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RHC Conference
Rural Health Legislative Update
Presented by:
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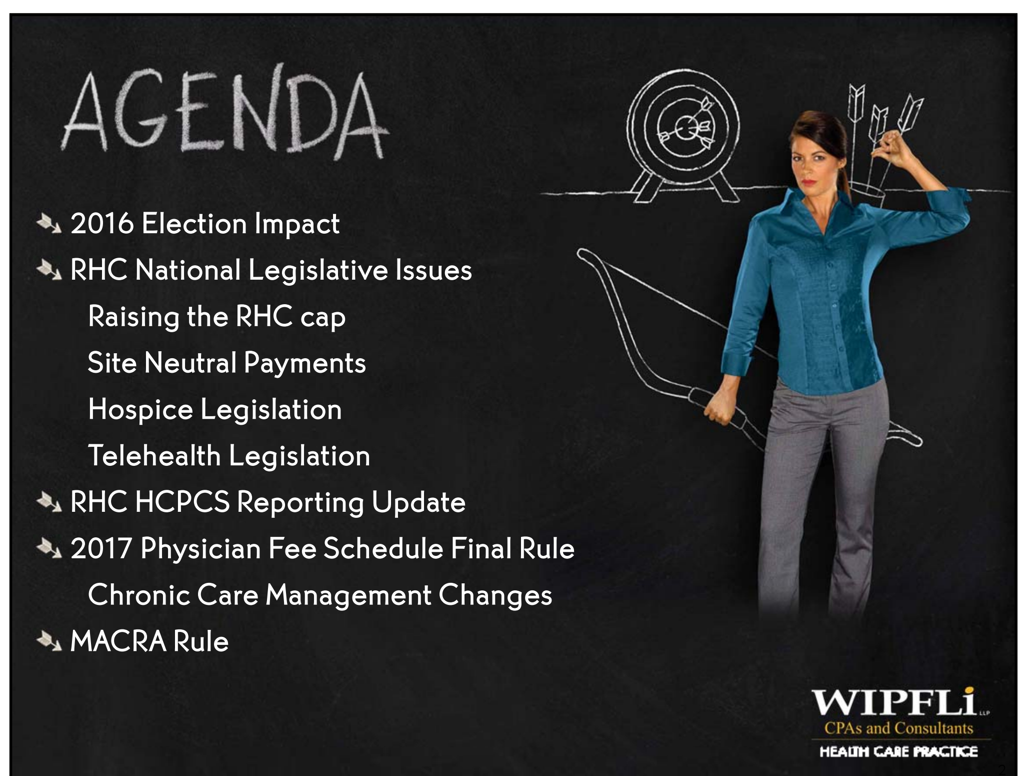
March 16, 2017


AGENDA
2016 Election Impact
RHC National Legislative Issues
Raising the RHC cap
Site Neutral Payments
Hospice Legislation
Telehealth Legislation
RHC HCPCS Reporting Update
2017 Physician Fee Schedule Final Rule
Chronic Care Management Changes
MACRA Rule
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No Matter What

- MACRA Implementation
- Cadillac Tax Delay/Repeal
- Site Neutral Payment Policies

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Republican Landslide

- Repeal and Replace ACA
- Selling Insurance Across State Lines
- Block Grants to States for Medicaid

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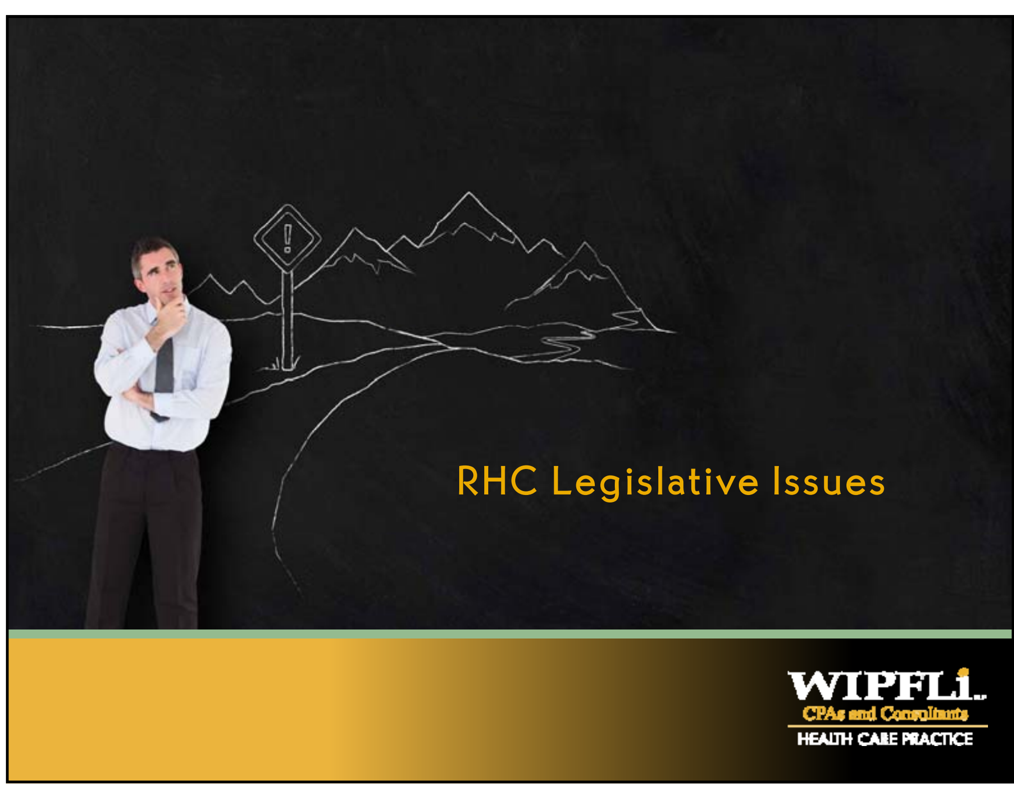

National Legislative Issues

- Raising the RHC cap
- Site neutral payment policies
- Hospice legislation
- Telehealth legislation

Raising the RHC Cap

NARHC continues to promote raising the RHC cap to at least $90.00 per visit for those RHCs subject to the cap.

- 2016 cap was $81.32
- 2017 cap is $82.30

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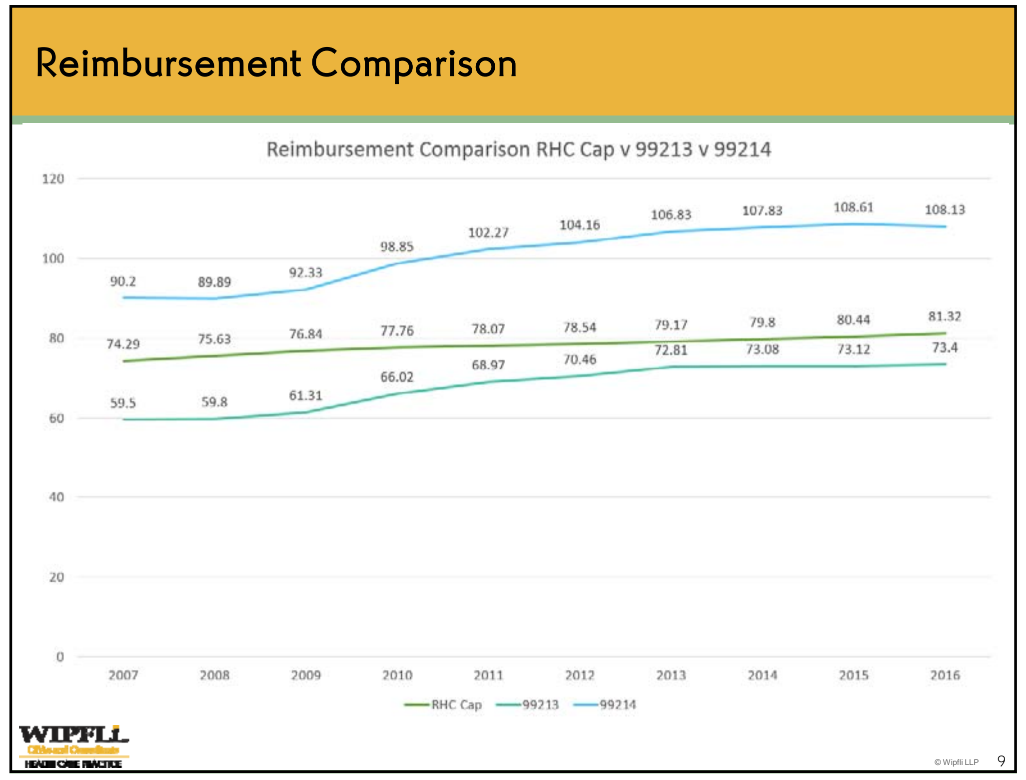

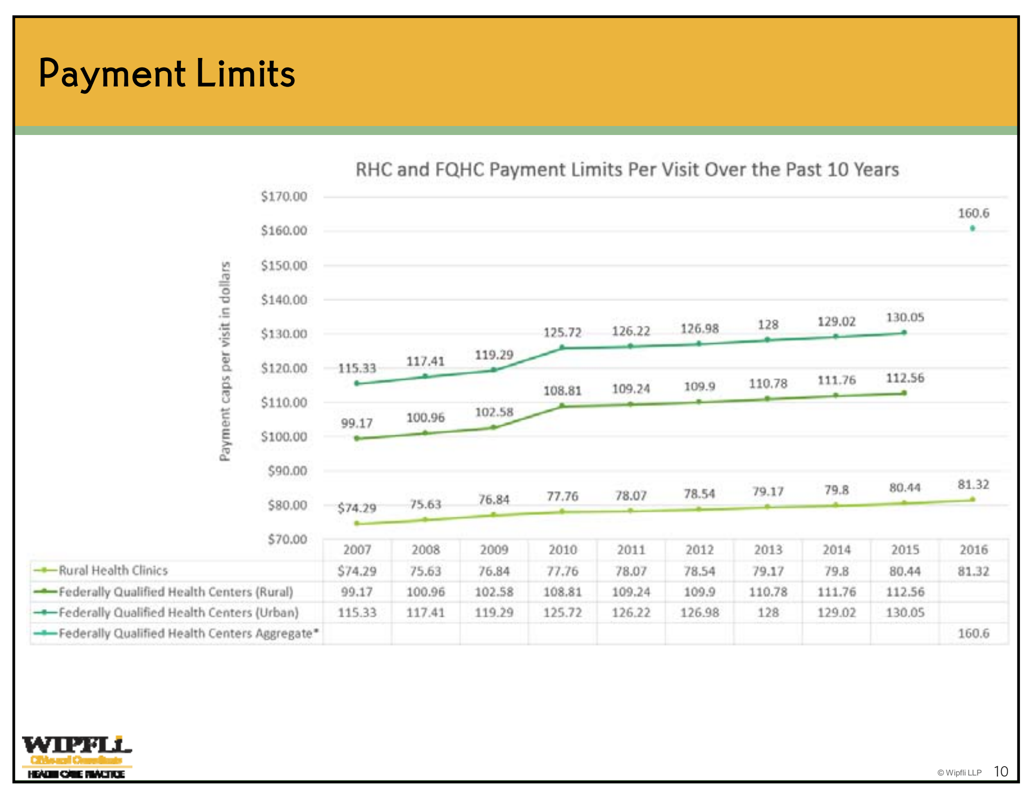

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Rural Health Clinics	$74.29	75.63	76.84	77.76	78.07	78.54	79.17	79.8	80.44	81.32
Federally Qualified Health Centers (Rural)	99.17	100.96	102.58	108.81	109.24	109.9	110.78	111.76	112.56	
Federally Qualified Health Centers (Urban)	115.33	117.41	119.29	125.72	126.22	126.98	128	129.02	130.05	
Federally Qualified Health Centers Aggregate*										160.6

Provider-Based and Independent RHCs

Provider-Based Total Allowable Cost per Actual Encounter (2015)	$185.59
Provider-Based Total Allowable Cost per Adjusted Encounter (2015)	$177.16
Independent Total Allowable Cost per Actual Encounter (2015)	$120.15
Independent Total Allowable Cost per Adjusted Encounter (2015)	$117.16

Source: RHC Benchmark Report
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How Do RHC Costs Compare to RHC Payments?

RHC Type	Actual Payment	RHC Actual Costs
Independent	$81.32	$106.22
provider-based to CAH	$164.36	$164.36
provider-based to Hospitals <50 Beds	$152.75	$152.75
provider-based to Hospitals >50 Beds	$81.32	$148.97

Source: RHC Benchmark Report
2014 data
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Site Neutral Payments

- What is Site Neutral Payment Policy?
- Does this affect RHCs?

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Site Neutral Payments

- This is essentially a policy whereby Medicare pays the same for a service regardless of the site in which it is performed.
- As of Bipartisan Budget Act of 2015 (the budget that Speaker Boehner resigned over), Medicare will no longer pay a higher fee to off-campus facilities designated as hospital outpatient departments for services that would have been covered under the physician fee schedule or ambulatory surgery schedule. Payment will be the same whether provided in the off-campus department or the physician's office.

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Site Neutral Payments

EXHIBIT 2

Differences in Medicare Program Payments and Beneficiary Cost Sharing for Midlevel Outpatient Office Visits Provided in Freestanding Practices and Hospital-Based Entities, 2014

	Service provided in freestanding physician practice	Service provided in a hospital outpatient department		
	MPFS physician office rate[a]	MPFS physician facility rate[a]	OPPS rate[b]	Total hospital-based rate
Program payment	$58.46	$41.26	$74.02	$115.28
Beneficiary cost sharing	$14.62	$10.32	$18.51	$28.83
Total payment	**$73.08**	**$51.58**	**$92.53**	**$144.11**

SOURCE Medicare Payment Advisory Commission table updated by the author with 2014 payment rates from Centers for Medicare and Medicaid Services website. The *Current Procedural Terminology* code used for this example under the physician fee schedule is 99213. The Healthcare Common Procedure Code Set code used for this example under the outpatient prospective payment system (OPPS) is G0462. NOTE MPFS is Medicare physician fee schedule. [a]Paid under the Medicare physician fee schedule. [b]Paid under the OPPS.

Sound Familiar?

- Although Provider-Based RHCs are NOT affected by this policy, it is something we should be prepared to deal with should it arise.
- To be clear, there is no evidence that extending site neutral payment policies to RHCs is under active consideration.
- *What do we do if it does?*

How Do RHC Costs Compare to RHC Payments?

RHC Type	Actual Payment	With parent Overhead	Without Parent Overhead
Independent	$81.32	$106.22	$106.22
provider-based to CAH	$164.36	$164.36	$106.24
provider-based to Hospitals <50 Beds	$152.75	$152.75	$98.69
provider-based to Hospitals >50 Beds	$81.32	$148.97	$93.55

Source: RHC Benchmark Report
2014 data
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Parent Provider Overhead

- It appears that parent provider overhead is the sole factor explaining the cost difference between provider-based RHCs and independent RHCs.

- Provider-based RHCs are not more costly or less efficient than their independent colleagues.

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Hospice Legislation

- NARHC is supporting efforts by the National Hospice and Palliative Care Organization to amend the Medicare statute to allow RHC physicians and NPs to be hospice care providers.
- The Rural Access to Hospice Act of 2016 was introduced by Senators Capito (R-WV) and Shaheen (D-NH) and would fix this issue.

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Telehealth Legislation

NARHC has endorsed The CONNECT for Health Act.

- This bill allows RHCs to serve as the distant site (where the provider is located) for telehealth visits.
- Also authorizes the use of "remote monitoring devices" for use with chronic care patients. Remote monitoring device is a device that transmits personal medical information from an applicable individual in one location via electronic communications technologies to an eligible provider in a different location and used by the eligible provider to furnish remote patient monitoring services to such individual.

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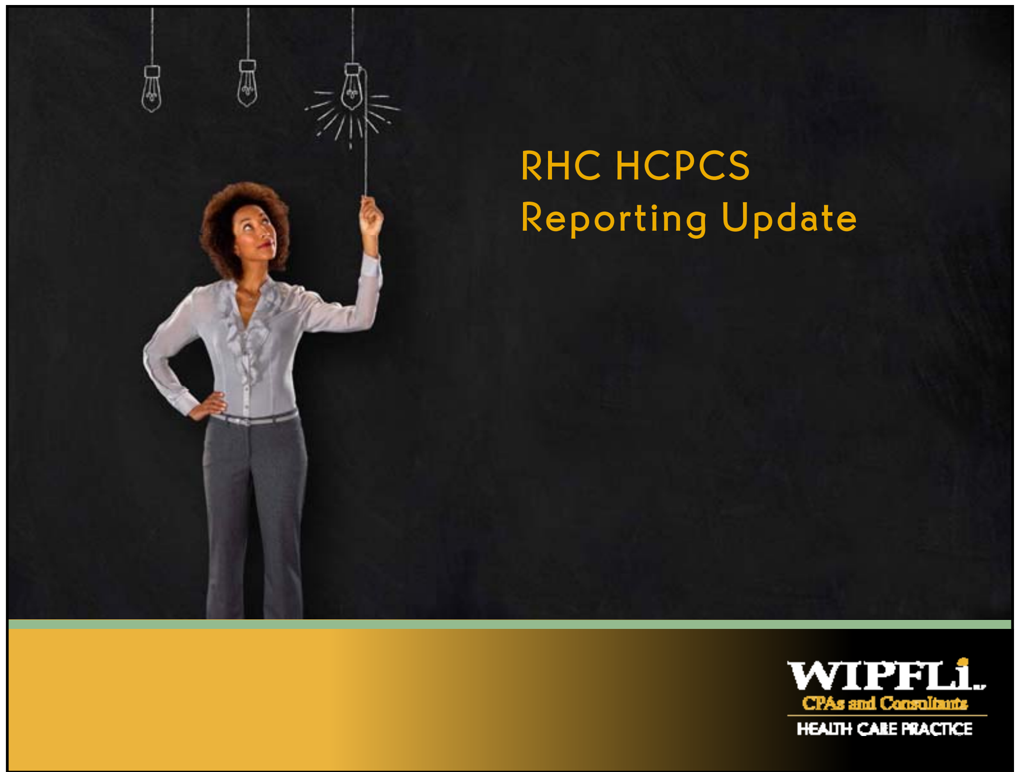

HCPCS Reporting Requirements – Oct. 1

- Beginning October 1, the qualifying visit list went away.
- Instead, all Medicare RHC claims must use a CG modifier to indicate which line contains the total charge subject to coinsurance and deductible.
- The following MLN Matters article best describes the October 1 changes:
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1611.pdf

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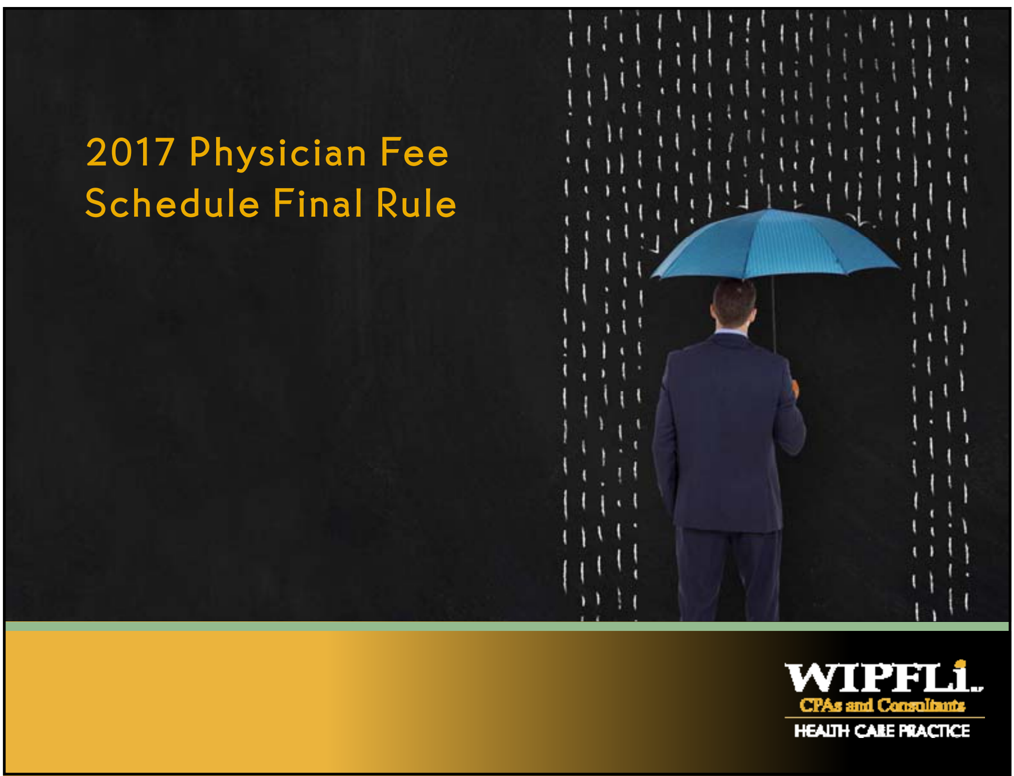

Final 2017 Physician Fee Schedule - CCM

- CMS changed the supervision requirement from Direct Supervision to General Supervision for CCM Services
- Allows RHC to more easily contract with third-party vendors
- CCM represents both an opportunity to improve outcomes and increase revenue in your RHC
- Began on January 1, 2017

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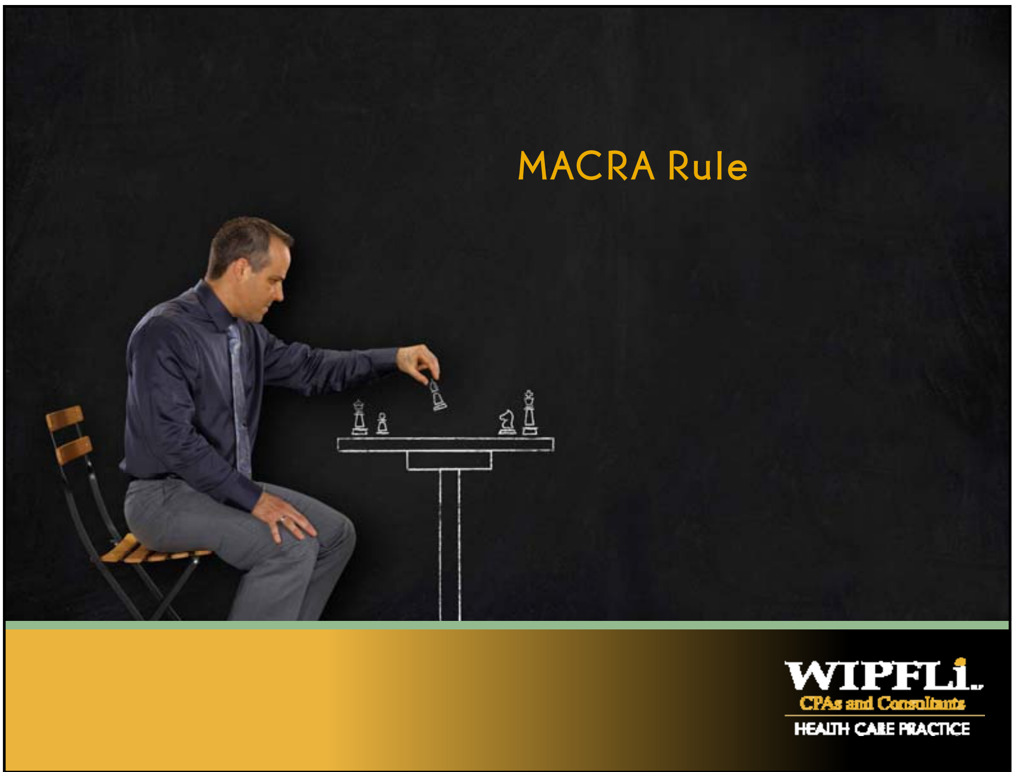

MACRA – Does It Apply to RHCs?

- MACRA (Medicare Access and CHIP Re-authorization Act) - Does it affect RHCs?
  - Mostly no
- We anticipate that most RHCs will not be affected by MACRA
- MIPS includes a low volume exception – RHCs should qualify
- APMs vs. "Advanced APM models" for the purposes of MACRA
- Could it affect RHCs in the future?
- Quality is coming to the RHC program, but it is unclear how

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MIPS RHC Voluntary Reporting

- CMS is allowing RHCs to voluntarily report
- Will have no bearing on RHC AIR
- May allow RHCs to test waters and transition to traditional office
- NARHC is warning CMS not to generalize the scores that are reported
- Unclear if all the moving parts of the MIPS CPS would translate well to RHC billing on the UB-04
- Low-volume exception currently proposed as:
  - Less than $10,000 of Part B charges AND provides care to fewer than 100 Part B-enrolled Medicare beneficiaries
- If you don't qualify for an exception . . . MIPS adjustments will only apply to those claims submitted on the 1500

APMs – What Are They?

- Harder to generalize because there are many different kinds of APMs
- To be an Advanced APM one must:
  - Require participants to use certified EHR technology
  - Provide payment for services based on the quality measures comparable to those used in MIPS
  - Bear more than nominal amount of risk for monetary losses
- APMs vs. "Advanced APMs" for purposes of MACRA:
  - Providers must be participating in Advanced APMs in order to avoid MIPS/receive the formal incentive payments in the MACRA law
  - Important to note that one of the main incentives to join an advanced APM involves a lump sum payment of 5% to providers. However, RHC services (because they are not reimbursed under the PFS) would not be included in the amount upon which the APM incentive payment is based.

APMs, Advanced APMs, and RHCs

- To be clear, RHCs CAN participate in APMs and advanced APMs.
- Any RHC joining an APM would do so not because of some formal government incentive payment, but rather because the APM itself offers value to the RHC.
- Still very early on in the development of advanced APMs.
- MCRH is actively involved in two ACOs in MI which both have RHCs.
- An example of an "APM" not an "advanced APM."

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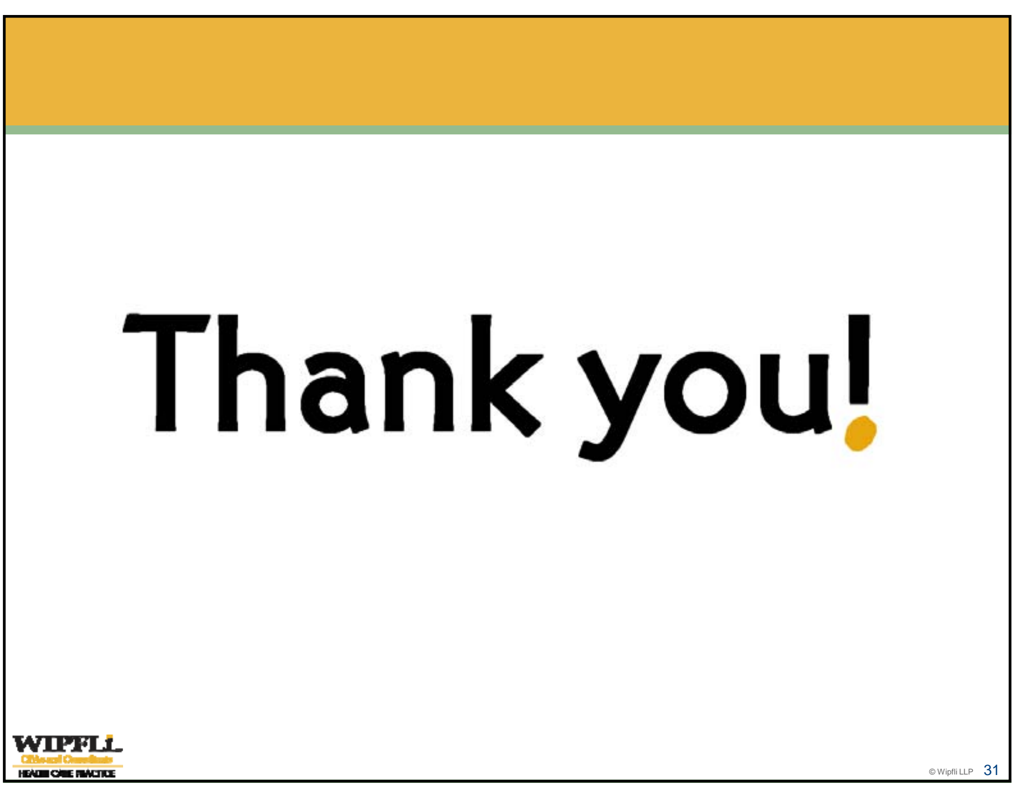
Thank you!
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