



# CAH PHYSICIAN networking

As the number of CAHs in rural America increases, it has become apparent that CAH designation is a necessary but not sufficient strategy for assuring access to an appropriate safety net of services. Given the enhanced payment opportunities offered by additional networking with physicians, CAHs should consider examining new reimbursement incentives for physician partners which provide the opportunity to add value for the CAH Network.

Reimbursement Incentives for CAH Networks:

- ▶ Provider-Based Rural Health Clinic
- ▶ Reimbursement at 115% of the Medicare Fee Schedule for professional services provided in the CAH under the all inclusive outpatient payment methodology.

## Provider Based Rural Health Clinic (PBRHC)

The PB-RHC opportunity has been available to rural hospitals for many years before the CAH Program was initiated. In our practice, we found that earlier attempts to utilize the PB-RHC had one of two goals – increase market share by establishing a clinic outside the hospital's current core geographic market or to shift non-emergent visits out of the emergency room. PB-RHCs were rarely developed in conjunction with the hospital medical staff and were often viewed by these physicians as competitive enterprises.

PB-RHCs of rural hospitals with less than 50 beds receive full cost-based reimbursement from Medicare. Under BIPA, Medicaid is now mandated to pay a prospective payment system (PPS) rate which is based on average clinic costs in FYs 1999 and 2000. Rural hospitals and CAHs considering implementation of a PB-RHC should consider the following questions:

1. Is building a network which can assure access part of the mission of the CAH?
2. Is the hospital in an underserved area?
3. Is the combined payor mix of Medicare and Medicaid patients that will be seen in the PB-RHC greater than 40%?

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4. Can the clinic recruit a Nurse Practitioner or Physician Assistant?
5. Will the local medical staff agree to participate in studying the PB-RHC opportunity?

If the answer to these questions is “Yes,” an analysis of the financial impact of development of a PB-RHC is in order. Because a CAH is already a cost-based entity, the addition of a new cost-based program will affect cost reporting and cost allocation. For example, if a CAH elects to partner with a primary care physician or group whose practice has low Medicare and Medicaid utilization, the end result could be to lower the cost allocation to the outpatient department and decrease reimbursement from Medicare.

Conversely, if a CAH develops a PB-RHC with existing physician practices in which utilization by Medicare and Medicaid patients is high, the potential to increase the allocation of costs to these programs becomes a possibility. Lastly, if a CAH elects to develop a PB-RHC without partnering with the local medical community, the results usually do not add financial value. Such competitive clinics, usually created to shift patients away from the ER, often have low Medicare and Medicaid utilization, which shifts allowable reimbursable costs out of the CAH, thereby lowering cost-based reimbursement from Medicare.

## Enhanced Professional Fee Schedule Payment under the All Inclusive Outpatient Payment Methodology.

If a CAH arranges to bill for professional services on behalf of its physicians under the all inclusive option, these services are eligible to be reimbursed at 115% of the Medicare fee schedule. Details on implementing this provision have not yet been issued by CMS, so it is difficult at this point to assess the financial implications. Nevertheless, CAHs should begin to explore the potential for appropriate speciality clinic services and other physician relationships which could increase local access to services. Our next newsletter will present more detail on this networking opportunity.

*“The addition of a new cost-based program will affect cost reporting and cost allocation.”*

# CASE examples

The following table shows four examples of hospitals we have worked with and provides insight into the issues that should be considered in analyzing the development of a PB-RHC.

**Hospital A** increased Medicare reimbursement by \$300,000 by converting to a CAH. Dialogue with the primary care physicians brought agreement to analyze the PB-RHC opportunity. Utilization of the physicians’ practices were 50% Medicare and 15% Medicaid by visits. The resulting analysis found significant added value in converting the practices to a PB-RHC. The combination of CAH and PB-RHC added more than \$600,000 to the facility’s bottom line.

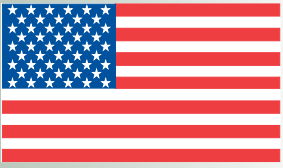
**Hospital B** was able to increase Medicare reimbursement by \$150,000 by converting to a CAH. Payor mix of the physician practices that were evaluated for PB-RHC were 38% Medicare and less than 5% Medicaid. Capital acquisition costs and increased personnel costs for the hospital, coupled with a projected reduction in Medicare payor mix in the CAH outpatient department as a result of the diversion of visits to the PB-RHC, found marginal added value in implementing a PB-RHC .

**Hospital C** increased Medicare reimbursement by \$275,000 by converting to a CAH. Hospital management saw PB-RHC simply as a way to redirect non-emergent patients from the ER and did not work with local medical staff in developing the clinic. Instead, without conducting an analysis of operations or impact on hospital finances, a PB-RHC with a mid level practitioner was added to empty hospital space. The clinic was open from 9:00 AM to 6:00 PM, a time of low ER usage, and the local medical community used it as a way to divert uninsured patients from their offices. The end result was that few of the PB-RHC costs were recoverable and the increase in utilization of non-Medicare/Medicaid patients lowered the recoverable costs of the CAH, as well.

**Hospital D**, a facility with 30% Medicare utilization, did not find CAH conversion to be advantageous. However, the clinic operated by the hospital had 80% utilization by Medicaid patients. Under the provisions of BIPA 2000, converting the clinic to a PB-RHC brought significant added value to the hospital.

## FINANCIAL IMPACT OF ADDITION OF PB-RHC TO CAH

Hospital	Increase/Decrease in Reimbursement Attributable to PB-RHC	Change in CAH Reimbursement as a Result of PB-RHC	Net Impact to CAH/PB-RHC Network
Hospital A	\$339,061	(\$36,842)	\$302,219
Hospital B	\$137,921	(\$119,465)	\$18,456
Hospital C	\$16,076	(\$168,339)	(\$152,263)
Hospital D	\$376,423	N.A.	\$376,423



# ISSUES and options

*“To guide one’s work in complex developmental processes requires effective measurement of key indicators of progress.”*

## ASSESSING THE CAH NETWORK

A Network which assures access, enhances quality of care, and covers network costs is the necessary goal of every CAH. It is our belief that the sustainability of local services requires that the CAH be the anchor of the local network. Since its inception, the vision of the Medicare Flex Program has centered on development of a network of services to assure access, enhance quality, and maintain financial viability. As the program has evolved since 1997, significant reimbursement enhancements have been incorporated which provide incentives for network development. As we have worked with CAHs around the country, we are reminded over and over that network building is an incremental process.

To guide one’s work in complex developmental processes requires effective measurement of key indicators of progress. In our practice we have found that monitoring the following data sets can keep a CAH on track toward appropriate network building activities.

### Financial Viability

- ▶ Trends in utilization by payor, by service
- ▶ CAH costs as a percent of total reimbursement
- ▶ Percent of costs of services to self-pay patients that are recovered
- ▶ Percent of G&A that is cost reimbursed
- ▶ Favorable cost to charge ratios
- ▶ Has the RHC opportunity been analyzed? Implemented?
- ▶ Has the FQHC opportunity been analyzed? Implemented?
- ▶ Has the potential for service expansion through use of enhanced physician payments at the CAH been explored?
- ▶ Are all rural reimbursement enhancements being maximized?
- ▶ Are all segments of the community and health care providers appropriately represented in this process?
- ▶ Did this process reach a consensus on the scope of services that should be provided locally?
- ▶ Is a monitoring system in place to assess barriers to access for the consensus scope of services?
- ▶ Is there a formal process of dialogue between local health providers?
- ▶ Is there a common planning process shared by local providers?
- ▶ Have local providers assessed the potential for added value from new organizational structures or partnerships?
- ▶ Have local providers assessed the potential for added value from common or shared administrative functions?

### Network Development

- ▶ Has the CAH conducted a Community Needs and Market Assessment, including a comprehensive resource inventory of services?
- ▶ Has the CAH facilitated a community process to consider the findings of the Community Needs and Market Assessment?

# RHC

Rural Health Consultants, Inc.