# Access the recordings and slides!

https://nosorh.org/educational-resources/nosorh-institutes/

NOSORH

National Organization of **State Offices of Rural Health**

# Tonne McCoy, TA Director

- Doctoral candidate in Idaho State University's Experimental Psychology PhD program with an emphasis in rural health.
- Served rural health for nearly a decade, so far
- Holds Certified Rural Health Clinic Professional (CRHCP) credentials
- Holds Lean Six Sigma Green Belt status
- Raised in and still lives in rural

# National Organization of State Offices of Rural Health

NOSORH promotes the capacity of State Offices of Rural Health and rural stakeholders to improve health in rural America through leadership development, advocacy, education, and partnerships.

NOSORH

National Organization of **State Offices of Rural Health**

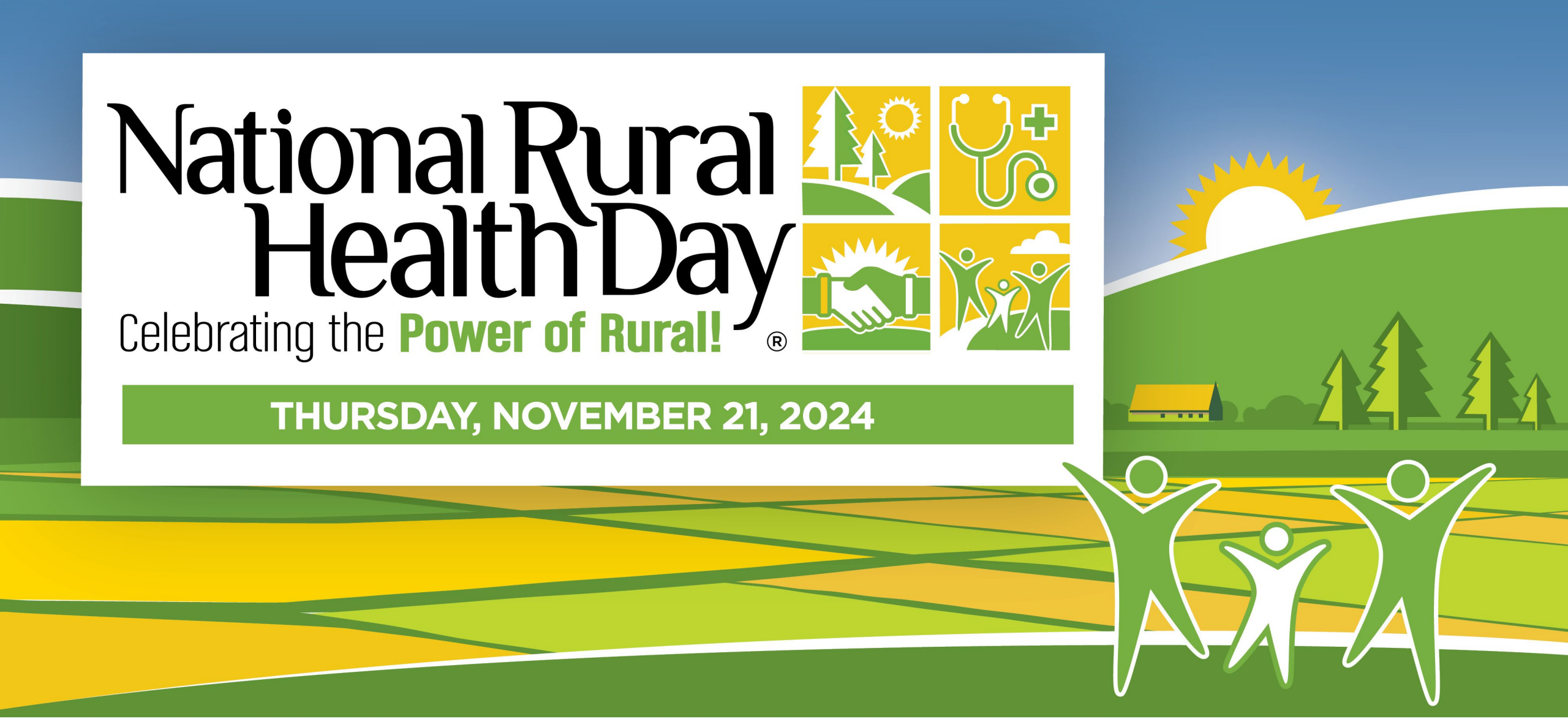
SORH are the connection to State and Federal resources for hospitals, clinics, and thousands of rural health partners across the United States and work to improve access to health care in rural and underserved areas.

**SORH have three core functions:**

Information Dissemination
Rural Health Coordination
Technical Assistance

**Find your SORH at the link below!**
*https://nosorh.org/nosorh-members/nosorh-members-browse-by-state/*

National Organization of
State Offices of Rural Health




https://www.powerofrural.org/

#PowerofRural

# National Association of Rural Health Clinics Overview

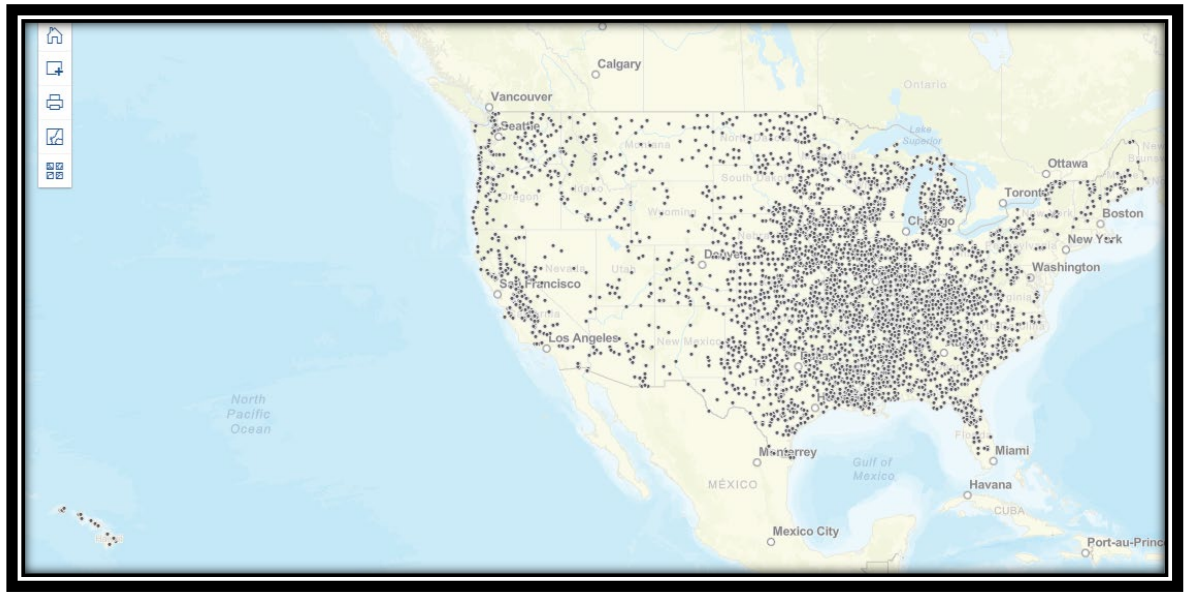
Sarah Hohman, MPH, CRHCP

Director of Government Affairs
National Association of Rural Health Clinics

202-543-0348
Sarah.Hohman@narhc.org

# Rural Health Clinics Overview

- 5,500+ clinics in 47 states
  - RHC program serves 38.7 million patients annually
    - 62% of the 60 million Americans that live in rural areas



# NARHC Overview

***"To educate and advocate for Rural Health Clinics, enhancing their ability to deliver cost-effective, quality health care to patients in rural, underserved communities."***

## Education:

NARHC ACADEMY
EDUCATING RHC PROFESSIONALS ACROSS THE US

- Intro to RHCs
- Certified Rural Health Clinic Professionals (CRHCP)

### Technical Assistance Webinars

- Mobile Units and Your RHC – Is this a good fit?
- RHC Billing 101

### Conferences



## Legislative & Regulatory Advocacy:

***NARHC serves as the primary resource to Congress, federal agencies, and the Administration on federal RHC issues. Aim to:***

- ***Increase access to care***
- ***remove unnecessary regulatory burdens***
- ***protect the integrity of the RHC program, &***
- ***enhance reimbursement policies that support rural, outpatient health care services.***

**NARHC Advocacy Letters and Comments**

NARHC often communicates with Congress and the Administration on issues of importance to the Rural Health Clinic community. The following is an archive of official communications we have sent advocating on behalf of the Rural Health Clinic Program. We have also included some communications and letters that NARHC has signed but were not authored by NARHC.

June 26, 2024 - Statement for the Record CMMI Hearing

June 18, 2024 - Statement for the Record 340B Oversight Hearing

May 30, 2024 - Joint Letter to Energy and Commerce Leadership

May 30, 2024 - Statement for the Record, Senate Finance Committee Rural Health Hearing

May 29, 2024 - CMS Medicare Advantage Data Request for Information Response

May 28, 2024 - RFI Response - Rural Definition Proposed Changes - FORHP Grants

April 25, 2024 - MedPAC April Public Meeting Statement for the Record

March 28, 2024 - CPT Category II – Letter to the Administrator

**Join the fight for rural health and make your voice heard here!**

2 E. Main St, Fremont, MI 49412 | 866-306-1961 | NARHC.org

# Awareness of RHCs

- When it comes to federal health policy, rural hospitals and other outpatient provider interests dominate the conversation

KFF Health News
https://kffhealthnews.org › news › article › rural-hospit...

Operating in the Red: Half of Rural Hospitals Lose Money ...

Mar 7, 2024 — A recent report finds **half of America's rural hospitals are losing money**, and many are struggling to stay open.

AP News
https://apnews.com › video

Federally qualified health centers under pressure


**Federally funded** community **health centers** serve 1 in 11 Americans, most of them low-income and many underinsured.

AP News · Jan 27, 2024

Becker's Hospital Review
https://www.beckershospitalreview.com › finance › stat...

States with the most rural hospital closures

Nov 28, 2023 — Rural hospitals, 37 of which have closed since 2020, continue to be at **risk of closure because they lose money providing services to patients**.

Reuters
https://www.reuters.com › legal › litigation › end-pande...

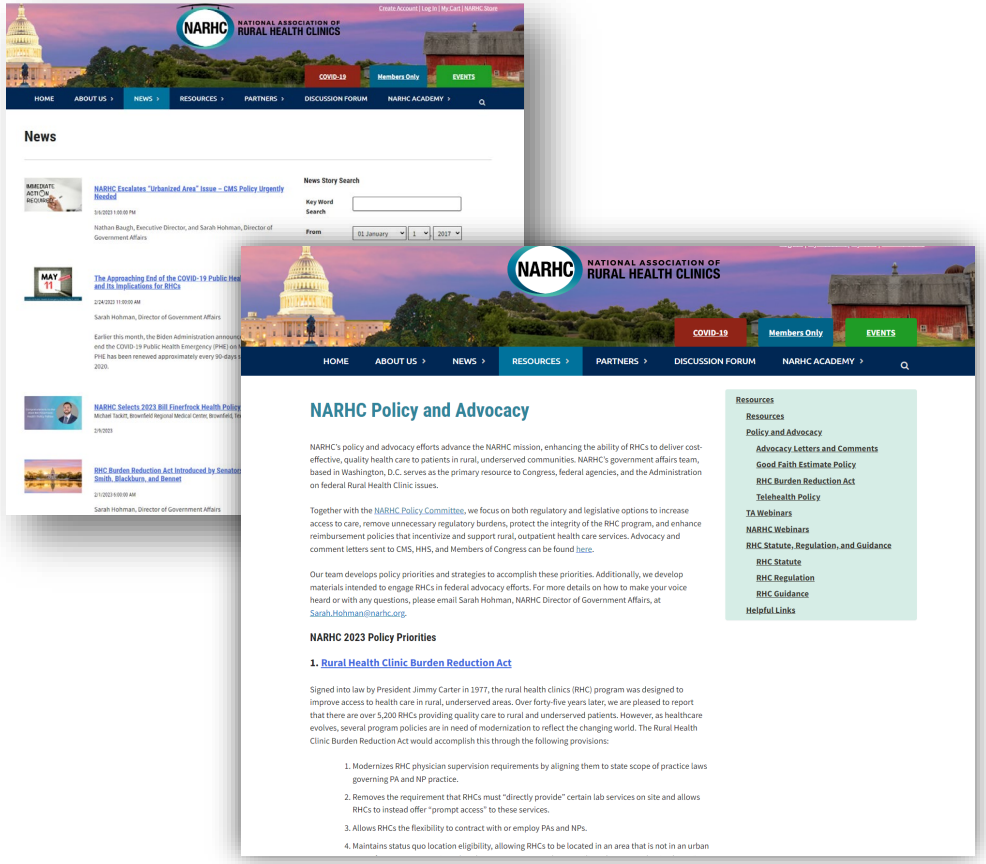
End of a pandemic era: What now for Federally Qualified ...

May 2, 2023 — 31, 2024, patients' homes will no longer be eligible originating sites for **FQHC**-covered telehealth services. **FQHCs** may serve as the originating ...



# Stay “In the Know” on RHC Issues

- NARHC.org
  - Email Listserv
  - Discussion Forum
  - News Tab
  - Resources Tab
    - TA Webinars
    - Policy and Advocacy
- State rural health organizations & offices of rural health
- Federal Office of Rural Health Policy (FORHP) Weekly Updates
- RHIhub
- CMS RHC Center



# NARHC Community Forum

Your resource to engage in discussions about all things Rural Health Clinics. The NARHC Community Forum serves as a valuable resource to ask questions, network with other professionals, share knowledge, and stay informed!

**Scan to join!**

## How to join:

- Access the registration form through this QR code!
- Sign up to create an account & verify email
- Build your Community profile
- Access the community and start interacting!

**Questions?** Contact us at Academy@NARHC.org



Sarah Hohman, MPH, CRHCP
Director of Government Affairs
National Association of Rural Health Clinics

202-543-0348
Sarah.Hohman@narhc.org



STROUDWATER

NOSORH
National Organization of
State Offices of Rural Health

NARHC
NATIONAL ASSOCIATION OF
RURAL HEALTH CLINICS

# 2024 INDEPENDENT RHC INSTITUTE

## PRE-SESSION

Sponsored by **NOSORH & NARHC**

# PRE-SESSION AGENDA

- **Introduction to the provider-based Rural Health Clinic**
- **Review of previous content**
  - Revenue Cycle Management and Measurement
  - RHC-specific Billing
  - Vendor Management & Payor Contracting
  - Cost Report Basics
  - Scheduling
  - Evaluation of Service Offerings
  - Community Relations & Marketing Your RHC
- **Audience Questions**

# INTRODUCTION TO THE PROVIDER-BASED RURAL HEALTH CLINIC (PB-RHC)

# INTRODUCTION TO THE PROVIDER-BASED RURAL HEALTH CLINIC

- **Requirements**
  - Located in a rural area designated as a shortage or underserved
  - Team Approach: Medical director, Advanced Practice Provider (“APP”) at least 50% of the time
  - Owned and operated as a part of a hospital, nursing home, or home health agency participating in Medicare
- Medicare reimburses a flat All-Inclusive Rate (AIR) for RHC services
- Payment limit per visit based on national statutory limits:
  - Calendar Year (CY) 2024 = $139.00
  - Medicare Administrative Contractors (MACs) calculate the payment limit per visit for “Grandfathered” RHCs
- For certain preventive services like the Annual Wellness Visit (AWV) and the Initial Preventive Physical Exam (IPPE), Medicare will pay the full AIR and patients do not have a co-pay
- Non-RHC services paid on the allowed amount for the service

# 2023 CONTENT REVIEW

# REVENUE CYCLE MANAGEMENT AND MEASUREMENT

## KEY CONCEPTS:

- **Revenue cycle** is a multifaceted process
- Activities are interdependent--If you get it wrong in the beginning, a domino effect occurs
- Need to make sure that you're monitoring the data
  - Do you have key indicators in place?
  - If not, why not?
- Credentialing needs to occur at the time you get ready to hire a physician
- You must have key indicators in place to monitor the process activities, as well as your AR

# RHC SPECIFIC BILLING

| CODE SET | IDENTIFY | RHC Billing on UB04 | Clinic & Tech Billing on 1500 |
|---|---|---|---|
| CPT | Procedures, services, drugs, combo services | ✓ | ✓ |
| HCPS | Procedures, services, drugs, combo services, supplies, DME | ✓ | ✓ |
| Revenue Code | Location, provider, type or procedure | ✓ | |
| Modifiers | Add-on information to HCPCS and CPTs: location, component of service, explanation of service | ✓ | ✓ |
| Type of Bill | 4-digit code representing the place of service, type of service and billing stage. Leading number is a zero | ✓ | |
| Place of Service | 2-digit code identifying the location of the provider, or type of service | | ✓ |
| ICD Diagnosis Codes | Internationally unified codes set describing accident, illness, injuries, conditions or circumstances describing any of these. Not included in CDM | ✓ | ✓ |

# RHC SPECIFIC BILLING

1

The primary service is considered the qualifying visit

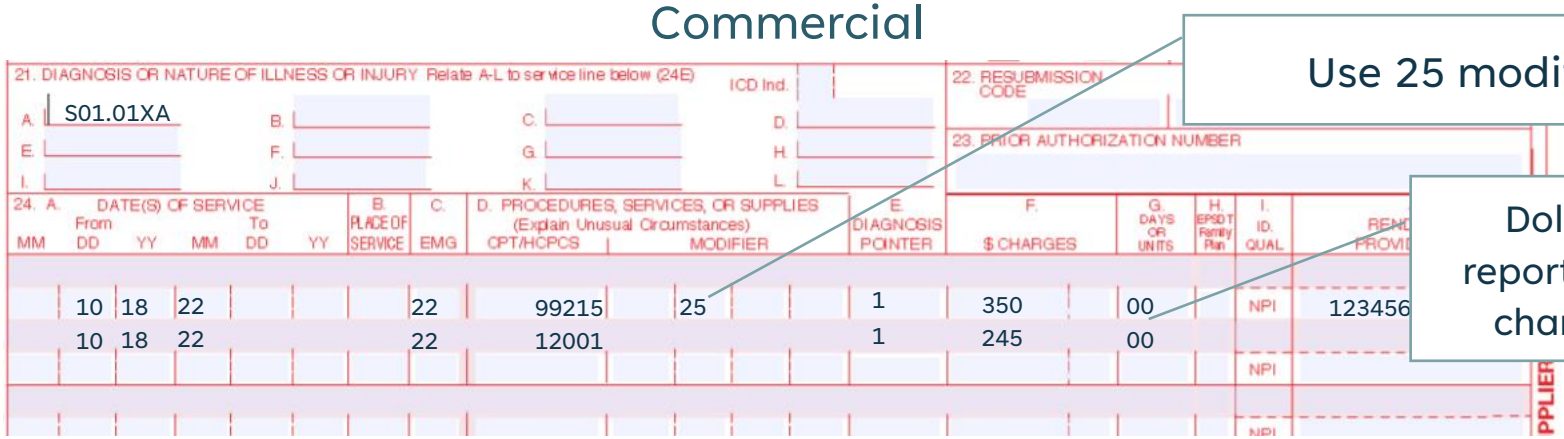
***CG modifier*** required for the line considered the qualifying visit

Report all charges on the service line with the qualifying visit CPT/HCPCS code, minus any charges for preventive services

Report charges associated with preventative med services on a separate line

# RHC SPECIFIC BILLING

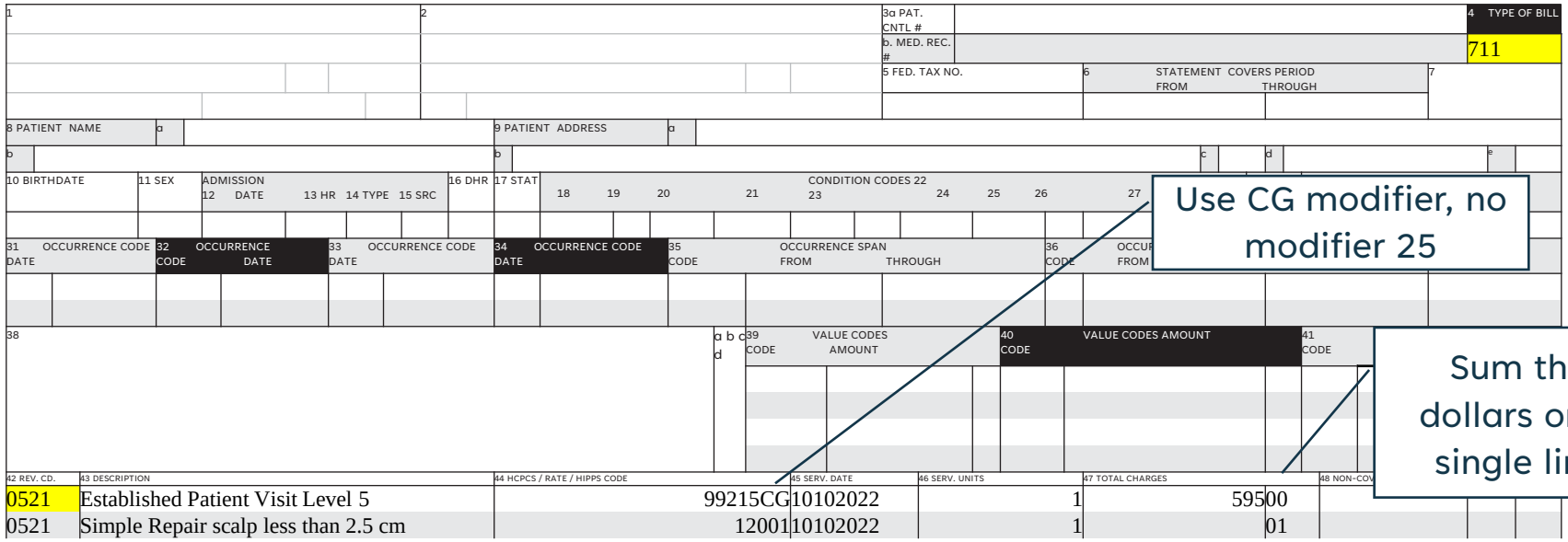
## Commercial




Use 25 modifier

Dollars reported as charged

## Medicare




Use CG modifier, no modifier 25

Sum the dollars on a single line

# VENDOR MANAGEMENT & PAYOR CONTRACTING

## KEY CONCEPTS:

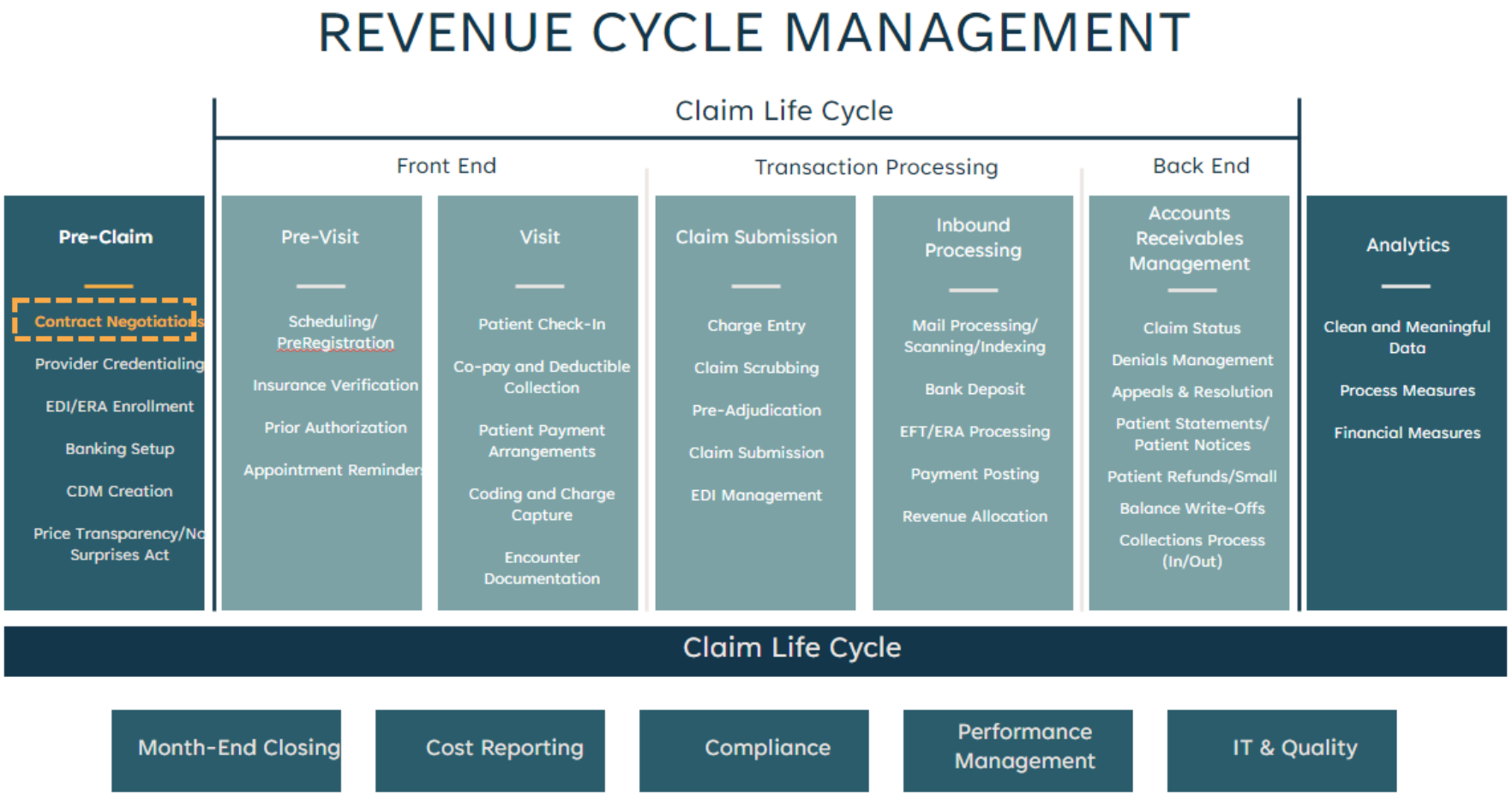
- **Vendor management** is the process that empowers your organization to take appropriate measures for identifying, evaluating, and managing relationships with vendors
- Vendor management policy
  - Vendor selection
  - Vendor contracting/credentialing
  - Access
  - Purchasing

# VENDOR MANAGEMENT & PAYOR CONTRACTING, CONT.

**KEY CONCEPTS:**

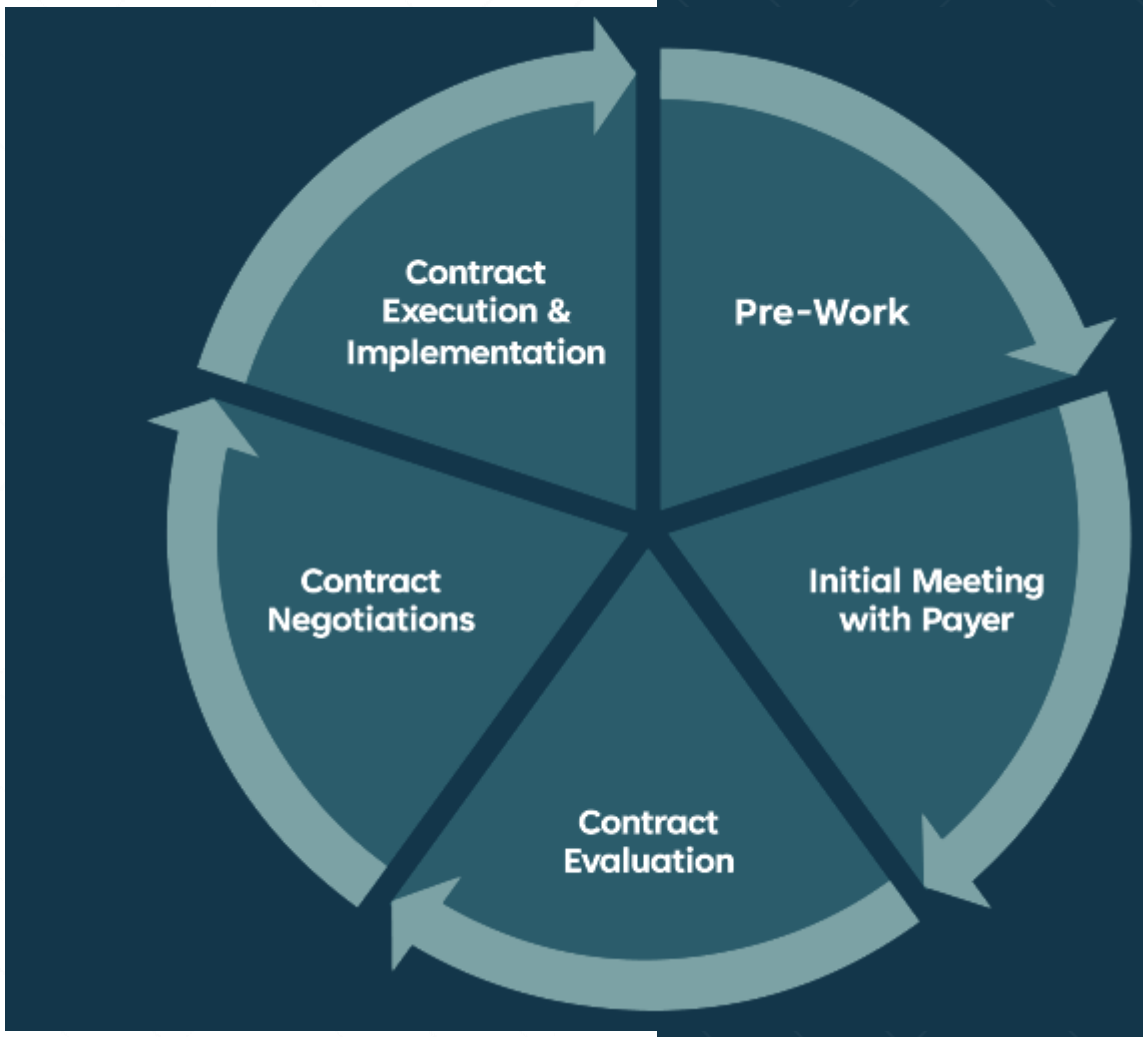
- Communication
  - Effective communication with vendors is essential
  - Establish best practices with vendors
    - Point of contact
    - Methodology
    - Cadence
    - Alignment on goals
- Measuring success
  - Reevaluate contracts regularly
  - Consider the following measures:
    - Cost savings
    - Quality
    - Timeliness of support
    - Improved utilization of internal resources
    - Improved patient care
    - Compliance

# VENDOR MANAGEMENT & PAYOR CONTRACTING: REVENUE CYCLE



# VENDOR MANAGEMENT & PAYOR CONTRACTING: LIFECYCLE

## PAYER CONTRACTING LIFECYCLE



# VENDOR MANAGEMENT & PAYOR CONTRACTING, CONT.

## KEY CONCEPTS:

- **Identifying objectives**
  - What are your objectives?
  - Which commercial payers are the most influential on your organization?
  - What is happening in your market?
  - What is your relationship with the payer?
  - Who will be the key stakeholder for the contract?
  - What impact will the payer contract have on your organization?
- **Contract status best practices**
  - Copies of the agreements
  - Pay attention to special clauses
  - Timely filing deadlines vs. payment windows

# VENDOR MANAGEMENT & PAYOR CONTRACTING, CONT.

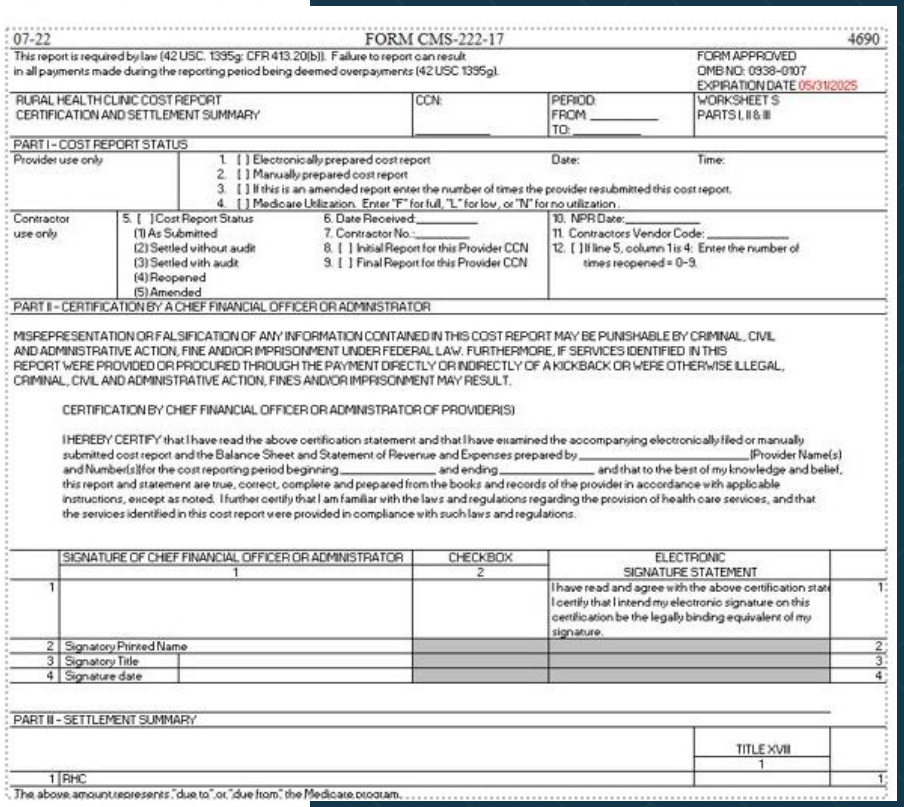
## KEY CONCEPTS:

- Evaluate financial competitiveness
- Things to remember with payer contracting:
  - Increases to Gross Charges do not always fall to the bottom line
  - Payer contracts may contain reimbursement methodology language
  - Renegotiate existing contract

# COST REPORT BASICS

## KEY CONCEPTS:

- A **Medicare Cost Report** is a document containing financial, operational, volume, productivity and payment information filed to your Medicare Administrative Contractor (MAC)
- Key documentation includes:
  - Financial records
  - Volume information
  - Provider information
  - Supplementary information



07-22 FORM CMS-222-17 4690

This report is required by law (42 USC. 1395g; CFR 413.20(b)). Failure to report can result in all payments made during the reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO: 0938-0107
EXPIRATION DATE 05/31/2025

| RURAL HEALTH CLINIC COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY | CCN: | PERIOD: FROM: _____ TO: _____ | WORKSHEET S PARTS I, II & III |
|---|---|---|---|

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically prepared cost report — Date: — Time:
2. [ ] Manually prepared cost report
3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report.
4. [ ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

Contractor use only

5. [ ] Cost Report Status
(1) As Submitted
(2) Settled without audit
(3) Settled with audit
(4) Reopened
(5) Amended

6. Date Received: _____
7. Contractor No.: _____
8. [ ] Initial Report for this Provider CCN
9. [ ] Final Report for this Provider CCN

10. NPR Date: _____
11. Contractors Vendor Code: _____
12. [ ] If line 5, column 1 is 4: Enter the number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ (Provider Name(s) and Number(s)) for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

| | SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR | CHECKBOX | ELECTRONIC SIGNATURE STATEMENT | |
|---|---|---|---|---|
| | 1 | 2 | | |
| 1 | | | I have read and agree with the above certification stat... I certify that I intend my electronic signature on this certification be the legally binding equivalent of my signature. | 1 |
| 2 | Signatory Printed Name | | | 2 |
| 3 | Signatory Title | | | 3 |
| 4 | Signature date | | | 4 |

PART III - SETTLEMENT SUMMARY

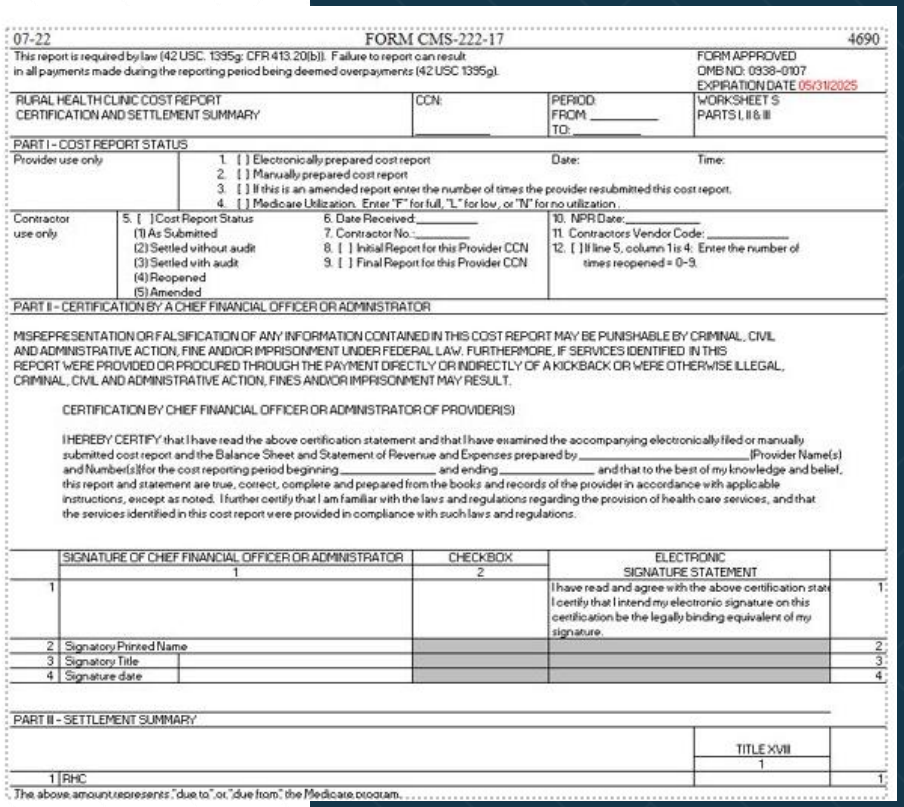
| | | TITLE XVIII | |
|---|---|---|---|
| | | 1 | |
| 1 | RHC | | 1 |

The above amount represents "due to", or "due from" the Medicare program.

# COST REPORT BASICS, CONT.

## KEY CONCEPTS:

- Understand your reimbursement drivers
- Reconcile, reconcile, reconcile
- Develop reasonableness tests
- Multi-tiered cost report review process is best practice



07-22 FORM CMS-222-17 4690

This report is required by law (42 USC. 1395g; CFR 413.20(b)). Failure to report can result in all payments made during the reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO: 0938-0107
EXPIRATION DATE 05/31/2025

| RURAL HEALTH CLINIC COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY | CCN: | PERIOD: FROM: _____ TO: _____ | WORKSHEET S PARTS I, II & III |
|---|---|---|---|

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically prepared cost report — Date: — Time:
2. [ ] Manually prepared cost report
3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report.
4. [ ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

Contractor use only

5. [ ] Cost Report Status
(1) As Submitted
(2) Settled without audit
(3) Settled with audit
(4) Reopened
(5) Amended

6. Date Received: _____
7. Contractor No.: _____
8. [ ] Initial Report for this Provider CCN
9. [ ] Final Report for this Provider CCN

10. NPR Date: _____
11. Contractors Vendor Code: _____
12. [ ] If line 5, column 1 is 4: Enter the number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ (Provider Name(s) and Number(s)) for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

| | SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR | CHECKBOX | ELECTRONIC SIGNATURE STATEMENT | |
|---|---|---|---|---|
| | 1 | 2 | | |
| 1 | | | I have read and agree with the above certification stat... I certify that I intend my electronic signature on this certification be the legally binding equivalent of my signature. | 1 |
| 2 | Signatory Printed Name | | | 2 |
| 3 | Signatory Title | | | 3 |
| 4 | Signature date | | | 4 |

PART III - SETTLEMENT SUMMARY

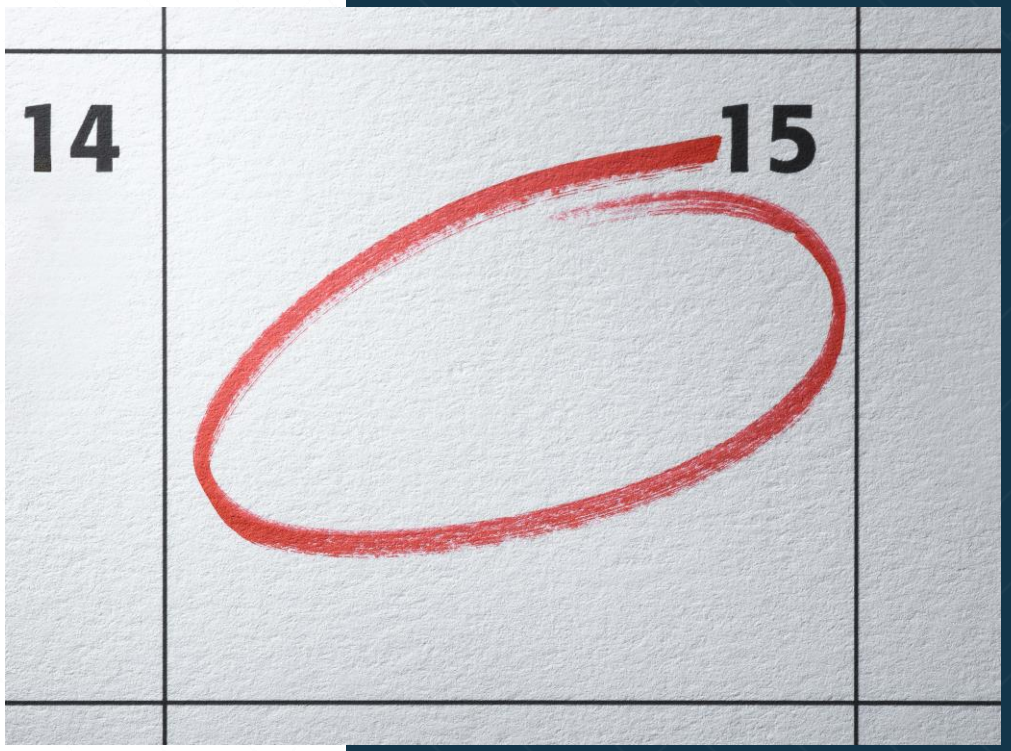
| | | TITLE XVIII | |
|---|---|---|---|
| | | 1 | |
| 1 | RHC | | 1 |

The above amount represents "due to", or "due from" the Medicare program.

# SCHEDULING

## KEY CONCEPTS:

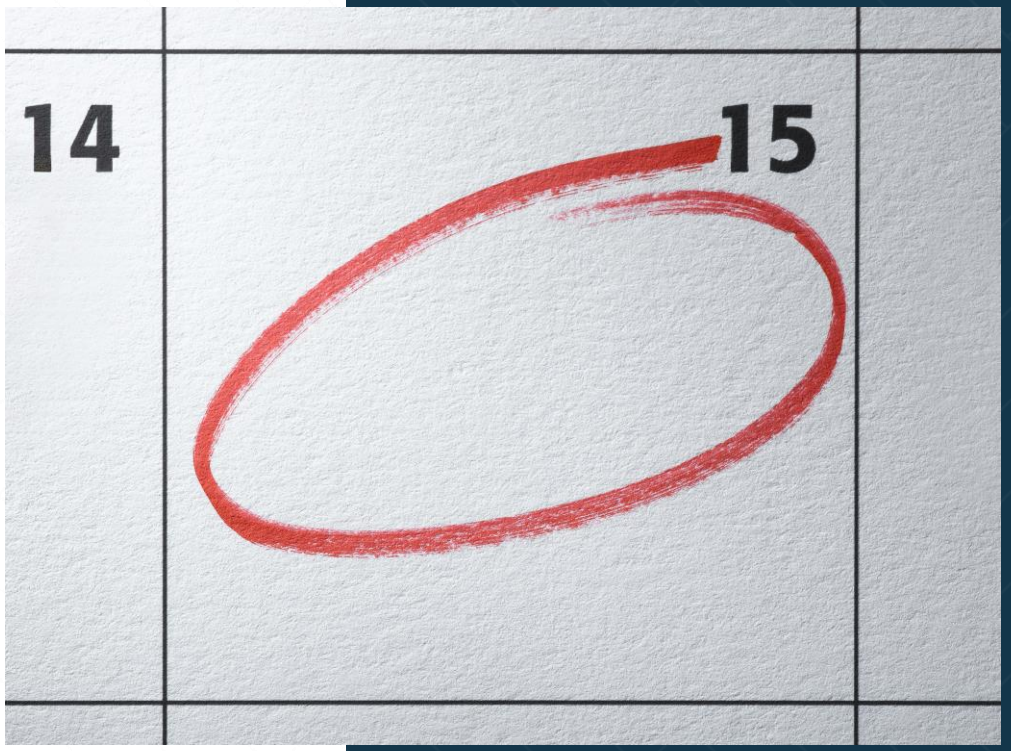
- Scheduling is critical for...
  - Improving and increasing access
  - Volume
  - Improving provider & employee engagement
  - Attracting referrals
- RHCs can leverage automation
  - Text/email reminders
  - Phone trees
  - Schedule monitoring
  - Referral management
  - Patient education
  - Post-visit care instructions



# SCHEDULING, CONT.

## KEY CONCEPTS:

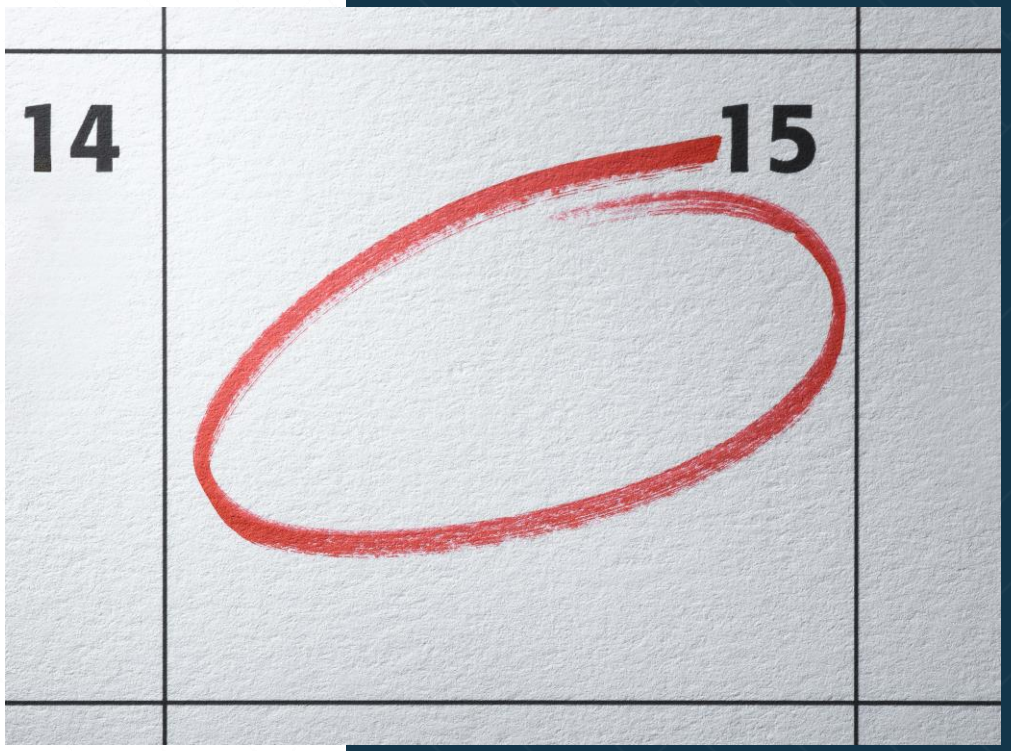
- Understanding historical data & trends
  - Peak no-show periods
  - Patient demographics
  - Patient preferences
  - Proactive weather adjustments
- Getting ahead of the bottlenecks
  - Inefficient scheduling
  - Staffing
  - Equipment malfunction/downtime
  - Overbooking/double-booking
  - Ineffective workflow
  - Lack of standardized processes
  - Miscommunication



# SCHEDULING, CONT.

## KEY CONCEPTS:

- Develop policies for…
  - Patient non-compliance
  - No-show communication
- Manage your organization’s metrics
  - Tracking
  - Dashboard
  - Benchmarking
  - Team involvement
  - Utilize metrics for data-driven decision making



# EVALUATION OF SERVICE OFFERINGS

## KEY CONCEPTS:

- Conduct a market analysis
  - Know your target market, patient demographics, and community needs
  - Use this to identify opportunities for growth
- Regularly evaluate your service offerings
  - Implement a consistent process for revisiting your service offerings
  - Continually update to meet community need

# EVALUATION OF SERVICE OFFERINGS, CONT.

## KEY CONCEPTS:

- Foster a community and patient-centric approach
  - Prioritize patient satisfaction
  - Ask for feedback
- Optimize operational efficiency
  - Regularly assess staffing, space, and provider capacity (consider aging providers!)
  - Pay attention—tweak and make updates to workflows

# EVALUATION OF SERVICE OFFERINGS, CONT.

## KEY CONCEPTS:

- Regularly monitor financial performance
  - Comprehensive proforma
  - Data-driven decision making

# COMMUNITY RELATIONS & MARKETING YOUR RHC

## KEY CONCEPTS:

- **Community Relations is an important concept because…**
  - It enhances trust, loyalty and support
  - It increases referrals
  - Sustainability
  - Staffing
  - Hospital partnerships
- **How to engage**
  - Understand the need
  - Participate in community events
  - Collaborate to provide health education
  - Offer outreach programs

# COMMUNITY RELATIONS & MARKETING YOUR RHC, CONT.

## KEY CONCEPTS:

- **Communication strategies**
  - Portal
  - Newsletters
  - Local newspapers
  - Social media
  - Radio station
- **Referral management** is the entire process of coordinating patient care between providers so that patients receive the right care at the right time

# COMMUNITY RELATIONS & MARKETING YOUR RHC, CONT.

## KEY CONCEPTS:

- **Referral management steps are…**
  - Initiation
  - Tracking
  - Communication
  - Follow-up
- **Best practices include:**
  - Team education
  - Relationship management & education
  - Metric monitoring
  - Ongoing QI

# AUDIENCE QUESTIONS

# UPCOMING SESSIONS

1

## Cost Report Basics

**7/15/24**

Understanding the nuances of their cost-reports, how the cost report affects reimbursement from Medicare, and key areas to review for accuracy.

2

## Financial Policies & Procedures

**7/17/24**

Understanding the basics of documentation for the cost report expenses. Topics such as documentation of bad debt and timelines for billing will be discussed.

3

## Office Hours

**7/22/24**

Join the Stroudwater Associates team for our designated office hours to ask specific questions related to your RHC.

4

## Revenue Cycle Management and Measurement

**7/24/24**

This session will focus on best practice strategies for effective revenue cycle processes.

5

## Mastering Revenue Cycle Key Performance Indicators

**7/29/24**

Improving financial performance and operational efficiency by better understanding key Revenue Cycle Key Performance Indicators (KPIs.)

6

## Office Hours

**7/31/24**

Join the Stroudwater Associates team for our designated office hours to ask specific questions related to your RHC.

STROUDWATER

# THANK YOU

Opal Greenway, Principal

ogreenway@Stroudwater.com

1685 Congress St. Suite 202

Portland, Maine 04102

207.221.8252

www.stroudwater.com