RHCs Management Considerations in 2019

Charles A. James, Jr.
President and CEO
North American Healthcare Management Services

RHC Modernization Act

"Increases reimbursements for RHCs. Currently, RHCs are paid an all-inclusive rate for the care they provide. This rate has not been legislatively updated since 1988. This legislation updates reimbursements to better reflect the quality of care provided by RHCs"

Sec. 7 Raising the Cap on Rural Health Clinic Payments.

Beginning in CY 2020, increase the upper limit (or cap) on RHC reimbursement to $105 per visit, in CY 2021 to $110 per visit and in CY 2022, to $115 per visit. Thereafter, cap is adjusted annually by MEI.

RHC Modernization Act

Please contact your US Representative AND US Senator!

NARHC Advocacy Page:
https://www.web.narhc.org/narhc/RHC_Modernization_Act_Advocacy.asp

Does NOT cut Provider-based rates. The rate increase is paid by limiting the future growth of RHC encounter rates to MEI.

Post-ObamaCare, TrumpCare(?), Medicare for All?

While we, as a nation, continue to discuss whether to further dismantle or reinforce Obamacare,

…the ground has shifted beneath us.

Primary Care has shifted and evolved.

- ✓ Dramatic shift to hospital ownership.
- ✓ Independent/small providers face SIGNIFICANT challenges.
- ✓ Healthcare entites are operating at losses or barely surviving, especially non-RHC.
- ✓ Hospital services are almost universally provided by non-RHC providers.
- ✓ Slowed provider productivity with a warped supply and demand curve for primary care providers.
- ✓ Corporate giants have entered primary care. They are willing to incur losses to attract your patients.

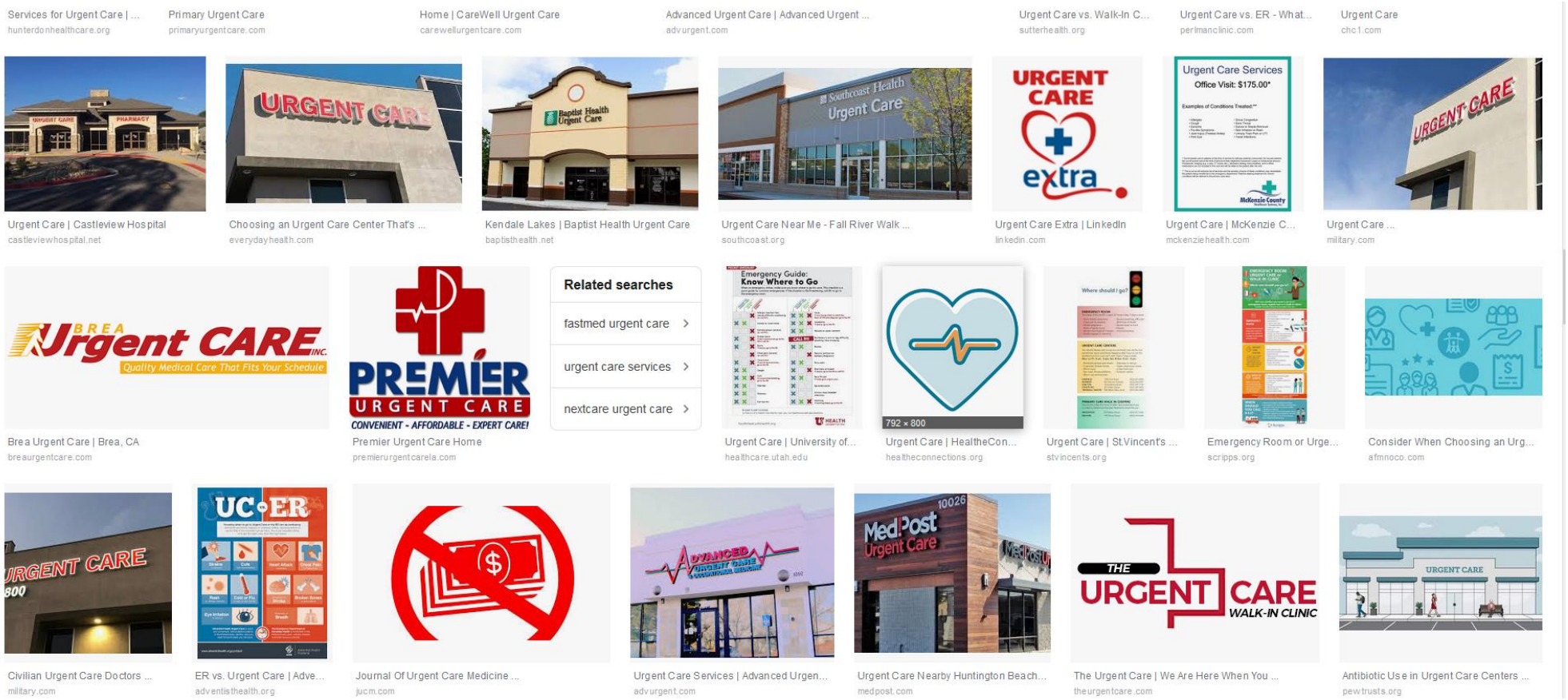
Employment and the changed economy.

- ✓ Rural employment trends have changed.
- ✓ Many of our rural communities suffer from under-employment and under-insurance.
- ✓ Many must commute for employment opportunities outside of their home town.
- ✓ Old, school 9 – 5 clinic hours are no longer sustainable.
- ✓ We need to accommodate our patients during the hours they need us.

Consolidation, Convenience, Reimbursement

- ✓ *Economic conditions have driven consolidation throughout the healthcare industry.*
- ✓ Patients demand immediate access to urgent care, acute care, and primary care.
- ✓ Provider reimbursement MUST be maximized in all ways.
- ✓ Quality performance, practice performance data, and documentation methods are vital.

Urgent Care Everywhere



We must ALL change according to this paradigm shift in Healthcare. Who are you? Who do you want to be?

Change or Die.

Charles A. James, Sr. –
Professor Emeritus, St. Louis University
Co-Founder, James Clinic
Founder, North American HMS

RHCs and Primary Care Practices in 2019 and Beyond

- ✓ RHC Modernization Act
- ✓ Patient-Oriented Culture
- ✓ Information is power.
- ✓ Patients demand convenience and efficiency.
- ✓ Team Orientation
- ✓ New sources of RHC Reimbursement
- ✓ Benchmarking: Watching the Controls

Culture – How does it feel to be in your office?

- ✓ How are patients spoken to at check-in?
- ✓ How do your patients hear YOU speaking with and about others you work with?
- ✓ YOU are there for the patients. The Patients are NOT there for you.
- ✓ Toxic/Negative work culture is a patient confidence killer.
- ✓ It is a provider productivity killer.
- ✓ What is the level of stress in your office. How/why/by whom is it created?

Communication. Communication. Communication.

Who is in charge of your RHC?

Staff? Patients? Providers? Finances?

Clinical Standards

- ✓ Patient-Oriented Culture
- ✓ Well-defined Job Descriptions and Work Flows
- ✓ Collaborative Agreements – Provider Collaboration
- ✓ Team Oriented Care – Patient-Centered Medical Care
- ✓ Team Communication – Electronic and Personal

Practice Workflows

- ✓ Electronic health record work-flows developed by all team members.
- ✓ Visit component documentation
- ✓ Discrete data vs. Free Text
- ✓ Referral Processes
- ✓ Patient Education
- ✓ Follow-Up Activity and Documentation

Operational Standards

- ✓ Front-Office Procedures
- ✓ Verify Insurance and Eligibility
- ✓ Know Payer Requirements!
- ✓ Know Enrollment Status!
- ✓ Collect Accurate Information!

Team-Oriented Care

- ✓ Team-oriented care is essential for today's demands.
- ✓ Relieves pressure from providers.
- ✓ Helps with completing notes in a timely manner.
- ✓ Increases ability to comply with performance measurements.

EHR and Quality – Information is power.

Information, how it flows in your organization, whether it can be tracked, and how easily, is a key component of the modern primary care office.

Quality Initiatives:

- ✓ How are measures being tracked? Excel?
- ✓ How are measures being documented in the EHR?
- ✓ Free text or Discreet Data?
- ✓ Are EHR workflows reasonable, and trackable? If not, what is the problem?

Reimbursement Opportunities for RHCs

"Urgent Care" and RHCs

Specialist Services in the RHC

Care Management Services for RHCs

Patient-Centered Medical Home Status

State Telehealth Services

“Urgent Care” and RHCs

RHCs may provide “Urgent Care Services”, “Immediate Care”, and “Convenient Care”.

Are RHCs “Urgent Care” Centers? (Not really – Define Urgent Care Center)

RHCs may provide care for both acute and chronic injuries and illnesses.

Extended hours on evenings and weekends can be incorporated into RHCs. Cost reporting and staffing considerations apply.

Specialists and RHCs

"[§ 491.9(a) Basic requirements:]

(2) The clinic . . . is primarily engaged in providing outpatient health services and meets all other conditions of the subpart."

State Operations Manual Appendix G:

In the context of an RHC, "primarily engaged" is determined by considering the total hours of an RHC's operation, and whether a majority, i.e., more than 50 percent, of those hours involve provision of RHC services.

Rural Health Services

- ✓ Physicians' services, as described in section 100;
- ✓ Services and supplies incident to a physician’s services, as described in section 110;
- ✓ Services of NPs, PAs, and CNMs, as described in section 120;
- ✓ Services and supplies incident to the services of NPs, PAs, and CNMs, as described in section 130;
- ✓ Clinical Psychologist and Clinical Social Worker services, as described in Section 140;
- ✓ Services and supplies incident to the services of CPs and CSWs, as described in Section 150; and
- ✓ Visiting nurse services to the homebound as described in Section 180.

Increasing Access to Care and Specialists

If question is: “does it increase access to services”, then it is part of our mission as RHCs.

Integrating specialists in the RHC is an excellent way to increase patient access to healthcare services.

There are various considerations for integrating specialists. Some are more complicated. Others less so. Some are very wrong.

There are EASY ways to mess it up.

Considerations for Specialists in the RHC

Are these specialists direct employees, or are they contracted? With whom are they contracted?

Are they billing as part of the RHC, or are they going to do their own billing?

If they are doing their own billing with their own staff, there are serious public awareness, cost reporting, and other considerations.

Managing and discussing commingling risk in these arrangements is ***critical***.

Section 100: Commingling

Commingling refers to the sharing of RHC or FQHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC or FQHC physician(s) and/or non-physician(s) practitioners.

Section 100: Treatment Space

"RHC and FQHC practitioners may not furnish or separately bill for RHC or FQHC- covered professional services as a Part B provider in the RHC or FQHC, or in an area outside of the certified RHC or FQHC space such as a treatment room adjacent to the RHC or FQHC, during RHC or FQHC hours of operation."

Space Sharing Requirements for Provider-based RHCs

CMS is clarifying how provider-based departments, and other entities share space.

Colocation: hospitals have co-located with other hospitals or other healthcare entities as they seek efficiencies and develop of different delivery systems of care.

This guidance clarifies how shared spaces, services, personnel and emergency services can be organized to allow the hospital to demonstrate independent compliance.

Space Sharing: Provider-based RHCs

"In general, under this guidance, sharing public areas such as entrances and waiting rooms would be permissible. However, due to infection control, patient management, confidentiality, and other quality and safety concerns, the use of shared clinical spaces would be limited."

QSO-19-13-Hospital May 3, 2019

DRAFT ONLY- Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities Comment period ended: July 2, 2019

Care Management Services for RHCs

These are NOT a high hill to climb! You can do it!

Most EHRs have an EHR module (or should!).

Many outsourcing opportunities if the clinic is not equipped.

These include broadened definitions to include modern HC and BH challenges.

- ✓ Care Management (G0511-G0512)
- ✓ Virtual Check-In [Tech-Based Service/Remote Evaluation] (G0071)

Patient-Centered Medical Home Status

- ✓ Commercial Payer Value-Based Payments
- ✓ Significant overlap with RHC Standards
- ✓ Achieve additional revenue on some payers that do NOT recognize RHC status.
- ✓ All states and plans vary. There IS investigation required on what and how your specific clinic payers will reimburse.
- ✓ (There are people in the room who can help!)

Telehealth

- ✓ Medicare still applies “originating site” and remote provider requirements to Telehealth.
- ✓ Many state Medicaid entities are allowing telehealth visits to be paid as encounters.
- ✓ Many states are working with schools to include school visits under state RHC encounter eligibility.
- ✓ HIPAA Compliant Mobile Video Applications.

“If you aren’t watching the controls – you aren’t flying the plane.”

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Practice Benchmarking

Medical practices are complex entities to manage

They have to be monitored and maintained with proper care.

Benchmarking quantifies performance, and helps make practice statistics meaningful.

It is important to keep and monitor practice statistics.

Clinical AND Financial Measures are important!

Common Financial Measures

- ✓ Gross Collection Percentage
- ✓ Adjusted Collection Percentage
- ✓ Charges/Payment/Adjustments By Payer Type!
- ✓ AR Days
- ✓ AR Aging

Clinical Measures

- ✓ Patient Wait Time
- ✓ No-Show Rates
- ✓ Open Charts
- ✓ Value-Based/Quality Measures
- ✓ HEDIS
- ✓ What is relevant for YOUR practice?

Top Practice Mistakes

- ✓ Did not start enrolling new provider soon enough.
- ✓ Started enrolling a new provider a week before starting.
- ✓ Did not enroll a new provider with at least 90 days lead-time (and that's BARELY enough).

Practice Mistakes 4-10

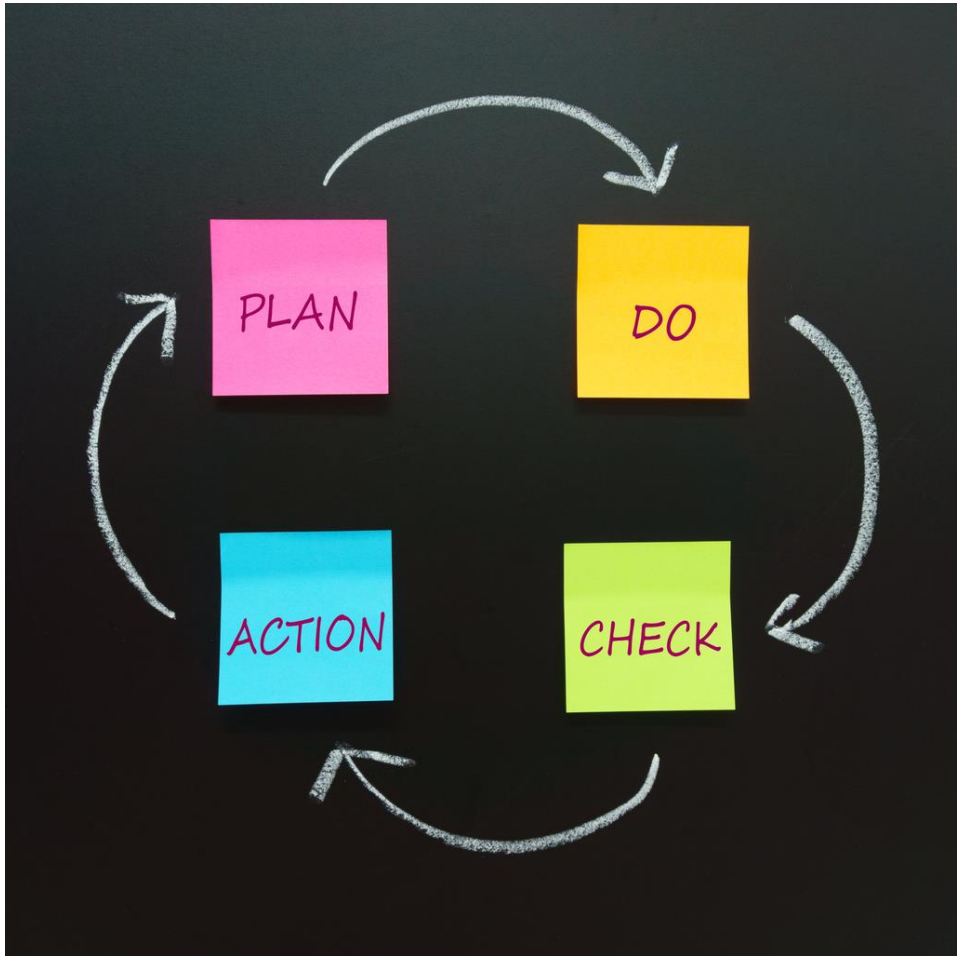
- ✓ Sloppy Front-End Practices
- ✓ Inability to collect patient balances
- ✓ Reacting versus planning
- ✓ Poor EHR/Practice Management *implementations!*
- ✓ Corrosive practice culture
- ✓ Work martyrdom

And the top mistake?

The Definition of Insanity (Einstein):

"Doing the same thing repeatedly, and expecting different results."

Don’t forget the basic principle:



Contact Information

Charles A. James, Jr.

North American Healthcare Management Services

President and CEO

cjamesjr@northamericanhms.com

www.northamericanhms.com

888.968.0076