Protecting the Financial Stability of Your Critical Access Hospital

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Agenda

- Current rural health landscape
- Federal and State programs
- CAH requirements and reimbursement
- Changing healthcare landscape
- Increasing financial struggles for CAHs
- Financial indicators
- Strategies for improvement
- Ohio Flex Program support
Rural Health Landscape

IN CRITICAL CONDITION
THE FRAGILE STATE OF CRITICAL ACCESS HOSPITALS
1,332 Critical Access Hospitals (CAHs) provide essential medical care to rural communities across 45 states. Each CAH maintains 25 or fewer beds and directly contributes an average of 204 jobs to the local economy. While their health care services have bolstered rural areas, CAHs are supported by a fragile financial foundation.

BRIDGING GAPS IN ACCESS TO CARE
CAHs’ service to America’s rural communities plays an important role in the nation’s health care landscape.

ANNUAL SERVICES PROVIDED TO PATIENTS
- 8 MILLION patients treated in CAH emergency departments.
- 38 MILLION outpatient visits to CAHs.
- 809,000 patients admitted to CAHs.
- 82,000 babies delivered at CAHs.

1,332 CAH LOCATIONS
19.3% of the U.S. population resides in rural areas, as of the U.S. Census Bureau’s 2010 Census.
Rural Health Landscape

- 30 rural hospitals closures since Jan. 1, 2013
- More closures in 23 months than total between 2003 and 2012 combined
- Some predict closure rate will likely double in 2015
Rural Health Landscape

- Strong fiscal conservative movement in congress
- CMS has competing initiatives for limited funding
- Confusing rural payment system – many see various payment components as “bonuses”
“Doc Fix” or “SGR Fix” bill benefits rural hospitals

- Included provisions from The Rural Hospitals Access Act
  - Medicare/Medicaid Dependent Hospital (MDH) enhanced funding
  - Low Volume Hospital (LVH) enhanced funding
    - Extending funding for 2.5 more years
Federal Program

Medicare Rural Hospital Flexibility Program - (The Flex Program)

Created by Congress in 1997, the Medicare Rural Hospital Flexibility Grant Program (The Flex Program) to assist rural hospitals and improve access through Critical Access Hospital (CAH) designation and offer grants to States to help implement initiatives to strengthen the rural health infrastructure.

The grant program is administered by the Health Resources Service Administration’s Federal Office of Rural Health Policy. HRSA is a division of the U.S. Department of Health and Human Services.
Federal Program

Medicare Rural Hospital Flexibility Program - (The Flex Program)

Focus next 3 year grant cycle:

- Quality Improvement
- Financial and Operational Improvement
- Population Health Management and Emergency Medical Services Integration
- Designation of CAHs in the State
- Integration of innovative Health Care Models
45 states have Flex Programs - States focus on the objectives specific to its needs
Ohio’s objectives include:

- **Program Area 1: Improve the quality of care provided by CAHs**
  - Assist CAHs in implementing quality improvement activities to improve patient outcomes.
  - Assist all CAHs in Ohio to consistently publicly report data on all required measures (MBQIP: HCP/OP-27, HCAHPS, EDTC, OP-1-7, ED through put and patient safety measures).
  - Support for Quality Network/Work Group Quality benchmarking and quality improvement (QI) activities.

- **Program Area 2: Improve financial and operational outcomes of CAHs**
  - Identify financial and operational strengths and challenges and to identify statewide and targeted strategies for improvement.
  - Identify more in-depth financial and operational strengths and problems based on trends or issues identified through assessments and to identify major strategies for improvement for a hospital or cohort of hospitals.

- **Program Area 3: Understand the community health and EMS needs of CAHs**
  - Determine collective issues and trends in population health management for CAHs.
  - Improve local/regional EMS capacity and performance in CAH communities. Improve integration of EMS in local/regional systems of care.
Ohio’s Program objectives over next 3 years:

- Improve financial and operational outcomes of CAHs.
- Provide Ohio CAHs with a structured environment and tools to improve financial and operational performance, exchange best practices and support the sustainability of Ohio CAHs.
- Action plan developed to improve financial and operational functions of Ohio CAHs.
Critical Access Hospitals are required to:

- be located in a **rural area** (or an area treated as rural)
- be **more than 35 miles from another hospital** or be certified before January 1, 2006 as being a necessary provider of health care service.
- provide **24-hour emergency care** services determined necessary by the State
- have a **maximum of 25** acute care and swing beds
- Maintain an annual average length of stay of **96 hours or less** for acute care patients
CAH Reimbursement

CAHs are reimbursed by Medicare for the reasonable cost of providing services. This reimbursement is designed to ensure that rural populations are able to access health care services.

- CAH reimbursement is based on the CAH’s costs and the share of these costs that are allocated to Medicare patients.
- CAHs receive cost based reimbursement for inpatient and outpatient services provided to Medicare patients (and Medicaid patients in some states)
- Cost based reimbursement permits CAHs to be paid 101% of allowable costs on hospital Medicare business.
Changing Healthcare Landscape

Patient Protection and Affordable Care Act (PPACA)

- Will need to transition from volume based reimbursement to value based reimbursement
- Reimbursement drivers are reducing admissions
  - Hospital closures – rural hardest hit
- System consolidation
Changing Healthcare Landscape

What will change:

- Innovative care delivery models
- Efficient, cost effective service
- Realignment of services
  - Many rural hospitals are becoming part of integrated health systems
  - Increased focus on delivery of emergency care and outpatient services
  - Provide primary care and population health management
Increasing Financial Struggles

Factors contributing to the decline in financial performance include:

- Changes in the way hospitals are paid for their services
  - Since April 2013, CAHs are receiving 99% of allowable costs due to sequestration – a 2% across-the-board cut in Medicare provider payment.

- More reliance on governmental programs
- Declining populations in many rural areas
Financial Indicators

The Flex Monitoring Team, a consortium of Rural Health Research Centers, under contract with the Federal Office of Rural Health Policy, is conducting a performance monitoring project for the Flex Program.

- The monitoring project is assessing the impact of the Flex Program on rural hospitals and communities and the role of states in achieving the objectives of the Flex Program.

- CAH Financial Indicators Report
  - Presents state and national median values for twenty-two financial indicators.
  - Distributed to CAH administrators annually.
  - Indicators specifically designed to capture the financial performance of CAHs.

www.flexmonitoring.org
Financial Indicators

Financial indicators, often in the form of ratios, can be used to monitor and determine the financial status of a CAH.

- Profitability indicators
- Liquidity indicators
- Capital structure indicators
- Revenue indicators
- Cost indicators
- Utilization indicators
Financial Indicators

Profitability

- Total Margin
- Cash Flow Margin
- Return on Equity Margin
- Operating Margin

Profitability Indicators Ohio CAHs
Profitability Indicators CAHs Nationwide
Financial Indicators

Liquidity

- Days Cash on Hand
- Days Revenue in AR

Liquidity Ohio CAHs
Liquidity CAHs Nationwide
Financial Indicators

Capital Structure

Equity Financing

Long-term debt to capitalization

Capital Structure Ohio CAHs

Capital Structure CAHs Nationwide
Financial Indicators

The chart illustrates various financial indicators, including:

- **Outpatient Revenue to Total Revenue**
- **Patient Deductions**
- **Medicare IP Payer Mix**
- **Medicare OP Payer Mix**

The chart compares Revenue for Ohio CAHs and CAHs Nationwide.
Financial Indicators

Cost

Cost Ohio CAHs
Cost CAHs Nationwide

Average Age of Plant
FTE per Adj. Occupied Bed

Cost

14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0

Average Age of Plant
FTE per Adj. Occupied Bed
Financial Indicators

Utilization

- Swing SNF Bed Days
- Acute Beds

Utilization Ohio CAHs
Utilization CAHs Nationwide
The 2012 CAH Financial Leadership Summit identified financial interventions that historically have been associated with improved financial performance.

- Cost report review and strategy
- Strategic, financial and operational assessments
- Revenue cycle management
- Physician practice management assessments
- Financial education for CAH department managers
- Financial education for CAH boards
- Developing CFO networks
- Benchmarking financial indicators
The Ohio Flex Program provides support to CAHs through the distribution of grant dollars and services, including support for financial and operational improvement utilizing:

- Assessment tools proven to encourage financial stability
- Financial and operational assessments

In 2012, 2013, and 2014, the Ohio Department of Health, through the Flex Program, offered financial and revenue cycle assessment services to CAHs in Ohio. Services included:

- Medicare Cost Report analysis
- Charge master analysis
- Revenue recovery assessment
- Coding & compliance education
Strategies – Medicare Cost Report Improvements

- Method II billing – an increased payment to a CAH for outpatient hospital based physician services
- Provider based billing –
  - Ohio Medicaid recognizes provider based billing
- Medicare HMO patient days and discharges not included on the cost report
- Capture accurate reimbursement for Meaningful Use EHR incentive payments
- Dual Eligible Medicare Bad Debt reporting
Strategies – Charge Master Analysis

- Implement charge reconciliation process for key departments (ED, OR, etc.)
- Use of technical component Evaluation & Management scorecard
- Resource based charge structures for Surgical Services to differentiate levels of operations provided
  - Staffing, equipment, trays
  - Still time based
- Eliminate use of Miscellaneous Supply code
Strategies – 340B

340B DRUG PRICING PROGRAM

PROTECTING THE SAFETY NET
For more than 20 years, Congress has provided relief from high prescription drug costs through the 340B Drug Pricing Program. The program requires participating pharmaceutical companies to self covered outpatient drugs at a discount to eligible health care organizations. To be eligible, hospitals must serve a disproportionate share of uninsured and low-income patients. This program gives patients better access to drugs they need and helps hospitals enhance care capabilities by stretching scarce federal resources.

Small Program, Big Benefits

2% Portion of the United States’ $325 billion in annual drug purchases made through the 340B program

$3.8 BILLION Total annual savings for 340B eligible providers

340B creates valuable savings on outpatient drug expenditures to reinvest in patient care and health activities to benefit the communities they serve. It also saves money for state and federal governments.

62% Percentage of all uncompensated care provided by 340B hospitals

340B increases access to care for our most vulnerable populations - participating hospitals provided $28.6 billion in uncompensated care in 2013.

Who Are 340B Hospitals?

About half are urban; half are rural.

929 (43.4%) are critical access hospitals (CAHs).

Located in 1,529 or 47% of all U.S. counties.

340B HOSPITALS MEET RIGOROUS REQUIREMENTS

340B ELIGIBILITY
Hospitals must:

- Be designated as a non-profit hospital.
- Be designated as a Children’s Hospital, Cancer Hospital, Rural or Community Hospital, Critical Access Hospital or a Medicare Dependent Hospital.
- Serve a large proportion of uninsured and low-income patients.
- Undergo random audits by the federal government and pharmaceutical manufacturers.
- Recently annually by an eligible 340B provider.

PRESERVE THE 340B PROGRAM; PROTECT THE SAFETY NET

SOURCES: HEALTH RESOURCES AND SERVICES ADMINISTRATION; IMS HEALTH; 2013 AMERICAN HOSPITAL ASSOCIATION ANNUAL SURVEY DATA, APEXUS
Stability may be uncertain, but…

While CAHs face challenges and future stability may be uncertain, targeted strategies and a well developed action plan can help protect the stability.

- Assess
- Monitor
- Educate
- Collaborate
- Innovate
QUESTIONS?

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