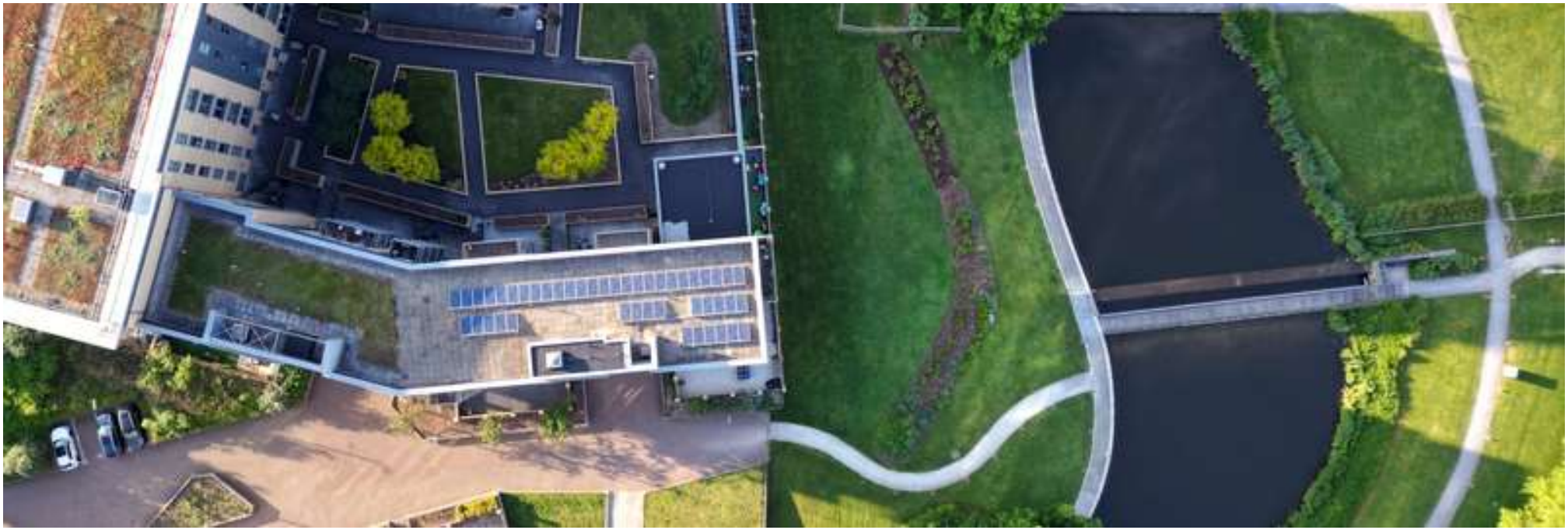

Indiana Pressler Memorial HFMA 2026 Annual Conference and Legislative Update

Capturing Key Clinic and 340B Strategies

February 12, 2026

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Objective

Comprehensive overview designed for rural hospitals seeking to increase reimbursement through clinic strategy and their organization's participation in the 340B Drug Pricing Program. This presentation includes updates on the legislative landscape.

Clinic Types

Freestanding Physician Practices	• Owned by hospital • Under contract with hospital
Provider-Based Clinics	• Bipartisan Budget Act of 2015, Section 603 regarding off campus – On-campus locations & CAH – not subject to Section 603 • Consolidated Appropriations Act, 2026
Rural Health Clinics	• H.R. 133, the Consolidated Appropriations Act of 2021 (COVID Relief Package)

Freestanding Physician Practice

Technical and professional components paid on global Medicare Physician Fee Schedule

- 100% work component
- 100% malpractice component
- 100% practice expense component

If under hospital TIN, reported on non-reimbursable line on the cost report

CPT	CY 2026 MPFS
99202	$70.90
99203	$110.53
99204	$167.22
99205	$222.76
99212	$55.94
99213	$90.09
99214	$128.33
99215	$182.08

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Provider-Based Status

Relationship between a main provider and another facility whereby the other entity is considered a subordinate part of the main provider

Determination of provider-based status is governed by the regulation at 42 CFR 413.65 and further explained in Program Memorandum Transmittal A-03-030

General Rule – Requirements apply to a facility if its status as provider-based or freestanding affects Medicare payment amounts and/or beneficiary liability for services furnished in the facility

Provider-Based Status

Three types:

- Department of a provider (Provider-Based Clinic)
- Provider-Based entities
  - Rural Health Clinic (RHC)
  - Skilled Nursing Facility (SNF)
  - Home Health Agency (HHA)
- Remote location of a hospital
  - Furnishes inpatient hospital services under the name, ownership, and financial and administrative control of the main provider

Provider-Based Clinic

On-Campus

- Reported on reimbursable line of the cost report
- 340B child site
- Within 250 yards of main provider
- Professional component paid facility fee (MPFS)
  - CMS-1500; POS 22
- Technical component paid 100% APC
  - UB-04; no modifier

Off-Campus Excepted

- Reported on reimbursable line of the cost report
- 340B child site
- Greater than 250 yards but within 35 miles (straight line)
- Provider-Based before 11/2/2015
- Professional component paid facility fee (MPFS)
  - CMS-1500; POS 19
- Technical component paid APC (except CAH)
  - 40% for E/M (G0463) and 100% all other services
  - UB-04; PO modifier

Off-Campus Non-Excepted

- Reported on reimbursable line of the cost report
- 340B child site
- Greater than 250 yards but within 35 miles (straight line)
- Provider-Based on or after 11/2/2015 or relocation
- Professional component paid facility fee (MPFS)
  - CMS-1500; POS 19
- Technical component paid APC (except CAH)
  - 40% for all services
  - UB-04; PN modifier

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Site Neutral Clinic Payments

- Section 603 – Bipartisan Budget Act
  - Applicable to off-campus Provider-Based Clinics to PPS hospitals
  - Critical Access Hospitals (CAH) not subject to Section 603
  - Rural Sole Community Hospitals (SCH) excepted Provider-Based Clinics paid 100% APC for E/M (G0463)
  - Regulatory intent – fee schedule payment operationalized as reduced OPPS payment
- **Legislative Updates – The Consolidated Appropriations Act, 2026 signed February 3, 2026**
  - CMS will stop paying for Medicare services at existing off-campus departments beginning January 1, 2028 unless the Hospital meets the following:
    - Obtain a unique NPI for all off-campus departments
    - Submit initial Provider-Based attestation between January 1, 2026-December 31, 2027 and subsequent attestations on a periodic basis
  - CCA, 2026 does not address how new off-campus departments will be paid by Medicare

Provider-Based Clinic Medicare Payment

On Campus Office Visit, Est Pt., Level 4 - CPT 99214

		Physician Fee Schedule	OPPS	Medicare Payment (80%)	Co-Pay (20%)	Total	
Freestanding Clinic							
Global Rate	99214	$ 128.33		$ 102.66	$ 25.67	$ 128.33	**Freestanding**
Hospital Outpatient							
Professional Fee		$ 80.95		$ 64.76	$ 16.19		
Facility Fee			$ 136.02	$ 108.82	$ 27.20		
Total Hospital OP Reimbursement				$ 173.58	$ 43.39	$ 216.97	**Hospital OP**
Difference per unit if billed as Hospital Outpatient				**$ 70.91**	**$ 17.73**	**$ 88.64**	

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Provider-Based Reimbursement Assessment

- Example assessment to determine if reimbursement is beneficial to convert a freestanding physician practice to Provider-Based Clinic and also evaluate potential 340B benefit

Traditional Medicare

			Current State	Future State					
Location Name	On/Off Campus	Medicare Units	Freestanding Reimbursement	Provider-Based Reimbursement	**Difference**	Estimated Co-Insurance Impact per Encounter		340B Opportunity	Total
Endocrinology Clinic	On	1,844	132,305	221,204	88,900	$	17.64	1,054,431	1,143,331
Internal Medicine Clinic	Off	5,173	287,752	310,073	22,320	$	4.70	777,146	799,466
Women's Clinic	On	4,806	191,155	404,600	213,444	$	28.33	462,186	675,630
Neurology Clinic	On	6,786	176,691	259,325	82,634	$	18.74	536,762	619,396
Urology Clinic	Off	33,324	500,336	514,084	13,749	$	1.06	295,238	308,987
Pain Clinic	On	4,705	253,599	454,677	201,078	$	20.04	107,467	308,545
Pulmonology & Critical Care Clinic	On	1,951	174,642	304,429	129,787	$	19.03	136,152	265,939
Multi-Specialty Clinic	Off	1,770	122,949	135,454	12,504	$	3.27	204,149	216,653
Family Medicine Clinic	Off	3,540	222,164	238,001	15,837	$	4.49	200,756	216,593
Foot & Ankle Clinic	On	4,326	281,990	475,545	193,555	$	25.47	-	193,555
Cardiology - 2	Off	6,046	272,323	305,308	32,986	$	4.85	114,307	147,293
Cardiology	On	1,212	85,807	194,507	108,700	$	88.37	36,474	145,174
Multi- Specialty Clinic - 2	Off	2,612	67,057	73,321	6,264	$	3.05	105,395	111,659
Physical Medicine and Rehab	On	2,057	65,093	119,100	54,007	$	56.55	13,543	67,550
Family Medicine Clinic - 2	Off	2,009	81,097	93,113	12,017	$	4.28	55,006	67,023
Brain and Spine Clinic	On	614	63,485	119,625	56,140	$	18.93	-	56,140
GI clinic	On	400	46,953	82,702	35,749	$	17.96	11,184	46,933
			$ 3,192,647	**$ 4,594,127**	**$ 1,401,480**			**$ 7,079,443**	**$8,480,923**

Provider-Based Considerations

Prior to going live as a provider-based (PB) clinic, the following elements of integration must be in place. The lift necessary to achieve these elements should be considered in all conversion decisions.

Credentialing

Clinic providers have hospital privileges

Shared Space

Clinics cannot share space with non-PB locations

Purchasing

Clinic purchases must be done on hospital accounts

Policies

Clinics fall under all hospital policies and procedures

Health & Safety

Clinics will be held to the same standard as the hospital

Billing

Clinics must possess software capable of dropping a split bill

Cost Center

Costs and revenues of clinics are reported in a hospital cost center

Public Awareness

Patients must be aware they are entering part of the main hospital

Co-Pay Notice

Off-campus PB clinics must provide advanced beneficiary notices

Admin

Administrative functions and reporting structures must be integrated

Provider-Based Advantages & Disadvantages

- Potential for higher reimbursement
- Increased coordination and integration between clinic and hospital providers
- Flexibility in financing and efficiencies with admin or shared staff
- More overhead costs remain allowable in ratio of cost to charge calculations
- Access to 340B Drug Pricing Program
- Must meet and maintain accreditation and life safety standards of the hospital (increased quality)

- Increased costs related to hospital wage and benefits, costly facilities, and less effective cost management
- Perceived billing complexities (split-billing) leading to potential customer service impacts
- Potential increases to patient coinsurance (depending on payor contracts)
- Decreased physician control of practice staff and accountability for finances and productivity
- Must meet and maintain accreditation and life safety standards of the hospital (increased cost)

Rural Health Clinic

- Federally certified outpatient facility with two main goals
  - Improve access to primary healthcare in rural, underserved communities through enhanced reimbursement to support financial sustainability
  - Promote a collaborative model of healthcare delivery using physicians, nurse practitioners, and physician assistants
- Location Criteria
  - Rural as defined by census bureau as “non-urbanized”
  - Shortage area (HPSA, MUA, Governor’s Designation) in last four years for initial qualification
- Two types – Over 5,200 RHCs located throughout the U.S.
  - 152 RHCs in Indiana
  - Provider-Based (approximately 40% of RHCs)
  - Independent (approximately 60% of RHCs)

Rural Health Clinic Reimbursement

Medicare

- RHC services paid at RHC all-inclusive rate
  - Independent RHCs paid Medicare payment limit
  - Provider-Based grandfathered RHCs (enrolled by 12/31/20) paid cost-based rate
- Billing form UB-04
- Independent RHCs complete a separate cost report
- Provider-Based RHCs reported on line 88 of Hospital cost report

Medicaid

- Each state varies. Indiana implemented PPS reimbursement. RHCs receive a facility-specific PPS rate determined by Myers and Stauffer.
- Billing form CMS-1500 using encounter code T1015

Commercial/MA Plans

- Commercial plans will not recognize RHC and clinics should continue to bill as contracted
- CMS 1500; POS 11
- MA plans may pay traditional Medicare rates but will depend on contract

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Consolidated Appropriations Act of 2021

- Comprehensive RHC payment reform
- Passed in December 2020, Section 130 of the CCA included a provision that increased the Medicare cost per visit cap over an eight-year period
- Subjects all “new” RHCs to the new per-visit cap
  - 2021 $100
  - 2022 $113
  - 2023 $126
  - 2024 $139
  - 2025 $152
  - 2026 $165
  - 2027 $178
  - 2028 $190
- After 2028 and in subsequent years, the cap increases by the Medicare Economic Index (MEI)
- RHCs will receive the lesser of per-visit cap vs. actual cost/visit

Consolidated Appropriations Act of 2021

- Summary of E/M Medicare reimbursement as compared to the FY 2026 MPFS
- Average E/M reimbursement typically around $130
- Depending on services RHC may be beneficial reimbursement methodology

CPT	CY 2026 MPFS	RHC 2026	RHC 2027	RHC 2028
99202	$70.90	$165	$178	$190
99203	$110.53			
99204	$167.22			
99205	$222.76			
99212	$55.94			
99213	$90.09			
99214	$128.33			
99215	$182.08			

Reimbursement Assessment

- Example assessment to determine if reimbursement is beneficial to convert a freestanding physician practice to Rural Health Clinic

Payor	Current	2025	2026	2027	2028
Medicare Visits	9,528	9,528	9,528	9,528	9,528
Rate/Visit	$ 140.85	$ 152.00	$ 165.00	$ 178.00	$ 190.00
Reimbursement	$ 1,342,048	$ 1,448,256	$ 1,572,120	$ 1,695,984	$ 1,810,320
Medicare HMO Visits	9,007	9,007	9,007	9,007	9,007
Rate/Visit	$ 155.47	$ 152.00	$ 165.00	$ 178.00	$ 190.00
Reimbursement	$ 1,400,323	$ 1,369,064	$ 1,486,155	$ 1,603,246	$ 1,711,330
Medicaid Visits	22,109	22,109	22,109	22,109	22,109
Rate/Visit	$ 81.45	$ 101.82	$ 103.86	$ 105.93	$ 108.05
Reimbursement	$ 1,800,713	$ 2,251,138	$ 2,296,161	$ 2,342,084	$ 2,388,926
Medicaid HMO Visits	1,105	1,105	1,105	1,105	1,105
Rate/Visit	$ 79.75	$ 101.82	$ 103.86	$ 105.93	$ 108.05
Reimbursement	$ 88,119	$ 112,511	$ 114,761	$ 117,057	$ 119,398
Total reimbursement	$ 4,631,202	$ 5,180,969	$ 5,469,197	$ 5,758,371	$ 6,029,974
Reimbursement Impact		**$ 410,831**	**$ 555,955**	**$ 697,731**	**$ 817,515**

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Rural Health Clinic Considerations

Prior to going live as a Rural Health Clinic (RHC), the following must be in place. The lift necessary to achieve these elements should be considered in all conversion decisions.

RHC Location

Clinics must be in a rural area and a MUA or HPSA within the last 4 years

Provision of Services

Clinics must have *some* primary care

Emergency Services

"First response services"

Policies

Clinics must have RHC policies and procedures

Patient Health Record

Clinics must keep accurate and up to date medical records

Billing

Clinics must possess software capable of dropping an RHC UB

Laboratory Services

Four required labs

Emergency Preparedness Procedure and Plan

Staffing Mix

Medical Director and APP requirements

Biennial Program Evaluation

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Provider-Based Advantages & Disadvantages

- Higher reimbursement compared to freestanding physician practice
- Reimbursement for Medicare Bad Debts
- Recruiting and retaining existing physicians and APPs in rural areas
- Potential to include specialty services/visiting providers for cost reimbursement
- Provider-Based RHC 340B eligibility
- Provider-Based RHC must meet accreditation and life safety standards (quality)

- Increased Medicare coinsurance (based on charge structure)
- Difference in billing from current practices
- .5 FTE APP at each RHC
- Timeframe for conversion (typically 6–9 months)
- Provider-Based RHC must meet accreditation and life safety standards (cost)

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Clinic Strategy Optimization

Provider-Based:

- Focus on on-campus expansion
- Expand services in existing Provider-Based locations
- Relocate off-campus Provider-Based locations to on-campus

Rural Health Clinic:

- Evaluate off-campus freestanding locations for Rural Health Clinic
- Expand services in existing grandfathered Provider-Based Rural Health Clinics
- Assess cost/visit at existing RHCs to ensure maximizing reimbursement limits

340B

- Optimize 340B opportunity through additional Provider-Based clinics, Provider-Based RHC, and/or contract pharmacy

Contact

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