Rural Healthcare
Primary Care Options

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Impact

- A health system in New York would realize $760K net financial benefit by converting five practices to provider-based Rural Health Clinics
  - *(Five practices had combined 47K Medicare and Medicaid visits)*

- A system in the Southeast would realize $7.6M net financial benefit by converting nine practices from free-standing health clinics to Federally Qualified Health Centers
  - *(Nine practices had combined 64k Medicare and Medicaid visits)*

- A hospital in the Midwest would realize $505K net financial benefit by integrating eight provider-based specialty providers with its provider-based Rural Health Clinic
  - *(Eight providers had combined 4k Medicare and Medicaid visits)*

- A health system in the Northeast would realize $720K net financial benefit by converting a freestanding health clinic to provider-based Rural Health Clinic
  – *(Practice had 14k Medicare and Medicaid visits)*

Contents

Overview

- With uncertainty around payment, insurance, and delivery-system reforms, the healthcare industry must address future market changes

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

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

RURAL & SHORTAGE AREA DESIGNATIONS

Rural and Shortage Area Designations

- Some clinic designation types require the clinic to provide services to specific group of patients and/or operate in certain location:
  - **Rural Area Location**
    - The federal government uses information from both the U.S. Census Bureau and Office of Management and Budget (OMB) to determine "rural" areas
      - The U.S. 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:
      - 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:
      - Metropolitan, which contains an urban area population of 50,000 or more
        - 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
    - Primary care HPSAs are based on a physician-to-population ratio of 1:3,500
      - The formula used to designate primary care HPSAs does not take into account the availability of additional primary care services provided by Nurse Practitioners and Physician Assistants in the area
    - An entity pursuing RHC designation in a HPSA must do so in an area where the HPSA designation is less than four (4) years old

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 a MUA, the clinic must operate in 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

- **Medically Underserved Population (MUP)**
  - MUPs are specific sub-groups of people living in a defined geographic area with a shortage of primary care health services
  - These groups may face economic, cultural, or linguistic barriers to healthcare and include, but are not limited to, those who are:
    - Homeless
    - Low-Income
    - Medicaid-eligible
    - Native American
    - Migrant Farmworkers
  - The Index of Medically Underserved (IMU) can range from 0 to 100, where zero represents the completely underserved
    - Areas or populations with IMUs of 62.0 or less qualify for designation as an MUA/P

Primary Care Clinic Designation Types

- Each of the four clinic types has different opportunities and reimbursement methodologies that can impact reimbursements received from Medicare and Medicaid
  - The various opportunities for each clinic type are as follows:

Opportunities	Federally Qualified Health Center (FQHC)	CAH	<50 Beds	Free-Standing Health Clinic (FSHC)
		Provider-based Entity (PBE)	Provider-based Rural Health Clinic (PB-RHC) *(includes CAHs)*	
330 Grant Funding	Yes	No	No	No
340B Pharmacy	Yes	Yes	Yes*	No
Un-Capped, Cost-Based Technical Charge	No	Yes	Yes	No
Method II Billing	No	Yes	No	No
Malpractice Savings *(From Tort Reform)*	Yes	No	No	No
Enhanced PPS Reimbursement	Yes	Yes	Yes	No
Additional information provided in the Definitions / Regulations section				

- Additional Definitions/Regulations included later in this document
- * For non-CAHs, Hospital needs to meet DSH % to qualify for 340B

STRATEGIC OPTIONS

2019 OPPS Proposed Rules

- The Bipartisan Budget Act (BBA) of 2015 clearly identified excepted provider-based items and services as those permitted to bill for items and services under the Outpatient Prospective Payment Systems (OPPS) after January 1, 2017, as the following:
  1. By a dedicated emergency department
  2. By an off-campus PBD that was billing for covered OPD services furnished prior to November 2, 2015, that has not impermissibly relocated or changed ownership
  3. In a PBD that is "on the campus," or within 250 yards of the hospital or a remote location of the hospital

- CMS proposed removing #2 above for practices billing HCPCS code G0463
  - The 2019 OPPS proposed rules state its intent, "to apply an amount equal to the site-specific PFS payment rate for services furnished by a nonexcepted off-campus PBD (the PFS payment rate), as described by HCPCS code G0463, when provided at an [excepted] off-campus PBD."

- The proposed rule will drastically change reimbursements for off-campus provider-based practices by removing the technical component - which highlights the need to evaluate practice alignment and designations

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 meeting specific eligibility requirements:
  1. Convert eligible practices within a health system or at a hospital to a designation that provides 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 < 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, it will increase functional, contractual, and governance alignment and increase the attributed lives associated with the hospital / health system

CASE STUDIES

Case Study 1: Multi-hospital System

- A five-hospital system with more than 1,000 physicians and other clinicians
  - Hospitals include:
    - 400-bed, short-term acute facility
    - 320-bed, short-term acute facility
    - 60-bed, short-term acute facility
    - 25-bed Critical Access Hospital (CAH)
    - 75-bed, short-term acute facility (HOSP)

- Hospital system operates five provider-based entity (PBE) health centers

- The system engaged Stroudwater to compare net impact on reimbursements under following scenarios:
  - Scenario #1 (*Current*): Reimbursements received as PBEs under HOSP
  - Scenario #2: Reimbursements received as PB-RHC under HOSP with >50 beds
  - Scenario #3: Reimbursements received as PB-RHC under HOSP with <50 beds

Case Study 1: Multi-hospital System

- The following table shows an average rate and reimbursements received from Medicare and Medicaid under each scenario:

Summary Data	Scenario #1 PBE	Scenario #2 PB-RHC >50 Beds	Scenario #3 PB-RHC <50 Beds
Medicare / Medcaid Average	$ 143.17	$ 82.30	$ 170.95
Annual Visits	27,338	27,338	27,338
Reimbursements Received	$ 3,913,934	$ 2,249,917	$ 4,673,391
340B Benefit	n/a	n/a	n/a
Variance w/ PBE (Scenario #1)		$ (1,664,017)	$ 759,457

- **Study Outcomes:**
  - Operating the five locations as PB-RHCs under a hospital with < 50 beds led to the highest average reimbursement from Medicare and Medicaid
  - Stroudwater continues to engage system leadership regarding the importance of evaluating designation and realignment from a system perspective, instead of evaluating each hospital independently

Case Study 2: Healthcare System in the South

STROUDWATER

- A municipally owned, three-hospital healthcare system with regional healthcare centers providing services to more than 250,000 people
  - Subsidiaries:
    - 275-bed short-term acute facility
    - 25-bed critical access hospital (CAH)
    - 30-bed short-term acute facility
    - A multi-site Federally Qualified Health Center (FQHC)
    - Network of primary care providers with multiple locations 100 providers (FSHC)

- The system engaged Stroudwater to compare the financial advantages and disadvantages of operating 9 FSHC locations with other designation types:
  - Scenario #1 (*Current*): Reimbursements received as an FSHC
  - Scenario #2: Reimbursements received as an FQHC
  - Scenario #3: Reimbursements received as a PBE/PB-RHC under the CAH

- As a municipally owned entity, the hospital has an opportunity to leverage all clinic designation types, including an FQHC, within the system

Case Study 2: Healthcare System in the South

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- The table shows an average rate and reimbursements received from Medicare and Medicaid under each scenario:

Summary Data	Scenario #1 FSHC	Scenario #2 FQHC	Scenario #3 PB-RHC
Medicare / Medcaid Average	$ 95.58	$ 155.82	$ 138.68
Annual Visits	64,018	64,018	7,693
Reimbursements Received	$ 6,118,840	$ 9,975,285	$ 1,066,865
340B Benefit		$ 3,764,000	$ 437,000
Variance w/ FQHC (Scenario #1)		$ 7,620,445	$ 768,568

- **Study Outcomes:**
  - Operating the nine locations as FQHCs led to the highest average reimbursement from Medicare and Medicaid
    - This option would also allow the clinics to pursue the 340B benefit
  - Since only two of the clinics currently qualify as a PB-RHC, the net benefit was limited to those two facilities
    - The clinics would have received roughly $770K more from Medicare and Medicaid due to higher reimbursements and 340B

Case Study 3: Medical Center in the Midwest

- A 15-bed, not-for-profit Critical Access Hospital (CAH) that serves approximately 10,000 residents
  - Operates primary and specialty care clinics:
    - Family care clinic, designated as Provider-Based Rural Health Clinic (PB-RHC)
    - Specialty clinic on campus, designated as Provider-Based Entity (PBE)
      - Specialty practice included seven providers with combined FTE of 0.8

- The hospital engaged Stroudwater to compare net impact on reimbursements under following scenarios:
  - Scenario #1 (*Current*): Reimbursements received as PB-RHC and PBE specialty practice under the CAH
  - Scenario #2: Reimbursements received as an integrated PB-RHC (primary and specialty care) under the CAH

Case Study 3: Medical Center in the Midwest

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- The table shows average rate and reimbursements received from Medicare and Medicaid under each scenario:

Summary Data	Scenario #1 PB-RHC & PBE	Scenario #2 PB-RHC
Specialty Practice		
Medicare / Medcaid Average	$ 217.55	$ 235.57
Annual Visits	2,954	2,954
Reimbursements Received	$ 642,655	$ 695,874
Primary Care Practice		
Medicare / Medcaid Average	$ 174.30	$ 235.57
Annual Visits	7,378	7,378
Reimbursements Received	$ 1,285,949	$ 1,738,036
Variance w/ PB-RHC & PBE (Scenario #1)		**$ 505,306**

- **Study Outcomes:**
  - Integrating the specialty practice (PBE) with the PB-RHC would lead to an increase in reimbursements of $505K from Medicare and Medicaid

Case Study 4: Health System in the Northeast

- Four-hospital integrated system
  - Corporate subsidiaries:
    - 200-bed, short-term acute facility
    - 65-bed, short-term acute facility
    - 30-bed psychiatric facility
    - 20-bed critical access hospital (CAH)

- The system engaged Stroudwater to compare financial advantages and disadvantages of operations as a six-site FQHC with other designation types under following scenarios:
  - Scenario #1 (*Current*): Reimbursements received as six-site FQHC
  - Scenario #2: Reimbursements received as FSHC under a STAC or CAH
  - Scenario #3: Reimbursements received as PBE/PB-RHC under a CAH

Case Study 4: Health System in the Northeast

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- Table shows average rate and reimbursements received from Medicare and Medicaid under each scenario:

Summary Data	Scenario #1 FQHC	Scenario #2 FSHC	Scenario #3 PBE-PB-RHC
Medicare / Medcaid Average	$ 153.61	$ 77.03	$ 168.39
Annual Visits	40,784	40,784	40,784
Reimbursements Received	$ 6,264,747	$ 3,141,578	$ 6,867,688
340B Benefit	n/a	n/a	n/a
Variance w/ FQHC (Scenario #1)		$ (3,123,169)	$ 602,941

- **Study Outcomes:**
  - Operating an FSHC, as seen in Scenario #2, led to the lowest net revenue, as the clinics would only receive fee schedule reimbursements
    - FSHCs would lose significant revenue from loss of 330 grant and 340B benefit
  - Scenario #3 led to the highest average reimbursement from Medicare and Medicaid
    - Operating a PBE/PB-RHC under a CAH allowed the clinics to maintain the 340B benefit; however, the entity would have experienced a temporary loss in the 340B benefit until the clinics could be added to the CAH cost report

DEFINITIONS / REGULATIONS

Critical Access Hospital Impact

- The clinic designation type selected will impact reimbursements received and could jeopardize a hospital's ability to maintain CAH designation

- Each CAH must comply with the following, in addition to other, conditions of participation (COPs):
  - Meet federal distance requirement that the CAH must be at least a 35-mile drive on primary roads or 15 miles on secondary roads to the nearest hospital or CAH
    - A CAH acquiring an off-campus PBE, unless entity is a PB-RHC, is required to meet distance requirements based on location of the acquired entity

- Section 42 CFR 413.65(e)(3)(i) requires that all off-campus provider-based facilities be located within a 35-mile radius of campus of hospital or CAH that is the potential main provider
  - Already-established RHCs are excluded from the list of off-campus facilities subject to that provision

Critical Access Hospital Impact

- Further, section 42 CFR 485.610(e)(2) requires that if a CAH operates an off-campus provider-based facility as defined in §413.65(a)(2), except for a rural health clinic (RHC), that was created or acquired on or after January 1, 2008, then the off-campus location must meet the federal distance requirement to the next-nearest hospital or CAH
  - 42 CFR 405.2401(b) excludes already-established RHCs from the list of provider-based facilities that must comply with this requirement
  - 42 CFR 413.65(a)(2) defines a campus as the physical area immediately adjacent to the provider's main buildings, other areas, and structures that are not strictly contiguous to the main buildings, but are located within 250 yards of the main buildings, and any other areas determined by the CMS regional office on an individual case basis to be part of the provider's campus

- Operating a provider-based facility that does not meet CAH distance requirements would lead to the loss of CAH designation even if the CAH is designated as a necessary provider

Federally Qualified Health Center

- An outpatient clinic where the main purpose is to enhance the provision of primary care services to patients from medically underserved urban and rural communities
  - In 1990, Section 4161 of the Omnibus Budget Reconciliation Act amended Section 1861(aa) of Social Security Act (SSA) to add the FQHC benefit under Medicare
  - FQHCs include all organizations receiving grants under Section 330 of Public Health Service Act (PHSA)
  - To qualify as an FQHC, the clinic must be owned by a public entity or private non-profit
    - A municipally-owned healthcare entity has the ability to operate an FQHC within the system

- The FQHC must agree to provide a very specific set of services provided:
  - Directly by the FQHC
  - Under formal written agreement
    - FQHC pays for service
  - Under formal written referral arrangement/agreement
    - FQHC does not pay for service

Federally Qualified Health Center

- Receives the following reimbursement and additional funding opportunities:
  - Enhanced reimbursement from Medicare, which is lesser of 80% of charge or FQHC PPS rate
    - Encounters with more than one FQHC practitioner on same day constitute a single visit except under certain circumstances
    - FQHCs can apply geographic, new patient, and initial preventive physical examination (IPPE) or annual wellness visit (AWV) adjustments
      - Currently the Medicare PPS rate is adjusted by a factor of 1.3416 when FQHC provides services to a new patient or to a patient for Initial Preventative Physical Exam (IPPE) or Annual Wellness Visit (AWV)
        - A new patient is one who has not received services at the FQHC, or by a provider associated with FQHC, in the last three years
  - Ability to participate in 340B Drug Pricing Program
  - Access to 330 grant funding through PHSA
  - Malpractice insurance premium savings due to Tort Reform

- FQHCs that are Health Center Program Grantees or Look-Alikes must serve people from one of the Health Resources & Services Administration (HRSA)-designated areas:
  - Medically Underserved Area (MUA)
  - Medically Underserved Population (MUP)

Provider-Based Entity

- A Provider-Based Entity is operated as an integrated department of main provider, including a hospital or CAH
  - PBE financial operations must be integrated with the main provider's financial system
  - The PBE must be held out to the public and other payors as a department of the main provider and patients must be made aware when they enter PBE that they are entering a department of main provider and will be billed accordingly
  - An off-campus CAH PBE must meet the federal distance requirement specified in the CAH Conditions of Participation or risk jeopardizing CAH designation
  - PBE must be 100% owned by the main provider

Provider-Based Entity

- PBEs have access to the following benefits:
  - A physician clinic operating as a PBE can receive higher Medicare and Medicaid payments than the same practice operating as freestanding clinic, and often as an RHC
  - A PBE can participate in the 340B Drug Pricing Program if that PBE meets the 340B eligibility requirements
  - PBE physician practices operated as a department of a CAH receive facility and professional payment from Medicare, which can include Method II election
    - For CAHs, Medicare reimburses the facility component based on an un-capped reasonable cost methodology, as determined in Medicare cost report
    - CAHs electing Method II will receive 115% of Medicare physician services fee schedule for the professional portion of the claim

Rural Health Clinic

- An RHC is a clinic located in a rural, medically underserved area that has a separate reimbursement structure from a standard medical office
  - Reimbursement structure is an all-inclusive payment that includes provider and practice costs per visit, subject to a cap for free-standing RHCs and RHCs of hospitals larger than 49 beds
  - RHCs can be public, nonprofit, or for-profit healthcare facilities; however, they must be located in a non-urbanized area, as defined by U.S. Census Bureau, and located in federally designated shortage area (MUA, HPSA, or HPSP)
  - RHCs must employ a physician assistant (PA), certified nurse midwife (CNM), and/or nurse practitioner (NP) for at least 50% of the time that practice is open to see patients
  - RHCs must be engaged in providing primary care services 51% or more of the time clinic operates

Rural Health Clinic

- A PB-RHC is an RHC meeting the criteria of a PBE
  - 42 CFR 405.2401(b) excludes RHCs from the list of PBEs that must meet the CAH distance requirement
  - A PB-RHC must be 100% owned by the main provider and financial operations must be integrated with main provider's financial system
  - The PB-RHC must be held out to the public and other payors as a department of the main provider, and patients must be made aware when they enter PBE that they are entering a department of the main provider and will be billed accordingly

- RHCs that operate as provider-based departments of hospitals with <50 beds, including CAHs, can receive higher Medicare and Medicaid reimbursements than practices operating as a freestanding clinic or RHC
  - Hospitals can receive an un-capped AIR for services provided due to cost-based reimbursement methodology for Medicare and Medicaid and can participate in the 340B Drug Pricing Program
    - For hospitals not designated as a CAH, the hospital would need to have a qualifying DSH percentage to participate in the 340B program

Free-Standing Health Clinic

- An FSHC is a physician practice that is not operated as a department of a main provider, including a hospital or CAH
  - An FSHC can be located anywhere and does not bring to question distance requirements for CAH eligibility
  - An FSHC does not require staffing by Advanced Practice Providers (APPs)

- FSHCs must bill under Medicare Physician Fee Schedule and are not eligible for the 340B program

- An FSHC is a non-cost-based department of a Critical Access Hospital
  - An FSHC operating under a CAH will carve out administrative cost from cost-based departments and re-allocate expenses to a non-cost-based service line
  - An off-site FSHC will not jeopardize or bring to question the federal distance requirements of a CAH

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