RHC Partnerships to Improve Patient Care and Payer Mix Opportunities

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Presentation Goal

• By the end of this presentation the course participants will be able to describe what Rural Health Clinic (RHC) partnerships look like and how these partnerships can lead to positive revenue streams, additional opportunities for collaboration, improvement in community exposure and perceptions and an improved RHC payer-mix.
Partnerships start with a willingness to collaborate with others in the healthcare industry.

Collaboration involves taking risk.

Collaboration starts with offering a service or skill to others who have a need for a given service.

Learning to collaborate is a skill worth developing.
Collaboration

Mother Teresa

"I can do things you cannot, you can do things I cannot; together we can do great things."

- www.InspirationBoost.com -
Collaboration – Can be Scary
Where to Start

Understanding Medicare payment system opportunities provide frameworks for determining the following:

• Determine incentives for expansion in your services to the community and the other community providers.
• Determine weaknesses in other providers programming and within their payment systems
• Look for opportunities for collaboration to meet each other’s programming needs within each others payment systems, regulatory requirements and frameworks.
Collaboration – How?

I'm more than happy to collaborate. Just tell me what to do.
A **Rural Health Clinic** (RHC) is a Federally regulated health clinic that is certified to receive special Medicare and Medicaid reimbursement. CMS provides advantageous reimbursement as a strategy to increase rural Medicare and Medicaid patients' access to primary care services in either Medically-Underserved or Health Professional Shortage Areas.
The purpose of ae Rural Health Clinic is to encourage and stabilize the provision of outpatient primary care in underserved rural areas through the use of physicians, physician assistants (PAs), nurse practitioners (NPs) and certified nurse midwives (CNMs). The following is an overview of the major requirements clinics must meet in order to become certified as a Rural Health Clinic.
RHC Location Requirements

• Rural Health Clinics must be located in communities that are both “rural” and “underserved”.
Last petrol for 60 kilometres
Last country doctor for 60 kilometres
• Physical Plant
  • May be a permanent structure, facility or unit or can be mobile (bus, RV, etc.)
  • Must have a preventive maintenance program
  • Must have in place non-medical emergency procedures
RHC Staffing Requirements

- **Staffing**
  - One or more physicians on staff
  - One or more Physician Assistants (PA’s), Nurse Practitioners (NPs) or Certified Nurse Midwife (CNM) on staff.
  - PA, NP or CNM must on-site and available to see patients 50% of the time the clinic open for patients.
RHC CoP - Provision of Services

- Each Rural Health Clinic must be capable of delivering outpatient primary care services. The Clinic must:
  - Maintain written patient care policies.
  - Direct Services (must be provided by clinic staff)
  - Provide diagnostic and therapeutic services commonly furnished in a physician’s office
  - Basic laboratory services (6 tests)
    - Chemical examinations of urine
    - Hemoglobin or Hematocrit
    - Blood sugar
    - Examination of stool specimens for occult blood
    - Pregnancy tests
    - Primary culturing for transmittal
Direct Care Services Required

- Emergency Services
  - First response to common life-threatening injuries & acute illnesses
  - Has drugs used commonly in life-saving procedures
- Services Provided through Arrangement (may be provided by individuals other than clinic staff)
  - In-patient hospital care
  - Specialized physician services
  - Specialized diagnostic and laboratory services
  - Interpreter for foreign language if indicated
  - Interpreters for deaf & devices to assist communication with blind
Direct Care Services Required, Cont.

- **Patient Health Records**
  - Record System Guided by Written Policies and procedures
  - Designated Professional Staff Member Responsible for Maintaining Records
  - Protection of Record Information Policies - Maintenance of confidentiality
“According to your HIPAA release form, I can’t share anything with you.”
RHC Provider Types

- Two Types
  - Freestanding RHC
  - Provider-Based RHC
    - The primary difference between free-standing and provider-based RHCs is the Medicare per visit payment limit. In order to support small rural hospitals, provider-based RHCs owned and operated by hospitals with fewer than 50 beds are exempt from the cost per visit limit.
Freestanding RHCs

- Freestanding or Independent RHCs are freestanding clinics owned by a provider or a provider entity. They may be owned and/or operated by a larger healthcare system, but do not qualify for, or have not sought, provider-based status. More than half of independent RHCs are owned by clinicians.
- These Clinics are paid a set cost per visit limit that is updated annually.
Provider-based RHCs are owned and operated as an essential part of a hospital, nursing home, or home health agency participating in the Medicare program. RHCs operate under the licensure, governance, and professional supervision of that organization. Most provider-based RHCs are hospital-owned.

If owning hospital entity is <50 beds – Medicare pays cost for services.
Medicare Payment for RHC Services

- If RHC is provider-based and owning hospital entity is > 50 beds – the RHC is paid a cost per visit limit:
  - CY 2016: $81.32 – however, actual cost of providing RHC services must be at least that high or higher.
- If provider-based hospital is <50 beds:
  - These provider-based clinics are eligible to be paid for the actual cost of care, including allocated hospital overhead.
Effect of Provider Productivity on Overall RHC Success

• Current Federal regulations require RHCs to meet specific productivity standards or cause their reimbursable cost per visit to be artificially reduced below actual cost. The current standards require:
  • 4,200 visits per full-time equivalent/MD
  • 2,100 visits per full-time equivalent non-physician medical provider.
• However, visit needs of certain RHC’s may not justify hiring FT practitioners but PT practitioners are hard to find.
CHEER UP. AT LEAST YOU HAVE A JOB!

“It’s not exactly the sort of morale booster I had in mind.”
This is Why We Need RHC Partnerships

- Improves provider productivity standards
  - Physician: 4,200 encounters per year
  - Mid-Level: 2,100 encounters per year
- Eliminates risk of an artificial reduction in cost per visit due to low productivity of providers.
- Broadens referral base
- Opportunity to improve reimbursement through volumes, relationships, partnership opportunities.
Types of RHC Partnerships

- Skilled Nursing Facility & Nursing Facility Partnerships
  - Sick care and routine visits
  - Skilled rounding services
- Assisted Living Partnerships
  - Sick visits and periodic rounding on residents
- Specialized Service Partnerships
  - Routine foot care services
  - Simple wound care services
Skilled Nursing Facility Partnerships

- **Sick Visit Services**
  - Provide mid-level practitioners to routinely round on patients at SNFs and NFs that are sick or needing medical evaluation or oversight
  - Must first have a Collaborative Practice Agreement with Medical Director
  - Establish communication protocols of reporting of patient issues between SNF Medical Director and mid-level practitioner
  - RHC practitioner can write orders, transfer/send patients to the hospital ER if further evaluation is warranted and/or ordered by the SNF Medical Director after collaboration
  - Act as “eyes and ears” for SNF Medical Director
  - Provide on-call assistance for the SNF
Skilled Nursing Facility Partnerships

Skilled Rounding Visits

- In the RUGs IV Prospective Payment System (PPS) – frequent provider order changes can in effect keep a patient in a skilled care category for the SNF. Stay covered by Medicare vs. Medicaid or self-pay.
- Diabetes: Special Care/High - Diabetes patient with daily injections (i.e., insulin) and two or more physician (provider) order changes over the past seven days are determined to be “skilled”.
- Completion of Wound Care Treatments: Special Care/Low or Clinically Complex payment categories
- Completion of Certification and Recertification Statements and Signatures:
  - Day 14
  - Every 30 days thereafter to remain “skilled”
Benefits to the Skilled Nursing Facility

Benefits to the SNF/NF:

- Reduces hospital admissions/readmissions
- Reduces trips to the ER
- Improves quality of care
- Increase Medicare patient days
- Increased reimbursement
- Bolsters SNF medical necessity as SNFs are now subject to RAC audits
- Improve compliance with LTC and SNF regulations r/t certification/recertification timeliness
- Relieves oversight burden by SNF Medical Director
- Meets requirements for compliance with monthly visit rules as defined in LTC regulations
SNF Partnerships – Benefits to the RHC

- Benefits to all types of RHCs:
  - Improves Medicare Payer Mix
  - Increases encounter numbers to improve provider productivity
  - Improves provider productivity requirements to allow allocation of full provider salaries into cost allocations/calculation for the cost reports
- Freestanding RHC Benefits:
  - Raises cost per visit to assure that full per visit limit ($80.44) is reached
  - No Medicare monies left on the table
- Provider-Based RHC Benefits (>50 bed host hospitals):
  - Improves allocation % from administrative & general cost categories on the Medicare cost report which raises overall costs per RHC visit
  - Establishes an additional community partner for further healthcare collaborations
  - Additional potential referral source for other hospital services
SNF Partnerships – Benefits to the RHC

- Provider-Based RHC Benefits (<50 bed host hospitals):
  - Improves overhead allocation percentage from administrative & general (A & G) cost categories on the Medicare cost report which in turn raises overall payments per RHC visit
  - Provider-Based RHC’s encounter rate is truly reflective of all the costs related to hospital management of the RHC. Potential encounter rates for these types of hospitals range from $140/visit - $220/visit depending upon organizational structure
  - Establishes an additional community partner for further healthcare collaborations
  - Additional potential referral source for other hospital services
Assisted Living Facility Partnerships

- Assisted Living Partnerships
  - Provide practitioners to round at the ALF for residents who are sick or needing medical evaluation or oversight
  - Consider an office to see residents-in on a weekly or bimonthly basis
  - Establish communication protocols for reporting of patient issues between resident physicians and the mid-level practitioner
  - Consider setting up partnerships to provide:
    - Routine, non-surgical Wound Care to ALF residents
    - Routine foot care and/or foot/nail services
  - First communicate with community physicians what services you propose to provide. Establish protocols/agreements to round and/or restrictions to round as allowed by the attending physician.
  - Collaborative practice agreements not required as no orders, progress notes or other “orders” or ALF documentation left at facility
  - Communication w MDs with each encounter after approval to round
Benefits to the Assisted Living Facility

- Benefits to the ALF:
  - Improves quality of life
  - Reduces hospital readmissions
  - Provides additional healthcare oversight staff to broaden the admissions potentials to the ALF – improves ability of ALF to admit more fragile clients
  - Bolsters ALF’s credibility with physicians and other healthcare providers
  - Relieves oversight burden from the resident’s families and community physicians
  - Great marketing potential for the ALF
ALF Partnerships – Benefits to the RHC

- Benefits to all types of RHCs:
  - Improves Medicare Payer Mix
  - Increases encounter numbers to improve provider productivity
  - Increases compliance with productivity requirements to allow allocation of provider salaries into cost allocations for the cost reports
  - Exposure to new potential patient populations
- Freestanding RHC Benefits:
  - Raises overall cost/visit so that visit limit ($80.44) is reached
  - No Medicare monies left on the table
- Provider-Based RHC Benefits (>50 bed host hospitals):
  - Improves overhead administrative & general cost categories on the Medicare cost report which in turn raises cost/visit
  - An additional partner for further healthcare collaborations
  - Additional potential referral source for other hospital services
Provider-Based RHC Benefits (<50 bed host hospitals):
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- Additional potential referral source for other hospital services
Specialized Services Partnerships

• Specialized services provided at any of the above settings previously discussed. To be provided on a weekly, bimonthly or monthly basis. Settings for services includes:
  • SNF
  • NF
  • Assisted Living Facilities
  • Adult Day Care Facilities
  • Senior Centers
• Specialized services can include:
  • Diabetic Foot Care Clinics
  • Routine Foot Care Clinics for fragile/elderly
  • Non-surgical wound care treatments
Disclaimer: It is recommended that mid-level practitioners receive appropriate foot care and/or wound care training and/or certification prior to offering any specialized services of this type to outside healthcare providers.

- Certifications in Wound Care are available
- Certifications in Foot Care are also available
- Check your local colleges and universities for current offerings in these areas
- If the higher education provider - provides accredited education for healthcare providers and/or allied health they may offer these courses.
Diabetic Foot Care Clinics

- Services are provided to clients with Diabetes in any of the above settings mentioned.
- NFs/SNFs particularly welcome this type of services from trained providers as most facilities are reticent of providing treatment for nail issues as legal exposure may result from any incident involving cutting/clipping of nails, etc.
- ALFs are also very welcoming of this service
- Privacy considerations have to be addressed if this service is provided in any other setting.
- Clients receiving these services must be considered “patients” of the RHC so all HIPAA, P & P’s, etc. related to establishing a new RHC patient must be followed. Admission to RHC/setting up of chart required.
Great need for these services
- Typically provided to each resident at least quarterly
- Specific diagnosis dictate/support medical necessity for these services in the Diabetic patient population
- Diabetes is predicted to effect 1/3rd of the population within the next ten years
- Initial way to get mid-level RHC rounding services established in NFs and SNFs
- Potential for additional services and/or billing opportunities if nail removals and/or dealing with nail issues is required
“This is what you call diabetic foot care?”

© 2007 Diabetes Health
Routine Foot Care

- Services can be provided at any of the settings discussed previously.
- Again, liability is an issue in the NF/SNF custodial care environments and assistance in providing this service is typically welcomed with open arms.
- Establishes relationship with these providers to further progress towards establishing routine mid-level provider rounding services.
Complex Nail Issues

• Complex nail issues may need to be treated directly at the RHC if localized anesthetic is required. Depends upon your providers comfort level and experience in this area:
  • Partial or full nail removal
  • Ingrown nails

• Alternatively, if the RHC is provider-based consider establishing a procedure room at the Hospital for treatment of these conditions. This then would no longer be an RHC encounter but instead an outpatient department of the hospital. Benefits of this:
  • Reimbursement through the hospital OPPS
  • Facility fee can be charged in additional to the OPPS reimbursement
  • Billed through the hospital
Wound Care Services

- Great need for this in NFs and SNFs
- Nursing care ratios are very low in these settings – not enough staff to provide for complex treatments
- Majority of NF staff is non-professional
- Residents in these settings require professional oversight by qualified, trained providers for wound care as protocols and products change frequently
  - RN coverage minimum staffing requirement is 8 hrs./day; 7 days per week
- Great way to initiate a relationship with NFs/SNFs to establish ongoing mid-level provider rounding services
...now apply pressure and hold it there. It's highly absorbent and will speed healing...
Benefits to Community Providers:

• Improves quality of life
• Reduces hospital admissions – improves risk of hospital readmission
• Provides additional healthcare staff to broaden the admissions potentials to any residential/community provider – improves ability to accept and treat more fragile clients
• Bolsters community provider’s credibility with physicians and other healthcare providers
• Great marketing potential for the community provider
RHC Benefits of Specialized Services

- Broadens reach of RHC into the communities it serves
- Increases encounter numbers to improve provider productivity
- Improves Medicare payer mix
- Improves overall financial performance of RHCs in several ways:
  - Allocation of all provider salary costs in that productivity levels are more easily met
  - Cost increases – so increases encounter rate to at least the limit allowable
  - Increases encounter rate exponentially to RHCs who are provider-based and host hospital is <50 licensed beds
Where to Start with Partnerships

• Set-up meetings with community providers and facilities to determine need for any of the following services:
  • Medical oversight and rounding services
  • Routine Foot Care
  • Diabetic Foot Care
  • Wound Care Consultation
• If favorable, establish contact with the Facility Medical Director and/or community attending physicians
  • Put Collaborative Practice Agreements in place – NFs/SNFs
  • Establish Medical Oversight agreements between the MDs and the mid-level staff
  • Establish communication protocols
  • Discuss expectations
“Noreen, have they added a reimbursement code for kale and yoga yet?”
Conclusion

• Development of community partnerships can improve many elements for the RHC
  • Payer Mix – increase Medicare numbers
  • Productivity of providers
  • Overhead allocation increase - ↑ Medicare
  • Revenue stream improvement
  • Referral relationship potential
  • Community exposure - marketing
  • Hospital based – establish new OP opportunities
• Feel free to contact with questions or collaboration opportunities:

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create

collaborate