2024 Oregon Rural Health Conference

Financial and Operational Challenges for RHCs: Strategy

CHANGES EVERYTHING.

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Overview of today's discussion points

RHC Basics

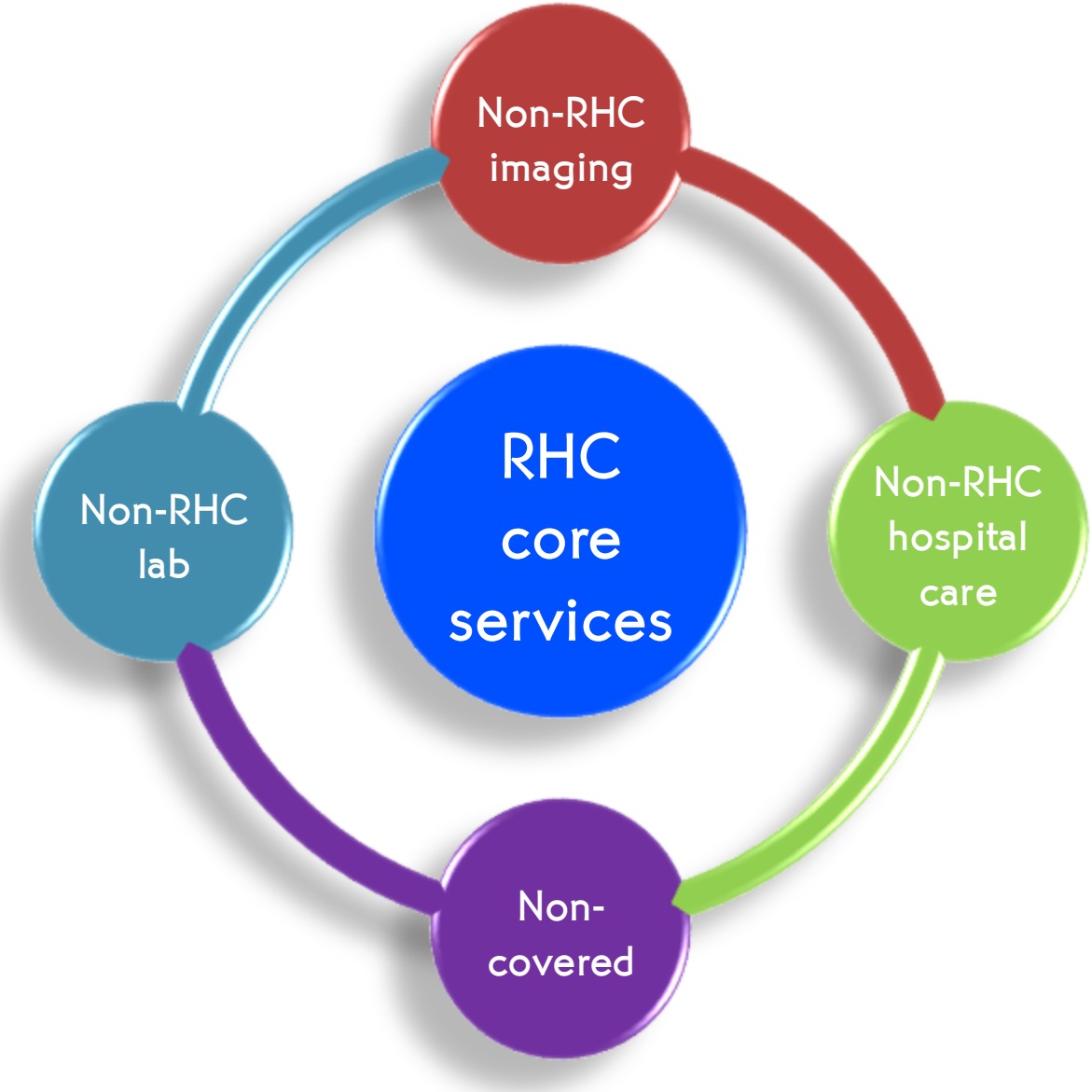
According to a recent survey performed by the National Association of Rural Health Clinics (NARHC), over 60% of rural Americans are served by Rural Health Clinics.

RHC Qualifications – The Basics

- Located in a rural area (based on census data)
- Current underserved designation (Population HPSA, Geographic HPSA, MUA, or Governor's designated)
- Primarily engaged in primary care services (>50%)
- Midlevel practitioner at least 50% of time clinic is open
- Operates under medical direction of a physician
- Ability to furnish six basic lab services
- RHC can be provider-based or free-standing (RHCs are provider-based "entities," have separate CCN)
- Paid an all-inclusive rate (AIR) per encounter

RHC Qualifications –

The Basics (Medicare)



RHC Qualifications – The Basics

RHC billing differences (core services)

Service	Independent	Provider-based
RHC services (face-to-face encounter in RHC site of service)	Billed to independent RHC regional Medicare Administrative Contractor (MAC) – RHC provider number on Form UB-04	Billed to host (e.g., hospital) provider MAC – RHC provider number on Form UB-04
Care management services – Transitional Care Management	Same as above - If it is the only service provided at time of visit, can be paid as stand-alone visit at the AIR. If furnished on the same day as another visit, only one visit is paid.	Same as above - If it is the only service provided at time of visit, can be paid as stand-alone visit at AIR. If furnished on the same day as another visit, only one visit is paid.
Care management services – All other (i.e., Chronic care, behavioral health integration, Psychiatric Collaborative Care Model)	Submitted to RHC MAC on a UB-04 – Except not paid at AIR, it is paid based on national average FFS payment (use G0511 or G0512)	Submitted to host provider MAC on a UB-04 – Except not paid at AIR, it is paid based on national average FFS payment (use G0511 or G0512)

RHC Qualifications – The Basics

RHC billing differences (non-RHC services)

Service	Independent	Provider-based
Laboratory (excluding the draw procedure, e.g., CPT 36415)	Billed to Part B carrier - existing group number on Form 1500	Billed on hospital O/P claim type (14x, 13x or 85x) on Form UB-04*
Other diagnostic/radiology - professional component	May be billed with encounter. If read by non-RHC provider, they will bill the carrier.	May be billed with encounter. If read by hospital radiologist, bill the carrier.
Other diagnostic/radiology - technical component	Billed to Part B carrier - existing group number on Form 1500	Billed on hospital O/P claim type (13x or 85x) on Form UB-04*
Non-RHC professional services (I/P, ER, other O/P services)	Billed to Part B carrier - existing group number on Form 1500	Billed to carrier using existing group number (or if elect Method II as CAH, bill FI for ER & other O/P pro fees)

*Non-RHC services billed with CAH CCN will not invoke CAH location test.

Consolidated Appropriations Act of 2021

Consolidated Appropriations Act, 2021

To maintain financial health and viability, rural health clinics (RHCs) have the following issues to address:

1. **All newly-certified RHCs are set at the same cap**
2. **Definition of "Grandfathered RHCs"**
3. **How do RHCs optimize their reimbursement based on changes in the payment rules**
4. **What strategies are available to optimize payment**

Caps for “newly certified” or freestanding RHCs

- New limitations for independent RHCs, those with hospitals greater than 50 beds, and all “new” provider-based RHCs with hospitals less than 50 beds.

2024	$139.00
2025	$152.00
2026	$165.00
2027	$178.00
2028	$190.00

After 2028 and in subsequent years, the cap is increased by the Medicare Economic Index (MEI).

Caps for “grandfathered RHCs”

- Existing provider-based RHCs furnishing services as of December 31, 2020, where bed availability was less than 50 beds, will establish a base year rate based on the finalized 2020 Medicare cost report OR the first finalized Medicare cost report which contains the clinic’s expenses for a full year.
- This base year rate (“limit”) will be increased annually by the Medicare Economic Index (MEI).
- MEI for CY 2024 was 4.6%.

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RHC Indicators

Wipfli/NARHC Rural Health Clinic Benchmark Report

Independent RHC Benchmark Report©

Category/Indicator	12/31/2020 OR	12/31/2020 Mean Western	12/31/2020 Nation	12/31/2021 OR	12/31/2021 Mean Western	12/31/2021 Nation	12/31/2022 OR	12/31/2022 Mean Western	12/31/2022 Nation
Number of Facilites	29	131	952	31	144	948	34	145	950
Encounters per FTE:									
Physicians	2,634	3,751	4,230	2,828	3,789	4,187	3,261	4,264	4,454
Physician Assistants	2,976	3,666	3,451	2,797	3,535	3,427	2,742	3,527	3,528
Nurse Practitioners	2,479	2,789	3,002	2,683	3,361	3,210	2,775	3,910	3,431
Certified Nurse Midwife	567	2,129	1,903	0	1,908	2,258	1,968	2,480	2,114
Clinical Psychologist/Social Worker	813	996	1,262	1,127	1,025	1,142	1,032	1,520	1,403
NP/PA/CNM Staffing Ratio	56%	60%	63%	52%	58%	64%	57%	58%	66%
NP/PA/CNM Visit Ratio	57%	56%	56%	52%	56%	58%	53%	55%	60%
Cost per Encounter:									
Physician	157.48	101.53	83.45	133.91	98.25	86.52	124.57	87.09	87.56
Physician Assistant	68.77	44.81	41.50	68.49	46.93	43.26	70.98	48.08	43.25
Nurse Practitioner	82.87	57.30	42.63	76.01	49.02	41.37	68.45	43.33	41.87
Certified Nurse Midwife	277.65	85.02	75.78	0.00	92.68	69.39	75.64	68.31	75.35
Clinical Psychologist/Social Worker	176.54	134.77	79.23	122.66	141.68	89.56	148.29	107.13	81.38
Allied Staff "RN,MA,etc."	38.97	27.11	16.54	35.12	26.93	17.90	37.24	26.95	17.91
Cost per FTE:									
Physician	402,933	348,964	339,797	371,686	346,451	350,427	400,644	344,052	376,828
Physician Asstistant	204,666	164,268	143,184	191,553	165,914	148,240	194,587	169,542	152,580
Nurse Practitioner	205,438	159,837	127,977	203,966	164,783	132,787	189,937	169,423	143,656
Clinical Psychologist/Social Worker	143,476	134,284	99,954	138,183	145,170	102,256	153,028	162,844	114,164
Total Healthcare Staff Costs per Provider FTE	106,480	94,457	59,213	99,795	98,447	65,263	113,026	109,127	68,982
Clinic Cost per Encounter:									
Total Health Care Staff	152.12	98.99	78.60	138.82	96.09	80.00	133.05	89.89	79.73
Total Direct Costs of Medical Services (a)	169.04	120.26	92.71	155.53	117.19	94.29	150.45	110.16	93.84
Facility Cost	19.86	15.59	12.39	21.31	15.84	12.72	15.78	15.11	12.88
Clinic Overhead	120.94	90.20	67.98	108.45	89.84	81.13	102.07	94.42	81.26
Allowable Overhead (b)	109.64	81.04	62.48	98.86	78.87	75.10	93.58	82.45	75.23
Allowable Overhead Ratio	91%	90%	92%	91%	88%	93%	92%	87%	93%
Total Allowable Cost per Actual Encounter (=a+b)	278.68	201.27	155.18	254.38	196.05	169.36	244.04	192.61	169.01
Total Allowable Cost per Adjusted Encounter	231.91	186.54	148.13	220.68	181.86	161.66	220.74	180.32	162.82
Cost of Vaccines and Administration per Adjusted Encounter (Reimbursed Separately)	(7.29)	(5.42)	(4.39)	(11.24)	(8.39)	(4.79)	(9.28)	(5.66)	(4.00)
Payment Rate per Adjusted Encounter	224.62	181.12	143.74	209.44	173.47	156.87	211.46	174.66	158.82
Total Encounters	327,694	1,641,987	11,166,562	400,564	1,938,876	11,525,508	436,267	2,110,885	12,154,226
Total Medicare Encounters	67,383	277,138	2,213,490	57,887	388,358	1,985,242	76,483	302,743	2,120,941
Average Medicare Encounters			2,325			2,094			2,233
Medicare Percent of Visits	21%	17%	20%	14%	20%	17%	18%	14%	17%
Injection Cost:									
Cost per Pneumococcal Injection	442.85	353.84	268.94	295.79	271.06	282.75	357.43	319.51	326.28
Cost per Influenza Injection	80.52	81.70	65.09	83.93	104.83	76.47	93.10	98.50	95.05

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NARHC REF Research & Education Foundation

Sample Market Demand

Primary care provider supply and demand, current and 5-year projections

	PSA, 2024			PSA, 2029		
	Supply	Demand	Variance	Supply	Demand	Variance
Primary Care						
Family Practice	5.6	3.4	2.2	5.6	3.4	2.2
Internal Medicine	1.1	2.8	(1.8)	1.1	2.8	(1.8)
Obstetrics/Gynecology	0.3	1.1	(0.8)	0.3	1.2	(0.9)
Pediatrics	0.0	1.4	(1.4)	0.0	1.5	(1.5)
Total	7.0	8.7	(1.7)	7.0	8.9	(1.9)

Other clinic indicators

- Production
- Staffing analysis
- In-migration/out-migration
  - patients
  - service-lines
- NET revenue

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RHC Strategies

Strategic Imperatives

Know where you stand

Optimize reimbursement

Plan for the future

RHC Reimbursement Optimization

Medicare

Despite the changes in Medicare payments for RHCs, newly certified RHCs are still proving to be a viable option for organizations. In addition, there are some options to consider for both grandfathered and newly-certified RHCs.

Medicaid

Knowing your state's reimbursement rules and rate setting opportunities is key to making the RHC program work for your clinic.

Commercial Payor Contracting

Often, one of the most overlooked areas for increased net revenue opportunities relates to commercial contracts. Understand the major payors, contract terms, and if it's time to ask for more.

Optimize Medicare Reimbursement

1. Has your rate been finalized and have you reserved for future adjustments?
2. Is there an opportunity to increase the rate?
3. Be mindful of future rate changes.
4. Keep existing “grandfathered” certifications.
5. Utilize any RHCs with the highest rates for future expansion.

Strategy: Mobile RHCs

- Mobile RHCs can utilize an existing RHC provider number.
  - If a hospital developed a mobile RHC, it may not be subject to the new Medicare RHC caps.
- Separate certification not required – The RHC is basically an extension of the existing RHC.
- RHC conditions of participation do not have to be met in the mobile unit as long as the clinic as a whole (permanent and mobile unit) meet the requirements.
- Must provide services in a rural area and that location must have a current shortage designation.
- Services in the location must have a consistent schedule.

Strategy: Mental health services

- Beginning in 2022, Medicare pays mental health telehealth services as a “distant site” paying at the AIR.
- Patients must have been seen within the last 12 months (there are exceptions to the rule).
- This change in reimbursement allows RHCs to contract with remote behavioral health providers to offer telehealth visits and receive their AIR payment.

Strategy: Mental health services (continued)

- Beginning 1/1/2024, the following additional RHC practitioners will be recognized by CMS* and with services paid at the AIR
  - Marriage and Family Therapists
  - A Mental Health Counselor is recognized as an individual who
    - ✓ Possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under the State law of the State in which such individual furnishes the services…
    - ✓ Is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished;
    - ✓ Meets such other requirements as specified by the Secretary."
  - CMS added Addiction Counselors to the definition of MHC

** Authorized through the passage of the Consolidated Appropriations Act of 2023*

Strategy: HOPD to RHC or stay as existing HOPD?

- As the Medicare cap continues to grow, it may be advantageous to convert existing hospital outpatient department (HOPD) clinics to RHCs.
  - RHCs not subject to location/mileage requirements
- Medicare RHC rates may eventually be higher than the Medicare fee for service rates and APC/CAH facility payment.
- HOPD status could be advantageous depending on the service mix; specialty services are often reimbursed higher by Medicare in a HOPD.
- Medicaid – Oregon Medicaid does recognize provider-based status
- New RHCs can be considered 340B child site

Strategy: Change of address

- "Grandfathered" RHCs can move and keep the existing RHC rate intact
  - Note that Health Professional Shortage Area (HPSA)/Medically Underserved Area (MUA), rural, and conditions of participation must be met
- Does your organization have a larger clinic that does not currently have RHC status?
- Could you move an already existing RHC certification with a grandfathered rate to a new site and recertify the smaller/less Medicare & Medicaid-utilized clinic? Or create a HOPD?

Strategy: Review the Medicaid RHC rate

- Make sure your RHC Medicaid rates are maximized.
- Has your clinic considered a change in scope of services?

Note: A loss in Medicare RHC reimbursement may be offset by a gain in Medicaid RHC reimbursement. RHC status may still make sense depending on your state's RHC reimbursement rates and your clinic's payer mix.

Strategy: Oregon's RHC rules do NOT mirror Medicare rules (cont.)

Know where an encounter can take place

- Oregon Medicaid RHC encounters do NOT have to take place within the clinic walls
- Services provided by RHC practitioners outside of the walls of the RHC can still be billed and paid under the RHC rate
  - This includes schools (without a "school-based health center" designation

Know the provider definition

- Oregon recognizes providers outside of Medicare's definition of RHC providers

Know what is paid in/out of an encounter

- Radiology and lab services are paid as part of the encounter
- Family planning supplies/meds are paid outside of the rate.

Strategy: Oregon wrap payment process

Know what payments have to be included in the wrap submission

- Quality payments should not be included
- PMPM payments without a qualified visit?

Know what visits can be included in the wrap submission

- Denied visits cannot be included; vs. zero payments

Know what has been submitted!

- Has your clinic submitted for its wrap payments?

Strategy: Home Health Shortage Area Designation

Visiting nurse services

- Covered if service area is considered to have a home health shortage area designation
- Services rendered to homebound patients
- Patient furnished part-time/intermittent nursing care by RN, LPN or licensed vocational nurse
- Needs to be an employee of RHC
- Services furnished under written POT:
  - Reviewed once every 62 days by supervising physician of RHC

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Additional Considerations

CY 2025 PFS Proposed rule – RHC provisions that could affect future strategy

In July, CMS released the proposed 2025 Physician Fee Schedule (PFS) that included several RHC payment and policy provisions:

- Elimination of productivity standards
  - Currently, 4,200 and 2,100 per FTE for Physicians and Non-physician practitioners (PA, Nurse Practitioner & Certified Nurse Midwife), respectively
  - Since all RHCs are now subject some cap, either the grandfathered specific cap, or the national statutory limits, the productivity standards have become less meaningful
- Elimination of primary care predominance
  - RHC regulations stipulate that RHCs must be primarily engaged in providing outpatient services – CMS State Operations Manual, Appendix G provides interpretation that RHC must be primarily engaged (more than 50%) in providing primary care
  - CMS is proposing to add:
    - *The clinic or center (FQHCs) must provide primary care*
    - *The clinic is not a rehabilitation agency or facility primarily for the care and treatment of mental diseases*

CY 2025 PFS Proposed rule – RHC provisions that could affect future strategy

Proposed 2025 Physician Fee Schedule (PFS) RHC provisions *(continued)*:

- Mental Health Services
  - Currently, the RHC regulations and interpretation mean that RHCs cannot provide more than 49% of their services as behavioral health services
  - CMS is proposing redefining outdated terminology i.e., “mental diseases” that is written in the law governing the RHC program
  - CMS is soliciting comments to help them define “mental diseases” so they can then issue guidance in a uniform way. Questions such as:
    - *What types of behavioral health (BH) services are currently offered (e.g., therapy, counseling, med management, addiction)*
    - *What type of providers are providing these services, e.g., physicians, psychologists, social workers, MFT or MHCs?*
    - *What is the clinics capacity to accept new BH patients?*
    - *What community impact would there be if RHC can provide more of BH services?*
    - *If not providing BH services, what are the barriers or challenges of the RHC to providing these services?*

CY 2025 PFS Proposed rule – RHC provisions that could affect future strategy

Proposed 2025 Physician Fee Schedule (PFS) RHC provisions *(continued)*:

- RHC Telehealth Policy extension protection
  - Current medical telehealth flexibilities will expire on December 31, 2024, without congressional action and include:
    - Expanding the list of qualifying providers to offer telehealth services.
    - Temporarily allowing audio-only services for certain services through December 31, 2024 (see list here)
    - Delaying the in-person requirement for mental health visits furnished by RHCs and FQHCs
  - CMS is proposing to use their authority to ensure these flexibilities do not lapse in the event congress doesn't pass legislation by December 31.
  - They would be proposing to extend the current telehealth policies (the G2025 methodology) through December 31, 2025, including waiving the in-person requirement for mental health telehealth.

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Closing comments

Closing Comments

Things to think about

- Optimize the Medicare/Medicaid rates that for your RHC
- Assess current state
- Plan for the future, utilizing your beneficial payment methodology

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