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Overview of today's discussion points

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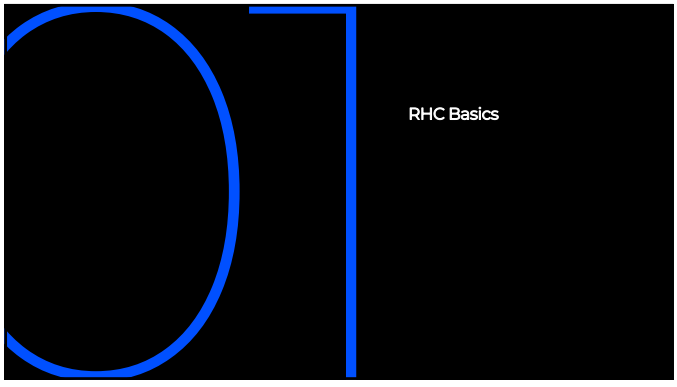

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RHC Qualifications – The Basics

- Located in a non-urbanized area(based on census data)
- Current underserved designation (Population HPSA, Geographic HPSA, MUA, or Governor's designated)
- ~~Primarily~~ engaged in primary care services
- Non-physician practitioner coverage at least 50% of time clinic is open
- Operates under medical direction of a physician
- Ability to furnish ~~six~~ four basic lab services
- RHC can be provider-based or free-standing (RHCs are provider-based "entities," have separate CCN)
- Paid an all-inclusive rate (AIR) per encounter

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HPSA Designations

- Note that primary care HPSAs are currently under review by HCAi, and many have already been revoked due to non-response by facilities.
- There is nothing to decertify a clinic that loses its HPSA or non-urbanized status.
- However, a change to the RHC (relocation, change of ownership) could cause a review of the location requirements.
- There may be other benefits of the HPSA (HPSA bonus payments).
- The window is opening March 15th and will be open through September

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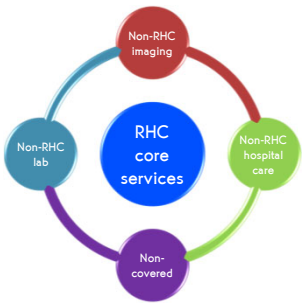
RHC Basics (Medicare)



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RHC Billing – The Basics

RHC billing differences

Service	Independent	Provider-based
Laboratory (excluding the draw procedure, e.g., CPT 36415)	Billed to Part B carrier – existing group number on Form 1500	Billed on hospital O/P claim type (14x, 13x or 85x) on Form UB-04
Other diagnostic/radiology – professional component	May be billed with encounter. If read by non-RHC provider, they will bill the carrier.	May be billed with encounter. If read by hospital radiologist, bill the carrier.
Other diagnostic/radiology – technical component	Billed to Part B carrier – existing group number on Form 1500	Billed on hospital O/P claim type (13x or 85x) on Form UB-04
Non-RHC professional services (I/P, ER, other O/P services)	Billed to Part B carrier – existing group number on Form 1500	Billed to carrier using existing group number (or if elect Method II as CAH, bill FI for ER & other O/P pro fees)

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RHC Billing – The Basics

RHC billing differences

Service	Independent	Provider-based
RHC services (face-to-face encounter in RHC site of service)	Billed to independent RHC regional Medicare Administrative Contractor (MAC) – RHC provider number on Form UB-04	Billed to host (e.g., hospital) provider MAC – RHC provider number on Form UB-04
Care management services – Transitional Care Management	Same as above – If it is the only service provided at time of visit, can be paid as stand-alone visit at the AIR. If furnished on the same day as another visit, only one visit is paid.	Same as above – If it is the only service provided at time of visit, can be paid as stand-alone visit at AIR. If furnished on the same day as another visit, only one visit is paid.
Care management services – All other (i.e., Chronic care, behavioral health integration, Psychiatric Collaborative Care Model)	Submitted to RHC MAC on a UB-04 – Except not paid at AIR, it is paid based on national average FFS payment (use G0511 or G0512)	Submitted to host provider MAC on a UB-04 – Except not paid at AIR, it is paid based on national average FFS payment (use G0511 or G0512)

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Consolidated Appropriations Act, 2021

To maintain financial health and viability, rural health clinics (RHCs) have the following issues to address:

1. **All newly-certified RHCs are set at the same cap**
2. **Definition of "Grandfathered RHCs"**
3. **How do RHCs optimize their reimbursement based on changes in the payment rules**
4. **What strategies are available to optimize payment**

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Caps for "newly certified" or freestanding RHCs

- New limitations for independent RHCs, those with hospitals greater than 50 beds, and all "new" provider-based RHCs with hospitals less than 50 beds.
  - 2024 $139.00
  - 2025 $152.00
  - 2026 $165.00
  - 2027 $178.00
  - 2028 $190.00

After 2028 and in subsequent years, the cap is increased by the Medicare Economic Index (MEI).

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Caps for "grandfathered RHCs"

- Existing provider-based RHCs furnishing services as of December 31, 2020, where bed availability was less than 50 beds, will establish a base year rate based on the finalized 2020 Medicare cost report OR the first finalized Medicare cost report which contains the clinic's expenses for a full year.
- This base year rate ("limit") will be increased annually by the Medicare Economic Index (MEI).
- MEI for CY 2025 was 3.5%.

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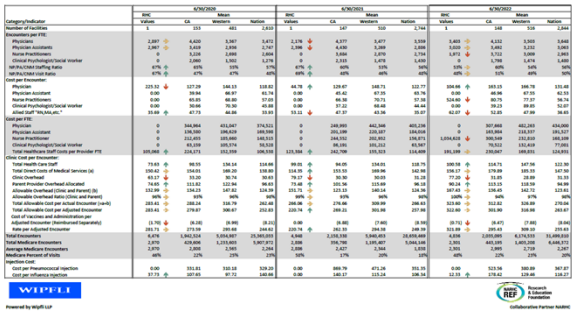
Wipfli/NARHC Rural Health Clinic Benchmark Report



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Sample Market Demand

Primary care provider supply and demand, current and 5-year projections

	PSA, 2024			PSA, 2029		
	Supply	Demand	Variance	Supply	Demand	Variance
Primary Care						
Family Practice	5.6	3.4	2.2	5.6	3.4	2.2
Internal Medicine	1.1	2.8	(1.8)	1.1	2.8	(1.8)
Obstetrics/Gynecology	0.3	1.1	(0.8)	0.3	1.2	(0.9)
Pediatrics	0.0	1.4	(1.4)	0.0	1.5	(1.5)
Total	7.0	8.7	(1.7)	7.0	8.9	(1.9)

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Other clinic indicators

- Production
- Staffing analysis
- In-migration/out-migration
  - patients
  - service-lines
- NET revenue

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RHC Strategies

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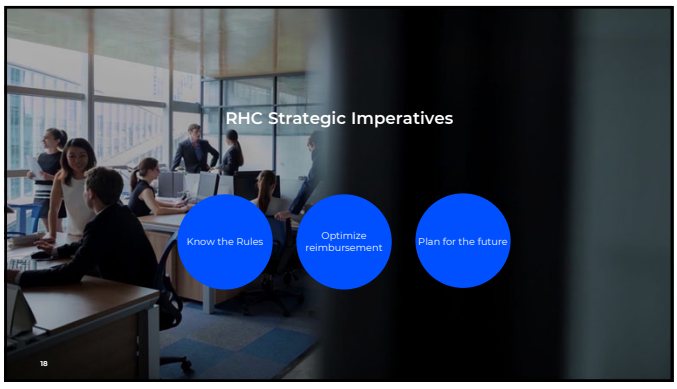

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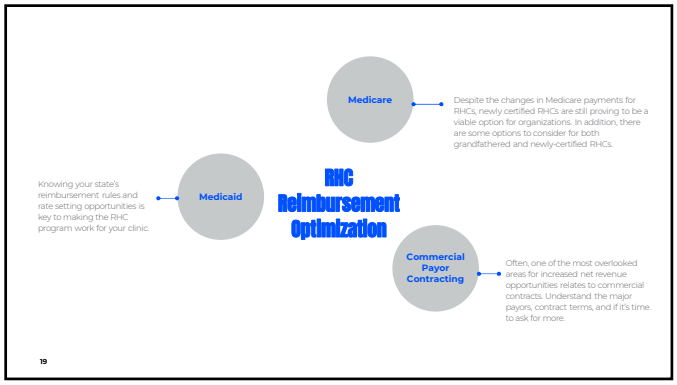
Medicare
Despite the changes in Medicare payments for RHCs, newly certified RHCs are still proving to be a viable option for organizations. In addition, there are some options to consider for both grandfathered and newly-certified RHCs.
Knowing your state's reimbursement rules and rate setting opportunities is key to making the RHC program work for your clinic.
Medicaid
RHC Reimbursement Optimization
Commercial Payor Contracting
Often, one of the most overlooked areas for increased net revenue opportunities relates to commercial contracts. Understand the major payors, contract terms, and if it's time to ask for more.
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Optimize Medicare/Medicaid Reimbursement
1 Has your rate been finalized and have you reserved for future adjustments?
2 Is there an opportunity to increase the rate?
3 Be mindful of future rate changes.
4 Keep existing "grandfathered" certifications.
5 Utilize any RHCs with the highest rates for future expansion.
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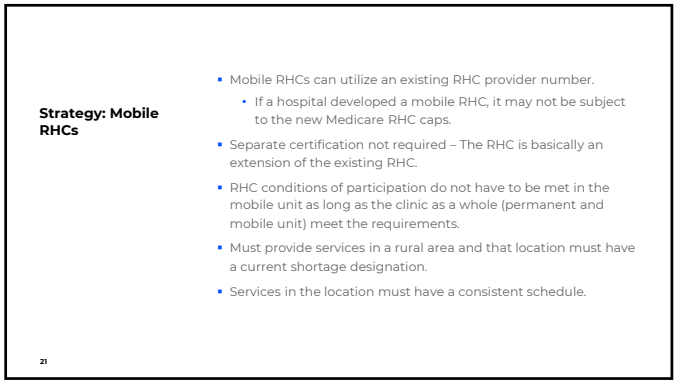
Strategy: Mobile RHCs
Mobile RHCs can utilize an existing RHC provider number.
If a hospital developed a mobile RHC, it may not be subject to the new Medicare RHC caps.
Separate certification not required – The RHC is basically an extension of the existing RHC.
RHC conditions of participation do not have to be met in the mobile unit as long as the clinic as a whole (permanent and mobile unit) meet the requirements.
Must provide services in a rural area and that location must have a current shortage designation.
Services in the location must have a consistent schedule.
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Strategy: Mental health services

- Beginning in 2022, Medicare pays mental health telehealth services as a "distant site" paying at the AIR.
- Patients must have been seen within the last 12 months (there are exceptions to the rule).
- This change in reimbursement allows RHCs to contract with remote behavioral health providers to offer telehealth visits and receive their AIR payment.

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Strategy: Mental health services (continued)

- Beginning 1/1/2024, the following additional RHC practitioners are recognized by CMS* and with services paid at the AIR.
  - Marriage and Family Therapists
  - A Mental Health Counselor is recognized as an individual who
    - ✓ Possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under the State law of the State in which such individual furnishes the services…
    - ✓ Is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished;
    - ✓ Meets such other requirements as specified by the Secretary.
  - CMS added Addiction Counselors to the definition of MHC

** Authorized through the passage of the Consolidated Appropriations Act of 2023*

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Strategy: HOPD to RHC or stay as existing HOPD?

- As the Medicare cap continues to grow, it may be advantageous to convert existing hospital outpatient department (HOPD) clinics to RHCs.
  - RHCs not subject to location/mileage requirements
- Medicare RHC rates may eventually be higher than the Medicare fee for service rates and APC/CAH facility payment.
- HOPD status could be advantageous depending on the service mix; specialty services are often reimbursed higher by Medicare in a HOPD.
- New RHCs can be considered a 340B child site.

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Strategy: Change of address

- "Grandfathered" RHCs can move and keep the existing RHC rate intact.
  - Note that Health Professional Shortage Area (HPSA)/Medically Underserved Area (MUA), rural, and conditions of participation must be met.
- Does your organization have a larger clinic that does not currently have RHC status?
- Could you move an already existing RHC certification with a grandfathered rate to a new site and recertify the smaller/less Medicare & Medicaid-utilized clinic? Or create a HOPD?

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Strategy: Review the Medicaid RHC rate

- Make sure your RHC Medicaid rates are maximized.
- Has your clinic considered a change in scope of services?

Note: A loss in Medicare RHC reimbursement may be offset by a gain in Medicaid RHC reimbursement. RHC status may still make sense depending on your state's RHC reimbursement rates and your clinic's payer mix.

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Strategy: Home Health Shortage Area Designation

Visiting nurse services

- Covered if service area is considered to have a home health shortage area designation
- Services rendered to homebound patients
- Patient furnished part-time/intermittent nursing care by RN, LPN, or licensed vocational nurse
- Needs to be an employee of RHC
- Services furnished under written POT:
  - Reviewed once every 62 days by supervising physician of RHC

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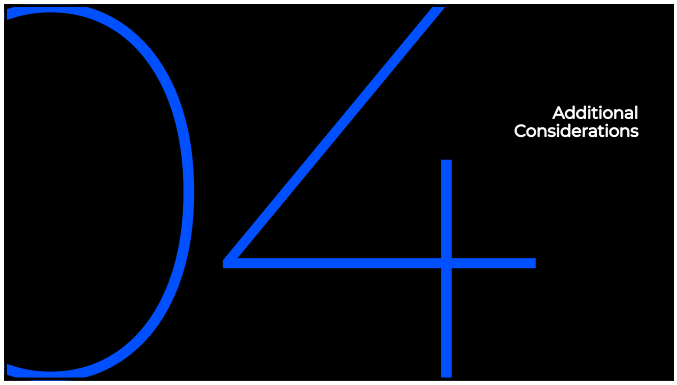

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CY 2025 PFS Final rule – RHC provisions that could affect future strategy

- Elimination of productivity standards
  - For cost reports ending after 12/31/2024, the 4,200 and 2,100 productivity standards per FTE have been eliminated for Physicians and Non-physician practitioners (PA, Nurse Practitioner & Certified Nurse Midwife), respectively
- Elimination of primary care predominance
  - Previously, RHC regulations stipulated that RHCs must be primarily engaged in providing outpatient services – CMS State Operations Manual, Appendix G provides interpretation that RHC must be primarily engaged (more than 50%) in providing primary care
  - The 2025 rule indicates:
    - *The clinic must provide primary care*
    - *The clinic is not a rehabilitation agency or facility primarily for the care and treatment of mental diseases*

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Additional Changes

- RHC Telehealth Policy limited extension protection
  - Current medical telehealth flexibilities will expire on March 31, 2025, in order to continue to bill using G2025 and receive payment under fee schedule amounts
- RHC Care Management Services
  - Beginning January 1, 2025, RHCs should bill on the RHC claim form, the specific CPT code (located here: https://www.cms.gov/center/provider-type/rural-health-clinics-center)
  - While some of the fee schedule reimbursements may be lower than the consolidated rate of $72.90, this change means RHCs will be eligible to bill for add-on time-based codes, too. Remote Therapeutic monitoring (RTM)
  - CMS has established a transition period for compliance with the new billing structure. From January 1, 2025, through July 1, 2025, RHCs may bill either G0511 or the individual CPT codes. After July 1, 2025, G0511 will no longer be reimbursable.

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Additional Changes

- Advanced Primary Care Management (APCM) services
  - A set of three G-codes intended to bundle existing care management codes based on complexity of patient condition, not time spent on each patient's care management activities, reimbursed as calendar month bundles. If an RHC bills for these codes, they will not bill for individual services.
  - These codes will be structured as follows:
    - G0556 – Patients with 0-1 chronic condition; ~$15 per month
    - G0557 – Patients with two or more chronic conditions; ~$50 per month
    - G0558 – Patients who are dual eligible with two or more chronic conditions; ~$110 per month
- Intensive Outpatient Program Services
  - Beginning 1/1/2024, RHCs can provide IOP services in order treat patients with acute mental illness (including depression, schizophrenia, substance use disorders, etc.). that need between 9-19 hours of care per week
  - Provided in person
  - Physician must certify patient for IOP and review no less than every other month
  - Reimbursement at $269.19 per patient per day equal to approximately three services per patient per day
  - Beginning January 1, 2025, will allow for RHCs to bill for the three or four ($408.55) services per day IOP, depending on the number of services provided.

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Additional Changes

- Pneumococcal, influenza, Covid-19 vaccines
  - Beginning, July 1, 2025, RHCs can bill for administration of Part B preventive vaccines (COVID-19, pneumococcal, influenza, and Hepatitis B???) at time of service, not entirely in a lump sum settlement on cost report, beginning July 1, 2025.
  - RHCs will still settle up to cost on the Medicare cost report (less what was paid during the year).
  - Is this optional or mandatory??

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Closing Comments

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Closing Comments

Things to think about

- Optimize the Medicare/Medicaid rates that for your RHC
- Assess current state
- Plan for the future utilizing your beneficial payment methodology

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