Rural Health Care Policy & Reform
Finance and Utilization Trends
Trends in Net Patient Revenues & Total Expenses (All Hospitals) 2008-2017
Trends in Iowa Hospitals Margins
2007-2017
Distribution of Iowa CAH Hospital Revenue

2011
- Inpatient: 24%
- Outpatient: 76%

2017
- Inpatient: 17%
- Outpatient: 83%
Trends in Iowa CAH Admissions
2008-2017

Admissions

2008 63,591
2009 60,252
2010 54,482
2011 53,714
2012 50,805
2013 48,057
2014 45,915
2015 46,801
2016 44,040
2017 42,065
Distribution of Iowa CAH Hospital Revenue by Payer

Payer mix remains relatively steady, as IP volumes decline

2011

- Medicare: 47%
- Medicaid: 21%
- Self Pay: 17%
- Wellmark: 5%
- Other: 10%

2018

- Medicare: 45%
- Medicaid: 23%
- Self Pay: 14%
- Wellmark: 4%
- Other: 14%

Medicaid ↑ 4%
# Iowa CAH Financial Benchmarks vs. National CAH Benchmarks (2016)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Iowa</th>
<th>U.S.</th>
<th>Favorable/Unfavorable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Ratio</td>
<td>2.74</td>
<td>2.48</td>
<td>Favorable</td>
</tr>
<tr>
<td>Cash Flow Margin</td>
<td>9.69</td>
<td>6.99</td>
<td>Favorable</td>
</tr>
<tr>
<td>Return on Equity</td>
<td>6.33</td>
<td>5.32</td>
<td>Favorable</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>147.71</td>
<td>77.72</td>
<td>Favorable</td>
</tr>
<tr>
<td>Net Days Revenue in A/R</td>
<td>52.79</td>
<td>51.34</td>
<td>Slight Unfavorable</td>
</tr>
<tr>
<td>Debt Service Coverage</td>
<td>3.19</td>
<td>3.35</td>
<td>Slight Unfavorable</td>
</tr>
<tr>
<td>Medicare Revenue per Day</td>
<td>2,682</td>
<td>2,592</td>
<td>Favorable</td>
</tr>
<tr>
<td>Salaries to Net Patient Revenue</td>
<td>42.50</td>
<td>44.90</td>
<td>Favorable</td>
</tr>
<tr>
<td>Average Age of Plant</td>
<td>10.28</td>
<td>10.48</td>
<td>Favorable</td>
</tr>
<tr>
<td>FTEs per Adjusted Occupied Bed</td>
<td>5.37</td>
<td>5.61</td>
<td>Favorable</td>
</tr>
</tbody>
</table>
Distribution of Iowa PPS Hospital Revenue

2011

- Inpatient: 48%
- Outpatient: 52%

2017

- Inpatient: 52%
- Outpatient: 48%
Trends in Iowa Rural/Rural Referral Admissions 2008-2018
Distribution of Iowa PPS Hospital Revenue by Payer

**July 2010- June 2011**
- Medicare: 17%
- Medicaid: 47%
- Self Pay: 21%
- Wellmark: 5%
- Other: 10%

**July 2017-June 2018**
- Medicare: 16%
- Medicaid: 42%
- Self Pay: 22%
- Wellmark: 3%
- Other: 17%

Medicaid ↑ 7%
State Environment

• MCO model likely affirmed by election.
• Continued legislator interest in IHA Third Way.
• Opportunities within current structure to improve payment.
Federal Environment
Senate Finance Committee Hearing

“Rural Health Care in America: Challenges and Opportunities”

May 24, 2018

Objectives:

• Highlight the unique challenges rural and frontier providers face in delivering high quality health care services in isolated communities

• Understand the data-driven trends in rural research today

• Identify targeted legislative solutions that the Committee may want to explore in the future.
Recent Activity

• Council on Representation & Advocacy
  – September Breakout Session to identify key issues

• Sen. Grassley’s Health Policy Staff
  – Dr. Karen Summar presented at All District Meeting

• *Seeking additional input on rural policy options.*
CMS Rural Strategy

• New Goals:
  – Apply a rural lens to CMS programs and policies
  – Improve access to care through provider engagement and support
  – Advance telehealth and telemedicine
  – Empower patients in rural communities to make decisions about their health care
  – Leverage partnerships to achieve the goals of the CMS Rural Health Strategy
Opportunities
Medicaid Opportunities

• Restore Retroactive Enrollment  
  – Eliminated in 2017  
  – Est. cost to restore: $3 million  

• Restore Critical Access Hospital Cost-Based Reimbursement  
  – Develop a “Cost Adjustment Factor” methodology that can be paid through MCOs  
  – Est. cost to restore: $4 million  

• Improve Reimbursement Policy for Emergency Room Services  
  – Work with state to develop effective strategies to reduce unnecessary ED usage.  

• Work with LTSS Advocates on strategies to impact ER use/Population Health for Medicaid  

* UIHC does not participate in the assessment
Medicare Opportunities

• Rural health policy package in 2019
• What should it look like?
IHA Rural Health Care Innovation Taskforce

• Establish an IHA Board-appointed taskforce
• Hold 4 meetings in 1\textsuperscript{st} quarter 2019
  – Topics and Goals:
    • Review Evolving Rural/CAH Payment and Delivery System Models and Evaluate Potential Applications in Iowa
    • Discuss Rural PPS payment programs and potential modifications/recommendations
    • Gain insight into ongoing innovation efforts among Iowa’s large PPS hospitals/systems (ACOs, etc.)
    • Generate a report to be shared with Iowa’s Congressional Delegation
## Rural PPS – Medicare Payment Designations

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Low-Volume 'Tweener'</th>
<th>Rural Hospital Demonstration</th>
<th>Medicare Dependent Hospital</th>
<th>Sole Community Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Rural PPS too large for CAH status, but too small to absorb PPS financial risk</td>
<td>Inpatient cost-based reimbursement (51 acute beds, ER, not eligible for CAH)</td>
<td>&lt; 100 beds; at least 60% of inpatient discharges are Medicare</td>
<td>Higher payments based on distance with potential adjustments for volume decreases</td>
</tr>
<tr>
<td>St. Anthony Regional Hospital</td>
<td>Demo →</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Skiff Medical Center</td>
<td>Demo →</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>Lakes Regional Health Care</td>
<td>Demo →</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>Grinnell Regional Medical</td>
<td>Demo →</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>UnityPoint Health - Keokuk Area Hospital</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>UnityPoint Health - Trinity Muscatine</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>Spencer Hospital</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>Fort Madison Community Hospital</td>
<td>✓</td>
<td>-</td>
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</tr>
</tbody>
</table>

| Estimated Annual Payments                    | $ 4 Million          | $ 11 Million                | $5 Million                  | $ 2 Million              |
| Expires                                      | 10/1/2019            | 10/1/2022                   | 10/1/2022                   | n/a                     |
CAH Transformation

• Develop a “rural-appropriate” payment system that facilitates participation in value-based payments.
  – “Renovate” cost-based payment methodology to fit with new VBP programs

• Lead discussions on policies like the “REACH” Act that would allow rural hospitals to transition to new designations designed to meet modern needs.
PPS Policy Themes

• Regulatory Relief
  – Site-neutral payment changes
  – Burdensome CoPs (State/Joint Commission)

• Medicaid VBP

• Affordability/Value

• Innovation and Transformation
340B – Prescription Drug Discount Program

• 98 Iowa Hospitals Participate
  – PPS 17  CAH 81

• Potential for additional efforts to:
  – Further regulate the program
  – Require transparency from hospitals
  – Scale back benefit of program
Private/Commercial
• Wellmark presented to IHA Board Retreat on moving to CPI-based payment updates.
• Has resulted in hospital reimbursement declining as CPI has been low
• IHA will facilitating meeting January 29th with Wellmark/CFOs
Questions/Discussion

IHA Advocacy Focus Areas for 2019 and beyond...