OREGON OFFICE of RURAL HEALTH

39th Annual Oregon
Rural Health Conference

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The Rural Health Clinic Workshop Presents
Strategizing with New RHC Payment Regulations

Speaker:
Katie Jo Raebel, CPA, Partner-Health Care Practice

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Strategizing with New RHC Payment Regulations

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Today's discussion:

- Overview of RHC payment reform
- Who is affected?
- RHC strategy
- Conclusions and discussion

Opening Thoughts . . .

Whether you are an RHC that has existed for years, considering purchasing a single RHC, or are developing an RHC strategy for a health system, optimizing opportunities and reimbursement under the current payment methodology is crucial.

Does your organization have an overall rural health clinic strategy?

Is your clinic a certified RHC and you are considering selling? Your RHC has value.

Overview

Of RHC payment reform

Background

- HR 133 - Consolidated Appropriations Act of 2021:
  - Highlights:
    - Phases in increases in the Medicare RHC cap over an eight-year time frame
    - All independent and all new RHCs are subject to a statutory limit
    - Controls the reimbursement growth of previously uncapped RHCs
    - Grandfathering provision for existing uncapped RHCs
    - Date of enactment was April 1, 2021

Background

- What drove payment reform:
  - Free-standing ("Independent") RHCs versus provider-based ("Hospital") RHCs
    - Free-standing RHCs and provider-based RHCs with 50 or more beds – Medicare cost limits inadequately low, e.g., $87.52 per visit in 2021
    - Provider-based RHCs under 50 beds, there was no per visit cost limit
      - Average uncapped PB RHC in 2021 encounter rate was approximately $240 compared to 2021 limit
      - Average cost per encounter for all independent RHCs is over $130 in 2021
  - Intended to level the playing field going forward while holding harmless existing Provider-based RHC (with less than 50 beds)
    - Controls the annual rate of growth for uncapped RHCs above statutory limits
    - Effectively fixes the site neutral problem, going forward

Consolidated Appropriations Act, 2021

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

January 1 – March 31: $87.52. On April 1 the cap goes to $100.00 per visit. It then rises at statutorily set increases as follows:

2022	$113.00
2023	$126.00
2024	$139.00
2025	$152.00
2026	$165.00
2027	$178.00
2028	$190.00

After 2028 and in subsequent years, the cap goes up by the Medicare Economic Index (MEI)

Consolidated Appropriations Act, 2021

- All new RHCs established after December 31, 2020, whether independent or provider-based to a hospital, are subject to the statutory limits
  - One Exception: If the new RHC is owned by a hospital with fewer than 50 beds and had submitted paperwork to become an RHC, either the Form CMS-855A or PECOS application for RHC status, prior to December 31, 2020, it will obtain grandfathered status and not be subject to the new statutory limits
- 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 December 31, 2020, cost report
  - The base year rate ("limit") will be increased annually by the Medicare Economic Index (MEI)
  - The encounter rate will be the lessor of the actual cost or the base year rate limit adjusted by the MEI

Who is affected?

Who is affected?

Payment reform provides both strategic opportunities and threats for RHCs whether provider-based or independent

Strategic statement	Opportunity	Threat
Significant increase in independent RHC rate	X	
PB RHC <50 beds “base year” cap limits		X
Specialist in the RHC (i.e., surgeons, mental health, podiatry)	X	X
Planned or incurred significant capital improvement costs	X	X
Planned or already added additional services and personnel	X	X
Change of ownership (selling to hospital or health system)	X	X
Large hospitals and health systems (i.e., more than 50 beds)	X	

RHC strategy

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 departments (HOPD) clinics to RHCs
  - Why? Medicare RHC rates may eventually be higher than the Medicare fee for service rates
- HOPD status could be advantageous depending on the service mix; specialty services are often reimbursed higher by Medicare in a HOPD
  - The 2021 increases in the Medicare physician fee schedule may be a factor
  - Does your state recognize HOPD status?

Strategy: HOPD to RHC or stay as existing HOPD?

- Consider differences between RHCs and HOPDs:
  - HOPDs may have to meet state hospital construction requirements
  - HOPDs must meet provider-based requirements (some are not required by RHCs – i.e., mileage requirements)
  - HOPDs do not have a non-physician coverage requirement
  - HOPDs do not have an underserved designation requirement
  - HOPDs do not have to provide predominantly primary care services

Strategy: Consolidating multiple RHCs under one location

- Use an existing "grandfathered" RHC for future MOB locations that house multiple clinics
  - Use the clinic with the highest rate (consider Medicaid rate, as well)
  - Do not give up a grandfathered status – find other opportunities for grandfathered rates (change of location does not negate a grandfathered rate)
    - Keep in mind that you may have multiple RHC certifications at one address that were certified as separate suite numbers

Strategy: Change of ownership

- Are your hospital-owned RHCs attached to the right hospital?
  - Medicare has indicated that a CHOW does not affect RHC status
  - RHCs that are attached to PPS hospitals do not affect cost-based reimbursement (as they do in a CAH)
  - RHCs do not have mileage requirements and can even be provider-based to a hospital in adjacent states

Strategy: Specialty services

Use of high-cost specialists in RHC setting may be re-evaluated

- General surgery and/or orthopedic surgery may be reimbursed better under Medicare physician fee schedule or in a hospital outpatient department
- Consider concentrating Medicare services, such as internal medicine, into higher all-inclusive rate (AIR), cost-limited RHCs

Strategy: Mobile RHCs

- Mobile RHCs for Medicare use an existing Medicare RHC rate:
  - So, in theory, if a hospital developed a mobile RHC, it may not be subject to the new Medicare RHC caps
  - No new certification – 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
  - How does your state treat mobile units?

Strategy: Mental health services

- Mental health
  - 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: Expand access

- "Walk-in"/"urgent care":
  - These services are still considered primary care and on their own can be certified as rural health clinics
  - We are seeing many hospitals implement this type of RHC next to the emergency room
  - Extended hours (i.e., after hours and weekends)
  - How will other payers reimburse for these services?

Strategy: Other service expansion opportunities

- Visiting nurse services:
  - Payable without a home health shortage designation during the public health emergency (PHE)
  - Outside of the PHE, can apply for a home health shortage designation if there are no other agencies that will service the area or there is inadequate coverage
  - Payments are made at RHC rates
- Care management services:
  - Paid at fee schedule amounts
  - Can be provided under general supervision (outsourced)

Strategy: Other service expansion opportunities

- Telehealth (primary care services):
  - Paid at $97.24 per visit by Medicare in 2022 ($99.45 in 2021) until the PHE has ended
    - Provided as a “distant” site provider while working at the RHC
    - Not a RHC service
  - May be payable at Medicaid RHC rates in some states
  - It’s probable that in the future, primary care telehealth services may follow mental health services allowing for RHCs to also be distant sites

Strategy: Preventive services

- Preventive services
  - RHCs are still missing out on annual wellness visits, vaccinations, and screenings
  - Generally, Medicare/Medicaid covers 100% of the AIR for these services, with no patient obligation
  - Getting Medicare/Medicaid patients to schedule these appointments can be a challenge; however, actively contacting the patients and getting them on the schedule at regular intervals can make a huge difference in volumes
  - Suggestion: Determine how frequently each active Medicare and Medicaid patient in the practice receives care at the clinic each year
    - Most "active" patients only come to the RHC when they are sick and are not receiving the full scope of preventive services
    - Target these patients for preventive visits and follow-ups

Strategy: New service areas

Moving into different service areas:

- No mileage requirements apply unless the hospital to which the RHC is provider-based is considered located in an urban area
  - Note that provider-based RHCs can be located in an adjacent state
- CMS Central has indicated moving an RHC to a new location will not result in a loss of a clinic's grandfathered rate when provider-based to a CAH.

Strategy: Review the Medicaid RHC rate

- Make sure your RHC Medicaid rates are maximized
- Has your clinic considered a change in scope of services request?
- Rural Health Clinic association in your state?

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.

Oregon Change in Scope of Services Request

- A change in the scope of FQHC or RHC services may occur if the FQHC or RHC has added, dropped or expanded any service that meets the definition of an FQHC or RHC service as defined by 42 USC § 1396d(a)(2)(B)–(C).
- A change in the cost of a service is not considered in and of itself a change in the scope of services. An FQHC or RHC must demonstrate how a change in the scope of services impacts the overall picture of health center services rather than focus on the specific change alone. For example, while health centers may increase services to higher-need populations, this increase may be offset by growth in the number of lower intensity visits. Health centers therefore need to demonstrate an overall change to health centers' services.

Oregon Change in Scope of Services Request

- To qualify for a rate adjustment, changes must result in a minimum 5% change in cost per visit.
- The new rate will be effective beginning the first day of the quarter immediately following the date the Division approves the change in scope of services adjustment (e.g. January, April, July, or October 1):

Conclusions

- Review the financial implications of each strategy
  - Medicare and Medicaid:
    - RHC status only applies to Medicare and Medicaid. What's your clinic's payor mix?
    - Review your 2020 Medicare cost to optimize your RHC rate (this is your base rate)
    - Do you want to negotiate Medicare rates with your Medicare Advantage Plans?
  - Commercial payers:
    - How can you negotiate the best contract in your clinic?
- An expansion of services in an existing RHC does not require notification to Medicare
- What does your state require for expansion of services, if any?

The Wipfli Way

Your presenters

Katie Jo Raebel, CPA

Partner, Healthcare Industry

- 509 232 2044
- kraebel@wipfli.com

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