Overview
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- On April 1, 2021, the RHC reimbursement methodology went through a material change due to the “Consolidated Appropriations Act, 2021 (CAA)” which changed the reimbursement methodology for Rural Health Clinics (RHC) starting on April 1, 2021
  - 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:
    - In 2021, after March 31, at $100 per visit;
    - In 2022, at $113 per visit;
    - In 2023, at $126 per visit;
    - In 2024, at $139 per visit;
    - In 2025, at $152 per visit;
    - In 2026, at $165 per visit;
    - In 2027, at $178 per visit;
    - In 2028, at $190 per visit;
  - In subsequent years, the rate will increase based on the Medicare Economic Index (MEI) for primary care
- RHCs owned and operated by a hospital with fewer than 50 beds and established on or before December 31, 2020, will use their 2020 rate to establish a clinic-specific grandfathered UPL that will then be increased each year based on the MEI
RHC Rate Establishment

Each facility is paid the lesser of their AIR or the established per visit limit*

Independent RHC
- RHC is part of hospital with 50+ beds

Provider-based RHC
- RHC is part of hospital with < 50 beds

(Not Grandfathered)
- RHC enrolled in Medicare after 12.31.20

(Grandfathered)
- RHC enrolled in Medicare or submitted application for enrollment as of 12.31.20

Lesser of their AIR or
- AIR capped at national limit
- AIR capped at national limit
- AIR capped at national limit
- AIR capped at the greater of the facility’s 2020 AIR (+ MEI) or national payment limit
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:

<table>
<thead>
<tr>
<th>Medicare Economic Index ¹</th>
<th>CY14</th>
<th>CY15 ²</th>
<th>CY16 ³</th>
<th>CY17</th>
<th>CY18</th>
<th>CY19</th>
<th>CY20</th>
<th>CY21</th>
<th>CY22</th>
<th>CY23</th>
<th>AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Basket Update</td>
<td>0.8</td>
<td>0.8</td>
<td>1.1</td>
<td>1.2</td>
<td>1.4</td>
<td>1.5</td>
<td>1.9</td>
<td>1.4</td>
<td>2.1</td>
<td>3.8</td>
<td>1.6</td>
</tr>
</tbody>
</table>

1. Physician payments were updated annually based on the MEI starting in 1992
   - The Medicare Economic Index has always included a productivity adjustment
3. The MEI market basket was used to update FQHC PPS payments in CY 2016
Operational Opportunities
Rural providers continue to experience cost increases, while having to address staffing shortages, outmigration, and significant policy/legislative changes.

The past few years have fundamentally changed how many patients receive healthcare services.

- Organizations must take a proactive approach to address these changes.
CAHs/RHCs serve an essential and unique role in the rural healthcare safety net. Organizations that have direct control or contractual alignment with its service area’s primary care provider network can shape and guide how prevention, education and patient care processes are implemented across the service area.

In rural America, we’ve learned to do more with less. This principle should apply to all service areas, when appropriate, by working with staff to work at the top of their license.

Compensation scale and design are key drivers of performance and satisfaction. How staff are paid can vary widely but compensation models should be tailored to your market realities.

Staff are the single most important asset and should be the primary focus for leaders. Having the right mix of motivated professionals is the key to performance.

The monitoring and target-setting process for rural relevant quality measures represents a new priority and challenge. Quality measures will also increasingly influence reimbursement via Value Based Payment programs.
Healthcare is a segmented industry where quality and finance continue to operate as separate business units with limited integration.

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality</th>
<th>Revenue Cycle</th>
<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980-1990</td>
<td>Quality Assurance (QA)</td>
<td>Revenue Cycle Committee</td>
<td>Budgets &amp; Statements</td>
</tr>
<tr>
<td>1990-2000</td>
<td>Quality Improvement (QI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000-2015</td>
<td>Performance Improvement (PI)</td>
<td>Revenue Cycle / Finance Committee KPIs, OKRs, etc.</td>
<td>Quality/Finance</td>
</tr>
<tr>
<td>Today</td>
<td>Quality/Finance</td>
<td></td>
<td>Strategy-Focused</td>
</tr>
<tr>
<td></td>
<td>Integrated Quality &amp; Finance Performance Improvement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Due to the changing healthcare landscape, healthcare entities must leverage additional revenue opportunities, including reimbursement methodologies, to drive improved financial performance.

Healthcare entities can leverage the following to improve reimbursements when those practices can meet certain eligibility requirements:

1. Periodically evaluate and convert practices to a designation that will improve the net financial position of that practice.
2. Establish system strategy and realign practices, when possible, to leverage alternative designation types.
3. Consolidate practices by integrating specialty practices and providers, when possible, within a PBC or RHC to realize operational efficiencies and leverage alternative reimbursement methodologies.
4. Pursue acquisition of independent practices to leverage reimbursement and revenue opportunities afforded to rural hospital providers.

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.
Organizations must focus and establish plans for each of the four identified areas to improve the organizational position:

**Operating**
- Demand-Based Staffing tools
- Departmental performance improvement
- Revenue cycle and coding
- Cost report optimization
- Practice / clinic designations
- Process improvement
- Supply chain & purchasing

**Financial**
- Define performance gaps
- Integrate department leaders into budgeting process
- Determine cash position and run rates
- Establish actionable metrics
- Pricing transparency and patient engagement

**Value**
- New market entry and increased competition
- Explore clinically integrated model
- Ambulatory network establishment
- Increase access to care
- Direct contracting
- Improve patient engagement and satisfaction

**Market**
- Payor contract reviews
- Value-based initiatives
- Population-based strategy
- Self-insured insurance plan offering
- Medicare Advantage negotiations
- Establish payor and provider partners
- Manage overall cost of care
Practice Management

- **Practice Management To Do List**
  - Work with your practice managers and physicians as a team to understand what is happening with:
    - Physician contracts
    - Physician compensation
    - Scheduling

- Set up management dashboard that monitors the following:
  - Gross collection rate
  - Net collection rate
  - Overhead ratio
  - Individual category expense ratio
  - Days in accounts receivable
  - wRVUs per provider
  - Accounts receivable per FTE physician
  - Staff ratio
  - Average cost and revenue per patient
  - Aging of accounts receivable by payor
  - Payor mix ratio
**RHC Cost Structure**

**Variable Costs:** Those costs that increase as visit volumes increase. Examples include supplies and medications.

~10 percent

**Fixed Costs:** Those costs that do not increase as visit volumes increase. Examples include salaries, benefits and overhead expenses such as utilities and administration.

~90 percent

**Fixed costs** are especially important for provider-based RHCs because they represent one of the key reimbursement opportunities for the hospital. Various organization-wide costs are allocated from what is typically considered traditional hospital operations to the clinic (e.g., hospital administration salaries). This is why we often see provider-based RHCs with larger expense structures and lower profit margins.
RHC Charge Structure

The fully-allocated cost for a single visit according to the hospital Medicare cost report
The "retail price" of the visit according to the RHC’s Chargemaster

The "retail price" of the visit according to the RHC’s Chargemaster

A typical co-payment for a primary care visit under a commercial policy

Medicare beneficiary out-of-pocket obligation based on a “percent of charges” methodology for provider-based RHCs

High prices disproportionately impact Medicare Beneficiaries

$200 RHC Cost
$300 RHC Charge
$20 Commercial
$40 20% Cost
$60 20% Charge

30%

of the cost of care is passed to the Medicare beneficiary via coinsurance ($60/$200)
Provider Complement

- Evaluate the integration of additional primary and specialty care providers into the RHC to leverage reimbursement advantages
  - Due to the increase in the UPL for independent RHCs, those practices now have additional opportunities to bring in specialty providers which before was often unsustainable

- Catalog all providers within the primary and secondary service area to better understand patient demand and provider availability
  - In today’s market, organizations must also include telehealth providers when cataloging providers

- Implement team-based initiatives to increase efficiencies and create an environment where staff operate at the top of their license
  - RHCs must leverage a complement of CMAs, RNs, APPs, and Physicians, based on patient need, to optimize care delivery models

- Leverage available data sources, such as the Medical Group Management Association (MGMA), to benchmark provider productivity and drive performance improvement initiatives
CMS defines a minimum expected number of patient visits for physicians and advanced practice providers (Nurse Practitioners and Physician Assistants)

4,200
Physicians

2,100
APPs

Note: Providers with regular scheduled time are subject to the Minimum Productivity standards
Note: Providers with non-regular scheduled time are not subject to the Minimum Productivity standards
Note: Contracted physician volumes are not included in the calculation
Note: If clinics do not meet productivity standards, the clinic will not get full cost-based reimbursement, subject to CAA provisions

RHCs must engage providers about their performance
Provider Contracts

- Notwithstanding fair market valuation regulations, in most instances the market and basic supply and demand dynamics drive provider compensation
  - Increasingly, RHC physicians and APPs are migrating away from straight salary arrangements toward productivity-based arrangements and in some cases, value-based compensation models

- The challenge for RHC operators is how to balance and accelerate these different types of compensation plans in a delicate rural healthcare market
  - Provider contracts now often include the following components:
    - Base Salary
    - wRVUs
    - Panel Size
    - Quality Scores
    - Patient Satisfaction Scores

Compensation Metrics
Salary and bonus metrics to assess and compare provider costs

<table>
<thead>
<tr>
<th>Compensation Metrics</th>
<th>Site Values</th>
<th>Calculated</th>
<th>RR Calculated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries for Medical Staff</td>
<td>$50,000</td>
<td>$52,000</td>
<td>$54,000</td>
</tr>
<tr>
<td>Salaries for Support Staff</td>
<td>$20,000</td>
<td>$22,000</td>
<td>$24,000</td>
</tr>
<tr>
<td>Salaries for Clinical Staff</td>
<td>$15,000</td>
<td>$17,000</td>
<td>$19,000</td>
</tr>
<tr>
<td>Salaries for RN/ED Staff</td>
<td>$12,000</td>
<td>$14,000</td>
<td>$16,000</td>
</tr>
<tr>
<td>Salaries for EMT/Paramedic</td>
<td>$10,000</td>
<td>$12,000</td>
<td>$14,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staffing Metrics</th>
<th>Site Values</th>
<th>Calculated</th>
<th>RR Calculated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>Site Values</td>
<td>Calculated</td>
<td>RR Calculated</td>
</tr>
<tr>
<td>Total Staff</td>
<td>100</td>
<td>105</td>
<td>110</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>50</td>
<td>55</td>
<td>60</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>20</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Clinical Staff</td>
<td>30</td>
<td>33</td>
<td>36</td>
</tr>
<tr>
<td>Support Staff</td>
<td>20</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>EMT/Paramedics</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>RN/ED Staff</td>
<td>15</td>
<td>16</td>
<td>18</td>
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</table>

<table>
<thead>
<tr>
<th>Quality Metrics</th>
<th>Site Values</th>
<th>Calculated</th>
<th>RR Calculated</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTF MIK Consulting</td>
<td>15%</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>MTF MIK Support</td>
<td>10%</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>MTF MIK Site</td>
<td>5%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>MTF MIK Staffing</td>
<td>20%</td>
<td>22%</td>
<td>24%</td>
</tr>
<tr>
<td>MTF MIK Staff</td>
<td>30%</td>
<td>33%</td>
<td>36%</td>
</tr>
<tr>
<td>MTF MIK IL</td>
<td>40%</td>
<td>44%</td>
<td>48%</td>
</tr>
<tr>
<td>MTF MIK MIK</td>
<td>50%</td>
<td>55%</td>
<td>60%</td>
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<table>
<thead>
<tr>
<th>Patient Satisfaction Scores</th>
<th>Site Values</th>
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<th>RR Calculated</th>
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<tbody>
<tr>
<td>Patient Satisfaction Score</td>
<td>90</td>
<td>95</td>
<td>100</td>
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</table>
RHCs must get away from viewing the Cost Report as an administrative function and realize the Cost Report has a direct impact on reimbursements received due to the new reimbursement methodology and UPLs, RHCs can quickly see their cost structure surpass reimbursements received from Medicare.

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### Cost Report Opportunities

<table>
<thead>
<tr>
<th>Positions</th>
<th>Number of FTE</th>
<th>Total Visits</th>
<th>Productivity Standard</th>
<th>Minimum Visits (col. 1 x col. 3)</th>
<th>Greater of col. 2 or col. 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Physicians</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2 Physician Assistants</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Nurse Practitioners</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Subtotal (sum of lines 1-3)</td>
<td>12</td>
<td>13</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Visiting Nurse</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Clinical Psychologist</td>
<td>9</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Clinical Social Worker</td>
<td>11</td>
<td>12</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.01 Medical Nutrition Therapist (FQHC only)</td>
<td>12</td>
<td>13</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.02 Diabetes Self Management Training (FQHC only)</td>
<td>14</td>
<td>15</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Total FTEs and Visits (sum of lines 4-7)</td>
<td>64</td>
<td>66</td>
<td>66</td>
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<td></td>
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<tr>
<td>9 Physician Services Under Agreements</td>
<td>9</td>
<td>10</td>
<td>10</td>
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Hierarchy of Quality Measurement (QM)

- **Structural measures**
  - The foundation of QM - evaluates infrastructure/capacity of health care organizations to provide care (e.g., equipment, personnel, or policies)
  - Examples - % of providers using an electronic health record, % of diabetics tracked in a patient registry, staff to patient ratio

- **Process measures**
  - The building blocks of QM that focus on evidence-based steps that should be followed to provide good care
  - When executed well, increases the likelihood of a desired outcome
  - Examples – medication reconciliation, colorectal cancer screening, use of aspirin for patients presenting with ischemic vascular disease
Outcome measures
- Evaluate/assess the results of care on a patient’s health, such as clinical events, recovery, or health status
- Outcome measures are slots into which process blocks fit
- Process and outcome measures go hand in hand as improving a process can result in an improved outcome
- Examples: optimal asthma control, long-term complications of diabetes, controlling high blood pressure

Composite measures
- Combines individual measures to produce one result that gives a more complete picture of quality for a specific area or disease
- Examples – comprehensive diabetes care, substance use screening and intervention, optimal vascular care
The National Quality Forum is responsible for coordinating the development and ratification of clinical quality measures. The following five NQF metrics have been identified via research by John Gale from the Maine Rural Health Research Center as the most rural relevant.

John Gale, Director of Policy Engagement
john.gale@maine.edu

The PQRS and then MIPS public reporting programs for physician practices included 100+ potential measures, most of which were relevant to large urban practices and multi-specialty practices. Few of the metrics were rural relevant and/or valid for small volume clinics.
Optimize Revenue Cycle Tasks and Functions

- Evaluate and improve revenue cycle functions by ensuring a fair distribution of work, clearly defined roles and task automation or improvement.
  - Make sure no matter how tasks are divided among departments, core task elements are incorporated and monitored.

<table>
<thead>
<tr>
<th>Revenue Cycle Administrative Functions</th>
<th>Pre-Registration</th>
<th>Registration</th>
<th>Coding</th>
<th>Patient Accounting - Claims</th>
<th>Patient Accounting - Follow-up</th>
<th>Collections</th>
<th>Data and Analytics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Negotiation</td>
<td>Scheduling and Financial Clearance</td>
<td>Patient Check In</td>
<td>Charge Reconciliation and Documentation review</td>
<td>Claim Scrubbing</td>
<td>EDI management</td>
<td>Patient Statement Management</td>
<td>Benchmarking and Reports</td>
</tr>
<tr>
<td>CDM Fee Schedule and Pricing</td>
<td>Pre-Registration and Coordination of Benefit Review</td>
<td>Confirmation of Financial Counseling, Balance due assessment</td>
<td>Correct Hierarchal coding</td>
<td>Error Correction</td>
<td>Remittance Posting</td>
<td>Charity Care Management</td>
<td>Performance Improvement Activities</td>
</tr>
<tr>
<td>EDI Transactional Enrollment</td>
<td>Financial Counseling/Charity and Pre-Service Collections</td>
<td>Patient Check Out – Verification of Patient Services ordered, scheduled, referred.</td>
<td>Physician Query – Medical Necessity</td>
<td>Claim Submission</td>
<td>Denials Management</td>
<td>Bad Debt Management</td>
<td>Strategy and Workflow focus and management</td>
</tr>
<tr>
<td>Provider Enrollment and Credentialing</td>
<td>Identification of Patient Health Outcome Delinquencies and need for services</td>
<td>Encounter Documentation and Charge Capture</td>
<td>Charge Entry as needed</td>
<td></td>
<td>Appeals and Recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appointment Management and Care Management Enrollment Identification</td>
<td>Beneficiary Notice Identification</td>
<td></td>
<td></td>
<td>Payor Credit Reconciliation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22
Revenue Cycle

- Transition managerial focus to the “front end” processes of revenue cycle (e.g. pre-authorizations, scheduling, registration, etc.) while driving an overall measurement culture
  - Organization should have the appropriate workflows to pre-register patients, facilitate point-of-service collections, review contracts, adjudicate claims, etc.
  - Ensure scheduling of outpatient services and prior authorizations received before the patient presents for services

- Implement and maintain a performance measurement system that evaluates key areas throughout revenue cycle
  - Macro and Micro measurement necessary to drive performance improvement

- Review price list (charge description master) at least annually to ensure the defensibility and accuracy of the price list
  - Organizations must also address meet pricing transparency requirements

- Prioritize point of service (POS) collections to improve cash flow
  - Staff must be held accountable for achieving POS goals
Additional Opportunities

- Leverage claims data to better understand opportunities for improved patient outcomes, the demand for additional service providers, and revenue capture opportunities
  - Data remains one of the valuable, but underutilized, resources available to RHCs that can drive strategy and performance improvement efforts

- Pursue the Patient Centered Medical Home (PCMH) model to drive patient outcomes
  - Negotiate with third-party payors to ensure the clinic receives PMPM payments

- Implement Chronic Care Management (CCM), Transitional Care Management (TCM), and Behavioral Health Intervention (BHI), among other opportunities, based on patient demand and available providers to improve patient outcomes and generate incremental revenue

- Explore the expansion of services to include Behavioral Health
  - RHCs can provide distant site behavioral health services even after the COVID waivers lapse

- If eligible, pursue the 340B program to drive additional revenue
Questions