

hot hot hot topics topics topics

TOPICS

IN RURAL HEALTH



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| | FOCUS ON CRITICAL ACCESS HOSPITAL DEVELOPMENT: | Vol. 2, No. 2 |
| | Integrated Part B: A reimbursement incentive for physician/hospital partnerships | |
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| | Options for hospitals that operate Gero-Psychiatric Units | |

Steve McDowell



Dear Friends,

For the past decade, Rural Health Consultants has had the privilege of working with health care providers, rural community leadership, government, and others to assure access to quality health care services. During the past two years, we have assisted rural community health systems in meeting the challenges imposed by the Balanced Budget Act of 1997 and, more recently, the Balanced Budget Refinement Act of 1999. A key element of BBA 97 is the Medicare Rural Hospital Flexibility Program, which creates the Critical Access Hospital (CAH) as a new type of provider eligible for cost-based Medicare reimbursement. Much of the responsibility for developing and administering this program falls on states and providers, a flexibility which brings both challenges and opportunities to participants.

Mike Fadden



The goal of this Newsletter is to provide you with practical information and insights we have learned through our experience in working with hospitals considering conversion to CAHs. It is our position that the CAH program by itself will not be enough to sustain struggling rural hospitals over the long term, but it can be a useful tool in building a local system of care that is sustainable and meets community needs. In this issue of *Hot Topics in Rural Health*, we discuss the potential of the Integrated Part B outpatient payment option as a system building strategy, present data from our practice on the financial impact of cost-based vs. fee schedule-based reimbursement for laboratory services, and provide options for rural hospitals that operate Gero-Psychiatric Units and are considering CAH conversion.

Sheldon Weisgrau



We hope these thoughts will be of value to you and your organization as you continue the mission of assuring access to quality health care services in your State and local community.

Sincerely,
Steve McDowell, Mike Fadden, and Sheldon Weisgrau

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“At the core of a rural integrated system is a viable partnership between physicians and hospitals.”

TOOLS FOR BUILDING PHYSICIAN HOSPITAL PARTNERSHIPS: Integrated Part B Payment And Provider-Based Rural Health Clinics

Building a local integrated system of care has been touted as a key element of efforts to sustain access to appropriate services in rural America. At the core of a rural integrated system is a viable partnership between physicians and hospitals. Building these partnerships is complex and is made more difficult by reimbursement systems that do not create an incentive for rural hospitals and rural physicians to work together to build locally appropriate systems of care. However, one of the key provisions of the proposed amendments to the CAH program, Integrated Part B outpatient reimbursement, does create an incentive to integrate physician and hospital services.

In the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) Program, the precursor to the CAH program, RPCHs could elect to be paid for Medicare outpatient services in one of two ways: (a) the “standard” option, in which facility services were paid on a cost basis and professional fees were reimbursed according to Medicare fee schedules, or (b) the “all-inclusive” or “Integrated Part B” option, which bundled the facility and professional components into a single cost-based payment. Key advantages of Integrated Part B payment include cost-based reimbursement for both facility and professional services, including Emergency Room services, better coordination of ancillary services and quality assurance activities, and an integrated physician/hospital patient record.

Because of flawed language in the legislation authorizing the CAH program, the Integrated Part B option is not available to CAHs. New statutory language that would allow CAHs to choose this payment option has been proposed in three bills currently pending in Congress - Senate Bills 2735 and 2987 and House Bill 4677. Whether this provision is enacted into law, however, is currently in doubt.

The Provider Based Rural Health Clinic (PB-RHC) Program, however, offers similar benefits as Integrated Part B payment and is currently available to all rural hospitals in underserved areas. Key advantages of PB-RHC are:

- ▶ Enhanced Payment - Cost based reimbursement from Medicare and Medicaid for primary care outpatient services.
- ▶ Partnership Flexibility - Physicians may be employees of the hospital or contracted to provide services.
- ▶ Enhanced Quality - The costs of required Quality Assurance efforts and necessary information system upgrades are allowable costs.
- ▶ Capital Improvement - The capital costs associated with outpatient primary care services are allowable costs.

Operationally, conversion to a PB-RHC requires planning and significant restructuring. A PB-RHC must be an integral and subordinate part of the hospital. Practically, this means:

- ▶ The hospital owns the patient charts.
- ▶ Clinic staff, including mid-level practitioners, must be employees of the hospital.
- ▶ The clinic must follow hospital outpatient department policies and procedures.

An assessment of the impact of developing a PB-RHC requires analysis of utilization and financial data for the hospital and each physician with whom it seeks a partnership. This data allows an understanding of the financial impact on both businesses if they operate as an integrated entity under PB-RHC designation. Creating a PB-RHC is often financially advantageous to all parties and can provide a powerful incentive to begin to build an integrated system that is more consumer friendly and keeps Quality as a key priority.

CASE examples

“Cost-based lab payment can be the deciding factor in determining whether CAH conversion is financially feasible.”

In our last newsletter, we alerted you to an error in the language of the Balanced Budget Refinement Act of 1997 that changes reimbursement for lab services in a CAH from cost-based payment to payment based on the lab fee schedule. HCFA will implement this new payment method on October 1st unless legislation is passed that corrects this error. Such legislation is included in several bills currently pending in Congress, including S. 2600, S. 2735, and H.R. 4677.

The following table shows the financial impact of CAH conversion on ten hospitals selected randomly from our practice. Shown are the total impact of CAH conversion and the specific impact on inpatient, outpatient, and lab services compared to previous hospital experience. Several conclusions can be drawn from these examples.

- ▶ CAH conversion is not an economically viable option for all rural hospitals. We have found that conversion is financially advantageous in about half of the hospitals for which we have completed analyses.

- ▶ Cost-based reimbursement almost always results in *less* inpatient revenue, showing that these rural hospitals are effectively managing their Medicare inpatients and generating surpluses from their inpatient Medicare business.
- ▶ Cost-based reimbursement for outpatient and lab services results in an increase in revenue in every hospital that we’ve worked with. Rural hospitals are faring very poorly under current outpatient and lab payment methods and further decreases in revenue can be expected when the Hospital Outpatient PPS is fully implemented.
- ▶ Cost-based lab payment can be the deciding factor in determining whether CAH conversion is financially feasible. Some CAHs may face serious financial hardship if fee schedule-based payment for lab services is implemented.

| | TOTAL CAH Impact | Inpatient Impact | Outpatient Impact | Lab Impact |
|--|-----------------------------|-------------------------|--------------------------|-------------------|
| 1 | (\$268,183) | (\$329,733) | \$41,602 | \$19,948 |
| 2 | (\$361,503) | (\$414,164) | \$42,138 | \$10,523 |
| 3 | \$82,571 | (\$18,547) | \$14,666 | \$86,632 |
| 4 | \$204,866 | \$14,420 | \$176,198 | \$14,428 |
| 5 | \$67,730 | (\$169,202) | \$107,405 | \$124,958 |
| 6 | (\$300,722) | (\$486,455) | \$92,789 | \$92,442 |
| 7 | (\$200,770) | (\$332,580) | \$75,125 | \$56,686 |
| 8 | \$535,658 | \$306,332 | \$173,966 | \$55,360 |
| 9 | (\$255,490) | (\$395,346) | \$74,852 | \$65,004 |
| 10 | \$170,220 | (\$83,083) | \$171,904 | \$81,399 |
| Average Impact of Cost-Based Lab Services | | | | \$60,738 |

ISSUES and options

“In making a decision on whether to convert, hospital board and management must consider disposition of the Gero-Psych unit.”

CAH Conversion And Gero-Psych Units:

Operation of a Gero-Psychiatric Unit has proven to be a profitable activity for many small rural hospitals. However, because of HCFA's interpretation that PPS-exempt units cannot be a part of a CAH, in making a decision on whether to convert, hospital board and management must consider disposition of the Gero-Psych unit. There are four options regarding this service:

- ▶ Close the Gero-Psych unit and take the beds out of service. In this case, the space occupied by the unit could remain empty or be reconfigured for other purposes. Hospitals considering using the space for other purposes should work closely with State regulators to ensure consistency with life safety codes and other requirements.
- ▶ Create a “hospital within a hospital” and license the space, for example, as a psychiatric hospital. As long as this new facility is separately licensed and certified and has its own provider number, it would not be considered part of the CAH even though it is located in the same physical plant. As a result, the length of stay and other CAH limitations would not apply; similarly, the new facility would not be cost reimbursed as part of the CAH. Space, services, and staff could be leased from the CAH, creating a source of revenue. The feasibility of this option, however, is probably marginal, given the limited number of beds and space available and the difficulty in meeting staffing and other conditions of participation for a “freestanding” psychiatric hospital. In addition, there may well be State regulatory limitations to carrying out such a plan.
- ▶ Convert the unit to a Distinct Part Skilled Nursing Facility (DP-SNF). Clearly, the services provided in a DP-SNF are not identical to those provided in a Gero-Psych unit and reimbursement is unlikely to be as favorable. Nevertheless, some of the same patients that are currently treated in the Gero-Psych unit may be able to be treated in a DP-SNF. Again, given the limited number of beds and possible regulatory constraints, this option may not be feasible.
- ▶ Lease the unit to an affiliated network/system provider. This option is similar to the second option above, but instead of creating a new provider, the Gero-Psych unit would become a “satellite” of the affiliate hospital. Again, space, staff, and ancillary and support services could be leased by the affiliate from the CAH. This may be a creative way for the network to use the space and continue to provide services that are needed by the community and profitable for the system. As with the other alternatives, there may be regulatory constraints to carrying out this option.

Clearly, the fourth option is the most positive alternative for the Gero-Psych Unit. This option both retains the services in the community and allows the CAH to garner additional revenue through the leasing of space, services, and staff. Furthermore, if the hospital that leases the Gero-Psych Unit is part of the same system as the CAH (i.e., commonly owned, leased, or managed), profits generated by the Gero-Psych Unit will remain within the system. This outcome would create a positive “win-win,” therefore, for the CAH and its network. The feasibility of this and any other options for the unit must be carefully assessed, however, to determine their financial, regulatory, and community impacts.

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