RURAL HEALTH CLINICS OVERVIEW

WHAT IS IT? A scheme established in 1977 under Medicare and administered by Center for Medicare and Medicaid (CMS) Services.

PURPOSE: To address an inadequate supply of physicians serving Medicare beneficiaries in underserved rural areas, and to increase the utilization of nurse practitioners (NP) and physician assistants (PA) in these areas

ADVANTAGES: Receive higher reimbursement rate for routine Medicare patient visits and for Medicaid patient encounters.

Benefit is greatest for Medicaid patients, as Medicaid has much lower payments for providers than Medicare.

- Washington reimburses RHCs for Medicaid patients at same rates as CMS.
    - For instance, RHC payments accounted for almost 2/3^{rds} of the reimbursement OFHC received for Medicaid patient encounters in 2018.

Lower reimbursement rate Medicare billing codes, (e.g, evaluation & management codes) see biggest gain from RHC status for Medicare patients.

- Reimbursement may actually be lower than Medicare for the most complex Medicare patient encounter billing codes.

RCH reimbursement is the same whether patient is seen by physician, PA or NP.

- Medicare reimburses PA and NP visits at a lower rate.

Medicare bad debt includable as reimbursable cost at 65% of bad debt amount.

- So providers get some relief for patient visit costs they have to write off.

Influenza and pneumococcal injections reimbursed at cost, including staff time and overhead.

- Medicare pays a very low fee for these injections, which may be less than cost of serum.

GEOGRAPHICAL REQUIREMENTS for establishing an RHC:

Located in a non-urbanized area, as certified by the US Census

Area must be one of the following:

- Medically underserved area (MUA);
- Medically underserved population (low income, Medicaid-eligible, indigenous, migrant seasonal worker, etc.)(MUP); or

- Certified health professional shortage area (HPSA).

Orcas island is a census-defined rural area and meets the other qualification in 2 different ways:

- Orcas Island was designated as a medically underserved population by the governor in 1994 (which meant that Orcas did not qualify as a MUA on the rating scale but the state convinced CMS that there were unusual factors to be considered)
    - San Juan and Lopez islands were separately certified by governor's exception in the same year.
- All of San Juan County was certified as an HPSA in 2017.

Designations as MUAs, MUPs and HPSAs are valid for 4 years. Governor's exceptions have no expiration.

RHC applications are more commonly based on HPSA certifications

ORGANIZATIONAL REQUIREMENTS:

Owners names and addresses must be disclosed. Owners can be:

- A physician
- A Physician's Assistant (PA), Nurse Practitioner (NP) or Certified Nurse Midwife (CNM) who has established a relationship with a physician to provide medical oversight.
- A non-profit or for- profit entity that owns the medical practice seeking certification as an RHC.

Written administrative and patient care policies that were jointly developed by the physician and the other providers.

- Patient care policies must meet requirements of 42 CFR 491.9(b).
- Policies must include:
    - Description of services offered directly and through agreements with others
    - Description of scope of medical acts to be performed by NPs, PAs, and CNMs.
    - Policies for procuring, storing, labeling, record-keeping, dispensing and destroying drugs and biologicals.

System for creation, storage, retention and protection of the confidentiality of written patient records.

An emergency preparedness plan that:

- Satisfies Federal, state and local requirements;

- Includes policies and procedures to be followed;
- Includes a communication plan to be followed in the event of an emergency; and
- Includes a training and testing plan.

STAFFING:

Physician (MD or OD) must direct RHC operations unless state law would permit it to operate under direction of a PA or NP.

Person directing medical operations need not be an employee of the RHC and need not be present at the RHC while providing medical direction.

- No minimum service level for the medical professional directing the operations.
    - Can be employed by both the RHC and a non-RHC but work times must differ (e.g., TuTh for RHC, MWF for non-RHC or 9-12 for RHC and 1-4 for non-RHC).
        - Would be problematic if RHC staffed with a provider who needed direction during times medical director was employed by or contracted to work with another facility.
    - Must provide medical direction at least once every 2 weeks and be available for consultation.
    - Responsible for:
        - Periodic review of patient records with RHC's other providers;
        - Providing medical orders; and
        - Providing medical care services to RHC patients during hours worked at the RHC.

RHC staff must include a PA or NP.

- Must have a PA, NP or certified nurse midwife (CNM) working at the RHC at least 50% of the time the RHC is open
    - PA, NP or CNM is not required to be an RHC employee (because we are on an island).
    - RHC can contract with other PAs, NPs, CNMs, clinical psychologists (CP), or clinical social workers (CSW) to provide services at the RHC.
    - Can be employed by RHC and non-RHC provider as long as work times differ (e.g., TuTh for RHC, MWF for non-RHC or 9-12 for RHC and 1-4 for non-RHC)
- At least one NP, PA or CNM must be an employee of the RHC.

- Some combination of MD, OD, NP, PA, CNM, CP or CSW must be on RHC premises offering services during all RHC service hours.

SERVICES:

Required Services:

- Physician services;
- Services and supplies furnished incident to a physician's services;
- NP, PA, or CNM services;
- Services and supplies furnished incident to an NP, PA, or CNM services';
- Drugs and biologicals on-site for the treatment of emergencies;
- Arrangements with at least one hospital for providing medically necessary services that are not available at the RHC;
- Preventative Services:
    - Influenza, Pneumococcal, Hepatitis B vaccinations;
    - Initial Preventative Physical Exam;
    - Annual Wellness Visit; and
    - Medicare-covered preventive.
- Routine lab and diagnostic services, including the following performed on-site:
    - Chemical examination of urine by stick or tablet method or both;
    - Hemoglobin or hematocrit;
    - Blood sugar;
    - Examination of stool specimens for occult blood;
    - Pregnancy tests; and
    - Primary culturing for transmittal to a certified laboratory
- After-hours telephonic access to physician, NP or PA to assess a patient's need for emergency medical care, and if appropriate, to refer the patient to an appropriate provider or facility that is open.

Optional RHC reimbursed services:

- Clinical psychologist (CP), and clinical social worker (CSW) services and services and supplies furnished incident to CP services; and
- Nursing visits to patients confined to the home that are furnished by a registered professional nurse (RN) or a licensed professional nurse (LPN);
- Care management services
- Behavioral health integration services: and
- Services provided by telephone or other virtual communication method.

RHCs may also provide other services approved by Medicare and separately bill Medicare for those services.

PAYMENT:

RHCs are paid 80% an all-inclusive rate (AIR) by CMS for the RHC approved services they provide.

- Patient billed 20% of AIR as coinsurance.
- Paid 100% of some preventative services.
- Rates are all inclusive, so if multiple procedures are performed on the same day, CMS only reimburses the RCH for one procedure.
    - RHC may bill Medicare separately for any Medicare-covered services provided during a patient visit that are non-RHC services
        - Some lab tests, X-rays, EKGs, telehealth consultations with distant specialists.

AIR Determination:

- The AIR for an RHC is the lower of the CMS cap for RHC payments or the RHC's adjusted cost/visit.
- In 2019, the CMS cap is ***$84.70 per visit***.
- Costs per visit is determined by dividing an RHC's total allowable costs by total number of its client visits.
    - Medicare uses the greater of its productivity standard or the RHCs' client visit number.
        - Medicare standard is 4200 patient visits for FTE physician and 2100 patient visits for FTE NP, PA, or CNM.
- Allowable costs
    - Must be reasonable and necessary
    - Must include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services
- As a result of the formula, higher provider productivity results in a lower reimbursement rate for the RHC.
    - Lower countable costs also reduce the reimbursement rate.
- AIR may not be higher than the rate that would be paid to a non-RHC provider billing at a higher-level office visit CPT code.

An interim rate for newly certified RHCs is established by the Medicare Administrative Contractor (MAC) based on the RHC's anticipated average cost for direct and supporting services.

- CMs will do a year end cost reconciliation at the end of the first year of operation.

RHC providers cannot bill for some encounters (e.g., e-prescribe)

Payments from Medicare Advantage plans are not part of this scheme and must be separately negotiated.

PROVIDER-BASED RHCs

RHCs attached to a 50 bed or smaller critical access hospital have ***uncapped RHC reimbursement rates*** *which averaged $206 per visit last year*.

- Hospital must have average daily census of less than 40 beds in use;
- Hospital must be a sole community hospital or an essential access community hospital; and
- Hospital must be located in a rural area.

35-mile geographical limitation for provider-based facilities does **NOT** apply to RHCs.

RHC must be 100% owned by the hospital; operated as an operational and financial integral and subordinate part of the hospital and governed by the same governing body.

CMS makes determination that an RHC qualifies as a PBD of the hospital, following receipt of an attestation from the clinic or hospital that all of the requirements for PBD status are satisfied.

- Filing the attestation is voluntary, but strongly advised.
- RHC may bill as a PBD once the attestation is filed with the Medicare Administrative Coordinator (MAC)
- MAC reviews attestation and makes recommendation to CMS.
- If CMS determines that the RHC is not a PBD, CMS will recover difference between RHC and PBD rates.

Provider-based RHCs can bill as hospital outpatient departments where appropriate for the services provided.

- However, CMS has legislative authority to adopt site neutrality rules to reduce or eliminate payment discrepancies between services provided at a privately-owned facility and those provided by a similar facility owned by a hospital.
    - In 2017, CMS used that authority to reduce payments to recently acquired off campus hospital departments.
    - RHCs are facilities, not departments so the reduction in payment does not apply to them.
        - CMS is studying other site neutral rules and further rule making can be expected.
        - PBD RHCs are a likely target as the number of RHCs that are hospital owned increased from a small number to 67% of all RHCs in the past 20 years or so.

- One downside for patients is that their Medicare 20% coinsurance payment is also higher in PHD RCHs.

COMMINGLING PROHIBITED:

Commingling is defined as sharing space, staff, supplies, services, equipment and/or other resources with an onsite Medicare Part B or Medicaid FFS practice *operated by the same RHC providers*.

An RHC practitioner may not furnish or separately bill for RHC-covered professional services as a Part B provider in the RHC, or in an area outside of the certified RHC space such as a treatment room adjacent to the RHC, during RHC hours of operation.

SHARED FACILITY:

RHC can share building with another <u>unaffiliated</u> medical service, but

- RHC treatment space and patient care space must be clearly delineated
- RHC patient care areas cannot be shared with non-RHC providers ***during RHC operating hours***
    - Can use space on different days
    - Can use space during different hours

Can share treatment space with non-RHC services, e.g., diagnostic testing, lab, emergency care, but:

- non-RHC personnel cannot travel through RHC space to utilize shared treatment space during RHC hours of operation
- If shared treatment space (e.g., x-ray, emergency room), non-RHC personnel must have a separate entrance that is not in the RHC patient care or treatment space.
- Costs have to be appropriately allocated between RHC and non-RHC functions
    - Allocations can be based on time studies on RHC vs. non-RHC functions
        - Must be conducted 1 week per month on different weeks for a full calendar year
        - Must be conducted for each cost reporting year
    - If staff shared, their benefits must be allocated as part of overhead allocation process
- May make more sense for non-RHC to provide services to RHC rather than having the two share the space.
    - Non-RHC can bill Medicare for services that would not be separately billable by RHC under single encounter rule.
        - E.g, triaging urgent or emergency care patients.
        - Lab services that are not billable by an RHC.
        - Procedures that RHC can not separately bill for.

Can share other types of space with non-RHC services, e.g., reception, lavatories, break room, etc.

- Must allocate cost of shared space for spaces that can be included in RHC's costs for determining AIR.

SHARED STAFF AND SERVICES:

An RHC can share staff (e.g., receptionist), telephones, etc.) with a non-affiliated medical practice.

- If receptionist shared, there must be separate patient registrations
- Costs have to be appropriately allocated between RHC and non-RHC functions
    - Allocations can be based on time studies on RHC vs. non-RHC functions
        - Must be conducted 1 week per month on different weeks for a full calendar year
        - Must be conducted for each cost reporting year
- If staff shared, their benefits must be allocated as part of overhead allocation process
- If staff performing testing shared, allocate the average wage, including benefits, of the employee performing the tests to the RHC based on the time required to conduct the test multiplied by the number of tests performed for the RHC during the year.

Visiting Specialists either:

- Bill through RHC
- Rents space, provides staff & bills separately –
    - RHC would have to carve space and overhead out of cost report