

Idaho FLEX Conference

Environmental Changes Affecting CAHs

John T. Supplitt, senior director
AHA Section for Small or Rural Hospitals

Agenda

- **Who/Where We Are**
- **Political Environment**
- **Advocacy Agenda**
- **Regulatory Environment**
- **Quality Measurement**
- **Community Benefit**
- **Recovery Audit Contractors**
- **Financial Performance**
- **Coverage**
- **Workforce**



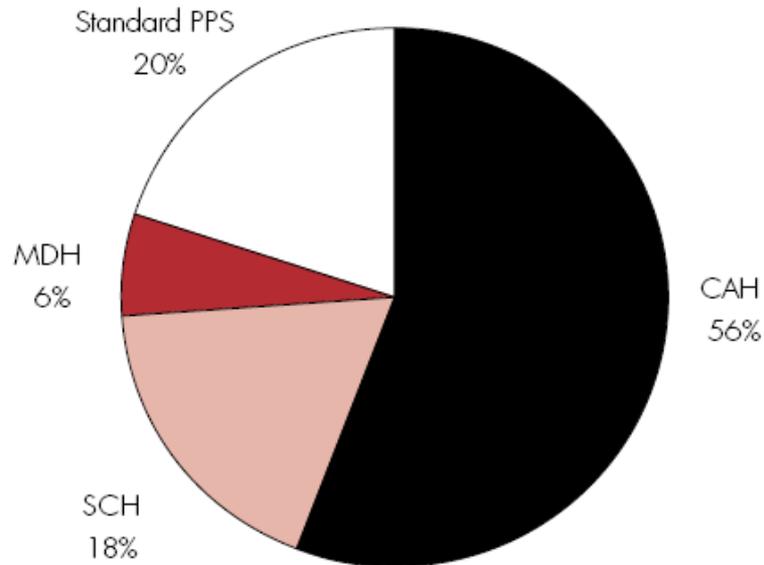
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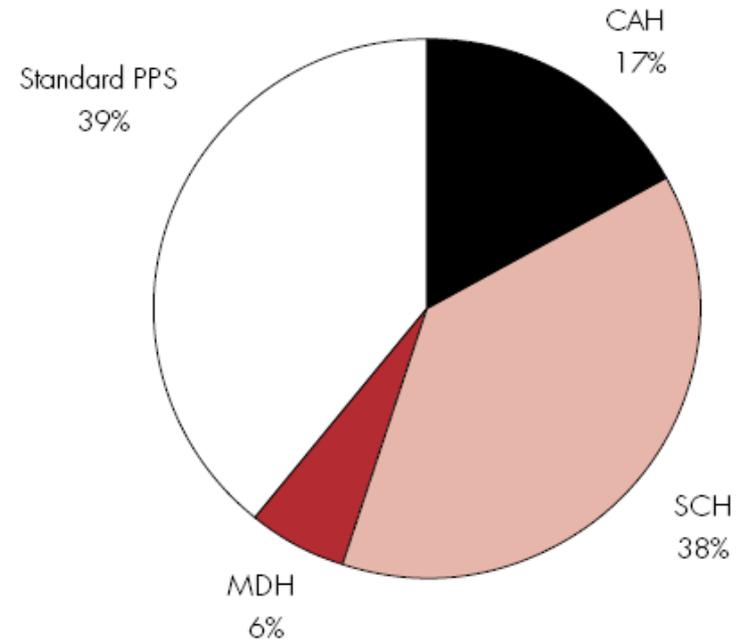
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Who We Are

Share of rural hospitals



Share of inpatient payments



Who We Are

December 2007, there were 1,291 CAHs.

- **71% have 25 beds**
- **20% have 15-24 beds**
- **69 have psych DPUs**
- **9 have rehab DPUs**

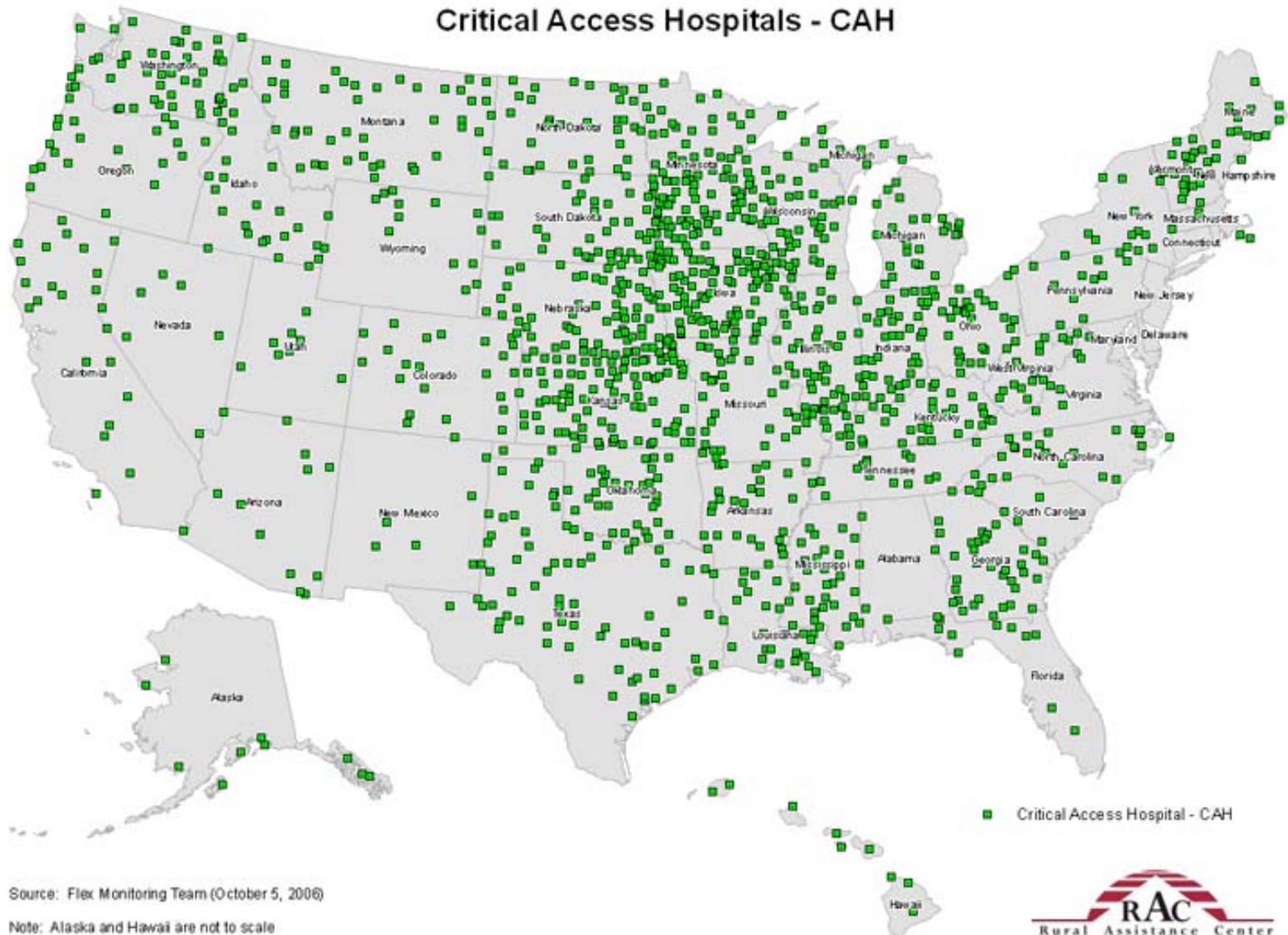
Over the last 10 years:

- **30 closed**
- **8 dropped CAH designation**
- **2 closed, then later reopened**



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Location of CAHs

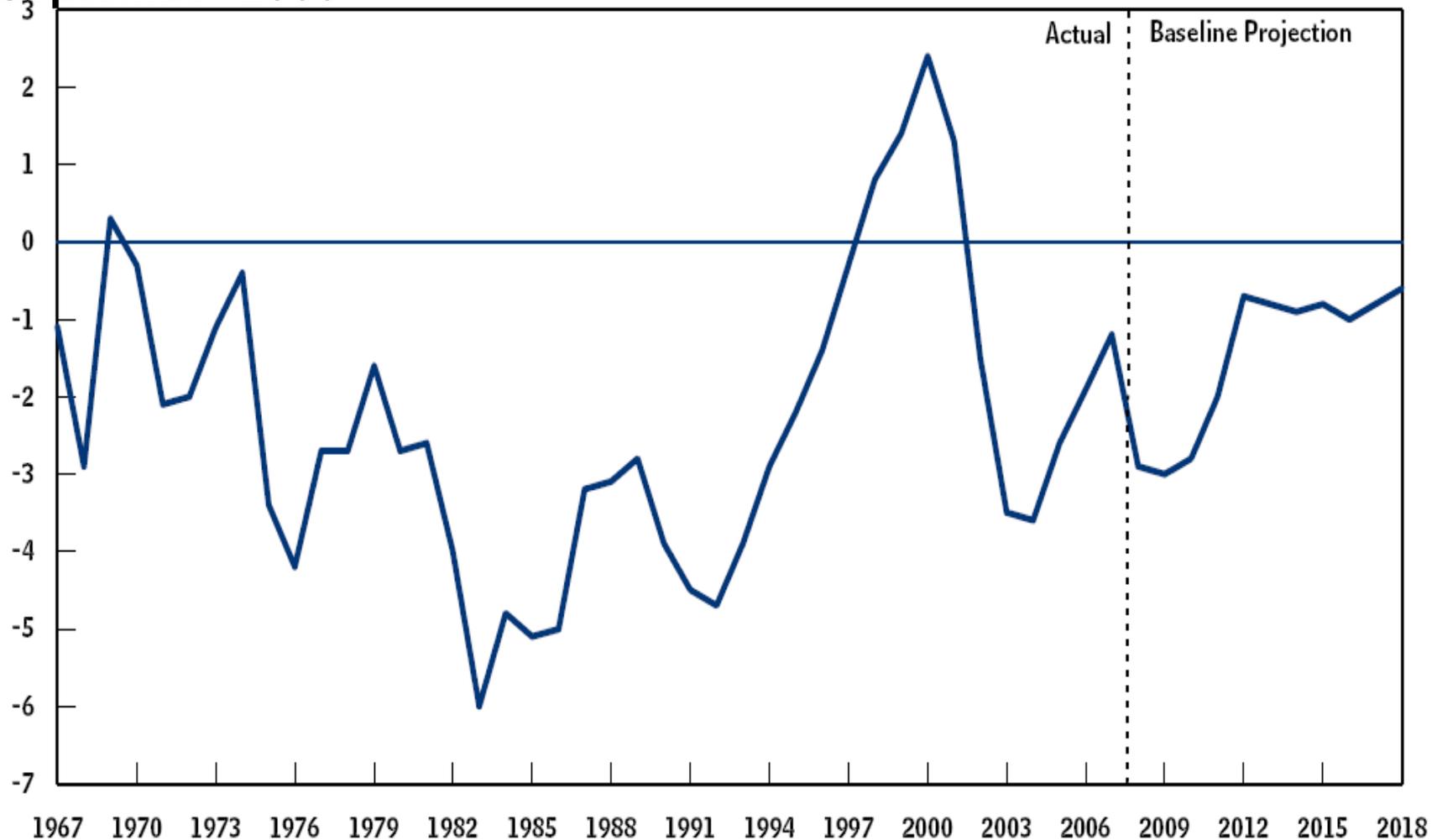




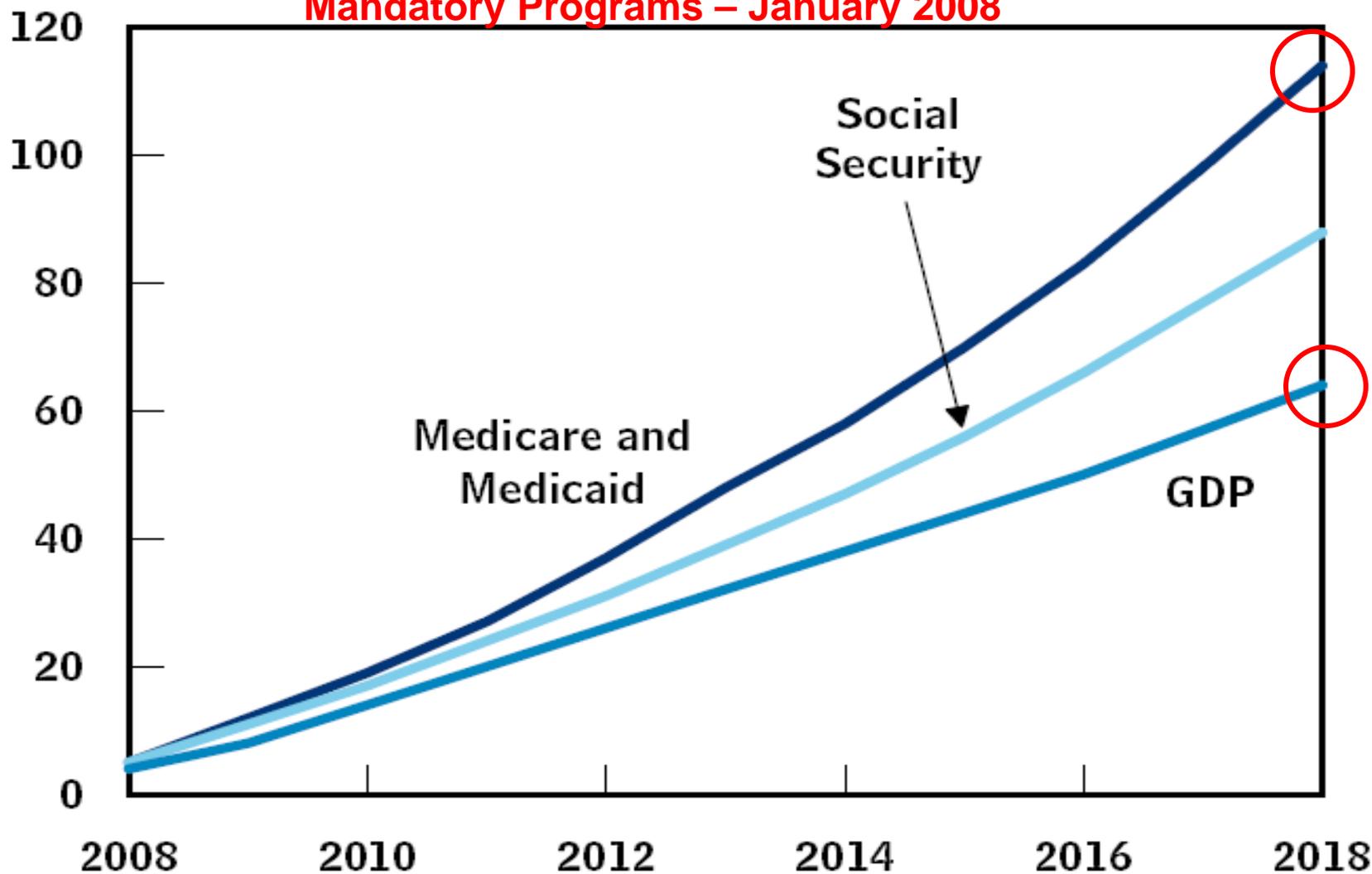
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Total Federal Budget Deficit or Surplus as Percent GDP

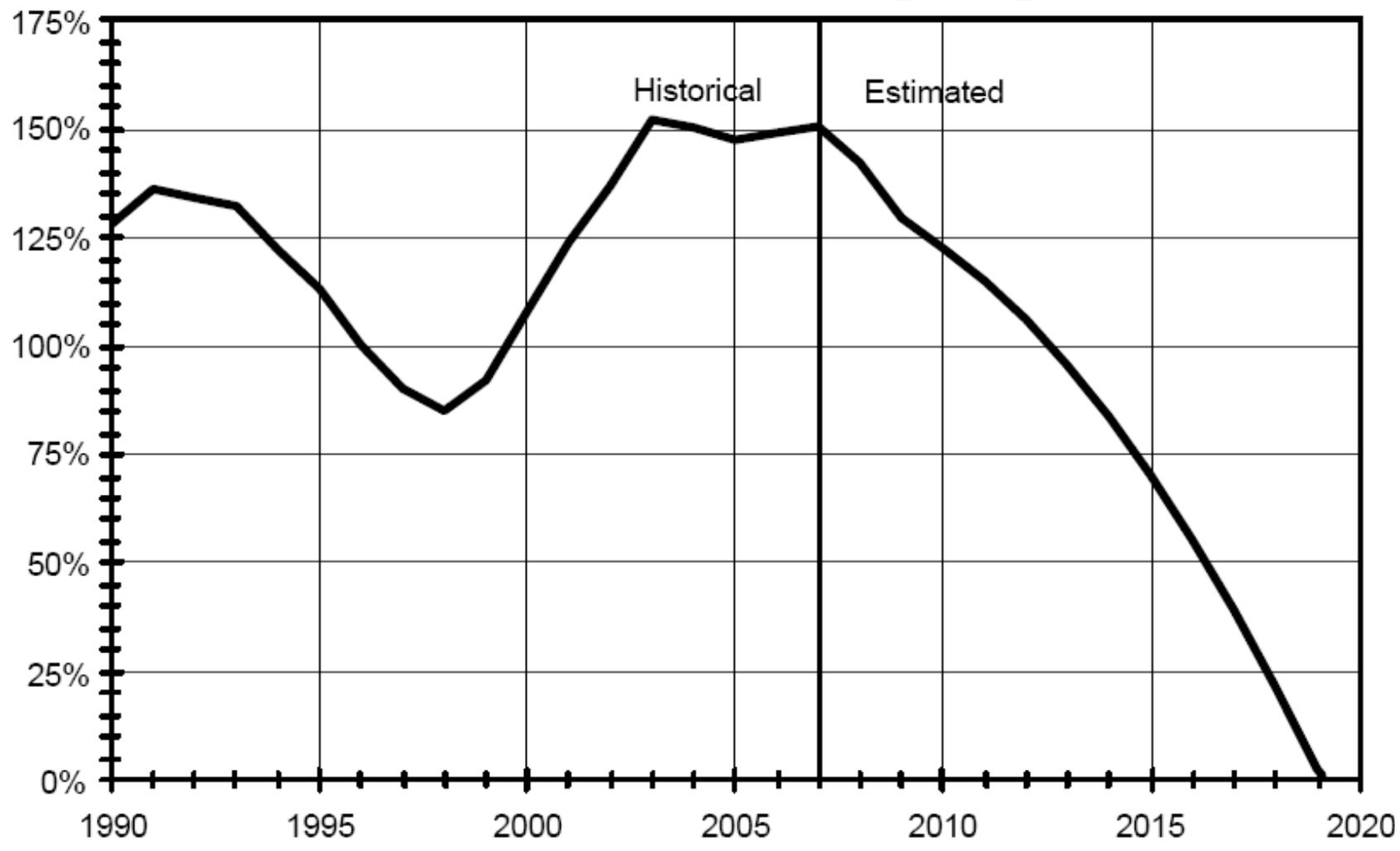
September 2008



Projected Growth of the U.S. Economy and Federal Spending for Major Mandatory Programs – January 2008

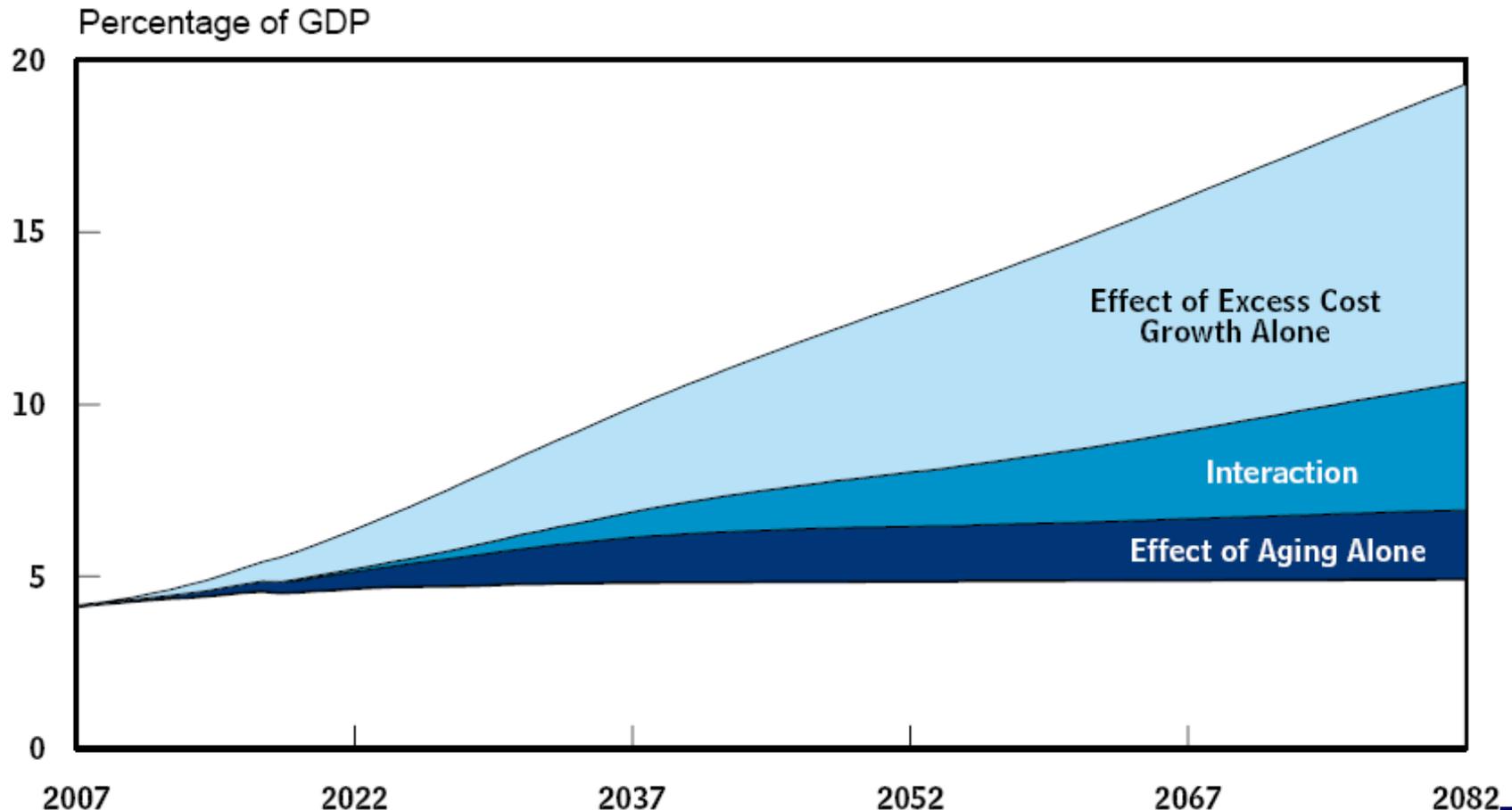


HI Trust Fund Balance at Beginning of Year



What's Driving Costs

Sources of Growth in Projected Federal Spending on Medicare and Medicaid (Percentage of GDP)



March 2008



CONGRESSIONAL BUDGET OFFICE

Federal Budget

Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 PL 110-329

An Act

Making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2008, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009”.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

DIVISION A—CONTINUING APPROPRIATIONS RESOLUTION, 2009



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Appropriations

RURAL PROGRAM (in millions)	FINAL FY 08	FINAL FY 09
Outreach Grants	\$48.0	\$48.0
Health Research	\$8.6	\$8.6
FLEX Grants	\$37.9	\$37.9
Delta Health Initiative	\$24.6	\$24.6
Automatic External Defibs	\$1.5	\$1.5
State Offices of Rural Health	\$8.0	\$8.0
Community Health Centers	\$2,065	\$2,065
NHSC	\$123.5	\$123.5
AHECs	\$28.2	\$28.2
Denali Commission	\$38.6	\$38.6
Telehealth	\$6.7	\$6.7

Emergency Economic Stabilization Act

Division A: The Emergency Economic Stabilization Act

Division B: The Energy Improvement and Extension

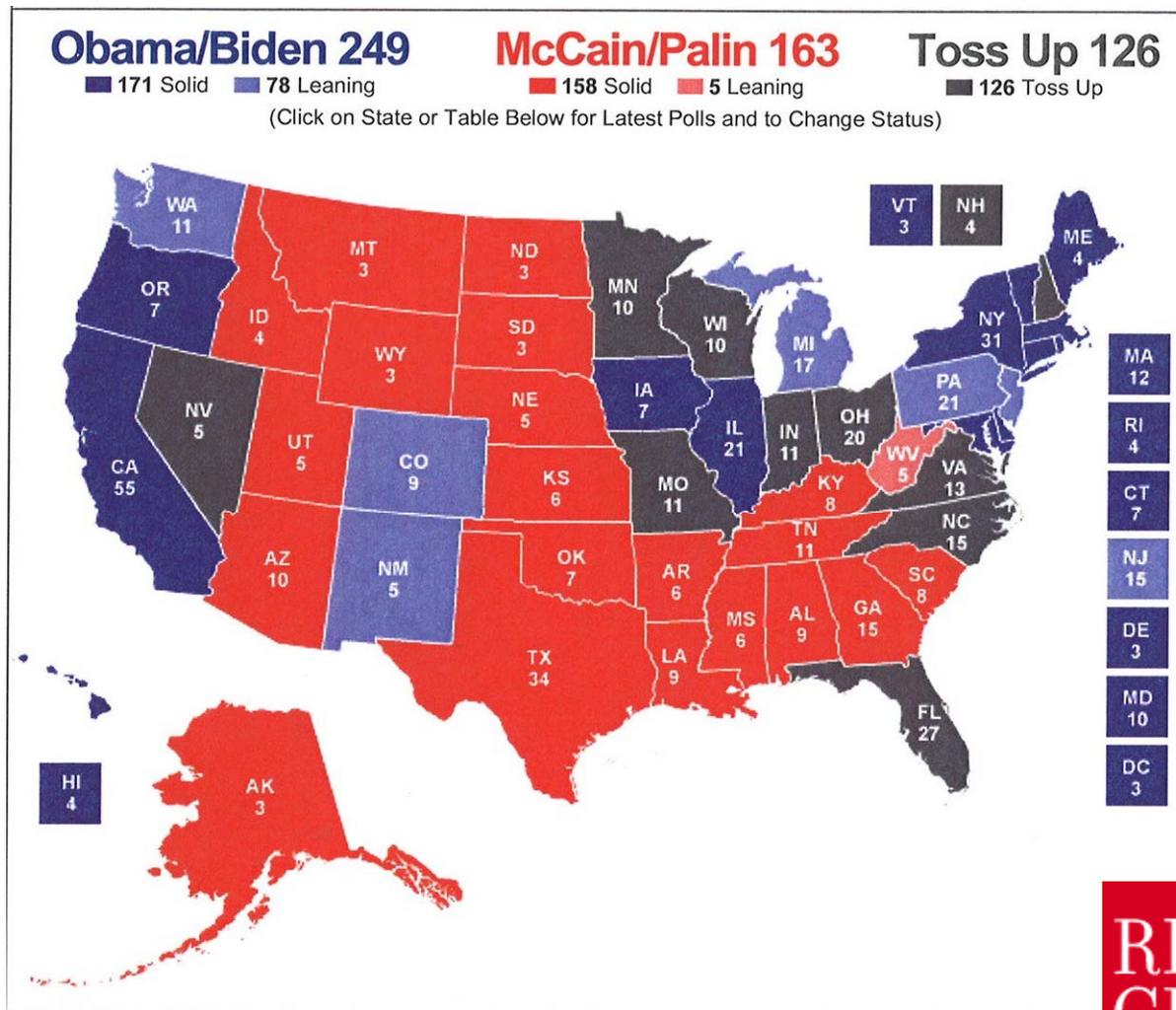
**Division C: The Tax Extenders and Alternative
Minimum Tax Relief Act**

- **Mental Health Parity bill**
- **Prohibits discrimination on the basis of genetic information with respect to health insurance and employment**



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Presidential Election



September 30, 2008



Health Care Coverage

REPUBLICANS

John McCain

Opposes federally mandated universal coverage. Believes competition will improve the quality of health insurance.



DEMOCRATS

Barack Obama

Would create a national health insurance program for individuals who do not have employer-provided health care and who do not qualify for other existing federal programs. Does not mandate individual coverage for all Americans, but requires coverage for all children. Allows individuals below age 25 to be covered through their parents' plans.





**AHA's
Rural Hospital
Advocacy
Agenda**



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War Funding

Supplemental Appropriations Act of 2008

H.R. 2642

House Resolution 1284

TITLE VII—MEDICAID PROVISIONS

SEC. 7001. (a) MORATORIA ON CERTAIN MEDICAID REGULATIONS.

1. state provider tax laws; and
2. case management services for people with disabilities
3. coverage of rehab services for people with disabilities;
4. CPEs, and IGTs;
5. graduate medical education
6. outreach and enrollment in schools and specialized medical transportation to school for children covered by Medicaid
7. coverage of hospital outpatient services



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House Medicare Package

The Medicare Improvements to the Patients and Providers Act of 2008 (H.R. 6331)

Prevents a 10.6 percent cut to physician payments that went into effect July 1 and provides a 1.1 percent increase for physicians in 2009. It extends a number of provisions slated to expire and contains several rural hospital provisions.



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MIPPA - H.R. 6331

Inpatient

Sec. 121 Extends the **FLEX program** through September 30, 2010 and **expands the program** to provide grants to mental health services for veterans and residents of rural areas. Provides assistance for small rural hospitals transitioning to SNFs.

Sec. 122 Provides a **new base year for SCHs** for cost reporting periods on or after Jan. 1, 2009 based on FY 2006 cost reports.

Sec. 123 Establishes a **demo project** to allow states (AK, MT, WY, ND and NV) to test ways to coordinate hospital, nursing home, home health and other health care services in rural areas.

Sec. 124 Extends the provisions of the MMA relating to **wage index reclassifications** for certain hospitals through Sept. 30, 2009.

Sec. 125 **Revokes the unique authority of the Joint Commission** to deem hospitals in compliance with the Medicare CoP.



MIPPA - H.R. 6331

Outpatient and Other

- Sec. 136** Extends for 18 months the provision that allows independent labs to continue to **bill Medicare directly for the physician pathology services** they provide to hospitals.
- Sec. 146** Reinstates the **add-on payment for ground ambulance services at 3% for rural services** and provides an 18-month hold harmless for air ambulance regions recently reclassified from rural to urban.
- Sec. 147** Extends until December 31, 2009, provisions that ensure **small rural hospitals receive payments for outpatient services** that are at least 85% of what they received before the Hospital OPPS took effect. This provision would also **extend to SCHs** under 100 beds.
- Sec. 148** Allows **CAHs serving rural areas to receive 101% of reasonable costs for clinical lab services** provided to Medicare beneficiaries regardless of whether the lab specimen was taken in the hospital or off-site at another facility operated by the CAH.

Conrad State 30 Improvement Act

110TH CONGRESS
2D SESSION

H.R. 5571

AMENDMENT

Extends the J-1 visa waiver program through March 6, 2009, subject to the overall limit of 30 participants per state.

Increases from five to 10 the number of alien physicians who may serve in state facilities.

Expresses the sense of Congress that:

- 1) federal programs are designed to promote the delivery of critically needed medical services to people lacking adequate access to physician care; and**
- 2) when determining a HPSA, the Secretary should consider:**
 - low-income and impoverished**
 - high infant mortality rates, and**
 - other signs of a lack of necessary physician services**



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Unfinished Business

Remaining Rural Legislative Efforts

- **R-HoPE S. 1605 and HCARE – HR 2860**
 - **Removes the cap on DSH adjustments for all hospitals**
 - **Extends physician scarcity bonus**
- **The Critical Access Hospital Flexibility Act**
- **The 340B Program Improvement and Integrity Act**
- **CAH Payments for CRNA Services**
- **Rural Health Services Preservation Act**



Lame Duck

Economic Stimulus Bill Advocacy Action

- ***An increase in FMAP***, the federal Medicaid matching rate
- ***A moratorium on a CMS cuts to IME*** adjustment in IPPS for capital costs.
- ***A moratorium on CMS' proposed cut to Medicaid outpatient services***, which would narrow the definition and scope of these services
- ***Reauthorization of Section 1011 funds*** to aid hospitals providing emergency care to undocumented immigrants; and
- ***A ban on self-referral to new physician-owned hospitals***, and grandfathering of existing facilities.



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CAH Interpretive Guidelines

CMS Manual System

Pub. 100-07 State Operations
Provider Certification

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal 32

Date: January 18, 2008

If a CAH is eligible for application of the shorter, 15-mile standard due to mountainous terrain or lack of primary roads.

If a necessary provider remains essentially the same provider, serving the same service area after relocation

CMS Manual System

Pub. 100-07 State Operations
Provider Certification

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal 34

Date: APRIL 4, 2008

CAH maintains no more than 25 inpatient beds that can be used for either inpatient or swing-bed services. Observation beds are not included.



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TRICARE

TRICARE; Reimbursement of CAHs

- **Currently CAHs are subject to the TRICARE DRG-based payment system for inpatient care.**
- **CAHs are reimbursed based on billed charges for facility charges for outpatient care.**
- **In Alaska CAHs are reimbursed the lesser of the billed charge or 101 percent of reasonable costs for inpatient and outpatient care.**
- **TRICARE is proposing to adopt this same reimbursement methodology for all CAHs.**
- **AHA urges TRICARE to adopt Medicare's exact payment methodology for CAHs and to include interim payments and cost settlement mechanisms in the rule to guarantee that CAHs are reimbursed in a timely manner at the appropriate level.**

DEPARTMENT OF DEFENSE

Office of the Secretary

[DoD-2008-HA-0007; 0720-AB21]

32 CFR Part 199

TRICARE; Reimbursement of Critical
Access Hospitals (CAHs)



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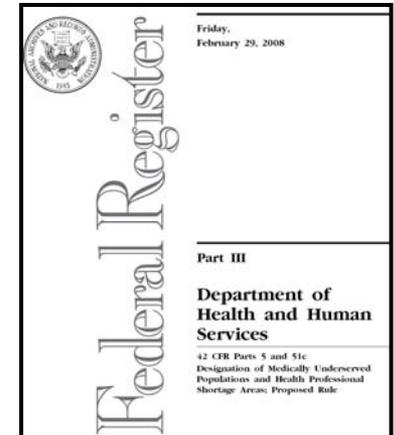
Other Proposed Rules

Index of Primary Care Underservice

Geographic HPSA

Population MUP

Safety-net facility HPSA



CoP and Payment of RHCs and FQHCs

Shortage area review

Exception criteria – essential provider

Payment methodology

Per-visit payment limit exception

CoPs



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Quality Measurement and Public Reporting



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Quality Measures

Hospital Compare - Required of PPS

For FY 2009, hospitals must report 30 measures including:

For 2010, CMS requires 13 new measures.

Propose minimum thresholds

- 5 cases/quarter for AMI, heart failure, pneumonia, etc.
- 5 cases/month for HCAHPS-eligible patients

Hospital Acquired Conditions – Required of PPS

- A total of 10 conditions are now identified for FY 2009
- Present on Admission is a required



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Hospital Compare

Key Findings

- **63% of CAHs participated in Hospital Compare as of December 2006, up from 53% in December 2005 and 41% in September 2004 on at least one measure.**
- **CAH participation varies widely by state from a low of 7.7% to 100% participation in 7 states.**
- **Another 10-15% of CAHs are submitting data to QIOs, but no publicly reporting to Hospital Compare.**
- **Approximately one-fourth of CAHs submitted data on all 20 measures.**

The Flex Program at 10 Years: QI and Measurement Lessons Learned and Future Directions, May 2008 presentation
Ira Moscovice, Ph.D., UMN, Rural Health Research Center



Hospital Compare

More Findings

- **Both CAHs and non-CAHs showed significant positive increases in the percent of patients receiving recommended care for the majority of quality measures.**
- **CAHs still have room for improvement, especially with regard to recommended care for acute myocardial infarction (heart attack or AMI) and heart failure patients.**
- **Low volume remains a problem for calculating a number of measures for CAHs, especially AMI measures, at the individual hospital level.**

CAH Year 2 Hospital Compare Participation and Quality Measure Results, May 2007

Michelle Casey, UMN, Rural Health Research Center



Quality Improvement

Other Quality Initiatives

- CAHs are participating in a wide range of quality improvement activities; the most common are medication safety initiatives.
- Two-thirds of CAHs participate in a quality reporting initiative other than Hospital Compare, including other national, state, and local efforts.
- The most frequently reported reasons cited by CAHs for not participating in Hospital Compare are an insufficient volume of patients and that it is not required by CMS

Next Steps

Rurally Relevant Measures

- Develop quality measures for **core rural hospital functions** not considered in existing measurement sets
- **Emergency department** (timeliness of care for AMI including aspirin at arrival, median time to: fibrinolysis, ECG, transfer for primary PCI)
- **Transfer communication** (i.e. administrative information, patient information, vital signs, medication communication, physician documentation, nursing documentation, tests and procedures)
- **Outpatient care**





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Definitions

Charitable Purpose

Programs or activities that provide treatment and/or promote health in response to an identified community need. Key criteria:

- **Generates a low or negative margin**
- **Responds to needs of special populations (e.g., uninsured)**
- **Supplies a service/program that would likely be discontinued if based on financial criteria**
- **Responds to public health needs, or**
- **Involves education or research that improves overall community health.**



Community Benefit “Standard”

- 1. Emergency room open to all regardless of ability to pay**
- 2. Independent board representative of the community**
- 3. Open medical staff policy**
- 4. Care for all patients able to pay through public or private insurance**
- 5. Use of surplus funds to improve care, expand facilities and advance medical training, education and research**



Internal Revenue Service
United States Department of the Treasury

Community Benefit

Key Findings

- **Most CAHs offer financial assistance to patients.**
- **CAHs are engaged in community needs assessments, gap-filling service development and other activities that address community and rural health system needs.**
- **Over three-quarters of CAHs have relationships with other hospitals, EMS, schools, and public health agencies. CAHs are also supporting many of these community organizations, especially schools, primary care, and EMS.**

IRS on Public Reporting

Form 990 Schedule H – Parts 1-6

1. Charity Care and Certain Other Community Benefits
2. Community Building Activities
3. Bad Debt, Medicare, and Collection Practices
4. Management Companies and Joint Ventures
5. Facility Information
6. Supplemental Information

SCHEDULE H
(Form 990)

Hospitals

OMB No. 1545-0047

2008

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

▶ Attach to Form 990. To be completed by organizations that answer "Yes" to Form 990, Part IV, line 20.

Name of the organization

Employer identification number

Part I Charity Care and Certain Other Community Benefits at Cost (Optional for 2008)

	Yes	No
1a Does the organization have a charity care policy? If "No," skip to question 6a		
b If "Yes," is it a written policy?		
2 If the organization has multiple hospitals, indicate which of the following best describes application of the charity care policy to the various hospitals. <input type="checkbox"/> Applied uniformly to all hospitals <input type="checkbox"/> Applied uniformly to most hospitals <input type="checkbox"/> Generally tailored to individual hospitals		
3 Answer the following based on the charity care eligibility criteria that applies to the largest number of the organization's patients. a Does the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing <i>free</i> care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
b Does the organization use FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes,"		

Recovery Audit Contractors



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Recovery Audit Contractors

Background

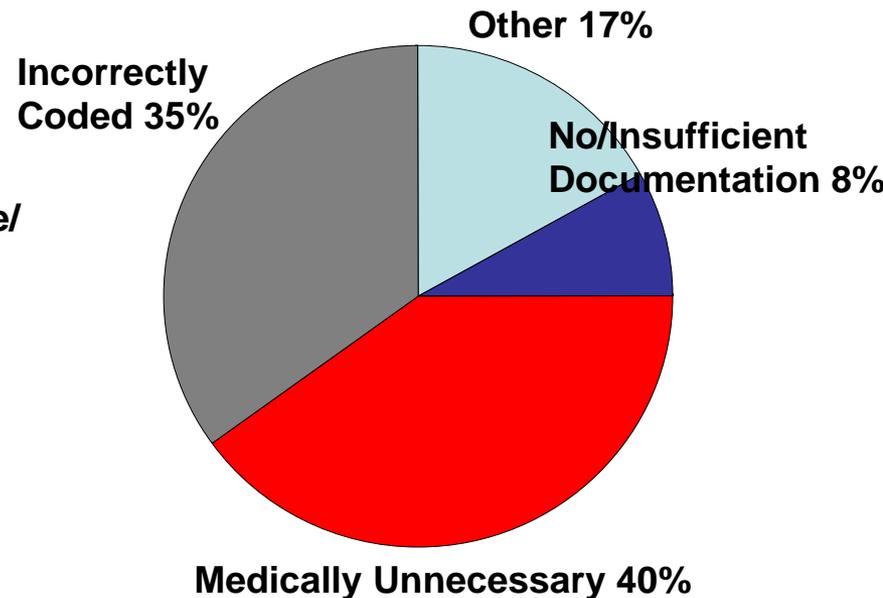
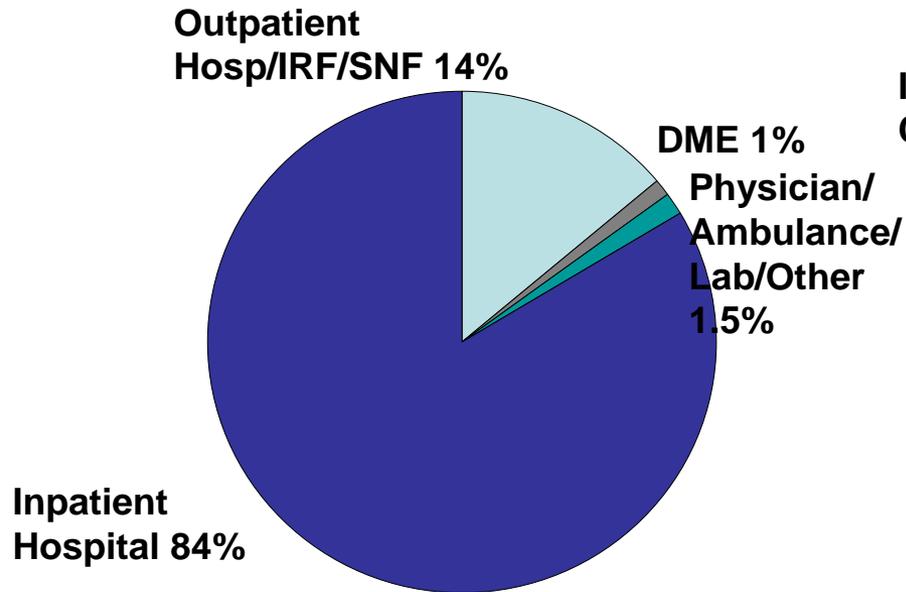


- Medicare Modernization Act (Rx bill)
 - 3-year demonstration project
- Recover overpayments and identify underpayments
- Payment made on a contingency fee basis
- 5 states selected based on highest per capita Medicare utilization:
 - California
 - Florida
 - New York
 - South Carolina
 - Massachusetts
- Tax Relief and Health Care Act of 2006
 - Expanded to all states by 2010



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Overpayments Collected



90%+
Of RAC Collections
from Hospitals

75% of Denials due to
Coding and Medical
Unnecessity

SOURCE: CMS Report: The Medicare Recovery Audit Contractor (RAC) Program, June 2008; released July 11, 2008.

Demo RAC Target Areas

Coding Targets:

- Correct coding for debridement (excisional or not)
- DRGs designated as complicated or having comorbidity, yet only one secondary diagnosis
- Incorrect discharge status for post-acute transfer
- Unit Coding
 - grams vs. milligram,
 - duplicate procedures on same day

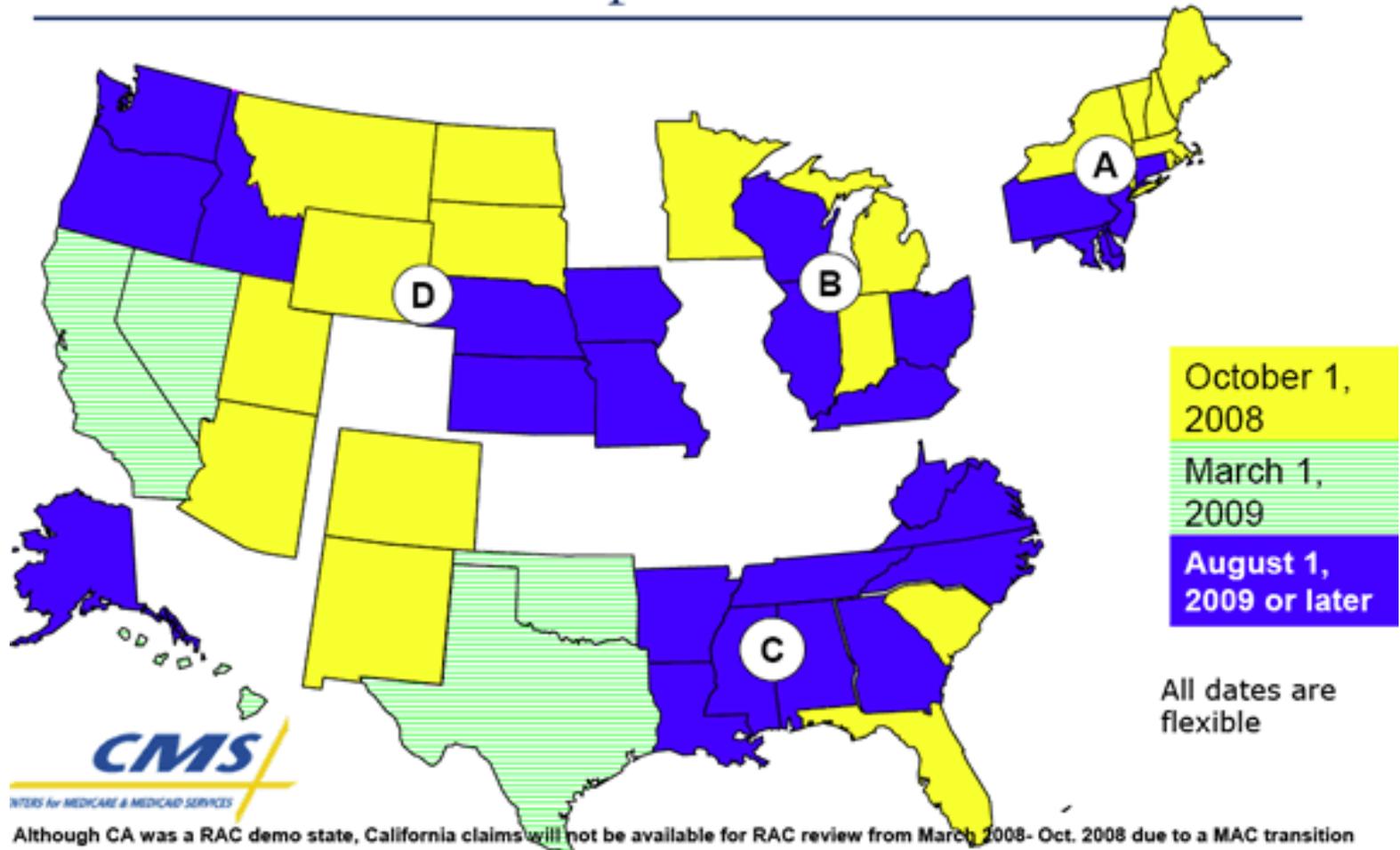
Medical Necessity Targets:

- Inpatient admissions for procedures eligible for outpatient surgery (eg. laparoscopy, cholecystectomy)
- One-day stays
 - Chest pain
 - Back Pain: DRG 243/MS-DRG 551
- Three-day stays to qualify for SNF care
- Inpatient rehabilitation (joint replacement patients)



National Expansion Schedule

Future – Program Expansion National Expansion Schedule



AHA Strategy

AHA's Three-tiered Approach

1. **Work with CMS on program improvements**
 - Assist with program refinements
 - Regular communication
2. **Seek relief from Congress**
 - Tell the other side of the story
 - Further RAC fixes
 - Medicare RAC Moratorium Act of 2007 – HR 4105
3. **Member Education**
 - Advisories
 - Call series



Prepare for RACs Today!

- Establish Interdisciplinary RAC Team: Coders, Finance, Clinical, Utilization Review, Case Management
- Collaborate with your physicians
- Identify RAC point of contact for internal and external RAC communications
- Develop a central tracking mechanism for all RAC correspondence
- Conduct self audit to identify potential problems
- Participate in RAC education call series
- RAC materials on AHA's RAC page:
www.aha.org/rac
- RAC inquiries to AHA: racinfo@aha.org



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CAH Financial Indicators Report: Summary of Indicator Medians by State, August 2008



**Flex
Monitoring
Team**

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine



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Profitability Ratios

Total Margin measures the control of expenses relative to revenues.

$$\text{Total margin} = \text{Net income} \div \text{Total revenue}$$

Cash Flow Margin measures the ability to generate cash flow from providing patient care services.

$$\text{Cash flow margin} = \text{Net income}^* \div (\text{Net patient revenue} + \text{Other income}^*)$$

* less contributions, investments, and appropriations

Return on Equity measures the net income generated by equity investment (net assets).

$$\text{Return on equity} = \text{Net income} \div \text{Net assets}$$

Profitability Indicators

State	Total Margin	Cash Flow Margin	Return on Equity
US	3.58%	5.92%	7.93%
ID	3.72	6.26	6.44
CO	5.3	7.25	10.76
MT	3.22	4.57	5.40
OR	5.55	6.22	9.79
WA	2.87	2.74	5.93

Revenue Indicators

State	Outpatient to Total Revenue	Medicare Inpatient Payer Mix	Medicare Revenue per Day
US	66.75%	76.76%	\$1470
ID	62.68	66.55	1756
CO	66.56	79.42	1657
MT	54.93	78.85	1374
OR	66.24	61.19	2176
WA	69.12	63.84	2057

Utilization Indicators

State	Swing and SNF Bed ADC	Acute Inpatient Bed ADC
US	1.62 days	4.38 days
ID	 0.88	3.56
CO	 1.59	2.80
MT	1.29	1.98
OR	1.00	 6.82
WA	0.91	4.36

Capital Structure Indicators

Equity Financing measures the percentage of total assets financed by equity.

$$\text{Equity financing} = \text{Net assets} \div \text{Total assets}$$

Debt Service Coverage measures the ability to pay obligations related to long-term debt, principal payments and interest expense.

$$\text{Debt service coverage} = (\text{Net income} + \text{Depreciation} + \text{Interest}) \div (\text{Principal payment} + \text{Interest})$$

Long-Term Debt to Capitalization measures the percentage of total capital that is debt.

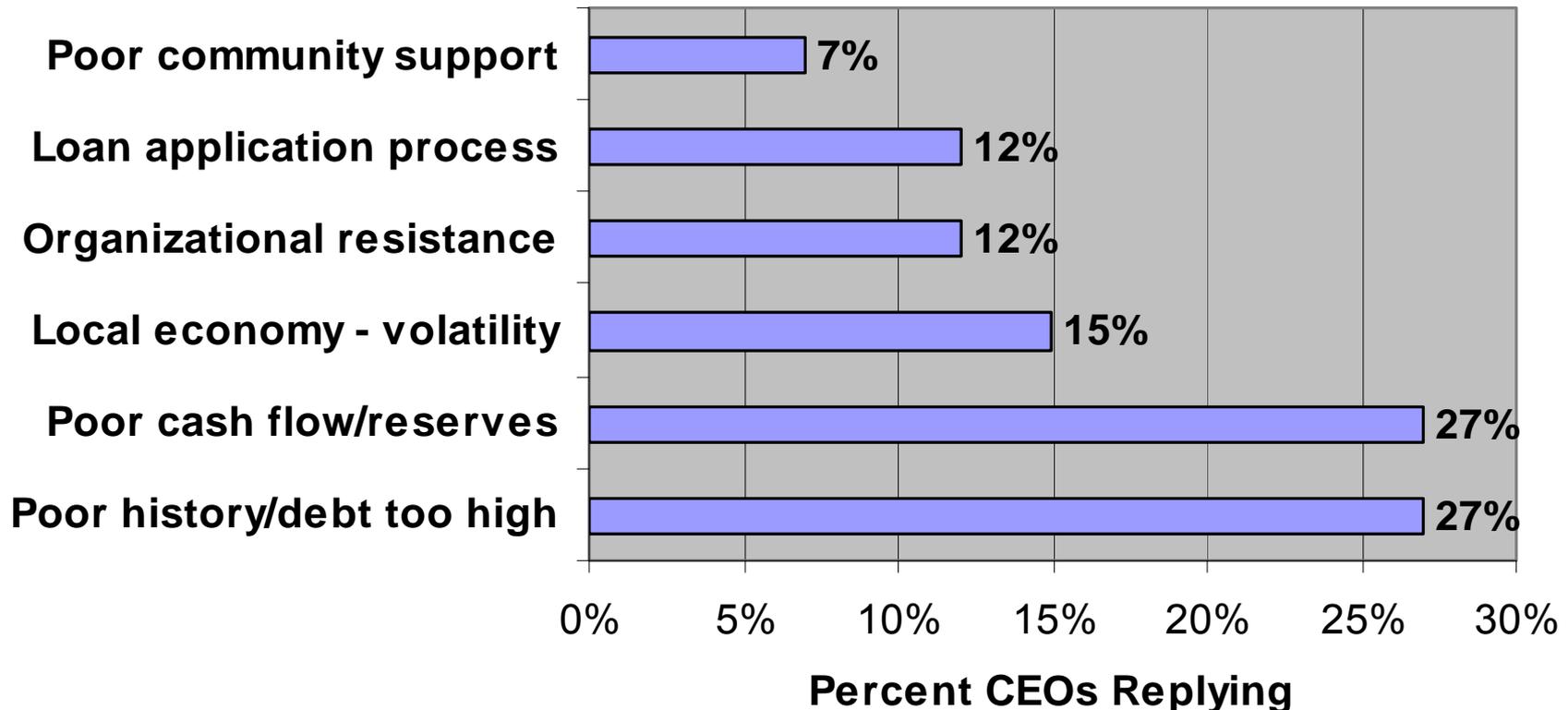
$$\text{Long-term debt to capitalization} = \text{Long-term debt} \div (\text{Long-term debt} + \text{Net assets})$$

Capital Structure Indicators

State	Equity Financing	Debt Service Coverage	LTD to Capitalization
US	60.81%	3.36 times	24.40%
ID	57.95	4.19	24.80
CO	48.32	5.08	38.94
MT	70.18	6.21	17.78
OR	63.03	3.26	27.69
WA	55.53	3.31	34.26

CAH Capital

Barriers to Accessing Loan Capital



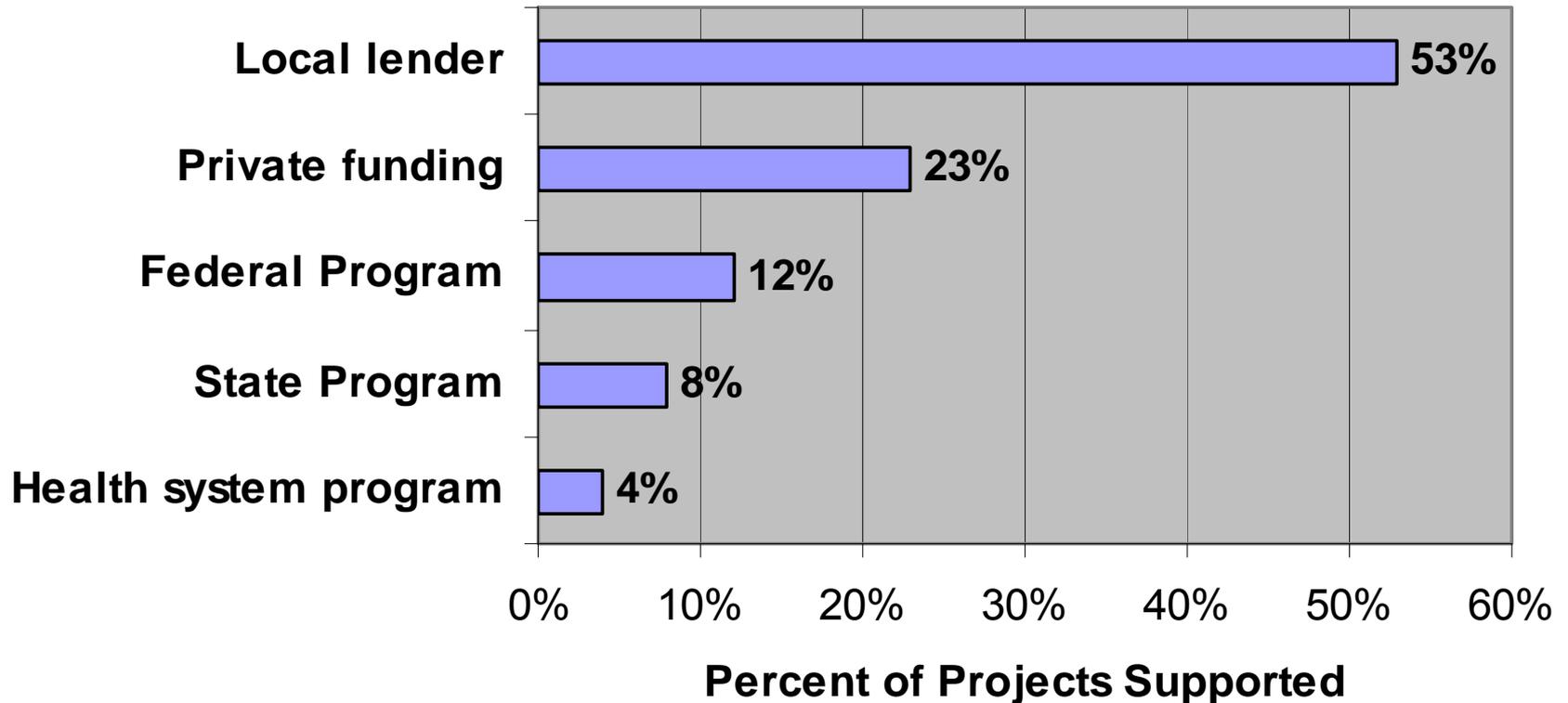
The Availability and Use of Capital by CAHs

Walter Gregg M.A., M.P.H.

University of Minnesota, March 2005

CAH Capital

CAH Sources of Capital



The Availability and Use of Capital by CAHs
Mar. 2005

CAH Capital

Most Important Loan Capital Investment Projects	All Projects (n=227)
General remodeling/modernization	17%
Clinical remodeling/expansion	23%
Clinical equipment purchasing	35%
Information technology	6%
Refinance old debt	8%
Diversification of services	5%
Total facility replacement	6%

Total Expenditures: \$418 million

Average Project Cost: \$2.4 million

The Availability and Use of Capital by CAHs
Mar. 2005

Credit Crunch



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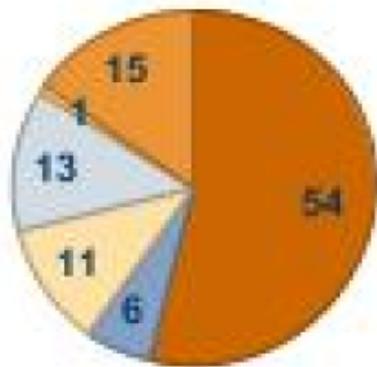
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Payer Mix

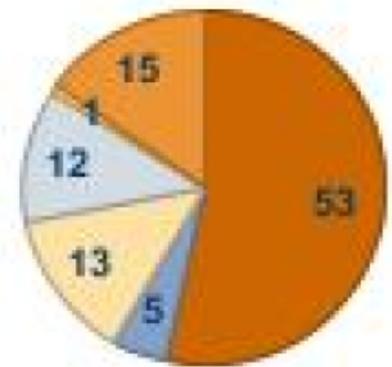
Idaho & United States

Total Residents, 2006-2007	
ID: 1,484,175	US: 298,215,355

Distribution by Insurance Status, 2006-2007	
Idaho	United States

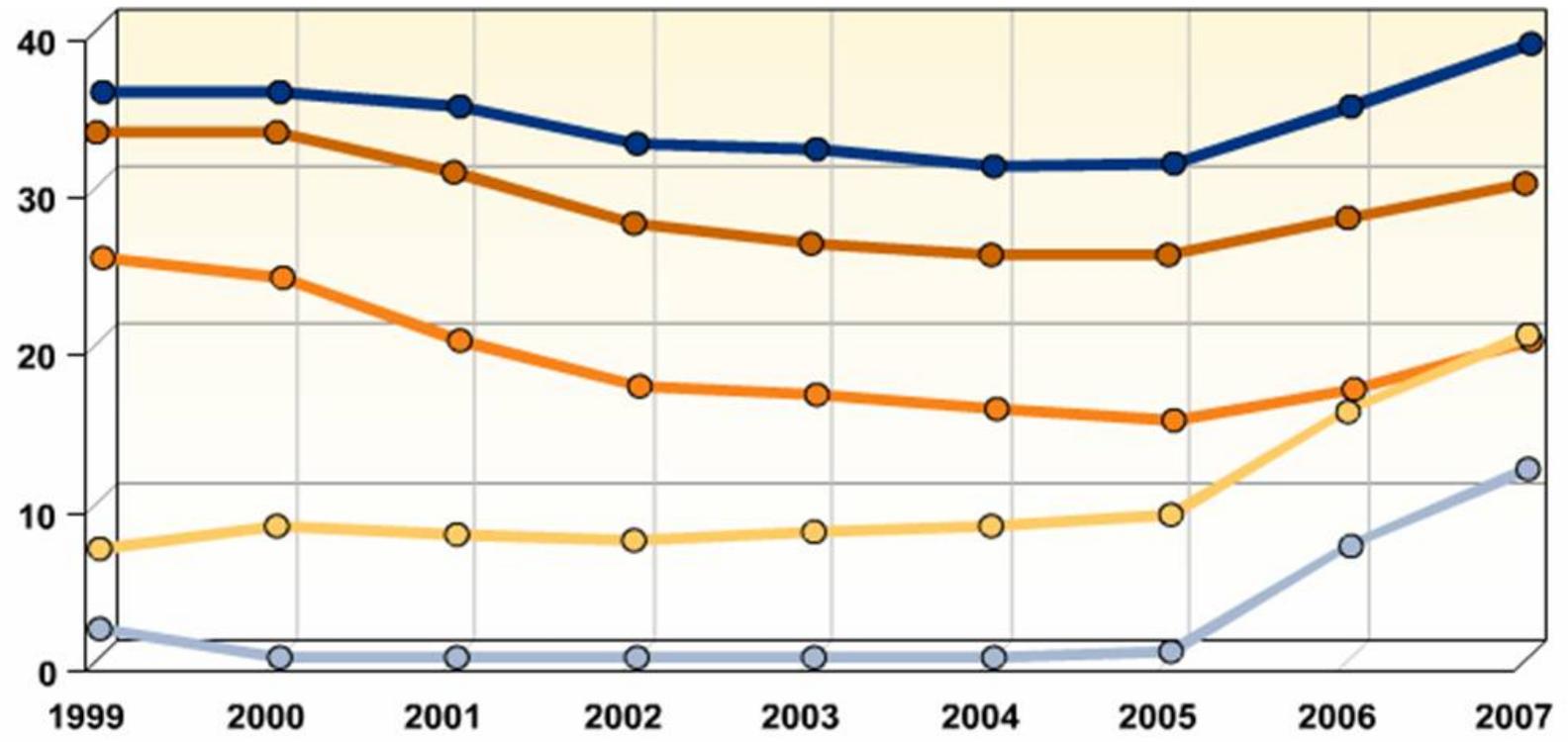


- **54% Employer** ●
- **6% Individual** ●
- **11% Medicaid** ●
- **13% Medicare** ●
- **1% Other Public** ●
- **15% Uninsured** ●



MA Penetration in Region

Medicare Advantage Plan Penetration: 1999 - 2007

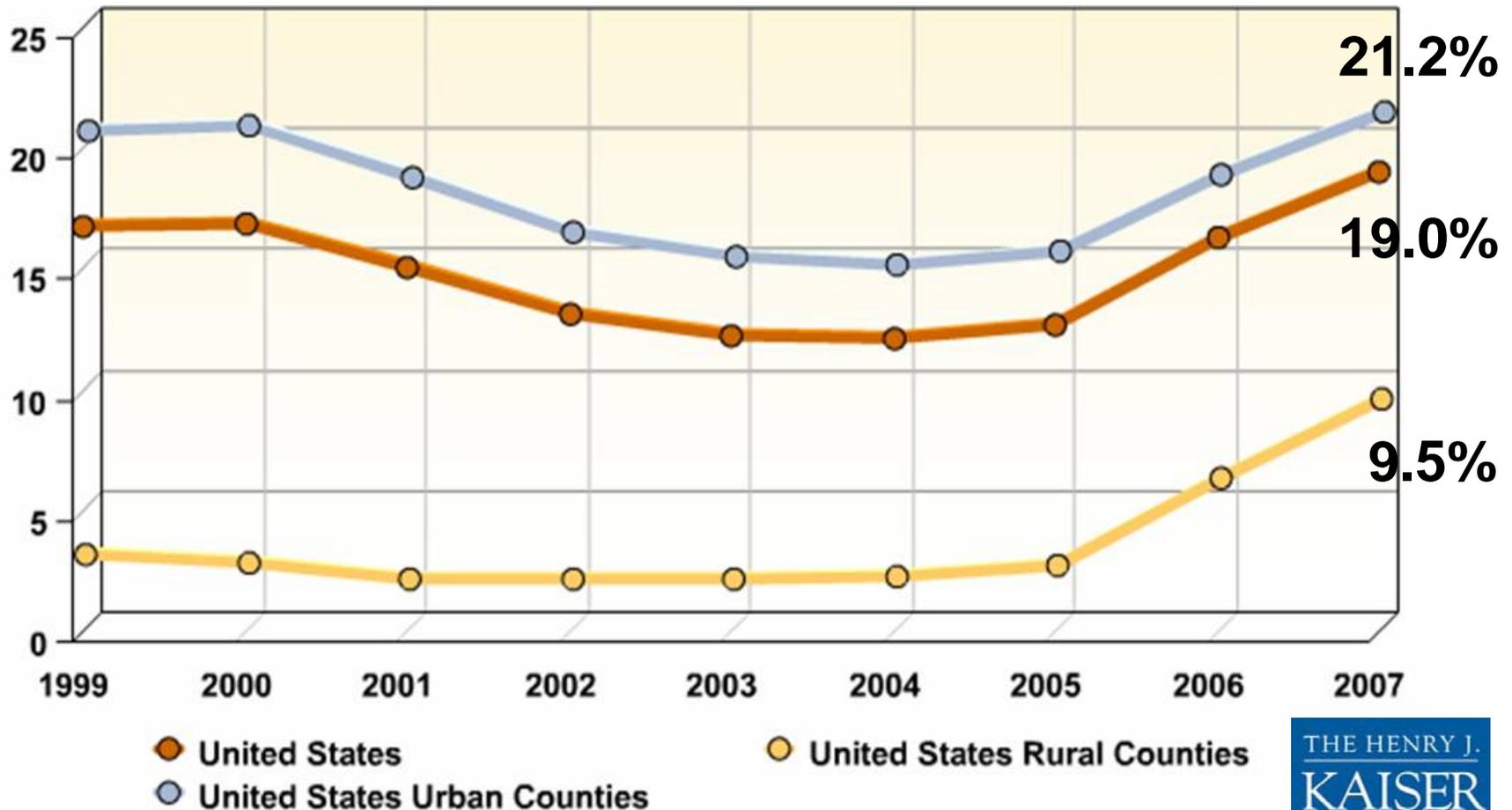


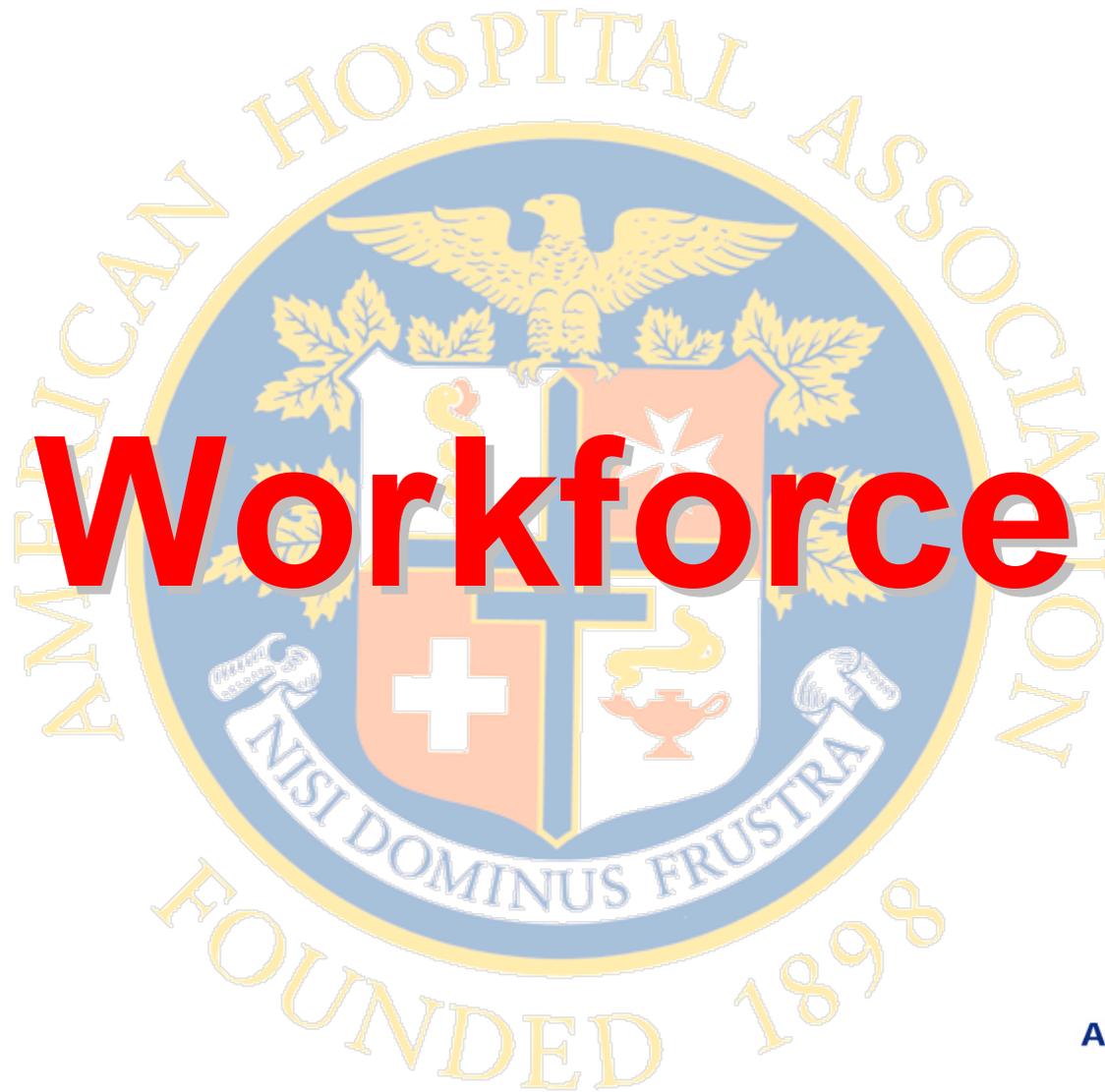
● Colorado
 ● Idaho
 ● Montana
 ● Oregon
 ● Washington

30.2% **20.4%** **11.9%** **38.7%** **20.0%**

MA Penetration by County

Medicare Advantage Plan Penetration: 1999 - 2007

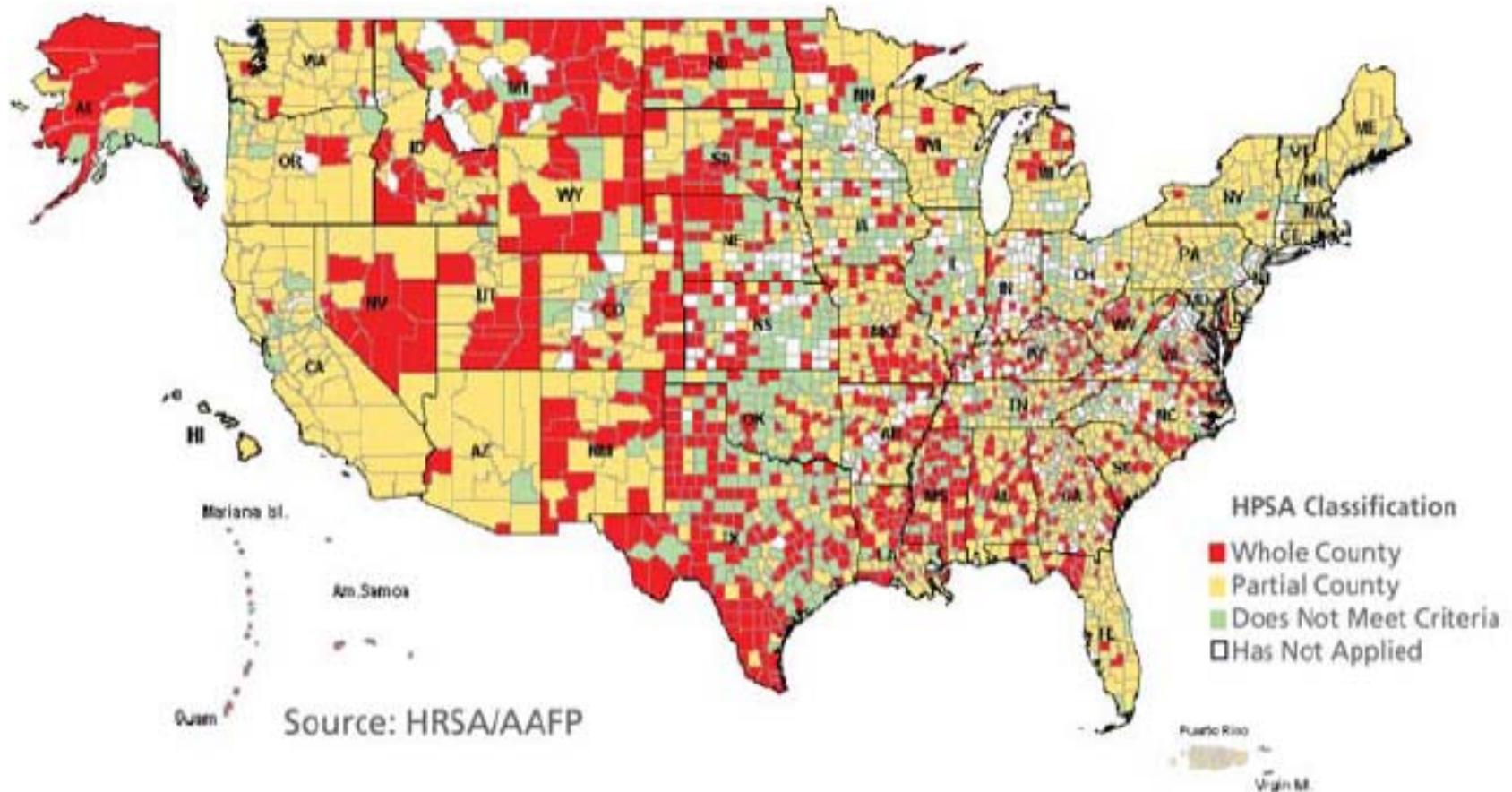




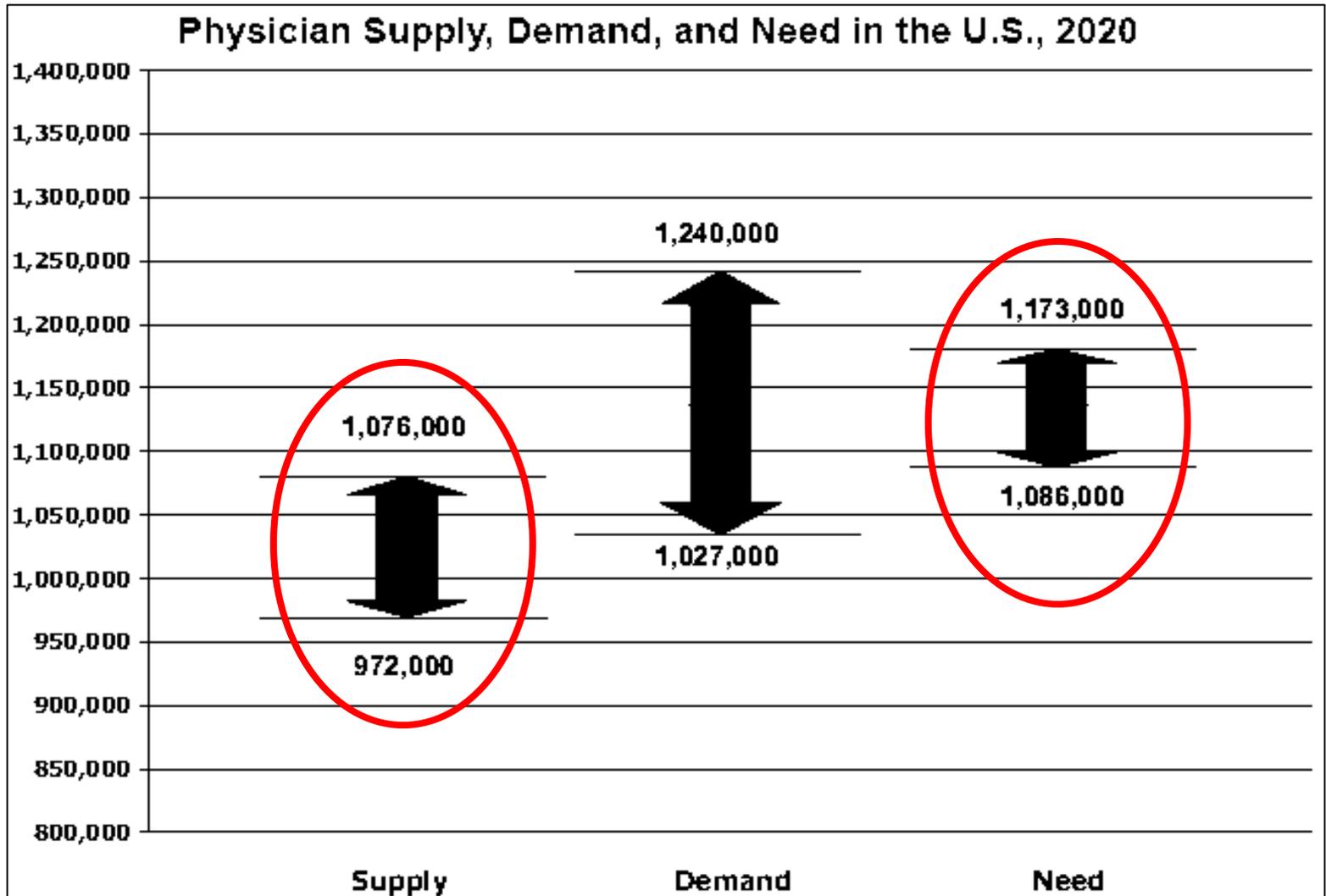
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HPSA Classification

30 Million People Live in Federally Designated Shortage Areas

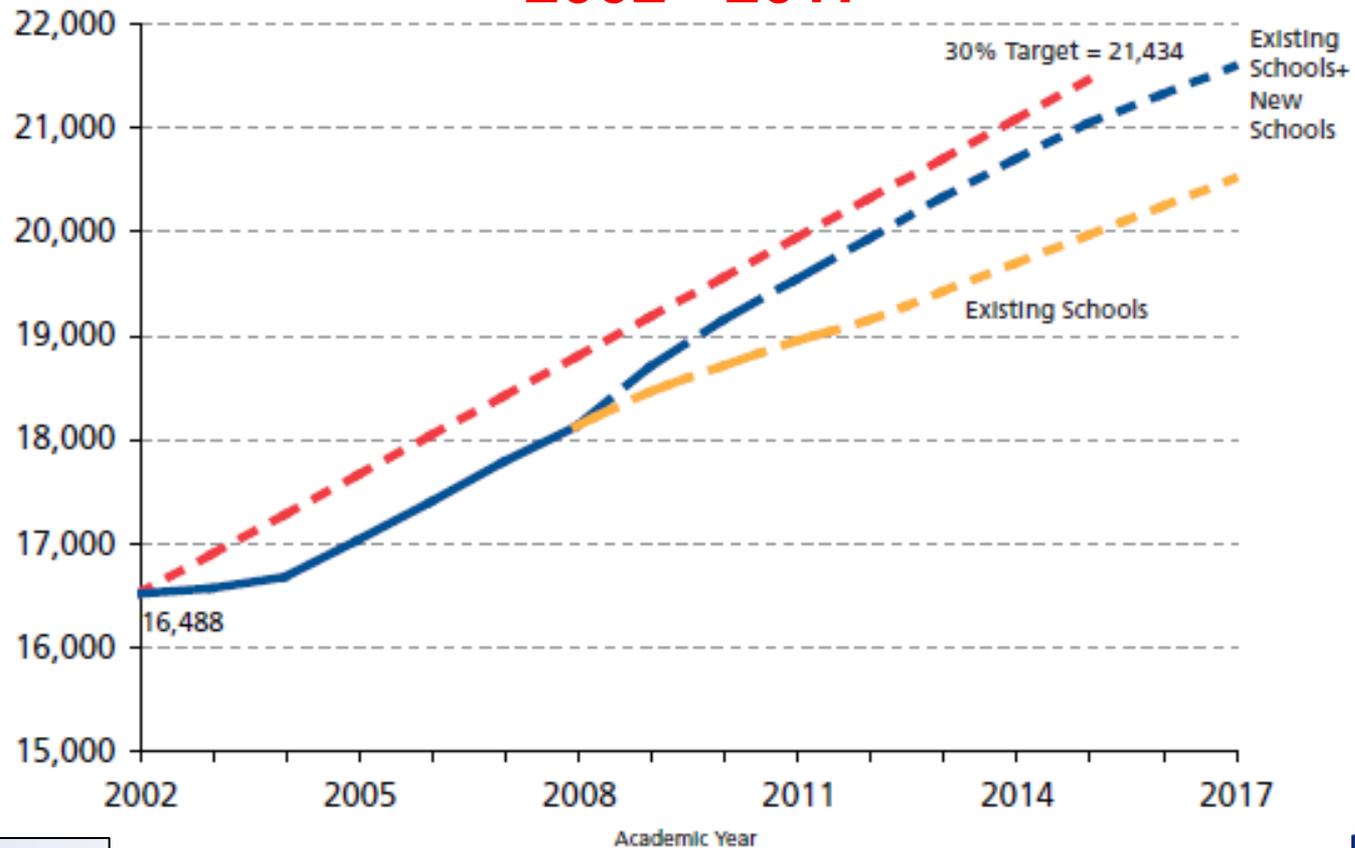


Physician Shortage



Medical School Graduates

Projected Number of Medical School Graduates, 2002 - 2017



30% Target Existing Schools + New Schools Existing Schools



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Workforce Initiatives

Support

- H.R. 5924, the Emergency Nurse Supply Relief Act
- S. 2672, Conrad State 30 Improvement Act
- Secret Ballot Protection Act (H.R. 866)
- Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Nurses to the US

Oppose

- Employee Free Choice Act (S. 1041/H.R. 800)
- Re-empowerment of Skilled and Professional Employees and Construction Tradeworkers Act (S. 969/H.R. 1644)



Contact Information

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