2026 Oregon Rural Health Conference Presentation Slides

RHC Strategy and Updates



CHANGES EVERYTHING.

WIPFLI

Overview of today's discussion points

RHC Knowledge **01**

RHC Strategy **02**

Action Planning & Discussion **03**

Rural Health Clinic Strategy


1
Know
2
Plan
3
Optimize

RHC Knowledge

RHC Knowledge – WHERE



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

- What other options might your clinic consider
  - Schools
    - “school-based health center” designation – not required
  - Local “Y”
  - Fire department partnership

RHC Knowledge - WHO

Know the provider definition

- Oregon, like many states, recognizes providers outside of Medicare's definition of RHC providers
  - e.g., pharmacists
  - When in doubt, ask OHA!

RHC Knowledge - WHAT

Know what is paid in/out of an encounter

- *Medicare*
  - Radiology and lab services are paid outside the RHC encounter rate (FFS if freestanding; under the hospital's payment methodology as provider-based)
- *Oregon Medicaid*
  - Radiology and lab services are paid as part of the RHC encounter rate (FFS if freestanding; under the hospital's payment methodology as provider-based)
  - Family planning supplies/meds are paid outside of the rate.

RHC Knowledge - WHAT

Know what is paid in/out of an encounter

- *Washington Medicaid*
  - Radiology and lab services are paid outside the RHC encounter rate
  - Family planning supplies/meds are paid outside of the rate.
- Has your clinic enrolled as a Medicaid RHC in another state if an option (Washington, Idaho, California)?

RHC Knowledge - WHAT

Know what services must be provided as an RHC

- *Primary care predominance*
  - No longer a requirement of a rural health clinic
  - Primary care encompasses: family med, internal med, women's health, pediatrics, "urgent care"
  - Mental health services cannot be predominant
  - Must have the *ability* to provide the basic 4 lab tests

RHC Knowledge - HOW

Know what is required in order to provide services and bill outside of the rate:

- *Licensing requirements*
  - RHCs are not licensed in the State of Oregon, but they are in the state of California.
  - If a clinic wanted to provide lab and radiology services outside of the RHC footprint to be able to bill those under the hospital, that space would have to be licensed under the hospital
    - Would distance requirements be met? Never put your critical access hospital in jeopardy!
    - Would licensing requirements be met (construction code standards, etc.)?

RHC Knowledge - WHY

<u>Know why your clinic may or may not have been set up a certain way:</u>

- *Oregon RHC antepartum/postpartum & deliveries*
  - As a freestanding RHC, Oregon RHCs will receive fee-for-service reimbursement for deliveries

    vs.

  - As a provider-based RHC, Oregon RHCs will receive the RHC PPS rate for deliveries

➢ Is your clinic receiving the FFS rate for deliveries if you are freestanding?

Other information to know as you strategize



Know current and future estimated:

- Provider need
- Patient out-migration
- Payor mix/demographics

- Have you estimated the effect of HR 1?

Wipfli/NARHC Rural Health Clinic Benchmark Report

Category/Indicator	6/30/2022 RHC Values	6/30/2022 Mean NC	6/30/2022 Mean Eastern	6/30/2022 Nation	6/30/2023 RHC Values	6/30/2023 Mean NC	6/30/2023 Mean Eastern	6/30/2023 Nation	6/30/2024 RHC Values	6/30/2024 Mean NC	6/30/2024 Mean Eastern	6/30/2024 Nation
Number of Facilites	1	16	65	950	1	13	70	1,008	1	30	95	1,069
Encounters per FTE:												
Physicians	3,266	4,262	4,274	4,454	4,602	4,314	4,402	4,319	4,929	3,853	3,838	4,335
Physician Assistants	2,242	3,769	3,846	3,528	2,624	2,954	3,252	3,502	2,865	3,380	3,474	3,597
Nurse Practitioners	2,291	2,937	3,270	3,431	2,305	2,812	2,930	3,387	2,654	3,043	2,892	3,336
Certified Nurse Midwife	0	0	0	2,114	0	0	0	2,142	0	1,197	3,799	2,217
Visiting Nurses	0	12	10	86	0	1	34	85	0	1	72	87
Clinical Psychologist/Social Worker	0	0	1,043	1,403	0	1,842	1,428	178	439	4,912	1,622	1,517
NP/PA/CNM Staffing Ratio	53%	71%	62%	66%	69%	76%	68%	68%	76%	68%	68%	70%
NP/PA/CNM Visit Ratio	44%	66%	58%	60%	54%	67%	59%	63%	63%	66%	64%	65%
Cost per Encounter:												
Physician	96.84	67.04	74.38	87.56	57.31	61.11	79.67	91.87	52.87	90.67	93.81	94.14
Physician Assistant	31.11	42.26	38.71	43.25	34.97	45.66	41.60	45.42	65.13	55.84	47.30	46.55
Nurse Practitioner	79.98	45.70	44.54	41.87	35.20	37.29	44.80	42.50	25.74	45.72	49.99	44.57
Certified Nurse Midwife	0	0.00	0.00	75.35	0	0.00	0.00	76.01	0	131.83	131.83	88.82
Visiting Nurse	0.00	1,538.50	4,718.43	718.11	0.00	17,533.00	1,407.07	677.10	0.00	17,533.00	650.84	830.97
Clinical Psychologist/Social Worker	0.00	0.00	87.01	81.38	0.00	81.00	80.04	65.37	164.14	93.40	87.71	77.93
Allied Staff "RN,MA,etc."	39.62	27.75	20.07	17.91	42.75	30.80	22.19	19.61	29.68	33.46	25.18	20.08
Cost per FTE:												
Physician	316,279	276,243	302,838	376,828	263,723	261,186	331,903	381,324	260,599	347,527	337,948	389,223
Physician Asstistant	69,744	159,290	148,870	152,580	91,766	134,872	135,300	159,087	186,603	188,758	164,334	167,403
Nurse Practitioner	183,207	134,193	145,644	143,656	81,131	104,855	131,247	143,922	68,321	139,141	144,575	148,687
Visiting Nurse	0	18,462	48,955	61,825	0	17,533	48,302	57,377	0	17,533	46,722	72,307
Clinical Psychologist/Social Worker	0	0	90,745	114,164	0	149,194	114,303	11,662	72,121	458,773	142,272	118,261
Total Healthcare Staff Costs per Provider FTE	107,941	102,779	77,240	68,982	131,447	101,878	78,887	74,082	97,135	117,889	85,687	75,582
Clinic Cost per Encounter:												
Total Health Care Staff	112.14	78.46	75.08	79.73	88.01	79.85	79.90	81.72	72.35	99.04	89.89	82.80
Total Direct Costs of Medical Services (a)	124.62	90.39	90.77	93.84	101.42	94.03	97.72	96.08	82.85	114.43	106.92	97.38
Facility Cost	14.09	9.92	10.56	12.88	17.39	11.07	12.58	14.40	27.35	16.10	14.94	15.02
Clinic Overhead	104.73	69.62	71.35	81.26	119.19	69.92	79.12	76.18	117.95	92.66	87.04	80.62
Allowable Overhead (b)	101.61	65.82	61.09	75.23	114.34	66.05	67.23	70.35	108.31	87.23	75.53	74.43
Allowable Overhead Ratio	97%	95%	86%	93%	96%	94%	85%	92%	92%	94%	87%	92%
Total Allowable Cost per Actual Encounter (=a+b)	226.23	156.21	151.63	169.01	215.76	160.08	164.59	166.41	191.16	201.67	182.12	171.78
Total Allowable Cost per Adjusted Encounter	226.23	145.58	144.26	162.82	215.76	153.16	159.50	160.17	191.16	188.17	173.15	166.52
Cost of Vaccines and Administration per Adjusted Encounter (Reimbursed Separately)	(9.54)	(3.63)	(3.91)	(4.00)	(12.62)	(2.79)	(3.56)	(4.09)	(15.64)	(5.21)	(5.26)	(4.42)
Payment Rate per Adjusted Encounter	216.69	141.95	140.35	158.82	203.14	150.37	155.94	156.08	175.52	182.96	167.89	162.10
Total Encounters	17,655	193,159	890,069	12,154,226	15,311	177,857	860,660	12,839,383	18,195	233,415	958,008	13,823,973
Total Medicare Encounters	3,637	28,612	126,498	2,120,941	2,988	26,170	121,570	2,194,514	2,863	27,891	131,898	2,343,637
Average Medicare Encounters				2,233				2,177				2,192
Medicare Percent of Visits	21%	15%	14%	17%	20%	15%	14%	17%	16%	12%	14%	17%
Injection Cost:												
Cost per Pneumococcal Injection	245.62	275.08	286.72	326.28	487.20	529.61	336.66	356.34	565.55	617.85	452.10	424.78
Cost per Influenza Injection	73.70	71.28	71.67	95.05	93.49	70.04	73.42	90.00	113.71	78.15	81.95	99.12

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02

RHC Strategy



RHC Strategy

Be a viable patient resource in your community by:

- Optimizing current reimbursement
- Planning for the future, understanding the effect on net revenue
- Aligning clinic locations and service mix with community needs, keeping your certification in mind

Optimize RHC Reimbursement

Optimize Medicare Reimbursement

1. Keep existing “grandfathered” certifications.
2. Utilize any RHCs with the highest rates for future expansion.
3. Which clinics are above/below their cap?
4. Should provider-based services be moved to RHC locations?
5. Do providers understand how RHCs are paid?

Grandfathered RHC Rates

- The RHC's actual cost per visit is compared to the grandfathered RHC cap that has been increased by the MEI each year
- Below, this clinic is also below the Medicare cap and is receiving full cost-based reimbursement.

DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		7,595,772	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		139,884	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		**7,455,888**	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		20,044	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		**20,044**	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		**371.98**	7.00
		Calculation of Limit (1)		
		Rate Period 1 (10/01/2024 through 12/31/2024)	Rate Period 2 (01/01/2025 through 09/30/2025)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	421.48	436.23	8.00
9.00	Rate for Program covered visits (see instructions)	371.98	371.98	9.00

Grandfathered RHC Rates

- Has your 2020 Medicare cost report or the first full year cost report containing the RHC been finalized?
  - Was there a productivity standard issue?
  - Do you have the ability to request a productivity standard exemption or review costs/visits before finalization?
- Keep your grandfathered RHC rates and optimize!
  - Does your clinic have room for additional expense that is cost-based reimbursed in the RHC when reviewing the Medicare actual cost per visit vs. the Medicare cap?

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?

Optimize Commercial Reimbursement

1. Who is reviewing commercial contracts?
2. Are Medicare Advantage plans contracted to pay at RHC rates? Do they have the latest rate letter?
3. Is the clinic's fee schedule up-to-date? Are payments being limited to the lesser of charge or the payor's fee schedule?

Expand RHC Access & Services

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) meets 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

- Medicare continues to pay qualifying mental health telehealth visits furnished by RHC practitioners under the AIR.
- A mental health visit and an additional qualifying visit on the same day receive two encounter rate payments from Medicare
- CP, LCSW, MHC, & LMFT are recognized Medicare practitioners
- The in-person visit requirement will not take effect until January 1, 2028.
- Use telebehavioral health strategically to expand access, strengthen continuity, and address workforce constraints.

Strategy: Provider-based Clinic Services vs. RHC Services

- It may be advantageous to move existing PBC services to services of the RHC
  - Know the initial why and this may have changed (primary care predominance?)
  - Analyze payment: Medicare, Medicaid, and Medicaid managed care (service mix is important)

- RHCs are certified by address – “Building 1” and “Building 2” of a particular address can be considered one RHC.
- RHC services do not have to be contiguous

Strategy: Provider-based Clinic Services vs. RHC Services

Why RHC over PBC?

- RHCs not subject to location/mileage requirements
- RHCs no longer have to be predominantly primary care
- RHCs are not licensed under the hospital in OR & WA
- For cost reports ending in 2025 and after, productivity standards are not applicable
- Medicaid – Oregon Medicaid does recognize provider-based status (MUST meet licensing/distance requirements)
- New RHCs can be considered 340B child sites
- If a clinic has a high volume of Medicare Advantage (MA) patients, would it be more advantageous to be an RHC in order to receive RHC payment rates (assuming the clinic is contracted with the MA plans at RHC rates – if not, they should be!)?

Strategy: Facility & Capital Planning



Do you have a future strategy?

- How will capital costs be reimbursed if part of your RHC (or a PBC)?
- Is there a future plan for a Medical Office Building?
  - Use your grandfathered RHC with the highest rate
  - How can you use other certifications?
  - Can part of the building be carved out as non-RHC?

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 or is it considering a future location with high utilization 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 PBC?

Strategy: Oregon RHC enrollment vs. provider-based payments

- Oregon Medicare-certified RHCs may or may not want to be enrolled as an RHC with OHA
  - Oregon recognizes provider-based status and will pay at outpatient rates
  - In addition, MCOs must pay at outpatient rates.
    - Provider salaries do not have to be removed from the DMAP report, which increases the outpatient rate.

Strategy: Oregon wrap payment process

Know what payments have to be included in the wrap submission

- Quality payments should not be included

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
- Services furnished under written POT:
  - Reviewed once every 60 days by supervising physician of RHC

03

Action Planning & Discussion

Action Planning & Discussion



Four questions to take home

- Are Medicare, Medicaid and commercial payments aligned with the services you deliver?
- Which services belong inside the RHC, outside the RHC or in a provider-based department?
- What operational, coding and cost-reporting gaps are suppressing reimbursement?
- What one strategic move should your organization model in the next 90 days?
- Model the financial impact before implementation.

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