Missouri
Leveraging RHCs to Expand Specialty Providers

Jonathan Pantenburg, MHA
JPantenburg@Stroudwater.com
April 27, 2021

STROUDWATER

Funding Source

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $205,000 (25 percent) funded by HRSA/HHS and $615,000 (75 percentage) funded by nongovernment sources through an award with the Missouri Department of Health and Senior Services, Office of Rural Health and Primary Care (DHSS, ORHPC). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA/HHS, or the U.S. Government.

Overview

- Overview
- Definitions / Regulations
- Leveraging RHCs for Specialty Providers
- Questions

OVERVIEW

Industry Changes

- With uncertainty around several significant provisions, such as payment, insurance, and delivery-system reforms, the healthcare industry must address future market changes

- An effective hospital primary and specialty care strategy is an essential component to address those market changes; especially in rural healthcare
  - The patients served, clinic location, and provider productivity must all be considered when developing a primary care strategy

- Since the hospital and clinic designation type can impact reimbursements and other opportunities received by the clinic, hospitals should evaluate each of the following clinic designation types to ensure an appropriate strategy:
  - Federally Qualified Healthcare Center (FQHC)
  - Provider-Based Clinic (PBC)
  - Rural Health Clinic (RHC)
    - Includes Provider-Based Rural Health Clinic (PB-RHC)
  - Free-Standing Health Clinic (FSHC)

Systems Approach to Revenue Optimization

- With declining reimbursements, all systems need to leverage available reimbursement opportunities to improve financial performance
- The following opportunities are available to hospitals and systems to improve reimbursements when those practices can meet certain eligibility requirements:
    1. Convert eligible practices within a health system or at a hospital to a designation that provides the most advantageous reimbursement opportunity
    2. Realign practices within a health system to leverage reimbursement advantages and additional revenue available to the system
    3. **Integrate specialty practices, when possible, with PB-RHCs under a hospital of less than 50 beds to leverage cost-based reimbursement**
    4. Acquire independent practices to leverage provider-based reimbursement opportunities and other additional revenue streams available to hospitals
        - This opportunity may not lead to a net positive return; however, will increase in functional, contractual, and governance alignment and increase the attributed lives associated with the hospital / health system

Practice Designation Types

- As seen, each of the four clinic types evaluated encompass different reimbursement methodologies that greatly impact reimbursements received from Medicare and Medicaid
  - The table below highlights those differences

Reimbursement Options	FQHC	CAH	<50 Beds	FSHC
		PBC	PB-RHC	
330 Grant	Yes	No	No	No
340B Pharmacy	Yes	Yes	Yes*	No
Un-Capped Technical Charge	No	Yes	Yes	No
Method II Billing	No	Yes	No	No
Tort Reform - Malpractice Savings	Yes	No	No	No
Enhanced PPS Reimbursement	Yes	Yes	Yes	No

- For non-CAHs, Hospital must meet DSH % to qualify for 340B

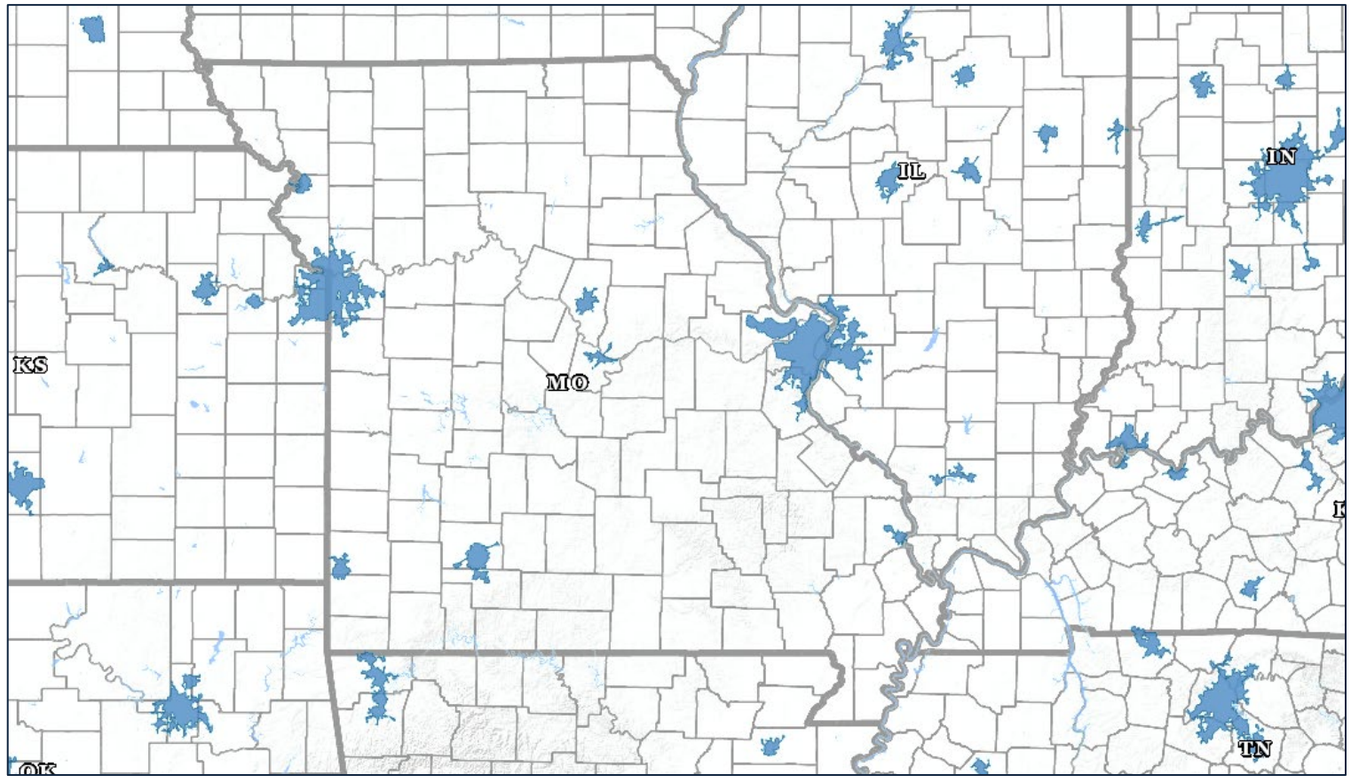
DEFINITIONS / REGULATIONS

New RHC Reimbursement Methodology

- On December 27, 2020, the President signed into law, the "*Consolidated Appropriations Act, 2021 (CAA)"* which changed the reimbursement methodology for Rural Health Clinics (RHC) starting on April 1, 2021
  - Starting on April 1, 2021, all new RHCs established after December 31, 2019, regardless of whether they are independent, owned and operated by a hospital with fewer than 50 beds, or owned and operated by a hospital with greater than 50 beds, shall be reimbursed based on reasonable cost with an upper payment limit (UPL) set at the following rates:
    a) In 2021, after March 31, at $100 per visit;
    b) In 2022, at $113 per visit;
    c) In 2023, at $126 per visit;
    d) In 2024, at $139 per visit;
    e) In 2025, at $152 per visit;
    f) In 2026, at $165 per visit;
    g) In 2027, at $178 per visit;
    h) In 2028, at $190 per visit;
    i) In subsequent years, the rate will increase based on the Medicare Economic Index (MEI) for primary care services
  - RHCs owned and operated by a hospital with fewer than 50 beds and established on or before December 31, 2019, will use their 2020 rate to establish a clinic-specific grandfathered UPL that will then be increased each year based on the MEI
- Since the final legislation varied greatly from the RHC Modernization Act and due to the impact on provider-based RHCs (PB-RHC), efforts are underway to change certain provisions
  - On April 14, 2021, the President signed H.R. 1868 into law which fixed some of the grandfathering issues caused through the change of the RHC reimbursement methodology in the Consolidated Appropriations Act, 2021

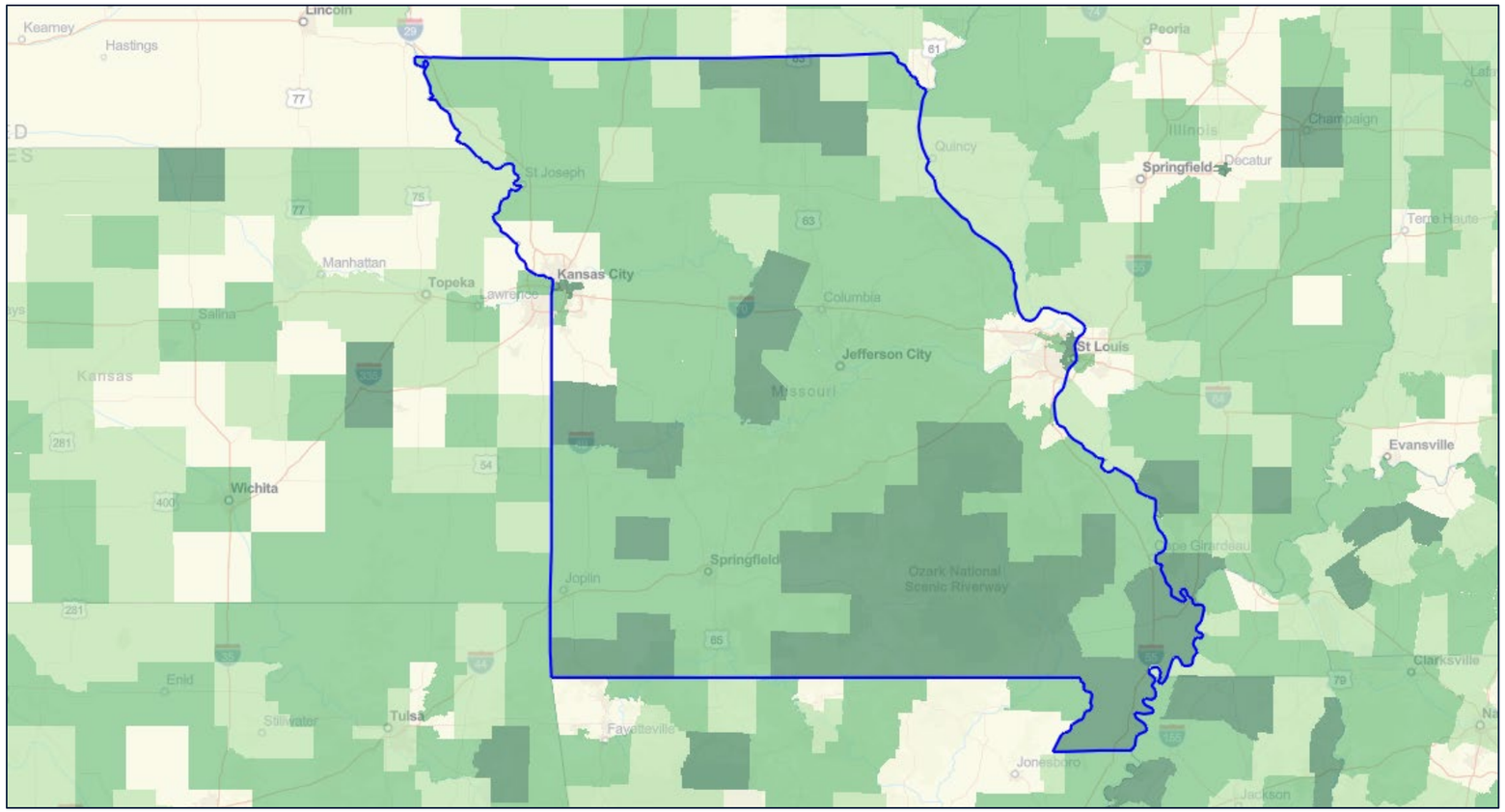
Rural and Shortage Area Designations

- Some clinic designation types require the clinic to provide services to a specific group of patients and or operate in a certain location such as the following:
  - **Rural Area Location**
    - The federal government uses both the U.S. Census Bureau and the Office of Management and Budget (OMB) to determine “rural” areas
      - The Census Bureau does not actually define “rural”; however, rural encompasses all population, housing, and territory not included within an urbanized area
    - The Census Bureau defines urban as the following:
      - Urbanized Areas (UAs) of 50,000 or more people
      - Urban Clusters (UCs) of at least 2,500 and less than 50,000 people
    - OMB defines urban areas as the following:
      - Metropolitan contains an urban area of 50,000 or more population
        - OMB considers all counties that are not part of a metropolitan area as rural



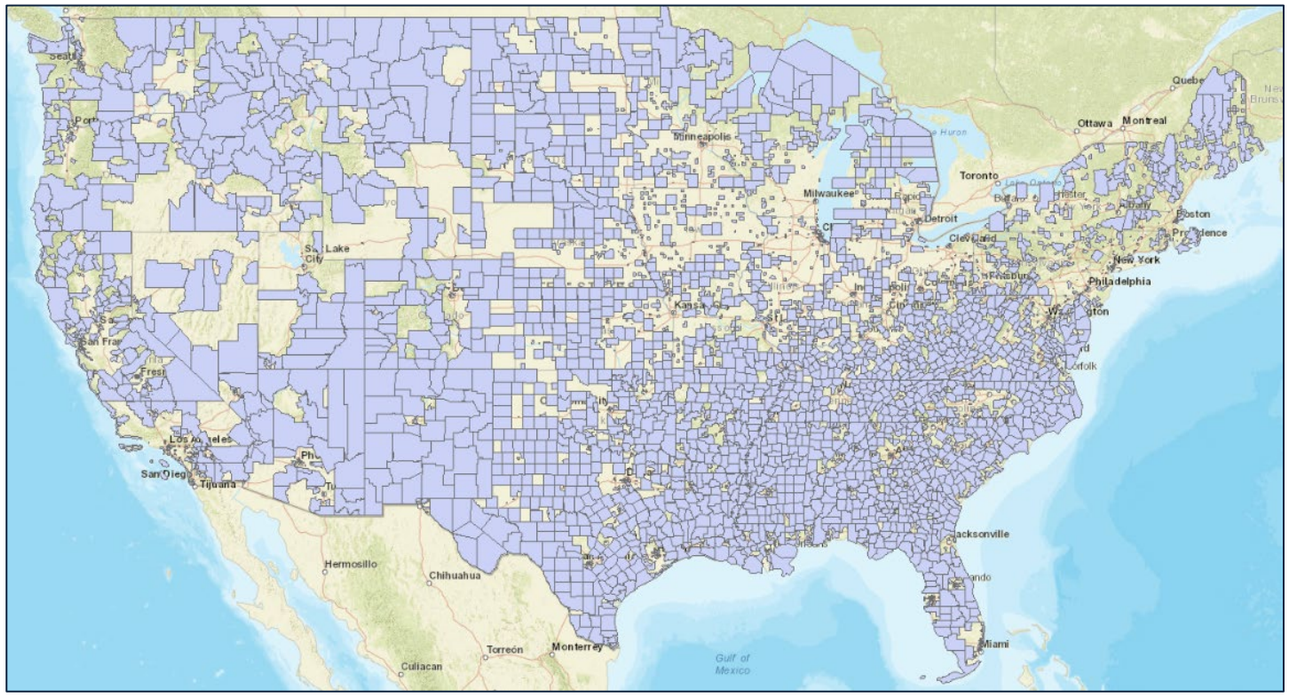
Rural and Shortage Area Designations

- **Health Professional Shortage Area (HPSA)**
  - Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary care, dental care, and/or mental health providers within a specific geographic area, population, or facility
    - The following presents the primary care HPSAs in Missouri



Rural and Shortage Area Designations

- **Medically Underserved Area (MUA)**
  - MUAs have a shortage of primary care health services within a geographic area such as:
    - a whole county;
    - a group of neighboring counties;
    - a group of urban census tracts; or
    - a group of county or civil divisions
  - To qualify as an MUA, the clinic must operate in an area with an Index of Medical Underservice (IMU) rating of 62.0 or less on a scale from 0 to 100
    - Public Law 99-280 states that a population group that does not have an IMU less than 62.0 can still obtain designation if “unusual local conditions exist which are a barrier to access to or the availability of personal health services”



Rural and Shortage Area Designations

- **Governor-Designated Shortage Areas**
  - Governors may designate areas of their state as shortage areas specifically for the purpose of Rural Health Clinic (RHC) certification. These areas must meet specific criteria
    - State-created and HRSA-certified plans outline how to identify areas that need RHC services, but do not otherwise qualify for HPSA or MUA/P designation
  - States wishing to acquire a Governor's Designated Shortage Area for an RHC must submit:
    - A signed letter from the governor requesting the designation; and,
    - A state-specific Shortage Area Plan detailing, at minimum state's rational service area criteria and component guidelines for HRSA's approval
  - According to the HRSA website, Missouri does not have any Governor-Designated and Secretary-Certified Shortage Areas

LEVERAGING RHCs TO EXPAND SPECIALTY PROVIDERS

Specialty Integration in an RHC

- RHCs afford hospitals and systems an opportunity to expand specialty access to rural communities by leveraging the unique reimbursement advantages associated with the program
  - **The regulations are:**
    - 42 CFR 491.9(a)(2)
      - The clinic or center is primarily engaged in providing **outpatient health services** and meets all other conditions of this subpart.
    - 42 CFR 491.2
      - Rural health clinic or clinic means a clinic that is located in a rural area designated as a shortage area, **is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases,** and meets all other requirements of this subpart."

  - **Interpretative Guidelines**
    - An RHC is required to be primarily engaged in providing primary care services or services provided at the entry point to health care services
    - RHCs are not prohibited from furnishing other services, for example, ambulatory surgical procedures or diagnostic imaging services
      - However, they may not be primarily engaged in providing such specialized services
      - In the context of an RHC, "primarily engaged" is determined by considering the total hours of an RHC's operation, and whether a majority, i.e., more than 50 percent, of those hours involve provision of RHC services
        - The survey can also include the Review a sample of patient health records covering at least the two previous months to determine the majority of specific services actually furnished

Case Study 1: Overview / Objectives

- Hospital is a 25-bed Critical Access Hospital (CAH) providing acute care and ancillary services

- Hospital currently operates three provider-based Rural Health Clinics to leverage cost-based reimbursement and improve access to care throughout the region

- Hospital has several specialty providers in the region and the hospital would like to evaluate the net financial impact of integrating a provider-based clinic (PBC) into one of the established PB-RHCs

Case Study 1: RHC Requirements

- **Advanced Practice Provider (APP) Requirement**
  - RHCs must employ an APP, which includes a physician assistant (PA), certified nurse midwife (CNM), and/or nurse practitioner (NP), for at least 50% of the time that the practice is open to see patients

Practice	Provider	Credential	Specialty	Hours of Operation	Productive Hours / Week	FTE	APP Coverage / Week	Meet APP Requirement
Surgical	Minzer	MD	General Surgery	M-W: 8:00a - 4:00p F: 8:00a - Noon	28.00	0.40	-	NO

  - Hospital would have to add an APP to Surgical or integrate that practice within a practice that employs an APP to meet this requirement
    - Surgical anticipates integrating the specialty practices within an established PB-RHCs which already meet this requirement

- **Primary Care Requirement**
  - RHCs must be “primarily engaged,” that is, at least 51 percent of the services provided, in primary medical care

Practice	Provider	Credential	Specialty	Hours of Operation	Productive Hours / Week	Primary Care Hours/Week	Meet Primary Care Requirement
Surgical	Minzer	MD	General Surgery	M-W: 8:00a - 4:00p F: 8:00a - Noon	28	0	NO

  - The Surgical practice does not meet the 51 percent primary care requirement to operate as a stand-alone RHC and would have to be integrated within one of the other RHCs to qualify for the RHC benefit

Case Study 1: Benefit

- **PB-RHC Impact**
  - The following presents the net financial impact on the hospital **if** the Surgical practice were integrated within one of the RHCs

Summary	Specialty as PBC			Specialty Integrated in PB-RHC		
Payor Data	Payment / Visit	Visits	Revenue	Payment / Visit	Visits	Revenue
Practice Impact						
Medicare	$ 156.95	5,531	868,093	$ 174.93	5,531	$ 967,559
Medicaid	156.77	12,163	1,906,796	174.93	12,163	2,127,720
Average	$ 156.83	17,694	$ 2,774,890	$ 174.93	17,694	$ 3,095,279
					Specialty Reimbursement Variance:	**$ 320,389**
Hospital Impact						
CAH Impact			$ -			$ (44,803)
Variance With Current State				**$**		**275,586**

- **Study Outcomes:**
  - Analysis shows the hospital would realize an increase in reimbursements of $276K by integrating the Surgical practice into an established RHC
    - The $276K increase in reimbursements as a PB-RHC offset the $45K reduction in reimbursements the hospital will experience from other cost-based programs as a CAH
    - The average Medicare and Medicaid reimbursement would increase from $156.83 to $174.93

STROUDWATER

1685 Congress St. Suite 202
Portland, Maine 04102
(207) 221-8250

www.stroudwater.com