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HBS Update

April 3, 2017

RHC Information Exchange Group

RHC Information Exchange Group on Facebook
"A place to share and find information on RHCs."

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Healthcare Business Specialists
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The American Health Care Act (AHCA)

It has been an extremely busy few months. The trips to Washington, DC, San Antonio, and now New York have been difficult in the midst of Medicare cost report season. As we all know healthcare reform was on the front burner for a short while. The American Health Care Act of 2017 was sold to the public and shelved faster than Trump University. Of course, like any good Zombie thriller or horror show, the villain (and I say villain because the NRHA, Physicians, and Hospital associations for the most part did not support the AHCA) will always resurrect itself and come back in some other form. So let's look at what was in the bills as it relates to rural health clinics and what our major advocacy institutions had to say about the Act. If you have not joined the NRHA or the NARHC now is the time to join. I attended both of their recent meetings and both had record attendance. Now is the time to be diligent in protecting the interest of the rural, underserved medical populations that we serve. I have included a listing of upcoming conferences that may interest you.

The good news is that in the two very short drafts of the bill, there is no mention of rural health clinics at all which indicates that our protected status in the Social Security Act and Medicare regulations will continue and bottom

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line – the states will continue to be required to pay the enhanced payments to RHCs. That is certainly great news if the assumption holds up.

The prospect of Medicaid Block Grants is of utmost concern to Rural Safety net providers including the 9,800 Federally Qualified Health Centers and 4,200 Rural Health Clinics which provide highly cost effective healthcare to over one in six rural residents and over 300,000 veterans. Medicaid Block or Per Capita grants without certain protections for safety net providers or Essential Community Providers could unravel the already fragile rural health environment and result in vast medical deserts especially for the vulnerable Medicaid populations.

RHCs have benefited from the expansion of Medicaid in those states that have in fact expanded Medicaid. Enhanced Medicaid payment is the driver of independent RHCs as Medicare payments have not kept pace with medical inflation or even the traditional Medicare fee schedule for that matter. We will provide examples of a couple of Medicare payment scenarios in this newsletter.

The CBO has issued a report indicating 24 million people will lose their health insurance due to the American Health Care Act (Trumpcare) with many of those being Medicaid patients that were newly eligible under the Affordable Care Act (Obamacare). There are many highly questionable assumptions in the CBO report such as Texas will expand Medicaid and then Medicaid will be taken away (about a .000001 percent chance of happening) and that because Medicaid patients are not mandated to have healthcare they will unenroll in the Medicaid program (again another very highly unlikely scenario). We will continue to update you when the zombie comes back to life. For now, we can breathe easy until the next apocalypse.

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Payment Examples for RHCs

We have provided a couple of examples of the most common CPT codes and how they are reimbursed in rural health clinics as compared to Medicare payments in traditional Medicare. Our assumptions are as follows:

1. The RHC cost per visit is above the $82.30 cap (99.5% are).
2. The RHC payment from Medicare is $64.52 per visit.
3. The RHC collects 20% of charges from the patient for all services.
4. We used the Part B fee schedule for Tennessee for the traditional Medicare payments.
5. The E and M code was a 99213 in the first example and 99214 in the second and each visit had blood draw (36415) and an injection. Please note that in 2005 the Medicare rules changed and allows an E and M code and an injection charge on the same day to be paid. Many office managers continue to cite this old, outdated rule,

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Here is our first example using the 99213 E and M code:

Rural Health Clinic Payment Review					
		Charge	Charge	Payment	Payment
CPT Code	Service	RHC	Traditional	RHC	Traditional
CPT 99213	Established Visit	100	100	84.52	69.08
CPT 96372	Injection Code	40	40	8.0	23.73
CPT 36415	Venipucture	10	10	2.0	3.00
CPT J3301	Triaminolone acetonide	10	10	2.0	1.34
Total Payments				96.52	97.15
Medicare Payment				64.52	83.31
Patient Payment				32.00	13.84
Patient Payment Percentage				33%	14%

Our second example is the 99214 E and M code:

		Charge	Charge	Payment	Payment
CPT Code	Service	RHC	Traditional	RHC	Traditional
CPT 99214	Established Visit	150	150	94.52	101.94
CPT 96372	Injection Code	40	40	8.0	23.73
CPT 36415	Venipucture	10	10	2.0	3.00
CPT J3301	Triaminolone acetonide	10	10	2.0	1.34
Total Payments				106.52	130.01
Medicare Payment				64.52	109.62
Patient Payment				42.00	20.39
Patient Payment Percentage				39%	16%

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What does it all mean? In both of examples the clinic receives a higher total payment from traditional Medicare than RHC and the RHC patient pays significantly more per visit each visit. The patient pays 106% more for the 99214 example and 131% more in the 99213 example.

The even more shocking example which is not shown above is when a patient has not meet their $183 Medicare Deductible and for example the RHC charge for services totals $183, the patient pays $183 and the RHC actually pays Medicare $101. This is called negative reimbursement and occurs for every RHC patient until the deductible has been meet.

In addition, RHCs are required to abide by burdensome Medicare Part A regulations such as completing Medicare Secondary Payer questionnaires for every Medicare patient visit and Quarterly Credit Balance Reports. (Form 838) We did confirm from Kim Robinson with Novitas that RHCs must obtain answers to the Medicare Questionnaire every visit at the meeting in San Antonio.

Information provided to our Senators and Congressman

On the next page, you will find the four-page handout we provided our Senators and Congressman as we meet with their staffs in Washington, D.C.

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"Don't judge each day by the harvest you reap but by the **seeds** that you **plant**." -
Robert Louis Stevenson

I would like to thank the Senate and Congressional Representatives that found the time in their busy schedules during the National Rural Health Association's Policy Institute to speak to the organization and allow us to personally visit and spend time discussing our concerns regarding healthcare in rural and underserved areas. Here is a summary of my discussion points in our meetings.

Medicaid Block Grants

The prospect of Medicaid Block Grants is of utmost concern to Rural Safety net providers including the 9,800 Federally Qualified Health Centers and 4,200 Rural Health Clinics which provide highly cost effective healthcare to over one in six rural residents and over 300,000 veterans. Medicaid block or per capita grants without certain protections for safety net providers or Essential Community Providers could unravel the already fragile rural health environment and result in vast medical deserts especially for the vulnerable Medicaid populations. The seed I would like to plant is Rural Safety net providers must continue to receive enhanced Medicaid payments to ensure the necessary health services are provided in rural and underserved areas in a cost-effective manner.

ACA and Insurance Exchange

Per the Kaiser Health Foundation, 11.5 million people receive health insurance from the ACA exchanges and 40% or 4.6 million people do not qualify for premium support. Most the 4.6 million people without premium support received quite a sticker shock in October, 2016. For example, in Tennessee, Blue Cross increased premiums by 62% and our premium for a family of three increased from $1,146.83 per month to $1,855.78 per month with a $10,000 + deductible and no pharmacy coverage to speak of. This

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insurance plan with an annual cost of $22,269 was the least expensive of the four plans offered in the Chattanooga market with the highest cost plan costing over $3,600 per month or $43,000 annually. Our fear of being bankrupted by a catastrophic health event has been replaced by being financially devastated by the high cost of health insurance coupled with the exorbitant increases in the out of pocket cost of pharmaceuticals, dental, immunizations, vaccines, and vision. The nation received a different kind of shock on November 8, 2016 when the votes were counted and this financially burdened group spoke with a loud voice that they could no longer carry the weight of insuring a large segment of the population.

Rural Health Clinics

Public Law 95-210 enacted in 1977 created Rural Health Clinics (RHC) which provide primary care to patients in rural, underserved communities throughout the United States. Like most 40-year-old programs, staying current and dynamic in a changing environment is a challenge and in many cases the RHC program has not been effective in doing so. Realizing that your time is valuable, I will simply list the issues confronting RHCs and am willing to elaborate in detail the concerns via email if you wish:

1. The Medicare cost per visit cap is woefully low with the current cap of $82 almost $40 per below the actual cost of the program.
2. The Medicare Economic Index (MEI) does not fairly represent medical inflation and creates the underfunding of RHCs.
3. The increased cost of pneumococcal and influenza vaccines is a heavy burden on RHCs. In some cases, RHCs must wait 2 to 3 years to be fully reimbursed for these costs.
4. Negative reimbursement for deductibles.
5. MACRA penalties for Part B billing.
6. Allowable Physician Compensation.
7. Significant delays in assigning provider numbers (CCN) numbers in some CMS regions.

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Rural Health Clinics

Issues from a Federal and Medicare Standpoint

1. Unrealistically low reimbursement cap on Independent RHC.
    a. The cap is currently $82.30 or $64.52 per visit from Medicare and 20% of the charge from the patient.
    b. It is based upon the Medicare Economic Index which is a flawed inflation calculations which results in unrealistically low inflation increases for RHCs. The 2017 increase of 1.2% was the highest percentage in 10 years with many years being close to .5%.
    c. The average cost per visit is approximately $115 per visit or $35 in excess of the cap for Independent RHCs.
2. The RHC reimbursement rate for independent clinics underfunds high RVU or intensity of services such as IPPEs, AWEs, Transition care management, 99214s, 99215s, etc. FQHCs receive a payment adjustment of 34.16% for new patients, IPPE, AWEs. Some system like this for RHCs would be welcome in RHCs.
3. Negative Reimbursement. Medicare annually takes money away from RHCs at the beginning of the year instead of paying them. For example, a patient is charged for a service $183 (the Medicare deductible). Medicare will take money from the RHC in the amount of $100.70 ($183-$82.30). If RHCs could be like FQHCs and not be subject to the deductible, it would help eliminate a large cost shift to Medicare beneficiaries.
4. New RHCs including provider-based RHCs are started at an interim rate of $50 per visit or an actual payment of $39.20 per visit. This is unrealistically low. The clinics are made to prepare budgets and cost reports to justify the maximum rate of $82.30 even through 99.5% of RHCs have a cost per visit above the cap. Cahaba and Novitas are very slow to change these unrealistically low initial rates and you must ask and ask again. In some cases you have to contact the regional rural health coordinators to place finally get the MACs to respond.
5. Influenza and Pneumococcal Reimbursement which may take several years before full payment for these expensive injections are settled through the cost report. Cahaba limits tentative settlements to $97 for pneumococcal and $35 for influenza

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shots when the direct cost of Prevnar 13 is $170 or more. The 2014 mean cost per pneumococcal for provider-based RHCs is $192.40 and $62.80 for Influenza. This delay is damaging for RHCs that must fund thousands of dollars of Medicare injections for many years.

6. If RHCs are expected to provide Women's and OB care per Senator Ryan, the non-payment for procedures or lack of additional payment for procedures is a problem as this work is much more procedurally oriented and includes numerous ultrasounds.
7. CG Modifier Rollout and lack of communication by the MACs and misleading and inaccurate communications by one MAC. The CG modifier at this point does not seem to serve any legitimate purpose except to make billing more complex and slow payments to RHCs.
8. MACRA penalties applying to services billed to Part B services including laboratory, diagnostic components, and hospital services.
9. Chronic Care Management (CCM) is not an allowable expense.
10. Inconsistency on timeframes for getting Tie In Notices, CHOWs, etc, processed by Medicare Regions.

A Comparison of Benchmarked data of Independent and Provider-based RHCs

The report on the next page was prepared comparing benchmarking data provided by Wipfli and the NARHC. We compared data from 2014 cost reports from provider-based and Independent RHCs. The report is prepared to highlight payment differences and productivity variances between the two types of clinics and is used by HBS to determine the reasonableness of our cost report submissions.

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Rural Health Clinic Benchmarking Report						
Comparision of Independent and Provider-based						
Based upon 12/31/2014 data from Wipli and the NARHC						
			Independent	Provider-Based	Variance	Percentage
Visits						
	Physicians		4,523	4,107	416	9.2%
	Physician Assistant		3,519	3,041	478	13.6%
	Nurse Practitioner		3,215	2,897	318	9.9%
Annual Compensation						
	Physicians		255,575	278,221	(22,646)	-8.9%
	Physician Assistant		117,020	127,794	(10,774)	-9.2%
	Nurse Practitioner		108,922	117,372	(8,450)	-7.8%
Annual Compensation per visit						
	Physicians		$ 56.51	$ 67.74	(11)	-19.9%
	Physician Assistant		$ 33.25	$ 42.02	(9)	-26.4%
	Nurse Practitioner		$ 33.88	$ 40.52	(7)	-19.6%
Cost Per Encounter per visit						
	Health Care Staffing		$ 60.96	$ 80.25	$ (19.29)	-31.64%
	Direct Health care cost		$ 70.06	$ 97.74	$ (27.68)	-39.51%
	Clinic/Facility Overhead		$ 9.79	$ 20.44	$ (10.65)	-108.78%
	Clinic Overhead		$ 52.35	$ 66.52	$ (14.17)	-27.07%
	Total Cost Per Visit		$ 115.72	$ 180.25	$ (64.53)	-55.76%
	Capped Reimbursement		$ 79.80	$ 180.25	$(100.45)	-125.88%
	Note: Novitas and Cahaba starts RHCs out at a rate of $50 per visit.					
Medicare Percentage of Patients			24.06%	25.22%	-1.16%	-4.82%
Injections:		Cahaba Tentative Cap				
	Pnu	$ 97.00	$ 157.58	$ 192.40	(34.82)	-22.10%
	Flu	$ 35.00	$ 44.67	$ 62.80	(18.13)	-40.59%

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Spring RHC Update Seminars

It is that time again. Spring is here and that means RHC Cost Reports are due May 31, 2017 and RHC seminars to help you stay up to date with the constant changing world of Medicare and Medicaid. We have done the heavy lifting and expense of attending the RHC meetings in Washington, D.C. and San Antonio and are bringing this information in a time efficient format close to your clinic. We have four locations for these full day seminars

We invite you to join us for the seminars especially to our clients which may attend without charge by using a discount code provided by us via email for up to two employees. The cost of the full day seminar is $250. You will go home with a wealth of information regarding RHCs and a USB which includes over 30 years of experience in it and templates and forms to help you manage compliance, billing, policies and procedures, annual evaluations, and cost reporting.

Sign up fast though. Space is limited to between 30 and 35 people per location and some of the locations fill up fast.

We have prepared a document that is filled with links to webinars, conferences, seminars, billing data, and emergency preparedness links.

https://static1.squarespace.com/static/53c5f79de4b0f4932a3942a8/t/58e27baf3a0411db1e3c8152/1491237808394/2017+HBS+Update+%28Document+Links%2C+Tables%2C+Seminars%2C+Webinars%2C+Emergency+links%2C+Billing+links+on+April+3%2C+2017.pdf

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Spring RHC Update Seminar Locations – 2017

JACKSON, TENNESSEE

APRIL 20, 2017

8:30 to 4:00

RESIDENCE INN BY MARRIOTT

126 OLD MEDINA CROSSING
TELEPHONE (731) 935-4100
JACKSON, TN 38305

For More Information go to the link below:

http://conta.cc/2mHESin

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KNOXVILLE, TENNESSEE

APRIL 21, 2017 – 8:30 TO 4:00

KNOXVILLE MARRIOTT

501 E. HILL AVENUE
TELEPHONE (865) 637-1234
KNOXVILLE, TN 38305

For More Information go to the link below:

HTTP://CONTA.CC/2MHT1AN

AUGUSTA, GEORGIA

APRIL 11, 2017 – 8:30 TO 3:30

AUGUSTA MARRIOTT AT THE CONVENTION CENTER

2 TENTH STREET
TELEPHONE (706) 722-8900
AUGUSTA, GA 30901

For More Information go to the link below:

HTTP://CONTA.CC/2NAZA63

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INDIANAPOLIS, INDIANA

APRIL 7, 2017

8:30 to 3:30

Location

Residence Inn Indianapolis Downtown on the Canal

350 W New York Street

Indianapolis, Indiana 46202

To Register for the RHC Update Seminar

http://conta.cc/2nAgMKv

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RHC Update Seminar Schedule

Time	Subject
8:00 AM to 8:30 AM	Registration
8:30 AM to 12:00 PM	The first hour will be an introductory session for people new to RHCs. If you have been around awhile, you already know this information and may elect to sleep in. At 9:45 we will start on the American Health Care Act of 2017 and RHC Compliance including legislative and regulatory updates, cost reporting updates including information on physician compensation, annual evaluations, policies and procedures, and other compliance issues facing RHCs including Community Disaster Planning requirements.
12:00 to 1:00 PM	Lunch (on your own)
1:00 to 3:30 PM	RHC Billing including a complete update of the April 1, 2016 changes to RHC billing including HCPCS coding, CG modifiers, 59 and 25 modifiers, and billing for procedures. Medicare Secondary Payor procedures and Medicare Advantage or Replacement Plans. Tennessee seminars will include 30 minutes on preparing the Tenncare quarterly report and may end a little later than the other seminars.

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RHC Update Seminar Information

The fee is $250 per person. If you are a client of HBS, email us and we will provide you with a discount code to register 2 people for no charge.

Coffee and Orange Juice will be provided in the morning, soft drinks available during the day, and a snack at the afternoon break. Lunch is own your own and is from 12:00 to 1:00.

We do not block or discount rooms, so the hotel may not know we are there. We are. Catering handles our contracts and sometimes they do not talk to reservations. There are no special rates that the hotel offers due to the small number in our group. We offer a 100% refund if you cannot attend as long as we know within 7 days of the seminar. Emergencies will be refunded if you call us. If you do not call or show up, there is no refund.

Each person will be receive a USB drive with 100's of files to help you manage you're Rural Health Clinic. The files include a policy and procedure manual with new policies to help manage your RHC, Annual Evaluation documents and templates, Cost Report workpapers and tools, and introducing the Line Item Benchmarking reports from RHC Cost Reports. We now have access to every RHC Cost Report in a data file and we have benchmarked 100 of the cost reports by Worksheet A line item. This will help you manage your expenses and help evaluate your expenses.

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SECURE YOUR HOSPITAL'S FUTURE WITH ONE CALL

The Seminars are sponsored by our proprietary Hospital Outpatient Laboratory Onboarding program that is bringing rural hospitals back to life with an infusion of much needed revenue and more importantly cash. Email Mark Lynn at marklynnrhc@gmail.com or call 423.243.6185 to find out how your hospital's financial issues could be solved with one call. This turnkey program is having amazing results. Take your place at the table while opportunities exist. Only two rural hospitals per state will be chosen to participate in most cases so the opportunity is very limited and will not be around long. Call or email today to secure your hospital's future.

HPSA Acumen, Inc.

Is your area no longer in a shortage area, have questions about bonus payments from Medicare including the 10% geographic bonus, questions about National Health Service Corp tax free loan repayments to providers, need a Community Health Assessment prepared? HPSA Acumen Inc. has been doing this type of work for over 30 years. For more information, here is their contact information.

HPSA Acumen Inc. - PO Box 274, 201 East 4th Street - 3rd Floor, Jamestown, NY 14701

Phone: (716) 483-0888 - Fax: (716) 487-0085

http://www.hpsa.us/

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Rural Behavioral Health, LLC which integrates mental health patients and rural health clinics to grow RHC revenues and provide care for an underserved population in rural areas.

http://www.ruralbehavioralhealth.com/.

We would also like to thank AMS software in Raleigh, North Carolina. They service over 40 RHCs with Electronic Health Record and practice management software. Alice Boykin will be at most of the meetings and will be there to answer billing questions.

http://www.ams-software.com/

Youtube Channel with RHC Webinars

HBS has started a YouTube Channel and it has all the recordings of previous webinars on it. Here is the link:

RHC YouTube Video and Webinar Channel with Recorded Webinars
Recorded Webinars on RHC Billing, Cost Reporting, Certification, and Annual Evaluations

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RHC Update Seminar Registration Form

Please complete the following registration information. Tell us about yourself (additional attendees from the same organization should use separate forms) – we must have an email address for each attendee to register and send materials.

Information Requested	Please Provide Information
Seminar Location	
Name	
Clinic	
Address (1)	
Address (2)	
City, State, Zip	
Telephone	
Email	

Please Provide Payment information on the next page

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RHC Update Seminar Payment Information

Payment Information

Payment Source	How to Pay	Credit Card Information
Sending Check	Mail to: Check to: HBS Healthcare Business Specialists Suite 214, 502 Shadow Parkway Chattanooga, TN 37421	
Pay Pal	**Email to** **la_vita_nouva@hotmail.com**	
Mastercard, Visa, or Discover	**Provide: Credit Card Number** **Provide: Expiration Date:** **Provide: Security Code**	_____ _____
Signature	**Please sign for Credit Cards**	_____

Please email or these two pages to Mark R. Lynn, CPA at marklynnrhc@gmail.com or fax to (800) 268-5055. Once we receive your information either via the mail, fax, or internet registration, we will prepare an invoice and mark it paid, email it to you with a Confirmation number indicating that we have received your payment and have a spot for you at the seminar.

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More Information about Us

For more information on the services of Healthcare Business Specialists including RHC cost reporting, annual evaluations, and startups or to view the resume of the primary speaker for this seminar, please go to our website at:

www.ruralhealthclinic.com

Become a Fan and like us on Facebook

We have a Facebook Fan page which is filled with information on a daily basis regarding rural health clinics. Why wait till Friday to find out what is going on? Become a fan by following the link and liking us.

http://www.facebook.com/pages/Healthcare-Business-Specialists/123096777748776

Healthcare Business Specialists, Chattanooga Tennessee

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H B S
Healthcare Business Specialists

Healthcare Business Specialists is a Chattanooga, Tennessee-based consulting firm which specializes in rural health clinic reimbursement and prepares rural health clinic cost reports, annual evaluations, provider re-enrollment, and RHC startups. Mark R. Lynn is trained as a certified public accountant and has over 35 years' experience in the healthcare field with almost 25 years of experience devoted almost exclusively to rural health clinics. We have been conducting rural health clinic seminars for over 25 years.

Annual Evaluations Cost Reports RHC Startups

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