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Rural Health Clinic Reimbursement Updates and Opportunities

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RHC Reimbursement Updates & Opportunities

CHANGES EVERYTHING.

WIPFLI

Overview of today's discussion points

RHC basics

RHC qualifications – the basics

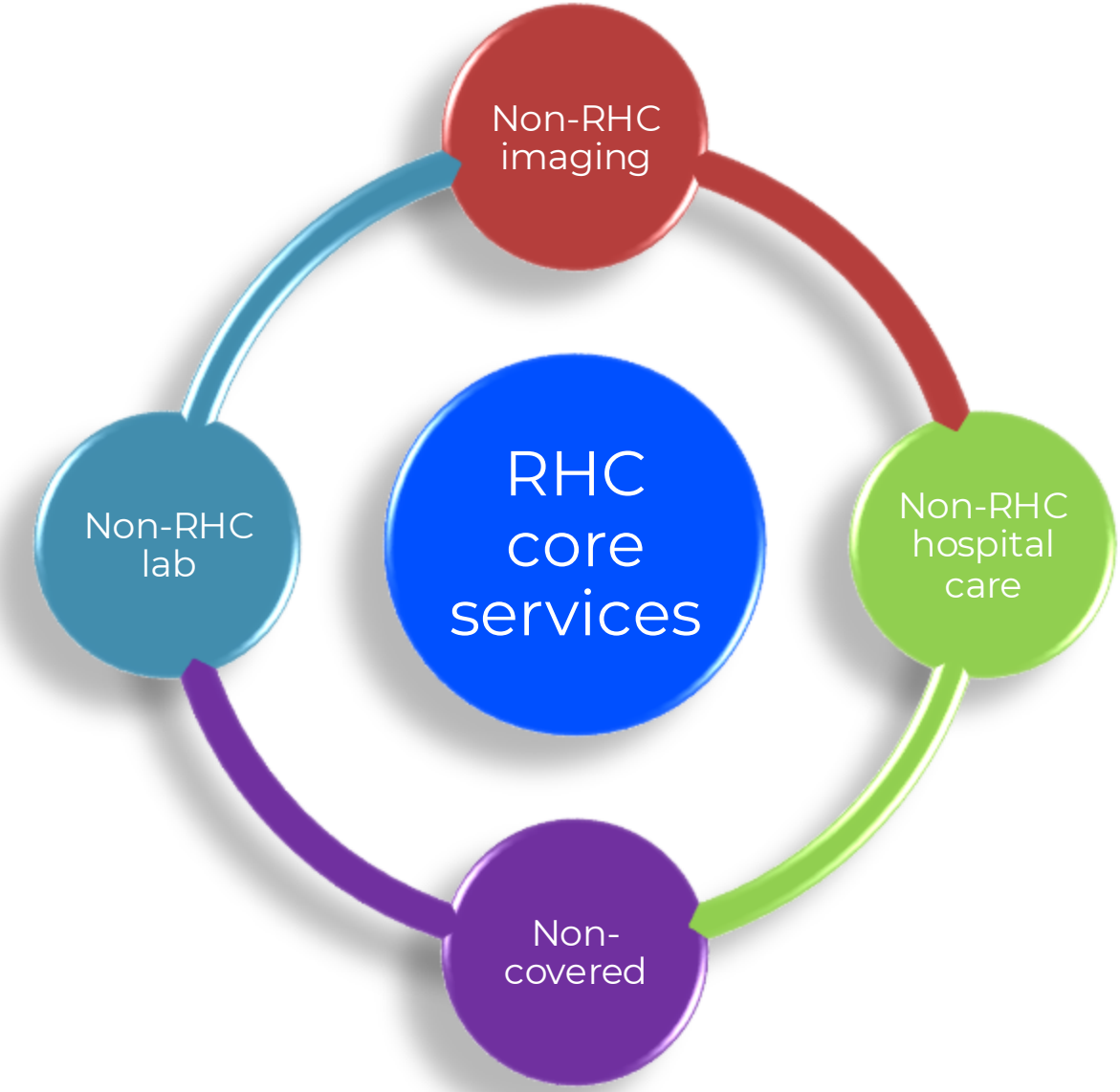
- Located in a rural area (based on census data)
- Current underserved designation (Population HPSA, Geographic HPSA, MUA, or Governor's designated)
- ~~Primarily~~ engaged in primary care services
- Non-physician practitioner coverage at least 50% of time clinic is open
- Operates under medical direction of a physician
- Ability to furnish ~~six~~ four 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

How are RHCs paid?

- RHCs are paid a flat rate for each face-to-face encounter based on the anticipated average cost for direct and supporting services (including allocated costs), with a reconciliation of costs (i.e., cost report) occurring at the end of the fiscal year.
- Cost-based reimbursement is determined on the average cost per visit. A visit is defined as a medically necessary face-to-face encounter between a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist or clinical social worker, licensed marriage and family therapist, mental health counselor and a patient.
- Distant site mental health services with a defined RHC practitioner are also paid at the RHC rate

RHC qualifications – the basics

(Medicare)



RHC Services

RHC billing differences (RHC services)

Service	Independent	Provider-based
RHC services (face-to-face encounter in RHC site of service)	Billed to independent RHC regional fiscal intermediary - RHC provider number on Form UB-04	Billed to host provider fiscal intermediary - RHC provider number on Form UB-04

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)

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.

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 2025 was 3.5%.

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RHC strategies

RHC Strategic Imperatives

Know the Rules

Optimize reimbursement

Plan for the future

Strategy: One State's RHC rules might NOT mirror Medicare rules

- Know where an encounter can take place
- Know the provider definition
- Know what is paid in/out of an encounter
- Know what opportunities exist for optimizing reimbursement

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.

Medicare Rates/ Productivity Standards

- Medicare cost reports ending in 2025 and after, productivity standards will no longer be used when calculating the actual cost-per-visit.
  - If a clinic's grandfathered cap was $450, but the actual cost-per-visit with productivity standards applied was $400, will your clinic now get above those without productivity standards?
  - What costs may you want to put in your RHC in order to maximize your rate?
    - Or, will this decrease your overall reimbursement?

RHC Rate calculation

$$\frac{\textit{Allowable RHC Costs}}{\textit{Rural Health Clinic Visits}} =$$

RHC Cost Per Visit (Rate)

(Not to exceed the maximum reimbursement limits.)

Optimize Medicaid reimbursement

1. Is your clinic billing properly in order to receive the Medicaid rate?
2. Is there an opportunity to increase the rate?
3. Have you submitted for Medicaid wrap payments?
4. Is there an opportunity to include quality incentives in the managed care contract?
5. What services could be provided outside of the clinic and paid at the RHC PPS rate?

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 – Does your state 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 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

Strategy: Volume Increases

- Since RHCs are paid by Medicare and Medicaid at a rate per visit, what would reimbursement change to the organization if we were to operate at minimum number of visits per day?
- Where do we fall with respect to other RHCs in the state, regionally, and nationally?
- Education to the providers on RHC reimbursement
- Scheduling and strategy

Strategy: Specialty Services

- With the elimination of the primary care predominance requirement, what specialty services may you want to implement in your RHC?
- What services might have been left out of the RHC and put in a PBC because the COPs were not being met
- Analyze!

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State-Specific considerations

Oregon

- 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)

Oregon

- Oregon recognizes providers outside of Medicare's definition of RHC providers
  - i.e. - pharmacists
- Radiology and lab services are paid as part of the encounter
- Family planning supplies/meds are paid outside of the rate
- A change in scope of services request can be made if a triggering event has occurred. However, a recalculation of the rate is not an entire rebasing.
- MCOs pay at contracted rates with a WRAP payment calculation to be submitted by the clinic. Has your clinic submitted for WRAP payments? Quality payments can be excluded from the calculation.

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Other considerations

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

- Elimination of productivity standards
  - For cost reports ending after 12/31/2024, the 4,200 and 2,100 productivity standards per FTE have been eliminated for Physicians and Non-physician practitioners (PA, Nurse Practitioner & Certified Nurse Midwife), respectively
- Elimination of primary care predominance
  - Previously, RHC regulations stipulated 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
  - The 2025 rule indicates:
    - *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*

Additional Changes

- RHC telehealth policy limited extension protection
  - Current medical telehealth flexibilities expired 9/30/2025
- RHC care management services
  - Beginning January 1, 2025, RHCs should bill on the RHC claim form, the specific CPT code (located here: https://www.cms.gov/center/provider-type/rural-health-clinics-center)
  - While some of the fee schedule reimbursements may be lower than the consolidated rate of $72.90, this change means RHCs will be eligible to bill for add-on time-based codes too. Remote Therapeutic Monitoring (RTM)
  - CMS has established a transition period for compliance with the new billing structure. From January 1, 2025, through July 1, 2025, RHCs may bill either G0511 or the individual CPT codes. After July 1, 2025, G0511 will no longer be reimbursable.

Additional Changes

- Advanced Primary Care Management (APCM) services
  - A set of three G-codes intended to bundle existing care management codes based on complexity of patient condition, not time spent on each patient's care management activities, reimbursed as calendar month bundles. If an RHC bills for these codes, they will not bill for individual services.
  - These codes will be structured as follows:
    - G0556 – Patients with 0-1 chronic condition; ~$15 per month
    - G0557 – Patients with two or more chronic conditions; ~$50 per month
    - G0558 – Patients who are dual eligible with two or more chronic conditions; ~$110 per month
- Intensive Outpatient Program (IOP) services
  - Beginning 1/1/2024, RHCs can provide IOP services in order treat patients with acute mental illness (including depression, schizophrenia, substance use disorders, etc.). that need between 9-19 hours of care per week
  - Provided in person
  - Physician must certify patient for IOP and review no less than every other month
  - Reimbursement at $269.19 per patient per day equal to approximately three services per patient per day
  - Beginning January 1, 2025, will allow for RHCs to bill for the three or four ($408.55) services per day IOP, depending on the number of services provided.

Additional Changes

- Pneumococcal, influenza, Covid-19, and Hep B Vaccines
  - Beginning, July 1, 2025, RHCs must bill for administration of Part B preventive vaccines (COVID-19, pneumococcal, influenza, and Hepatitis B) at time of service, not entirely in a lump sum settlement on cost report, beginning July 1, 2025.
  - This is mandatory

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Closing comments

Closing Comments

Things to think about

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

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