Reporting Principles

Identify in general ledger or profit/loss any other income that is not visit encounter income:

- Medical record transcripts
- Sale of medical supplies to non patients
- Refund, rebate, or discount
- Office rental income
- Interest income or dividends
- Sale of assets- not subject to offset or add on
- Reimbursement of expenses
- Any other type of other income

- Reduction in expense impacts cost per visit and injection costs.

Cost Reporting Principles

Identify in general ledger or profit/loss expense that must be removed from costs:

- Lobbying percentage on Healthcare Dues
- Club dues
- Advertising to increase patient census
- Marketing to increase patient census
- Donations
- Outside reference lab expense

- Impacts cost per visit and vaccine administration expense.

Cost Reporting Principles

- Identify contract physicians that are not regularly scheduled to staff the RHC as not subject to the visit productivity standard.
- Identify the total visits and expense.
- Be careful to not include vaccines into the visit count, as this elevates the visit count and dilutes the computed cost per visit.

Cost Reporting Principles

Document hours worked for regularly staffed healthcare staff and total visits whether salaried or contract:

- Physicians
- Physician Assistant
- Nurse Practitioner
- Visiting Nurse
- Clinical Psychologist
- Clinical Social worker

- Important to not overstate hours worked as increases the minimum required visits CMS forms compute to arrive at cost per visit for reimbursement.

Cost Reporting Principles

- Track total visits by practitioner name.
- Identify total visits for contract physicians who are not regular staff as not subject to the CMS productivity standard.
- Overstatement of visits causes the cost per visit to decrease.
- For example see how your system is tracking weekly return injections that are not visits.

Cost Reporting Principles

- Rate per Visit – Example:

Hours Worked FTE	.60 FTE
CMS Physician Standard Visit	4,200
Minimum Visits Required	2,520
Actual Visits Worked	1,000

- In the aggregate the greater of required vs. actual visits is used to compute the cost per visit which is the 2520 in this case. Impact on cost per visit:

  $150,000 / 2520 = $59.52 cost per visit

  $150,000/ 1000 = $150.00 cost per visit

- If RHC would be capped at the CMS limit for 2019 calendar yr of $84.70.

- If hospital based rural under 50 beds, no cap applied.

- Alternative to the RHC computed cost per visit would likely be a physician fee schedule payment, based on acuity of visit and CPT coding for the respective visit.

Cost Reporting Principles

- Influenza and Pneumococcal Injections maintain a separate log for each type of injection that lists the following:
  - Patient name
  - Date of injection/date of service
  - Medicare HIC number with alpha character
  - Financial class of patient
- Summarize total Traditional Medicare vs. other financial classes of patients for each log.
- Traditional Medicare utilization is based on this log for each type of vaccination.
- For audit purposes keep the signed patient release form authorizes RHC to provide the injection.
- Do not bill Traditional Medicare injections to the Program as payment is through the cost report.

Cost Reporting Principles

- For influenza and pneumococcal administration time MAC may accept 10 minutes without a detail time study.
- Must only include the actual time of administering the vaccination.
- If conduct detail time study it should reflect the date, specific duties with time, signed and be representative during the season. No less than 2 week time study.
- Identify the staff providing these injections
- Identify the total nursing hours plus all other healthcare staff hours, excluding contract physician hours not on regular staff
- Ratio of administering injection to total healthcare time excluding contract physicians time is used to compute ratio for cost report reimbursement.

Cost Reporting Principles

- Document the supply cost of influenza and pneumococcal injections with paid invoices.
- Do not include a discount in the cost of the injection.
- Compute overall average of supply cost per injection for each type
- Vials for influenza usually have 10 injections and pneumococcal 5 injections.
- Supply expense is added to the administration of vaccine expense to compute ratio of vaccinations to direct healthcare staff costs that computes overhead.
- Traditional Medicare utilization based on injections is used to compute allowable Medicare vaccination expense.
- Cannot bill Traditional Medicare patients for injections

Cost Reporting Principles

Medicare-Medicaid Crossover Bad Debt Classification

Providers claiming Medicare bad debt must meet 42 CFR 413.89 and all requirements from Chapter 3 of the Provider Reimbursement Manual (https://go.usa.gov/xEuwd). Correctly classified unpaid deductible and coinsurance amounts for Medicare-Medicaid crossover claims in your accounting records. For bad debt amounts:

- Do not write off to a contractual allowance account
- Charge to an expense account for uncollectible accounts (bad debts)

Effective for cost reporting periods beginning on or after October 1, 2019, providers must comply with these longstanding Medicare bad debt requirements.

Cost Reporting Principles

- Medicare Bad Debts are reduced by 65%.
- Collection efforts must be similar for all classes of patients and cannot deem uncollectible until all efforts ceased
- Efforts should be on set interval basis and documentation of phone calls and demand letters kept
- Bad Debt collection and write off policy should be in writing and actually enforced. Outside agency policy should be kept and comply with Medicare.
- Only deductible coinsurance related to the RHC service under RHC Medicare number should be claimed net of any payments made prior to write off.
- The collection cycle begins again if any payments are made during the cycle
- Must bill crossovers to Medicaid and other insurance with proof of denial

Cost Reporting Principles

- Indigent bad debts require documentation to be maintained for BOTH the asset liquidity test and income/expense test.
- RHC must make the determination of indigence and not accept patient declaration and document action taken with copies of source documents maintained.
- Must exhaust all other responsible parties responsibility to pay patient deductible or coinsurance.
- CMS very particular.

Cost Reporting Principles

Crossover or Dual Eligible Bad Debts

If Medicaid does not pay the complete coinsurance or deductible; a RHC can include this difference as an allowable bad debt on the cost report and Medicare will reimburse you for this bad debt.

Keep this in a separate file.

Cost Reporting Principles

- Bad Debt List Required for Cost Report Filing:

  -Patient Name

  -Date of service, not combined

  -Patient HIC number with alpha character

  -Indigent or not

  -Medicaid number

  - Amount of write off for patient deductible coinsurance unpaid

  -Date returned from collection agency in cost report year and must have at least 120 days from date of first bill.

  - Date deemed worthless or write off date and must be at least 120 days from date first billed patient for liability

  - Recoveries by patient name and date of recovery

Exhibit 2

Listing of Medicare Bad Debts and Appropriate Supporting Data

Provider ____________________

Prov. Number____________________

FYE ____________________

Prepared By ____________________

Date Prepared ____________________

Inpatient ____________________ Outpatient ____________________

SNF ____________________ RHC____________________

(1) Patient Name	(2) HIC NO.	(3) Dates of Service		(4) Indigency & Wel. Recip (ck if apply)		(5) Date First Bill Sent To Beneficiary	(6) Date Collection Efforts Ceased	(7) Medicare Remittance Advice Date	(8) Deduct	(9) Co-Ins	(10) Total
		From	To	Yes	Medicaid #						
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Electronic Filing of RHC Cost Reports

Currently 50,000 cost reports claiming $200 billion of Medicare funds are filed annually to 12 different MACs

Effective July 2, 2018 Cost Reports may be filed using the following methods:

1. Via mail or express delivery services
2. Via MCReF portal in the EIDM system

Electronic filing is not Required

Electronic Filing Details

MCReF – a new application allows you to electronically transmit (e-File) your Medicare cost report.

- Available as of 5/1/2018
- Usage is optional. Mail and hand-delivery remain filing options.
- Accessible by your EIDM (Enterprise Identity Management System) PD&R Security Official (SO) and Backup Security Official (BSO)
- Your MAC will have access to e-Filed cost report materials

MCReF Detailed Overview

System Login: https://mcref.cms.gov

- Access is controlled by EIDM
- Restricted to EIDM PS&R SO / BSO
- Existing PS&R SOs / BSOs already have access
- Any organization without access to PS&R must register a PS&R SO with EIDM

MCReF Authorized Cost Report Filer

CMS has created within EIDM a dedicated MCReF role that the EIDM Security official of your organization or Backup Security Official could delegate out to a particular person that they want for cost report filing. And the SO or BSO will be able to approve that role. And it's called the MCReF authorized cost report filer role.

RHCs and Primary Care Practices in 2019 and Beyond

- RHC Modernization Act
- Patient-Oriented Culture
- Information is power.
- Patients demand convenience and efficiency.
- Team Orientation
- New sources of RHC Reimbursement
- Benchmarking: Watching the Controls

RHC Modernization Act

"Increases reimbursements for RHCs. Currently, RHCs are paid an all-inclusive rate for the care they provide. This rate has not been legislatively updated since 1988. This legislation updates reimbursements to better reflect the quality of care provided by RHCs.

Sec 7 Raising the Cap on Rural Health Clinic Payments.

Beginning in CY 2020, increase the upper limit (or cap) on RHC reimbursement to $105 per visit, in CY 2021 to $110 per visit and in CY 2022, to $115 per visit. Thereafter, cap is adjusted annually by MEI.

Does NOT cut Provider-based rates. The rate increase is paid by limiting the future growth of RHC encounter rates to MEI.

New Legislation
Rural Health Clinic Modernization Act of 2019

- S. 1037 –J. Barrasso (R- WY) – April 2019
- H.R 2788 – A. Smith (R – NE) – May 2019

- Updates provision for lab services and diagnostic services performed through the RHC.

- Allows RHCs to contract with Physician Asst and Nurse Practitioners. This eliminates the need to employ a mid-level in the RHC.

- Allows RHCs to be the distant site for e telehealth visit. This allows for RHC rates for a telehealth visit, as opposed to a site facility fee only for telehealth.

- Sets new Medicare Cap rates beginning in FFY 2020 – $105 / visit,
  FFY 2021 - $110 / visit, and FFY 2022 - $115 / visit.

New Legislation

- Medicaid Improvement and Enhancement of Services for Low Income Mothers
  - S. 1343 – C. Booker (D - NJ)
- Expands Medicaid and Federal match programs for low income moms
- Expands eligibility of FMAP programs for visits through an RHC.

- Chronic Care Management Improvement Act
  - H.R. 3436 – S. DelBene (D – WA)
- Removes Cost Sharing provision for Chronic Care visits through the RHC and FQHC.
- Reimbursement is 100% of the lessor of actual charge or cost per visit.

71

DISCOVERY
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