Primary Care Options in Rural Healthcare

Jonathan Pantenburg, MHA, Senior Consultant
JPantenburg@Stroudwater.com
September 15, 2017
Overview

- Market Updates

Definitions / Regulations

- Rural and Shortage Area Designations
- Primary Care Clinic Designations
- Critical Access Hospital Impact

Case Studies

- Maury Regional Health
- Susquehanna Health

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 Entity (PBE)
  • Rural Health Clinic (RHC)
    • Includes Provider-Based Rural Health Clinic (PB-RHC)
  • Free-Standing Health Clinic (FSHC)
On April 14, 2017, CMS released its IPPS Proposed Rule for 2018. Important proposals include:

- **CAH 96-hour certification requirement now a “Low Priority”**
  - Beginning October 1, 2017, CAHs will not receive any medical record requests from Medicare contractors related to 96-hour certification unless gaming suspected

- **Medicare Inpatient payment rate to increase 1.6%**
  - Market basket increase of 2.9% reduced by .4% productivity cut and .75 ACA reduction

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2018 inflation (market basket) update</td>
<td>2.9</td>
</tr>
<tr>
<td>Multifactor productivity adjustment</td>
<td>-0.4</td>
</tr>
<tr>
<td>Additional -0.75 percentage point update adjustment required by the ACA</td>
<td>-0.75</td>
</tr>
<tr>
<td>Subtotal – “applicable percentage increase”</td>
<td>1.75</td>
</tr>
<tr>
<td>Documentation and Coding Adjustment Required by 21st Century Cures Act</td>
<td>+0.4588</td>
</tr>
<tr>
<td>“2 Midnight” Adjustment</td>
<td>-0.6</td>
</tr>
<tr>
<td>Net increase in national standardized amounts (before application of budget neutrality factors)</td>
<td>1.6088*</td>
</tr>
</tbody>
</table>

*CMS displays this amount as 1.6 percent on page 1692 of the display copy of the final rule. In column 1 of the impact table on page 1687, this figure is 1.5 percent to reflect the lower update for hospitals that are paid in full or part based on hospital-specific rates.*
Overview

Case Studies

Definitions / Regulations

Questions

FY18 IPPS Proposed Rule - Finalized 8.3.17

Table I Impact Analysis

Detailed impact estimates are displayed in Table I of the proposed rule (reproduced in the Appendix to this summary). The following table summarizes the impact by hospital category.

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>All Proposed Rule Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Hospitals</td>
<td>1.7%</td>
</tr>
<tr>
<td>Large Urban</td>
<td>1.7%</td>
</tr>
<tr>
<td>Other Urban</td>
<td>1.8%</td>
</tr>
<tr>
<td>Rural</td>
<td>0.8%</td>
</tr>
<tr>
<td>Major Teaching</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

• Socioeconomic adjustment to be implemented by 2019 for Hospital Readmissions Reduction Program
  • Leveling of playing field for hospitals serving low income/disadvantaged patients
• Worksheet S-10 to be used as basis for determining Uncompensated Care costs and reimbursement
  • To be implemented over a three year period
  • Definition of uncompensated care costs to include all unreimbursed (Medicaid Shortfalls and discounts for uninsured) and uncompensated care costs
• Proposed Rule Finalized on August 3, 2017
On July 20, 2017, CMS released its OPPS Proposed Rule for 2018. Important proposals include:

- Medicare OPPS conversion factor to increase 1.9%
  - 2.9% Inflation less .4% productivity and .75% ACA Adjustment

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Projected 2018 Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary</td>
<td>1.9%</td>
</tr>
<tr>
<td>Proprietary</td>
<td>2.3%</td>
</tr>
<tr>
<td>Government</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

*Excludes hospitals permanently held harmless and CMHCs
• **Payment for Part B Drugs Acquired Under the 340B Program**
  - Beginning in FY 2018, CMS to reduce payment for Part B drugs acquired under the 340B program from average sales price (ASP) +6% to ASP -22%
  - “We believe that any payment changes should be limited to separately payable drugs under the OPPS, with certain exclusions” (Page 305)

• **Non Exempt Provider Based Clinics (under section 603 of Bipartisan Budget Act of 2015)**
  - Proposing to reduce payment for non-exempt provider-based clinics (new off-campus clinics that were not in process by 11/2/2015) from 50% of OPPS payment to 25%

• **Direct Supervision of Hospital OP Therapeutic Services**
  - Reinstate non-enforcement of direct supervision requirements for OP therapeutic services for CAHs and small rural hospitals for CYs 2018 and 2019
The Committee is concerned about the 340B program’s rapid growth without additional and proportional oversight. Provisions in the Patient Protection and Affordable Care Act (PPACA) expanded the definition of eligible entities to include “free-standing cancer, community and critical access hospitals on the basis of their disproportionate share hospital (DSH) percentage,” which has increased program enrollment substantially. 340B drug sales
Delay of Bundled Payment - 6.2.17

- Delayed implementation of bundled payment rules from July 1, 2017, to January 1, 2018

CMS-5519-F3

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 510 and 512

[CMS-5519-F3]

RIN 0938-AS90

Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR); Delay of Effective Date

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule; delay of effective date.
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS-2394-P]

RIN 0938-AS63

Medicaid Program; State Disproportionate Share Hospital Allotment Reductions

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

• Proposed rule delineates the DSH Health Reform Methodology (DHRM) to implement annual Medicaid allotment reductions required as part of ACA
  • Reductions to occur between FY2018 and FY2025
  • Note: TN and District of Columbia excluded from reductions
State DSH Reductions - Proposed Rule 7.28.17

- Methodology must:
  - Impose a smaller % reduction on low DSH states
  - Impose largest % reductions on:
    - States that have lowest % of uninsured individuals
    - States that do not target DSH payments on hospitals with high volume of Medicaid patients
    - States that do not target their DSH payments on hospitals with high levels of uncompensated care

- Reductions to occur as follows:
  - $2B for FY 2018
  - $3B for FY 2019
  - $4B for FY 2020
  - $5B for FY 2021
  - $6B for FY 2022
  - $7B for FY 2023
  - $8B for FY 2024
  - $8B for FY 2025
The Effects of Terminating Payments for Cost-Sharing Reductions

- **Summary Effects:**
  - Gross premiums for silver plans would be 20% higher in 2018 and 25% higher in 2020 which would boost premium tax credits.
  - Most people would pay net premiums (after premium tax credits) of the same amount through the next decade.
  - Federal deficits would increase by $6B in 2018, $21B in 2020, and $26B in 2026.
  - Number of uninsured would be slightly higher in 2018 and slightly lower starting in 2020.
Anthem's new outpatient imaging policy likely to hit hospitals' bottom line

By Shelby Livingston | August 26, 2017

(Story updated Aug. 30, 2017)

In what may be the first strike in a battle over what healthcare services should be provided in a hospital, Blues giant Anthem will no longer pay for MRIs and CT scans performed on an outpatient basis in hospitals across the country.
IRS revokes hospital's tax-exempt status for failure to comply with ACA rule

The Internal Revenue Service has revoked the tax-exempt status of an unnamed nonprofit hospital for failure conduct a community health needs assessment, adopt an implementation strategy and make it widely available to the public.

In a letter dated Feb. 14, 2017, and released earlier this month, the IRS said it revoked the hospital's tax-exempt status for failure to comply with section 501(r) of the Internal Revenue Code.

The ACA added new requirements that hospitals must meet to qualify as a tax-exempt facility under section 501(c)(3) of the Internal Revenue Code. Specifically, the ACA added section 501(r), which imposes four new requirements, one of which requires hospitals to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to address community health needs identified in the assessment.

The IRS revoked the tax-exempt status of the unnamed hospital for what the agency referred to as "egregious failures when reviewed in the context of [section] 501(r)." Although the name of the hospital is not included in the letter from the IRS, previous correspondence from the agency identified the facility as a disproportionate share hospital and a critical care access facility.

Source: Becker’s Hospital Review 8-17-2017
No-Pay Policy for Non-Emergent ED Use Spreading

RICH DALY, HFMA SENIOR WRITER/EDITOR

THE POLICY IS EXPECTED TO INCREASE THE BAD-DEBT FINANCIAL BURDEN ON HOSPITALS AND AFFILIATED PHYSICIANS, A HOSPITAL ADVOCATE SAYS.

June 7—By mid-summer, Anthem Blue Cross and Blue Shield (BCBS) plans in at least four states are expected to offer no payment for non-emergent use of the emergency department (ED).

BCBS Georgia individual-market plans on July 1 will become the newest group to implement the policy. Anthem added the policy for its Missouri plans on June 1 and for its Kentucky plans in late 2015. Meanwhile, New York plans have had a “similar program in place for several years,” said Gene Rodriguez, director of public relations for Anthem Inc.
DEFINITIONS / REGULATIONS
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
• Health Professional Shortage Area (HPSA)
  • Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary care, dental care, and/or mental health providers within a specific geographic area, population, or facility
    • Primary care HPSAs are based on a physician-to-population ratio of 1:3,500
      • The formula used to designate primary care HPSAs does not take into account the availability of additional primary care services provided by Nurse Practitioners and Physician Assistants in the area
    • An entity pursuing RHC designation in an HPSA must do so in an area where the HPSA designation is less than four (4) years old
• **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”
• **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
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

<table>
<thead>
<tr>
<th>Reimbursement Options</th>
<th>FQHC</th>
<th>CAH PBE</th>
<th>CAH PBRHC</th>
<th>FSHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>330 Grant</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>340B Pharmacy</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Un-Capped Technical Charge</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Method II Billing</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Tort Reform - Malpractice Savings</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Enhanced PPS Reimbursement</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Additional Materials</td>
<td>Appendix 1</td>
<td>Appendix 2</td>
<td>Appendix 3</td>
<td>Appendix 4</td>
</tr>
</tbody>
</table>

- Additional Definitions/Regulations included as an Appendix to this presentation
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 PBE, 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
CASE STUDIES
Case Study #1: Maury Regional Health

- Maury Regional Health (MRH) is a municipally owned, three-hospital healthcare system with regional health care centers providing services to more than 250,000 people throughout south-central Tennessee
  - Subsidiaries include:
    - Maury Regional Medical Center (MRMC), a 275-bed short-term acute facility
    - Marshall Medical Center (MMC), a 25-bed critical access hospital (CAH)
    - Wayne Medical Center, a 32-bed short-term acute facility
    - Lewis Health Center (LHC), a Federally Qualified Health Center (FQHC)
    - Maury Regional Spring Hill, an outpatient facility providing limited ancillary services
    - Family Health Group (FHG), an affiliate of MRMC and provides a network of primary care services with more than 20 locations and 100 providers
Case Study #1: Maury Regional Health

- In 2016, MRH engaged Stroudwater to compare the financial advantages and disadvantages of FHG operations as FSHC with other designation types under the following scenarios:
  - Scenario #1: Reimbursements received as a FSHC under FHG
  - Scenario #2: Reimbursements received as a FQHC under the LHC
  - Scenario #3: Reimbursements received as a PBE/PB-RHC under MMC
- As a municipally owned entity, MRH has the opportunity to leverage all clinic designation types, including a FQHC, within the system
- Due to location and proximity, none of the clinics could operate as a PBE under a CAH
Case Study #1: Maury Regional Health

- At the time, two of the clinics were located in a HPSA based on available information from Health Resources and Services Administration (HRSA) and could qualify as a RHC
  - Green colored areas on the map are deemed a HPSA and the red squares signify each of the two clinics
- Three of the clinics were located in a MUA based on available information from HRSA; however, a FQHC does not have to be located in a MUA so long as the clinic can prove they serve patients from a MUP/MUA
  - Purple colored areas on the map are deemed a MUA and the red squares signify each of the two clinics
Case Study #1: Maury Regional Health

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

<table>
<thead>
<tr>
<th>Summary Data</th>
<th>Scenario #1 FSHC</th>
<th>Scenario #2 FQHC</th>
<th>Scenario #3 PB-RHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare / Medicaid Average</td>
<td>$95.58</td>
<td>$155.82</td>
<td>$138.68</td>
</tr>
<tr>
<td>Annual Visits</td>
<td>64,018</td>
<td>64,018</td>
<td>7,693</td>
</tr>
<tr>
<td>Reimbursements Received</td>
<td>$6,118,840</td>
<td>$9,975,285</td>
<td>$1,066,865</td>
</tr>
<tr>
<td>340B Benefit</td>
<td></td>
<td>$3,764,000</td>
<td>$437,000</td>
</tr>
<tr>
<td>Variance w/ FQHC (Scenario #1)</td>
<td></td>
<td>$7,620,444</td>
<td>$768,568</td>
</tr>
</tbody>
</table>

• **Study Outcomes:**
  - Operating the nine locations as FQHCs led to the highest average reimbursement from Medicare and Medicaid
    - This option would also allow the clinics to pursue the 340B benefit
  - Since only two of the clinics could currently qualify as a PB-RHC, the net benefit was limited to those two facilities
    - However, those two clinics would have received roughly $770K more from Medicare and Medicaid due to higher reimbursements and 340B
Case Study #2: Susquehanna Health

- Susquehanna Health System, doing business as Susquehanna Health (SH), is a four-hospital integrated system in northcentral Pennsylvania
  - Corporate subsidiaries include:
    - Williamsport Hospital, a 202-bed, short-term acute facility
    - Soldiers & Sailors Memorial Hospital (SSMH), a 67-bed, short-term acute facility
    - Divine Providence Hospital, a 31-bed psychiatric facility
    - Muncy Valley Hospital, a 20-bed critical access hospital (CAH)
- In 2016, SH engaged Stroudwater to compare the financial advantages and disadvantages of operations as a six-site FQHC with other designation types under the following scenarios:
  - Scenario #1: Reimbursements received as a six-site FQHC
  - Scenario #2: Reimbursements received as a FSHC under a STAC or CAH
  - Scenario #3: Reimbursements received as a PBE/PB-RHC under a CAH
Case Study #2: Susquehanna Health

- At the time, four of the clinics were located in a HPSA based on available information from Health Resources and Services Administration (HRSA) and could qualify as a RHC
  - Green colored areas on the map are deemed a HPSA and the red squares signify each of the six clinic locations in relation to a HPSA area
  - SH would pursue RHC designation for one of the locations that not in a HPSA, but could qualify in a MUA
  - SH could operate the last location as a PB-RHC under a CAH
- The location of the clinics and, in some situations, the proximity of those clinics to other hospitals, impacted the designation type
Case Study #2: Susquehanna Health

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

<table>
<thead>
<tr>
<th>Summary Data</th>
<th>Scenario #1 FQHC</th>
<th>Scenario #2 FSHC</th>
<th>Scenario #3 PBE/PBRHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare / Medicaid Average</td>
<td>$153.61</td>
<td>$77.03</td>
<td>$168.39</td>
</tr>
<tr>
<td>Annual Visits</td>
<td>40,784</td>
<td>40,784</td>
<td>40,784</td>
</tr>
<tr>
<td>Reimbursements Received</td>
<td>$6,264,747</td>
<td>$3,141,578</td>
<td>$6,867,688</td>
</tr>
<tr>
<td>Variance w/ FQHC (Scenario #1)</td>
<td>$(3,123,168)</td>
<td></td>
<td>$602,941</td>
</tr>
</tbody>
</table>

- **Study Outcomes:**
  - Operating a FSHC, as seen in Scenario #2, led to the lowest net revenue since the clinics would only receive fee schedule reimbursements
    - FSHCs would also lose significant revenue from the loss of a 330 grant and the 340B benefit
  - Scenario #3 led to the highest average reimbursement from Medicare and Medicaid
    - Operating a PBE/PB-RHC under a CAH allowed the clinics to maintain the 340B benefit
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 (FQHC) (continued)

• 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 Entity (PBE)**
  • A Provider-Based Entity is operated as an integrated department of a main provider, including a hospital or CAH
    • PBE financial operations must be integrated with the main provider’s financial system
    • The PBE 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 PBE that they are entering a department of the main provider and will be billed accordingly
    • An off-campus CAH PBE must meet the federal distance requirement specified in the CAH Conditions of Participation or risk jeopardizing the CAH designation
    • The PBE must be 100% owned by the main provider
Appendix 2 - Provider Based Entity

- Provider-Based Entity (PBE) (*continued*)
  - PBEs and have access to the following benefits:
    - A physician clinic operating as a PBE can receive higher Medicare and Medicaid payments than the same practice operating as a freestanding clinic and often as an RHC
    - A PBE can participate in the 340B Drug Pricing Program
    - PBE 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 uncapped 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

- Rural Health Clinic (RHC) (continued)
  - A PB-RHC is an RHC meeting the criteria of a PBE
    - 42 CFR 405.2401(b) excludes RHCs from the list of PBEs 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 PBE 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

**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