Rural CMS Updates and Hot Topics

Presented by: Kami Matzek, CPA

2024 Washington HFMA

Outline

- Proposed RHC changes
- Miscellaneous
- Desk review focus
- OIG

Proposed RHC/FQHC Changes

- Eliminate RHC productivity standards
- Rebase FQHC rates on 2022 cost reports
- RHC/FQHC rates on 2022 cost reports
- RHC/FQHC behavioral health in person - January 1, 2026
- RHC/FQHC bill for vaccine administration at time of service
  - Includes pneumococcal, influenza, hepatitis B, and Covid-19
  - Still settles on cost
  - Proposed date of July 1, 2025
  - Uncertainty remains about billing and payment status
- If the above measures are approved, a payment may be available for in-home vaccinations

When your husband says we don't have room for any more dogs

Proposed RHC/FQHC Changes

- RHCs/FQHCs can bill individual care management code
- Dental at AIR if “inextricably linked to specific covered services”
- RHC primary care intention:
  - Current definition: Greater than 50% of the time services are provided
  - Proposed: Explicitly requires RHC to provide primary care services; cannot be rehabilitation agency or primarily for mental diseases
- Removes hemoglobin and hematocrit from “must provide” list

Proposed RHC/FQHC Changes

- Intensive outpatient - can now bill 4!!!
- There may be an extension for distant telehealth, but there's an effort to refer to it as an encounter
- HIV prep drugs are covered by part B in RHC/FQHC
- Reminder: telehealth services only permitted during RHC hours

RHC Changes

- Adds RHC/FQHC practitioners
  - Marriage and family therapists
  - Mental health counselors
- Allows the above to register directly with Medicare

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"I hope this email finds you well"

The email finding me

RHC/FQHCs To Provide Intensive Outpatient Program

- Individuals with mental health needs
- Carved out of AIR
- Paid hospital rates
- Effective January 1, 2024

RHC/FQHCs IOP

- Daily care of less than 24 hours
  - At least 9 hours of therapeutic services per week
- Three distinct qualifying services per day
  - Could be less on occasion
- Services not provided in the patient’s home
- Provided in-person
- Certified by physician

RHC/FQHCs IOP Benefits

- Group or individual therapy
- Occupational therapy
- Social workers
- Therapeutic drugs
- Activity therapy
- Family counseling
- Patient training and beneficiary education
- Diagnostic services

RHC/FQHCs IOP Payment

- PPS rate
- Daily per-diem for three services (approximately $259.40)
  - FQHCs will charge the lower of the per-diem or their standard rate
- Codes:
  - Revenue Code 905
  - Condition Code 92
  - RHC should use CG modifier as coinsurance applies
  - At least one primary service need to be included
- Billing for a mental health encounter on the same day is not permitted


DAY 11: THE DOG
STILL THINKS I'M FUR

RHC Rural

- Census Bureau stops defining “urbanized”
- Affects new RHCs as well as relocating RHCs
- CMS issues interim rule:
  - Uses 2010 Census Bureau data
  - Physical address is “non-urbanized” or in an “urban cluster”
  - OR of not urban area per 2020 Census Bureau data

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RHC Caps

- Short cost reports
  - Won’t be your cap
  - Utilize the first complete year as your foundation
- Don’t forget to scrub your base year’s data
- Don’t forget your productivity waivers

2023 Appropriations Act

- Telehealth expansions - through December 31, 2024
  - RHC designated as distant site providers
  - Enhanced technology options
    - Audio-only services available for select treatments
  - Expanded practitioners (PT, ST, OT)
  - New MH encounters via audio-only do not require an in-person visit
  - Access to telehealth in non-rural areas
  - Patient’s home recognized as originating site
    - Payment parity for home telehealth ended May 11, 2023
- Virtual direct supervision ends December 31, 2023
- PAYGO sequester from the ARP will shift from 2023 to 2025

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CAH CoPs

- CMS outlines what constitutes “primary roads”
  - You know, what a secondary road is not
  - These are numbered federal or state highways with at least two lanes in each direction
- Impacts non-necessary providers, including CAHs and those aspiring to become CAHs
- Consider changes to your off-campus locations

EHR Reporting

- Any consecutive 90-day period through 2023
- 2024 moving forward is consecutive 180-day period

Rural Emergency Hospitals (REH)

- Rural hospital with 50 or fewer beds as of the date of the Act (December 27, 2020)
- Licensed as REH under state law
  - https://www.ncsl.org/health/rural-emergency-hospitals
  - Washington is not a state that has enacted a law establishing REH licensure
- Staffed 24/7 by MD, NP, PA, or clinical nurse specialist
- Staffing requirements similar to that of a CAH
- Document and report on use of subsidy
- Quality reporting required

REH Statutory Requirements

- Provide outpatient services only
  - Can have a nursing home (distinct part)
  - CanNOT have distinct part psychiatric or rehabilitation units
- Emergency room services required
- Observation required
- Other outpatient services allowed
- Must have transfer agreement with Level I/II trauma center
- Must submit action plan to convert

REH Payments

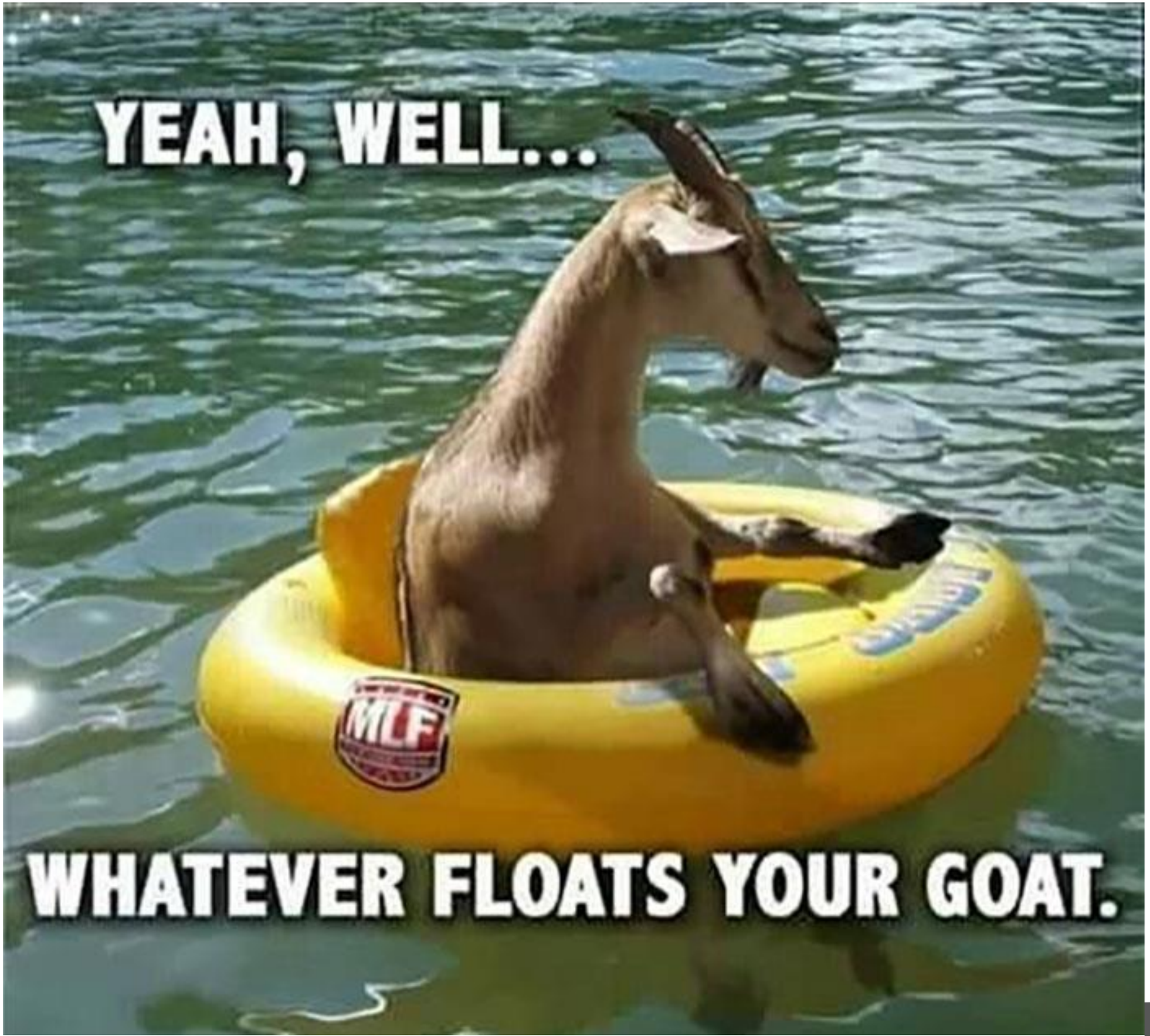
- OPPS plus 5%
  - Patient does not pay 5%
- NonOPPS services paid fee schedule
  - Ambulance, lab, diagnostics
  - No 5% add-on
- Add on “average CAH amount”
  - Based on 2019 payments to CAHs
  - Inflated by market basket update
  - 2024’s amount is $281,871 a month
- Submit on a UB

REH Issues

- Not 340B covered entity
- Must be able to transfer (EMS issues)
- Medicaid reimbursement is unknown
  - Most supplemental payments are bed days driven
  - DSH clearly goes away
- Amount of fixed/semi-fixed cost now spread over fewer services.
- Estimating impact to services hard to estimate

REH

- Residents
  - Defines REH as “nonProvider” site
  - If costs incurred: pay at 100% of cost
- 2024-month subsidy $281,871



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Desk Reviews and Audits

- Initial Stage
  - Typically involves sampling bad debts
  - Reconciling MCR with audited financial statement revenues and expenses
  - Significant emphasis on variances and new checklists
    - CCRs, revenues, expenses, adjustments, reclassifications, etc.
    - Evidence will be required to support responses
    - Specifics of various general ledger accounts
  - Requesting CMS Form 1539 (beds reported on S-3)
    - Fun fact – you should not have this!
  - CMS-339s questionnaire must be signed by ER director, chief of staff, or CMO
    - Should be completed at time of filing

Desk Reviews and Audits

- Focus areas:
  - Days!
  - Physician contracts
    - Medical Director
    - Allocations
      - “New workpaper from CMS” Very ominous
  - Vaccine logs and costs
  - PBC locations attestations and locations in PECOS
  - Construction costs and capitalization
  - Contracted therapies
    - Invoices
    - Splitting apart if reported together.
  - Approval for non-standard statistical allocations

Desk Reviews and Audits

- Testing stage
  - Concentrate on specific areas based on the scope
- Adjustments suggested by auditor
  - PS&R related
  - Tentative settlements applied
  - From review procedures
    - Look for adjustments that affect the expenses, revenues, and days

OIG Reports

OIG Reports

- Review of 2-midnight rule
- Medicare payment for COVID-19 cases
  - Aligning with federal mandates
- PRF payments for nursing home
  - “hey, guidance was hard to use” lol
  - Suggestion to consult HRSA
    - “Record lessons learned”
    - Expedite audits
  - Discovered that the guidance lacked clarity until the reporting phrase, rather than during the spending phase
- Accelerated payments
  - Collected as intended

OIG Work Plan

- Covid audits
  - Several of HRSA
  - Duplicate payments for uninsured portal and grant funding
- GEMT programs
- CMS’ oversight of price transparency
- Cost report amended settlements after finalization
- Hospital compliance with out-of-network for COVID cases
- Updating the swing bed analysis

Questions?

Kami Matzek, CPA, Owner

509.321.9476

kmatzek@dza.cpa

dza.cpa

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