RURAL CLINICS

HOW THEY HELP RURAL HOSPITALS SUCCEED

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Why are Clinics Important for Rural Hospitals ?

1. Provides network to feed services into the Hospital
2. Provides linkage between primary care, specialty care, and hospital services
3. Improves access to care for patients (other than ER)
4. May help fill out Medical Staff needs at Hospital
5. May assist in bringing specialists to community

6. Hospitals can enlarge their footprint by opening clinics in nearby areas

7. Allows extended coverage hours other than Emergency Room

8. Improves access especially for Elderly and Poor

WHAT ARE THE BASIC TYPES OF CLINICS

1. FQHC (Federally Qualified Health Centers)
2. Free standing Clinics
3. Provider Based Clinics
4. Rural Health Clinics

F Q H C

1. **Two Basic Types of Clinics**
   - **Fed. Funded with PHS (Public Health Service) Grant**
   - **Look Alike FQHC – No PHS Grant**

2. Facilities apply for either type of status and can change status from look alike to granted FQHC if their Grant is approved. Facilities reapply every 3 years for Grants

3. FQHC is not for profit, and board must consist of 51% local community user population

4. Organization must meet conditions to apply for FQHC status and be in a "shortage area" designation (MUP) or MUA

   MUP Medically Underserved Population

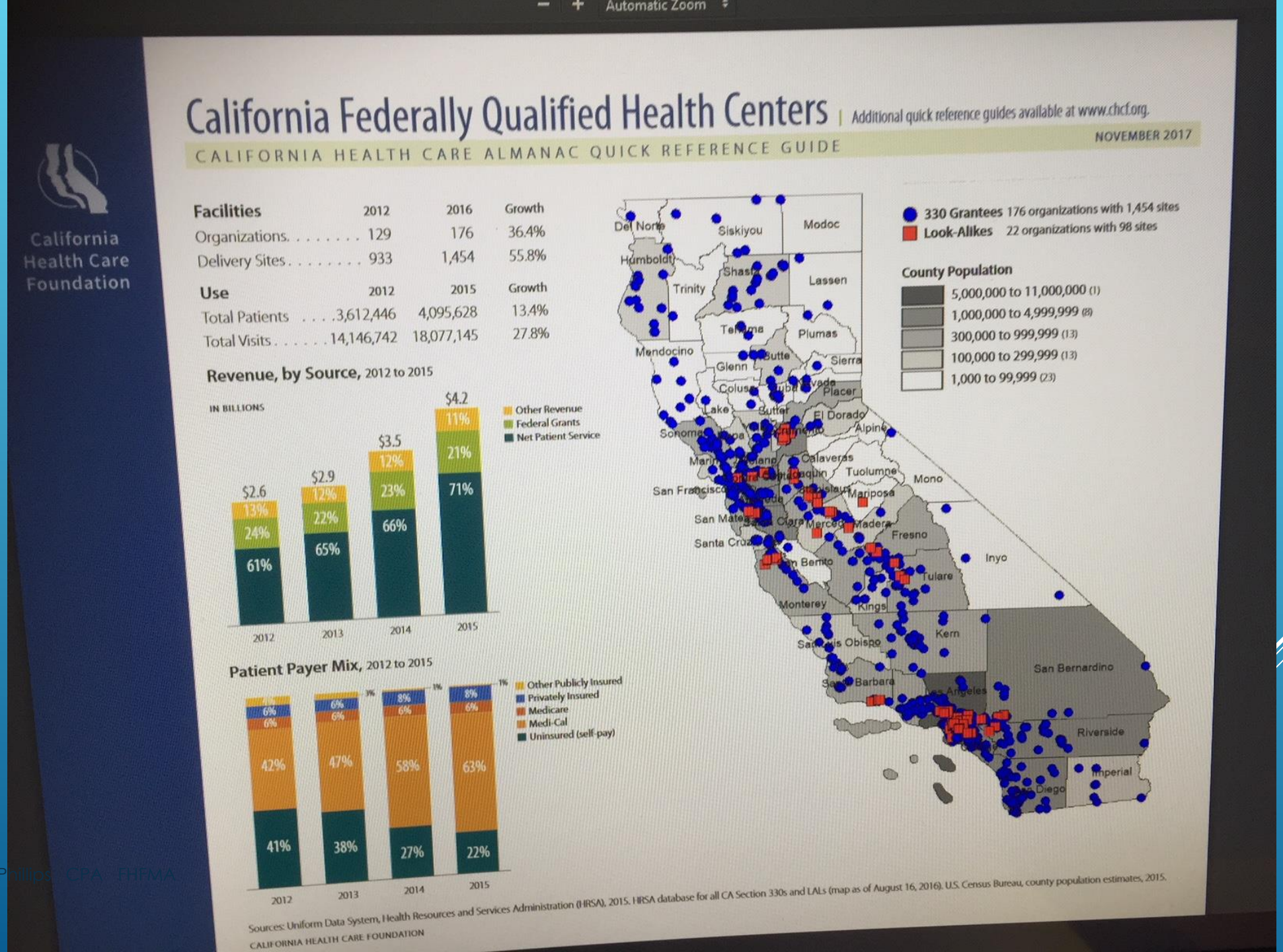
   MUA Medically underserved Area (Doctor shortage)

FQHC PAYMENT

MEDICARE - Cost Based up to $ 166.60 per visit
File Medicare Cost Report form 222-96

Medi-cal - Paid under a PPS system based upon cost
Rates vary by provider or group of providers

Frequently they are a direct competitor to a hospital based Clinic


Automatic Zoom
California Federally Qualified Health Centers | Additional quick reference guides available at www.chcf.org.
CALIFORNIA HEALTH CARE ALMANAC QUICK REFERENCE GUIDE
NOVEMBER 2017
California Health Care Foundation
Facilities 2012 2016 Growth
Organizations 129 176 36.4%
Delivery Sites 933 1,454 55.8%
Use 2012 2015 Growth
Total Patients 3,612,446 4,095,628 13.4%
Total Visits 14,146,742 18,077,145 27.8%
Revenue, by Source, 2012 to 2015
IN BILLIONS
$2.6 $2.9 $3.5 $4.2
13% 12% 12% 11%
24% 22% 23% 21%
61% 65% 66% 71%
2012 2013 2014 2015
Other Revenue
Federal Grants
Net Patient Service
Patient Payer Mix, 2012 to 2015
6% 6% 8% 8%
6% 6% 6% 6%
42% 47% 58% 63%
41% 38% 27% 22%
3% 1% 1%
2012 2013 2014 2015
Other Publicly Insured
Privately Insured
Medicare
Medi-Cal
Uninsured (self-pay)
330 Grantees 176 organizations with 1,454 sites
Look-Alikes 22 organizations with 98 sites
County Population
5,000,000 to 11,000,000 (1)
1,000,000 to 4,999,999 (8)
300,000 to 999,999 (13)
100,000 to 299,999 (13)
1,000 to 99,999 (23)
Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Plumas
Mendocino
Glenn
Butte
Sierra
Colusa
Placer
Lake
Sutter
El Dorado
Alpine
Sonoma
Calaveras
Tuolumne
Mono
San Francisco
Mariposa
San Mateo
Madera
Fresno
Santa Cruz
Inyo
Tulare
Monterey
Kings
Kern
San Bernardino
Riverside
Imperial
Diego
Sources: Uniform Data System, Health Resources and Services Administration (HRSA), 2015. HRSA database for all CA Section 330s and LALs (map as of August 16, 2016). U.S. Census Bureau, county population estimates, 2015.
CALIFORNIA HEALTH CARE FOUNDATION

CALIFORNIA FQHC SPECIFICS 2015 data

1. 176 Organizations
2. 1,552 Delivery sites
3. Over 4 million patients
4. Over 18 million patient visits
5. 330 Grant Types 1454 sites
   Non-330 Grant (Look Alike) 98 sites
6. Medi-cal was 63% of patients in 2015

HOW DO FQHC affect Hospital Operations ?

1. FHQC refers patients to hospital for additional services
2. FQHC doctors will likely be on hospital staff
3. In the case of Clinics , they may be a competitor
4. In a small community politics plays into the relationship
5. Ideally the two organizations work collaboratively to better Serve their patients

PROVIDER BASED CLINICS

1. Clinic is owned and operated by the hospital

2. Doctors are either contracted by or employed by Hospital

3. Clinic uses Hospital Tax ID

4. Clinic is just another department of the hospital in all respects
5. Payment depends upon whether a CAH hospital or PPS Hospital

PROVIDER BASED CLINIC - PPS Based for MEDICARE

1. Facility Fee billed on UB04 physician services billed on CMS 1500
2. Facility fee paid under Outpatient APC formula rate
3. Professional services billed under Medicare FFS based upon CPT Codes
4. Patient gets two bills, one for Facility Fee, one for Dr. Fee with attending insurances for each (confusion and anger by patient)

PROVIDER BASED CLINIC - CAH (Critical Access Hospital)

1. May bill on one billing if Facility has elected "Type II" billing method
2. Facility portion paid on "Cost" basis through Cost report (interim rate applied)
3. Professional fee included on UB under Rev. Code 96XXX, 97XXX, 98XXX
4. Prof Fees paid at 115% of usual and customary Medicare Fee X 80 %
5. Facility portion paid under RCC (cost to charge ratio for THAT CLINIC)

PB CLINIC - CAH

6. Patients may experience higher co pays since Facility co pay is based upon 20% of BILLED CHARGES

7. Medicare bad debts may not include the physician portion of any copays not collected

8. PB Clinics Reported in Med. Cost Report Line 90 (not 192)

9. Clinic patients are eligible for 340B drugs if Hospital participates

10. Medi-cal Supplemental Payments AB 915 allow use of line 90 claims

WHAT ARE "PROVIDER BASED" ENTITIES ?

A service which is owned and operated by a Hospital and is an integrated part of the Hospital and which may be either on campus or off campus.

It is paid by Medicare (and probably Medicaid) at a higher rate than if it was provided through a doctors office, or other medical entity other than a hospital.

EXAMPLES ::

1. Cancer Treatment Center
2. Ambulatory Surgical Center
3. Clinic (specialty or primary care)
4. Radiology Center
5. Laboratory
6. Urgent Care Center
7. Physical Therapy Office

BENEFITS OF PROVIDER BASED STATUS

1, Generally higher payments by Medicare and Medi-cal
2. Patients may be eligible for 340B pricing on drugs
3. Hospital eligible for additional Outpatient Supplemental Payments
4. For a CAH facility cost payment instead of a fee schedule
5. For a CAH PT, OT, and ST paid on cost basis

PB STATUS IS NOT GUARANTEED UNLESS AN ATTESTATION IS FILED

Consider filing a Provider Based Attestation (see Reg. 42 CFR 413.65)

If no attestation is filed, and CMS deems entity is not provider based significant penalties can be imposed such as

1. All claims are deemed overpayments and must be rebilled as a fee schedule
2. Licenses may be wrong
3. Potential problem with 340B drug issuances

If a provider has filed a PB Attestation with CMS, penalties only accrue as far back as when the attestation was filed. (Limits liability)

PROVIDER BASED QUALIFICATIONS

1. Regulation 42 CFR 413.65

2. Requirements

   Licensure
   Clinical Integration
   Financial Integration
   Public Awareness
   Ownership and Control
   Administration / Supervision
   Location

Licensure Requirements

Should show on Hospital License (depends upon state)

Clinical Integration

Prof. Staff have hospital privileges
Medical Director of Hospital has reporting relationship with PB Entity
Pat. Med. Records are part of Hospital records
Patients seen in PB entity can be transferred to hospital for follow up care

Financial Integration

PB entity is reported on hospitals Trial Balance
Financial records integrated with hospital records
Entity is on Hospitals Medicare Cost Report

Public Awareness

Outside and inside markings show PB Entity is a part of the Hospital
"Such as XYZ Radiology Operated by ABC Hospital"

Ownership and Control

PB entity is 100% owned by hospital
PB entity and hospital have same governing board
Both subject to same bylaws, rules, reporting
PB entity subject to all hospital policies

Admin. & Supervision

Common systems are integrated such as ::
Billing Services
Records storage and protections
Human Resources activity provided by hospital
Payroll managed by Hospital
Employee Benefits are same
Salary structure is same
Purchasing is done through hospital

LOCATION (CHANGES IN PROCESS)

OLD RULE (prior to Nov. 2, 2015)

REVISED RULE (BBA 2015 Changes to PB Location) on or after Nov. 2, 2015)

PROPOSED RULE (OPPS 2019) - beg. Oct. 1, 2018

OLD RULE

1. **PB PRACTICE** is within 35 miles Mother Hospital - qualifies or

2. PB PRACTICE is a State or Local Government Provider and has a DSH ratio of at least 11.75%. - EXEMPT from requirement or

3. PB Practices is more that 35 miles BUT meets one of the following

   a. At least 75% of Practice Patients reside in same ZIP as Hospital or

   b. at least 75% of patients of the practice admitted to a hospital were admitted to the Mother Hospital (for services offered) in prior year or

   c. If the Practice was new, then it must be located in the same ZIP code (s) that represent 75% of patient admissions to the hospital in the prior year.

BBA ACT 2015 SECTION 603 (Site of Service Limit)
Bipartisan Budget Act of 2015

ON CAMPUS = within 250 yards of Main Hospital Building
OFF CAMPUS = more than 250 yards

ISSUES IMPACTING PB STATUS

1. If services was off campus but was billing to CMS before 11/2/15 then it is "GRAND FATHERED" and considered On Campus

2. If service was not billing prior to 11/2/15 and is more than 250 yards from Hospital then it is off campus, and while provider based, it will be paid at a lower rate.

3. Effective 1/1/2016 all Off Campus PB services billed with POS code as follows:

   Code POS 19 = Off Campus
   Code POS 22 = On Campus

   All Grand fathered Services are considered as "On Campus"

OTHER ISSUES WITH OFF CAMPUS

1. CY 2017 Outpatient PPS Rules set "off Campus" to 50% of OPPS Rate
2. CAH Hospitals - Violation of PB rules may result in CAH losing its Status
3. If a PB services moves, it must meet all the new requirements related to location with certain exceptions (ie expansion, not moving)

PROPOSED OPPS RULES FY 2019

1. Only services in same "Clinical Family" allowed to be added to excepted PB Department. (Rule lists 19 Clinical Families). Other services will be paid under Medicare FFS rates.

2. Proposed reduction in payment for E&M codes at excepted PB departments reduction of 60% of OPPS facility payment.

3. Higher Payments for 340B to Off Campus Grand Fathered PB departments is reduced to AWS minus 22.5%

4. Effective Jan. 1, 2019. Comment period up to Sept. 24.

RURAL HEALTH CLINICS (RHC)

1. Established under Public Law 98-210
2. Located in NON-URBANIZED AREA.
   Not same definition as MSA (defined by 2010 Census)
3. California as a lot of Non-Urbanized Areas within MSA s
4. Specific Areas known as “Goldsmith Modification” areas

BUTTE CALIFORNIA
EL DORADO CALIFORNIA
FRESNO CALIFORNIA
KERN CALIFORNIA
LOS ANGELES CALIFORNIA
MADERA CALIFORNIA
MERCED CALIFORNIA
MONTEREY CALIFORNIA
PLACER CALIFORNIA
RIVERSIDE CALIFORNIA

SAN BERNARDINO CALIFORNIA
SAN DIEGO CALIFORNIA
SAN JOAQUIN CALIFORNIA
SAN LUIS OBISPO CALIFORNIA
SANTA BARBARA CALIFORNIA
SANTA CLARA CALIFORNIA
SHASTA CALIFORNIA
SONOMA CALIFORNIA
STANISLAUS CALIFORNIA
TULARE CALIFORNIA
VENTURA CALIFORNIA

5. Other Counties may also have areas that contain "rural census tracts" that meet the definition of rural based upon census for the area. Research HRSA web site

6. Health Resource and Services Administration (HRSA) has tools to determine

7. So, the hospital could be Urban for Payment purposes and the Clinic rural based upon HRSA data.

OTHER REQUIREMENTS FOR RURAL HEALTH CLINIC

1. Must be a defined "shortage" area

   - MUP Medically Underserved Population or
   - MUA Medically Underserved Area

   - Must have been reviewed or approved within prior 4 calendar years

2. Must be "Primarily" set to deliver Primary Care Services including

   - Family Practice
   - Internal Medicine
   - OB Gyn
   - Pediatrics

3. Clinic may have other specialties that compliment the primary care focus

4. Other Required Services include ::

- Lab (five basic tests) plus referral to outside Lab
- Radiology (in house or by referral)
- Inpatient Care (by referral)
- Specialists (by referral)

STAFFING REQUIREMENTS

1. At least one Mid Level provider available 50% of time clinic is open

2. Adequate staffing to delivery proper care

3. Proper Policy and Procedures manuals to assure compliance with
   Conditions of Participation Agreement

OWNERSHIP STATUS OF CLINIC

May be either Provider Based or non-provider based. May be owned by Physician or Other owner type : Governmental, Indian Health, etc

Ownership status will impact Medicare Medicaid Payments.

PAYMENT BY MEDICARE

1. Non-provider based are paid a cost per visit not to exceed a Federal cap of 83.45 per visit. (A visit is a face to face encounter with a doctor or mid level provider)

2. The rate is referred to as AIR or All Inclusive Rate

3. Rate is for non-provider based, and Provider Based with Acute beds of 50 or more

4. Hospitals with less than 50 beds, the AIR is the cost per visit per M-3 (cost Report)

PAYMENT (Continued)

1. The rate is adjusted for productivity by providers as follows:

   Doctors subject to minimum of 4,200 visits per FTE
   Mid Level providers minimum of 2,100 visits per FTE

2. The productivity cap is applied in total not by provider individually

3. Application of Productivity adjustment could reduce payment per visit

4. Many small facilities have rates well in excess of the $ 83.45 cap

5. The cost per visit based upon "fully allocated costs" includes overhead

MEDI-CAL PAYMENTS TO RURAL HEALTH CLINICS

1. Medi-cal pays a "prospective rate" based upon one of two methods :

   a. 3 similar facilities rate

   b. Base Year cost per visit rate

2. The 3 similar facility rate is immediate without retroactive adjustment

3. The base year rate is based upon the first FULL year in operation. A partial year is not used. There is an interim estimated rate used until the base year audit is completed.

4. Medi-cal Managed Care, and Dual Eligible claims are subject to "reconciliation"

5. The rate per visit is not subject to Medicare's Upper Payment Limits

6. The Rate determination is subject to Administrative Appeal / and Adjudication of prior paid claims.

RECONCILIATION

1. Retroactive Adjustment is made on Medi-cal Fee for Service claims once the "base Year" determination is made. It can be either a payable due the Program or additional funds due the hospital (May occur a few years after initial PPS rate is set)

2. Medi-cal Managed Care claims receive two payments:
    a. Managed Care Rate Payment (lower than PPS rate)
    b. Code 18 supplemental payment by State

3. A reconciliation of the two payments to the "official" PPS rate is made and settlement is made to the provider.

4. For Medicare Primary / Medi-cal Secondary there are two payments:
    a. Medicare Payment (depends on cost and bed size)
    b. Code 02 Supplemental payment by State (maybe)

5. A reconciliation of the two payments to the official PPS rate is made and a settlement is made for the difference.

CHANGE IN SCOPE OF SERVICE

- When changes occur in a Rural Health Clinic, the costs may increase causing the Medi-cal Payment Rate to not be sufficient to treat patients.

- We can request a "change in scope of service" if such change caused The cost per visit to increase more than 1.75 % from the PPS Rate

- The Request must be filed no later than 150 days from close of the period in which the change occurred. (Tight time line)

- Use DHCS Form 3096 (Available on web portal)

CHANGE IN SCOPE OF SVC. (Continued)

- One of the following reasons must apply :

A. Change caused by amended regulatory requirement
B. Change due to remodeling or relocation
C. Change due to technology changes or medical practice
D. Change due to changes in patient type, or service intensity
E. Changes in provider mix

CHANGE IN SCOPE OF SVC. (Continued)

- The Dept. Of Health Care Services (DHCS) will audit the request and review all supporting documents.
- It is unlikely the full amount of the request will be approved
- Adverse decisions are appealable
- The Dept has shown increased interest in denying all or part of these requests.

FINANCIAL IMPLICATIONS

1. Highest Return is likely from Provider Based RHC under 50 beds

    a. Possibly highest payment rates for Medicare and Medi-cal
    b. Medi-cal rate can be affixed at a high rate
    c. Reconciliation for Managed Care and Duals increases return
    d. Location not limited to 250 yards from Hospital

2. Second Highest Rate likely from Provider Based over 50 Beds

    a. Medicaid is still not limited by Medicare upper payment cap
    b. Reconciliation for dual eligibles under Medi-cal = additional $
    c. Can still use RHC to establish “off campus” clinics

3. Third Selection is Provider Based "On Campus" Clinics - CAH

   a. Can establish easily since it is department of hospital
   b. Payment for Technical portion is FULL COST based
   c. Professional Component can be billed under Method 2
   d. Physician Director is paid on "Cost Basis"

4. Fourth Selection is Provider Based - On Campus - Not CAH

    a. Currently APC for the technical portion is still higher than free standing prof. Component
    b. Physicians are still aligned with the hospital
    c. Can delivery other ancillary services at site

5. Non-Provider Based Clinic

    a. Paid on Medicare Usual and Customary Fee Schedule by CPT code

    b. Still provides some alignment of Doctors to Hospital

SUMMARY / CONCLUSION

Rural Health Clinics and Provider Based Clinics provide :

1. Higher payments that what is possible in a non PB status Clinic
2. These clinics allow hospitals to compensate physicians a higher payment rate to recruit them to a rural area
3. Depending on workload the Doctors can also serve as Clinical Directors (who drive additional payment for a CAH)
4. The Medi-cal program's higher payments for RHC allows Hospital to provide needed coverage for an underserved population