HBS

Healthcare Business Specialists

COVID-19 Current Reimbursement Issues for Rural Health Clinics July 27, 2020

Thank you to all our healthcare heroes that are battling COVID-19. While the battle has raged for some five months now, it seems the front lines have moved closer to home and treating patients is becoming more and more dangerous for our providers. While the administrative and financial battle has drug on and the pace of information on the grant and reimbursement front has slowed down in recent months (it is sure to pick up with the latest incarnation of the stimulus bill set to be released soon), we wanted to provide an update on some of the major issues that affect RHCs as they deal with the impact of COVID-19 on operations, reimbursement, finances, and cost reporting.

We have prepared this update for RHCs related to the following five items as it relates to RHCs.

1. HHS renews the Public Health Emergency (PHE) for 90 more days
2. Provider Relief Fund Reporting Requirements
3. Provider Relief Funds are Taxable
4. Exceptions to Productivity Screens for RHCs
5. Cost Reporting implications of the Payroll Protection Program

502 Shadow Parkway Chattanooga, TN 37421 ● Telephone 833-787-2542 ● www.ruralhealthclinic.com

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HHS renews public health emergency

The Department of Health and Human Services (HHS) on July 23 formally renewed the COVID-19 public health emergency declaration. The 90-day extension will help RHCs, hospitals, and other providers continue to combat COVID-19 in their communities. **RHCs will especially benefit from the continuation of the Telehealth reimbursement rules that allow RHCs to act as distant site providers and patient's homes to be originating sites.** The previous declaration was set to expire on July 25.

To read the announcement go to the following address or view the image below:

https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-23June2020.aspx

Public Health Emergency
Public Health and Medical Emergency Support for a Nation Prepared

Search...

PHE Home > Emergency > News & Multimedia > Public Health Actions > PHE > Renewal of Determination That A Public Health Emergency Exists

Renewal of Determination That A Public Health Emergency Exists

As a result of the continued consequences of Coronavirus Disease 2019 (COVID-19) pandemic, on this date and after consultation with public health officials as necessary, I, Alex M. Azar II, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby renew, effective July 25, 2020, my January 31, 2020, determination that I previously renewed on April 21, 2020, that a public health emergency exists and has existed since January 27, 2020, nationwide.

July 23, 2020	/s/
Date	Alex M. Azar II

More Emergency and Response Information

- Declarations of a Public Health Emergency
- Public Health Emergency Determinations to Support an Emergency Use Authorization
- Section 1135 Waivers
- Emergency Use Authorizations

This page last reviewed: July 23, 202

HHS issues new details on provider relief fund reporting requirements

The Department of Health and Human Services (HHS) last week shared additional information on reporting requirements for recipients of provider relief funds authorized under the Coronavirus Aid, Relief, and Economic Security Act and Paycheck Protection Program and Health Care Enhancement Act. In its notice, HHS said recipients that received one or more payments exceeding $10,000 in the aggregate from the Provider Relief Fund will be required to submit reports to the agency on how the funds have been expended using a portal that will open on Oct. 1, 2020. Detailed instructions regarding the reports will be released by Aug. 17, 2020. To read the notice, go to: **https://tinyurl.com/y6jktsxa**

We have included pictures of the guidance on the next page.

General and Targeted Distribution
Post-Payment Notice of Reporting Requirements

July 20, 2020

Purpose

The purpose of this notice is to inform Provider Relief Fund (PRF) recipients that received one or more payments exceeding $10,000 in the aggregate from the PRF of the timing of future reporting requirements. Detailed instructions regarding these reports will be released by August 17, 2020.

Overview

Congress appropriated funding to reimburse eligible health care providers for health care related expenses or lost revenues attributable to coronavirus. The Health Resources and Services Administration (HRSA) is administering the distribution of payments under the PRF program, funded through appropriations in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136) and the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139). Each recipient of a payment from the PRF that used any part of that payment agreed to a set of Terms and Conditions (T&Cs) which, among other obligations, require each recipient to submit reports to the Department of Health and Human Services (HHS). The reports shall be in such form, with such content, as specified by the Secretary of HHS in future program instructions directed to all recipients. HHS will be releasing detailed reporting instructions by August 17, 2020.

These reporting instructions will provide directions on reporting obligations applicable to any provider that received a payment from the following CARES Act/PRF distributions:

General Distributions:

- Initial Medicare Distribution
- Additional Medicare Distribution
- Medicaid, Dental & CHIP Distribution

Targeted Distributions:

- High Impact Area Distribution
- Rural Distribution
- Skilled Nursing Facilities Distribution
- Indian Health Service Distribution
- Safety Net Hospital Distribution

The reports will allow providers to demonstrate compliance with the T&Cs, including use of funds for allowable purposes, for each PRF payment. HRSA plans to provide recipients with Question and Answer (Q&A) Sessions via Webinar in advance of the submission deadline. Additional details will follow regarding the Q&A Sessions.

Notice on Timing of Reports

The reporting system will become available to recipients for reporting on **October 1, 2020.**

- All recipients must report within 45 days of the end of calendar year 2020 on their expenditures through the period ending December 31, 2020.

- Recipients who have expended funds in full prior to December 31, 2020 may submit a single final report at any time during the window that begins October 1, 2020, but no later than February 15, 2021.
- Recipients with funds unexpended after December 31, 2020, must submit a second and final report no later than July 31, 2021.
- Detailed PRF reporting instructions and a data collection template with the necessary data elements will be available through the HRSA website by August 17, 2020.

The key pieces of information related to Provider Relief Funding are as follows:

1. Quarterly reports are **not** required as previously thought.
2. More instructions and forms are going to be released on August 17, 2020
3. If you clinic has expended all of their provider relief funds they can report this using a portal that will open October 1st and they must report by February 15, 2021.
4. If clinics have expended all their funds by December 31, 2020, they must submit a second report by July 31, 2021.

Like many of the RHC consulting and accounting firms, we are adding this reporting to our cost reporting services and agreements that will be coming out in October and November for 12/31/2020 cost reports. We will know the pricing of the add-on service once we determine what the requirement are when the August 17, 2020 information is released.

Provider Relief Funds are Taxable

Yes, Provider Relief Funds are includable as gross income for healthcare providers. See

https://www.irs.gov/newsroom/frequently-asked-questions-about-taxation-of-provider-relief-payments

Q1: May a health care provider that receives a payment from the Provider Relief Fund exclude this payment from gross income as a qualified disaster relief payment under section 139 of the Internal Revenue Code (Code)?

A: No. A payment to a business, even if the business is a sole proprietorship, does not qualify as a qualified disaster relief payment under section 139. The payment from the Provider Relief Fund is includible in gross income under section 61 of the Code.

Waiver of Productivity Screens in RHCs due to COVID-19

On July 6, 2020, CMS released a revised SE20016 Medlearn Matters titled New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE). We have included a picture of the section related to Productivity screens in the document below.

Exception to the Productivity Standards for RHCs

Productivity standards are used to help determine the average cost per patient for Medicare reimbursement in RHCs. Physicians, nurse practitioners, physician assistants, and certified nurse midwives are held to a minimum number of visits per full time employee (FTE) that they are expected to furnish in the RHC. Failure to meet this minimum may indicate that they are operating at an excessive staffing level, thus, generating excessive cost.

Many RHCs have had to change the way they staff their clinics and bill for RHC services during the COVID-19 public health emergency (PHE). As a result, these RHCs may have difficulty in meeting the productivity standards. To minimize the burden on RHCs, exceptions to the productivity standard may be granted by your MAC during the COVID-19 PHE. Further direction will be forthcoming from your MAC.

ADDITIONAL INFORMATION

View the complete list of coronavirus waivers.

Review information on the current emergencies webpage at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network

Section 80.4 from Chapter 13 of the Medicare Benefit Policy Manual – Rural Health Clinic addresses productivity screens. This section reads as follows:

80.4 – RHC Productivity Standards (Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18) Productivity standards are used to help determine the average cost per patient for Medicare reimbursement in RHCs. The current productivity standards require 4,200 visits per full-time equivalent physician and 2,100 visits per full-time equivalent nonphysician practitioner (NP, PA, or CNM). Physician and non-physician practitioner productivity may be combined. The FTE on the cost report for providers is the time spent seeing patients or scheduled to see patients and does not include administrative time.

At the end of the cost reporting year, the A/B MAC re-calculates the AIR by dividing the total allowable costs across all patient types (i.e., the numerator) by the number of visits (as defined in section 40) for all patient types (i.e., the denominator). If fewer than expected visits based on the productivity standards have been furnished, the A/B MAC substitutes the expected number of visits for the denominator and uses that instead of the actual number of visits. The total allowable costs (numerator) would be divided by the higher, expected number of visits (denominator). In this example, this would have the effect of lowering the AIR.

Here is the picture of a slide from one of our recent Cost Report webinars related to Productivity standards.

The Provider FTE calculation is important
For Productivity Calculations
(based up a 2,080 Hour work year)

Provider Type	Minimum Productivity
Physician	4,200
Nurse Practitioner/ Physician Assistant	2,100

RHC cost reports are submitted to Medicare Administrative Contractors (MAC) who process the cost reports, establish rates, settle payment data, and approve RHC requests for waivers. Each of the MACs have separate rules for approval of the exception to Productivity Standards. We have included the guidance from Palmetto, CGS, and Novitas. You should reach out to your MAC for their specific guidance and any form they may have.

palmettogba.com / JJ Part A / Browse by Topic / Emergency and Disaster Instructions

RHC Productivity Standard Exceptions

Per CMS Publication 100-02, Chapter 13 (PDF, 400 KB), Section 80.4, productivity standards require 4,200 visits per physician and 2,100 visits per practitioner.

If you are having difficulty meeting productivity standards as a result of COVID-19 PHE, you may request an exception to the productivity standards. The following information is required.

- Visit count that you are requesting as an exception to the standard of 4,200 for physicians and 2,100 for mid-level practitioners
- Documentation to justify an exception to the standard

A separate request is required for each facility/clinic, and we may ask for additional information after receipt of the request.

Last Updated: 07/21/2020

CGS Exception to Productivity Standards

CMS wants to minimize the burden on RHCs who have experienced disruptions in staffing and services and have had difficulty in meeting productivity standards as a result of COVID-19 public health emergency. If you would like to request an exception to the productivity standards, please send your request to RHCException@cgsadmin.com. Please include your provider name, provider number, cost reporting period and an explanation for your request.

JoElla Draper| J15 Manager, Provider Audit |CGS

Regular Mail	Courier Service (FedEx/UPS)
CGS Audit & Reimbursement	CGS Audit & Reimbursement
PO Box 20020, Nashville, TN 37202.	26 Century Blvd ST610, Nashville, TN 37214

email: joella.draper@cgsadmin.com **| voice:** 217-726-6240 (ext. 205)

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Novitas Productivity Standard Exemptions for COVID-19

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00228302

Medicare JH
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Rural Health Clinic productivity standard exemptions for COVID-19

Many RHCs have had to change the way they staff their clinics and bill for RHC services as a result of the COVID-19 public health emergency (PHE). As a result, some RHCs may have difficulty in meeting the productivity standards.

Novitas Solutions will provide an exception to any RHC that has had difficulty in meeting the productivity standards as a result of the COVID-19 PHE. Novitas will grant productivity exceptions to RHCs who have experienced disruptions in staffing and services as a result of the COVID-19 pandemic and made a written request to the Novitas Provider Audit and Reimbursement Department.

Please submit the completed request form to:

Novitas Solutions
Provider Audit & Reimbursement
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050

Request form (Form will download to your computer device)

The forms can be sent to following attention as well as any questions pertaining to this form:

JL: Jesse Yu: Jesse.Yu@novitas-solutions.com
JH: Theresa Bigsby: NovitasReimbursement@Novitas-Solutions.com

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Novitas Excel Form for Productivity Exception Requests

RHC Productivity Standard Exception Requests

Background: Providers are held to a minimum number of visits per FTE that their Physicians and/or mid-level practitioners are expected to be able to perform in the Rural Health Clinics. These standards are 4,200 visits per Physician FTE and 2,100 visits per mid-level practitioner FTE.

Failure to meet this minimum number of visits may indicate that the facility is operating at an excessive staffing level compared with the patient level they are currently operating at, thus incurring excessive cost. This excessive cost would not be considered reasonable, and thus would not be allowable for reimbursement on the cost report.

When the minimum number of visits is not met, the minimum number is used in lieu of actual visits on worksheet M-2, Column 5, Lines 1-7 and subscripts. This increased number of visits in turn decreases the cost per visit, thus reducing the Medicare reimbursement.

CMS Policy at CMS Pub. 100-02, Chapter 13, §80.4 allows for providers to request an exception to these minimum standards, **subject to the MACs discretion**. This checklist has been developed as a guide to address some of the more common situations that, taken in combination, may potentially be considered adequate for an exception to these standards. **This checklist should not be construed as a guarantee that any individual criterion, or combination of criteria, will result in approval.**

Note that the manual does not include a specific time frame on when these RHC Productivity Standard Requests should be submitted by the provider, nor does it include a required timeframe for review and approval by the MAC. If the RHC Productivity Standard Request is submitted after the start of the desk review, the results may not necessarily be incorporated into that final settlement. In such a case, the additional documentation can be submitted as part of a request for consideration of a reopening. Ultimately, the decision as to whether or not to reopen will be left up to the MAC.

Source:	CMS Pub. 100-02, Chapter 13, §80.4 47 FR 54163 (12/1/1982)
Main Hospital Name:	
Main Hospital Provider Number (CCN):	
RHC Provider Number (a separate tab should be completed for each clinic):	
Impacted FYE:	
RHC City:	
RHC County:	
Date of Submission of Request:	

1.) What is the current number of FTEs and visits for the RHC for this cost reporting period for each category of staff?

	Col. 1 FTEs	***Col. 2 Total Visits***
W/S M-2 Line 1 - Physician =		
W/S M-2 Line 2 - Physician Assistants =		
W/S M-2 Line 3 - Nurse Practitioner =		
Add additional lines as needed		

2.) What was the number of clinic visits for the RHC in the prior year, and did the RHC request and receive approval for an RHC standard in that prior year?

	Col. 1 FTEs	***Col. 2 Total Visits***
W/S M-2 Line 1 - Physician =		
W/S M-2 Line 2 - Physician Assistants =		
W/S M-2 Line 3 - Nurse Practitioner =		
Add additional lines as needed		

3.) What visit count are you requesting as an exception to the standards of 4,200 (Physicians) and 2,100 (Mid-Level Practitioners)?

For questions 4 through 8, you only need to complete the ones that relate to your request, and that you believe may help justify the request for an exception to the RHC Productivity Standards.

4.) Explain and demonstrate whether the clinic employs no more than the minimum number of staff (physician and mid-level practitioners) necessary to meet applicable certification requirements. Include details on what the current staffing level is for each type and what the minimum certification requirements are.

5.) Is the clinic listed in a Primary Care Health Professional Shortage Area (HPSA)? If so, provide documentation from the below link or another similar resource.

https://data.hrsa.gov/tools/shortage-area/hpsa-find

6.) Document how the population base of the service area is significantly lower than would be needed to generate sufficient visits meet the minimum number of visits required of the RHC Productivity Standards. This generally requires evidence for #4 as well.

7.) Document whether any new physicians or mid-level practitioners were added during the cost reporting period in question and when they started. Explain why you believe this may require a temporary reduction to the RHC Productivity Standards.

8.) Explain and document any other justification for an exception to the RHC Productivity Standards.

Name of Submitter:
Title of Submitter:
Date Submitted:

What should RHCs do now regarding Productivity Standard Exceptions

First, there is no need to panic. There Is no immediate deadline to complete these forms requesting an exception to the productivity standards. These exception request may be filed with the cost report, so for example you are a 12/31/2 020 year-end, the cost report will be due 5/31/2021 and as long as the Productivity Standard Exception Request is submitted by the time the cost report is reviewed by the MAC, the MAC will consider the Exception.

If you think your clinic is going to have a difficult time meeting the RHC productivity standards due to COVID-19, you should submit your Visit and FTE information in early to your cost report preparer. That way they can have extra time to review this information and complete the request for a waiver along with the cost report filing. Additionally, I would go ahead a review the form that your MAC uses to determine if you are eligible for the Exception or not. If you think you may be eligible for the Exception, you may want to start accumulating the information requested in the form your MAC uses.

Cost Reporting implications of the Payroll Protection Program

Just as we said “Don’t Panic” above, this one may require a little bit of panic. **CMS has indicated that expenditures paid with proceeds from the SBA Payroll Protection Program (PPP) can not be included in the allowable expense claimed on the Medicare Cost Report. This could potentially lower the reimbursable cost per visit and result in lower payment from Medicare when the cost report is settled.** If there is any good news, many independent RHCs (but certainly not all) are paid so far below their actual cost due to the Medicare cap of $86.31 they may not lose any reimbursement. Provider-based RHCs not subject to the cap would all lose reimbursement under this scenario. Both the NARHC and NRHA are looking closely at this situation and need some lobbying help to rectify this interpretation before it does irreparable harm to our RHCs and hospitals. I have added a picture of the letter that the NRHA sent to Administrator Seema Verma on July 22, 2020. You are encouraged to reach out to your legislators while the next round of stimulus funding is being debated.

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202-639-0550
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July 22nd, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Dear Administrator Verma,

The National Rural Health Association (NRHA) writes today with urgent concerns regarding the Small Business Administration's (SBA) Paycheck Protection Program's (PPP) treatment within the Centers for Medicare and Medicaid Services (CMS) Medicare cost reporting. Recent interpretations of this program by CMS will undermine the program's intent, financially devastate rural providers, and significantly exacerbate the rural hospital and rural health clinic closure crises.

As you know, the PPP, created within the Coronavirus Aid, Relief, and Economic Security (CARES) Act, has been a much-needed lifeline for rural providers who are operating at the narrowest of financial margins. Pre-pandemic, hundreds of rural hospitals were vulnerable to closure; a record number of closures occurred last year. When healthcare providers nationwide ceased elective and non-emergency care in March 2020, in response to the COVID-19 pandemic Public Health Emergency (PHE), rural providers lost on average 50-80 percent of their revenue. Four rural hospitals were forced to close. Many others were forced to lay off 30-50 percent of their staff. According to a study last year by the National Bureau of Economic Research, rural hospital closures cause mortality rates in rural communities to increase by nearly six percent. In comparison, the study also found that urban hospital closures had no measurable impact on mortality rates. Additionally, when a rural hospital closes, extreme economic decline of a community ensues.

The PPP program was a critical part of the relief provided by Congress. It has literally enabled thousands of rural health care providers keep access to necessary health care services in their communities during this pandemic, which has proven especially critical as COVID-19 hotspots have recently begun to flare up across rural America. NRHA worked closely with the SBA to provide a series of webinars to educate rural providers on the importance of this program and how it could help them continue to provide necessary health care services to their communities during this pandemic. It was our understanding that if a recipient utilized the program properly, such using

funds to keep health care providers employed, they would not be penalized for the funds that did not have to be repaid.

However, recent notifications from CMS directing PPP funds to be offset on labor expenses of Critical Access Hospital (CAH) and Rural Health Clinic's (RHC) cost reports are deeply troubling. We were extremely disturbed when one of our members received the following notice:

> *"To prevent the duplication of benefits from the federal government - i.e., once via the SBA's PPP loan forgiveness and a second time in reimbursement for Medicare's share of providers' reasonable costs, funded by the loan forgiveness – providers must offset the amount of the SBA's PPP loan forgiveness from the operating expenses they report on their Medicare cost report."*

We are not aware of any other recipients of the PPP who are penalized for proper use of the program and are unclear why CMS would require this of rural health providers during the pandemic. As you know, the result of this cost-offset could result in a reduction in reimbursement for Critical Access Hospitals (CAH) and Rural Health Clinics (RHC) for Medicare and Medicaid in most states. This could amount to a loss of 70-80 percent of their PPP loan forgiveness amount.

Such a requirement will prove disastrous for the necessary rural health care providers and will likely accelerate the rural hospital and rural health clinic closure crises. We do not believe that the intent of Congress, nor the President, was for the SBAs PPP to fund the Medicare trust fund. We believe this program was created to help keep employees working and we strongly urge you to reconsider.

Thank you for working to improve the health of rural Americas. We look forward to collaborating with you to resolve this troubling issue. If you would like additional information, please contact Josh Jorgensen at jjorgensen@nrharural.org, or 202-639-0550.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association

CC: Alex Azar, Secretary of the Department of Health and Human Services; Eric Hargan, Deputy Secretary of the Department of Health and Human Services

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COVID-19 Current Reimbursement Issues for Rural Health Clinics Webinar

This one-hour Webinar will update RHCs on the following five issues and provide time for questions at the end of the session:

1. HHS renews the Public Health Emergency (PHE) for 90 more days
2. Provider Relief Fund Reporting Requirements
3. Provider Relief Funds are Taxable
4. Exceptions to Productivity Screens for RHCs
5. Cost Reporting implications of the Payroll Protection Program

Please register for COVID-19 Current Reimbursement Issues for Rural Health Clinics on Jul 31, 2020 12:00 PM CDT at: https://attendee.gotowebinar.com/register/4779006807954089486

Thank you for what you are doing. We appreciate you and our prayers are with you.

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Join our Facebook Group https://www.facebook.com/groups/1503414633296362/

COVID-19 Resources: http://www.ruralhealthclinic.com/covid19