Understanding Your Options
Primary Care Designation Strategies

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WINTERGREEN

Practice Designations and Alignment

- The Rural Environment and Performance Improvement Model
- Rural and Shortage Areas
- Practice Designation Types
  - Federally Qualified Health Centers (FQHC)
  - Provider-based Clinic
  - Rural Health Clinics (RHC)
    - Includes Provider-based Rural Health Clinics (PB-RHC)
  - Free-Standing Health Clinic (FSHC)
- Reimbursement Trends and Strategic Opportunities

The Rural Environment

Market

One in five Americans live in rural communities

Barriers

Highly fragmented provider community with various clinic designations

Entrenched need for autonomy and cultural resistance to change -- coupled with trust issues

Complex, arcane and fluid regulatory environment tied to optimal reimbursement

Opportunity

Organizations must take steps to improve their operational performance, service delivery, and financial position: specifically looking at the alignment and designation of each rural practice to improve performance

Rural markets are built on relationships that strengthen trust, honor legacy models and provide the type of innovation and expertise that is not present in the current, inefficient industry

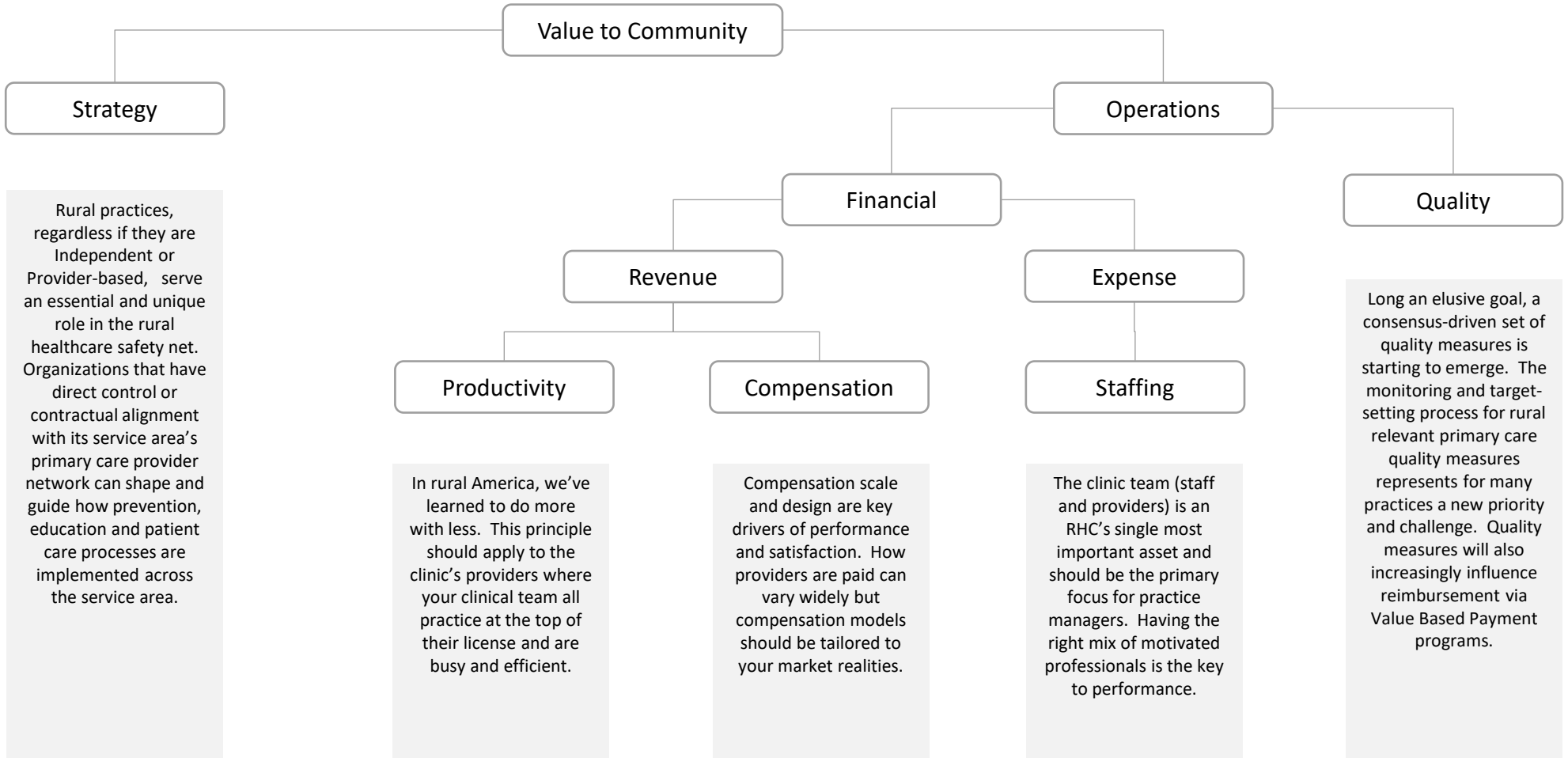
Medicare Economic Index (MEI)

- The Medicare Economic Index (MEI) was developed in 1975 and is the baseline for each year's payment update calculation
  - The following table presents the MEI from 2014 through 2023

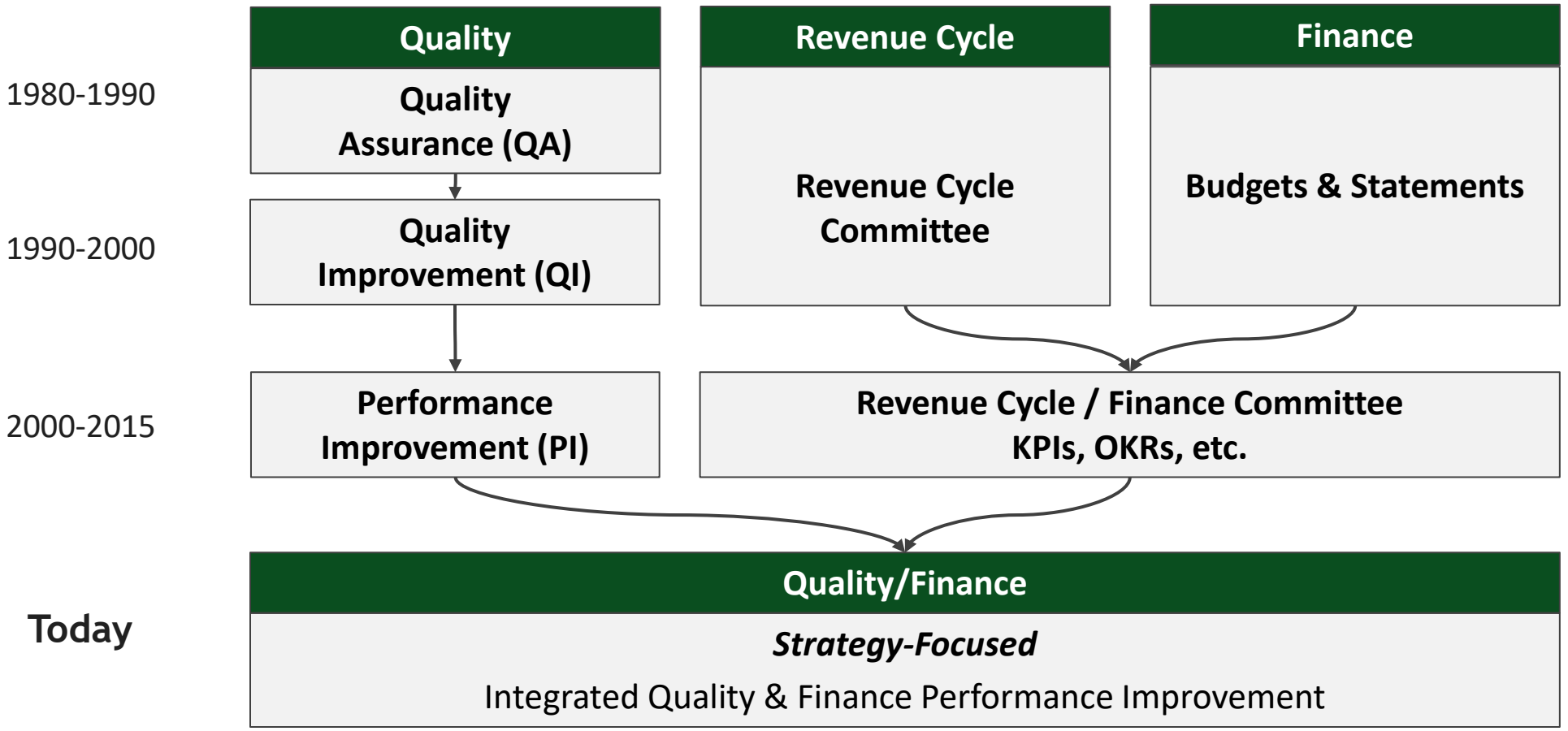
Medicare Economic Index [1]	CY14	CY15 [2]	CY16 [3]	CY17	CY18	CY19	CY20	CY21	CY22	CY23	AVERAGE
Market Basket Update	0.8	0.8	1.1	1.2	1.4	1.5	1.9	1.4	2.1	3.8	1.6

1. Physician payments were updated annually based on the MEI starting in 1992
   - The Medicare Economic Index has always included a productivity adjustment
2. The Medicare Access and CHIP Reauthorization Act of 2015,ended use of the SGR and replaced with defined annual update factors from 2015 through 2025. https://www.congress.gov/bill/114th-congress/house-bill/2/text
3. The MEI market basket was used to update FQHC PPS payments in CY 2016

Performance Improvement Model



Evolution of Improvement Models



Rural and Shortage Areas

Rural and Shortage Areas

- 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
    - Based on the 2020 Census, The Census Bureau took the following actions regarding urban areas:
      - Increased the minimum population threshold to qualify as urban from 2,500 to 5,000 and added the ability to qualify based on a minimum housing unit threshold
      - Use housing unit density instead of population density
      - No longer distinguish between different types of urban areas
        - Prior, The Census bureau distinguished between Urban Areas and Urban Clusters
    - 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
    - Geographic HPSA
      - A shortage of providers for an entire group of people within a defined geographic area
        - 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
    - Population HPSA
      - A shortage of providers for a specific group of people within a defined geographic area (e.g. low-income, migrant farm workers)
    - Facility HPSA
      - HRSA automatically applies a facility HPSA to the following:
        - Federally Qualified Health Center (FQHC)
        - FQHC Look-A-Likes
        - Indian Health Facilities
        - IHS and Tribal Hospitals
        - Dual-funded Community Health Centers/Tribal Clinics
        - CMS-Certified Rural Health Clinics (RHC)

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

- **Medically Underserved Population (MUP)**
  - MUPs are specific sub-groups of people living in a defined geographic area with a shortage of primary care services
  - These groups may face economic, cultural, or linguistic barriers to health care and include, but are not limited to, those who are:
    - Homeless, Low-Income, Medicaid-eligible, Native American; or Migrant Farmworkers
      - 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

Rural and Shortage Area Designations

- **Governor-Designated Secretary-Certified 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

Practice Designations

Federally Qualified Health Center

- **Federally Qualified Health Center (FQHC)**
  - An FQHC is 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 the Social Security Act (SSA) to add the FQHC benefit under Medicare
    - FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act (PHSA)
    - To qualify as an FQHC, the clinic must be owned by a public entity or a private non-profit
      - A municipally-owned healthcare entity can operate an FQHC within the system
  - An FQHC receives the following reimbursement and additional funding opportunities
    - Enhanced reimbursement from Medicare,
    - Ability to participate in the 340B Drug Pricing Program
    - Access to 330 grant funding through the PHSA
    - Malpractice insurance premium savings due to Tort Reform

Federally Qualified Health Center

- **Federally Qualified Health Center (FQHC)**
  - An FQHC must agree to provide a very specific set of services provided by:
    - Directly by the applicant
    - Under a formal written agreement
      - The FQHC pays for service
    - Under a formal written referral arrangement/agreement
      - The FQHC does not pay for the service
  - 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 Clinic

- **Provider-Based Clinic (PBC)**
  - A Provider-Based Clinic is operated as an integrated department of a main provider, including a hospital or CAH
    - PBC financial operations must be integrated with the main provider's financial system
    - The PBC must be held out to the public and other payers as a department of the main provider
    - An off-campus CAH PBC must meet the federal distance requirement specified in the CAH Conditions of Participation or risk jeopardizing the CAH designation
    - The PBC must be 100% owned by the main provider
  - PBCs and have access to the following benefits:
    - A physician clinic operating as an on-campus PBC can receive higher Medicare and Medicaid payments than the same practice operating as a freestanding clinic and often as an RHC
      - However, site neutrality went into effect in 2019
    - A PBC can participate in the 340B Drug Pricing Program
    - PBC physician practices operated as a department of a CAH receive a facility and a professional payment from Medicare, which can include a Method II election
      - For CAHs, Medicare reimburses the facility component based on an un-capped reasonable cost, as determined in the Medicare cost report
      - CAHs electing Method II will receive 115% of the Medicare physician services fee schedule for the professional portion of the claim

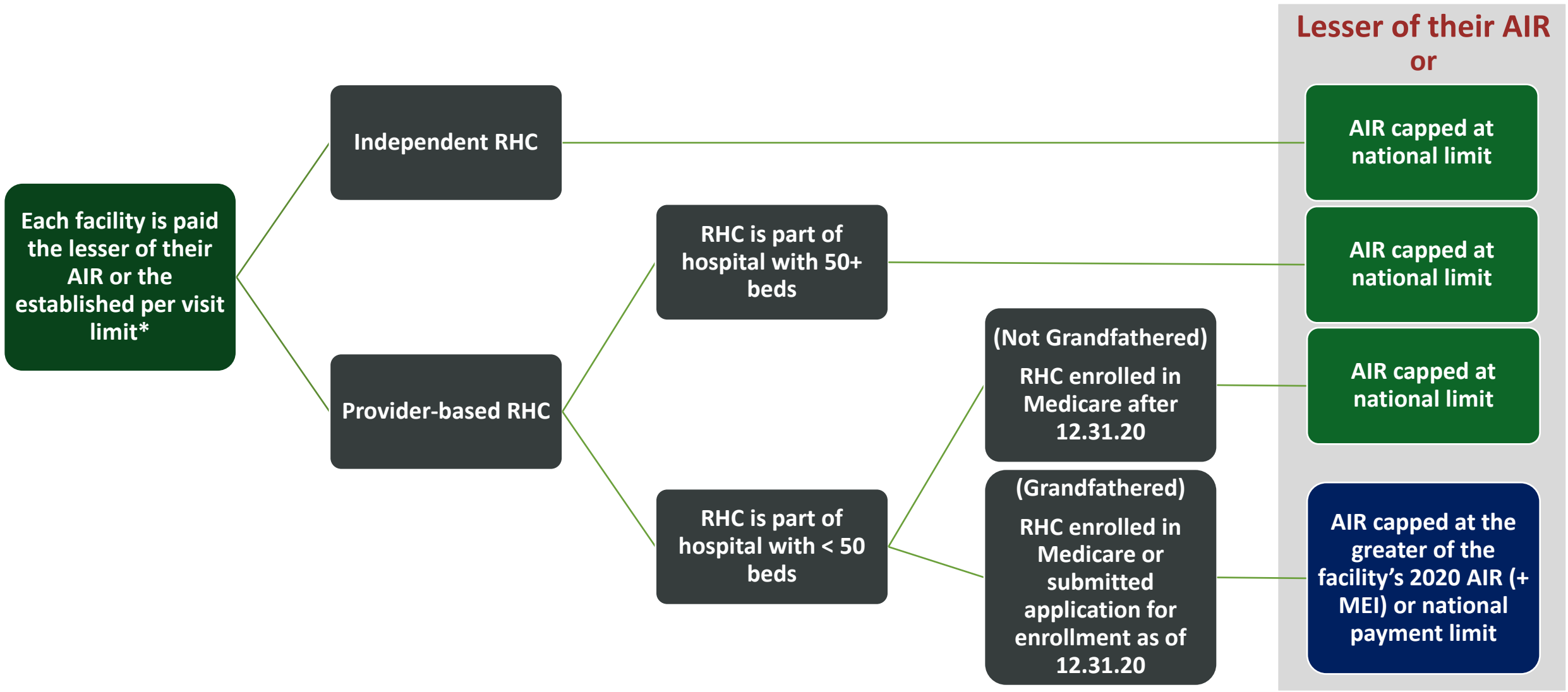
Rural Health Clinic

- **Rural Health Clinic (RHC)**
  - A RHC is a clinic located in a rural, medically underserved area that has a separate reimbursement structure from a standard medical office
    - RHCs can be public, nonprofit, or for-profit healthcare facilities; however, they must be located in a non-urbanized area, as defined by the U.S. Census Bureau, and located in a federally designated shortage area (MUA, HPSA, or HPSP)
      - ***Note**: The removal of urbanized areas will likely be an issue since 491.5 clearly states a rural area is an area "not delineated as urbanized areas in the last census conducted by the Census Bureau"*
    - RHCs must employ 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
    - RHCs must be engaged in providing primary care services 50% or more of the time the clinic operates
  - Starting on April 1, 2021, all new RHCs established after December 31, 2020, 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:
    - Starting at $100 per visit on April 1, 2021 and trending towards $190 per visit in 2028
    - 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, 2020 or those that applied before December 31, 2020 will qualify as a grandfathered RHC

Rural Health Clinic

- **Rural Health Clinic (RHC)**
  - 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 CAH distance requirement
    - A PB-RHC must be 100% owned by main provider and financial operations must be integrated with the main provider's financial system
    - The PB-RHC must be held out to the public and other payers as a department of the main provider and patients must be made aware when they enter the PBE that they are entering a department of the main provider and will be billed accordingly
  - ***Note**: Since new PB-RHCs no longer receive a financial benefit from Medicare, an organization wishing to establish an RHC no longer must establish that practice as provider-based*
    - However, organizations should still evaluate the impact on Medicaid reimbursement

RHC Rate Establishment



https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_fqhc_final_sec.pdf

Free-Standing Health Clinic

- **Free-Standing Health Clinic (FSHC)**
  - 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 (APP)
  - FSHCs must bill under the 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 the expense to a non-cost-based department

Reimbursement Trends and Strategic Opportunties

Practice Approach to Revenue Optimization

- As seen, each of the four clinic types evaluated encompass different reimbursement methodologies that greatly impact reimbursements received from Medicare and Medicaid and must be factored when evaluating primary and specialty providers
  - The table below highlights those differences

Reimbursement Options	FQHC	CAH PBC	<50 Beds PB-RHC	FSHC
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 needs to meet DSH % to qualify for 340B

RHC Reimbursement Methodology

- With declining reimbursements, healthcare entities must 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 to a designation that provides the most advantageous reimbursement opportunity
  2. Realign practices within a health system to leverage reimbursement advantages and additional revenue
  3. Integrate specialty practices and providers, when possible, within a PBC or RHC to leverage alternative reimbursement methodologies
  4. Acquire independent practices to leverage provider-based reimbursement opportunities and other additional revenue streams available to hospitals such as 340B
     - 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
     - **Note:** *An RHC owned and operated by a hospital that qualifies for 340B does not have to meet the provider-based rules at 42 CFR 413.65 to be registered as a child site for 340B purposes*

Opportunity 1: Practice Designations – (PB)

- The following table shows the net financial impact of different designations on a hospital:

			Before Change		After Change
Summary Data	**Scenario #1 PBC**	**After 2019 OPPS Final Rule (PBC)**	**Scenario #2 PB-RHC >50 Beds**	**Scenario #3 PB-RHC <50 Beds**	**Scenario #4 RHC Post 4/1/21**
Medicare / Medicaid Average	$ 149.06	$ 136.86	$ 86.32	$ 187.82	$ 127.92
Annual Visits	28,294	28,294	28,294	28,294	28,294
Reimbursements Received	$ 4,217,643	$ 3,872,319	$ 2,442,338	$ 5,314,296	$ 3,619,368
340B Benefit	n/a	n/a	n/a	n/a	n/a
Variance w/ Before 2019 PBC (Scenario #1)		$ (345,324)	$ (1,775,305)	$ 1,096,653	$ (598,275)
Variance w/ After 2019 PBC (Scenario #1)			$ (1,429,981)	$ 1,441,977	$ (252,951)

- <u>Outcomes:</u>
  - Prior to the change in the RHC reimbursement methodology, the PB-RHC would have been the most advantageous designation; however, under the new reimbursement methodology, the practices would be better served to remain as a PBC until the RHC UPL surpasses the average PBC rate
    - Since the practices were already PBCs, there was no additional 340B benefit by converting the practices to RHCs

Opportunity 1: Practice Designations – (Ind.)

- The following table shows the net financial impact of different designations on an independent practice:

				Before Change			After Change		
Summary Payor Data	FSHC Payment / Visit	FSHC Visits	FSHC Revenue	RHC Payment / Visit	RHC Visits	RHC Revenue	RHC Payment / Visit	RHC Visits	RHC Revenue
Practice Impact									
Medicare	$ 117.74	4,581	539,362	$ 86.32	4,581	$ 395,432	$ 113.00	4,581	$ 517,653
Medicaid	67.86	3,875	262,960	106.76	3,875	413,705	106.76	3,875	413,705
Average	$ 94.88	8,456	$ 802,322	$ 95.69	8,456	$ 809,137	$ 110.14	8,456	$ 931,358
Variance With Current State				**$**		**6,815**	**$**		**129,036**

- Outcomes:
  - Prior to the change in the RHC reimbursement methodology, the RHC designation would have increased reimbursements by nearly $7K; however, all of the gain would have been attributed to Medicaid
  - After the change in the law, the RHC designation would have increased reimbursements by $129K

Opportunity 2: Practice Realignment

- The following table shows the net financial impact of different designations on a hospital:

		Before Change		After Change
Summary Data	**Scenario #1 FSHC**	**Scenario #2 PB-RHCs under STAC**	**Scenario #3 PB-RHCs under CAHs**	**Scenario #4 PB-RHCs under CAHs**
Practices Impact				
Medicare / Medicaid Average	$ 110.02	$ 189.63	$ 194.27	$ 113.00
Annual Visits	53,291	53,291	53,291	53,291
Reimbursements Received	$ 5,863,215	$ 10,105,572	$ 10,352,843	$ 6,021,883
Other Impact				
Medicare / Medicaid Reimbursement	$ -	$ -	$ (1,464,212)	$ (1,464,212)
340B Revenue	-	-	2,642,197	2,642,197
Reimbursements Received	$ -	$ -	$ 1,177,985	$ 1,177,985
Variance w/ FSHC (Scenario #1)		**$ 4,242,357**	**$ 5,667,613**	**$ 1,336,653**

- Outcomes:
  - Although the RHC reimbursement methodology changed, the designation is still more favorable than operating as FSHCs; however, important to note the net gain is dependent upon the 340B program under the new reimbursement methodology

Opportunity 3: Specialty Integration

- The following table shows the net financial impact of integrating a behavioral health provider into an RHC

Summary Data	Scenario #1 Separate	Scenario #2 Intergrated	Variance
Free-Standing Health Clinic			
Medicare / Medicaid Average	$ 75.64	$ -	$ (75.64)
Annual Visits	641	-	(641)
Reimbursements Received	$ 48,485	$ -	$ (48,485)
Provider-Based Rural Health Clinic			
Medicare / Medicaid Average	$ 197.24	$ 191.65	$ (5.59)
Annual Visits	4,769	5,410	641
Reimbursements Received	$ 940,638	$ 1,036,827	$ 96,189
Critical Access Hospital			
Medicare / Medicaid Reimbursement	$ 9,967,243	$ 9,956,219	$ (11,024)
340B Revenue	367,241	367,241	-
Reimbursements Received	$ 10,334,484	$ 10,323,460	$ (11,024)
Integrated Benefit			**$ 36,680**

- <u>Outcomes:</u>
  - Under this scenario, integrating a behavioral health provider into an RHC, instead of operating as a separate practice, would improve the net position of the combined entity

Opportunity 4: Practice Acquisition

- The following table shows the net financial impact of different designations on a hospital:

		Before Change	After Change
Summary Data	**Scenario #1 FSHC**	**Scenario #2 PB-RHC**	**Scenario #2 PB-RHC**
Independent FSHC			
Medicare / Medicaid Average	$ 94.43	$ 199.20	$ 113.00
Annual Visits	2,724	2,724	2,724
Reimbursements Received	$ 257,219	$ 542,622	$ 307,812
Critical Access Hospital			
Medicare / Medicaid Reimbursement	$ 11,244,531	$ 11,041,322	$ 11,041,322
340B Revenue	-	179,240	179,240
Reimbursements Received	$ 11,244,531	$ 11,220,562	$ 11,220,562
Variance w/ FSHC (Scenario #1)		**$ 261,434**	**$ 26,624**

- Outcomes:
  - Acquiring the practice and operating as a PB-RHC would improve the net financial position of the acquired practice; however, once again, the benefit is dependent up on the 340B program
    - ***Note**: Due to the location of the practice, operating as a PBC was not an option*

Questions

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