Primary Care Options in Rural Healthcare

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Overview

- A health system in New York would realize a $1.1M net financial benefit by converting 5 practices to provider-based Rural Health Clinics
  - *(5 practices had a combined 47K visits)*

- A health system in Virginia would realize a $7.1M net financial benefit by converting 3 practices from free-standing health clinics to provider-based Rural Health Clinics
  - *(3 practices had a combined 116k visits)*

- A hospital in Missouri would realize a $505K net financial benefit by integrating 8 provider-based specialty providers with their provider-based Rural Health Clinic
  - *(8 providers had a combined 4k visits)*

- A hospital in Massachusetts would realize a $396K net financial benefit by converting a freestanding health clinic to a provider-based Rural Health Clinic
  – *(practice had 14k visits)*

Overview

- Overview
- Definitions / Regulations
- Strategic Options
- Case Studies
- Questions

Overview

- With uncertainty around a majority of significant provisions, such as 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 those market changes; especially in rural healthcare
  - The patients served, clinic location, and provider productivity must all be considered when developing a primary care strategy
- Since the hospital and clinic designation type can impact reimbursements and other opportunities received by the clinic, hospitals should evaluate each of the following clinic designation types to ensure an appropriate strategy:
  - Federally Qualified Healthcare Center (FQHC)
  - Provider-Based Clinic (PBC)
  - Rural Health Clinic (RHC)
    - Includes Provider-Based Rural Health Clinic (PB-RHC)
  - Free-Standing Health Clinic (FSHC)

DEFINITIONS / REGULATIONS

2019 OPPS Final Rule

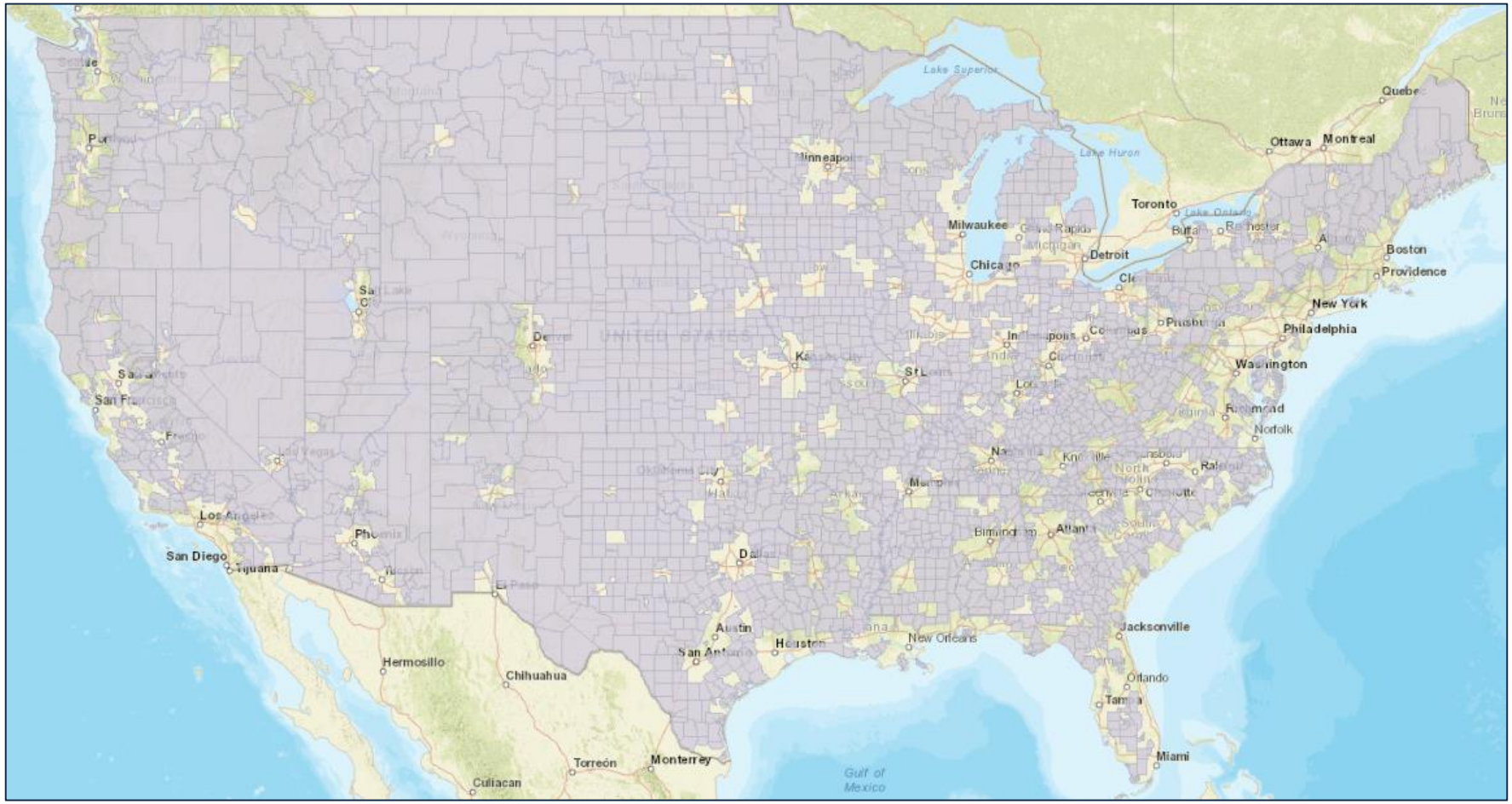
- The Bipartisan Budget Act (BBA) of 2015 clearly identified excepted provider-based items and services as those permitted to bill for items and services under OPPS after January 1, 2017, as the following:
  1. By a dedicated emergency department;
  2. By an off-campus PBD that was billing for covered OPD services furnished prior to November 2, 2015, that has not impermissibly relocated or changed ownership; or
  3. In a PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital.
- CMS removed #2 above for clinic visits which is the most common service billed under the OPPS, and CMS estimates this change will save the Medicare program and beneficiaries a combined $380m in 2019
  - Under the final rule, CMS is making payments for clinic visits site-neutral by reducing the payment rate for hospital outpatient clinic visits provided at off-campus provider-based departments by 60% with a two-year phase-in of this policy in 2019 and 2020

Rural and Shortage Area Designations

- 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
    - The Census Bureau defines urban as the following:
      - 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 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
    - For the purposes of RHC designations, an UC is a rural area

Rural and Shortage Area Designations

- **Rural Area Designations**



Rural and Shortage Area Designations

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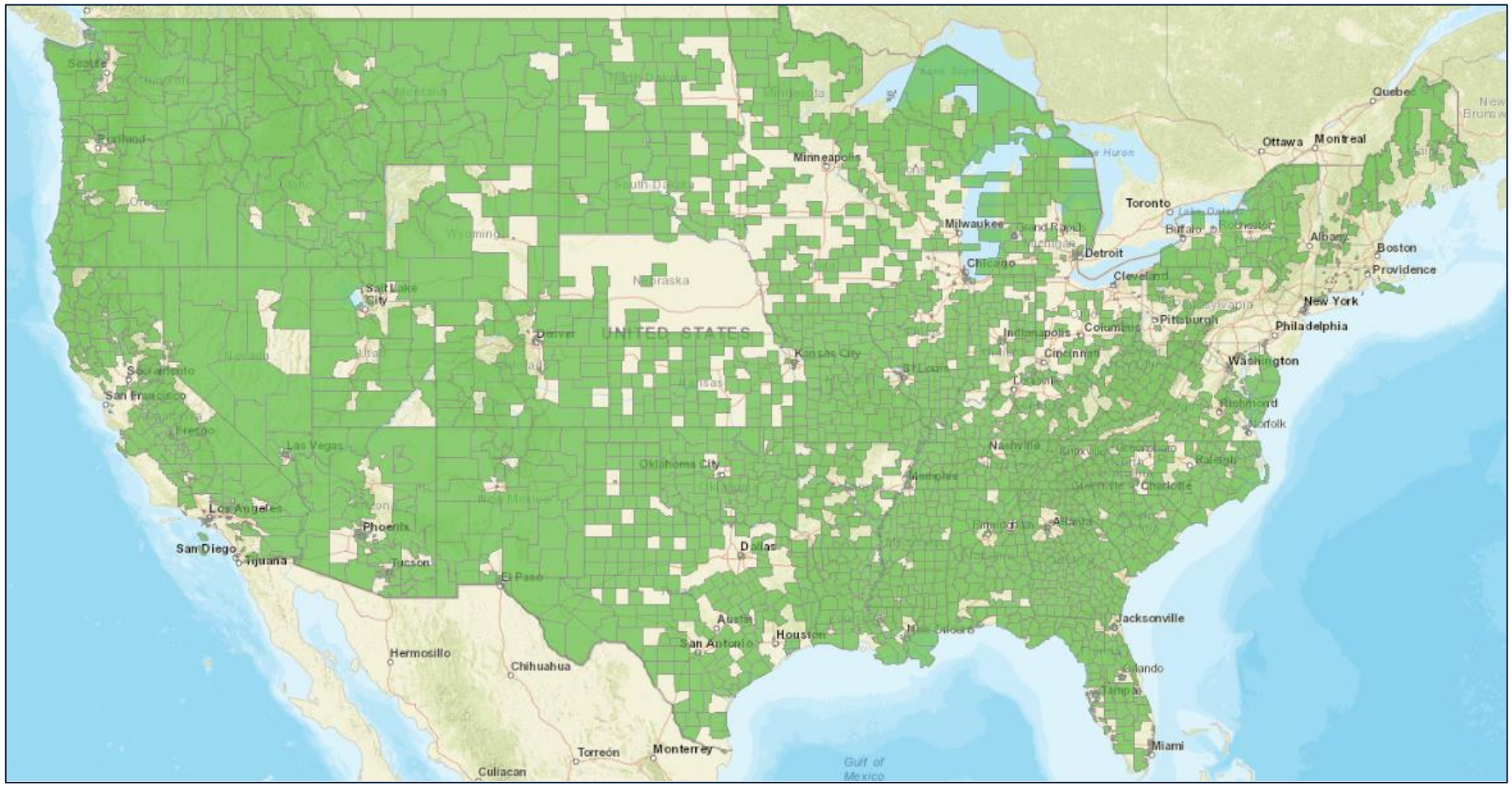
- **Health Professional Shortage Area (HPSA)**
  - Health Professional Shortage Areas (HPSAs) are designations that indicate health care provider shortages in:
    - Primary Care;
    - Dental Health; or
    - Mental Health
  - These shortages may be geographic, population, or facility-based:
    - Geographic Area
      - A shortage of providers for the entire population with a defined geographic area
    - Population
      - A shortage of providers for a specific population group(s) within a defined geographic area (e.g. low income, migrant farmworkers, etc.)
    - Facilities
      - Includes Other Facility (OFAC), Correctional Facility, State Mental Hospitals, and Automatic HPSAs (Auto HPSAs)

Rural and Shortage Area Designations

- **Health Professional Shortage Area (HPSA)**
  - Primary Care



Rural and Shortage Area Designations

- **Governor's Designated Shortage Areas**
  - The process for governor's designation for Rural Health Clinic certification requires the submission of a Shortage Area plan which requires HRSA approval and often includes the following requirements:
    - Located in a non-urbanized area, contiguous area
    - Cannot be eligible for, or located in, a HPSA or MUA designated within the last 4 years
    - Accept Medicare, Medicaid, and the state's CHIP patients and have a sliding fee scale for patients below 200% FPL
    - Population-to-primary care physician ration of at least 2,400:1, or a ratio between 2,000:1 and 2,399:1 and meet one of the following:
      - Percent of service area population under 200% FPL is higher than state average
      - Population percent over 64 is higher than state average
      - Unemployment percent is higher than state average
      - Uninsured population is higher than state average; or
      - Unusually high health indicators such as heart disease, diabetes, chronic respiratory disease, etc.

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 an MUA, the clinic must operate in an 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

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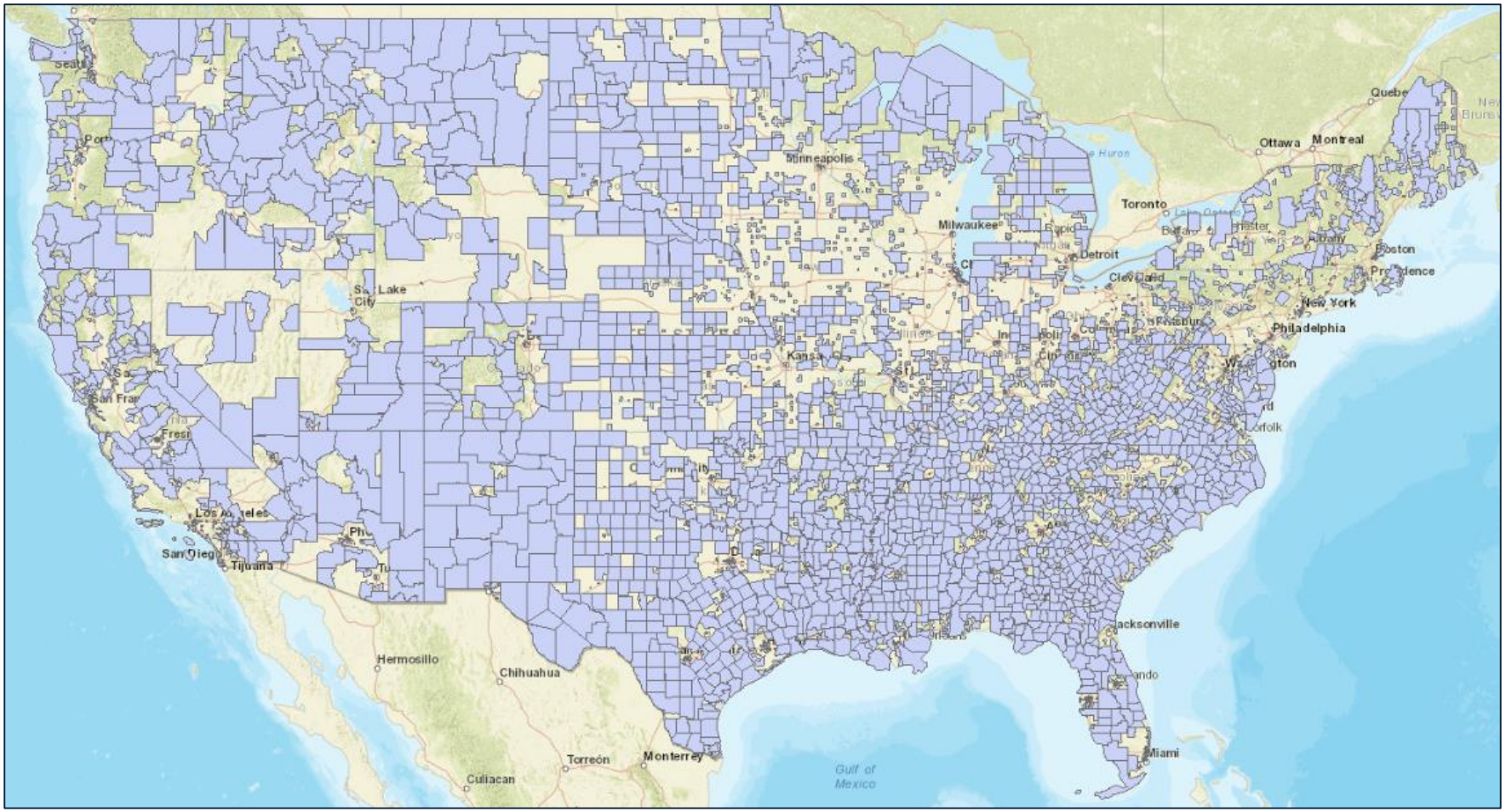
- **Medically Underserved Population (MUP)**
  - MUPs are specific sub-groups of people living in a defined geographic area with a shortage of primary care health services
  - These groups may face economic, cultural, or linguistic barriers to health care and include, but are not limited to, those who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

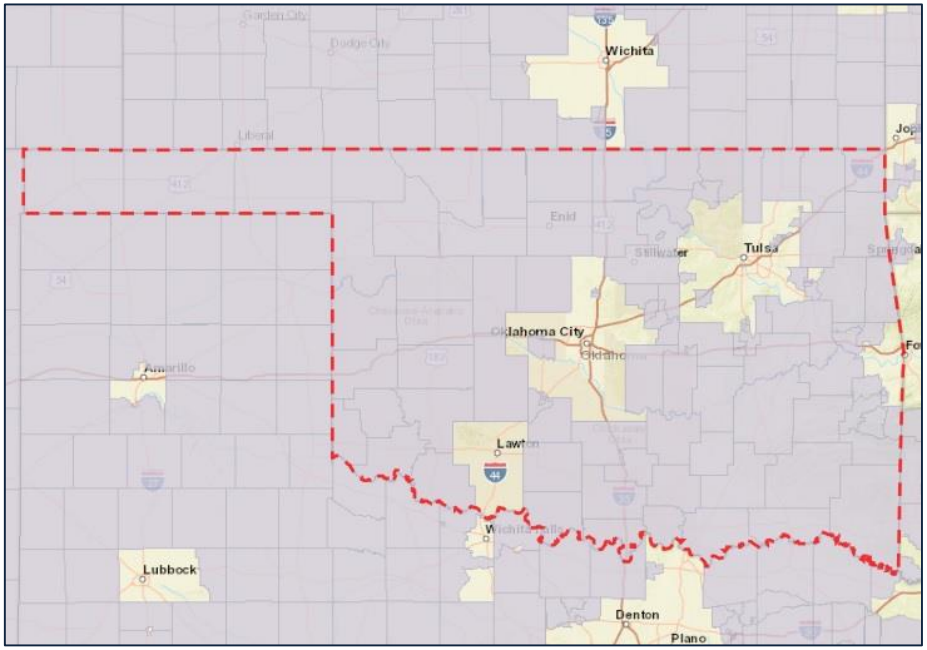
- **Medically Underserved Areas and Populations**



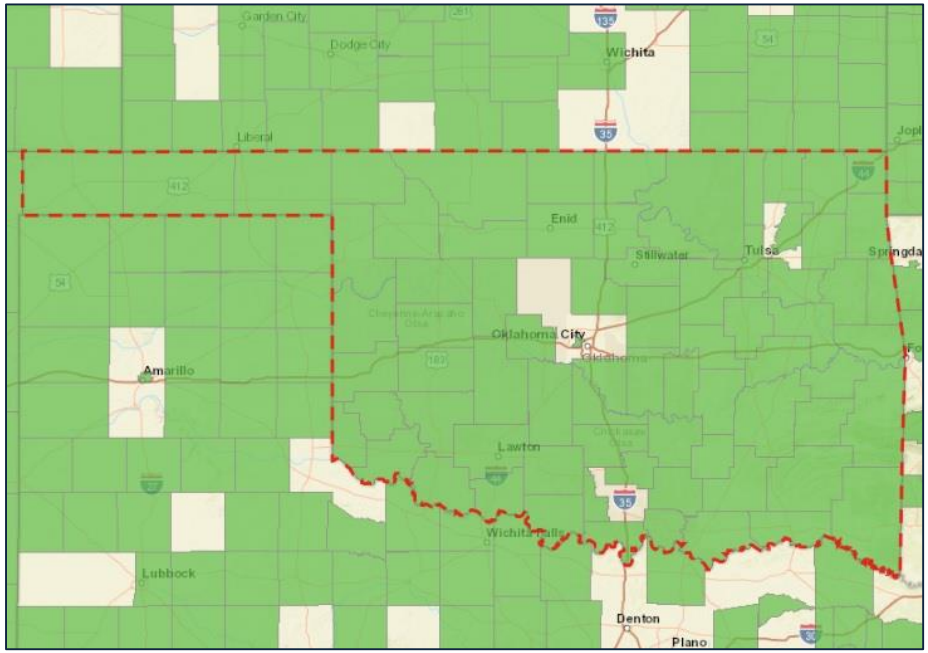
SORH Assistance

- SORH plays a critical role in the ability of hospitals to qualify for certain designations
  - HPSA Designation and Renewal
  - RHC Rate Establishment
  - Rural Designation
  - Application Assistance
  - CAH Distance Analysis
  - Provider-Based Requirements

Rural Areas



HPSA – Primary Care



Primary Care Clinic Designation Types

- As seen, each of the four clinic types evaluated encompass different reimbursement methodologies that greatly impact reimbursements received from Medicare and Medicaid
  - The table below highlights those differences

Reimbursement Options	FQHC	CAH	<50 Beds	FSHC
		PBC	PB-RHC	
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
Additional Materials	**Appendix 1**	**Appendix 2**	**Appendix 3**	**Appendix 4**

- Additional Definitions/Regulations included as an Appendix to this presentation
- * For non-CAHs, Hospital needs to meet DSH % to qualify for 340B

STRATEGIC OPTIONS

Systems Approach to Revenue Optimization

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- 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 those practices can meet certain eligibility requirements:
    1. Convert eligible practices within a health system or at a hospital to a designation that provides the 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 less than 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, will increase in functional, contractual, and governance alignment and increase the attributed lives associated with the hospital / health system

CASE STUDIES

Opportunity 1: Multi-hospital System (NY)

- A five-hospital system with more than 1,000 physicians and other clinicians
  - Hospitals include:
    - A 400-bed, short-term acute facility
    - A 320-bed, short-term acute facility
    - A 60-bed, short-term acute facility
    - A 25-bed Critical Access Hospital (CAH)
    - HMA, a 75-bed, short-term acute facility
- HMA operates five PBCs
  - 4 practices are off-campus and would be impacted by site neutrality
- HMA engaged Stroudwater to compare the net impact on reimbursements under the following scenarios:
  - Scenario #1: Reimbursements received as PBCs under HMA both before and after implementation of 2019 OPPS Final Rule
  - Scenario #2: Reimbursements received as PB-RHC under HMA with more than 50 beds
  - Scenario #3: Reimbursements received as PB-RHC under HMA with fewer than 50 beds

Opportunity 1: Multi-hospital System (NY)

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

Summary Data	Scenario #1 Before 2019 Final OPPS Rule (PBE)	Scenario #1 After 2019 Final OPPS Rule (PBE)	Scenario #2 PB-RHC >50 Beds	Scenario #3 PB-RHC <50 Beds
Medicare / Medicaid Average	$ 143.17	$ 127.65	$ 82.30	$ 183.42
Annual Visits	27,338	27,338	27,338	27,338
Reimbursements Received	$ 3,913,934	$ 3,489,588	$ 2,249,917	$ 5,014,296
340B Benefit	n/a	n/a	n/a	n/a
Variance w/ Before 2019 PBE (Scenario #1)		$ (424,346)	$ (1,664,017)	$ 1,100,362
Variance w/ After 2019 PBE (Scenario #1)			$ (1,239,671)	$ 1,524,708

- **Study Outcomes:**
  - Operating the five locations as PB-RHCs under a hospital with less than 50 beds led to the highest average reimbursement from Medicare and Medicaid
    - Only 4 of the 5 practices were off-campus and thus the ($424K) impact was limited to those practices

Opportunity 2: Multi-hospital System (VA)

- HMB is a not-for-profit, 1,000-bed, multi-hospital system with regional health care centers providing services to more than 1 million people throughout Virginia
  - System includes, but not limited to:
    - A 600-bed short-term acute care facility
    - A 35-bed short-term acute care facility
    - A 25-bed critical access hospital (CAH)
    - A 25-bed critical access hospital (CAH)
    - A primary care physician group with more than 200 practice sites and 700 employed providers

Opportunity 2: Multi-hospital System (VA)

- HMB engaged Stroudwater to quantify and compare the financial advantages and disadvantages of 3 practices currently designated as FSHCs with the PB-RHC designation under the following scenarios:
  - Scenario #1: Reimbursements received as a FSHC
  - Scenario #2: Reimbursements received as PB-RHCs aligned under the 35-bed PPS hospital
  - Scenario #3: Reimbursements received as a PB-RHCs split between the two CAHs
- Due to location and proximity, none of the clinics could operate as a PBC under a CAH or receive an APC payment under a PPS hospital

Opportunity 2: Multi-hospital System (VA)

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

Summary Data	Scenario #1 FSHC	Scenario #2 PB-RHCs under STAC	Scenario #2 PB-RHCs under CAHs
Practices Impact			
Medicare / Medicaid Average	$ 109.58	$ 179.82	$ 181.32
Annual Visits	75,174	75,174	75,174
Reimbursements Received	$ 8,237,552	$ 13,517,880	$ 13,630,349
Critical Access Hospital Impact			
Medicare / Medicaid Reimbursement	$ -	$ -	$ (1,879,112)
340B Revenue	-	-	3,577,538
Reimbursements Received	$ -	$ -	$ 1,698,426
Variance w/ FSHC (Scenario #1)		**$ 5,280,328**	**$ 7,091,223**

- **Study Outcomes:**
  - Operating the three locations as PB-RHCs led to the highest average reimbursement from Medicare and Medicaid
    - This option would also allow the clinics to pursue the 340B benefit
  - The STAC in Scenario #2 did not have a high enough DSH % to qualify for the 340B program

Opportunity 3: Independent Hospital

- HMC is a 15-bed, not-for-profit Critical Access Hospital (CAH) that services approximately 10,000 residents
  - HMC operates the following primary and specialty care clinics:
    - HMC Family Care Clinic, which is designated as a Provider-Based Rural Health Clinic (PB-RHC)
    - HMC Center Specialty Clinic on campus, which is designated as a PBC
      - Specialty practice included 7 providers with a combined FTE of 0.8
- HMC engaged Stroudwater to compare the net impact on reimbursements under the following scenarios:
  - Scenario #1: Reimbursements received as a PB-RHC and PBC specialty practice under HMC
  - Scenario #2: Reimbursements received as an integrated PB-RHC (primary and specialty care) under HMC

Opportunity 3: Independent Hospital

- The following table shows an 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 / Medicaid Average	$ 217.55	$ 235.57
Annual Visits	2,954	2,954
Reimbursements Received	$ 642,655	$ 695,874
Primary Care Practice		
Medicare / Medicaid 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 (PBC) with the PB-RHC would lead to an increase in reimbursements of $505K from Medicare and Medicaid

Opportunity 4: Multi-hospital System (MA)

- A two-hospital system that provides services to over 50,000 residents throughout multiple counties
  - Hospitals include:
    - A 135-bed, short-term acute facility
    - HMD, A 25-bed Critical Access Hospital (CAH)
- HMD entered into acquisition discussions with an independent 3-provider FSHC in the same town as the hospital
- HMD engaged Stroudwater to compare the net impact on reimbursements under the following scenarios:
  - Scenario #1: Reimbursements received as a free-standing independent physician practice
  - Scenario #2: Reimbursements received as a PB-RHC under HMD with fewer than 50 beds

Opportunity 4: Multi-hospital System (MA)

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

Summary Data	Scenario #1 FSHC	Scenario #2 PB-RHC
Independent FSHC		
Medicare / Medicaid Average	$ 97.03	$ 197.89
Annual Visits	2,833	2,833
Reimbursements Received	$ 274,889	$ 560,622
Critical Access Hospital		
Medicare / Medicaid Reimbursement	$ 10,044,434	$ 9,971,421
340B Revenue	-	183,240
Reimbursements Received	$ 10,044,434	$ 10,154,661
Variance w/ FSHC (Scenario #1)		**$ 395,960**

- **Study Outcomes:**
  - Acquiring and operating the clinic as a PB-RHC under HMD would lead to an increase in reimbursements of $396K from Medicare and Medicaid

QUESTIONS

APPENDIX

Appendix 1 – 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 has the ability to operate an FQHC within the system

Appendix 1 – Federally Qualified Health Center

- **Federally Qualified Health Center (FQHC)** ***(continued)***
  - An FQHC receives the following reimbursement and additional funding opportunities
    - Enhanced reimbursement from Medicare, which is the lesser of 80% of charge or the FQHC PPS rate
      - Encounters with more than one FQHC practitioner on the 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 the FQHC provides services to a new patient or to patient for Initial Preventative Physical Exam (IPPE) or an Annual Wellness Visit (AWV)
          - A new patient is one who has not received services at the FQHC, or by a provider associated with the FQHC, in the last three years

Appendix 1 – Federally Qualified Health Center

- **Federally Qualified Health Center (FQHC)** ***(continued)***
  - 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
- 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)

Appendix 2 – Provider Based Entity

- **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 and patients must be made aware when they enter the PBC that they are entering a department of the main provider and will be billed accordingly
    - 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

Appendix 2 – Provider Based Entity

- **Provider-Based Clinic (PBC)** ***(continued)***
  - 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
      - In 2019, off-campus PBCs will receive the same reimbursement as freestanding practices due to site neutrality
    - 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

Appendix 3 – 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
    - 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 the U.S. Census Bureau, and located in a 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 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

Appendix 3 – Rural Health Clinic

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- **Rural Health Clinic (RHC)** ***(continued)***
  - A PB-RHC is an RHC meeting the criteria of a PBC
    - 42 CFR 405.2401(b) excludes RHCs from the list of PBCs 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 PBC 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 fewer than 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

Appendix 4 – Free-Standing Health Clinic

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- **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 mid-levels
  - 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
    - An off-site FSHC will not jeopardize or bring to question the federal distance requirements of a CAH

Appendix 5 – Critical Access Hospital Impact

- **Critical Access Hospital (CAH)**
  - The clinic designation type selected will not only impact reimbursements received, but could also jeopardize the 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 a 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-site PBC, unless the entity is a PB-RHC, is required to meet distance requirements based on the location of the acquired entity
  - Section 42 CFR 413.65(e)(3)(i) requires all off-campus provider-based facilities to be located within a 35-mile radius of the campus of the hospital or CAH that is the potential main provider
    - Already-established RHCs are excluded from the list of off-campus facilities subject to this provision

Appendix 5 – Critical Access Hospital Impact

- **Critical Access Hospital (CAH)** ***(continued)***
  - 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 which does not meet the distance requirements would lead to the loss of their CAH designation even if the CAH is designated as a necessary provider

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