

How Primary Care and Hospital Operations Can Work Together

June 5, 2023



Primary Care and Hospital Integration



- The Rural Environment and Performance Improvement Model
- Practice Designation Types
 - Federally Qualified Health Centers (FQHC)
 - Provider-based Clinic
 - Rural Health Clinics (RHC)
 - Includes Provider-based Rural Health Clinics (PB-RHC)
 - Free-Standing Health Clinic (FSHC)
- Reimbursement Trends and Strategic Opportunities
- Integration Opportunities



Market

One in five Americans live in rural communities

Barriers

Highly fragmented provider community with various clinic designations

Entrenched need for autonomy and cultural resistance to change -- coupled with trust issues

Complex, arcane and fluid regulatory environment tied to optimal reimbursement

Opportunity

Organizations must take steps to improve their operational performance, service delivery, and financial position: specifically looking at the alignment and designation of each rural practice to improve performance

Rural markets are built on relationships that strengthen trust, honor legacy models and provide the type of innovation and expertise that is not present in the current, inefficient industry

Medicare Economic Index (MEI)

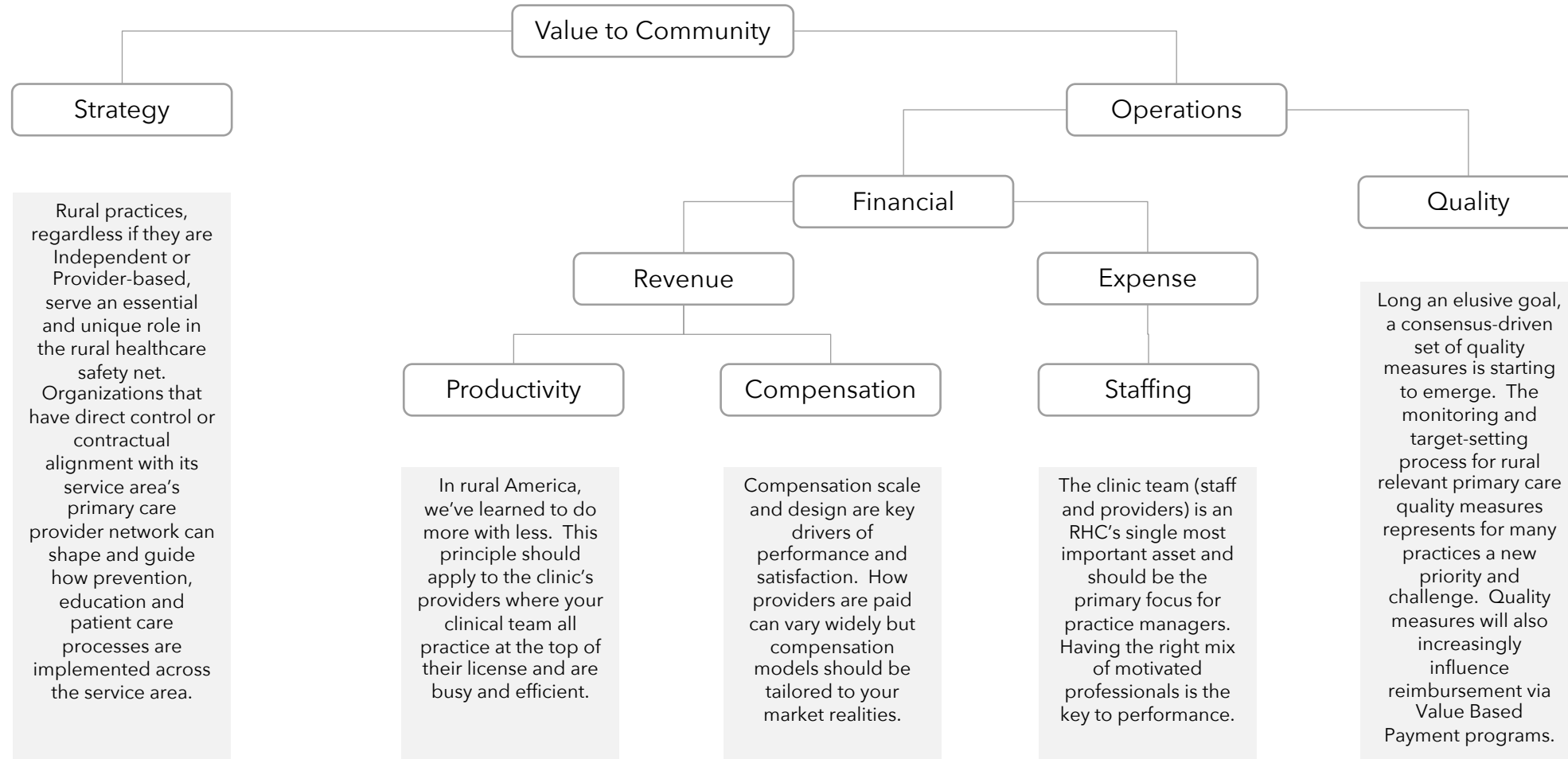


- The Medicare Economic Index (MEI) was developed in 1975 and is the baseline for each year’s payment update calculation
 - The following table presents the MEI from 2014 through 2023

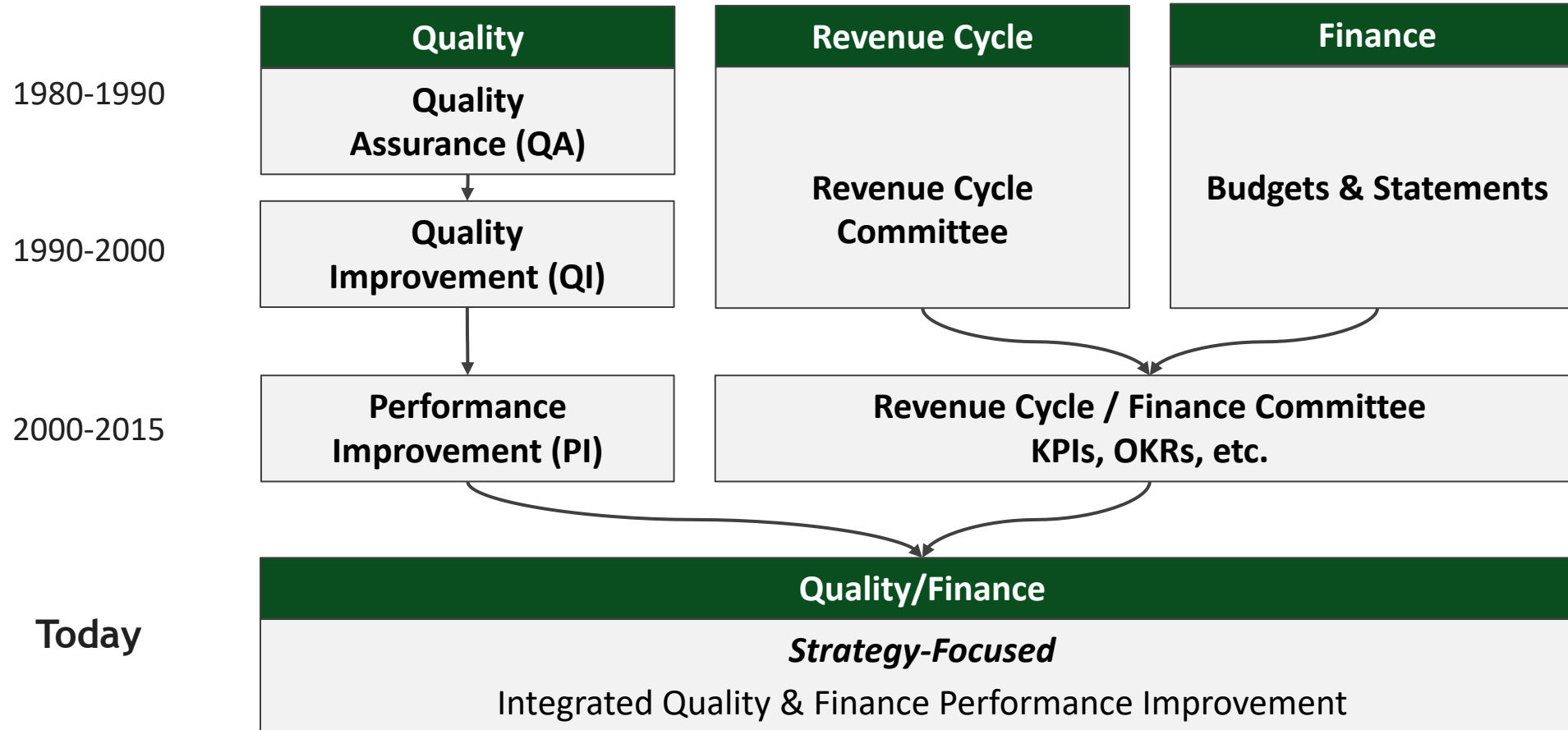
Medicare Economic Index ¹	CY14	CY15 ²	CY16 ³	CY17	CY18	CY19	CY20	CY21	CY22	CY23	AVERAGE
Market Basket Update	0.8	0.8	1.1	1.2	1.4	1.5	1.9	1.4	2.1	3.8	1.6

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

Performance Improvement Model

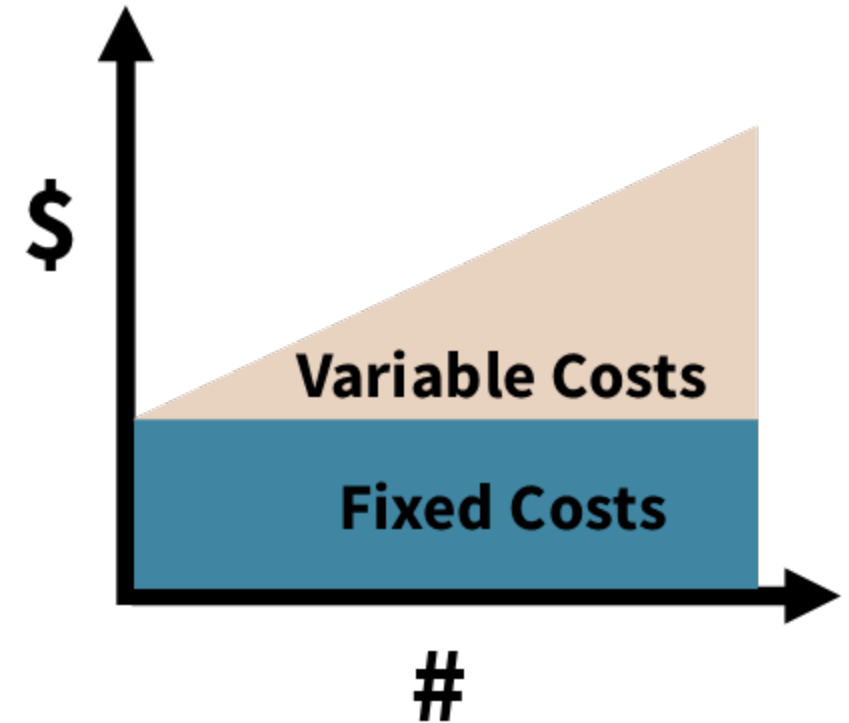


Evolution of Improvement Models



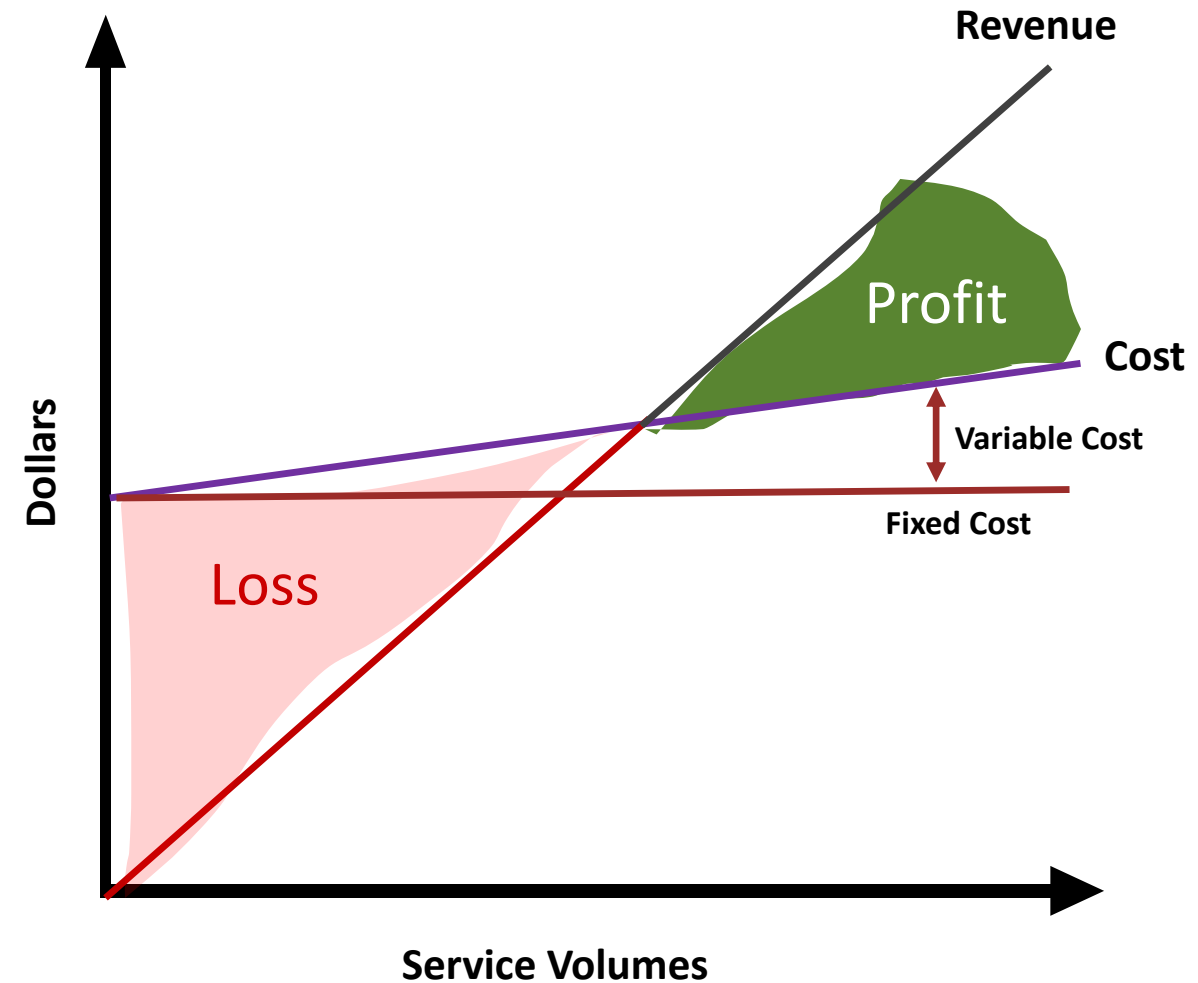
Understanding Your Cost Structure

- Fixed costs are those which exist irrespective of volume
 - Unit staffing, medical direction, medical equipment, par levels of supplies
- Variable costs are those which would be incurred with each additional CAH/RHC visit
 - Incremental medical supplies and pharmaceuticals
- In comparison to fixed costs, variable costs represent only a fraction of CAH/RHC costs
 - As volume grows, fixed costs are diluted faster than variable costs grow



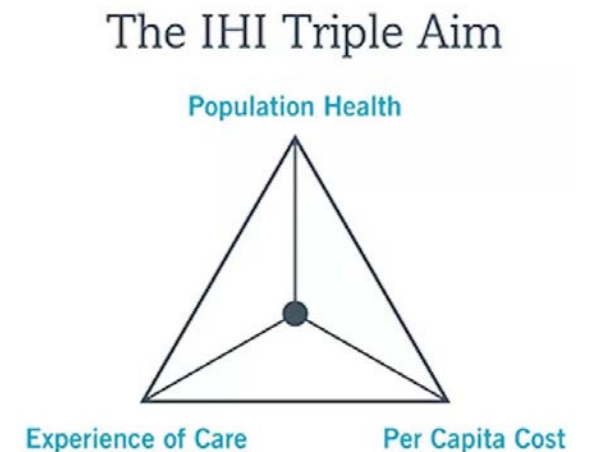
Economic Philosophy

- The financial solvency of a CAH 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
 - CAHs need to break down the silos between quality and finance for improved outcomes



The IHI – Triple Aim

- The United States health care system is the costliest in the world and changes must occur to maintain the sustainability of services and care
 - The IHI Triple Aim framework, developed by the Institutes for Healthcare Improvement (IHI), describes an approach to optimizing health system performance
- IHI believes the United States must develop new designs that simultaneously pursue three dimensions: the Triple Aim
 - Improving the patient experience of care (including quality and satisfaction)
 - Improving the health of populations; and
 - Reducing the per capita cost of health care¹
- Generally, in the United States health care environment, no one is accountable for all three dimensions of the IHI Triple Aim and thus lead to the following conceptual design:
 - Focus on individuals and families
 - Redesign of primary care services and structures
 - Population health management
 - Cost control platform
 - System integration and execution



Practice Designations

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 can operate an FQHC within the system
- An FQHC receives the following reimbursement and additional funding opportunities
 - Enhanced reimbursement from Medicare,
 - 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

Federally Qualified Health Center



- **Federally Qualified Health Center (FQHC)**

- 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)

Provider-Based Clinic



- **Provider-Based Clinic (PBC)**

- A Provider-Based Clinic is operated as an integrated department of a main provider, including a hospital or CAH
 - PBC financial operations must be integrated with the main provider's financial system
 - The PBC must be held out to the public and other payers as a department of the main provider
 - An off-campus CAH PBC must meet the federal distance requirement specified in the CAH Conditions of Participation or risk jeopardizing the CAH designation
 - The PBC must be 100% owned by the main provider
- PBCs and have access to the following benefits:
 - A physician clinic operating as an on-campus PBC can receive higher Medicare and Medicaid payments than the same practice operating as a freestanding clinic and often as an RHC
 - However, site neutrality went into effect in 2019
 - A PBC can participate in the 340B Drug Pricing Program
 - PBC 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 un-capped 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

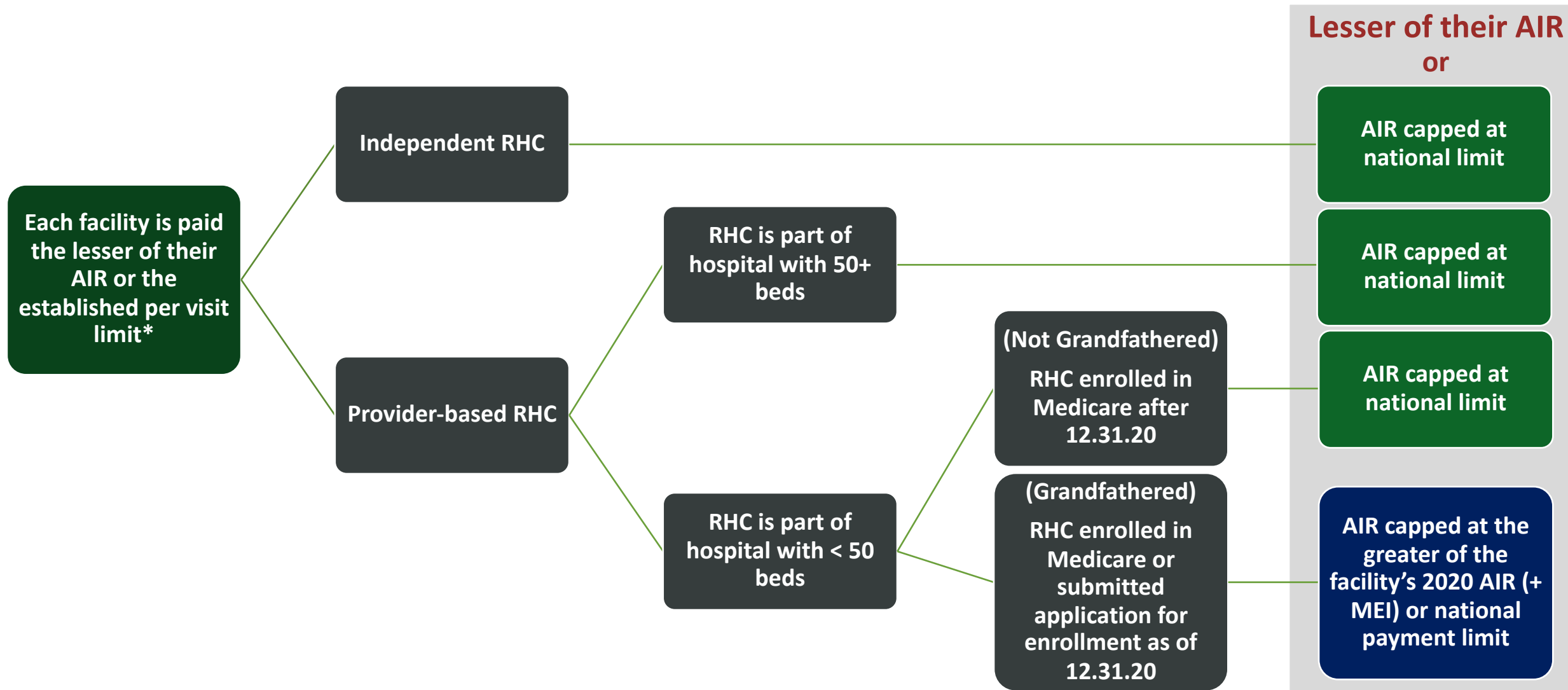
- **Rural Health Clinic (RHC)**

- A RHC is a clinic located in a rural, medically underserved area that has a separate reimbursement structure from a standard medical office
 - 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)
 - **Note:** *The removal of urbanized areas will likely be an issue since 491.5 clearly states a rural area is an area “not delineated as urbanized areas in the last census conducted by the Census Bureau”*
 - 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
- Starting on April 1, 2021, all new RHCs established after December 31, 2020, regardless of whether they are independent, owned and operated by a hospital with fewer than 50 beds, or owned and operated by a hospital with greater than 50 beds, shall be reimbursed based on reasonable cost with an upper payment limit (UPL) set at the following rates:
 - Starting at \$100 per visit on April 1, 2021 and trending towards \$190 per visit in 2028
 - In subsequent years, the rate will increase based on the Medicare Economic Index (MEI) for primary care services
 - RHCs owned and operated by a hospital with fewer than 50 beds and established on or before December 31, 2020 or those that applied before December 31, 2020 will qualify as a grandfathered RHC

- **Rural Health Clinic (RHC)**

- 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
- **Note:** *Since new PB-RHCs no longer receive a financial benefit from Medicare, an organization wishing to establish an RHC no longer must establish that practice as provider-based*
 - However, organizations should still evaluate the impact on Medicaid reimbursement

RHC Rate Establishment



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 Advanced Practice Providers (APP)
- 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

Reimbursement Trends and Strategic Opportunities

Practice Approach to Revenue Optimization



- As seen, each of the four clinic types evaluated encompass different reimbursement methodologies that greatly impact reimbursements received from Medicare and Medicaid and must be factored when evaluating primary and specialty providers
 - The table below highlights those differences

Reimbursement Options	FQHC	CAH PBC	<50 Beds PB-RHC	FSHC
330 Grant	Yes	No	No	No
340B Pharmacy	Yes	Yes	Yes*	No
Un-Capped Technical Charge	No	Yes	Yes	No
Method II Billing	No	Yes	No	No
Tort Reform - Malpractice Savings	Yes	No	No	No
Enhanced PPS Reimbursement	Yes	Yes	Yes	No

- * For non-CAHs, Hospital needs to meet DSH % to qualify for 340B

RHC Reimbursement Methodology



- With declining reimbursements, healthcare entities must leverage available reimbursement opportunities to improve financial performance
- The following opportunities are available to hospitals and systems to improve reimbursements when those practices can meet certain eligibility requirements:
 1. Convert eligible practices to a designation that provides the most advantageous reimbursement opportunity
 2. Realign practices within a health system to leverage reimbursement advantages and additional revenue
 3. Integrate specialty practices and providers, when possible, within a PBC or RHC to leverage alternative reimbursement methodologies
 4. Acquire independent practices to leverage provider-based reimbursement opportunities and other additional revenue streams available to hospitals such as 340B
 - This opportunity may not lead to a net positive return; however, will increase in functional, contractual, and governance alignment and increase the attributed lives associated with the hospital / health system
 - **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*

Opportunity 1: Practice Designations – (PB)



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

Summary Data	Scenario #1 PBC	After 2019 OPPS Final Rule (PBC)	Before Change		After Change
			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

Opportunity 1: Practice Designations – (Ind.)



- The following table shows the net financial impact of different designations on an independent practice:

Summary Payor Data	FSHC Visits	Revenue	Before Change			After Change			
			RHC Payment / Visit	RHC Visits	RHC Revenue	RHC Payment / Visit	RHC Visits	RHC Revenue	
Practice Impact									
Medicare	\$ 117.74	4,581	\$ 539,362	\$ 86.32	4,581	\$ 395,432	\$ 113.00	4,581	\$ 517,653
Medicaid	67.86	3,875	262,960	106.76	3,875	413,705	106.76	3,875	413,705
Average	\$ 94.88	8,456	\$ 802,322	\$ 95.69	8,456	\$ 809,137	\$ 110.14	8,456	\$ 931,358
Variance With Current State				\$ 6,815			\$ 129,036		

- Outcomes:

- Prior to the change in the RHC reimbursement methodology, the RHC designation would have increased reimbursements by nearly \$7K; however, all of the gain would have been attributed to Medicaid
- After the change in the law, the RHC designation would have increased reimbursements by \$129K

Opportunity 2: Practice Realignment



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

Summary Data	Before Change			After Change
	Scenario #1 FSHC	Scenario #2 PB-RHCs under STAC	Scenario #3 PB-RHCs under CAHs	Scenario #4 PB-RHCs under CAHs
Practices Impact				
Medicare / Medicaid Average	\$ 110.02	\$ 189.63	\$ 194.27	\$ 113.00
Annual Visits	53,291	53,291	53,291	53,291
Reimbursements Received	\$ 5,863,215	\$ 10,105,572	\$ 10,352,843	\$ 6,021,883
Other Impact				
Medicare / Medicaid Reimbursement	\$ -	\$ -	\$ (1,464,212)	\$ (1,464,212)
340B Revenue	-	-	2,642,197	2,642,197
Reimbursements Received	\$ -	\$ -	\$ 1,177,985	\$ 1,177,985
Variance w/ FSHC (Scenario #1)		\$ 4,242,357	\$ 5,667,613	\$ 1,336,653

- Outcomes:
 - Although the RHC reimbursement methodology changed, the designation is still more favorable than operating as FSHCs; however, important to note the net gain is dependent upon the 340B program under the new reimbursement methodology

Opportunity 3: Specialty Integration



- The following table shows the net financial impact of integrating a behavioral health provider into an RHC

Summary Data	Scenario #1 Separate	Scenario #2 Intergrated	Variance
Free-Standing Health Clinic			
Medicare / Medicaid Average	\$ 75.64	\$ -	\$ (75.64)
Annual Visits	641	-	(641)
Reimbursements Received	\$ 48,485	\$ -	\$ (48,485)
Provider-Based Rural Health Clinic			
Medicare / Medicaid Average	\$ 197.24	\$ 191.65	\$ (5.59)
Annual Visits	4,769	5,410	641
Reimbursements Received	\$ 940,638	\$ 1,036,827	\$ 96,189
Critical Access Hospital			
Medicare / Medicaid Reimbursement	\$ 9,967,243	\$ 9,956,219	\$ (11,024)
340B Revenue	367,241	367,241	-
Reimbursements Received	\$ 10,334,484	\$ 10,323,460	\$ (11,024)
Integrated Benefit			\$ 36,680

- Outcomes:

- Under this scenario, integrating a behavioral health provider into an RHC, instead of operating as a separate practice, would improve the net position of the combined entity

Opportunity 4: Practice Acquisition



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

Summary Data	Scenario #1 FSHC	Before Change	After Change
		Scenario #2 PB-RHC	Scenario #2 PB-RHC
Independent FSHC			
Medicare / Medicaid Average	\$ 94.43	\$ 199.20	\$ 113.00
Annual Visits	2,724	2,724	2,724
Reimbursements Received	\$ 257,219	\$ 542,622	\$ 307,812
Critical Access Hospital			
Medicare / Medicaid Reimbursement	\$ 11,244,531	\$ 11,041,322	\$ 11,041,322
340B Revenue	-	179,240	179,240
Reimbursements Received	\$ 11,244,531	\$ 11,220,562	\$ 11,220,562
Variance w/ FSHC (Scenario #1)		\$ 261,434	\$ 26,624

- Outcomes:
 - Acquiring the practice and operating as a PB-RHC would improve the net financial position of the acquired practice; however, once again, the benefit is dependent up on the 340B program
 - Note:** Due to the location of the practice, operating as a PBC was not an option

Integration Opportunities

Operational Considerations

- **Clinically Integrated Networks**

- Operational Functions

- Team-based Care
 - Proactive Care
 - Clinical Guideline Use
 - Clinical Variation Reduction
 - Quality Improvement
 - Care Coordination
 - Data Sharing and Analysis
 - Clinical Accountability
 - Efficiency Improvement
 - Legal Protection

- Organizational Components

- Clinical Leadership
 - Performance Improvement
 - Information Technology
 - Legal and Contracting Options
 - Membership Criteria
 - Fund Flows

Operational Considerations

- **Internal Referral Process**

- Structural integration and co-location (e.g. shared space)
- Fully integrated (single organizational structure with employed staff)
- Single medical record
- Shared billing and scheduling systems
- Shared risk

- **Integrated care initiatives should be:**

- Patient centered (e.g., address the needs of the patient; is responsive to patient preferences, needs, and values; and ensures that patient values guide all clinical decisions);
- Expand access to care, decrease burden of illness, optimize care;
- Delivered in settings preferred by patients;
- Evidence based;
- Driven by clinical and care issues and functions not practice and administrative issues;
- Focused not only on integrating care within practices/facilities but also across practices and care settings; and
- Focused on both physical health and behavioral health settings

- Medicare allows care management services that include transitional care management (TCM), chronic care management (CCM), principal care management (PCM), general behavioral health integration (BHI), and psychiatric collaborative care model (CoCM) services
 - **Transitional Care Management Services (TCM)**
 - Transitional Care Management (TCM) services address the hand-off period between the inpatient and community setting
 - After hospitalization or other inpatient stay, the patient may be dealing with a medical crisis, new diagnosis, or change in medication therapy that requires assistance post discharge
 - General TCM services include:
 - Contact the beneficiary or caregiver within two business days following a discharge
 - The contact may be via telephone, email, or a face-to-face visit
 - Conduct a follow-up visit within 7 or 14 days of discharge, depending on the complexity of medical decision making involved
 - The face-to-face visit is part of the TCM service and should not be reported separately
 - Medicine reconciliation and management must be furnished no later than the date of the face-to-face visit
 - Educate the beneficiary, family member, caregiver, and/or guardian
 - Establish or re-establish referrals with community providers and services, if necessary
 - Assist in scheduling follow-up visits with providers and services, if necessary

Care Management Services



- **Chronic Care Management (CCM)**

- CCM is for members with two or more chronic conditions and includes the management of medications, appointments, and services managed by one healthcare provider
 - Providers can receive payment when at least 20 minutes of qualifying CCM services are provided during a calendar month
- General CCM services include:
 - Management of care across providers
 - Coordination of your care between hospitals, pharmacies, and clinics
 - Management of medications taken
 - Providing round-the-clock access to emergency care
 - Education around conditions and medications
 - Management of community services such as transportation to appointments

- **Principal Care Management (PCM)**

- PCM is like Medicare's CCM with a few key differences
 - Under the new PCM codes, specialists may now be reimbursed for providing their patients with care management services that are more targeted within their own particular area of specialty
 - PCM services may be furnished to patients with a single high-risk or complex condition that is expected to last at least 3 months and may have led to a recent hospitalization, and/or placed the patient at significant risk of death and requires a minimum of 30 minutes of qualifying PCM services are furnished during a calendar month
- General PCM services include:
 - A single complex chronic condition lasting at least 3 months, which is the focus of the care plan;
 - The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization;
 - The condition requires development or revision of disease-specific care plan;
 - The condition requires frequent adjustments in the medication regiment; and
 - The condition is unusually complex due to comorbidities

- **General Behavioral Health Integration (BHI)**

- BHI is a team-based, collaborative approach to care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions
 - RHCs can receive payment when at least 20 minutes of qualifying BHI services are provided during a calendar month
- General BHI services include:
 - An initial assessment and ongoing monitoring using validated clinical rating scales;
 - Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
 - Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
 - Continuity of care with a designated member of the care team

- **Psychiatric Collaborative Care Model (CoCM)**

- Psychiatric CoCM is a specific model of care provided by a primary care team consisting of a primary care provider and a health care manager who work in collaboration with a psychiatric consultant to integrate primary health care services with care management support for patients receiving behavioral health treatment and includes the following:
 - Regular psychiatric inter-specialty consultations with primary care team
 - Regular review of treatment plan by primary care team
 - Specific requirements for the RHC providers, behavioral health care manager, and psychiatric provider
- At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months, of psychiatric CoCM services must have been furnished in order to bill for this service
 - Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted toward the minimum 60 minutes
 - Does not include administrative activities such as transcription or translation services
 - Psychiatric CoCM services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99492 and CPT code 99493 when psychiatric CoCM HCPCS code, G0512, is on an RHC claim, either alone or with other payable services

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
 - Your medical team will be invested in your 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

Questions



Jonathan Pantenburg, Principal
Jpantenburg@wintergreenme.com

808.853.8086