We Make Healthcare Reimbursement Easy

THE RYBAR GROUP

From Acorn to Oak Tree: Rural Healthcare Reimbursement Opportunities

November 8, 2022

With You Today

Caren Puvalowski, CHFP
Manager, Rural Healthcare Reimbursement

Disclaimer

- The information provided in today's presentation is current as of November 8, 2022.
- This presentation is provided "as is" without any express or implied warranty. This presentation is for educational purposes only. If you require additional guidance, please consult The Rybar Group to discuss the specifics of your facility's situation and needs.
- All materials are the sole property of The Rybar Group and cannot be published, copied or disseminated without prior approval from The Rybar Group.

Agenda + Objectives

- Discuss the pain points for rural health
- Identify the different Rural Healthcare provider types
- Discuss the various reimbursement models for Rural Healthcare providers and the related revenue opportunities.

To start,
let's answer the question:

Is Rural Health Really Different?

The answer:

Yes, It is!

What is Rural?

Depends

- Who is determining the classification
- What funding program
- Where located
- When data is updated or reviewed
- How data is interpreted

Am I Rural?

Am I Rural? Tool - Rural Health Information Hub

https://www.ruralhealthinfo.org/am-i-rural

- CMS – Rural Health Clinic Program
- FORHP – Grant Programs
- Other Rural Definitions
- Shortage Designations:
  - Health Professional Shortage Area
  - Medically Underserved Area/Population

RHI hub
Rural Health Information Hub

Am I Rural? – Report

Report produced by the Rural Health Information Hub on 05/16/22.

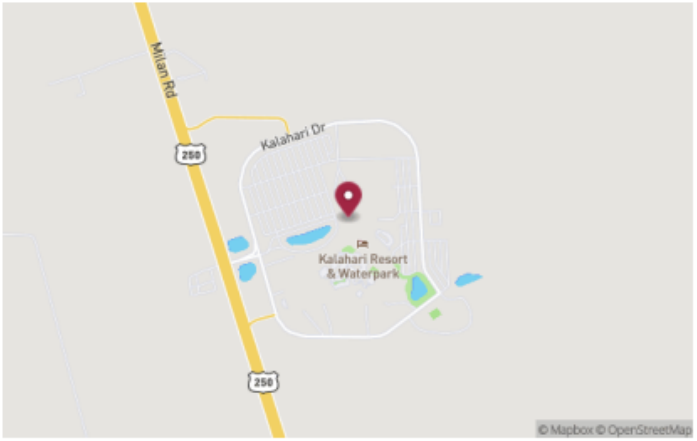
Location

Report Address:
7000 Kalahari Dr, Sandusky, OH 44870 *

Latitude: 41.38426
Longitude: -82.64168

Census Tract: 39043040400
(Based on 2019 boundaries)

County:
Erie County, OH



* Report is for a specific point in 7000 Kalahari Dr, Sandusky, OH 44870. Results may not be the same for all points in 7000 Kalahari Dr, Sandusky, OH 44870.

The information provided by this service addresses only the rural aspect of a program's requirements. Your *Am I Rural?* report is not a guarantee of your rural status. Please check with the program contacts directly to verify your eligibility for specific federal programs.

Program Eligibility

Program	Rural?	
CMS - Rural Health Clinics (RHC) Program	**YES**	The Rural Health Clinics Program requires that your location be outside an Urbanized Area as defined by the U.S. Census. (Please note there are additional location requirements (https://www.ruralhealthinfo.org/topics/rural-health-clinics#location-requirements) for RHCs.) This location is not in an Urbanized Area.
FORHP - Grant Programs	**YES**	This location is eligible for Federal Office of Rural Health Policy grant programs. Erie County, OH has been designated by FORHP as rural. (For FY22 grant cycle)

Common Rural Definitions

	How Your Location is Defined
Census 2010, Percent Rural	Information for Erie County • Percent of County Population that is Rural: 26.48
Core Based Statistical Areas (CBSAs)	• CBSA Type: Micropolitan • CBSA Name: Sandusky, OH Micro Area • CBSA ID: 41780
Federal Office of Rural Health Policy (FORHP) defined rural areas	Erie County, OH has been designated by FORHP as rural.
Frontier and Remote Area (FAR) 2010	Not located in a Frontier and/or Remote area.
Rural Urban Commuting Areas (RUCAs) by census tract	• RUCA Code: 4.0 • Primary Description: Micropolitan area core: primary flow within an Urban Cluster (UC) of 10,000 through 49,999 (large UC)
Rural Urban Continuum Codes (RUCCs)	RUCCs are assigned at the county level. Information for Erie County • RUCC Code: 4 • RUCC Description: Nonmetro - Urban population of 20,000 or more, adjacent to a metro area
Urban Influence Codes (UICs) 2013	Information for Erie County • Urban Influence Code: 3 • UIC Description: Micropolitan adjacent to a large metro area
Urbanized Areas / Urban Clusters	Not located in an Urbanized Area or Urban Cluster.

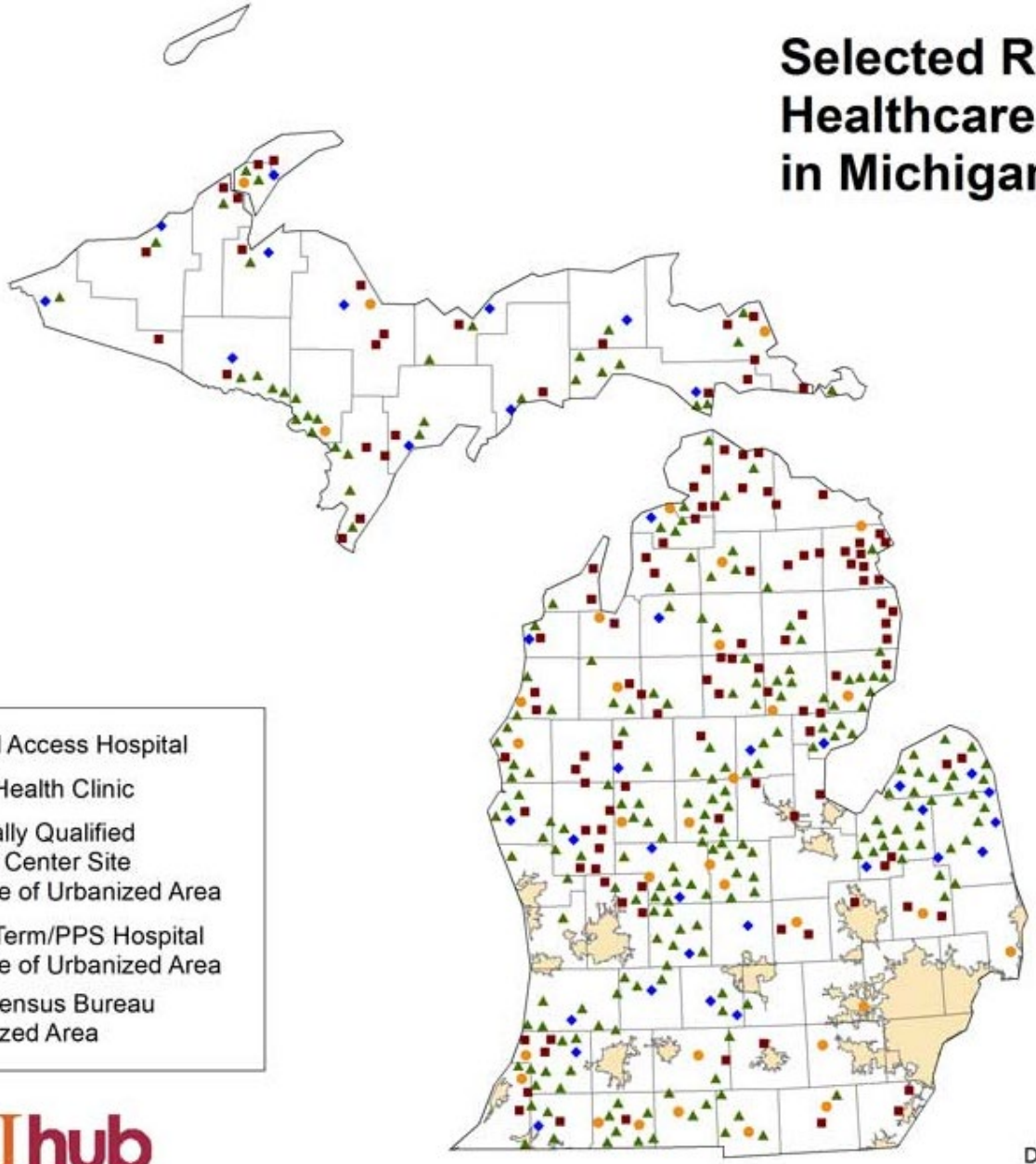
Shortage Designations

Health Professional Shortage Areas		
Primary Care	NO	
Dental Care	YES	• Name: LI-Erie County • Date of Designation: October 11, 2017 • Last Update: September 7, 2021
Mental Health	YES	• Name: Ottawa/Erie Counties • Date of Designation: November 18, 2010 • Last Update: September 7, 2021

Medically Underserved Areas/Populations	
Medically Underserved Area (MUA)	NO
Medically Underserved Population (MUP)	NO
Medically Underserved Area - Governor's Exception (MUA-GE)	NO
Medically Underserved Population - Governor's Exception (MUP-GE)	NO

For data sources and definitions, see the Rural Classifications (/am-i-rural/help#classification) help section.

Selected Rural Healthcare Facilities in Michigan



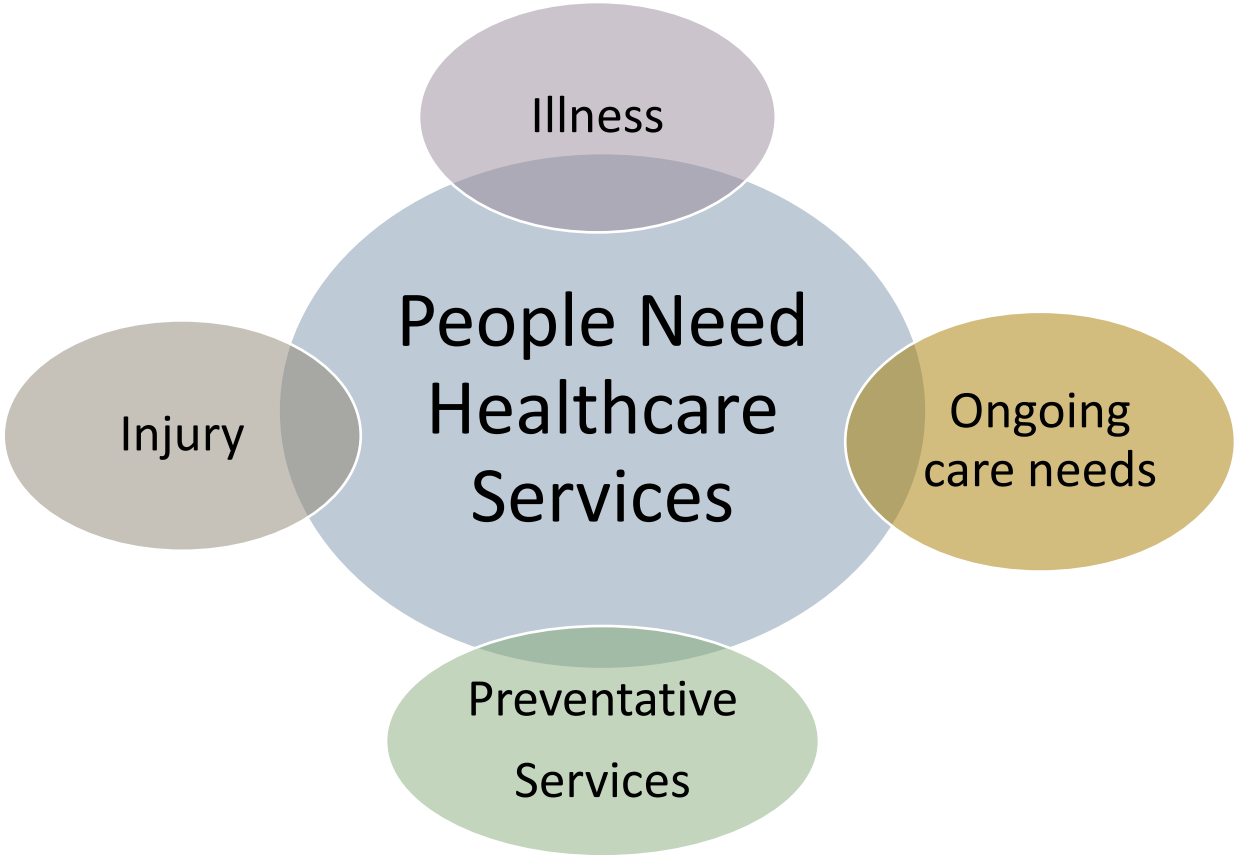
RHIhub
Rural Health Information Hub

Data Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, July 2022

How are Rural and Urban the Same

People make a choice to live there – family/friends, work, education, social, lifestyle, other reasons

But they still have basic needs…



Rural vs. Urban

National Rural Health Snapshot	Rural	Urban
Percentage of population	19.3%	80.7%
Number of physicians per 10,000 people	13.1	31.2
Number of specialists per 100,000 people	30	263
Population aged 65 and older	18%	12%
Average per capita income	$45,482	$53,657
Non-Hispanic white population	69-82%	45%
Adults who describe health status as fair/poor	19.5%	15.6%
Adolescents who smoke	11%	5%
Male life expectancy in years	76.2	74.1
Female life expectancy	81.3	79.7
Percentage of dual-eligible Medicare beneficiaries	30%	70%
Medicare beneficiaries without drug coverage	43%	27%
Percentage covered by Medicaid	16%	13%
All information in this table is from the Health Resources and Services Administration and Rural Health Information Hub.		

Urban areas make up 3% of the entire land area of the country.

While 19.3% of Americans live in the 97% of the country considered rural.

How is Rural different than Urban?

- Fewer options
- Transportation
- Harder to recruit – Providers, Clinical and Non-clinical staff
- Significant local economic impact
- Community support important for success of rural facilities
- Broad range of services
- Limited staff with same reporting responsibilities as larger facilities

Rural Strategy

- Rural strategy is different than an urban strategy
- Payers
  - Need higher reimbursement due to smaller volumes
  - Difficult to exclude when you need the patients
  - Don't forget about geographic coverage
  - Need to keep lines of communication open with large employers in the area
- Cannot be all things to all patients
- Can be the best at what services are provided
  - High patient satisfaction
  - High retention of staff/providers

Why Be Aware of the Differences?

Know what reimbursement opportunities are available to you, how you should be reimbursed and how you are being reimbursed.

Remember – your facility and community are unique to you.

Although similarities may exist – not a one size fits all answer.

Rural Health Reimbursement Pain Points

- Patient Volumes
  - Efficiencies are an issue without adequate volumes
  - Aging of “Baby Boomers”
  - Fee for value vs. volume
- Staffing Costs + Recruitment/Retention of Staff
  - Staffing of scarce resources is a challenge
- Other Organizational Costs
  - Low Margins create capital funding constraints
- Cash Flows
  - Shift of payments to patient responsibility
  - Payor Rate Increases not keeping pace with cost
- Other
  - Hospitals continue to have to be strategic in growth and market share
  - Smaller Providers in large systems not receiving same attention as larger urban counterparts
  - There is not one universal definition of rural – different government programs have different definitions of rural.

Why is it Harder to Recruit Providers and Staff?

- Rural Lifestyle
  - Not as much accessible entertainment or other “things to do”
  - Social settings can be significantly different
- Not as many providers so there is a large on-call commitment
  - Some feel like they can’t achieve a work-life balance
- Hard to pay as much as urban areas due to lower patient volumes and therefore revenue

National Health Services Corp (NHSC)

- Health Resources & Services Administration (HRSA) program

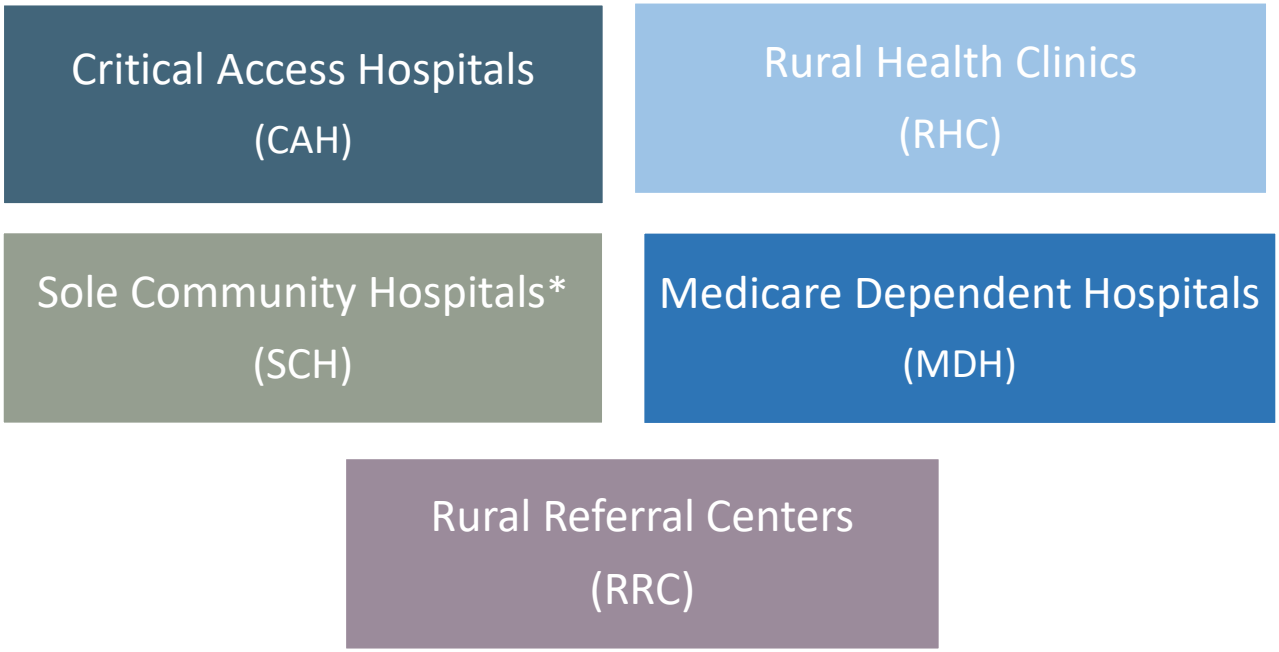
- Eligible for primary care providers:
  - Physicians, Nurse Practitioners, Physician Assistants, Dental Professionals, Mental Health Professionals, Registered Nurses, Pharmacists, Substance use disorder counselors

- New site applications
  - Auto approval available for select providers

- Benefits
  - Job Search
  - Loan Repayment
  - Scholarships
  - Award Preference

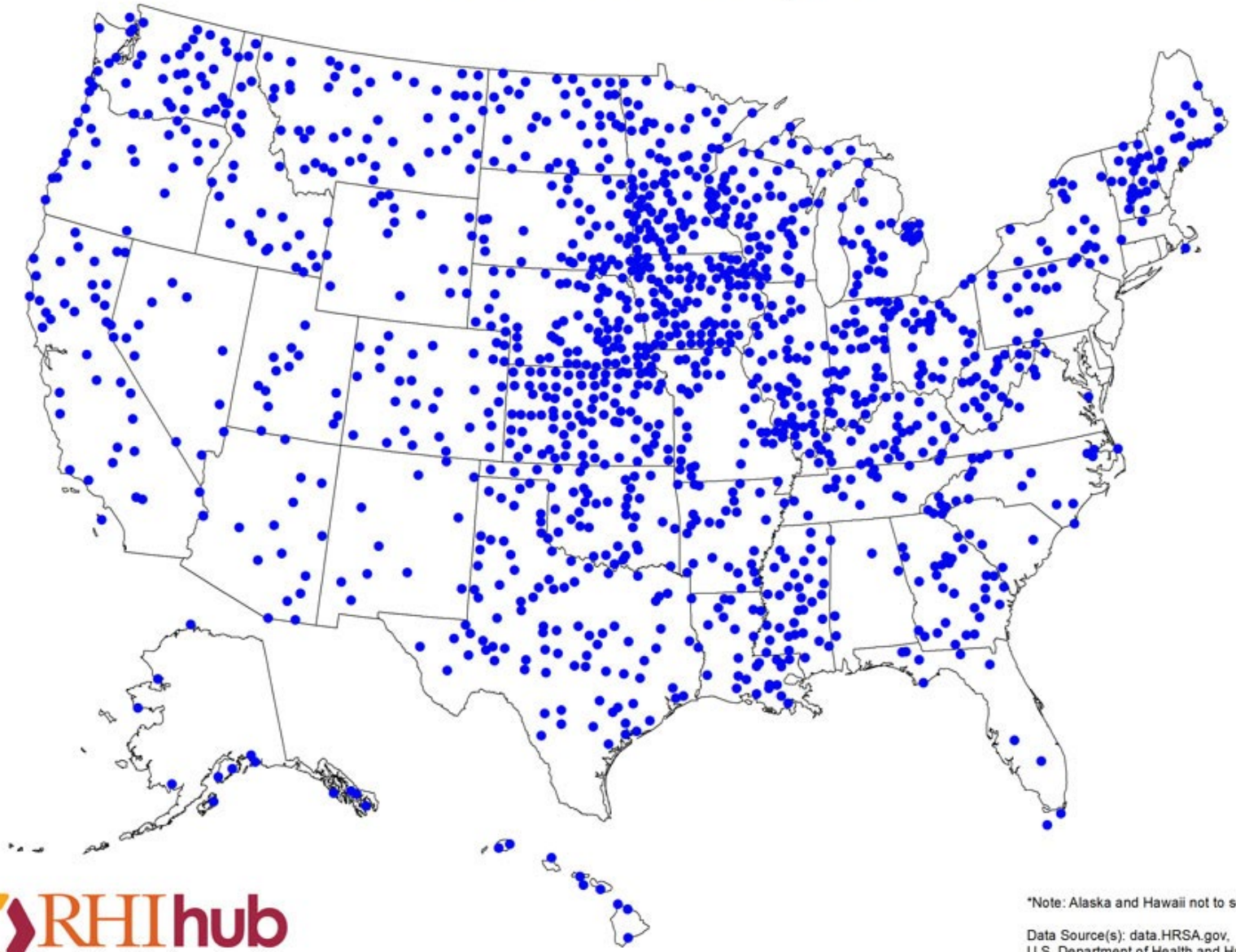
- https://nhsc.hrsa.gov/

Rural Health Payment Programs



- *SCHs are not just a rural program but have enhanced payment for rural hospitals
- Before applying for any of these, model the impact to make sure that the hospital will benefit from them.
- Make sure the hospital qualifies before you apply.

Critical Access Hospitals



RHIhub
Rural Health Information Hub

*Note: Alaska and Hawaii not to scale

Data Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, April 2022

Critical Access Hospitals Overview

- Acute Care Inpatient Beds - 25 or fewer
- Location
- Average length of stay of 96 hours or less for acute care patients (excluding swing bed and distinct part unit services)
- Must provide 24/7 emergency care services
- There are 1,360 CAH located in 45 states
- They are REAL HOSPITALS

Critical Access Hospitals - CAH

Services provided:

- 24/7 ER Care
- Trauma Center
- Operating Room
- OB
- Swing Beds
- Skilled Nursing Facility
- Ancillary – Lab, X-ray, Sleep Lab
- Therapy – IV, Respiratory, Physical, Occupational, Speech
- Physician Services – Clinics
- Rental Space – Specialists – Neuro, Urology, Podiatry, Oncology, Allergy, Cardiology, etc.
- Anything that any hospital can provide – As long as the average LOS is under 96 hours and Meets the Community Need

Critical Access Hospitals - 8 Special Medicare Rules & Advantages

1. Cost Reimbursed at 101%
2. Can provide Swing Bed Services
3. Eligible for 340B Pharmacy Benefits
4. Excluded from Provider Based Restrictions
5. Full Cost Reimbursement for RHC Services**
6. Professional Provider Opportunities
7. More Flexible Staffing Requirements
8. Additional Capital Funding Resources and Options Available

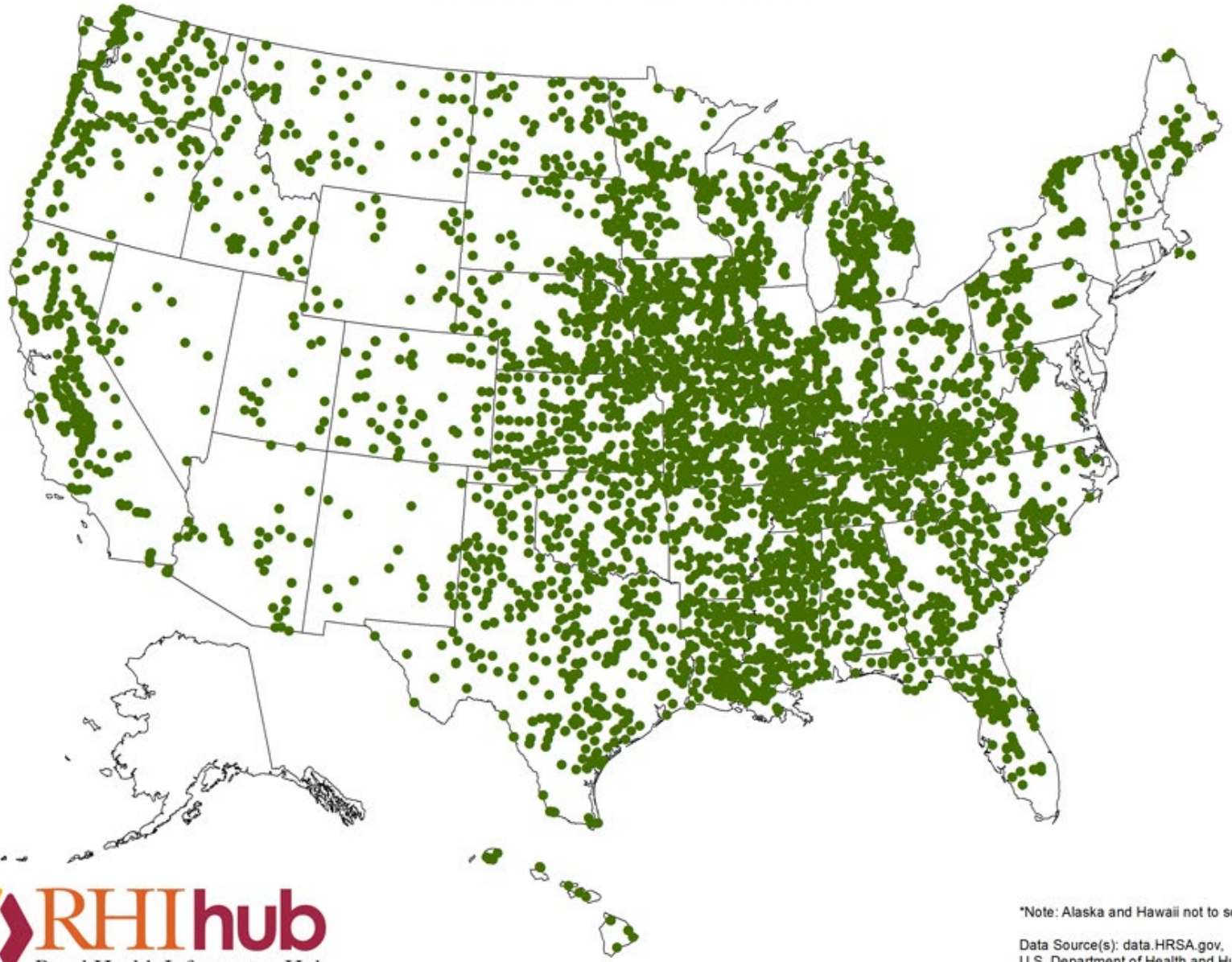
Critical Access Hospitals – Medicare Cost Report

- Accuracy – Charges, costs, stat allocations = current year reimbursement + future year interim payment rates
- Review Charges
- Interim Cost Report – planning, budgeting, financials, year end prep
- Other reimbursement options
  - Medicare Managed Care
  - Bad Debts

Critical Access Hospital
OP Charge Copay Example

Outpatient Charges	10,000,000	8,000,000	6,000,000
Cost to Charge Ratio	50%	63%	83%
Medicare Costs	5,000,000	5,000,000	5,000,000
Coinsurance (20% of billed charges)	2,000,000	1,600,000	1,200,000
Medicare Cash	3,000,000	3,400,000	3,800,000

Rural Health Clinics



RHI hub
Rural Health Information Hub

*Note: Alaska and Hawaii not to scale

Data Source(s): data.HRSA.gov,
U.S. Department of Health and Human Services, April 2022

Rural Health Clinics (RHCs) Overview

- Must be physically located in a HRSA designated Health Professional Shortage Area
- Must employ one non-physician provider
  - NP or PA working at least 50% of the time the clinic is open
- Types
  - Free Standing – usually owned by clinicians
  - Provider Based – usually owned by a hospital

Rural Health Clinics (RHCs) - Medicare

Major changes in the All-Inclusive Rate – AIR as of 04/01/2021:

<u>Current Rates effective 01/01/22:</u>

- Provider-based RHC < 50 beds enrolled before 01/01/21:
  - Clinic specific AIR with cap
- Independent RHC's, PB RHC's > 50 beds, New RHCs (after 01/01/2021):
  - $113 per visit

- Future rates?

Rural Health Clinics (RHCs) - Medicare

- Medicare Cost Report (All-Inclusive Rate – AIR)
  - Optimize the costs
  - Calculate the appropriate provider FTE
  - Correctly report the visits
  - Track vaccines for reimbursement

- Other Considerations:
  - Bad Debts
  - Provider Productivity for employed providers
    - Physician (4,200 per FTE)
    - NP/PA (2,100 per FTE)
  - Other Services

Rural Health Clinics (RHCs) - Medicaid

- Medicaid Reimbursement
  - Traditional Medicaid
  - Medicaid Managed Care
- Medicaid Managed Care Contracts
- Set up with State
- Accurate visits billed = reimbursement

Rural Health Clinics (RHCs) - Other

- Other Payors – Documentation, Coding + Charges are important
  - Medicare Managed Care
    - Contracting
  - Medicaid Fee for Service
    - State specific reimbursement
  - Medicaid HMO
    - Contracting
    - Additional State reimbursement?
  - Commercial
    - Contracting
    - E/M levels and services billed determine reimbursement

Sole Community Hospitals (SCH)

- Criteria: Must be located more than:
  - 35 miles from another like hospital (IPPS acute care hospital not a CAH)
  - Or located in a rural area with inaccessibility due to topography or severe weather conditions
- SCHs can receive operating payments based on the HIGHER
  - Hospital-Specific Payment
  - Federal Rate
- Capital payments are solely based on the capital base rate (like all other IPPS hospitals).
- Additional payment opportunity if total inpatient volumes decreases by 5% of greater from the prior year
- Rural SCH receive a 7.1% higher APC payment for outpatient services
- 340B Drug Pricing available if greater then an 8% DSH adjustment
- Approximately 450 hospitals in 47 states have SCH status.

Medicare Dependent Hospitals (MDH)

- Criteria
  - Medicare days/discharges over 60%
  - Less then 100 beds
- MDHs can receive operating payments based on the HIGHER
  - Hospital-Specific Payment
  - Federal Rate
- If hospital specific is greater, the MDH is paid the federal plus 75% of the difference between the hospital-specific rate and federal rate.
- A MDH's capital payments are solely based on the capital base rate.
- MDHs may also qualify for a payment adjustment if the hospital experiences a significant volume decrease.
- Can not be designated as a sole community hospital.
- Approximately 160 hospitals in 32 states have MDH status.

Rural Referral Centers (RRC)

- Purpose
  - Supports high volume rural hospitals who treat complicated cases
- Criteria
  - Must be rural and meet certain criteria
- Benefit
  - Easier to get reclassified to an urban area from Wage Index purposes
    - Can apply for the closest urban or rural area
    - Only needs to meet the 82% AHW comparison if hospital has ever been an RRC
  - Eligible for 340B with DSH Adjustment of at least 8%
  - Not subject to the rural hospital 12% DSH payment cap
- Approximately 460 hospitals in 46 states have RRC status

Rural Health Reimbursement – PPS Facilities

Medicare Cost Report

- Current reimbursement
  - Medicaid
  - Clinics
  - Special Payment Provision
- Rate Setting Implications
  - Still has relevance
  - Uncertainty of future Medicare changes
- Monitoring of Performance
  - Volumes
  - Losing money on Medicare?

Rural Health Reimbursement – PPS Facilities

Medicare Cost Report (continued)

- Uncompensated Care (S-10)
- Medicare Bad Debts
- Modeling of impacts

Rural Health Reimbursement – PPS Facilities

Medicaid Cost Reports

Utilized to determine:

- Hospitals share of Supplemental Payments
- Hospital Specific Taxes

Other Reimbursement

- Commercial Contracts
- Grants
- Donations

Other Reimbursement Opportunities

- Health Professional Shortage Area HPSA
- 340B
- Managed Care Contracting
- Out of State Medicaid Patients
  - Cost Reporting
  - Supplemental Payments
- Revenue Cycle Opportunities

Health System – Rural Facilities

- Rural Areas call for a different strategy than an urban strategy
- Home Office Cost Reporting
- Medicare Managed Care Contracts
- Medicare Cost Report
  - Reimbursement
  - Strategic
- Review chargemaster rates

COVID-19 Rural Focused Relief Programs

- Medicare Advanced and Accelerated Payments–demand letters if not PIF
- Paycheck Protection Program (PPP)
- Rural Health Clinics
- Provider Relief Funds
- Other funding available at different levels:
  - State
  - Association
  - Local
  - Governmental
  - Grants
  - FEMA
- Sequestration was suspended - now up to 2% as of 07/01/22

Be careful of overlapping funding – Documentation is KEY

Education and Communication

- Management and the Board need to understand the Cost Reporting implications of their decisions. Reimbursement is directly tied to the Cost Report.
  - Every decision that is made may impact reimbursement
  - Need to model impact
  - Consider more than just Medicare

- Turnover of C-suite, board, managers/directors

- Communication is very important between the Finance Staff and the Clinical and Operations Staff.

- Every decision that is made impacts reimbursement. It is important to model the effects and consider more than just Medicare.

Rural Healthcare in the Future?

- Rural Emergency Hospital (REH) – effective 01/01/23
- Cash Flow
- Operational Challenges
- Hospital Consolidations
- Hospital Closures
- Telemedicine
- Technology and Infrastructure
- Funding?

Summary

- Rural Providers are different than Urban Providers
- They each have their own strategy
- Make sure you understand their uniqueness
- There are several special payment provisions for rural facilities
- Cost reports and Contracts drive your reimbursement
- Accuracy and documentation are critical
- Rural Hospitals are the backbone of the country's rural health system

References & Resources

- Rural Health Information Hub https://www.ruralhealthinfo.org
- National Rural Health Resource Center https://www.ruralcenter.org
- National Association of Rural Health Clinics https://www.narhc.org
- Medicare Learning Network http://go.cms.gov/MLNGenInfo
- Flex Monitoring Team http://www.flexmonitoring.org
- National Rural Health Association https://www.ruralhealthweb.org

THE RYBAR GROUP

Questions?

Contact Information

Caren Puvalowski, CHFP

Manager, Rural Health Reimbursement
The Rybar Group, Inc.

Direct: (810) 853-6185

cpuvalowski@TheRybarGroup.com

THE RYBAR GROUP

AN INDEPENDENT MEMBER OF BDO ALLIANCE USA

To learn more, visit:

www.TheRybarGroup.com

https://www.linkedin.com/company/the-rybar-group/