Rural Health Clinics

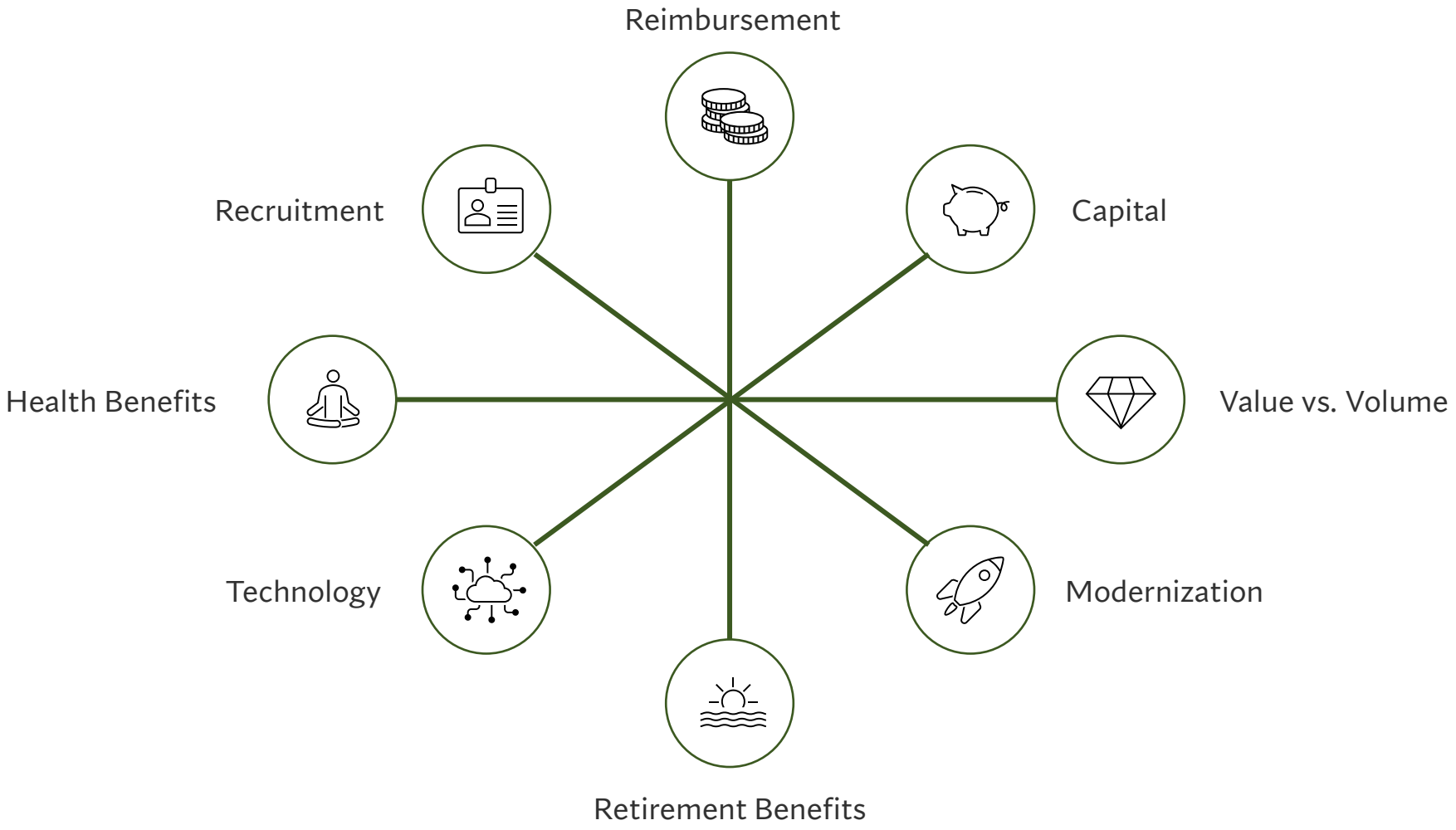
Optimizing RHC Reimbursement Opportunities

April 24, 2025

WINTERGREEN

OVERVIEW

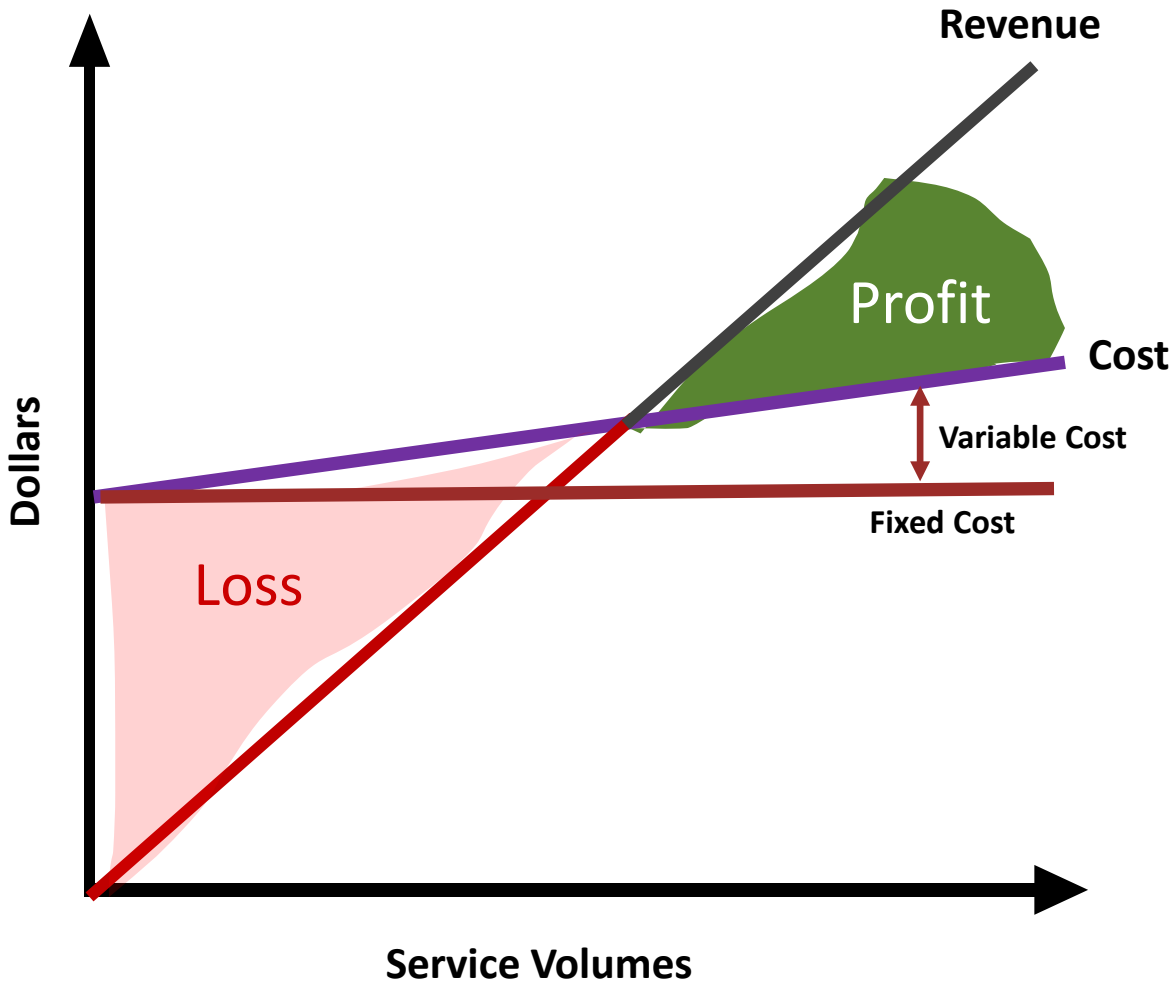
Interdependence of Major Drivers



DOING MORE WITH LESS

Economic Philosophy

- The financial solvency of a RHC is dependent upon the realization that revenue (volume) and expenses both contribute to the financial position of an organization
  - Value is unlocked by marginal revenue gains that help dilute down a high fixed cost environment
  - Organizations need to understand the different and impact of contribution margin
  - Cost-based reimbursement will not generate profit and only cover the costs for those proportional services
  - RHCs must break down the silos between quality and finance for improved outcomes

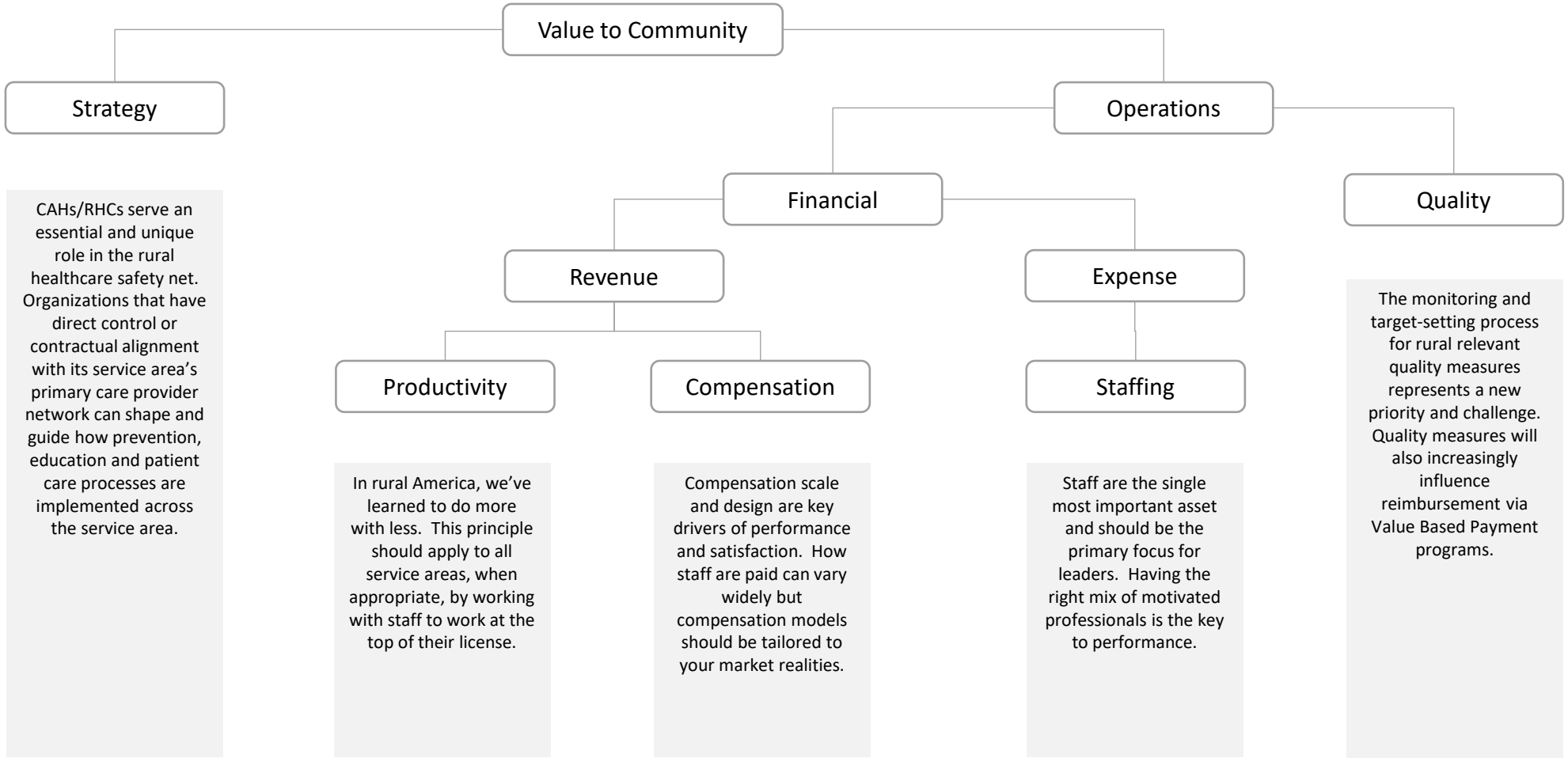


Payment Model – Fee-For-Service

- Under the fee-for-service payment methodology, providers receive payment for specific, individual services provided to a patient
  - The services provided and complexity of those services dictate the reimbursements received by the provider
  - The following table identifies several pros and cons associated with the fee-for-service reimbursement model

PROS	CONS
Encourages and incentivizes the delivery of care and maximizing patient visits	Does not incentivize providers to offer efficient and effective care
Offers great flexibility in the delivery of care	Limits care coordination and the management of specific conditions due to the lack of reimbursement for those services
Holds providers directly accountable for the services the provide	The system is complicated and patients often have difficulties management the system
Affords patients the opportunity to search out different providers of care	Can lead to unnecessary or more costly procedures due to the reimbursements received for those procedures

Performance Model



Alignment and Designation Strategies

- 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*

Practice Alignment and Designation

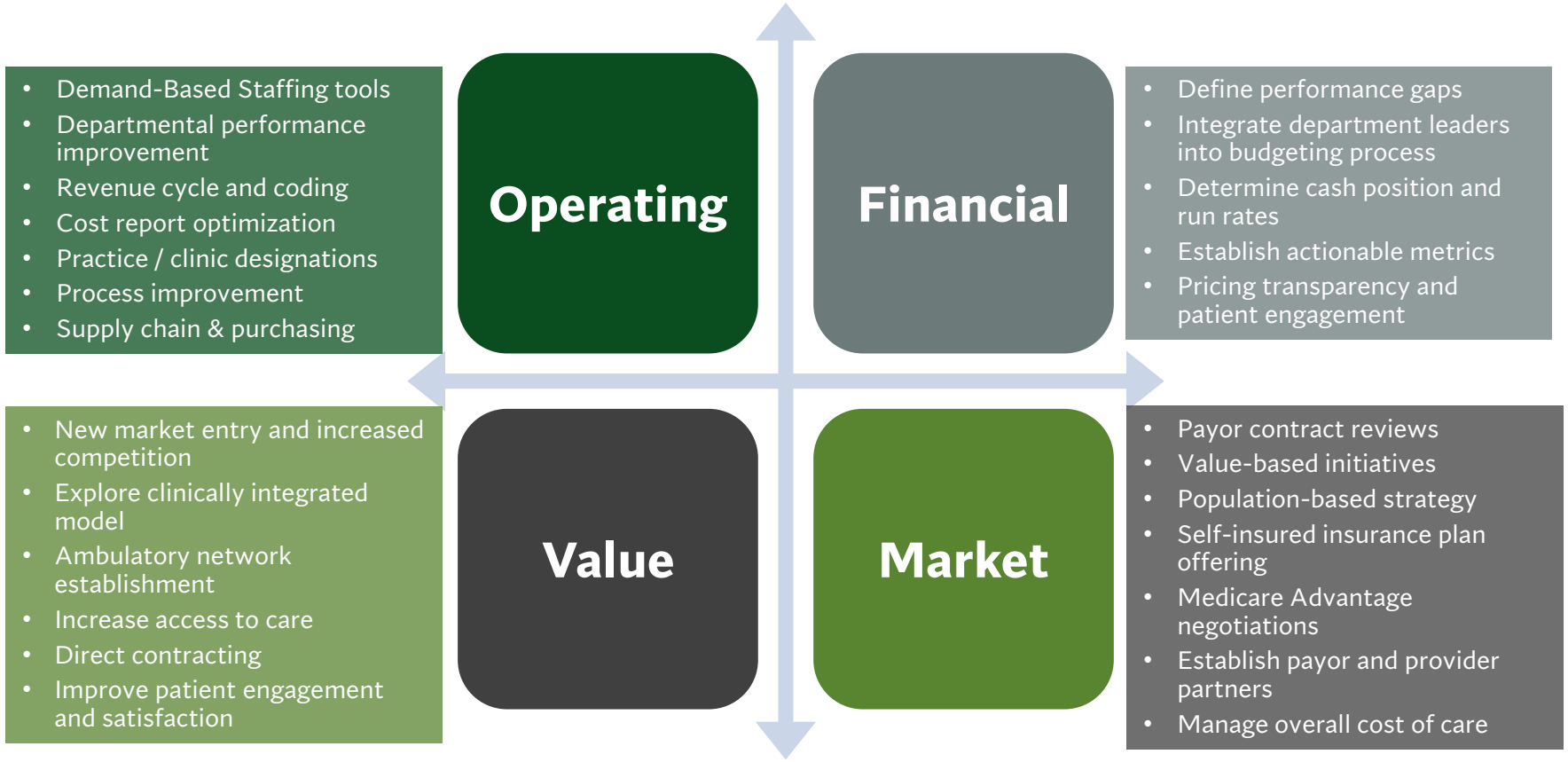
- The following table shows the net financial impact of different designations on a hospital:

			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)

- Outcomes:
  - 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

Performance Improvement Opportunities

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



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

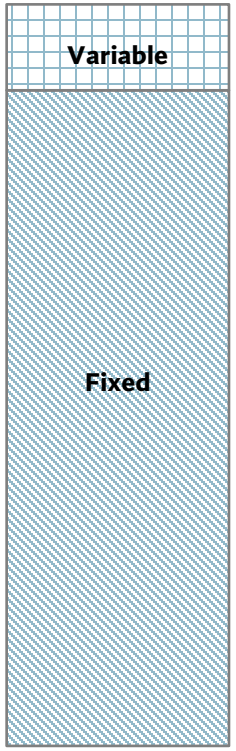
RHC Cost Structure

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.

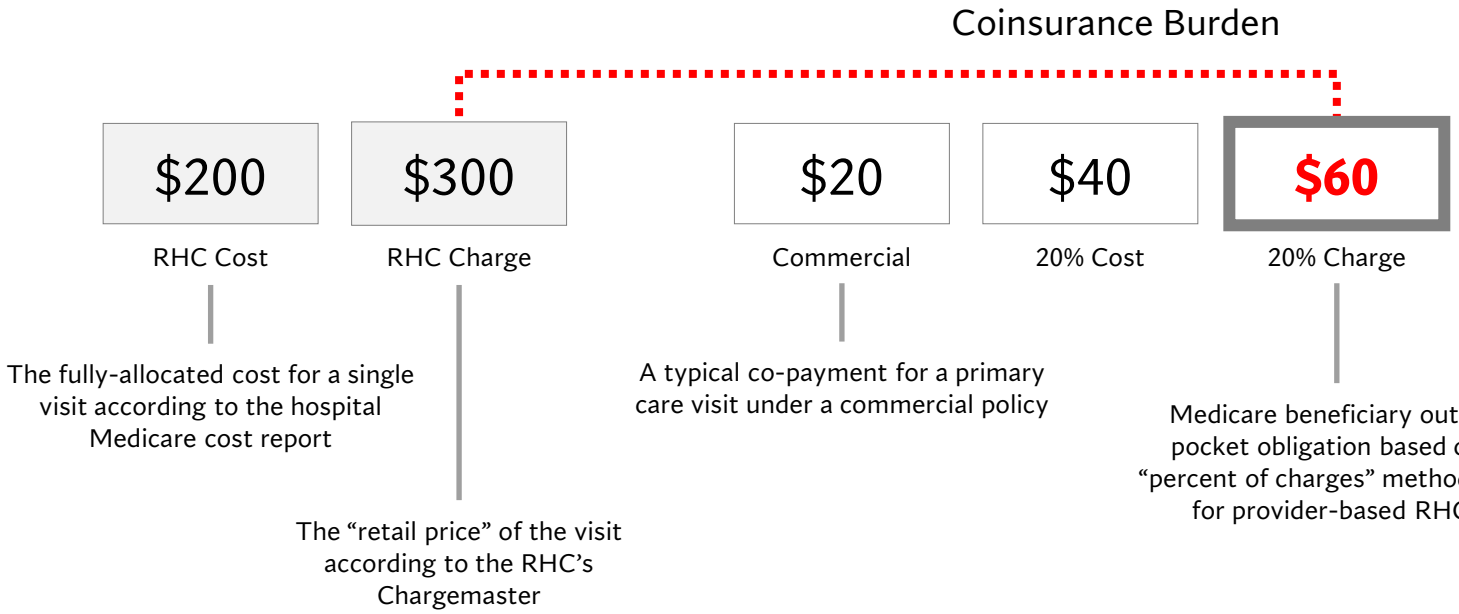
Medicare Economic Index (MEI)

- 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]	CY 15[2]	CY 16[3]	CY 17	CY 18	CY 19	CY 20	CY 21	CY 22	CY 23	CY24	AVERAGE
Market Basket Update	0.8	1.1	1.2	1.4	1.5	1.9	1.4	2.1	3.8	4.6	2.0

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

RHC Charge Structure



30%

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

High prices disproportionately impact Medicare Beneficiaries

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

Provider Productivity and Engagement

CMS no longer 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

Cost Report Opportunities

- 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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ALLOCATION OF OVERHEAD TO HOSPTIAL-BASED RHC/FQHC SERVICES	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET M-2

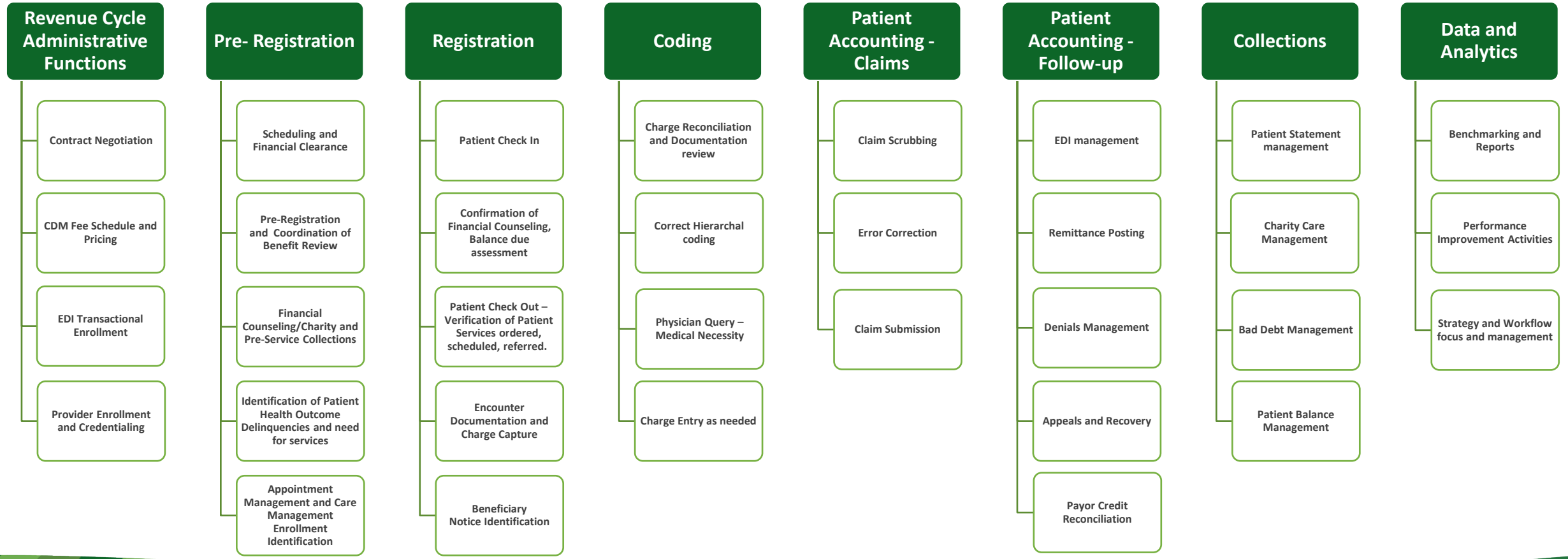
Check applicable box: [ ] Hospital-based RHC [ ] Hospital-based FQHC

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (sum of lines 1-3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4-7)						8
9	Physician Services Under Agreements						9

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



Revenue Cycle

- **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

Payment Model – Value-Based Care

- Under a value-based payment model (often referred to as accountable care, population health, or at-risk contracting) organizations receive payments for specific objectives, such as reducing costs and improving quality, instead of directly providing care to patients

- The following are the 4 main types of value-based models:
  - Shared Risk: Requires organizations to keep costs at or below a certain target
  - Bundles: Rewards organizations to reduce costs associated with certain services within the bundle
  - Global Capitation: Focused on per member, per month (PM/PM) agreement where members share in short-term and long-term costs
  - Shared Savings: Incentivizes organizations to meet a target budget spend

Patient Centered Medical Home (PCMH)

Patient-centered medical home is a model of care where patients have a direct relationship with a provider who coordinates a cooperative team of healthcare, whether you're being seen at the doctor's office, if you become hospitalized or recuperating at home, through ongoing preventative care

Why become a PCMH as a value-based strategy	Medicare has moved to change how it structures payment from a quantity to a quality approach Medicare will provide incentives for better processes and outcomes Medicaid programs have made enhanced payments to providers who achieved certain distinctions or process measures
Benefits of a PCMH strategy	Make primary care more accessible, comprehensive and coordinated. Provides better support and communication Creates stronger relationships with your providers Improves patient outcomes Lowers overall healthcare costs
Benefits of a PCMH to the Bottom Line	A more efficient use of practice resources, resulting in cost savings A practice equipped to take advantage of payment incentives for adopting medical home functions A practice is better prepared for enhanced payment under MIPS or Alternative Payment Models, to participate in an ACO, and provide chronic care management services

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

QUESTIONS

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