Episode 4 – Primary Care Options: Enhancing Hospital and System Reimbursement

Transcript:

Dan Given:	00:01	Hi, I'm your host, Dan Given. Thank you for listening to Stroudwater's Findings From The Field podcast. Through this podcast we hope to bring you healthcare updates, shed light on various challenges and provide solutions to solve issues that healthcare administrators and providers frequently face in the ever changing and challenging healthcare landscape.
Dan Given:	00:19	On this episode, we have Jonathan Pantenburg. Jonathan joined Stroudwater in 2016 and brings to the firm a strong record of leadership in Rural Health Care. Before joining Stroudwater, Jonathan served as Chief Financial Officer and Chief Operating Officer of Kahuku Medical Center, a 21-bed nonprofit critical access hospital on the North shore of Oahu, Hawaii.
Dan Given:	00:39	Under his leadership, Kahuku Medical Center received accreditation from the Joint Commission and saw increased post audit, total margin and operating revenue. Jonathon modified, maintained and performed ongoing internal audits, expanded services to include primary care and implemented a business office function and a fully integrated clinical EHR among other improvements.
Dan Given:	01:02	Jonathan, thank you for coming onto the podcast.
Jonathan P.:	01:05	Thanks Dan. Really excited to share some different opportunities that we've seen with some different hospitals.
Dan Given:	01:09	Jonathan, when you talk about primary and specialty care options in some of your work that you've done, what do you mean by that?
Jonathan P.:	01:16	What we mean by primary care options is really looking at different opportunities for hospitals and systems to

leverage reimbursement advantages throughout the region. A lot of times hospitals have always operated under the, this is the way we've always done business, and what we want to do is look at different ways that they can leverage those advantages, whether it's designation opportunities, whether it's the realignment of practices and really look at how those play across a system.

Dan Given: 01:43 All right Jonathan. What are the different type of designations that are out there that the hospitals can pursue?

Jonathan P.: 01:49 Dan there's a few different designation types. The first is a provider-based clinic. This is one that's operated as a department of the hospital in which it operates under. You have a free-standing clinic. If you're a critical access hospital, this is operated as a private physician practice, a non-cost-based practice. You also have the Rural Health Clinic program. The Rural Health Clinic Program has certain requirements that you have to meet to qualify for that designation. You also have federally qualified health centers. Again, these also have designation requirements. You also have provider based Rural Health Clinics.

Jonathan P.: 02:23 A provider based Rural Health Clinic is one that meets the provider base designation requirements but also meets the provider based Rural Health Clinic requirements. Again, each one of these different designations has different financial advantages. Each one has different opportunities and each one has different designation requirements. You really have to look at what is beneficial to each hospital and which one of these designation types is really the most advantageous for that hospital or that system.

Dan Given: 02:49 What are some of the requirements for the different designations?

Jonathan P.: 02:53 Exactly. When you look at that, again, each clinic has different designation requirements. If you're a provider-based clinic, you have to meet the provider-based rules. You have to be within certain proximity of the hospital, operates under, you have to meet the ownership requirements. If you're a Rural Health Clinic, you have to be in a HPSA or a medically underserved area. You

also have to be in a rural area. If you're a federally qualified health center, those have certain governance requirements and certain services that you have to provide.

Jonathan P.: 03:24 Again, when we're evaluating these practices, each one has those different advantages. Each one has those different regulation requirements. In addition to that, you also have to look at the hospital that is looking to operate those clinics and we'll take critical access hospitals for example. If a critical access hospital were to operate a provider-based clinic that was off-campus, that provider-based clinic has to meet the CAH designation requirements.

Jonathan P.: 03:51 These designation requirements come down to distance requirements from other hospitals. Same thing with the provider based Rural Health Clinic. Depending upon what hospital operates that clinic, if you have fewer than 50 beds as a provider based Rural Health Clinic, you can get an uncapped cost-based rate. If you are a provider-based clinic that is a Rural Health Clinic under a hospital that has 50 beds or more, then you get a capped rate as the Rural Health Clinic.

Jonathan P.: 04:17 Again, it's looking at all these nuances and how they play off each other to really determine again, what that clinic can meet from a designation requirement perspective and then what yields the most favorable return for the hospital and that clinic.

Dan Given: 04:32 Why does this matter and who should be looking into these designation and alignment opportunities?

Jonathan P.: 04:37 That's a good question. Really every hospital and system should be looking at these different opportunities. With a decline in reimbursement that we're seeing across the country, particularly with Medicare and some other payers, systems have to be more aware of the opportunities that are afforded to them through these designations. As we work with larger systems, what we're generally seeing is that systems are starting to move towards leveraging rural opportunities in a way to improve reimbursements for the systems.

Dan Given: 05:09 Are there specific strategies hospitals and systems should be evaluating?

Jonathan P.:	05:14	Yeah, I really take it back to say that there's ultimately four major strategies that hospitals and systems should be looking at with regard to this. The first one is really looking at... For the clinics that are owned by a hospital now, have they evaluated the designation of those practices to ensure that the designation yields them the highest reimbursement for that practice? And what I mean by this is comparing Rural Health Clinics to provider-based clinics to provider based Rural Health Clinics to freestanding and really looking at all those different opportunities to leverage the most reimbursement for that hospital.
Jonathan P.:	05:51	The second one is looking at, are there independent practices within a community that we want to look at potentially acquiring or aligning with the hospital so we can take advantage of those provider based opportunities and leverage other things such as 340B.
Jonathan P.:	06:07	The third strategy is looking at the realignment of practices within a system. If you go back to some of the older models, many systems used to align practices under a large physician group, and they would either bill out the pro-fees or they would align it under a larger hospital and bill out the OPPS reimbursement for that. What we're looking at now is how do we realign those practices under critical access and rural hospitals so that we can yield more advantageous reimbursement.
Jonathan P.:	06:37	The last strategy is really the one that can yield often the biggest gains for hospitals. What it looks at is how do we realign or integrate our specialty providers into rural practices again, to yield some of those higher returns and reimbursement for those practices.
Dan Given:	06:55	Are there certain requirements that have to be met to qualify for these different designations? Because it almost sounds like if you can enhance your reimbursement, why wouldn't everyone be doing it?
Jonathan P.:	07:07	Yeah, there definitely are. And I would say that that's probably one of the reasons why many systems are not doing this is just not knowing exactly how all the regulations come into effect with one another.
Dan Given:	07:18	Can you provide some examples of the financial impact on hospitals, and or systems who have implemented

these strategies? What is the return that they're seeing or able to see?

Jonathan P.: 07:29 The return definitely varies depending upon the size of the clinics, how many providers we're looking at. If it's going from provider base to provider based Rural Health Clinic or free standing. Again, there's no consistent methodology that we've seen relative to reimbursements, but to provide some examples. We worked with one system that had about 110,000 primary care visits spread between three clinics.

Jonathan P.: 07:56 This system ended up looking at realigning those three practices from free standing in a wholly owned physician group to provider based Rural Health Clinics under their critical access hospitals. The analysis showed in this example that it was about a $7 million difference in reimbursements by realigning those as provider based Rural Health Clinics under the critical access hospitals. The variance or the difference really came from two different opportunities. One was the enhanced reimbursement based on the difference in reimbursement rates for each clinic visit. The second one was really the difference achieved through the 340B program.

Jonathan P.: 08:34 By making these practices provider based under the critical access hospitals, allowed them to gain access to the 340B program, which they did not have access to before.

Jonathan P.: 08:45 Another example is an independent hospital we worked with in the South. This hospital operated a provider based Rural Health Clinic. In addition to that, they also had a number of specialty providers that ended up operating in a provider-based clinic. What we looked at for this system was integrating those seven specialty providers into the Rural Health Clinic to again, to take advantage of some of those reimbursement opportunities.

Jonathan P.: 09:11 By aligning those seven providers into that rural health clinic yielded about a $700,000 difference in reimbursements for those providers. And again, it's based on the different methodology of reimbursement that allowed them to yield that increased value.

Jonathan P.:	09:27	Now, I'll give one more example. There was an independent hospital again that wanted to look at acquiring a freestanding private practice. This hospital ended up wanting to go through and state, "If we were to acquire this practice, what would be the difference in reimbursement for that practice and how would it impact the critical access hospital?"
Jonathan P.:	09:49	What we did is we ended up overlaying the cost and assume that that practice were now to be operated by that critical access hospital, and doing that led to about a $900,000 gain for that hospital. Again, because by adding it under the critical access hospital allowed them to get access to 340B, and by adding it under the critical access hospital allowed them to get a difference in reimbursement by adding that clinic under the critical access hospital.
Dan Given:	10:17	It sounds like 340B is the major contributor in the reasoning behind pursuing some of these strategies, but is it the sole benefit?
Jonathan P.:	10:25	No, Dan. It's definitely not the sole benefit. The reason why I highlighted a couple of those examples was just to show the magnitude of some of the value that hospitals can achieve. I'll give you one more example here where this was another system where the larger hospital had three provider-based clinics operating under the hospital. They were already getting 340B through the system. What they had looked at was realigning those practices under one of their critical access hospitals to get cost-based reimbursement under the critical access hospital as a Rural Health Clinic.
Jonathan P.:	10:58	By doing that and realigning those practices was about a $1.5 million gain, and this gain was solely due to the difference in reimbursements between what the larger hospital was getting by having provider based clinics and then also what the critical access hospital was getting by operating them as provider based Rural Health Clinics.
Jonathan P.:	11:17	Again, 340B is a big opportunity, but hospitals can also yield considerable gains just by changing the designation, which also changes the reimbursement advantages and the methodology for those practices.

Dan Given:	11:30	These opportunities sound great, but why are hospitals pursuing them now? Has something changed?
Jonathan P.:	11:36	Most of these programs have been around for a while. The Rural Health Clinic provider-based programs have been around for decades. I think what has really started to precipitate the drive to moving in this direction, in 2015 they came out with the Bipartisan Budget Act, which eliminated the ability to add off-campus provider-based departments after 2017. What ended up happening is many of these practices were grandfathered in. In 2018 Medicare came out and gave a proposed rule where they wanted to eliminate the off-campus differential, they called it site neutrality. That went into effect in 2019.
Jonathan P.:	12:17	In 2019 off-campus provider based clinics that are reimbursed under OPPS are receiving 30% reduction on their APC payments for those practices. 2020 they're also going to see another 30%. Over a two-year period, all of these practices that are aligned under these larger hospitals and receiving that provider-based benefit are going to see a 60% reduction in those APC payments.
Jonathan P.:	12:46	Many hospitals cannot afford to lose that type of reimbursement. We did an assessment for another system that had these practices off-campus and the loss for them, they operated about 24 different practices throughout the system and they were all aligned as provider based. This system was going to lose about $6 million in reimbursements due to that OPPS site neutrality impact. What's happening is that now that hospitals are realizing that Medicare again is going to reduce reimbursements, they're looking at other ways to leverage rural hospitals and different designation types to not only combat that reimbursement offset, but to also try to look at different ways to increase reimbursements going forward.
Dan Given:	13:30	If someone is interested in learning more about primary care options and the provider based Rural Health Clinic designation, how might they reach you?
Jonathan P.:	13:38	I can be reached whether it's through phone or through email. We're more than willing to have a conversation. Again, a lot of these tie back to strategies. It ties back to financial analysis. Each system is different. We'd like to

		assume that the designations are the same, but every system's different and the opportunities are different for every system or hospital that's looking at these programs.
Dan Given:	13:59	All right, well, thank you for coming on Jonathan. I really appreciate the talk.
Jonathan P.:	14:03	Thanks Dan.
Dan Given:	14:03	Jonathon can be reached by phone at (207) 221-8253 or email at jpantenburg@stroudwater.com. That's J-P-A-N-T-E-N-B-U-R-G@stroudwater.com. For more information about Stroudwater Associates, call (1800) 947-5712 or visit our website at stroudwater.com for more information about our advisory services, revenue cycle solutions, data analytic capabilities, free webinars and articles.
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