# Washington Update Louisiana Rural Health Conference

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NARHC



# Allocations from the Federal Government

- General Allocation ($50 billion total)
  - Payment 1 – 6.2% of Medicare reimbursement in 2019
  - Payment 2 – 2% of 2018 net patient revenue MINUS payment 1
- Rural distribution
  - Independent RHCs $100,000 + 3.6% of operating expenses then multiplied by 1.03253231
  - Rural hospital distribution is even more complicated
- RHC Testing
  - Each RHC gets $49.5k
- Medicaid/CHIP Allocation
  - For those providers who did not receive anything from the general allocation
- Phase 4 to include another round?
  - Appears similar to “RHC Testing” round



# How can we spend it?

- Look at terms and conditions

**Rural provider relief fund**

- FAQ for provider relief payments: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html
- “health care related expenses or lost revenues that are attributable to coronavirus”

**RHC Testing Money**

- Look at this FAQ for testing fund: https://www.hrsa.gov/rural-health/coronavirus/frequently-asked-questions
- “COVID-19 testing and COVID-19 related expenses”



# Cost Report and Tax Implications

- Taxes
  - Provider Relief Fund – Yes
  - Paycheck Protection Program – No
- Cost reporting
  - Question: Should SBA loan forgiveness amounts offset expenses on the Medicare cost report? **Answer: No**.
  - Question: Should PRF payments offset expenses on the Medicare cost report? **Answer: No,** providers should not adjust the expenses on the Medicare cost report based on PRF payments received.
  - https://www.narhc.org/News/28575/CMS-Clarifies-that-Provider-Relief-Funds--Paycheck-Protection-Program-Loans-will-NOT-Offset-Expenses-on-Medicare-Cost-Report
  - https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

# RHC COVID-19 Testing Program Data Collection Requirement

- www.RHCcovidreporting.com
- Visit NARHC.org > Resources > TA Webinars for detailed walk through of this reporting requirement
- Data will be organized at the TIN-level
- RHCs and their parent organizations will want to have records of testing by month
- We would like the most accurate figures possible but estimates will be allowed
- You are not required to do COVID testing but you are required to use the funds for tests or testing related activities

The Compliance Team

NARHC NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

# RHC TA Community Centric Covid 19 Testing

**We appreciate your time, consideration, and your service to our rural neighbors.**

**National Association of Rural Health Clinics**

Funded by: FORHP

**Resources provided to participating RHCs include:**

- an individualized strategy to build collaboration
- resources to develop and implement a comprehensive, community centric COVID-19 testing program
- comprehensive tools to build RHC capacity
- customized, in-depth, remote technical assistance (TA) to
  - meet the needs of the RHC and community
  - grow operational and clinical viability
  - provide access to subject matter experts
- assistance with reporting requirements process

**Contact us at rhccovidtestinginfo@nosorh.org for additional information!**

- Provider Relief Fund Reporting is a different process
- More financial in nature
- Portal opens up in January

## Summary reporting requirements for recipients of the Provider Relief Fund (PRF)

Providers that receive PRF payments exceeding $10,000 in aggregate are required to report their use of funds, as per the program Terms and Conditions

**Key dates and actions required:**

- **Jan. 15, 2021:** reporting portal opens for providers
- **Feb. 15, 2021:** first reporting deadline for all providers on use of PRF funds
- **July 31, 2021:** final reporting deadline for providers who did not fully expend PRF funds prior to December 31, 2020

**Guidelines for use of PRF funds:**

- PRF funds can be used in the following manner and order:
  - Expenses attributable to coronavirus that are not reimbursed or obligated to be reimbursed from other sources
  - Lost revenues, as represented by a change in net patient care operating income from 2019 to 2020 (revenue less expenses)

### Required reporting data elements

**Lost revenues:**

- Revenue/net charges from patient care
- Revenue by patient care payor mix

**Expenses attributable to coronavirus:**

- General and administrative (G&A) expenses
- Healthcare-related expenses

For recipients of over $500,000 in aggregate PRF payments, providers must provide a further expense breakdown that includes:

- Mortgage/rent
- Personnel
- Utilities
- Supplies
- Equipment
- …and other high-level expense categories

**Basic organization information:**

- Taxpayer Identification Number
- National Provider Identifier *(optional)*
- Fiscal year end date
- Federal tax classification

**Other assistance received in 2020:**

- Paycheck Protection Program
- FEMA CARES Act
- CARES Act Testing
- Local/State/Tribal Government assistance
- Business insurance
- Other assistance

**Non-financial information:**

- Employees (i.e. total, re-hires)
- Patients (i.e. visits, admissions)
- Facility (i.e. staffed beds)

Please visit the PRF website for complete reporting guidance and details, as well as FAQs and other program information



# Telehealth Policy

| Name of Telehealth Service | Brief Description | How to bill | Payment |
|---|---|---|---|
| Virtual Check-In or Virtual Care Communications | Remote evaluation of a picture – G2010<br>Brief communication with patient (5 min) – G2012 | G0071<br>Bill on UB-04<br>No modifier necessary<br>Rev Code 052X | $24.76 |
| Digital e-visits | Online digital evaluation and management<br>99421-99423 | G0071<br>Bill on UB-04<br>No modifier<br>Rev Code 052X | $24.76 |
| Telehealth Visits | One to one substitutes for in-person services/visits ~ many | G2025<br>Bill on UB-04<br>(95 optional) (CS for preventive)<br>Rev Code 052X | $92.03 |
| Telephone Audio-Only E/M Visits | Telephone E/M<br>99441-99443 | Can bill as G2025 services | $92.03 |



# RHC Telehealth Update

- Major update to the RHC telehealth policy was released on April 30th MLN Matters SE20016 (latest revision July 6)
- RHCs are to use the HCPCS code G2025 (w/ modifier CG) for all telehealth distant site visit claims
- RHCs can now use HCPCs code G2025 to bill for audio-only telehealth visits (previously was shoehorned into a G0071 service)
- Payment for G2025 is **$92.03**. Prior to July 1, RHCs received their normal All-Inclusive Rate. MACs are currently in the process of reconciling the pre-July over or under payments.
- Recoupments occurred in July for those who billed prior to June 30.

# RHC Telehealth Update

- CMS significantly expanded the codes that providers can bill via telehealth on April 30th.
- In that update, they specified a significant number of codes that can be billed audio-only.
- Currently less relevant for us because we bill all these codes with G2025
- Use modifier CS to waive coinsurance for services related to COVID testing/preventive services
- https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes



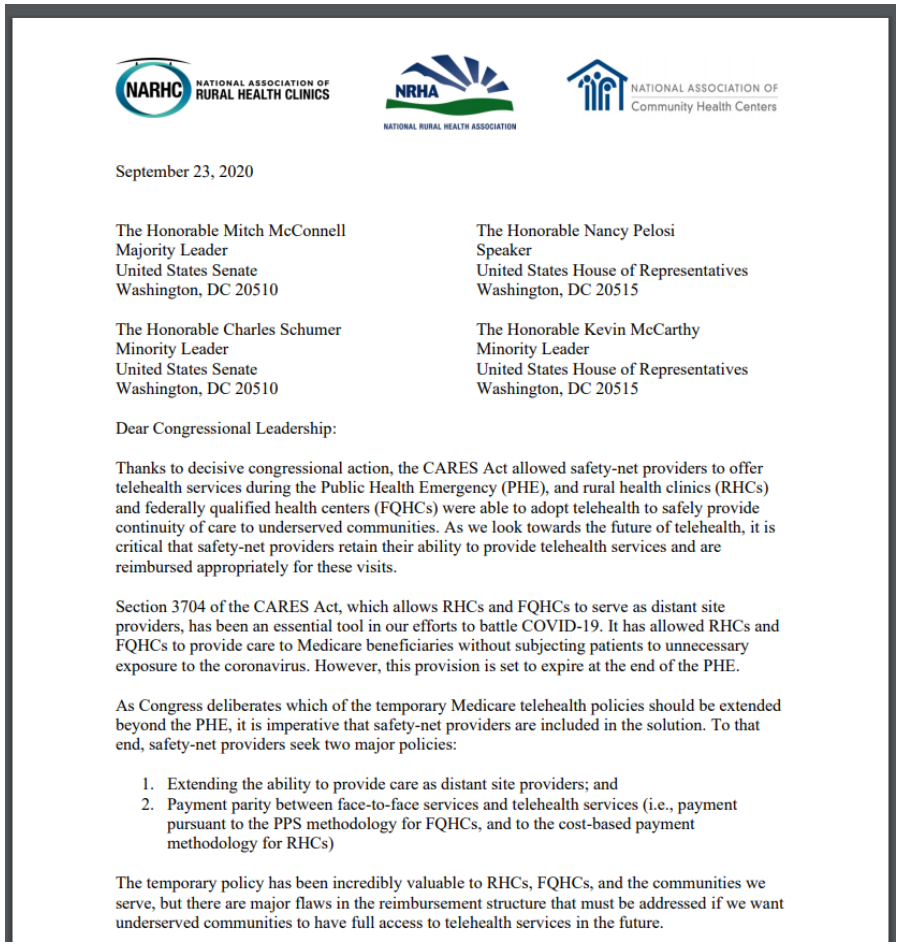
# MAC Payments not calculating G2025 correctly

- **Current policy:**
  - MACs are paying $92.03 minus the coinsurance amount charged to the patient.

- **What we believe the policy should be:**
  - MACs pay 80% of the composite rate. Coinsurance is based off the charges but should not impact the RHC's G2025 reimbursement from the MAC.



# Letter to Congressional leadership



NARHC NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS
NRHA NATIONAL RURAL HEALTH ASSOCIATION
NATIONAL ASSOCIATION OF Community Health Centers

September 23, 2020

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Charles Schumer
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Kevin McCarthy
Minority Leader
United States House of Representatives
Washington, DC 20515

Dear Congressional Leadership:

Thanks to decisive congressional action, the CARES Act allowed safety-net providers to offer telehealth services during the Public Health Emergency (PHE), and rural health clinics (RHCs) and federally qualified health centers (FQHCs) were able to adopt telehealth to safely provide continuity of care to underserved communities. As we look towards the future of telehealth, it is critical that safety-net providers retain their ability to provide telehealth services and are reimbursed appropriately for these visits.

Section 3704 of the CARES Act, which allows RHCs and FQHCs to serve as distant site providers, has been an essential tool in our efforts to battle COVID-19. It has allowed RHCs and FQHCs to provide care to Medicare beneficiaries without subjecting patients to unnecessary exposure to the coronavirus. However, this provision is set to expire at the end of the PHE.

As Congress deliberates which of the temporary Medicare telehealth policies should be extended beyond the PHE, it is imperative that safety-net providers are included in the solution. To that end, safety-net providers seek two major policies:

1. Extending the ability to provide care as distant site providers; and
2. Payment parity between face-to-face services and telehealth services (i.e., payment pursuant to the PPS methodology for FQHCs, and to the cost-based payment methodology for RHCs)

The temporary policy has been incredibly valuable to RHCs, FQHCs, and the communities we serve, but there are major flaws in the reimbursement structure that must be addressed if we want underserved communities to have full access to telehealth services in the future.

- Full letter may be downloaded here: https://www.narhc.org/narhc/NARHC_ADVOCACY.asp
- The policy we want:
  - Extending the ability to provide care as distant site providers; and
  - Payment parity between face-to-face services and telehealth services (i.e., payment pursuant to the PPS methodology for FQHCs, and to the cost-based payment methodology for RHCs)
- Multiple pieces of legislation that move the policy the right way…



# Telehealth visits post-PHE?

- What we need to advocate for
  - Extending the ability to provide care as distant site providers; and
  - Fair reimbursement for telehealth services relative to our fee-for-service peers.



# Menu of Policy Options

- **H.R. 6792, S. 3998:** The *Improving Telehealth for Underserved Communities Act of 2020* allows RHCs and FQHCs to use normal coding and billing for telehealth services (payment parity between telehealth and in-person services) for the duration of the public health emergency while raising the limits on payment for independent rural health clinics who have long been paid below cost due to the RHC Medicare "cap."
- **H.R. 7663:** The *Protecting Access to Post-COVID-19 Telehealth Act of 2020* permanently expands distant site provisions for RHCs and FQHCs and allows payment for telehealth services to be paid via our normal in-person rates as if the services were provided without the use of a telecommunications device.
- **H.R. 7187:** The *HEALTH Act of 2020* permanently expands distant site provisions for RHCs and FQHCs and e*xplicitly* requires telehealth reimbursement for safety-net providers be made through normal safety-net reimbursement mechanisms. Rural Health Clinics would receive their All-Inclusive Rate (AIR) payment while Federally Qualified Health Centers would receive their normal Prospective Payment System (PPS) rate.
- **H.R. 8156:** The *Ensuring Telehealth Expansion Act* allows RHCs and FQHCs to continue to provide distant site services until the end of 2025 while eliminating the special payment rule such that RHCs and FQHCs are reimbursed their normal in-person rates for telehealth services.



# ADVOCATE!

- To get policy wins we need grassroots advocacy + “inside the beltway” advocacy

- https://www.narhc.org/narhc/NARHC_ADVOCACY.asp
- https://www.narhc.org/narhc/RHC_Modernization_Act_Advocacy.asp



# Questions and Answers

- Contact:

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