

Rural Health Clinic (RHC) Program Update

Presented by Gail Nickerson
to the 2011 Idaho Conference for
RHCs, CAHs and Free Medical Clinics
November 4, 2011
Boise, ID



Session Overview

- Current Rural Health Clinic (RHC) Changes
- RHC–Related Policy Changes Being Pursued
- Who is the Rural Safety Net?
- Collaboration with FQHCs
- Linking Quality and Payment
- New Medicare Enrollment Fee
- HPSA/MUP Rulemaking Process



Current RHC Changes

- The Proposed Rule for RHCs that was published in 2008 expired on June 27, 2011. This means that the regulations have not changed as expected.
- The RHC upper payment limit per visit was increased from \$77.76 to \$78.07 effective January 1, 2011. The 2011 rate reflects a 0.4 % increase over the 2010 payment limit.



RHC-Related Policy Changes Being Pursued

- Raising the RHC Cap to \$101.00* per visit.
- Expanding Medicare and Medicaid incentives to RHCs for EHR utilization
- Expanding PQRI and E-prescribing



RHC-Related Policy Changes Being Pursued

- State Definition of “Rural” - Certified RHCs that LOSE their “rural” designation using the federal standard would be allowed to retain RHC designation IF they were in an area defined by the STATE as “Rural”.



RHC-Related Policy Changes Being Pursued

- Medicare Advantage (MA) organizations would be required to provide payment for RHC services furnished to plan enrollees whether or not the services are furnished pursuant to an agreement between the MA and a RHC that is:
 - Not less than the RHC's Medicare payment rate (which includes the payment of an interim rate and a subsequent cost reconciliation) OR
 - If the RHC determines appropriate, 103 % of the applicable interim payment rate (with no reconciliation).



RHC-Related Policy Changes Being Pursued

- Establish a 10 state demonstration program providing grants to RHCs to assist with covering the cost of physician, PA, NP, CNM malpractice insurance premiums
 - Grants would be \$5,000 (\$10,000 for OB-GYN) per provider or 50% of the premium (whichever is less).



RHC-Related Policy Changes Being Pursued

- Modify the definition of “employ” in RHC statute - Current law requires every RHC to “employ” a PA, NP or CNM. CMS interprets this to mean that the PA, NP or CNM must be a W-2 employee and cannot be an independent contractor. NARHC is seeking a change that would allow RHCs to work with PAs, NPs or CNMs using an independent contractor model as well as a traditional employment model.



Who is the Rural Safety Net?

- Statistics from CMS for 2008 RHC and rural FQHC provision of care to Medicare and Medicaid became available last year for the first time.



Who is the Rural Safety Net?

National Medicare Data 2008

	RHC	Rural FQHC
Medicare Claims	7,492,863	1,111,356
Medicare Patients	1,634,413	265,468
Total Medicare Charges	\$754,276,321	\$120,928,890
Average Charge Per Claim	\$101	\$109
Average Visits/Medicare Patient	4.5 visits	4.2 visits
Total Medicare Claim Payment	\$489,696,104	\$92,335,118
Average Payment per Claim	\$65	\$83
Patient Deductible	\$79,259,358	\$0
Patient Co-Pay	\$136,402,810	\$25,467,492



Who is the Rural Safety Net?

National Medicaid Data 2008

RHC Services Payments	\$659,962,933
RHC Services Beneficiary	2,049,171
Rural FQHC Payments	\$326,656,694
Rural FQHC Beneficiary	919,567
Rural FQHC % of all FQHCs	36.3%



Who is the Rural Safety Net?

State of Idaho Medicaid Data 2008

RHC Services Payments	\$7,378,623
RHC Services Beneficiary	26,052
RHC Cost Per Ben.	\$283.83
Rural FQHC Payments	\$3,741,841
Rural FQHC Beneficiary	8,815
FQHC Cost Per Ben.	\$424.51
Rural FQHC % of all FQHCs	46.0%



Collaboration with FQHCs

- PPACA has language directing that Health Resources and Services Administration (HRSA) to encourage great collaboration/cooperation between FQHCs and other safety net providers including:
 - RHCs
 - CAHs,
 - Small Community Hospitals



Linking Quality and Payment in RHCs

- PPACA directed the Secretary of HHS to analyze and make recommendations to Congress on how to link payments to RHCs, FQHCs and Free clinics to quality incentives/quality outcomes.
- George Washington University has been awarded the contract to do this research and NARHC Executive Director Bill Finerfrock has been appointed to the GW Advisory Committee as a Subject Matter Expert.



New Medicare Enrollment Fee

- Effective Friday, March 25, 2011, all NEW providers enrolling in Medicare are required to pay an application fee as a condition for enrolling in Medicare.
- The application fee is \$505.00. RHC can seek a waiver of the fee base on “hardship”. CMS has not issued guidelines for qualifying for a hardship exception.



History of Shortage Area Designation

- Shortage area designation was developed in the 1970s to help target federal resources designed to assist the most needy.
- There are 28 programs that depend on these designations, including Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), as well as National Health Service Corps (NHSC) and Medicare Bonus Payments.



History

- Two types of designations were developed: Health Professional Shortage Areas (HPSAs), where there were not enough physicians for the area residents, and Medically Underserved Areas (MUAs), where the population's health status was poor and the number of physicians was low.



History

- HPSAs have been based entirely on the ratio of physicians to the population of the area (P2P).
- There have been geographic or “geo” HPSAs (where the area is underserved at a ratio greater than 3500 residents:1 FTE physician) and also population or “pop” HPSAs (where a specific group is underserved at a ratio greater than 3000:1).



History

- MUAs have been based on the Index of Medical Underservice (IMU) with four factors:
 - Percentage of people in poverty
 - Percentage of seniors (age 65)
 - Percentage of infant mortality
 - P2P



History

- Based on the IMU, each of these factors was scored. The median total score was 62 when the method was set up, and any area with a lower score qualified as an MUA.
- There has also been designation of Medically Underserved Populations (MUPs), using the same factors but focused on the specific population in question.



History

- There were about 200 million Americans when these regulations were first established – there are almost 110 million more of us now, and rural and urban areas have changed.
- HPSAs have had to be redesignated every 4 or so years, but MUA/MUPs have not been.



History

In both (MUA and Geo)	1060	27%
In both (MUA and Pop)	895	23%
In a MUA only	410	11%
in a Geo HPSA only	354	9%
in a Pop HPSA only	850	22%
Not in either	312	8%
Total Number of RHCs	3881	



History

- The Negotiated Rulemaking Act of 1996 encouraged the use of negotiation to determine complicated regulations and directed agencies and negotiated rulemaking committees to use consensus to the maximum extent possible consistent with law.
- The Act also set forth notice of the requirements for forming a negotiated rulemaking committee.



History

- The negotiated rulemaking process for Health Professional Shortage Areas, Medically Underserved Areas and Populations was mandated by Congress in PPACA.



History

- The HPSA/MUP (as it was known) Negotiated Rulemaking Committee was created after two failed Notices of Proposed Rulemaking (NPRMs) in 1998 and 2008 that attempted to revise the rules that govern the designation of HPSAs and MUA/MUPs.
- The purpose of the committee was to assure that the areas, populations and entities to be designated under the rules, which become eligible for various Federal programs/resources, are truly underserved and/or have workforce shortages.



Duties of the Committee

- With assistance of neutral facilitators, the Committee worked to try to reach consensus, which was defined as unanimous acceptance.
- The focus of the group was primary care HPSAs, MUAs and MUPs.



Duties of the Committee

- If the Committee reached consensus on all or some aspects of the proposed rule, it would be able to recommend through Mary Wakefield, the HRSA Administrator, that Kathleen Sebelius, the Secretary of HHS, adopt the Committee consensus as the basis for an interim final rule.



Meetings

- Meetings were held monthly in the Washington DC area since September of 2010 with an original goal of submitting the final report to HRSA by July 2011.
- The original timeline was extended and the revised work plan is to complete the final report by October 31, 2011.
- The last meeting was held in Alexandria, VA on October 12 and 13, 2011.



Committee Membership

- There were 28 members of the committee.
- Members were chosen for their abilities to represent various interests that will be significantly affected by the rule and/or for technical expertise which was useful in defining medical underservice and health profession shortage.



Committee Membership

- Representatives included physicians and other clinicians, National Association of RHCs (NARHC), National Association of Community Health Centers (NACHC), National Rural Health Association (NRHA), American Hospital Association (AHA), American Academy of Family Physicians (AAFP), counties, state health and primary care offices, and advocates for historically marginalized people such as racial/ethnic groups, tribal members, persons with disability, elderly, those with HIV/AIDS and lesbian/gay/bisexual/transgender (LGBT).



Committee Membership

- There were a variety of subcommittees also that reported back to the committee. These included groups that discussed workforce, barriers to care, weighting of factors in the calculation of HPSAs and MUAs, and implementation of the new methods.



Committee Membership



Framework Questions

- Are these objectives of MUA/MUP and HPSA clearly different, justifying two separate processes?
- The HPSA and MUA/MUP statutes require inclusion of factors indicative of health status, ability to pay, access, and availability of health professionals as well as need.
 - What should be included and how should they be defined?
 - To what extent should national data sources be used versus state and local sources?
 - What data sources are accurate and reliable enough to use?
 - What provider availability resource?
 - What economic factors influence access and how to measure?
 - What health status indicators should be included?
 - What demographic indicators should be included, if any?



Framework Questions

- What methodology should be used to incorporate the impact of underservice indicators? Should they be combined in the same way for MUA/MUP and HPSA?
- Provider availability – who should be counted? How do we define FTE?
- Should providers in a federal program be counted in the process or excluded?
- How to define “rational service areas” (RSAs)?
- What population groups to consider?
- What is the role of facility designations?



Framework Questions

- How should threshold levels of various indicators be identified to separate those areas such as population groups and facilities found to qualify?
- How can the process be designed to reduce the burden of the application and update process for states and local entities?
- How can the Committee assess the impact of revised methodologies? How to best summarize and display the impact of the methodologies?
- How can the new methodology be implemented in a manner that minimizes disruption and access?



Factors Considered

- **Provider/Supply**
 - Health professionals (population to provider ratio or P2P)
- **Health Status/Outcome/Need**
 - Health status (social determinants)
 - Direct measures of health (low birth weight, chronic disease such as diabetes, etc.)
 - Barriers (access, ability to pay, social barriers)



Process

- How to factor in Nurse Practitioners (NPs), Physician Assistants (PAs) and Certified Nurse Midwives (CNMs), as well as Obstetricians, was another major discussion. The group wanted to honor the important work that these individuals do, but did not want to overestimate capacity and disqualify areas that might have a number of these providers but few primary care physicians.
- There were public comments from other groups wanting to be acknowledged as health service providers.



Process

- How much to count P2P and how much to factor in health status were other major conversations.
- Once the factors were defined and weighting of factors was suggested, there was extensive impact testing by John Snow Inc. (JSI) with lots of summary charts and mapping.
- We found that the data available was less than perfect – especially in rural areas, since P.O. Box addresses may not calculate correctly. Also, NPI may assign a provider to their home RSA rather than the one where they work, and doesn't show who works part-time.



Process

- Frontier areas really took a hit when they were measured the same as all other areas. This is probably because of the new inclusion of NPs, PAs and CNMs, and possibly also because of the smaller populations in some rural areas. We were able to get agreement on the Committee to use only P2P in frontier RSAs, but in the end, full consensus was not reached on HPSA calculation methodology.



Process

- Consensus was reached on many items at the September meeting, but then after that, through emails and at the last meeting in October, it became clear that a few individuals decided that they could not agree with the group.
- At the last meeting, attended by 23 out of the 28 members, there was agreement on some items, but full consensus was not achieved - a number of items had 1 and 4 members voting no.



Outcome

- There was 100% agreement (“thumbs up”) on a number of aspects
 - Everyone agreed on the introduction to the report
 - There was 100% agreement on the conceptual framework
 - Evidence-Based & Data Driven
 - Simplicity
 - Reasonableness
 - Consequences to Existing Safety-Net



Outcome

- Other “thumbs up” items
 - Everyone agreed that there should be a small advisory committee in the aftermath of the process to work with HRSA on areas on which we did not achieve consensus.
 - There was 100% agreement that Rational Service Areas (RSAs) meet four criteria: made up of discrete defined geographic-based areas, continuous, different parts of the area are interrelated, and distinct from adjacent contiguous areas.



Outcome

- Other “thumbs up” items (continued)
 - There was full agreement on the “severability language”, which says that the Committee intends the separate report sections to be severable so that those sections for which consensus was reached shall be implemented as recommended, while those sections for which consensus was not reached may be considered, taking into account the vote in the committee for each such section.



Outcome

- Other “thumbs up” items (continued)
 - Everyone agreed on the Exceptional Medically Underserved Population (EMUP) designation language, which serves a population that does not meet MUA/MUP criteria but is recommended by the Governor of the state.
 - There was 100% support of the overall description of facility HPSAs, which include RHCs and FQHCs.



Outcome

- All of the other topics had at least 15 Committee members (a majority) voting “thumbs up” but had 1-4 voting against and some abstaining. These were very important aspects including:
 - Calculation of P2P
 - HPSA geo/pop methodologies
 - MUA/MUP methodologies
 - Back-out of RHC/FQHC/NHSC/J-1 providers to avoid the “yo-yo” effect
 - Inclusion of county correctional facilities as potential facility HPSAs



Outcome

- On Friday, October 21, Committee members received a copy of the revised draft of the discussions and decisions and comments were returned by October 25.
- Last Thursday, October 27, was the day that the final draft was circulated. Comments by Committee members on the document were submitted by Friday, October 28.
- The report was submitted to the Secretary on October 31.



Questions?

Gail Nickerson
Vice President, NARHC
Director, Clinic Services
Adventist Health
2100 Douglas Boulevard
Roseville, CA 95661
NickerGW@ah.org

