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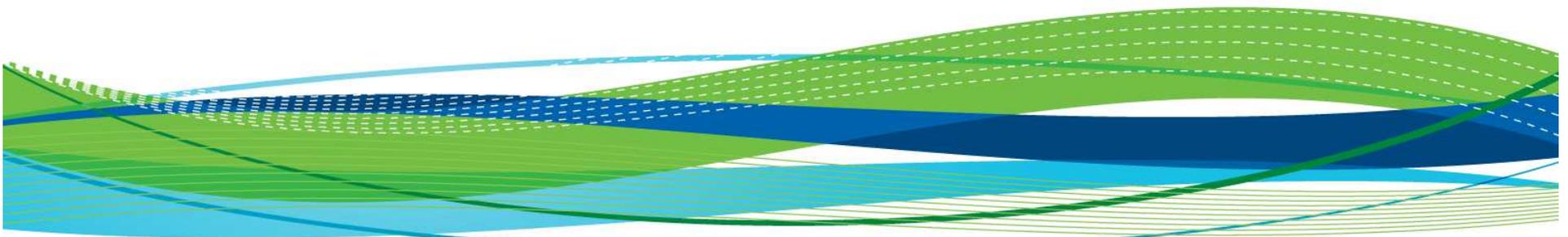
Unit 1: Financing Rural Hospital Operations

The Evolving Rural Hospital

Brock Slabach, MPH, FACHE

Senior Vice President for Member Services

National Rural Health Association

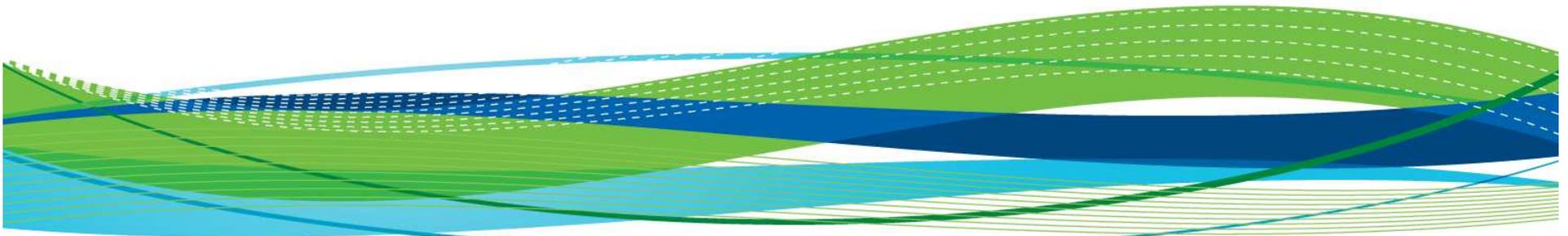




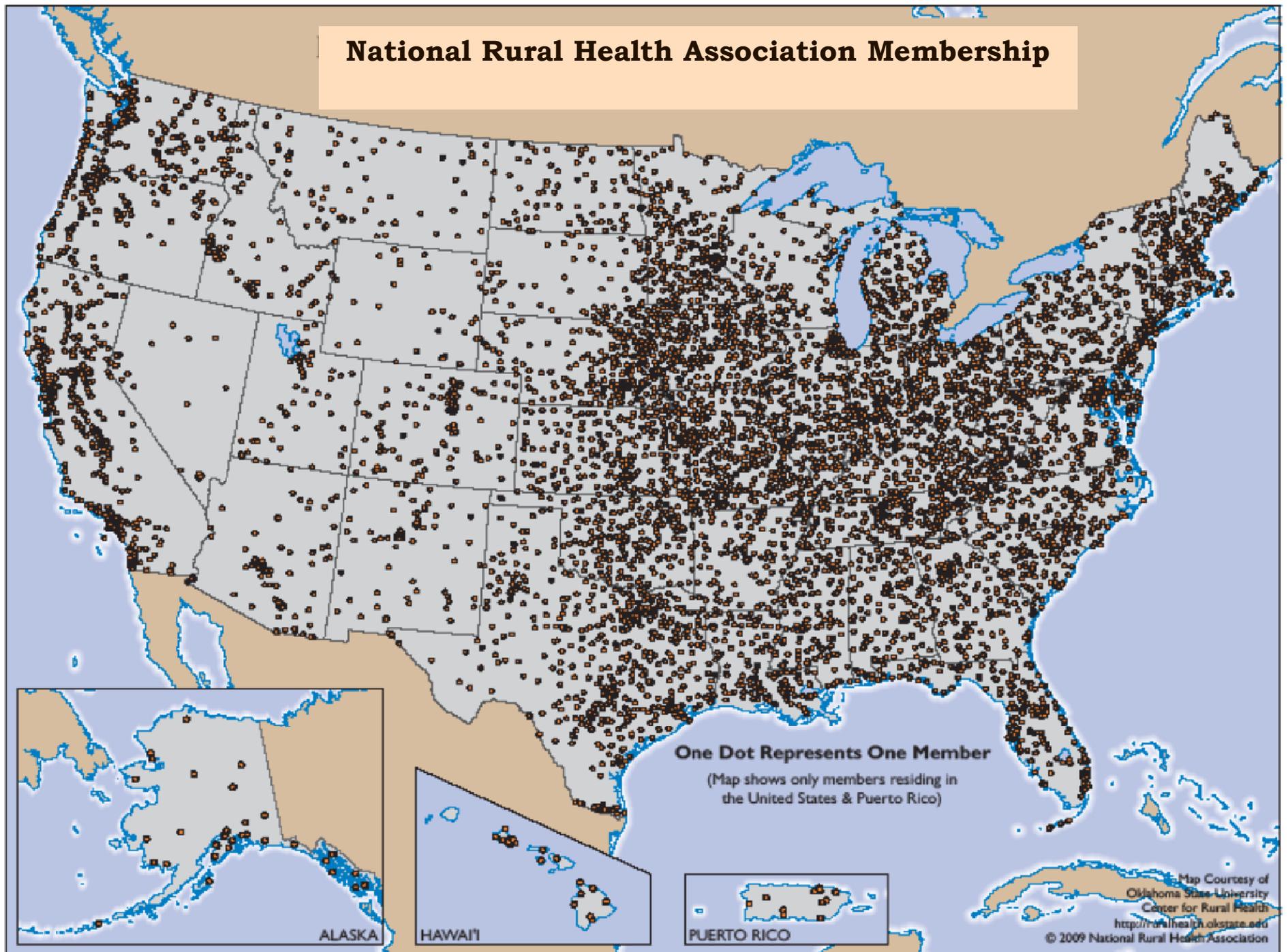
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**Improving the health of the
62 million who call rural
America home.**

**NRHA is non-profit
and non-partisan.**



National Rural Health Association Membership



Map Courtesy of
Oklahoma State University
Center for Rural Health
<http://ruralhealth.okstate.edu>
© 2009 National Rural Health Association

Destination NRHA



Plan now to attend these upcoming events.

Quality Clinical Conference – Jul. 13-15, 2016 • Oakland, CA

RHC/CAH Conference – Sept. 20-23, 2016 • Kansas City, MO

Policy Institute—February 6-9, 2017 • Washington, DC

Annual Conference—May 9-12, 2017 • San Diego, CA

Rural Hospital Innovation Summit—May 9-12, 2017 • San Diego, CA

Visit RuralHealthWeb.org

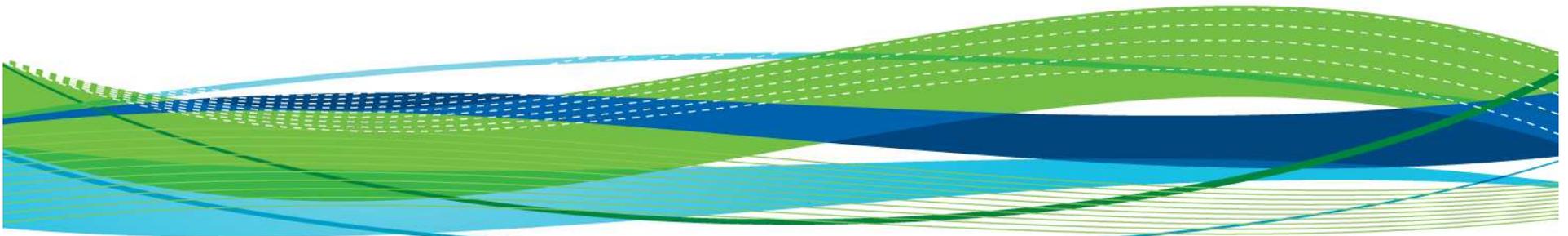
for details and discounts.



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Our Grassroots Effort

- NRHA doesn't have a PAC
- Website: ruralhealthweb.org
- Depends solely on grassroots advocacy
- Members have access to:
 - ✓ Rural Health Network:
[NRHA Connect](#)
- Join NRHA today at ruralhealthweb.org

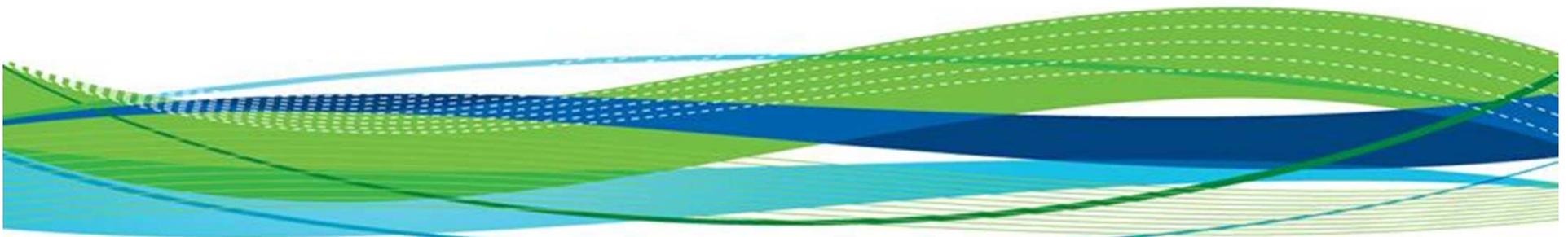


2016 Top 20 CAHs



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- Aspirus Grand View Hospital - Ironwood, Mich.
- Aspirus Medford Hospital & Clinics, Inc. - Medford, Wis.
- Bridgton Hospital - Bridgton, Maine
- Carrington Health - Carrington, N.D.
- Central Montana Medical Center - Lewistown, Mont.
- Floyd Valley Healthcare - Le Mars, Iowa
- Good Samaritan Health Center - Merrill, Wis.
- Livingston Healthcare - Livingston, Mont.
- Margaret Mary Health - Batesville, Ind.
- **Memorial Health Care Systems - Seward, Neb.**
- Ministry Door County Medical Center - Sturgeon Bay, Wis.

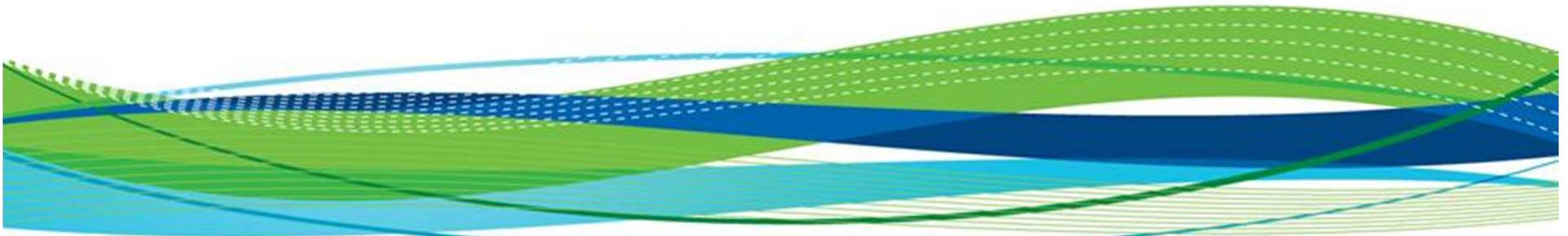


2016 Top 20 CAHs



Your voice. Louder.

- Ministry Door County Medical Center - Sturgeon Bay, Wis.
- Myrtue Medical Center - Harlan, Iowa
- Perry County Memorial Hospital - Perryville, Mo.
- Providence Mount Carmel Hospital - Colville, Wash.
- Sanford Mayville Medical Center - Mayville, N.D.
- Sparrow Clinton Hospital - Saint Johns, Mich.
- Steele Memorial Medical Center - Salmon, Idaho
- Tomah Memorial Hospital - Tomah, Wis.
- Transylvania Regional Hospital, Inc. - Brevard, N.C.
- Winneshiek Medical Center - Decorah, Iowa



Top 20 Best Practice CAH

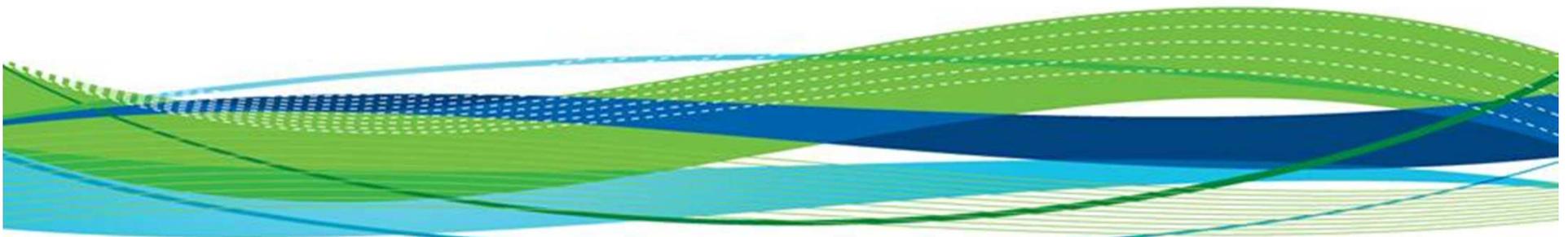


- **QUALITY**

- Memorial Health Care Systems - Seward, Neb.

- **PATIENT SATISFACTION**

- Pawnee County Memorial Hospital - Pawnee City, Neb.

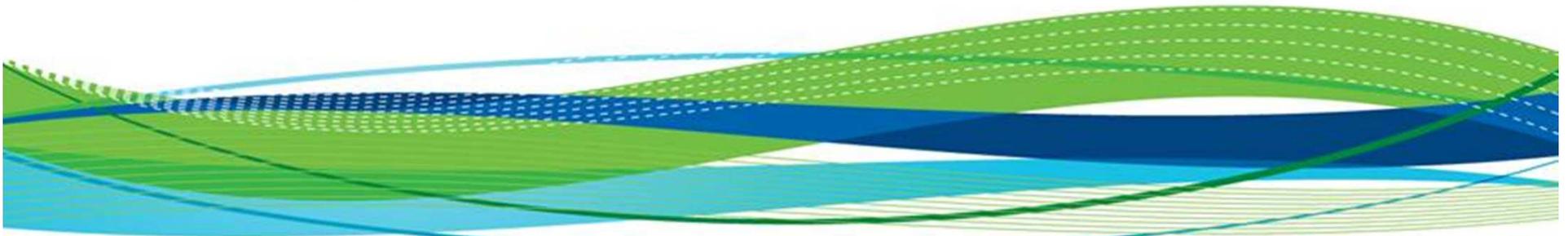


2015 Neb. Top 20 CAHs



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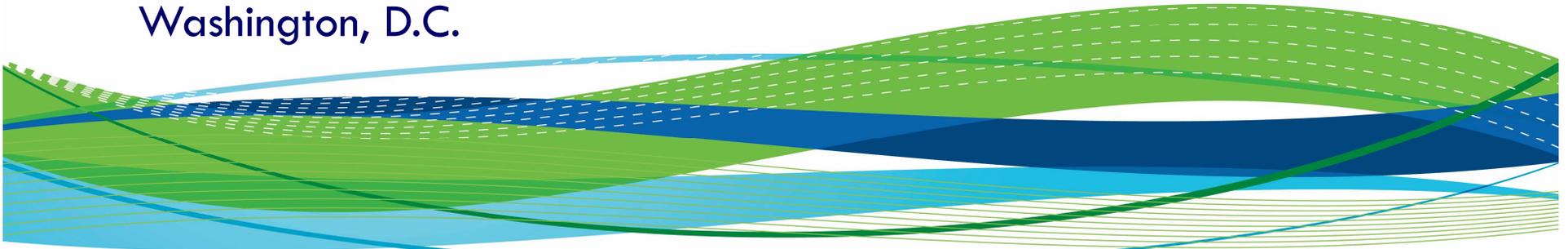
- Overall
 - Cherry County Hospital, Valentine, Neb.
 - Memorial Health Systems, Seward, Neb.
- Quality Best Practice
 - Memorial Healthcare Systems, Seward, Neb.
- Patient Satisfaction Best Practice
 - Pender Community Hospital, Pender, Neb.
 - Regional West Garden City Hospital, Oshkosh, Neb.



Rural Overview



- 62 million patients rely on rural providers.
 - Population challenges
 - Geographic challenges
 - Cultural challenges
- Rural providers face health care delivery challenges like no other provider.
 - Workforce shortages
 - Fiscal constraints
- Rural providers and patients are disproportionately dependent on Federal Government.
 - Medicare, Medicaid
 - Appropriations
 - Regulatory Process
- Now, rural providers face unprecedented challenges from Washington, D.C.

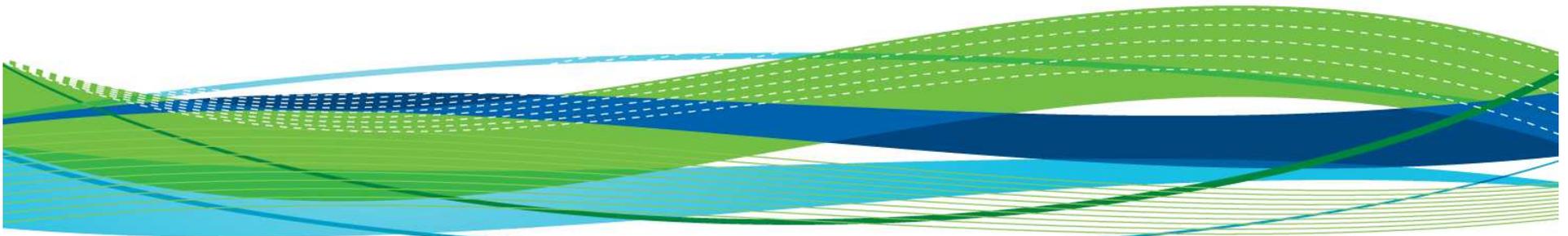


A History (short) of Rural Health

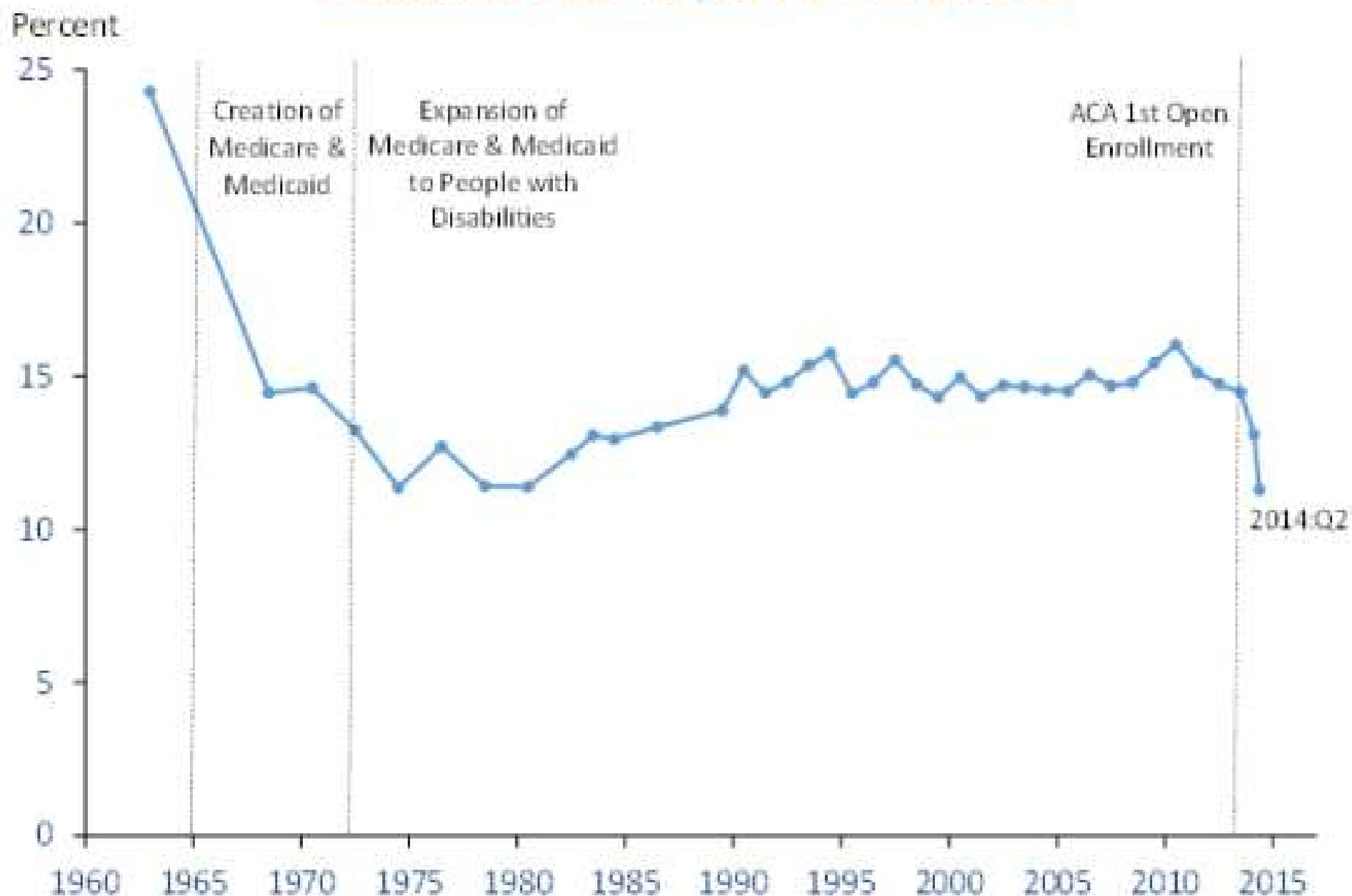


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- War on Poverty in the 60's
- Community Health Centers, created in the War on Poverty
- Rural Health Clinics –38 Years Old (1978), 4,100 nationwide
- Result of PPS 1983: 440 hospital closures
- Policy Response 1992-2003:
 - State Office of Rural Health (SORH)
 - Medicare Dependent Hospitals (MDH)
 - Critical Access Hospital (CAH) 1997
 - Medicare Rural Flexibility Program (1997)
 - Low-Volume Hospital (LVH) Adjustment (2003 and 2010)
- Patient Protection and Affordable Care Act (ACA) 2010
- Medicare Access and Chip Reauthorization Act (MACRA) 2015



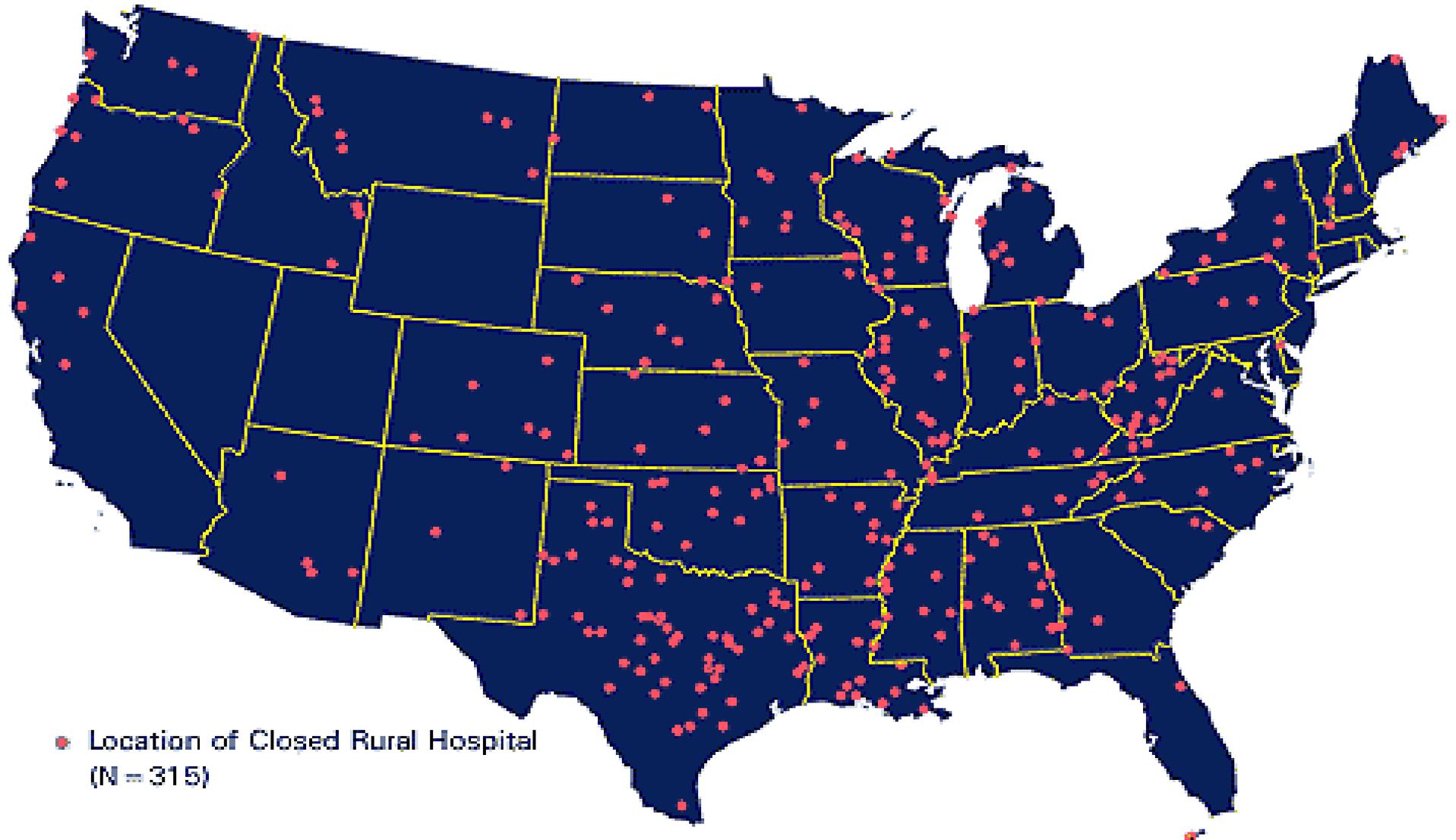
Uninsured Rate, 1963-2014:Q2



Source: NHIS; Cohen et al. (2009); Klemm (2000); CMS (2009); CEA calculations (see appendix).

Note: Data for 2014 are quarterly. Data for earlier years are generally either annual or bi-annual.

Rural Hospital Closures: 1983-97



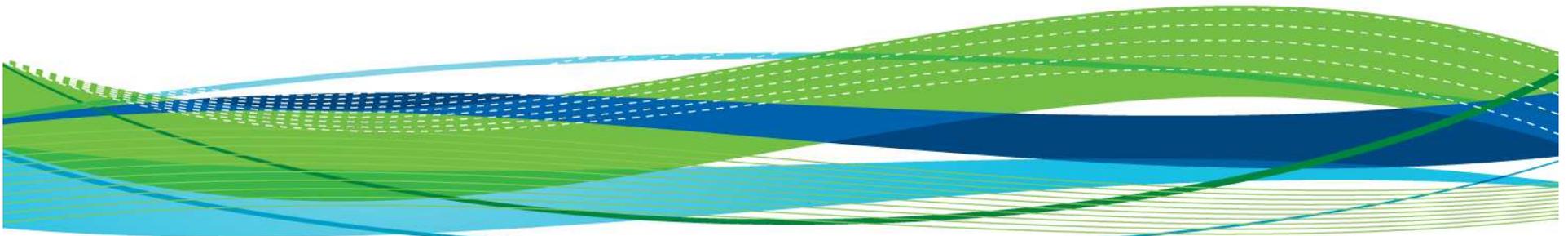
We're not finished yet...



Rural differentiation:

“Rural Americans are ***older, poorer and sicker*** than their urban counterparts... Rural areas have higher rates of poverty, chronic disease, and uninsured and underinsured, and millions of rural Americans have limited access to a primary care provider.” (HHS, 2011)

Disparities are compounded if you are a senior or minority in rural America



We're not finished yet...



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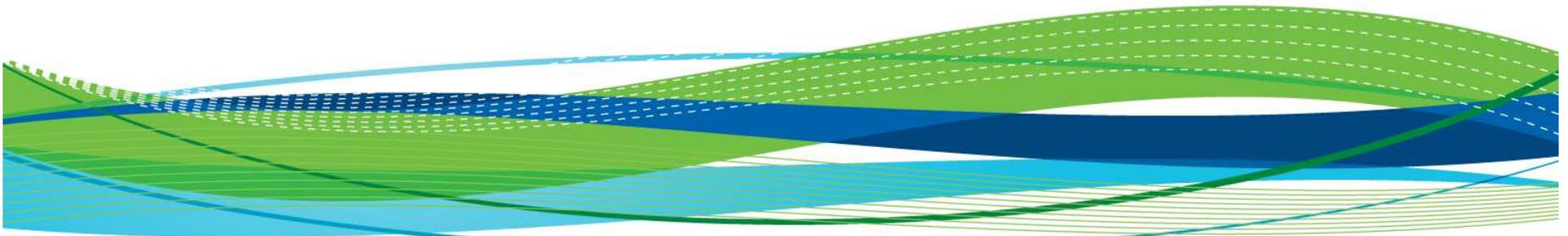
Health Equates to Wealth:

People who live in wealthy areas like San Francisco, Colorado, or the suburbs of Washington, D.C. are likely to be as healthy as their counterparts in Switzerland or Japan, but those who live in Appalachia or the rural South are likely to be as unhealthy as people in Algeria or Bangladesh.

--University of Washington, July, 2013

Rural counties have the highest rates of premature death, lagging far behind other counties, [RWJF Report](#), March, 2016

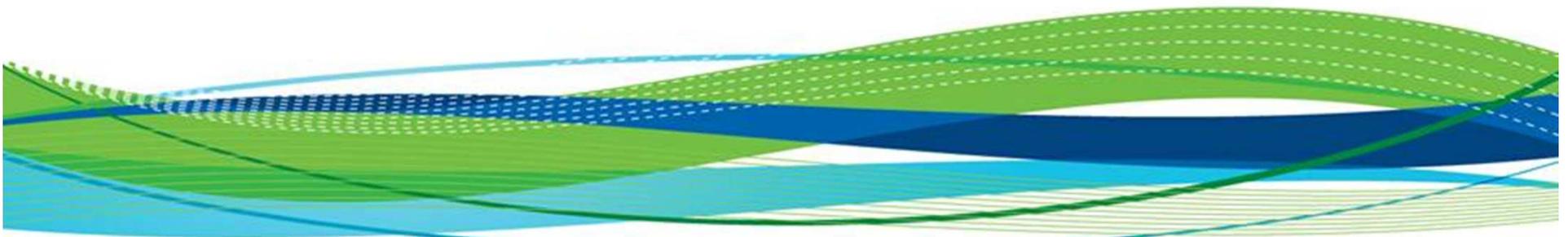
Rural counties have had the highest rates of premature death for many years, lagging far behind other counties. While urban counties continue to show improvement, premature death rates are worsening in rural counties.



Financing Rural Health



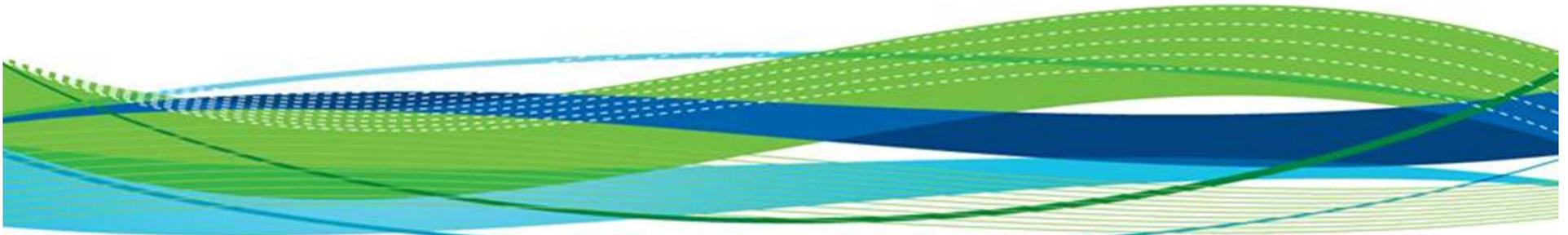
- The Rural Health Players
 - CAH
 - PPS
 - Cost-based Reimbursement
 - Rural Health Clinics
 - Federally Qualified Health Centers



Rural Hospital Overview



- Total Rural Hospitals: 1,855
 - 1,329 Critical Access Hospitals (CAH)
 - 526 Prospective Payment System (PPS) Hospitals (less than 100 staffed beds)
- CAH: Paid on Cost Based Reimbursement (CBR)
- PPS: Paid on a Diagnosis Related Group (DRG), with a prospective rate

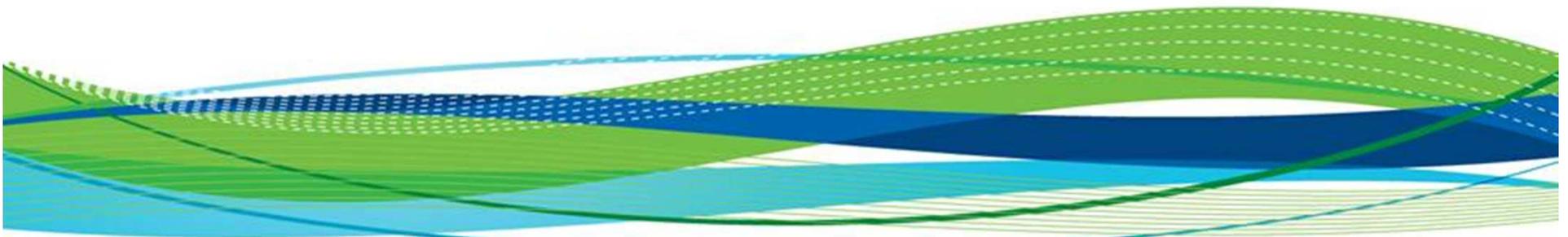




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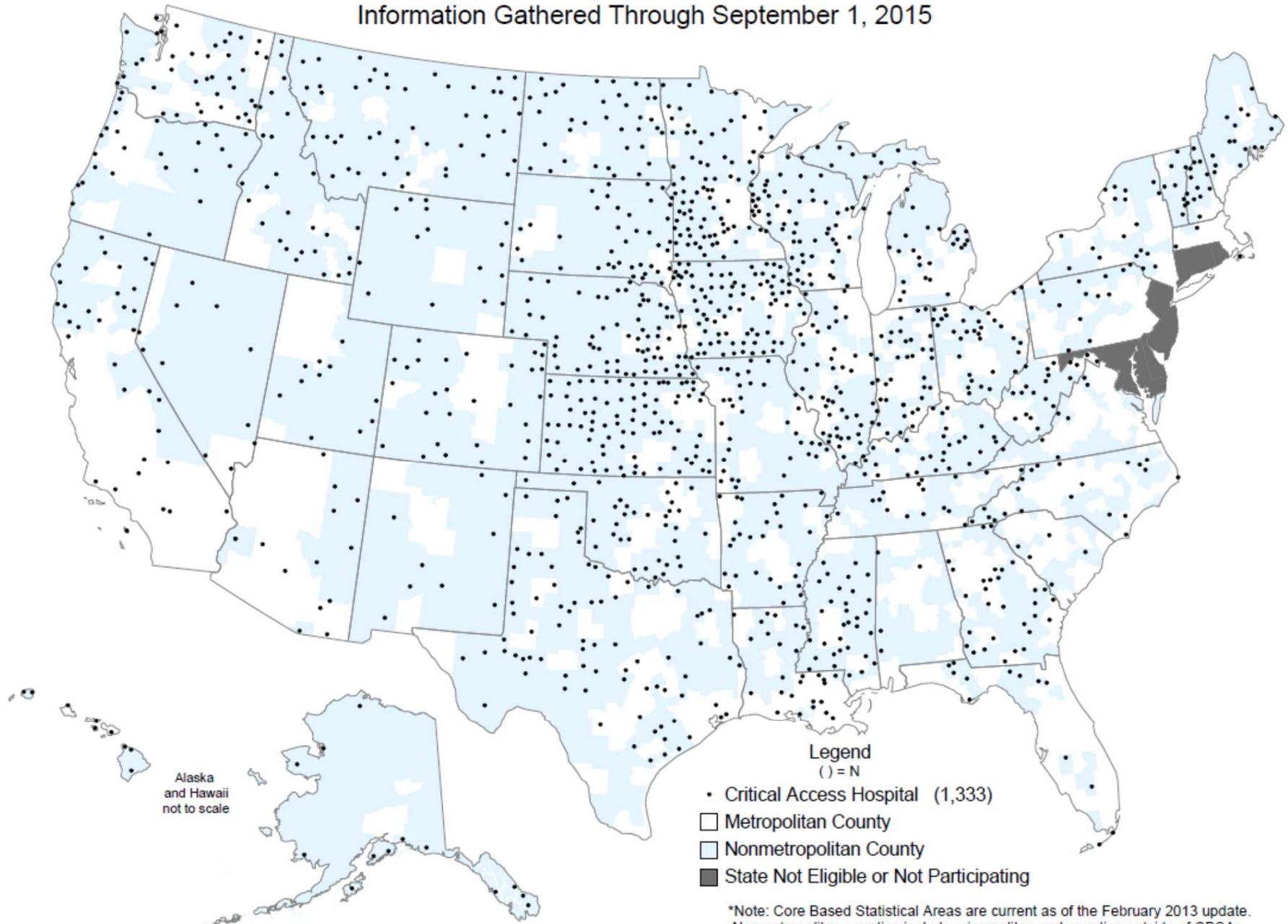
“Even small health care institutions are complex, barely manageable places...large health care organizations may be the most complex organizations in human history.”

~ Peter Drucker



Location of Critical Access Hospitals

Information Gathered Through September 1, 2015



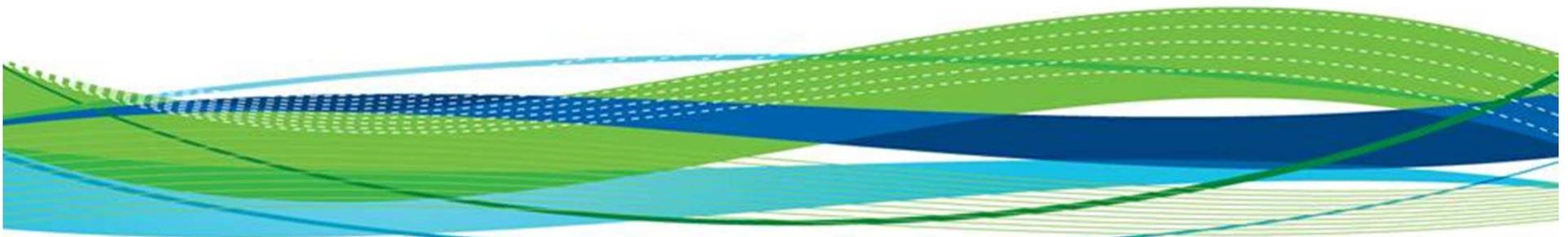
Sources: US Census Bureau, 2013; CMS Regional Office, ORHP, and State Offices Coordinating with MRHFP, 2015.



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Cost-Based Reimbursement

- Reimbursable—Medicare Covers the cost
- Non-Reimbursable—Medicare does NOT cover the cost

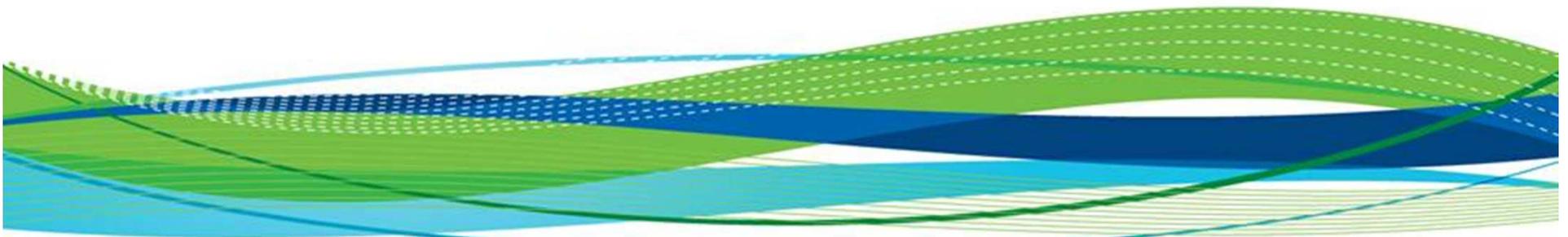




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Medicaid

- Many States Medicaid Programs have recognized CBR and pay their CAH's cost, using the Medicare procedure
- Many, also, have NOT

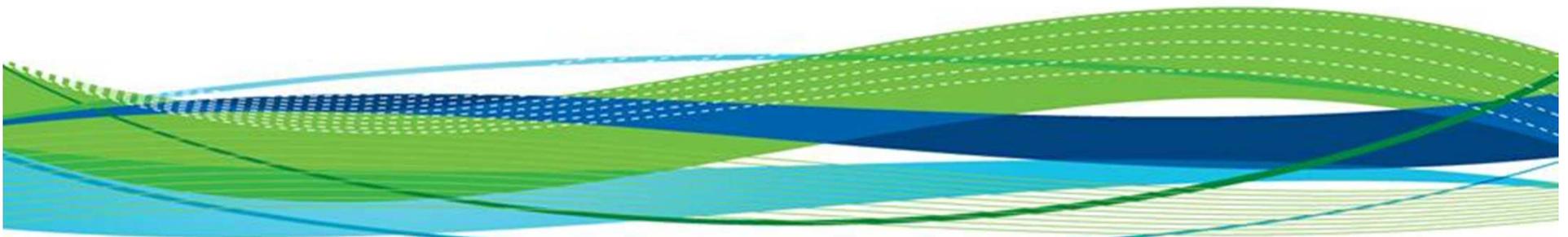




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What CBR Does Not Consider:

- Inpatient Prospective Payment (IPPS)
- Swing Bed Prospective Payment (RUG)
- Outpatient Prospective Payment (APC)
- Outpatient Lab Fee Schedule
- Therapy (Rehab) Fee Schedule

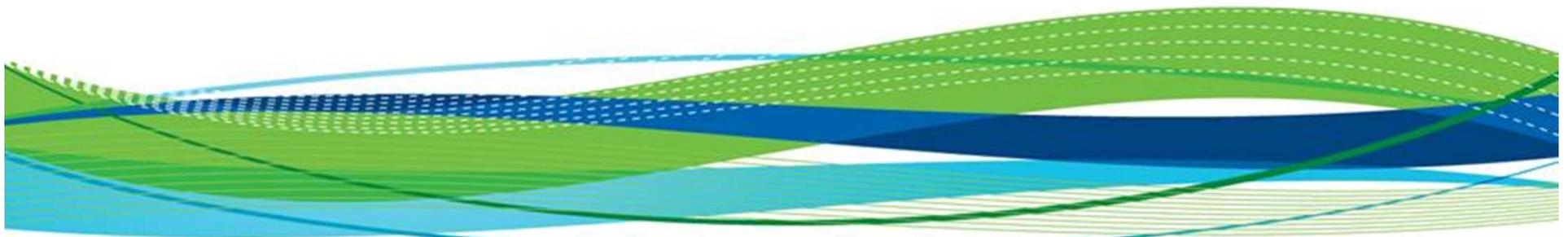




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Reimbursable Examples

- Medical/Surgical
- Operating Room
- Lab
- Radiology
- PT/OT/Speech
- Cardio-Pulmonary Therapy
- Emergency Room
- Pharmacy
- Supplies
- Swing Bed
- Provider-based Clinics



Non-Reimbursable Examples

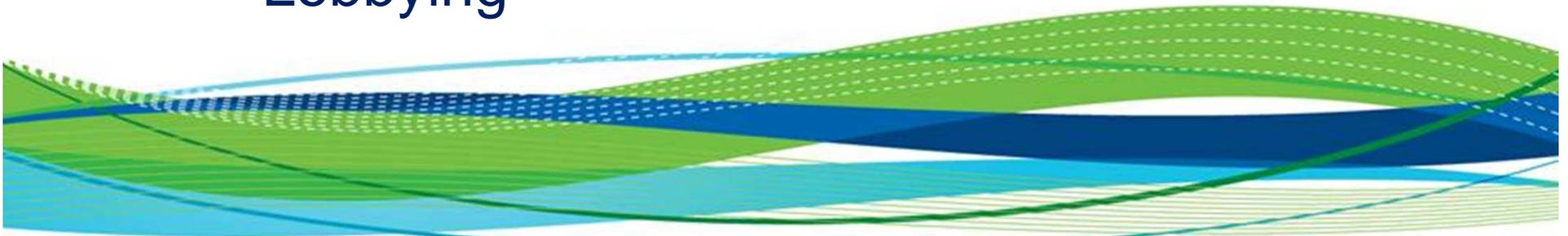


- Home Health
- Hospice
- Skilled Nursing Facility
- Assisted Living
- Meals-on-Wheels
- Day Care
- Non Provider-Based Clinics



Allowable Costs

- Costs are not allowed if they do not relate directly to patient care:
 - Patient Phones
 - Televisions
 - Advertising
 - Physician Recruitment (except RHC)
 - Lobbying

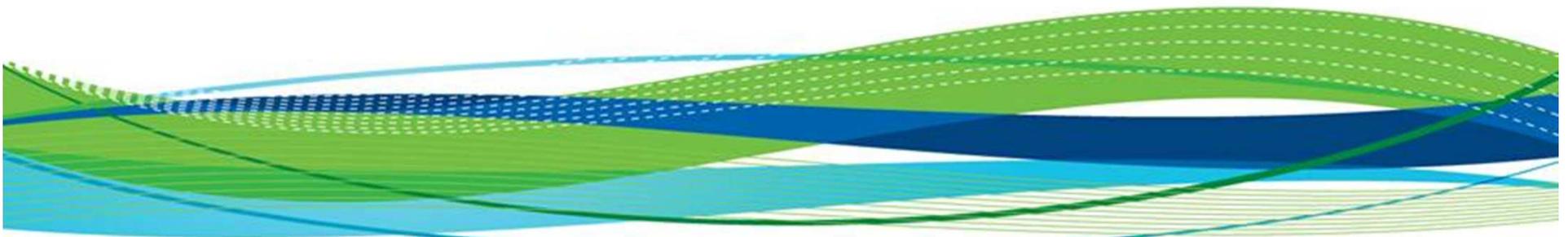




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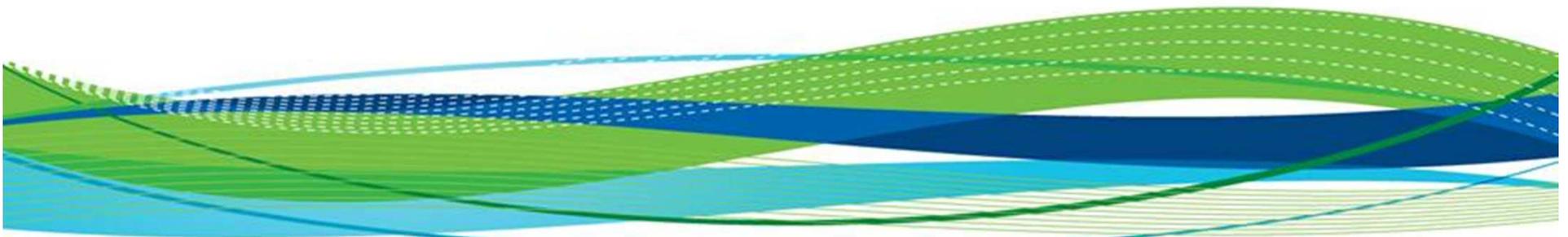
Costs That Exceed Limits

- Contracted
 - Rehabilitation: PT, OT, Speech and Cardio-pulmonary
- Employee or Contract
 - Provider-based physicians
 - Reasonable cost limitations apply



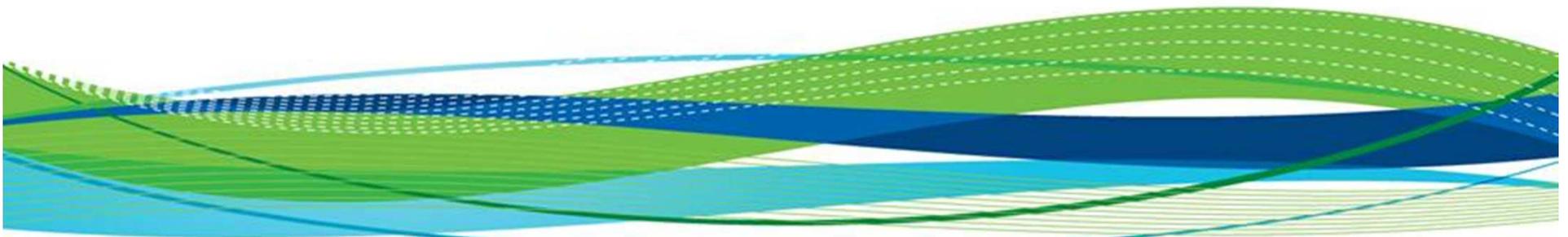
Allowable Costs

- Non-patient revenues Offsets:
 - Cafeteria
 - Medical Record Copies
 - Interest Income



Cost Allocations

- Costs are reimbursed according to percentage of Medicare utilization in each department
 - Direct Costs (salary and supplies)
 - Allocated Costs (Housekeeping, dietary, laundry and A&G)

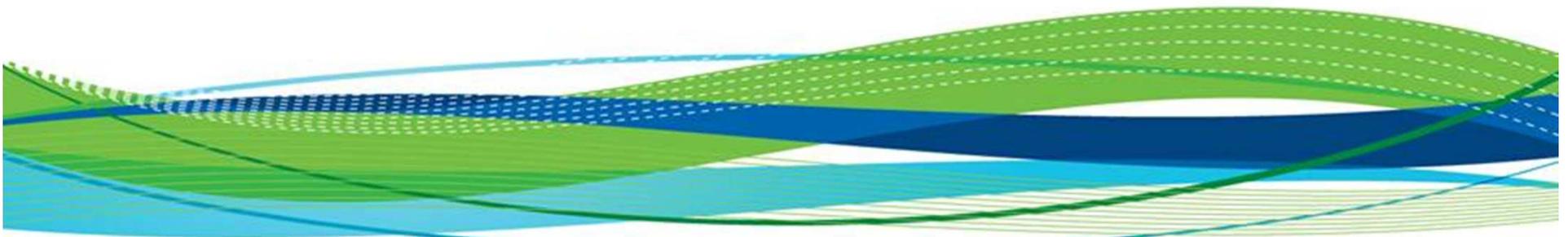




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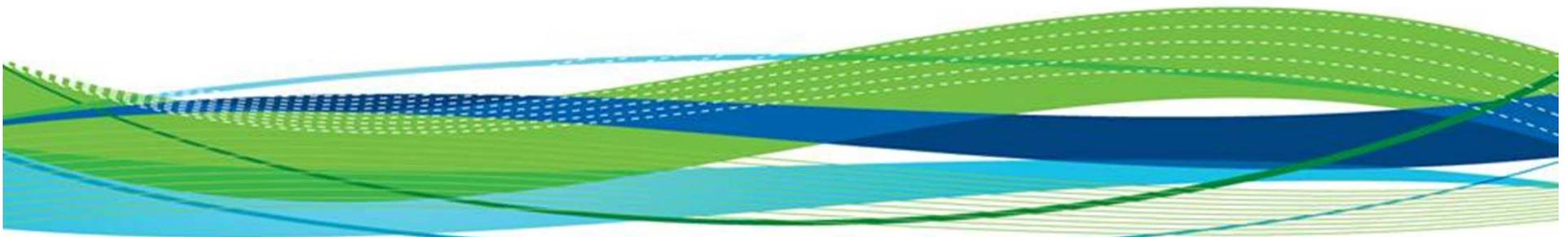
Cost Report

- Costs for Departments use a cost-to-charge ratio
- Routine Med/Surg and Swing Bed are calculated based on cost per day



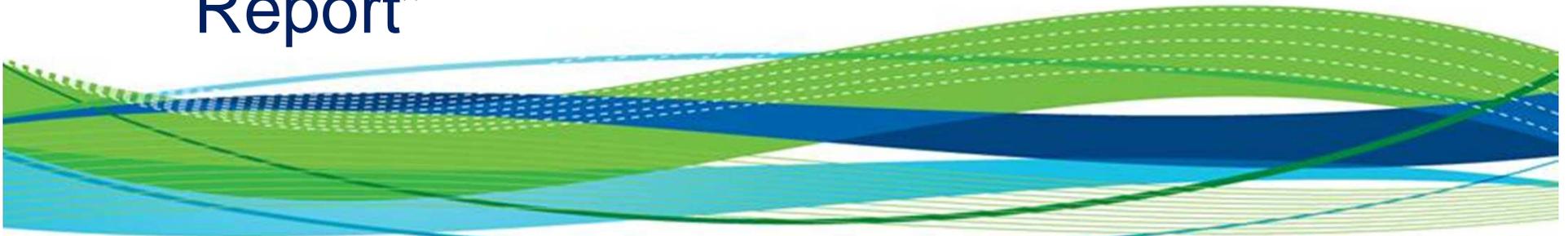
Medicare Pays Cost in Two Ways

- Routine Costs
- Ancillary Costs



Medicare Payments

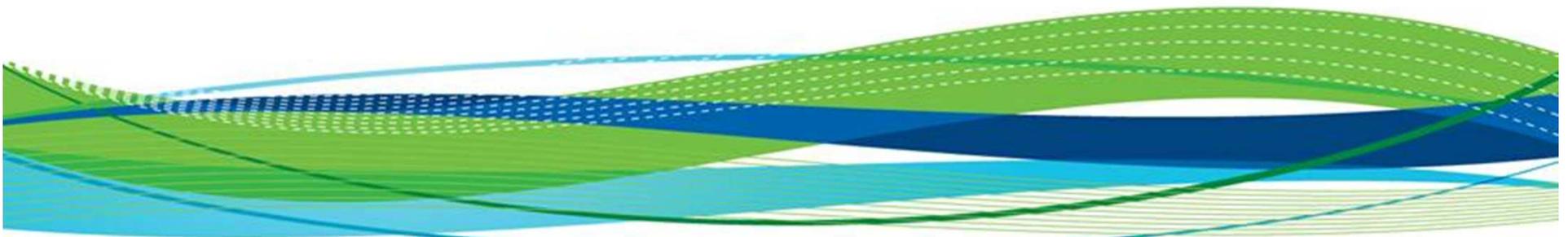
- Interim Payments throughout year called “transmittals”
- Generally a per diem
- Interim rates are based on prior year costs
- Final reconciliation done on “Cost Report”



Examples

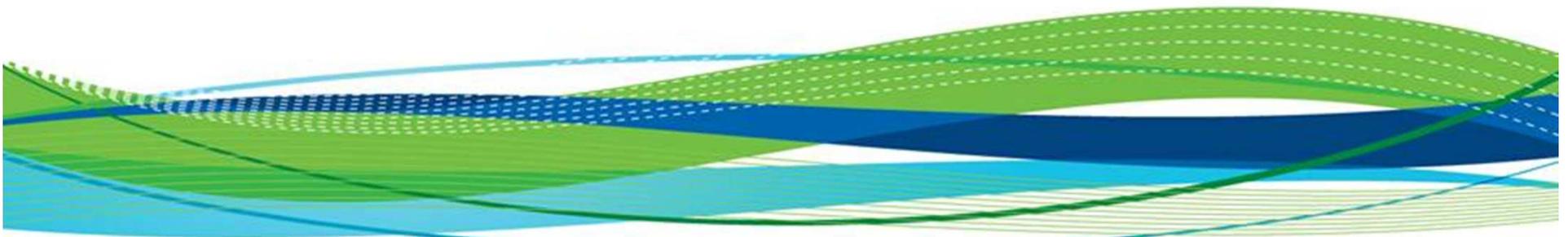


- Medicare Utilization by Department (percentage of total volume):
 - Med/Surg 65%
 - Cardio-pulmonary 92%
 - Emergency Department 22%
 - Radiology 45%
 - Lab 30%



Examples

- Cost-to-Charge Ratios
 - Lab 18%
 - Radiology 35%

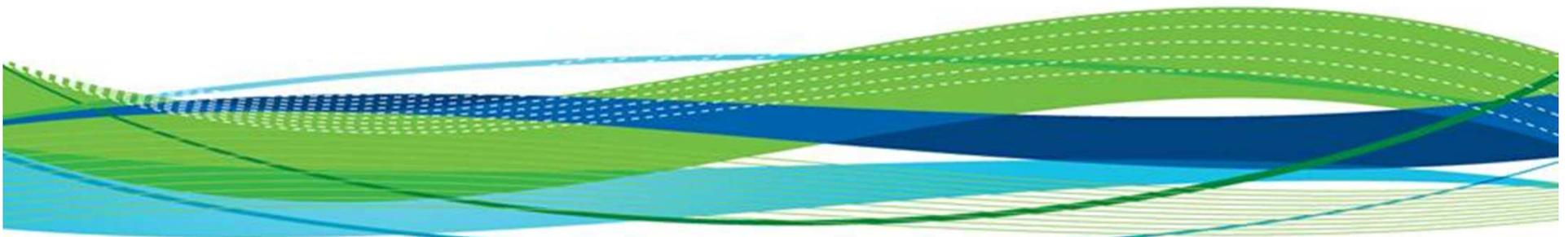




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Routine Costs

- Total med/surg costs = \$2,000,000
- Total Patient Days = 2,000
- Per Day “routine” costs are \$1,000
- If there were 1,500 Medicare patient days, how much would Medicare pay?

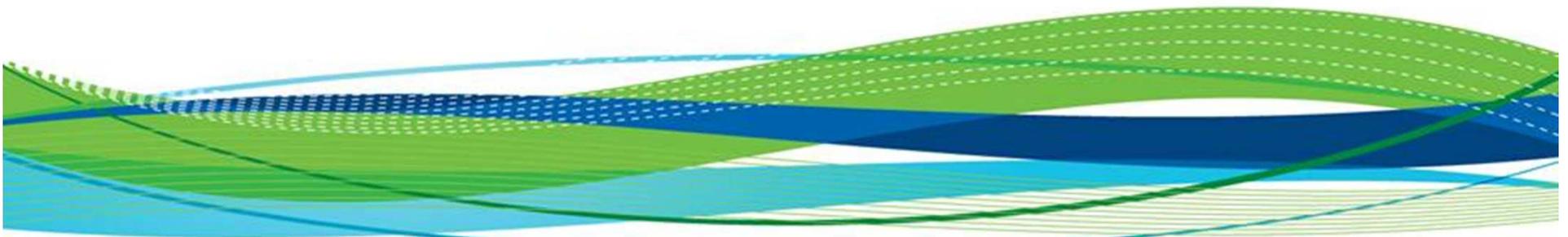




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Ancillary Costs

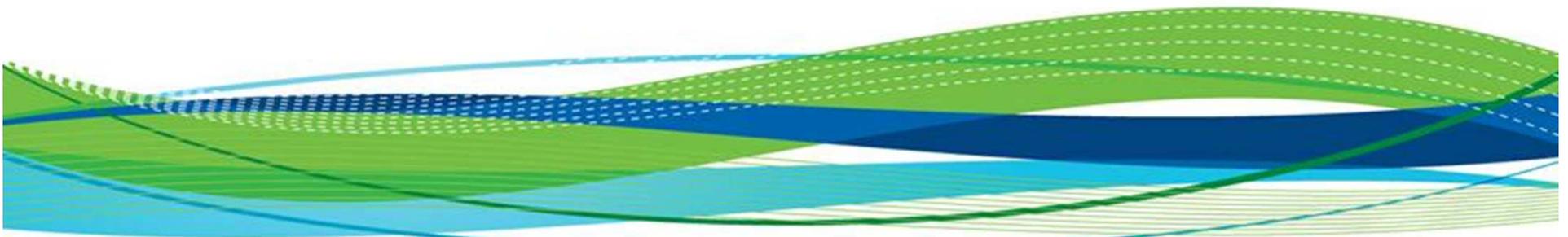
- If Radiology Total Charges = \$500,000
- Total Department Cost = \$250,000
- Cost-to-Charge Ratio = 50%
- Radiology Medicare Charges = \$300,000
- What is the Medicare Payment?



Factors that Impact Year-End Settlement



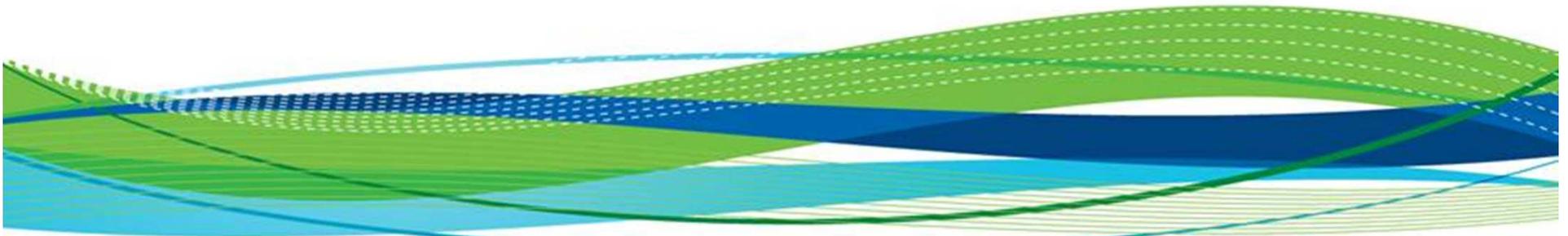
- Volume
- Medicare Utilization
- Changes in Charges
- Changes in Expenses



Alice in Wonderland: CBR Realities



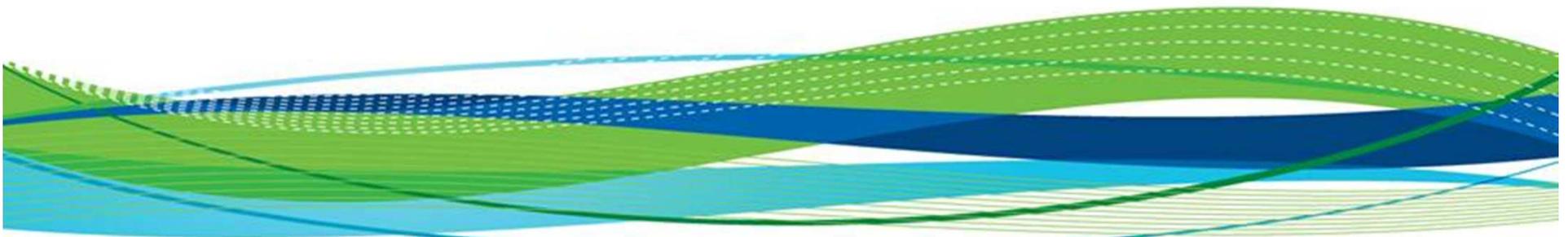
- Decreasing expenses (i.e., layoffs) may reduce Medicare reimbursement
- New Services (i.e., RHC's) may reduce A&G allocation to other hospital departments
- Year-end “surprise” of a cost report Overpayment or Underpayment (just like an IRS tax return)



Alice in Wonderland: CBR Realities



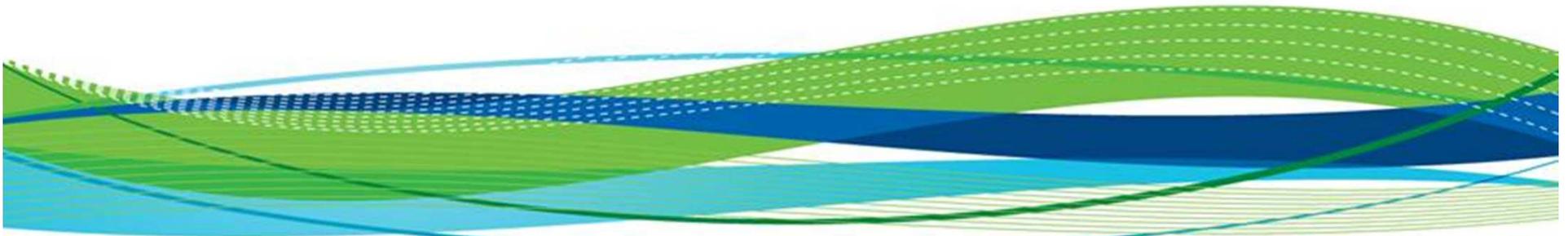
- Allocation of A&G to non-reimbursable services: Nursing Homes, Hospice, Clinics, Assisted Living



Annual Planning



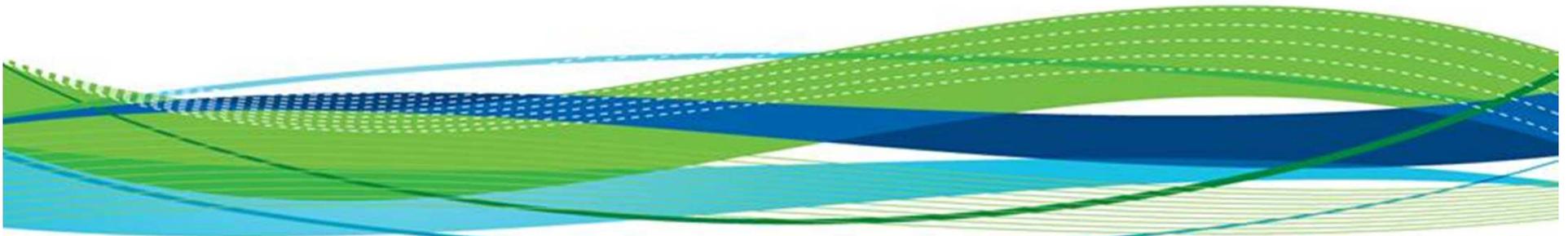
- Medicare Conditions of Participation (COP) Require:
 - An Annual Operating Budget
 - Capital Expenditure Plan (3 years)
 - Identify specific expenditures
 - Note anticipated Sources of Financing



Capital Reimbursement



- Cost-based
- Based upon Depreciation Method and anticipated useful life (AHA Guide)
- Financing Expenses are reimbursable (unless there is “funded depreciation” to cover the purchase)

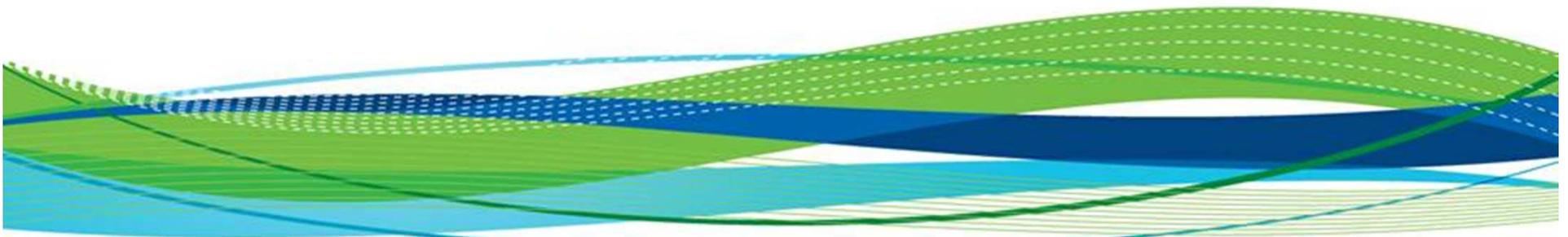


CAH Summary



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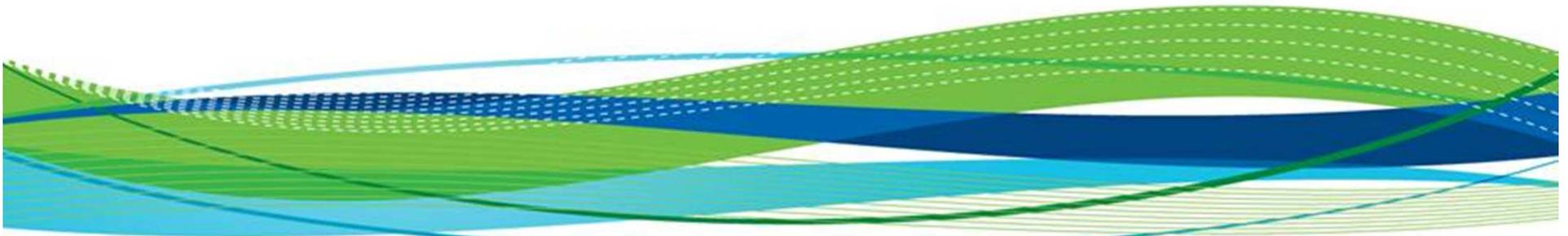
- Just because a hospital converts to CAH does NOT mean its financial challenges are over
- CBR removes the effect of volume on reimbursement
- CAH Administrators still must diligently manage operations



PPS Hospitals



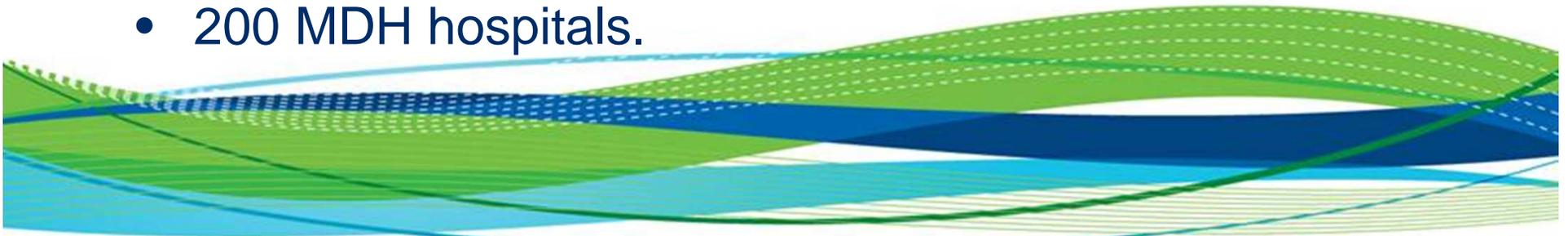
- Paid on Diagnosis Related Groups (DRGs), prospectively set rate
- Sole Community Hospital
- Medicare Dependent Hospital
- Low-Volume Hospital Adjustment



Medicare Dependent Hospital



- Established in 1990 to support small rural hospitals who treat significant Medicare patients. To qualify as a MDH, a hospital must be
 - located in a rural area,
 - have no more than 100 beds, and
 - demonstrate that Medicare patients constitute at least 60 percent of its inpatient days or discharges.
- The Congressional Budget Office scored the one year extension in the ACA as costing less than
- Cost: \$100 million over 10 years.
- 200 MDH hospitals.



States with Most MDH Facilities



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Tennessee: 24

Texas: 19

Illinois: 13

Mississippi: 13

Pennsylvania: 13

Kentucky: 11

New York: 11

North Carolina: 11

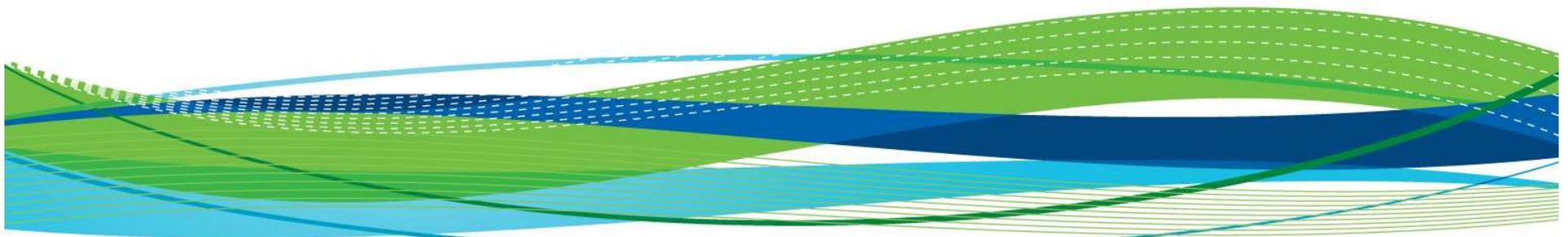
Louisiana: 10

Alabama: 8

Missouri: 8

Virginia: 8

Oklahoma: 8



MDH



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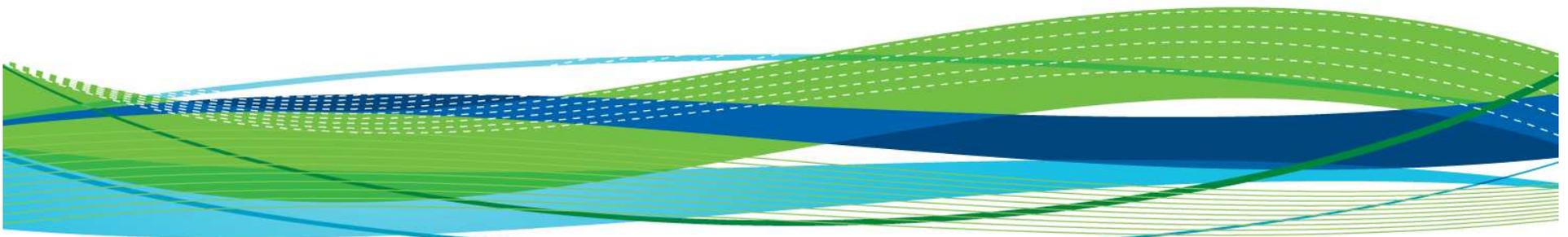
Medicare Dependent Hospitals

[Study](#) by North Carolina Rural Health Research and Policy Analysis Center on the economic benefits of rural MDH facilities.

[List](#) of All Medicare Dependent Hospitals in the United States.

[Map](#) of all Medicare Dependent Hospitals State by State.

Expires Oct. 1, 2017

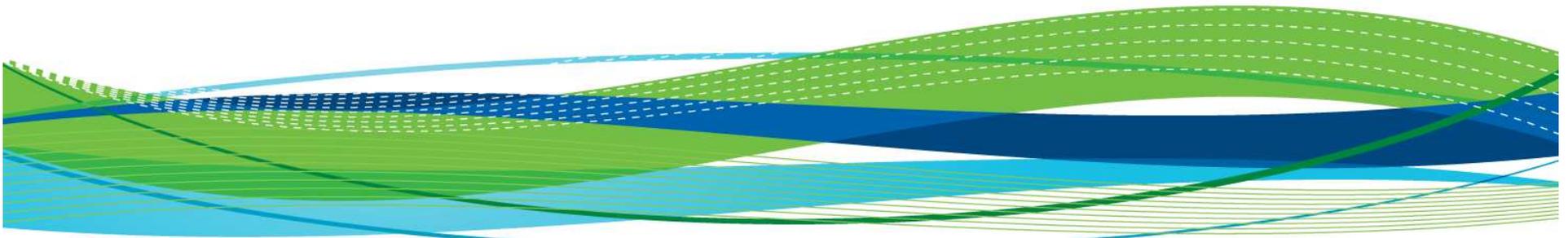


Low-Volume Adjustment



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- [Fact Sheet](#) - find out why Low-Volume hospitals are important
- Expires Oct. 1, 2017



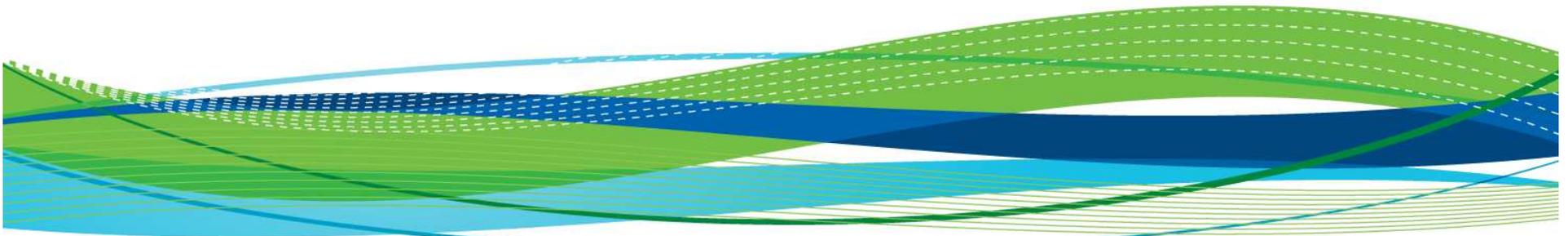
Rural Health Clinics (RHC)



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Two types (4,100 nationwide):

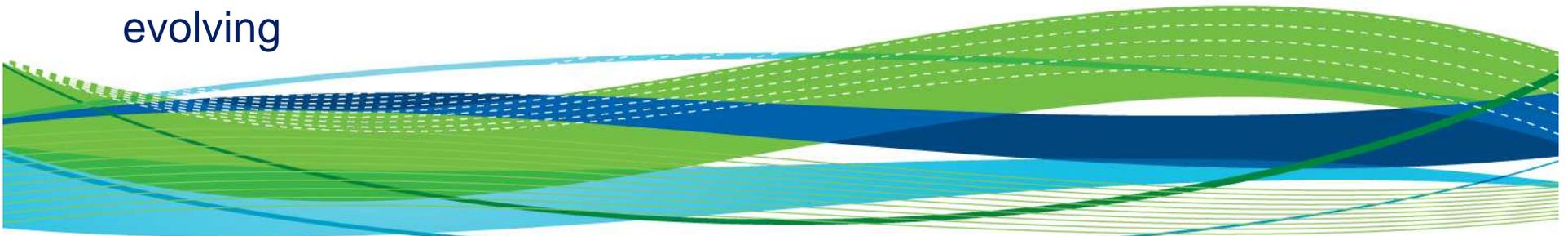
- Freestanding
- Provider-based (PB)
- Both types are cost-based reimbursed
- Freestanding subject to “upper payment limit” (UPL)
- UPL for calendar 2016 is \$81.32 per visit
- PB RHCs are owned and operated as a department of the hospital, no UPL
- Both RHC types must complete a cost-report at fiscal year end
- RHCs must follow Conditions of Participation set forth by CMS
- Major difference: RHC submit claims to Medicare Part A on a UB-04. HCPCS codes required on April 1, 2016



Federally Qualified Health Centers (FQHC)



- FQHCs are HRSA grantees under section 330B of US Code
- FQHCs must
 - Be operated by a community board made up of at least 51% users of the clinic
 - The community board is independent and can not be owned or operated by a third party
 - Operate a sliding scale fee schedule based on the patient's ability to pay
- FQHCs are paid based on the lesser of charges or the PPS rate which is \$160.60 per visit for 2016 (subject to Geographic Adjustment Factor)
- Approximately 1,500 FQHC grantees nationwide with over 5,000 sites. One-half of FQHCs are required by law to be in a rural area
- FQHCs and rural hospitals are often at odds, although this is evolving

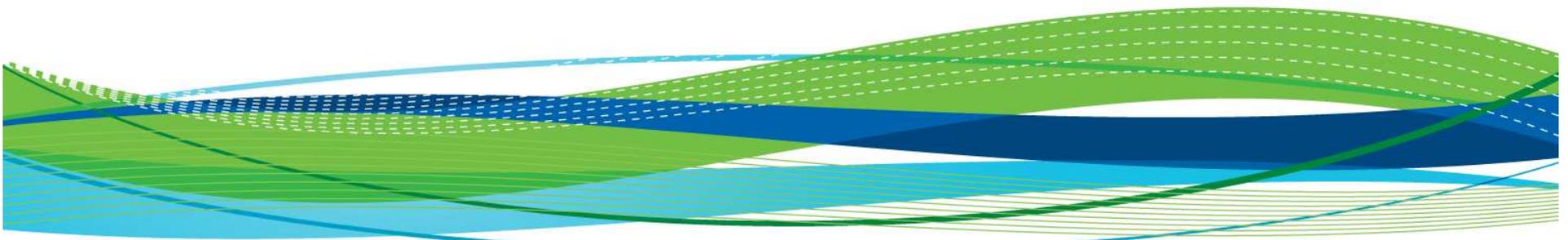


Summary



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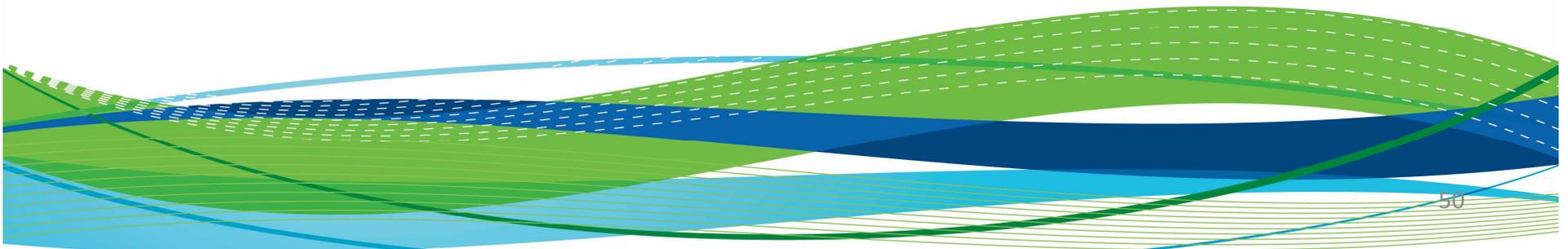
- CAH
- PPS
 - MDH
 - LVH
 - SCH
- RHC
- FQHC





Operations

CHARTING A NEW COURSE



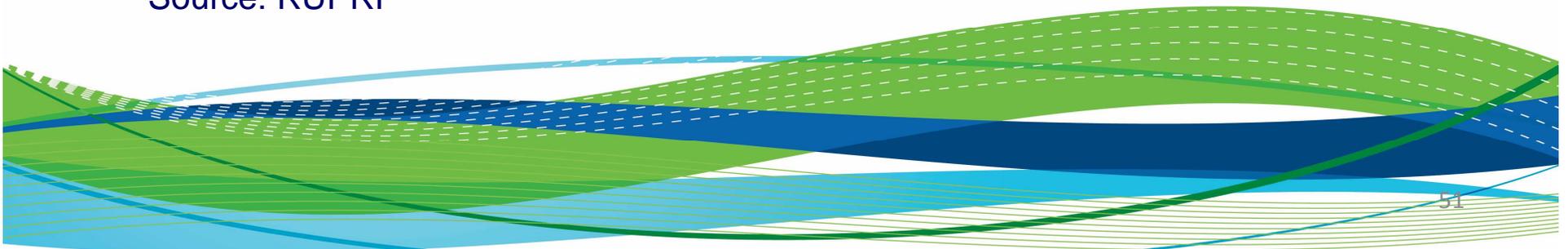
Opportunities for Rural Hospitals



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- Optimize fee-for-service (transition)
- Attend to performance and innovation
- Drive in efficiency
- Drive out variation
- Develop medical homes (Pop Health)
- Engage the medical staff

Source: RUPRI



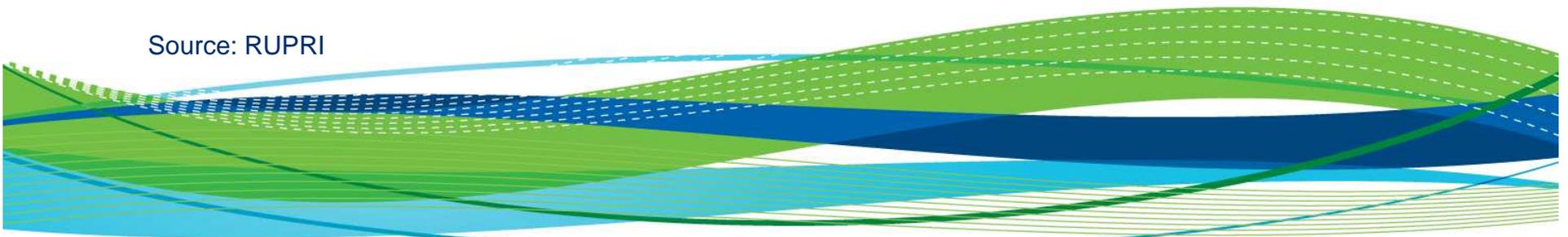
Rural Hospital Tool Box Continued



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- Develop Patient Centered Medical Homes...(DSR)
- Get Paid for Quality/Value...(PR)
- Coordinate Care
- Establish a Referral Network
- Engage Your Community
- Consider Regionalization

Source: RUPRI

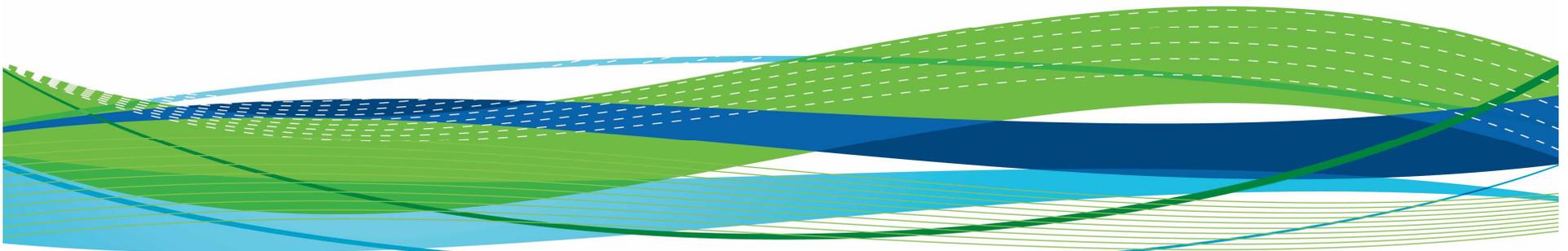


Optimize Fee for Service

- Market share
- Revenue cycle
- Payer contracts
- Group purchasing
- Inventory
- Appropriate utilization



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Performance and Innovation



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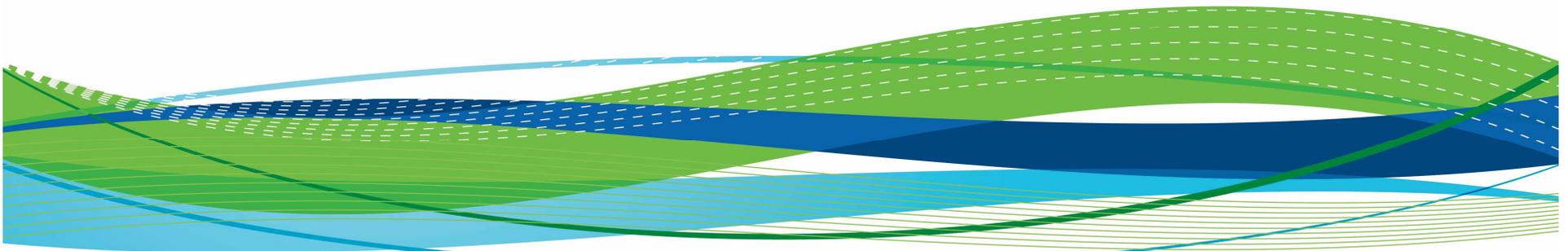
- Telehealth
 - Tele-emergency [surveyor guidelines](#)
 - Expanded services in [PFS 2015](#)
- Expand primary-care
- Consolidations and affiliations
- Community health needs assessment
- Health risk assessments
- EHR optimization
- Value-based assessment in CAHs
- Bundled Payments
- ACOs



Your voice. Louder.

Focus on Efficiency

- Eliminate waste (lean)
- Flatten organizational structure
- Aggressively review “bricks and mortar” budgets

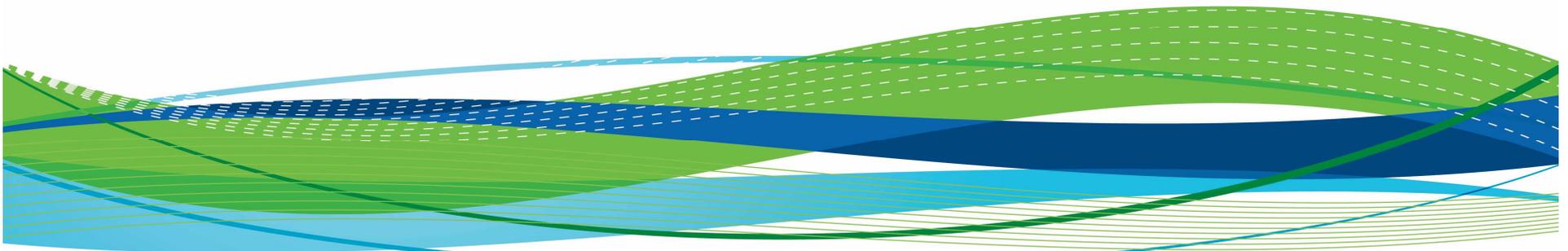




Your voice. Louder.

Eliminate Variation

- Evidenced-based practice
- Care should vary by unique patient needs
- Care should not vary by
 - Doctor or nurse
 - Day of week or time of day
- Different than “cookbook” medicine
 - Document rationale for deviation from best-practice

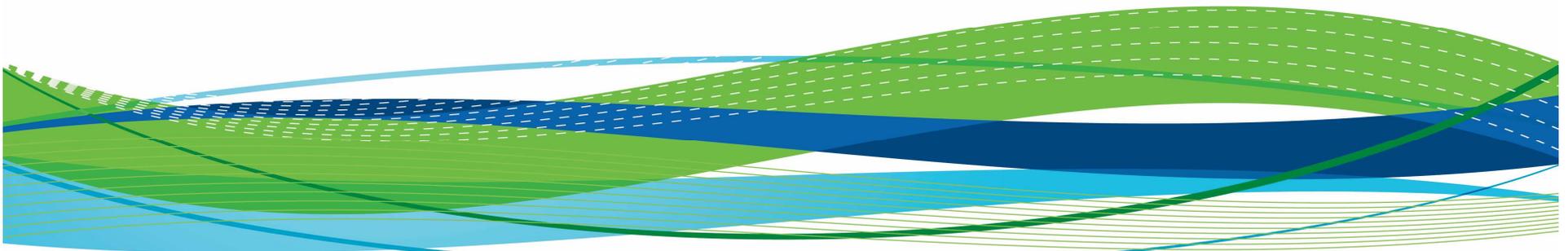




Your voice. Louder.

Population Health

- Patient-centered medical homes (PCMH)
- Decision support
- Mapping
- Interventions: population as patient

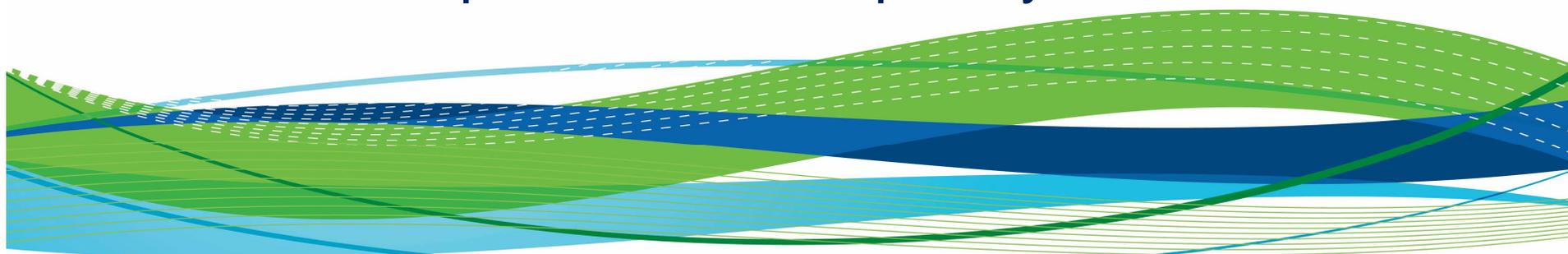


Engage the Medical Staff



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- Suggestions:
 - Invest in leadership training
 - Provide data transparency, including physician specific performance
 - Comprehensive pay packages
 - Involve at every level of organizational leadership
 - Recognize and reward accomplishment...frequently





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Questions?

THANK YOU

Brock Slabach

Senior Vice President

National Rural Health Association

bslabach@nrharural.org

