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Practices in Underserved Areas May Qualify for CMS Incentives

For many rural physicians, the patient load is large and poor, colleagues are few, and the hours are seemingly endless. These factors not only cause doctors to leave practice early, but make it difficult to find replacements. The Rural Health Clinic (RHC) program, started by federal mandate in 1977, was designed to help address these problems and improve access to primary care.

"A huge number of trained midlevel practitioners—nurse practitioners (NPs) and physician assistants (PAs)—were coming back from the Vietnam War and needed jobs," recalls Dennis Owens, president and chief executive officer of Rural Health Associates in Wichita, Kan. "And there was a tremendous shortage of health care providers in rural areas. The sponsors thought that with incentives, these extenders would go to rural areas and find a place to work—which is what happened."

RHC status can be very helpful to the struggling country practitioner. "If you're a single doc out there who's really having trouble being on call 24/7, it gives you the ability to pay an extender to help out," he notes. "In addition, reimbursement is cost-based, and this allows you to at least cover the costs for services you provide to Medicare and Medicaid patients."

How payment differs

RHCs can be hospital-based or physician-owned. Either way, RHCs are entitled to so-called special reasonable cost reimbursements from Medicare and Medicaid. Whereas physicians in a typical practice code for each separate service they've provided and are reimbursed accordingly, those in RHCs get a flat fee per visit based on their annual expenses, Owens explains. Each year, the clinic submits a detailed cost report to the Centers for Medicare and Medicaid Services (CMS), and the reimbursement per patient visit for Medicare patients is determined by dividing the clinic's allowable costs, including salaries, utilities, supplies, and building costs, by the number of Medicare visits, up to a current cap of $64.78 per visit. (That figure increases each January and is tied to the percentage increase in the Medicare Economic Index related to primary care physician services.) Medicare pays 80% of that, and the patient is responsible for the other 20%.

For Medicaid patients, states can adopt a similar prospective payment system or they can structure their programs differently—as long as RHCs receive payment comparable to what Medicare is giving them. This means that most clinics get up to $64.78 for both their Medicare and Medicaid patient visits. Using a very rough gauge, Owens estimates that RHCs probably receive $13 to $15 more than a conventional practice for each Medicare visit and about $25 more for each Medicaid encounter.

Unlike outpatient services delivered in a standard setting, those provided through RHCs are covered under Medicare Part A. Instead of using CPT codes to describe services rendered to Medicare and Medicaid patients, RHC physicians seeking the predetermined fee-per-visit select from a handful of hospital revenue codes—521 and 522 are common choices. These are entered on the CMS-1450, also known as the UB-92, a form usually reserved for hospital billing.

However, services outside the scope

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of routine primary care services come under Medicare Part B. But the risk here is what's called "commingling"—being paid out of two funds for the same service, which is prohibited. To prevent that, clinics are expected to excise the costs of providing the care they bill to Part B from their annual RHC cost report. "If you want to remove facial lesions from a patient, Medicare will pay about $100 for each lesion under Part B. But while you are treating that patient, Medicare is also paying you Part A monies to keep your operation open," points out Ramsey L. Longbotham, executive director of the Texas Association of Rural Health Clinics. "Theoretically, you have to carve the expenses you incurred while you were providing those Part B services—the nurse's salary, the receptionist's salary, the utilities, everything—out of your cost report. That can be hard to track. But if you don't, that's commingling because you're getting money from Part A and Part B at the same time."

Another useful example: As of January 1, 2001, diagnostic tests can be billed to Part B. "But one of those tests is the urine dipstick test, which takes almost no time to perform," Longbotham continues. "Our Medicare fiscal intermediary told us the clinics were supposed to carve out how long it took the nurse to unscrew the bottle, take the stick out, and put it in the urine. Many are saying that's a waste of time; they're not even going to bill for it. But if you did, that's considered commingling."

Unfortunately, the regulations are not always as explicit as they could be with respect to what is considered a specialty service. Owens, who calculates cost reports for his clients, says, "It's possible to interpret the regulation to mean that chemotherapy services, if performed at an RHC, should be covered under the same flat fee as for the standard rural office visit. But if something costs $1,000 per injection, the doctor can't be expected to include that in a $50 office visit." he adds. "The position we've taken is that if a clinic is providing items that we feel are definitely outside the realm of the standard RHC visit, we take them out of our cost reports, so we're not charging the government for them under the RHC program. Then we charge them to Part B. As long as I'm not using that cost when I'm calculating the payment per visit, then it's not commingling."

Owens also attaches a cover letter to every cost report explaining what's been done. The same letter is included in the RHC's policies and procedures, which must also be approved by the state and federal government. "That allows me to say I'm not doing anything that wasn't approved. There's no intention of cheating," he explains. "We've successfully defended the policy in audits and surveys." He advises other RHCs to consult experts well versed in Medicare allowances and the RHC program when it comes time to compile the annual cost report. "If you don't get help, you might not get everything that's coming to you. Worse, you might end up in a situation where you didn't carve out the appropriate expenses and that's a definite no-no."

Location, location, location

Kendra Parry, a health care consultant based in Forestville, Calif, has helped set up at least 100 RHCs since the program began. "The typical call I get is from a rural physician who has a huge low-income patient population," she says. "The practice is going under, and the doctor doesn't know how to go forward. If he or she qualifies, this program works very well."

First, you must be physically located in a rural area, which is defined, first, as "nonurbanized" under the US Census. Beyond that, more rigorous state designations often exist. "You can get this information from your state department of health services, rural health care agency, or through the federal Bureau of Primary Health Care, which maintains a list of rural counties by state," Parry says. The list can also be found on the Web at www.rhc.universalservice.org/eligibility/ruralareas.asp.

Once you've established that you're rural, you need to determine whether you're in a designated health professional shortage area (HPSA) or a medically underserved area (MUA). A location may qualify as one or the other, depending which criteria it meets. The Bureau of Health Professionals maintains information on HPSAs and MUAs, including searchable HPSA and MUA databases. Check the following Web site: bphr.hrsa.gov/shortage. "If you're in an area that isn't a designated HPSA, or whose designation is more than three years old, there's an application process," Parry explains. "The basic criterion is no more than one physician for 3,500 residents. We sometimes can get the designation in areas with one physician per 3,000 people, if other conditions are met—for instance, if there is a shortage of physicians who'll take Medicaid patients."

Parry cites as an example the Tahoe resort area, on the California-Nevada border. "The physicians there had no interest in Medicaid patients. You have people with second and third homes, and the service industry people. There was a huge poor population without health insurance and without access. They were driving hours into Nevada to try to get health care. The local hospital's emergency department (ED) was improperly utilized, and it was going broke. We helped the

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hospital get an RHC going, and they've attracted 12 physicians. That's the type of thing this program can do that we feel good about."

Does Medicare or Medicaid cover a high proportion of your patient base? That's important. According to a survey done by the National Association of Rural Health Clinics (NARHC), which represents some 3,400 RHCs, the typical RHC practice breakdown is about 27% to 29% Medicare, 30% Medicaid, 25% to 30% commercial insurance, and 10% to 15% uninsured. "RHCs are free to see privately insured patients, too," Owens adds. "All of the clinics I work with do.You can't be the only clinic in town and not do that."

Once you've established that your practice is in an area qualifying for RHC and HPSA status, you can turn your attention to the services the clinic is required to provide for its patients. First and foremost, the clinic must provide the normal spectrum of primary care services, and must have an NP, a PA, or a certified nurse-midwife (CNM) who is on duty at least 50% of the time that the clinic is open to see patients. The clinic must have a medical director—a licensed physician—who oversees the work of the midlevel practitioners and is present at least four hours a month, depending on state laws regarding supervision of midlevel healthcare workers.

Practices must also develop a remarkably detailed manual of policies and procedures. "For many practices, that's the kicker," Parry says. "Most people find it very difficult because you have to have a policy and procedure on absolutely everything that goes on in that clinic. And you need to have it in a certain order to match the regulations if you want the site review to go well. Usually, it's a three-inch, three-ring binder, and it better be signed by the medical director and the people who put it together."

The clinic also must have a lab capable of performing several basic laboratory tests:

- Chemical evaluation of urine by stick or tablet method or both (including urine ketones)
- Hemoglobin or hematocrit
- Blood glucose
- Examination of stool specimens for occult blood
- Pregnancy tests
- Primary culturing for transmission to a certified laboratory.

As noted, these tests were included under the payment for a rural visit, but since 2001, clinics are permitted to bill Medicare Part B for them.

A good thing

In 1997, the US government did a study to see if the RHC program was actually bringing practitioners to underserved areas. "A concern at the time was why the existing practices were converting from traditional Medicare status to RHC status," comments William Finerfrock, executive director of the NARHC. "A question posed was, if the practice already existed, was access to health care really improved? Or are we simply paying more for providers to stay in areas where they had already established a presence?"

Mathematica Health Policy Research, an outside firm, took a random sampling of communities in five different states. "Two things were discovered," Finerfrock says. "First, since an RHC had to have a PA, an NP, or a CNM providing care at least 50% of the time that the clinic is open to see patients, they were bringing in clinicians and increasing access, even though the practice had previously existed. Many solo practitioners were being overwhelmed but could not afford to bring in another physician. By becoming an RHC, the practice was able to recruit a PA or an NP into the community, which meant that more patients had access to the system and the physician wasn't getting burned out."

The findings also indicated a dramatic drop in ED use by the Medicaid population after the RHC designation was granted to a local clinic. "While the clinic wasn't refusing to serve Medicaid patients, very often it would be difficult for them to get in because the practice was overburdened," Finerfrock continues. As a result, patients with Medicaid would turn to the ED in order to be seen more quickly. But with RHC status, the practice has adequate reimbursement and more personnel, making it possible to handle more patients on a timely basis. "So instead of patients going to the ED and incurring a significant cost to Medicaid for emergency room visits, we've moved them into a much more cost-effective environment," he says.

"I think Medicaid and Medicare have done some tremendous good," Owens remarks. "I've been an administrator in rural hospitals, and I'm telling you that many of these patients are very proud. Without these programs, a lot of them would stay home and die if they couldn't afford to go to the doctor."

"We've turned gas stations and car dealerships into RHCs in rural areas that needed health care," Parry adds. "It's a darn good program that will continue to save a lot of country doctors and small rural hospitals. I'd fight fiercely if they tried to take it away because I've seen all the good that it does."

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