Healthcare Financial Management Association (HFMA) Spring 2024 Conference

Reimbursement Updates

WIPFLI

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Overview

Medicare DSH

DSH Day Reporting

- DSH audits played a large roll in the revisions found in Transmittal 18
- New form required template 3a
    - Cost reports beginning on or after 10/1/2022
- Hospitals impacted DSH and LIP
- If Hospital Specific Payment is greater than Federal Specific Payment completion is not required.

DSH Day Reporting

EXHIBIT 3A

TITLE	*MEDICAID ELIGIBLE DAYS FOR A DSH ELIGIBLE HOSPITAL*
PROVIDER NAME	
CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
WS S-2, PT. I, LINE #	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMNS 10 &12	
TOTAL COLUMN 11	

PATIENT CLAIM INFORMATION							
PATIENT LAST NAME	*PATIENT FIRST NAME*	*DATE OF SERVICE - FROM*	*DATE OF SERVICE - TO*	*PATIENT ACCOUNT NUMBER*	*MEDICAID NUMBER*	*STATE ELIGIBILITY CODE*	*PATIENT POPU-LATION CODE*
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*

MEDICAID DAYS				*INSURANCE OR OTHER PAYER NAME*		*MEDICARE ELIGIBILITY*			
WKST S-2, PART I COLUMN NUMBER	*ELIGIBLE DAYS*	*LABOR & DELIVERY ROOM DAYS*	*NEWBORN BABY DAYS*	*PRIMARY*	*SECONDARY*	*A/B INDICATOR*	*START DATE*	*END DATE*	*COMMENTS*
9	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*

DSH Day Reporting

- Take aways:
  - Columns 6 through 8 - Every record must include Medicaid number, State plan code, identify restricted vs. unrestricted MCD eligible day (pregnancy/labor and delivery days, Emergency Services, User defined restricted eligibility)
  - Columns 9 through 12 - Concurring new born days would be included in column 12 under Mother's record, but subsequent days after mothers discharge would be a new record in Col 10
  - New items to track:
    - State Eligibility Code (Colum 7) - Enter the applicable State plan eligibility code number, if available. To report more than one code, report the additional State plan eligibility codes in column 18.

DSH Day Reporting

- Patient Population Code (Column 8) - Enter a unique patient population code to identify a restricted or unrestricted Medicaid eligible day. For restricted eligibility, use code R1 for pregnancy/labor and delivery services; use code R2 for emergency services; or use a code R3 through R9 for user-defined restricted Medicaid eligibility and provide the definition for the code in column 18. For unrestricted Medicaid eligibility, use code U1 for general or use a code U2 through U9 for user-defined unrestricted Medicaid eligibility and provide the definition for the code in column 18.

https://www.cms.gov/medicare/audits-compliance/part-cost-report-audit/electronic-cost-report-exhibit-templates

02

Uncompensated Care

Uncompensated Care Reporting – Form S-10

- S-10, Part I - uncompensated care for the entire hospital complex (current requirements) (Template Exhibit 3B)
- S-10, Part II - IP and OP billable services under CMS provider number (excludes distinct part units included in Part I) (Template Exhibit 3C)
- Patients could have services under both hospital and distinct part units
- Part II calculates a new CCR for charity and bad debt but may not have direct impact on uncompensated care payments.
- Hospital’s charity care policy determine S-10 eligibility.
- S-10 should exclude patients covered by COVID-19 funding

Uncompensated Care Reporting

- Insured/Uninsured – if any payment is made on patient behalf
- New Line 25.01 – Charges for insured patients liability

Uncompensated Care Reporting – Charity Care

EXHIBIT 3B

TITLE	*CHARITY CARE CHARGES*
PROVIDER NAME	
HOSPITAL CCN	
COMPONENT CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
PREPARED BY	
DATE PREPARED	
UNINSURED COLUMN 20	
INSURED COLUMN 20	

PATIENT CLAIM INFORMATION										
PATIENT NAME - LAST 1	*PATIENT NAME - FIRST* 2	*DATE OF SERVICE - FROM* 3	*DATE OF SERVICE - TO* 4	*PATIENT ACCOUNT NUMBER* 5	*INSURANCE STATUS* 6	*PRIMARY PAYOR* 7	*SECONDARY PAYOR* 8	*TOTAL CHARGES FOR CLAIM* 9	*PHYSICIAN / PROFES-SIONAL CHARGES* 10	*DEDUCT-IBLE / COINSUR / COPAY AMOUNTS* 11

TOTAL THIRD PARTY PAYMENTS 12	*INSURED CONTRAC-TUAL ALLOWANCE AMOUNT* 13	*OTHER NON-ALLOWABLE AMOUNTS* 14	*TOTAL PATIENT PAYMENTS* 15	*AMOUNTS WRITTEN OFF AS BAD DEBT* 16	*UNINSURED DISCOUNT AMOUNTS* 17	*CHARITY CARE NON-COVERED CHARGES* 18	*OTHER CHARITY CARE CHARGES* 19	*AMOUNTS WRITTEN OFF TO CHARITY CARE AND UNINSURED DISCOUNTS* 20	*WRITE OFF DATE* 21

Uncompensated Care Reporting – Charity Care

- Template Exhibit 3B completed for charity care component of S-10
- Form represents current S-10 audit template
- Column 6 – 1 = Insured 2 = Insured but not covered 3 = Uninsured
- Total charges – physician charges – coins/deductibles/copay – third party payments – C/A – other adjustments – patient payments – bad debt = Charity Care Write Offs.

Uncompensated Care Reporting – Bad Debt

EXHIBIT 3C

TITLE	TOTAL BAD DEBTS
PROVIDER NAME	
HOSPITAL CCN	
COMPONENT CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 17	

PATIENT CLAIM INFORMATION					INSURANCE STATUS	PRIMARY PAYOR	SECONDARY PAYOR
PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCT NUMBER			
1	2	3	4	5	6	7	8

SERVICE INDICATOR (IP / OP)	TOTAL CHARGES	TOTAL PHYS-ICIAN / PROFES-SIONAL CHGS	TOTAL PATIENT PAYMENTS	TOTAL THIRD PARTY PAYMENTS	PATIENT CHARITY CARE AMOUNT	CONTRACTUAL ALLOWANCE / OTHER AMOUNT	A/R WRITE OFF DATE	PATIENT BAD DEBT WRITE OFF AMOUNT
9	10	11	12	13	14	15	16	17

Uncompensated Care Reporting – Bad Debt

- Template Exhibit 3C completed for bad debt component of S-10
- Mirrors Charity Care layout
- Column 17 - Patient bad debt ratio (col 10 / sum of col 10 and col 11). Apply ratio to total payments, discounts, and allowances (12 – 15) and subtract the results form total charges (col 10).

https://www.cms.gov/medicare/audits-compliance/part-cost-report-audit/electronic-cost-report-exhibit-templates

03

Medicare Bad Debt

Medicare Bad Debt

EXHIBIT 2A

TITLE	MEDICARE BAD DEBTS
PROVIDER NAME	
CCN	
SUBPROVIDER CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
INPATIENT / OUTPATIENT	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 23	
TOTAL DUAL ELIGIBLE	

PATIENT NAME LAST	PATIENT NAME FIRST	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	PATIENT ACCOUNT NUMBER	MBI OR HICN	MEDI-CAID NUMBER	PROVIDER DEEMED INDI-GENT	MEDI-CARE REMIT-TANCE ADVICE DATE	MEDI-CAID REMIT-TANCE ADVICE DATE	SEC-ONDARY PAYER RA RE-CEIVED DATE	BENE-FICIARY RESPON-SIBILITY AMOUNT	DATE FIRST BILL SENT TO BENE
1	2	3	4	5	6	7	8	9	10	11	12	13

A/R WRITE OFF DATE	SENT TO COLLEC-TION AGENCY (Y/N)	RETURN FROM COLLEC-TION AGENCY DATE	COLLEC-TION EFFORT CEASED DATE	MEDI-CARE WRITE OFF DATE	RECOVER-IES ONLY: AMOUNT RECEIVED	RECOVER-IES ONLY: MCR FYE DATE	MEDI-CARE DE-DUCTIBLE AMOUNT*	MEDI-CARE CO-INSUR-ANCE AMOUNT*	PAYMENTS RECEIVED PRIOR TO WRITE-OFF	ALLOW-ABLE BAD DEBTS AMOUNT	COMMENTS
14	15A	15	16	17	18	19	20	21	22	23	24

Medicare Bad Debt

- Expanded from 10 to 24 columns.
- Columns 14 through 17 could be the same date
- Column 23 = Coinsurance (sum col 20 & 21) – payments (col 18 & 22)

https://www.cms.gov/medicare/audits-compliance/part-cost-report-audit/electronic-cost-report-exhibit-templates

04

Other Changes

Other Changes

- Modification to DGME payment calculation – correction to the FTE cap
- Extended low volume and MDH through 12/31/2024 (3,800 total discharges and 15 miles from nearest like hospital)
- Temporary expansion beds for COVID-19, added line 34 to S-3 to report temporary added beds. These temp beds will need separate breakout of days for MCR, MCD and Total.

05

Upcoming Changes

Upcoming Changes

- Transmittal 20 effective for cost report periods beginning on or after 4/1/2023.
    - Revised instructions for Rural Emergency Hospital (REH) provider type

- 96 hour waiver previously granted for the Health Emergency ending May 11, 2023. IP LOS after this date are now subject to the original 96 hour rule.

- MCReF Changes
    - CMS will be requiring MACs to share Interim Rate, Tentative Settlement, and Final Settlement documentation through MCReF for activities July 2023 and onward

    - Updated template Exhibit 1 to be used with RHCs, FQHCs & SNF Medicare bad debts. The updated template is the original 12 columns but should be used for MCReF compatibility.

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06

RHC Updates

2020 Census removes non-urbanized definition

- CMS officially released the interim process that will be used in determining RHC rural location determinations following the Census Bureau's definition changes.

- The interim process is as follows:

  RHC applicants or relocating RHCs will meet the rural location requirement if the physical address is "non-urbanized" or in an "urban cluster" per the 2010 Census Bureau Data, OR if the physical address is not an urban area per the 2020 Census Bureau Data.

Addition of RHC-defined practitioners

(Consolidated Appropriations Act of 2023)

- Beginning 1/1/2024, the following additional RHC practitioners will be recognized by CMS and with services paid at the AIR
  - Marriage and Family Therapists
  - A Mental Health Counselor is recognized as an individual who
    - ✓ Possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under the State law of the State in which such individual furnishes the services…
    - ✓ Is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished;
    - ✓ After obtaining such a degree has performed at least 2 years of clinical supervised experience in mental health counseling;
    - ✓ Meets such other requirements as specified by the Secretary."

Ending of RHC-specific waivers

- Staffing requirements – Nurse Practitioner (NP), Physicians Assistant (PA), or Certified Nurse Midwife (CNM) must be available to provide patient care at least 50% of the time the RHC is open.
- Temporary Expansion Locations – additional use of permanent locations billed under an already certified RHC are no longer allowed.
- Bed Count for Provider-based RHCs – “grandfathered RHCs” must meet the 50 bed or less requirement in order to keep their grandfathered payments.
- Home Nursing Visits – an official home health shortage area designation will need to be in place in order to bill for visiting nurse services. – during the PHE, you did not need the designation to bill these services.
- Virtual Communication Services – digital evaluation and management codes are no longer part of the definition of a G0071.

Extension of distant site RHC services

(CAA of 2023)

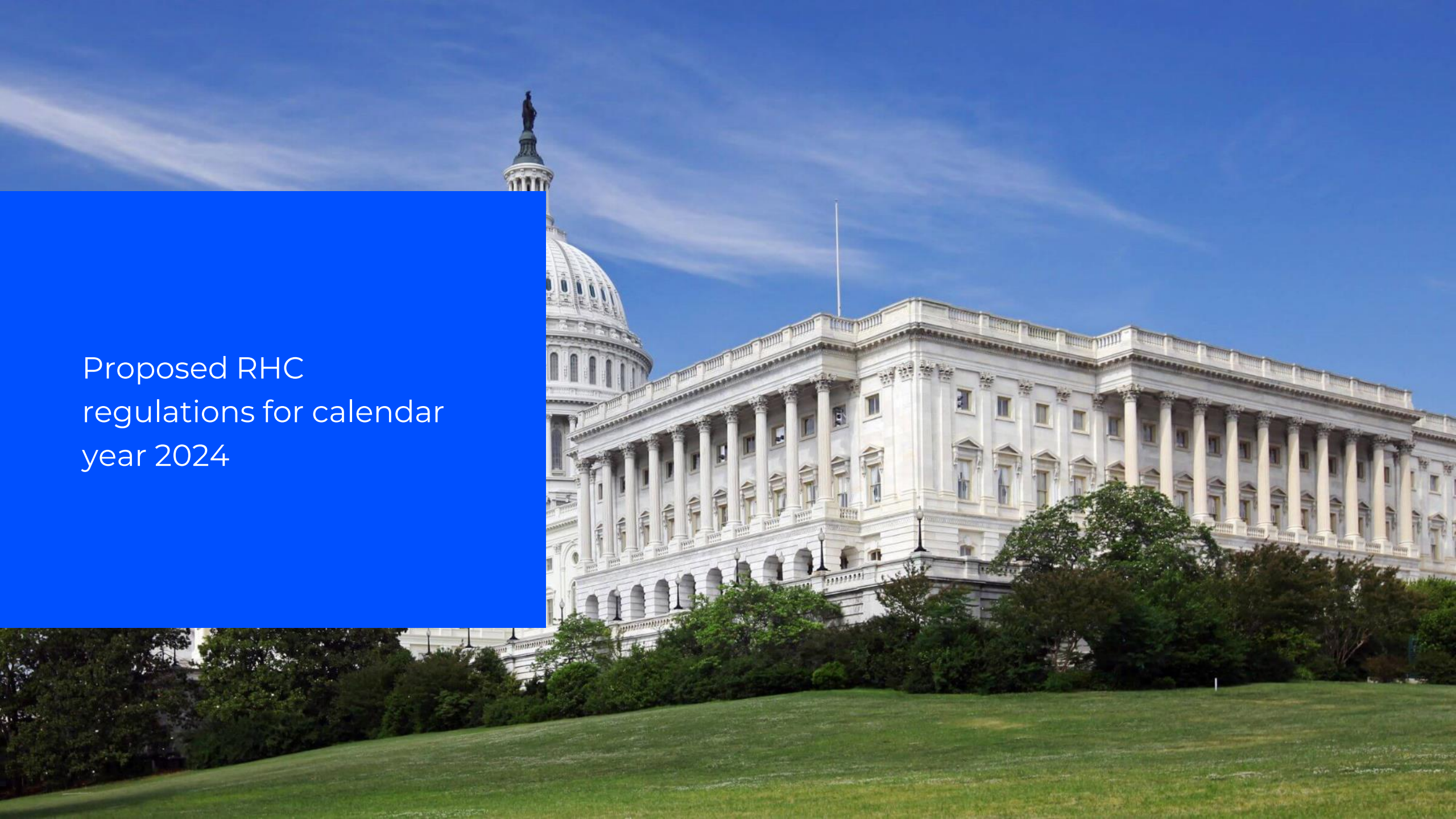
- RHCs will continue to have the ability to provide distant site telehealth services through the end of 2024 – note that these services are not be paid at the all-inclusive encounter rate (AIR) and will continue to be paid at the lesser of fee schedule or actual charge.
- Telehealth services to be provided through non-HIPAA-secure communications technology ended with the PHE, and providers had 60 days to get into compliance. However, the HIPAA privacy rule does not prevent providers from offering covered audio-only telehealth services.

Mental health distant site RHC services

(CAA of 2023)

- RHCs permanently have the ability to provide mental health services via telehealth and these services are paid at the AIR (effective 1/1/2022).
  - MHCs and MFTs can provide these services
- Medicare does not say the provider has to be sitting within the clinic.
- The in-person mental health visit requirement has been waived until 12/31/2024.

Proposed RHC regulations for calendar year 2024



CY 2024 PFS Final rule – RHC provisions

(November 11, 2024)

- Provides definitions (see earlier slide) of MFTs and MHCs and noting they can receive RHC payment.
- Addiction counselors that meet the requirements of MHCs can enroll in Medicare as MHCs
- CMS proposes that MFTs/MHCs have at least 2 years or 3,000 hours of post master's degree supervised clinical experience
- MFTs and MHCs can provide services under G0323, similar to CPs and CSWs
  - Billed under G0511 to remain consistent

CY 2024 HOPPS Final rule – RHC provisions

(November 11, 2024)

In July, CMS released the proposed 2024 Hospital Outpatient Prospective Payment System Rule that included a new service available to RHCs beginning January 1, 2024:

- Intensive Outpatient Program (IOP):
  - Implemented provisions from CAA 2023 that allows RHCs, as well as HOPDs, community mental health centers and FQHCs to bill for these services. RHCs will be paid differently.
  - IOP is behavioral health for patients with acute mental health illness such as substance abuse, depression, etc. intended for patients requiring higher level service than an O/P visit with a mental health provider.
  - Requires a physician to certify patient needs services for at least 9 hours but less than 19 hours per week.
  - Patient's plan of care must be documented (no less than frequently than every other month) including certain requirements
  - Proposed payment is $284 per day. Note this is not a "core RHC" service (not billed as an RHC encounter), instead, the service would be carved out likely to a new non-RHC cost center on the cost report similar to care management services.
  - CMS elected to not grant the flexibility to provide 3 or 4 service days and stated that the 3 service day only is sufficient.

CY 2024 PFS Final rule – RHC provisions

(November 11, 2024)

- The proposed rule includes allowing for payment of Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring services (RTM) in conjunction with other services. Specific to RHCs and FQHCs, CMS is expanding these services and allowing payment under the existing general care management code of G0511 ($77.24 in 2023)
- CMS proposing two new care management codes, Community Health Integration and Principal Illness Navigation, all to be paid through the G0511 code.
- CMS clarified that an RHC may bill G0511 multiple times in a calendar month as long as they are “medically reasonable and necessary, meet all requirements, and not be duplicative of services paid to RHCs/FQHCs under the general care management code for an episode of care in a given calendar month”
- G0511 care management code payment revision:
  - CMS is proposing to change the payment by using a weighted average utilization vs. the average of all the codes beginning in 2024. Problem for RHCs is there is no utilization data on the codes since they use one general code. Using non-RHC utilization, the proposed fee is $72.98, which is a decrease from 2023.

CY 2024 PFS Final rule – RHC provisions

(November 11, 2024)

- Proposes a change in the definition of a Nurse Practitioner (Conditions of Certification, Sec. 491.2(1) or the RHC regulations) by changing the certification requirements language to include other national certifying organizations.
- Proposal to change the definition of nurse practitioner at § 491.2(1)
  - Current definition:
    - *"Is currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates;"*
  - Proposed definition:
    - *"Be certified as a primary care nurse practitioner at the time of provision of services by a recognized national certifying body that has established standards for nurse practitioners and possess a master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree."*

Hot Topics

Hot Topic –

Medicare Advantage in rural health

- FQHCs are eligible to get paid the difference between Medicare and Medicare Advantage (MA) payment to be made whole through WRAP.
- RHCs are currently not eligible as MA plans are considered commercial.
  - NARHC is really exploring solutions to establish policies with MA plans
  - NARHC reported that:
    - In 2010, **11%** of eligible rural beneficiaries are enrolled in an MA plan, with **9 plans** available
    - In 2023, **40%** of eligible rural beneficiaries are enrolled in an MA plan, with **27 plans** available

Questions?

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HFMA Conference – March 2024

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APPENDIX:

CAH & RHC Benchmarsk

Legislative Bills in Congress related to RHC’s

CAH Benchmarks

Patient Stats	Alaska (13)	Washington (39)	Western (299)	Top 100 CAH 25th Percentile	Top 100 CAH Median	Top 100 CAH 75th Percentile
Acute Medicare Days (Inc ICU)	275	518	424	302	508	1,019
Acute Medicaid Days (Inc ICU)	428	29	62	4	21	91
Acute Total Days (Inc ICU)	940	945	953	489	982	1,785
Acute Medicare Utilization	39%	50%	47%	47%	58%	68%
Acute Medicaid Utilization	27%	2%	8%	1%	2%	8%
Swing Bed Medicare Days	267	387	301	260	442	672
Swing Bed Total Days	474	781	559	412	667	1,062
Swing Bed Medicare Utilization	61%	42%	60%	57%	76%	84%
Discharges - Medicare	88	142	119	93	154	283
Discharges - Total	280	296	304	161	327	552
Average Length of Stay - Days	3.06	3.56	3.21	2.83	3.11	3.45
Average Length of Stay - Hours	73.4	85.51	77.06	68.04	74.56	82.82
Cost Report Statistics						
Acute Medicare Routine Costs per Day	5,035	3,705	3,066	1,922	2,421	3,121
Acute Medicare Ancillary Costs Per Day	1,805	1,003	1,118	672	931	1,231
Acute Medicare Cost Per Day	6,407	4,777	4,400	2,675	3,476	4,363
Swing Bed Medicare Routine Costs per Day	5,265	3,662	2,927	1,923	2,391	3,142
Swing Bed Medicare Ancillary Costs per Day	811	394	453	378	422	511
Swing Bed Medicare Cost Per Day	6,317	4,052	3,453	2,383	2,857	3,640
Part B Medicare CCR	80%	47%	48%	41%	46%	56%
Acute Medicare Ancillary Charges Per Day	2,839	2,077	2,372	1,494	2,000	2,635
Swing Bed Medicare Ancillary Charges per Day	928	770	835	655	863	1,002
Inpatient Medicare Bad Debt Claimed per Day	0	38.3	14.44	2.63	11.25	29.97
Outpatient Medicare Bad Debt Claimed / Medicare OP Charges	0.00%	0.72%	0.51%	0.07%	0.29%	1.06%
Swing Bed Medicare Bad Debt Claimed per Day	0	0	0	0	0	0
Cost Report Metrics						
Acute Medicare Cost Percent of Total Allowable Cost	4%	8%	6%	5%	8%	10%
Swing Bed Medicare Cost Percent of Total Allowable Cost	3%	5%	3%	3%	5%	9%
Outpatient Medicare Cost Percent of Total Allowable Cost	11%	17%	15%	17%	23%	26%
Total Medicare Cost Percent of Total Allowable Cost	22%	33%	29%	30%	37%	45%

Profitability Metrics	Alaska (12)	Washington (38)	Western (295)	Top 100 CAH 25th Percentile	Top 100 CAH Median	Top 100 CAH 75th Percentile
EBITDA Margin	8.83%	4.31%	4.64%	2.70%	6.55%	9.97%
Operating Margin	5.96%	2.44%	2.60%	-0.53%	5.92%	9.87%
Total Margin	6.73%	2.58%	2.77%	-0.61%	6.47%	11.06%
Liquidity Metrics						
Current Ratio	2.15	4.18	3.5	2.17	3.42	4.67
Days Cash on Hand	54.3	99.59	91.79	55.26	126.06	231.19
Day Revenue in Accounts Receivable - Net	55.22	55.58	53.73	38.52	49.14	57.81
Capital Metrics						
LTD to Capital	0	0.19	0.06	0	0.05	0.21
Net Assets / Total Assets	0.76	0.64	0.67	0.55	0.72	0.85
Debt Service Coverage	2.74	2.43	3.71	1.66	4.51	10.82
Average age of Plant	2.08	15.59	12.52	10.84	13.36	19.56
Staffing Metrics						
FTEs	358.77	190.47	172.03	95.9	152.35	236.81
Salary per FTE	76,639	86,887	77,566	61,106	70,671	81,319
Salary/Total Expense	0.42	0.44	0.41	0.37	0.41	0.46
Salary to Net Patient Service Revenue	0.41	0.45	0.43	0.36	0.43	0.5
Payor Mix						
Outpatient Medicare	15%	21%	20%	21%	28%	32%

	2022		2021		2020	
Patient Stats	**Alaska (13)**	**Washington (39)**	**Alaska (13)**	**Washington (39)**	**Alaska (12)**	**Washington (38)**
Acute Medicare Days (Inc ICU)	275	518	334	479	311	464
Acute Medicaid Days (Inc ICU)	428	29	209	31	300	20
Acute Total Days (Inc ICU)	940	945	757	993	864	842
Acute Medicare Utilization	39%	50%	41%	52%	41%	57%
Acute Medicaid Utilization	27%	2%	27%	2%	26%	2%
Swing Bed Medicare Days	267	387	177	332	264	458
Swing Bed Total Days	474	781	580	806	451	970
Swing Bed Medicare Utilization	61%	42%	65%	53%	64%	50%
Discharges - Medicare	88	142	91	152	88	149
Discharges - Total	280	296	248	269	307	275
Average Length of Stay - Days	3.06	3.56	3	3.62	3.01	3
Average Length of Stay - Hours	73.4	85.51	72	86.99	72.35	71.9
Cost Report Statistics						
Acute Medicare Routine Costs per Day	5,035	3,705	3,661	3,180	4,123	2,885
Acute Medicare Ancillary Costs Per Day	1,805	1,003	1,774	1,103	1,924	1,135
Acute Medicare Cost Per Day	6,407	4,777	5,550	4,430	5,972	4,106
Swing Bed Medicare Routine Costs per Day	5,265	3,662	4,456	3,062	4,240	2,773
Swing Bed Medicare Ancillary Costs per Day	811	394	810	452	684	482
Swing Bed Medicare Cost Per Day	6,317	4,052	5,266	3,625	5,589	3,377
Part B Medicare CCR	80%	47%	73%	47%	79%	46%
Acute Medicare Ancillary Charges Per Day	2,839	2,077	2,509	2,120	2,682	2,179
Swing Bed Medicare Ancillary Charges per Day	928	770	939	777	857	842
Inpatient Medicare Bad Debt Claimed per Day	0	38.3	0	15	0	40.23
Outpatient Medicare Bad Debt Claimed / Medicare OP Charges	0.00%	0.72%	0.00%	0.79%	0.00%	0.70%
Swing Bed Medicare Bad Debt Claimed per Day	0	0	0	0	0	0
Cost Report Metrics						
Acute Medicare Cost Percent of Total Allowable Cost	4%	8%	4%	8%	4%	8%
Swing Bed Medicare Cost Percent of Total Allowable Cost	3%	5%	2%	5%	3%	5%
Outpatient Medicare Cost Percent of Total Allowable Cost	11%	17%	10%	17%	10%	17%
Total Medicare Cost Percent of Total Allowable Cost	22%	33%	18%	33%	19%	35%

	2022		2021		2020	
Profitability Metrics	**Alaska (12)**	**Washington (38)**	**Alaska (12)**	**Washington (38)**	**Alaska (12)**	**Washington (38)**
EBITDA Margin	8.83%	4.31%	16.85%	10.13%	10.19%	6.08%
Operating Margin	5.96%	2.44%	13.96%	11.26%	9.34%	3.54%
Total Margin	6.73%	2.58%	18.82%	12.75%	9.45%	4.13%
Liquidity Metrics						
Current Ratio	2.15	4.18	1.76	3.08	1.73	2.05
Days Cash on Hand	54.3	99.59	44.68	170.53	101.74	197.93
Day Revenue in Accounts Receivable - Net	55.22	55.58	54.08	53.97	48.46	45.96
Capital Metrics						
LTD to Capital	0	0.19	0	0.17	0	0.29
Net Assets / Total Assets	0.76	0.64	0.63	0.53	0.6	0.36
Debt Service Coverage	2.74	2.43	11.6	8.71	3.03	4.77
Average age of Plant	2.08	15.59	0.2	14.88	4.35	13.72
Staffing Metrics						
FTEs	358.77	190.47	387	191.35	369.87	199.94
Salary per FTE	76,639	86,887	70,477	82,182	66,423	78,541
Salary/Total Expense	0.42	0.44	0.44	0.45	0.46	0.46
Salary to Net Patient Service Revenue	0.41	0.45	0.42	0.48	0.45	0.5
Payor Mix						
Outpatient Medicare	15%	21%	14%	23%	12%	23%

RHC Updates

	12/31/2020			12/31/2021			12/31/2022		
	Mean			Mean			Mean		
Category/Indicator	**WA**	**Western**	**Nation**	**WA**	**Western**	**Nation**	**WA**	**Western**	**Nation**
Number of Facilities	75	481	2,610	83	510	2,744	83	516	2,844
Encounters per FTE:									
Physician FTEs	129	660.79	3,504.94	187	776.65	3,859.78	171	802.26	4,026.68
Physician Encounters	375,277	2,224,889	12,168,825	599,918	2,700,027	13,737,144	555,446	2,810,686	14,690,355
Physician Services Under Agreement Encounters	2,509	412,413	766,030	15,312	428,786	856,776	31,407	281,524	748,537
Physicians	2,916	3,367	3,472	3,207	3,477	3,559	3,247	3,503	3,648
Physician Assistant FTEs	60	346.11	1,326.41	85	376.06	1,411.60	85	408.00	1,454.18
Physician Assistant Encounters	154,423	1,016,246	3,643,748	236,829	1,229,364	4,074,152	258,855	1,318,734	4,454,035
Physician Assistants	2,578	2,936	2,747	2,779	3,269	2,886	3,030	3,232	3,063
Nurse Practitioner FTEs	70	475.67	3,245.95	94	505.63	3,513.30	95	534.35	3,761.01
Nurse Practitioner Encounters	163,167	1,283,590	8,452,880	228,441	1,451,081	9,605,273	239,144	1,607,932	11,142,306
Nurse Practitioners	2,338	2,698	2,604	2,424	2,870	2,734	2,511	3,009	2,963
Visiting Nurse FTEs	0	7.16	63.78	0	12.36	58.74	1	17.37	64.59
Visiting Nurse Encounters	0	6,786	18,462	811	10,599	16,940	1,608	13,914	28,701
Visiting Nurses	0	948	289	2,079	858	288	2,062	801	444
Clinical Psychologist FTEs	5	16.28	54.88	7	18.59	52.27	16	34.75	75.68
Clinical Psychologist Encounters	6,670	27,264	84,784	9,414	31,244	96,500	20,102	50,344	125,207
Clinical Social Worker FTEs	11	44.36	192.14	23	63.01	205.65	17	60.55	217.88
Clinical Social Worker Encounters	10,138	63,799	230,300	29,881	89,352	272,391	18,597	90,108	309,364
Clinical Psychologist/Social Worker	1,062	1,502	1,276	1,312	1,478	1,430	1,169	1,474	1,480
Total Staff Encounters	712,184	5,034,987	25,365,033	1,120,606	5,940,453	28,659,469	1,125,159	6,174,533	31,499,810
Total Encounters	712,184	5,034,987	25,365,033	1,120,606	5,940,453	28,659,469	1,125,159	6,174,533	31,499,810
Midlevel Staffing Ratio	50%	55%	57%	49%	53%	56%	51%	54%	56%
Midlevel Visit Ratio	46%	47%	48%	43%	46%	48%	46%	49%	50%

	12/31/2020			12/31/2021			12/31/2022		
	Mean			Mean			Mean		
	WA	Western	Nation	WA	Western	Nation	WA	Western	Nation
	75	481	2,610	83	510	2,744	83	516	2,844
Cost per Encounter:									
Physician	162.13	144.13	118.82	162.35	148.71	122.77	186.16	166.78	131.48
Physician Assistant	104.32	66.97	61.74	98.30	67.35	63.76	85.51	67.55	62.53
Nurse Practitioners	69.45	68.80	57.03	58.63	70.71	57.38	75.40	77.37	56.74
Visiting Nurse	0.00	283.80	312.59	0.00	123.06	286.12	0.00	131.31	178.23
Clinical Psychologist/Social Worker	107.96	70.30	45.88	55.21	68.48	44.44	105.69	89.85	52.07
Total Health Care Staff Cost	48.38	44.86	33.93	39.54	43.36	35.07	47.33	47.99	36.65
Cost per FTE:									
Physician	434,770	431,047	374,521	504,467	442,346	403,236	596,170	482,263	434,000
Physician Assistant	268,927	196,629	169,598	273,186	220,187	184,016	259,135	218,337	191,527
Nurse Practitioner	162,370	185,660	148,515	142,083	202,932	156,871	189,356	232,810	168,109
Visiting Nurse	0	268,975	90,485	0	105,527	82,513	0	105,187	79,198
Clinical Psychologist/Social Worker	114,698	105,574	58,528	72,438	101,212	63,567	123,531	132,419	77,081
Total Healthcare Staff Costs per Provider FTE	133,338	152,359	106,538	120,885	155,323	114,409	151,407	169,831	124,931
Clinic Cost per Encounter:									
Total Health Care Staff	168.02	134.14	114.66	158.41	134.01	118.75	177.30	147.56	122.30
Total Direct Costs of Medical Services	190.56	169.20	138.80	175.24	169.96	142.98	197.40	185.33	147.50
Allowable GME Overhead	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Clinic Overhead	37.62	30.74	30.63	35.95	30.03	31.28	33.45	28.89	31.33
Parent Provider Overhead Allocated	137.63	122.94	96.63	120.43	115.69	96.18	129.89	118.59	94.99
Allowable Overhead (Clinic and Parent)	170.93	147.82	124.39	149.93	140.14	124.36	159.62	142.72	123.61
Allowable Overhead Ratio (Clinic and Parent)	98%	96%	98%	96%	96%	98%	98%	97%	98%
Total Allowable Cost per Actual Encounter	359.85	316.79	262.48	324.63	309.99	266.63	357.02	326.89	270.04
Total Allowable Cost per Adjusted Encounter	332.74	300.67	252.83	321.43	301.98	257.98	349.53	316.98	263.67
Cost of Vaccines and Administration per Adjusted Encounter (Reimbursed Separately)	(8.29)	(6.99)	(8.21)	(6.46)	(7.60)	(8.59)	(8.99)	(7.88)	(8.04)
Rate per Adjusted Encounter	324.45	293.68	244.62	314.97	294.38	249.39	340.54	309.10	255.63
Total Medicare Encounters	199,901	1,233,603	5,907,972	293,341	1,195,407	5,044,146	295,685	1,403,208	6,446,372
Average Medicare Encounters	2,665	2,565	2,264	3,534	2,344	1,838	3,562	2,719	2,267
Medicare Percent of Visits	28%	25%	23%	26%	20%	18%	26%	23%	20%
Injection Cost:									
Cost per Pneumococcal Injection	298.58	310.18	329.20	329.99	471.26	351.35	322.39	380.89	367.87
Cost per Influenza Injection	87.03	97.72	140.66	104.69	115.24	106.34	157.70	129.46	116.27

Rural Health Clinic Burden Reduction Act (S.198)

Bill is aimed at modernizing provisions related to RHC's under Medicare (Introduced 02/01/2023, not law)

- Modernizes RHC physician supervision requirements by aligning them to state scope of practice laws governing PA and NP practice.
- Removes the requirement that RHCs must "directly provide" certain lab services on site and allows RHCs to instead offer "prompt access" to these services.
- Allows RHCs the flexibility to contract with or employ PAs and NPs.
- Maintains status quo location eligibility, allowing RHCs to be located in an area that is not in an urban area of 50,000 or more, given that the Census Bureau no longer utilizes the term "urbanized area."
- Removes a regulatory barrier that limits RHCs provision of behavioral health services in areas experiencing a shortage of such services.

Save America's Rural Hospital Act

(H.R. 833)

Primarily a bill that is for rural hospitals, but includes one important RHC (and FQHC) provision (Introduced 02/06/2023, not law)

- Make permanent Medicare telehealth in RHCs and Federally Qualified Health Centers (FQHCs) and allows them to be paid like other in-person visits.
- If enacted, the provision would be effective January 1, 2025.

Rural Health Innovation Act of 2023

(H.R. 1712 & S. 953)

Creates grant programs for RHCs and FQHCs under HRSA to expand urgent/triage care in rural communities (Introduced 03/23/2023, not law)

- Application process to receive $500,000 for existing facilities and $750,000 for new facilities.
- Must serve individuals in a rural area as a walk-in urgent care center and as a triage center or staging facility for necessary air or ambulance transport to an emergency department.
- Funds can be used to
  - Expand hours of operations.
  - Pay for the cost of construction or renovations.
  - Carry out operations of the clinic (including personnel and equipment costs).
- Can be used for start-up centers and clinics. Priority will be given to RHCs and FQHCs currently operating, however, start-ups in an area with existing coverage may be given consideration if they can demonstrate unmet need.
- There will be reporting requirements.