NOSORH

STROUDWATER

RHC REVENUE CYCLE BILLING

Amy Graham, Principal

July 13, 2023

RURAL HEALTH CLINIC (RHC):

THE BASICS

WHAT IS AN RHC?

- Rural Health Center (RHC) is a CMS designation
- RHCs provide access to primary care in underserved areas
  - All state Medicaid required to recognize RHCs
  - Commercial payors make no distinction for RHCs
- Team approach
  - Physicians – MDs and Dos
  - Mid-levels (NP, PA, CNM)
  - Clinical psychologist
  - Dietician and diabetic educators (considered incident to in RHC)
- At least 51% of the services provided must be primary care services
- At least 50% of the time, the clinic must be staffed with mid-levels
- Medicare reimbursement is based on an all-inclusive rate (AIR)
- Each provider must have their own NPI (National Provider Identifier) number

RHC VISITS

Visits can take place

- In RHC
- At the patient's residence (including an assisted living facility)
- In a Medicare-covered Part A Skilled Nursing Facility
- At the scene of an accident

REIMBURSEMENT

- Medicare reimburses a flat All-Inclusive Rate (AIR) for RHC services
- Payment limit per visit based on national statutory limits:
  - Calendar Year (CY) 2023 = $126.00
  - Calendar Year (CY) 2024 = $139.00
  - Medicare Administrative Contractors (MACs) calculate the payment limit per visit for “Grandfathered” RHCs
- Medicare Part B deductible and coinsurance rates apply. This means that once patients meet their Part B deductible, Medicare pays 80% of the AIR and the patient pays the remaining 20%.
- 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

RHC QUALIFYING VISITS (QV)

- An RHC visit is defined as a medically necessary medical or mental health visit or a qualified preventive health visit
- The visit must be a face-to-face (one-on-one) encounter between the patient and an RHC practitioner during which time one or more RHC services are furnished
- Over 400 CPT/HCPCS codes can be considered as Qualifying Visits (QV)
- Note: Distant site Telehealth and Chronic Care visits do not require a patient and provider in the same place to perform the service, so these are not QV services

NON-RHC SERVICES – (NOT CONSIDERED A QV)

"Incident to" nurse visit only services

Distant site Telehealth and Chronic Care visits do not require a patient and provider in the same place to perform the service

Charges may be included on the claim associated with a qualifying visit if performed up to 30 days from the date of the reportable encounter

- Suture removal
- Dressing changes
- Injections
- Blood pressure monitoring
- Medical Nutritional Therapy (MNT)
- Diabetes Self-Management Training (DSMT)

Technical component (TC) of diagnostic tests (e.g., Taking X-rays is considered a TC)

Separately reportable as non-RHC services by the reading physician if not resulted by the servicing provider and billed on 1500 form

MULTIPLE VISITS ON SAME DAY

- Visits with more than 1 RHC practitioner on the same day, or multiple visits with the same RHC practitioner on the same day, count as a single visit, except when:
  - Patient returns to the RHC for diagnosis or treatment of an injury or illness that happened after the initial visit; for example, a patient sees their practitioner in the morning because they have flu symptoms, then later in the day they cut their finger and return to the RHC
  - Patient has a qualified medical and mental health visit on the same day
  - Patient has an IPPE and a separate medical or mental health visit on the same day

GOVERNMENT VS COMMERCIAL TREATMENT

Government

- Specific guidelines apply for Medicaid/Medicare
- Distinction made between RHC and Non-RHC services
- Bill Professional services on UB-04 form using RHC Provider number
- Bill Technical services on UB-04 form using CAH Provider number
- Bill Non-RHC services on 1500 form using Clinic Provider number

*unless the State Medicaid program has other instructions

Commercial

- Each payor is unique
- No Distinction made for services provided
- Bill Professional services on 1500 form using Clinic Provider number
- Bill Technical services on 1500 form using Clinic Provider number

*unless payor has other instructions

RHC CLAIM FORM COMPONENTS

CHARGE FORM COMPONENTS

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	✓	✓

CHARGE FORM COMPONENTS

CODE SET	IDENTIFY	RHC Billing on UB04	Clinic & Tech Billing on 1500
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REVENUE CODES

4-digit codes (leading zero) that categorize the type of service or product delivered, describe where the service took place and/or who performed or is billing the service (professional or technical)

All procedure codes billed on a hospital UB-04 (or electronic 837i) must be paired with a revenue code

Revenue code/procedure code pairing must make sense, must follow National Uniform Billing Committee guidelines, and must be acceptable to payors

Revenue code and CPT/HCPCS mismatches are automatic denials in many cases

RHC REVENUE CODES

Revenue Code	Revenue Category
0300-0319	Lab
0320-0329	Diagnostic Radiology
0400-0409	Other Imaging Services
0521	Clinic Visit by member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to a member in a covered Part A stay at a Skilled Nursing Facility (SNF)
0525	Visit by RHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0527	RHC Visiting Nurse Service(s) to a member's home when in a Home Health Shortage Area
0523	Visit by RHC practitioner to other non RHC site (e.g., scene of accident)
0900	Behavioral Health Treatments/Services

CHARGE FORM COMPONENTS

CODE SET	IDENTIFY	RHC Billing on UB04	Clinic & Tech Billing on 1500
CPT	Procedures, services, drugs, combo services	✓	✓
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ICD Diagnosis Codes	Internationally unified codes set describing accident, illness, injuries, conditions or circumstances describing any of these. Not included in CDM	✓	✓

RHC QUALIFYING VISIT MODIFIER

1

The primary service is considered the qualifying visit

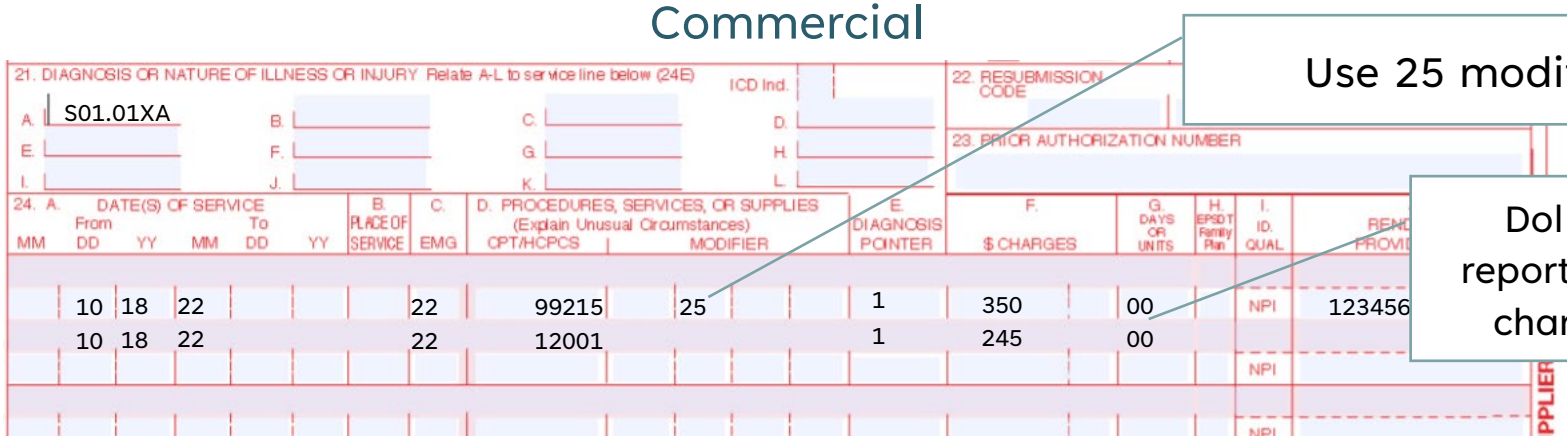
CG modifier required for the line considered the qualifying visit

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 & CLINIC VISIT – MODIFIER EXAMPLE

Commercial



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. S01.01XA B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE

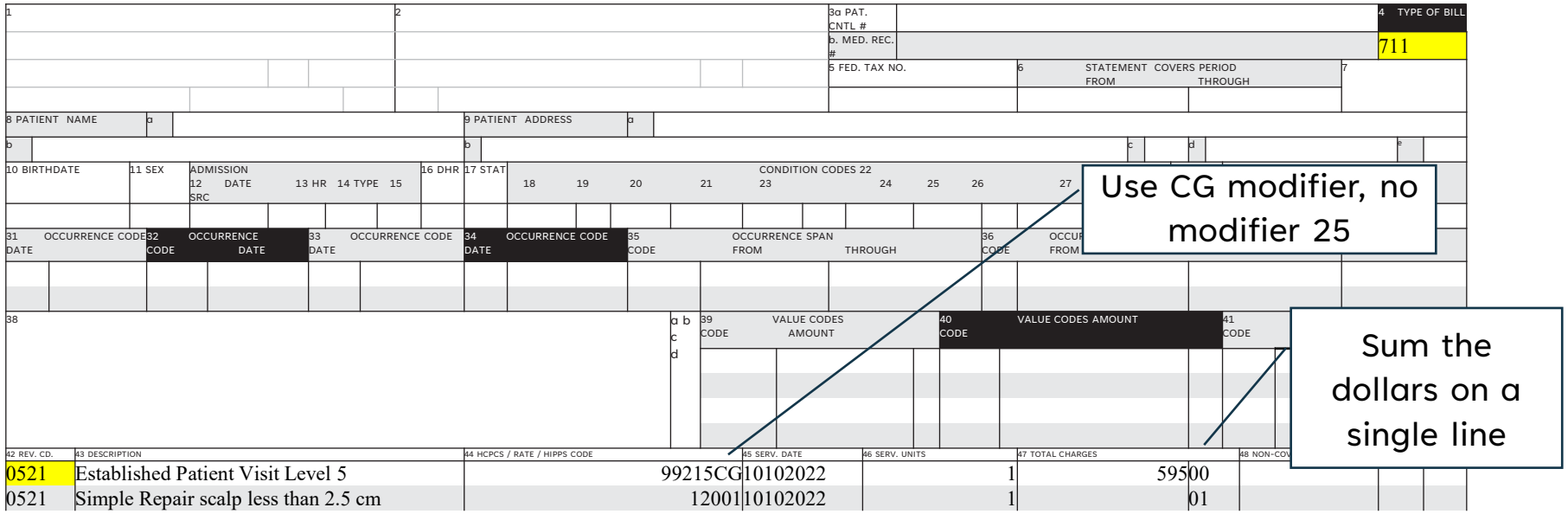
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	RENDERING PROVIDER ID. #
10	18	22				22		99215	25	1	350	00		NPI	123456
10	18	22				22		12001		1	245	00		NPI	
														NPI	

Use 25 modifier

Dollars reported as charged

Medicare



1 | 2 | 3a PAT. CNTL # | 4 TYPE OF BILL: 711

b. MED. REC. #

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME a | 9 PATIENT ADDRESS a

b | b | c | d | e

10 BIRTHDATE | 11 SEX | 12 ADMISSION DATE SRC | 13 HR | 14 TYPE | 15 | 16 DHR | 17 STAT | 18 | 19 | 20 | 21 | CONDITION CODES 22 | 23 | 24 | 25 | 26 | 27

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 CODE FROM

38 | a b c d

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES AMOUNT CODE | 41 CODE

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COV
0521	Established Patient Visit Level 5	99215CG	10102022	1	595	00
0521	Simple Repair scalp less than 2.5 cm	12001	10102022	1		01

Use CG modifier, no modifier 25

Sum the dollars on a single line

CHARGE FORM COMPONENTS

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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	✓	
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TYPE OF BILL

- Required on a UB-04
- Serves a similar function as the place of service on a physician bill (HCFA 1500), except each number provides a separate piece of information

TYPE OF BILL – EXAMPLES

First Digit

- Leading zero. Ignored by CMS

Second Digit = Type of facility

- 1 - Hospital
- 2 - Skilled Nursing
- 3 - Home Health
- 7 - Clinic (RHC)
- 8 - CAH

Third Digit = Type of care

- 1 - Inpatient or clinic
- 2 - Inpatient Part B, Hospital-based clinics, Hospice, Home Health
- 3- Outpatient
- 5- Special Facilities (CAH)

Fourth Digit = Sequence of this bill in this episode of care. Referred to as a "frequency" code

- 1- Admit to Discharge initial claim
- 7- Adjustment claim
- 8 - Cancel claim
- 0 - No Payment

PLACE OF SERVICE

- Required on HCFA 1500 form
- Two-digit code specifying the entity where the services were rendered
- Must match the address and zip entered in the service location to avoid denials of claims

11
OFFICE

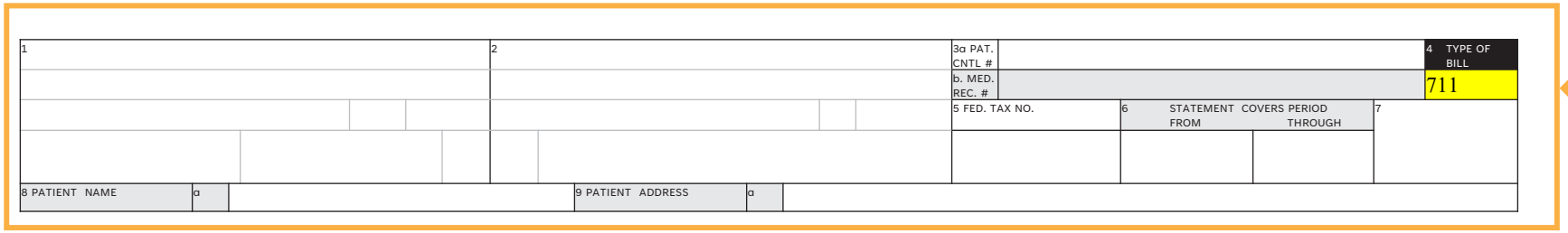
21
INPATIENT HOSPITAL

22
OUTPATIENT HOSPITAL

TYPE OF BILL VS PLACE OF SERVICE CLAIM EXAMPLE

UB Type of Bill 711	HCFA 1500
7 - Clinic (Type of Facility)	11 Office
1 - RHC (Type of Care	22 Outpatient Hospital
1 - (First or final bill)	21 Inpatient Hospital

UB-04 Form



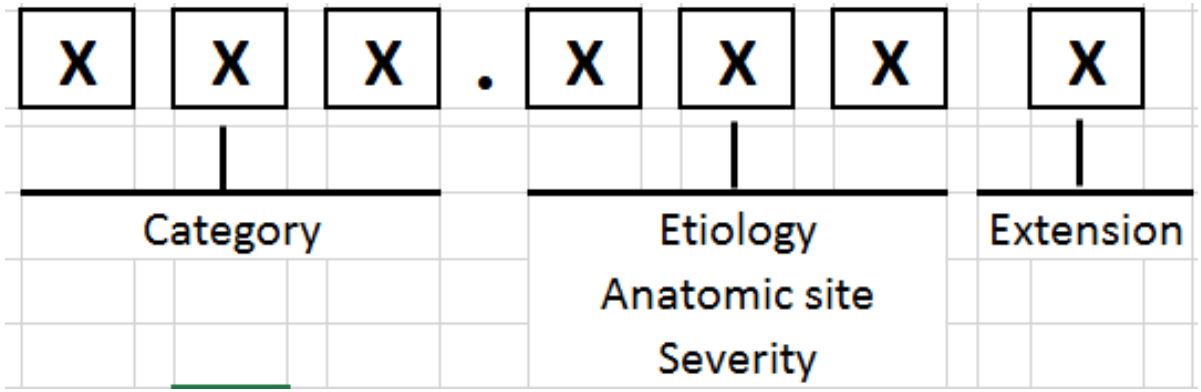
1500 Form

CHARGE FORM COMPONENTS

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	✓	✓

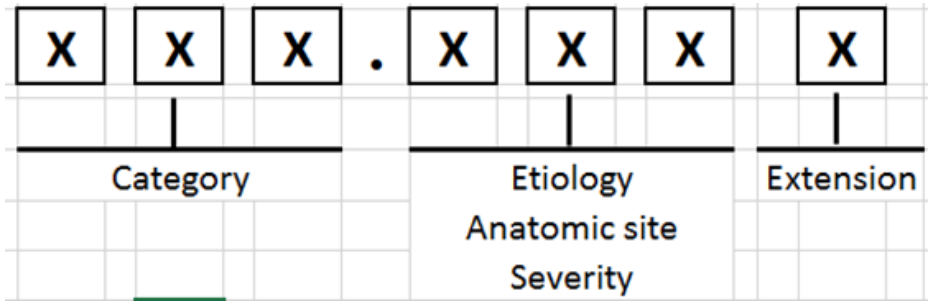
ICD-10 CODE STRUCTURE

- First 3 characters represent the category
  - May rarely be a complete code
- Next 3 characters provide detail on disease, condition, location, severity, etc. Extra characters may be populated with X.
- Seventh character characterizes
  - Episode of care
    - Initial
    - Subsequent
    - Sequela – visit due to complication
  - Type of fracture
  - Fracture care
  - Complication of pregnancy



7TH CHARACTER (EXTENSION)

Fracture of Shoulder and Upper Arm, Does not Require Gustilo Classifications	
A	Initial encounter for closed fracture
B	Initial encounter for open fracture
D	Subsequent encounter for fracture with routine healing
G	Subsequent encounter for fracture with delayed healing
K	Subsequent encounter for fracture with nonunion
P	Subsequent encounter for fracture with malunion
S	Sequela



Multiple Gestations	
0	not applicable or unspecified
1	fetus 1
2	fetus 2
3	fetus 3
4	fetus 4
5	fetus 5
9	other fetus

ICD-10 TERMINOLOGY

“and”	interpreted as “and” or “or”
“Includes” notes	Immediately appear under a three-character code title to further define, or give examples of, the content of the category
“with”	“Associated with” or “due to”
+ or √	Additional characters required

ADDITIONAL ANNOTATIONS

BRACKETS [ ]

Used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases

Used in the Alphabetic Index to identify manifestation codes

Sequence second

PARENTHESES ( )

Used in both the Alphabetic Index and Tabular List to isolate non-essential modifiers (supplemental words that do not affect the code assignment)

COLON:

Used in the Tabular List after an incomplete term that needs one or more of the modifiers following the colon to make it assignable to a given category

CODING TIPS AND TRICKS

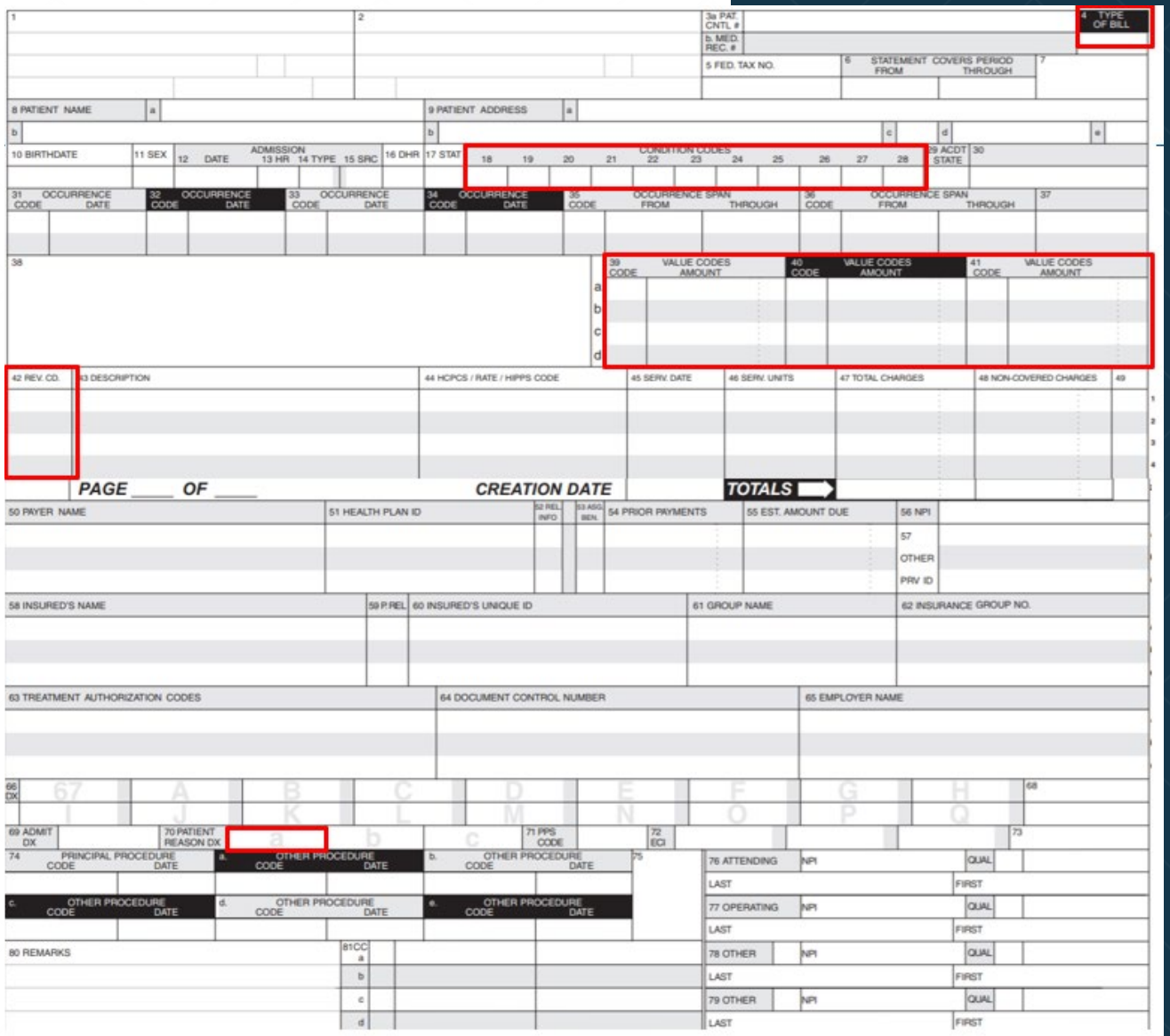
UB-04 DIAGNOSIS CODING

Diagnoses are not specific to a single line, but apply to the entire claim

Must complete box 70 Diagnosis “Reason for Visit”

Additional diagnoses must be sequenced

UB-04 EXAMPLE



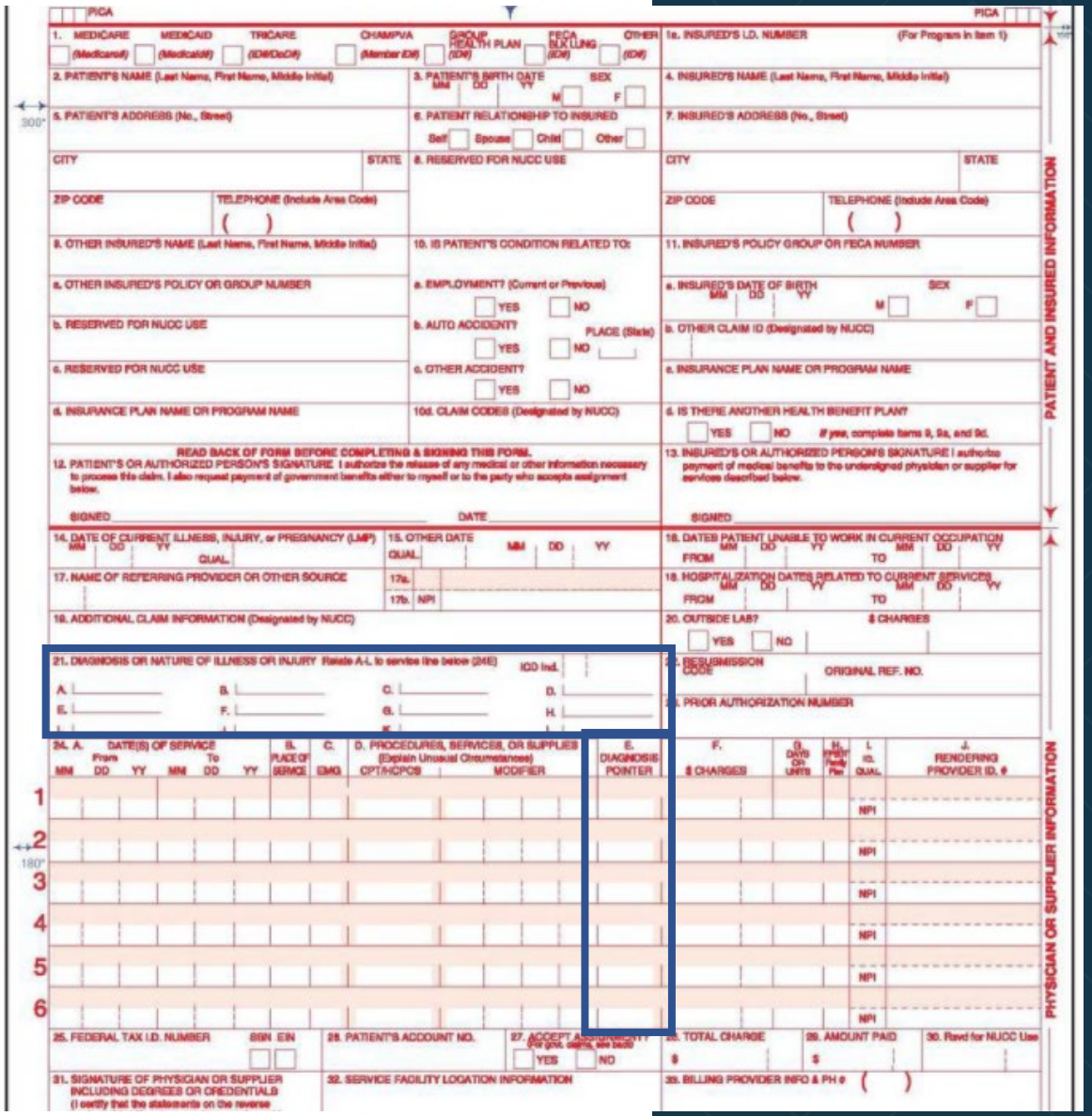
HCFA-1500 DIAGNOSIS CODING

Used to bill all services to commercial payors

Used to report Medicare Part B services

Requires Diagnosis codes specific to each line of service

HCFA-1500 EXAMPLE



OUTPATIENT DIAGNOSES REPORTING

Report the full diagnosis code to the highest level of specificity for the diagnosis shown to be reason for the outpatient services

Report symptom in absence of finding addressed in the provider note

Do not report suspected

Do not report rule out

Reading physician must always report finding if applicable

Report reason for encounter (Z code) for encounters with no symptoms or findings

HISTORY CODES

Personal History Codes

- Relevant to reason for visit, example: cough
  - Don’t report personal history of contraception Z92.0 range
  - Report
    - History of nicotine dependence – Z87.891 if applicable
    - History of tuberculosis – Z86.11 if applicable
- Relevant to treatment options
- Support reason for screening services

Almost always relevant

- Personal history of cancer, malignant neoplasms (leukemia, lymphoma)
- Personal history of falling – Z91.81

Family history

- Risk factors relevant to visit
- Screening services

CODE FIRST

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology

Sequence underlying condition (etiology) first and manifestation second

If manifestation codes have in the code title, “in diseases classified elsewhere” are never permitted to be first listed or principal diagnosis codes

- Use in conjunction with underlying condition
- Code underlying condition first

“use additional code” – Two codes required to fully describe a single condition that affects multiple body systems

Sequencing should be etiology/manifestation

CLAIM FORM EXAMPLES

MEDICARE WELLNESS AND FOLLOW-UP APPOINTMENT

Services Provided

- G0439 Annual Wellness Visit (AWV), PPS Subsequent Visit*
- G0442 annual alcohol screening*
- G0444 annual depression screening*
- 99214 (follow chronic disease management)

*Preventive service as defined by Medicare

MEDICARE WELLNESS AND FOLLOW-UP APPOINTMENT

Medicare Wellness and Follow-Up Appointment

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		711
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30

31 CODE OCCURRENCE DATE	32 CODE OCCURRENCE DATE	33 CODE OCCURRENCE DATE	34 CODE OCCURRENCE DATE	35 CODE OCCURRENCE SPAN FROM THROUGH	36 CODE OCCURRENCE SPAN FROM THROUGH	37
a						a
b						b

38	39 CODE VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES AMOUNT
Medicare Part A address city, st zip	a		
	b		
	c		
	d		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0521	AWV, PPPS, Subseq visit	G0439	03/31/2022		190.00			1
2	0521	Annual alcohol screen 15 min	G0442	03/31/2022		28.00			2
3	0521	Depression Screen annual	G0444	03/31/2022		40.00			3
4	0521	office Est Pt 30-39 min	99214CG	03/31/2022		164.00			4
5									5

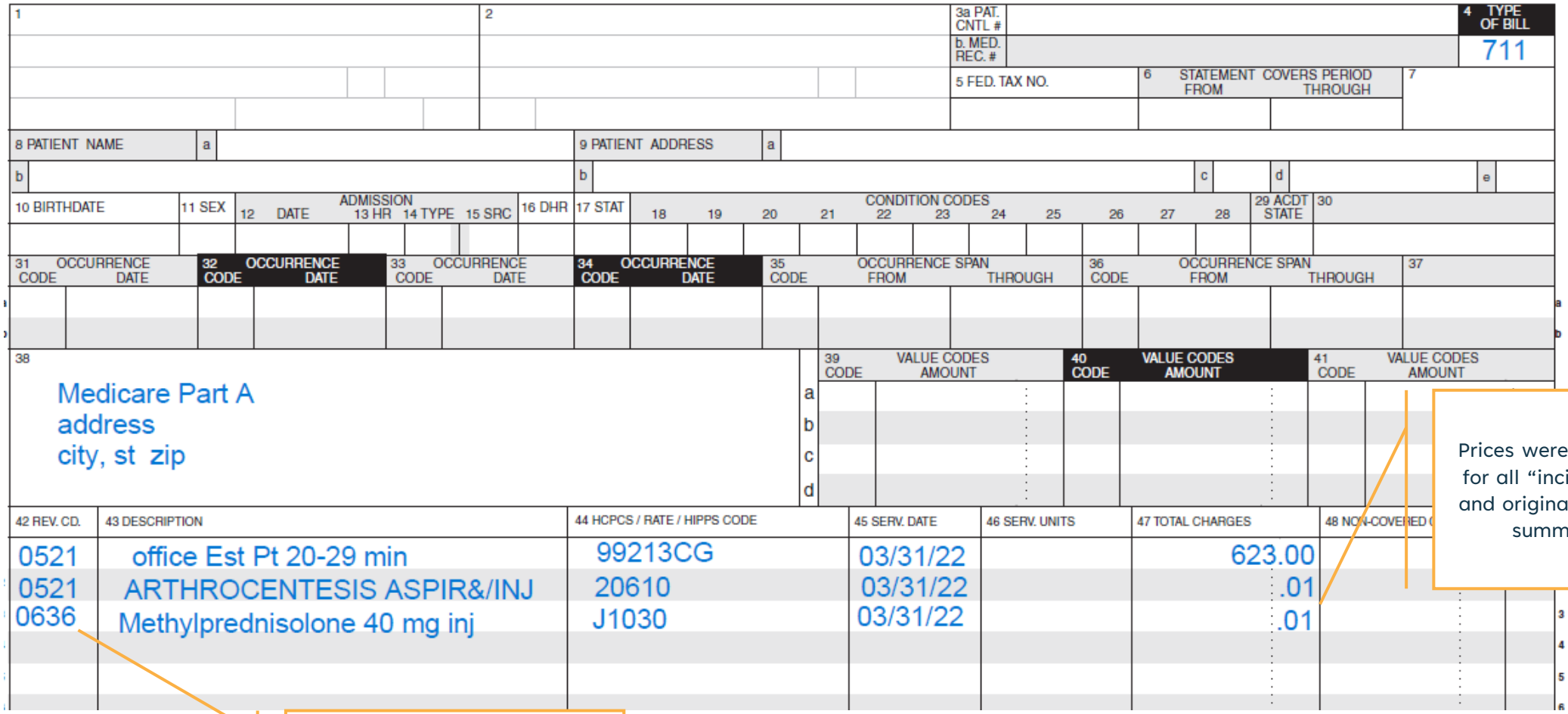
If this was an Initial Preventive Physical Exam (IPPE) it would count as two separate visits

SINUSITIS – SHOULDER PAIN - INJECTION

Services Provided

- 99213 dx sinusitis
- 20610 shoulder pain
- J1030 Injection Methylprednisolone

SINUSITIS – SHOULDER PAIN - INJECTION



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31 CODE DATE	32 CODE DATE	33 CODE DATE	34 CODE DATE	35 CODE OCCURRENCE SPAN FROM THROUGH	36 CODE OCCURRENCE SPAN FROM THROUGH	37
						a b

38

Medicare Part A
address
city, st zip

	39 CODE VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES AMOUNT
a			
b			
c			
d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED
0521	office Est Pt 20-29 min	99213CG	03/31/22		623.00	
0521	ARTHROCENTESIS ASPIR&/INJ	20610	03/31/22		.01	
0636	Methylprednisolone 40 mg inj	J1030	03/31/22		.01	

Prices were reduced to $0.01 for all “incident to services” and original charge amounts summed on line 1

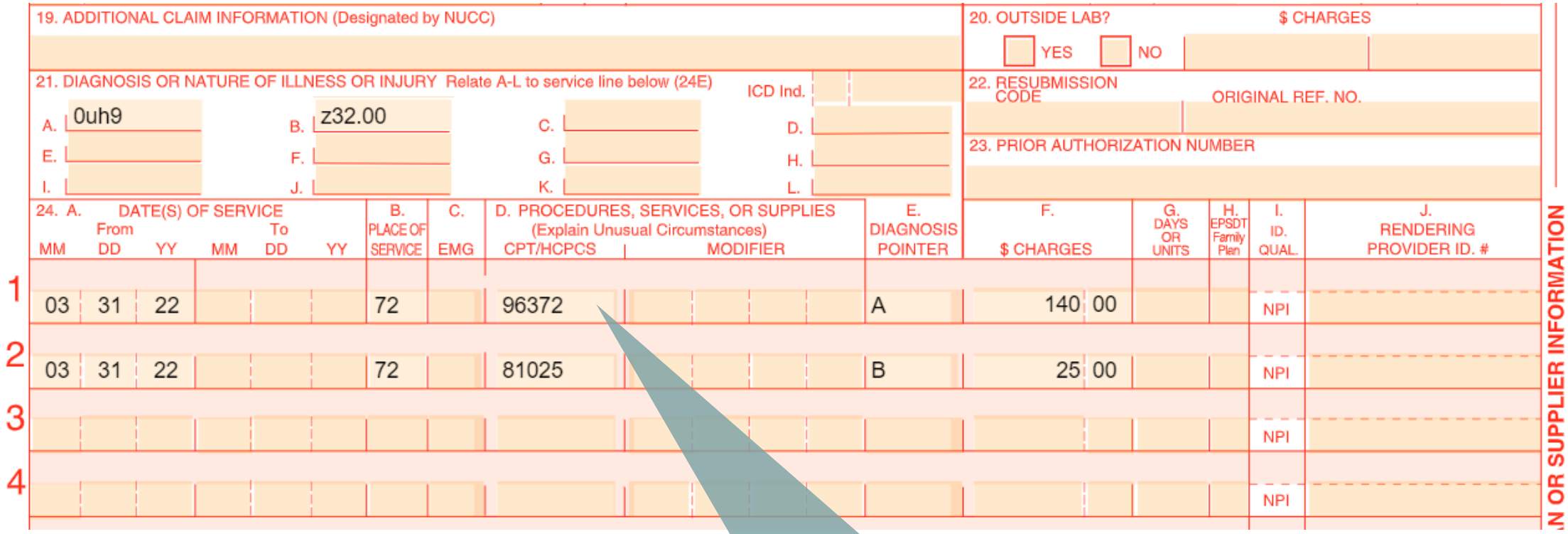
Revenue Code related to service was reported

THERAPEUTIC INJECTION FOR CONTRACEPTIVE AND PREGNANCY TEST

Services Provided

- 96372 Therapeutic injection for Contraceptive (patient's own Meds)
- 81025 urine pregnancy test

THERAPEUTIC INJECTION FOR CONTRACEPTIVE AND PREGNANCY TEST



No Qualifying Visit was performed – Bill on 1500 form

CHRONIC DISEASE MANAGEMENT – TWO INJECTIONS

Services Provided

- 99214 chronic disease management
- 96372 therapeutic injection (testosterone) patient's own meds)
- 95117 allergy injections

CHRONIC DISEASE MANAGEMENT – TWO INJECTIONS

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		711
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37	
a																a
b																b

38		39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
Medicare Part A address city, st zip	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0521	office Est Pt 30-39 min	99214 CG	03/31/22		334 00			1
2	0521	therapeutic injection	96372	03/31/22		01			2
3	0521	pr svc allg imntx w/prv allgic njs	95117	03/31/22		01			3
4									4
5									5
6									6

Qualifying Visit performed
Injections included with visit – Bill on UB04 form

FOLLOW ON HYPERTENSION – REMOVAL OF LESIONS

Services Provided

- 99213 Follow on Hypertension
- 17000 Destruction actinic Keratosis (1 lesion)
- 17003 (3 lesions) additional
- 11102 skin biopsy single lesion uncertain behavior

FOLLOW ON HYPERTENSION – REMOVAL OF LESIONS

Hypertension Follow Up - Removal of Lesions

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		711
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
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10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28 CONDITION CODES	29 ACDT STATE	30

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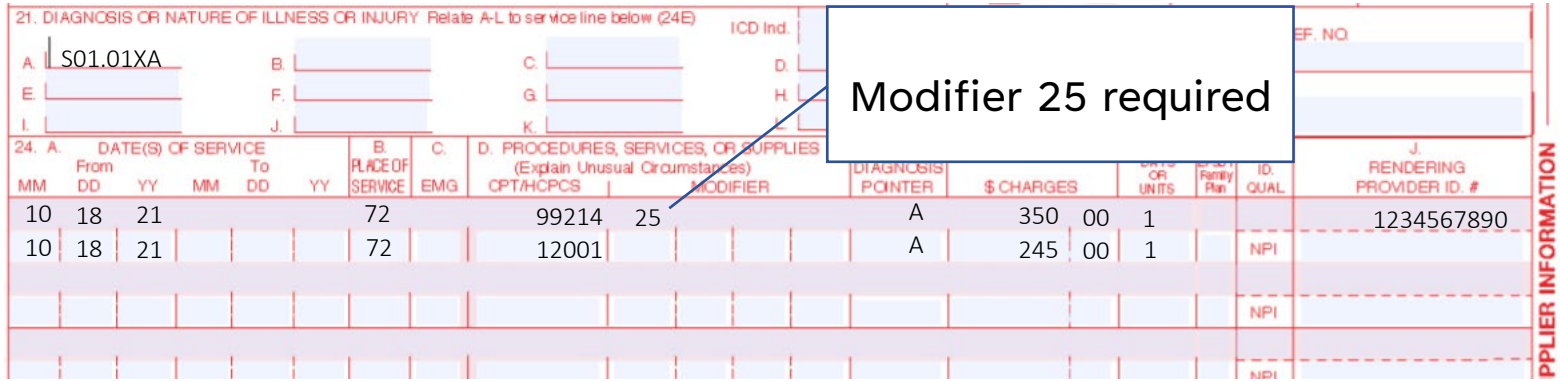
a																a
b																b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
Medicare Part A address city, st zip	a						
	b						
	c						
	d						

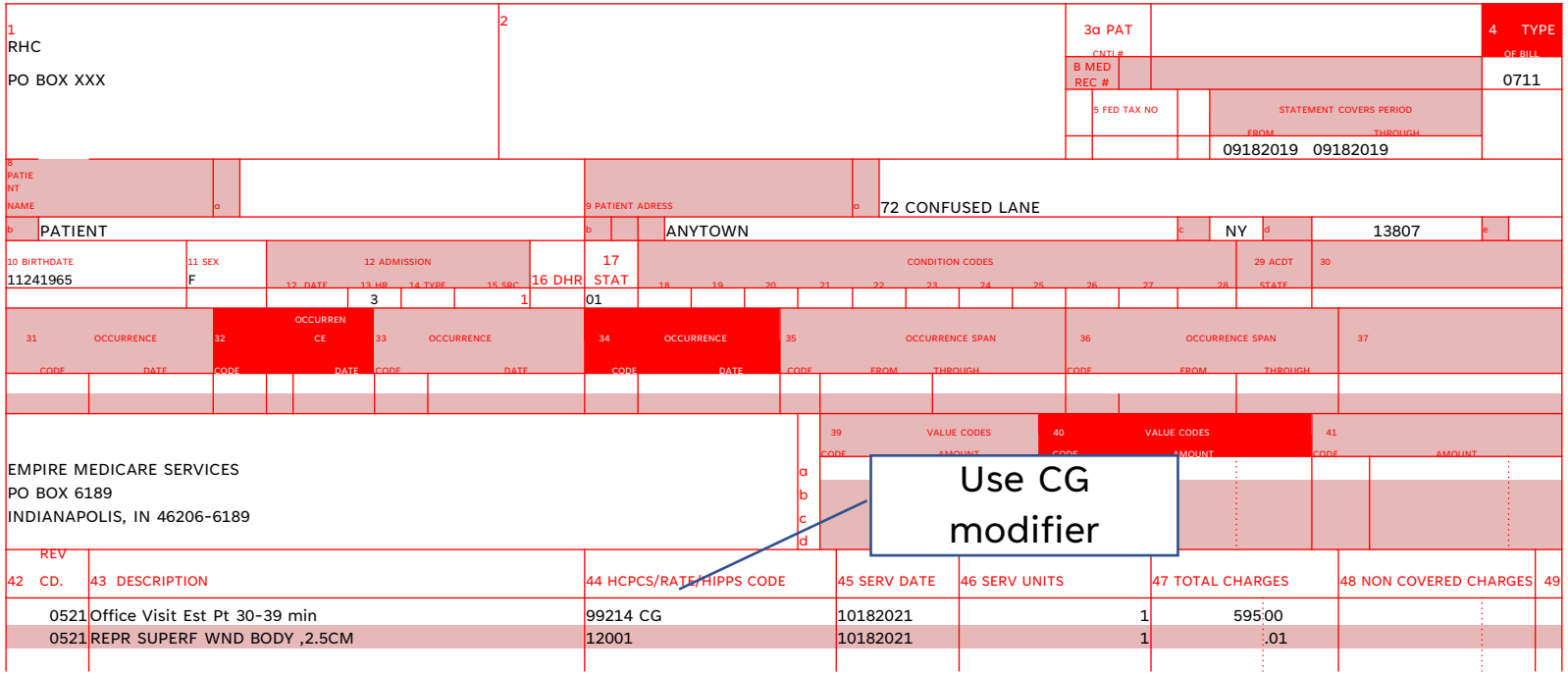
	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0521	office Est Pt 20-29 min	99213CG	03/31/22		664.00			1
2	0521	DEST PREMALIGNANT LESION 1ST	17000	03/31/22		.01			2
3	0521	DEST PREMALIGNANT LES 2-14 EA	17003	03/31/22		.01			3
4	0521	TANGENTIAL BX SKIN SINGLE LESIO	11102	03/31/22		.01			4
5									5
6									6
7									7

RHC CLINIC VISIT COMMERCIAL VS. MEDICARE

Commercial Insurance:
Bill on 1500 Form



Medicare:
Bill on UB04 form



ANCILLARY TESTING

X-rays can be performed in RHCs

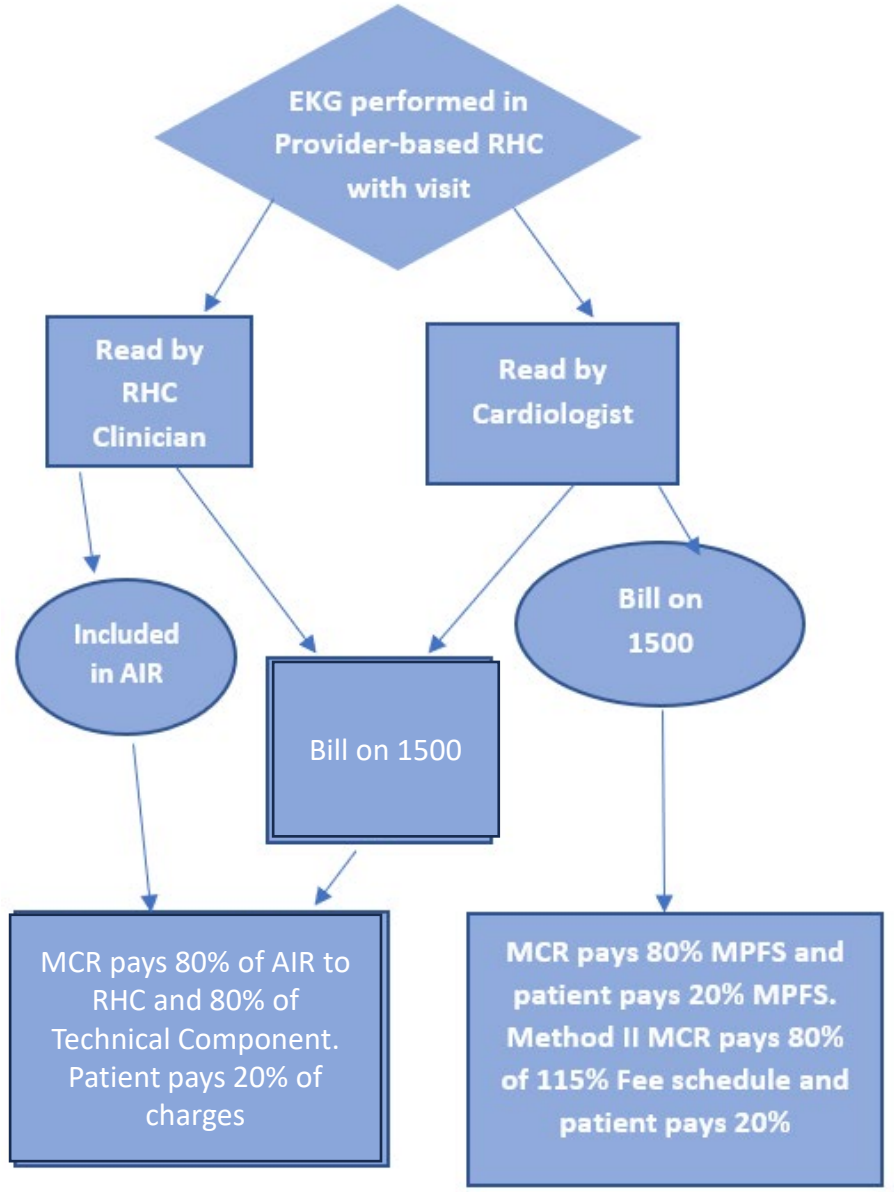
- Taking X-rays is considered a Technical Component (TC) and is not part of an RHC visit
  - Provider-based RHCs report taking of X-ray on the hospital UB-04
- Reading X-rays is a Professional service
  - Included in the RHC visit if the provider reads the X-ray during the face-to-face visit
  - Separately reportable as a non RHC services by the reading physician if not resulted by the servicing provider

EKGs can be performed in RHCs

- Taking EKGs is considered a Technical Component (TC) and is not part of the RHC Visit
  - Provider-based RHCs report taking EKG on the hospital UB-04
- Reading EKG is a professional service
  - If the RHC provider reads the EKG, the reading is considered part of the professional service of the RHC visit
  - If the Cardiologist reads the EKG, Cardiologist will bill for service separately

EKG PERFORMED

	Read by RHC Clinician	Read by Independent Clinician	Technical
Claim Type (form)	RHC UB-04	1500	1500
Type of Bill (TOB) on UB-04 or Place of Service (POS) on 1500	TOB - 711	POS - 72	POS-11
HCPCS, Modifier	93010	93010	93005
Payment	Included in AIR (All inclusive rate)	80% MPFS (physician fee schedule)	80% of Fee Schedule
Coinsurance	20% of RHC charge	20% of MPFS	20% of Fee Schedule



NOSORH

Q&A

STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

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THANK YOU

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USEFUL LINKS

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