

Rural Health Clinic Designation and Enhanced Cost-Based Reimbursements to Rural Pediatricians

List Serv Discussion Topic Summary

American Academy of Pediatrics

Council on Community Pediatrics

Rural Health Special Interest Group

August 2006

Introduction

Robert Holmberg, MD – Chair, Rural Health SIG

The following is a brief description of the rural health clinic designation by Dr. Francis Rushton of the Rural Health SIG Steering Committee and Chair of the Council on Community Pediatrics at the AAP. If you qualify as a federally designated shortage area, you would be wise to look into this process as it will lead to enhanced cost-based Medicaid reimbursements and may help you improve access to underserved children in your rural geography with the aid of a nurse practitioner/PA. We are very interested in learning how many of you have had experience with a rural health clinic and can share some pros and cons in discussion. Please take a minute to respond to this important topic that I find many solo rural pediatricians in Maine are still unaware.

Topic

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Our office has rural health clinic status. It enables us to get enhanced cost-based reimbursement for Medicaid patients and to be able to fund mental health services for this population. In order to be eligible for rural health clinic status, your office must be in a rural health care shortage area, and have at least one mid-level practitioner on staff. We have found the program to be essential for our financial well being, as approximately 60 percent of our visits are to Medicaid patients. Others practice in Federally Qualified Community Health Care Centers, which have more liberal cost-based reimbursement rules but more stringent and comprehensive service requirements.

Questions

I am interested in knowing how many of our Rural SIG Listserv participants are currently getting cost-based reimbursement through the rural health clinic or Federally Qualified Community Health Centers programs, and how has this enhanced reimbursement impacted physician incomes and ability to provide service?

Responses

The following responses were received through the Rural Health SIG list serv during the month of August 2006 about the discussion topic.

from Kurt Kooyer, MD, FAAP – West Fargo, ND

I wanted to weigh in on the discussion regarding rural health clinics and cost-based reimbursement. From 1992 to 2002, I worked as medical director for an RHC in rural

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Mississippi where cost-based reimbursement was a great help to us. Most of us know that in many states, traditional fee for service Medicaid has been woefully (pathetically?!) inadequate. Cost-based reimbursement (CBR) is designed to more fairly reimburse a medical practice serving a disproportionate amount of Medicaid patients and works basically like this: you create an annual cost report which spells out all of your clinic expenses including operational overhead, salaries, etc. Then you divide that amount by the total number of patients you see annually. You come up with the amount of money, on average, it costs you to see each patient and that becomes your rural health rate. You then receive that amount for each Medicaid or Medicare patient visit. In essence, if you saw only Medicaid and Medicare patients, you would break even at the end of the year. For individually owned rural health clinics (RHCs), there was a cap on how high your rural health rate could go (presumably encouraging you to run a tight ship and to avoid having to finance overly inflated salaries), but if your costs were reasonable, you kept good books, and you employed a mid-level practitioner, you could survive quite nicely in a rural and impoverished region like the Mississippi Delta. When we first gained our RHC designation, our per patient visit rural health rate was around \$50. At that time, Mississippi's fee for service Medicaid rate was around \$18. Quite a contrast!

I'd like to mention three issues, however, that put a negative spin on the RHC and CBR:

1. Recall that a practice's rural health rate is derived from dividing total annual operating costs by total annual patient visits. Provided those visits are either Medicaid, Medicare, or private insurance patients, you make out all right. But if you see a significant amount of uninsured, indigent patients (and that was certainly our case in the Mississippi Delta), the denominator is increased without changing the numerator. For us, it meant that every indigent (unreimbursed) patient visit hurt us in two ways: we didn't get paid for that particular visit, and it dragged down our rural health rate meaning we also got paid less for each Medicaid/Medicare visit. By design, RHCs are traditionally set up in poorer, rural, medically underserved areas, but oddly, we found the nature of their reimbursement formula penalized us for taking care of the uninsured.

2. Though the rules may have changed since the 1990s, while individually owned RHCs had caps on their rural health rates for the reasons outlined above, so-called "provider-based" RHCs did not. I was aware of a hospital-owned (provider-based) RHC in central Mississippi that had enough costs shifted into it to drive its rural health rate over \$200 per visit! Needless to say, that attracted governmental interest and for a time, threatened the continuation of the RHC model, at least in our part of the country.

3. Finally, due to the complexities of the RHC or Federally Qualified Health Center (FQHCs also use utilize cost-based reimbursement but operate by different rules), not all practices located in areas meeting the medically underserved designation choose to

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pursue these models, and yet they may see a significant number of Medicaid patients. These practices would only be entitled to fee for service rates from Medicaid. I was aware of one such traditional private practice group of pediatricians in Vicksburg who desired to do their part to take care of the Medicaid population. They had their own Medicaid patients and they were also the consulting pediatricians for Medicaid patients referred by family physicians employed by a local FQHC. It was ironic that their reimbursement was a fraction of what the referring family physicians were reimbursed for visits by the same patients. Understandably, there has been a tendency for private practices to steer Medicaid patients toward FQHCs. Unfortunately, FQHCs with which I was familiar in Mississippi and Chicago's south side, seemed to have a higher rate of physician turnover and operational difficulties than did the traditional private practices so this trend tended to upset continuity of care and the concept of a medical home.

I would be interested in hearing the experiences of others.

from Adrienne Butler, MD – Waycross, GA

I have had the interesting experience of working at a Federally Qualified Health Center (FQHC), then leaving it to open my own practice (because I couldn't see the children with special health care needs (CSHCNs) there---not cost-effective!). The FQHC was about six blocks away. I left that location, opened a solo practice, and many many patients followed me. At the FQHC in 1994 the Medicaid reimbursement for either a 99212 or a 99213 was about \$76. In my office, a 99212 nets about \$21 and a 99213 gets \$40.70. The FQHC was in a census tract that at the time of its establishment (1994) was an underserved area. I was six blocks away; ineligible of course for rural health clinic (RHC) status (as was our entire county).

I never told my pediatric colleagues in the community about the difference in reimbursement, because it seemed so grossly unfair, and there was no point in angering them. But I deeply resent a system which punishes those who try to serve the underserved by simply serving them, using their own dollars, and being considered "for profit" operations. Another interesting phenomenon was that we were a "Reach Out and Read" site at the FQHC. We were able to purchase books for the children at greatly reduced prices, and gave them to mothers starting at the six month well baby check, as I am sure others in the ROR program do. When I went solo, I purchased books for my patients for Christmas and for scary or painful procedures. I was ineligible for the ROR prices, because I was "for profit". I could no longer afford to do it after the last series of Medicaid cuts.

Something is terribly wrong with this system. I have no idea how to fix it, and in fact worked my last day today. I am retiring rather than deal with the latest Georgia

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Medicaid iteration---the switch September 1 to "CMOs". I hope that the younger pediatricians will continue to fight for what is right for children. I fear that gains in infant mortality, vaccine preventable illnesses, care for at-risk children, and proactive care for CSHCNs will be lost as we sort out the health care disaster in this country. I hope I am wrong, and will follow with interest what the SIG, the AAP and our state chapter does about these injustices. Good luck, and God bless!

From Pierette Mimi Poinsett, MD, FAAP – Petaluma, CA

I was also a former NHSC scholar (in Las Vegas and Lamont CA) and also worked for several years in a FQHC in Modesto, CA before doing 6 years of private practice in Modesto. Patients did follow me. I became the doctor who would take on the complicated kids with mental health issues that no one else wanted to follow. Soon my private practice was 50% Medicaid, 25% CHIPS and the rest a mix of private HMO and fee for service patients.

Couldn't keep up with the overhead. Couldn't pay myself a decent wage. So I closed my practice in February 06 to move to Petaluma CA to work for another CHC. This lasted all of 2 weeks as my son became seriously ill and had to be hospitalized for a month. The Health Care District that brought me to Petaluma along with the CHC wanted me to stay in town and open a solo practice and take Medicaid. A daunting task as docs in Sonoma County are closing their practices either to retire, join Kaiser or leave California.

So to keep my roots in public health, I am starting to work very part time for Sonoma County California Childrens' Services (case management program for children with special health care needs who are on Medicaid or low income). I am doing locum tenens in pediatric urgent care to pay the bills.

It's not exactly where I want to be. I miss working directly with children with ADHD and other learning problems. I miss my breastfeeding moms and well child physicals. But I have reached a point where having retirement (I have virtually none at 48) and sending my son to college (he is 9) is taking precedent over most of my ideals.

from Francis Rushton, MD, FAAP – Beaufort, SC

I have to also admit to be an "ex" FQHC employee. For a variety of reasons, but mostly for professional control of my practice I to have entered private practice, now for 25 years. But.. somehow those of us who are concerned about health care equity (It's in the AAP's strategic plan) have to figure out how to use existing opportunities.. (for some of us that's been the Rural Health Clinic program, others have been successful with state advocacy).. and how to change the system so that we can keep people like Kurt

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and Adrienne working here in the rural south, and keep Gil and Dave open and functioning and seeing all children who need their services. So what's the next step? Figuring out a better way to partner with the FQHC's so we can get their rate? State advocacy? Working with the health department like Dr. Poinsett? Providing financial consultants to rural pediatricians with practices focused on the underserved so they can take advantage of existing programs?

I do believe that for many children the FQHC's and RHC's (like my own) have been a major tool to enable us to see poor children.

If anybody else is having problems with Reach Out and Read, please let me know. Reach Out and Read can be used in for profit pediatric practices.

What else do you think the Academy and the Rural Health SIG can do to support the pediatrician in the field? What can we do to support each other?

from Arnold Gold, MD, FAAP – Live Oak, CA

I am also disturbed that despite all the hand wringing so little can be done to help all the pediatricians who wish to take care of all children and not just those with " good insurance."

Certainly some of us will work with the gov't to obtain the dollars to keep our practice going and then help children without any means others see children without means and work all year to get grants to pay for their care.

I see little help from any organization we belong to. I see more work going into compensation than practicing pediatrics.

Isn't it time to rethink the way we work, and the way we get compensated? Going along this road has gotten us nowhere and hurt many docs to the point of leaving their practice and leaving many children without care.

We need to be more proactive and not accept whatever is thrown at us. We need the type of leaders that I see in the OB, surgical, and anesthesia groups. All have gotten significant increases in their reimbursement while peds has hardly moved at all.

Is this something we could discuss or are we too far apart philosophically and geographically?