Orcas Island Health Care District
Clinic Considerations

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Today's Agenda

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- Current State
- Review of Analysis and Assumptions
- Future Options
  - FQHC Overview and Options
  - RHC Overview and Options
- Moving Forward

Current State

Current State

Orcas Island Health Care District provides financial support for two medical practices on the island:

- Orcas Family Health Center, a current freestanding rural health clinic
  - Subject to Medicare cost-per-visit limit of $84.70 for 2019
  - Current Medicaid RHC rate of $114.

- UW Medicine Orcas Island Clinic, a freestanding, fee-schedule-paid clinic.

Current State

- Orcas Island Health Care District is exploring options in order to optimize reimbursement from different payers and continue to provide primary care services to the residents of Orcas Island.
- An analysis was performed by DZA, illustrating the potential differences in net revenue based on the federal certifications of the clinics (or one clinic) under various scenarios.
- Our goal is to help navigate those options and provide additional information regarding the various scenarios.

Future Options

Future Options

1. **Partner with an existing FQHC**
2. **Develop a Co-Applicant FQHC (FQHC Look-Alike)**
3. **Combined Freestanding Rural Health Clinic (RHC)**
4. **Combined Provider-based Rural Health Clinic (PB-RHC)**
5. **Continue as is: (subsidizing two clinics(1)) while improving reimbursement and operations**

(1) – District does not formally own or control the two clinics – any change to another structure would either require a change ownership to the District or other provider

Federally Qualified Health Center Overview

FQHC Overview

What is an FQHC?

- FQHCs are outpatient clinics that qualify for specific reimbursement under Medicare and Medicaid
- They may be community health centers, migrant health centers, health care for the homeless, and health centers for residents of public housing (original 330 grantees)
- Designated by the Bureau of Primary Care
- Enhanced reimbursement = designated service mandates

FQHC Overview

What is an FQHC? (continued)

- Grant-Supported Federally Qualified Health Centers are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs.
- Three types of FQHC's
  - 330 grantees
  - Look-alikes
  - Sub-recipient
- Can be private or public model
- District can apply for public model with co-applicant but could also just fund private model

FQHC Overview

What is an FQHC Look-Alike?

- Federally Qualified Health Center Look-Alikes are health centers that have been identified by HRSA and certified by the Centers for Medicare and Medicaid services as meeting the definition of “health center” under Section 330 of the PHS Act, although they do not receive funding under Section 330
- Clinics **without** grant and Federal Tort Claims Act (FTCA) funding, although they “look like a 330”

FQHC Overview

Benefits of FQHC Status

- Section 330 grant funds to offset the costs of uncompensated care and key enabling services (not for Look-alikes):
  - Education
  - Translation
  - Transportation
- Access to medical malpractice coverage under Federal Tort Claims Act (FTCA) (not for Look-alikes)
- Prospective Payment System reimbursement for services to Medicare & Medicaid patients
- Deductible is waived for Medicare patients

FQHC Overview

Benefits of FQHC Status (continued)

- Access to National Health Service Corps (NHSC) medical, dental and mental health providers
- Drug Pricing Discounts for pharmaceutical products under the 340B program
- Federal loan guarantees for capital improvements (not for Look-alikes)

FQHC Overview

Requirements of FQHC Status

- Located in or serve a high need community (designated Medically Underserved Area or Population (“MUA or MUP”) – pre-analysis
- Governed by a community board composed of a majority (51% or more) of health center patients who represent the population served
- Provide comprehensive primary health care services as well as supportive services (education, case management, translation and transportation, etc.) that promote access to health care
- Provide services available to all with fees adjusted based on ability to pay
- Meet other performance and accountability requirements regarding administrative, clinical, and financial operations

FQHC Overview

Requirements of FQHC Status (continued)

- Complete annual reporting requirements to HRSA besides the normal state and federal reporting requirements
- Have an on-going quality assurance program
- Pediatrics to geriatrics
- Referral agreements in place
- OSV audits (on-site HRSA audits)

FQHC Overview

Obstacles to FQHC Status

- Need a separate 501(c) 3 non-profit corporation
  - recommended for patient board for co-applicant
- Need to operate as an FQHC to obtain historical data as a look-alike before submitting FQHC application
- Need have 9 to 25 members on Board, 51% of them being patients.
- For the non-patient users, no more than 50% of the remaining Board members can be people in the health care field
  - (defined as 10% of their income derived from the healthcare industry)
  - HRSA wants to make sure the boards are not composed of physicians and healthcare administrative types
- Current Board would need to give up formal authority to community board – delegation of duties spelled out in Policy Information Notice (PIN)

FQHC Overview

Obstacles to FQHC Status (continued)

- Application is sort of like the old certificate of need applications. You could still be turned down as a FQHC applicant because of lack of perceived need in the area – no guarantee or approval
  - RHC's do not have this litmus test
- Timing - it would take approximately up to 18 months to obtain a new FQHC designation
- Significant working capital requirements
- Will always require a subsidy because enhanced reimbursement only applies to Medicare and Medicaid
- Additional staffing requirements due to mandatory service structure

FQHC Overview

Governance Requirements

- HRSA considers both the public agency and the co-applicant Board collectively as the health center. Together, the public agency and the Co-Applicant Board meet all HRSA requirements and work collaboratively to manage the approved health center project.
- The Co-Applicant Board is separate from, and independent of, the public agency. It essentially mirrors a governing board of a non profit FQHC, both in terms of composition and the decision-making authority to set policy and oversee program operations.
- The Co-Applicant Agreement along with the Co-Applicant Board Bylaws define the respective roles and responsibilities of the public agency and Co-Applicant Board, including shared or collaborative roles and responsibilities

FQHC Overview

Governance Requirements (continued)

- A general statement of the purpose of the agreement;
- Overall shared goals for operating the FQHC;
- Selection of co-applicant board members and specifically how many and which categories of members are appointed by the public agency(s);
- Responsibilities of the co-applicant board, ensuring all required authorities are addressed and how responsibilities are shared with the public agency;
- Responsibilities of the public agency, including how fiscal and personnel responsibilities are shared with the co-applicant board.

FQHC Overview

Governance Requirements (continued)

- Section 330 program requirements defining board authority include:
  - Public agency may have a role in forming the initial Co-Applicant board, but from then on the Co-Applicant board is an independent self perpetuating board that has authority to appoint itself
  - Public agency boards may retain responsibility for general fiscal and personnel issues

FQHC Overview

Framework for Shared Responsibilities

- The Co-Applicant agreement is the signed working document that ensures that the Joint Board understand and agree to their respective roles and responsibilities. It will include:
  - A general statement of the purpose of the agreement;
  - Overall shared goals for operating the FQHC;
  - Selection of Co-Applicant board members and specifically how many and which categories of members are appointed by the public agency(s);
  - Responsibilities of the Co-Applicant board, ensuring all required authorities are addressed and how responsibilities are shared with the public agency;
  - Responsibilities of the public agency, including how fiscal and personnel responsibilities are shared with the Co-Applicant board.

Source: Public Centers, A Discussion Monograph, April 2014

FQHC Overview

Reimbursement Considerations

- FQHCs are paid at a prospective rate for Medicare visits (as long as charges are equal to the rate (approximately $170)
- FQHCs in Washington state are paid at a prospective rate without productivity standards applied to the cost-per-visit calculation.
- 340B Benefit

FQHC Options

Partner with an Existing FQHC

Partner with an Existing FQHC

Options

- Letter of interest to potential FQHCs in close proximity to gauge interest
- Based on interest, terms are discussed

Partner with an Existing FQHC

Financial Considerations

- Subsidy could be negotiated. Keep in mind that the FQHC would not get any additional grant funding unless a new access point grant was available and secured.

Partner with an Existing FQHC

Control Considerations

- Most if not all control would transfer to the new ownership.
- Potential for local advisory board and/or one to two board members being a part of the existing FQHC board

Partner with an Existing FQHC

Timeline

- Dependent on interest with existing FQHCs
- Clinic could be added to the scope of project to add the clinic to the existing FQHC certification in order to bill and receive payment as an FQHC

Develop a Co-Applicant FQHC (Look-Alike)

Develop a Co-Applicant FQHC

Process

- Determine whether District is amenable to a parallel board that would have formal control of the clinic.
- One year to eighteen months for approval (500 page application with documentation)

Develop a Co-Applicant FQHC

Financial Considerations

- Financial model would improve due to Medicaid and Medicare reimbursement per visit increased from current payment
- Expenses for application, implementation, legal, audit, additional staffing positions will be incurred (which are not included the financial analysis)
- If and when a grant access point comes available, the clinic is in a better position to apply for that grant

Develop a Co-Applicant FQHC

Control Considerations

- Informal control with no formal control (due to budget approvals)

Develop a Co-Applicant FQHC

Timeline

- One year to 18 months, with no guarantee of approval

Rural Health Clinic Overview

RHC Overview

Medicare Freestanding RHC reimbursement

As a freestanding RHC, the Medicare rate-per-encounter is capped at the rate in effect for that period (2020 rate is updated to $86.31, a 1.9% increase over the 2019 rate of $84.70) Total reimbursement includes the following:

1) Medicare pays 80% of the interim rate for qualifying RHC encounters.

2) Patient coinsurance is based on 20% of the total charges.

In addition, Medicare flu and pneumonia injections are paid at cost on the Medicare cost report. Medicare bad debt can also be claimed on the year end Medicare cost report and paid at a percentage (65%). Laboratory services and the technical component of diagnostics (i.e. – EKGs and CSTs) are billed to the Part B carrier and paid at fee schedule.

RHC Overview

Medicare Provider-based RHC reimbursement

- No upper payment limit currently exists for RHCs that are provider-based to a hospital with less than 50 beds
- Laboratory services and the technical component of diagnostics (i.e. – EKGs and CSTs) are billed to the under the hospital to which the clinic is provider-based.

RHC Overview

Washington Medicaid Freestanding RHC reimbursement

- Currently, Orcas Family Health's Medicaid rate is $114 and is updated yearly by the Medicare Economic Index (the MEI for 2020 is 1.9%).
- Should the clinics combine, a new rate could be calculated via a change in scope or a change in ownership process.

Rural Health Clinic Designation

Washington Medicaid Freestanding RHC reimbursement

- As a new provider-based rural health clinic, a new Medicaid RHC rate would be calculated after the first Medicare cost report is finalized that includes the clinic. This rate is the updated yearly by the Medicare economic index (MEI), making it a prospective rate.

RHC Overview

$$\frac{\textit{Allowable RHC Costs}}{\textit{Rural Health Clinic Visits}} =$$

RHC Cost Per Visit (Rate)

(Not to exceed the maximum reimbursement limits.)

RHC Overview

Medicare Productivity Standards:

- Physician 4,200 visits annually for 1.0 FTE
- Midlevel 2,100 visits annually for 1.0 FTE

Total visits used in calculation of cost per visit is the greater of the actual visits or minimum allowed (FTEs x Productivity Standard).

RHC Overview

Sample Reconciliation of Provider FTE:

Clinical FTE	**0.70**
Administrative FTE	0.05
Hospital FTE	0.20
Medical Director FTE	0.05
Total FTE	**1.00**

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RHC Overview

- Total visits, the denominator in the cost per visit calculation, should include all “visits” that take place in the RHC during hours of operation, home visits, and SNF visits for all payers.
- Total visits should not include hospital visits (either inpatient or outpatient visits) or “nurse-only” visits in the RHC setting.

NOTE: The cost-per-visit calculation considers total costs; therefore, all visits (regardless of payer type) should be included in the cost report.

RHC Overview

Example 1 – Visits Equal Productivity Standards

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
		1	2	3	4	5
1	Physicians	6.87	25,890	4,200	28,854	
2	Physician Assistants	2.16	7,500	2,100	4,536	
3	Nurse Practitioners			2,100	-	
4	Subtotal (sum of lines 1-3)	9.03	33,390		33,390	33,390
5	Visiting Nurse					
6	Clinical Psychologist					
7	Clinical Social Worker					
8	Total FTEs and Visits (sum of lines 4-7)	9.03	33,390			33,390

RHC Overview

Example 2 – Productivity Standards Are Greater Than Visits

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
		1	2	3	4	5
1	Physicians	6.87	16,221	4,200	28,854	
2	Physician Assistants	2.16	4,773	2,100	4,536	
3	Nurse Practitioners			2,100	-	
4	Subtotal (sum of lines 1-3)	9.03	20,994		33,390	33,390
5	Visiting Nurse					
6	Clinical Psychologist					
7	Clinical Social Worker					
8	Total FTEs and Visits (sum of lines 4-7)	9.03	20,994			33,390

RHC Overview

Effect on Cost-Per-Visit

	Greater of Actual Visits or Productivity Standard Visits	Allowable Costs for Cost-Per-Visit Calculation	RHC Cost-Per-Visit
		$ 5,798,460	
Example 1	33,390		$ 173.66
Example 2	20,994		276.20

- Independent RHC – no effect; cost-per-visit limit
- Provider-based RHC to a hospital with less than 50 beds, $102.54 per visit difference
- Could affect Medicaid rate yearly or indefinitely

RHC Overview

RHC Payment Example

- Customary charge for 99213 is $120
- Assume Medicare fee schedule allowable is $70
- Medicare encounter rate is $160:
  - Limited to $80 for independent RHC
  - No limit for provider-based RHC - Available beds < 50
- Deductibles have been met already

RHC Overview

Comparison Between RHCs and Part B Payment Example

Description	RHC Amount (Independent)	RHC Amount (Provider-Based)	Part B Amount
Customary Charge	$120.00	$120.00	$120.00
Patient Copay	24.00	24.00	14.00
Medicare Pays	64.00	128.00	56.00
Total Payment	88.00	152.00	70.00
Contractual Adjustment	32.00	(32.00)	50.00

Rural Health Clinic Options

Combined Freestanding Rural Health Clinic

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Combined Freestanding Rural Health Clinic

Options

- In order to combine into one rural health clinic, the entire operation would need to be under the same tax ID
    - Whether a change of ownership exists or not, the current RHC certification can remain and no new certification needs to be gained.

Combined Freestanding Rural Health Clinic

Opportunities

- Reduction of expenses and efficiencies gained
- Increase in Medicaid RHC Rate
  - Either through a change-in-scope of services or a change of ownership

Combined Freestanding Rural Health Clinic

Financial Analysis Questions

- Does the analysis take into account that the Medicare payment can be more than the RHC rate-per-visit cap due to patient payment (20% of coinsurance)?
- Could Medicare and Medicaid visits be overstated (counting all eligible CPT codes as visits – i.e. – could have a procedure and another visit on the same day. This would be counted as one billable encounter)?
- Are total visits correct (note that the cost report is prepared internally)?
    - The reported visits are over productivity standards, which is often unusual for an RHC.
- Were lab and technical component of diagnostic services considered in the calculation as separately reimbursed (outside of the RHC rate per encounter)?

Combined Provider-Based Rural Health Clinic

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Combined Provider-Based Rural Health Clinic

Medicare Provider-based RHC reimbursement

- As a provider-based RHC to a hospital with less than 50 beds, the Medicare rate-per-encounter is paid at the full cost-per-visit, with no limit (unlike freestanding RHCs). Both freestanding RHCs and provider-based RHCs are subject to productivity standards.
- Laboratory services and the technical component of diagnostics (i.e. – EKGs and CSTs) are billed under the hospital to which the clinic is provider-based and paid under that methodology.
- Provider-based RHCs rates typically range from $120.00 - $300.00 (every RHC is different).

Combined Provider-Based Rural Health Clinic

Financial Analysis Questions

- Was overhead that would be allocated from a hospital considered in the calculation of the Medicare and Medicaid RHC rates? Per the report:
  "The District could choose to join with one of hospitals near the island to become provider-based rural health clinics, or to start a critical access hospital of its own. Both of those, while options, exceed the scope of this analysis; estimating the feasibility or cost of a provider-based clinic requires analysis of the costs of the hospital. As such, we will instead discuss these as options in broad terms."
  - Note – allocation of overhead from a Critical Access Hospital may have a negative effect on the CAHs current Medicare and Medicaid reimbursement.
- Were lab a diagnostic services reimbursement considered separate from the RHC cost-per-visit calculation and billing?

Combined Provider-Based Rural Health Clinic

Options and Considerations

- Seek interested hospitals for partnership of a rural health clinic
  - Note that in order to be provider-based to a particular hospital, the clinic must be under the tax ID of the hospital.

Moving Forward

Moving Forward

What is important to the District?

- Control?
- Financial Stability?
- Additional Services?

Moving Forward

Key Assumptions of the Various Options

- Assumes hospital or existing FQHC would be interested in pursuing ownership of clinics
- Assumes Orcas Family Health Center and UW Medicine Orcas Island (current clinic operators), would be willing participants in giving/selling clinics to another health care provider or District
- Assumes District would be willing to offer the type of subsidy going forward to hospital and or FQHC is looking for to be made whole

Questions?

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