



Maui Health Care Initiative Task Force

Critical Access Hospital Program Overview

October 2007

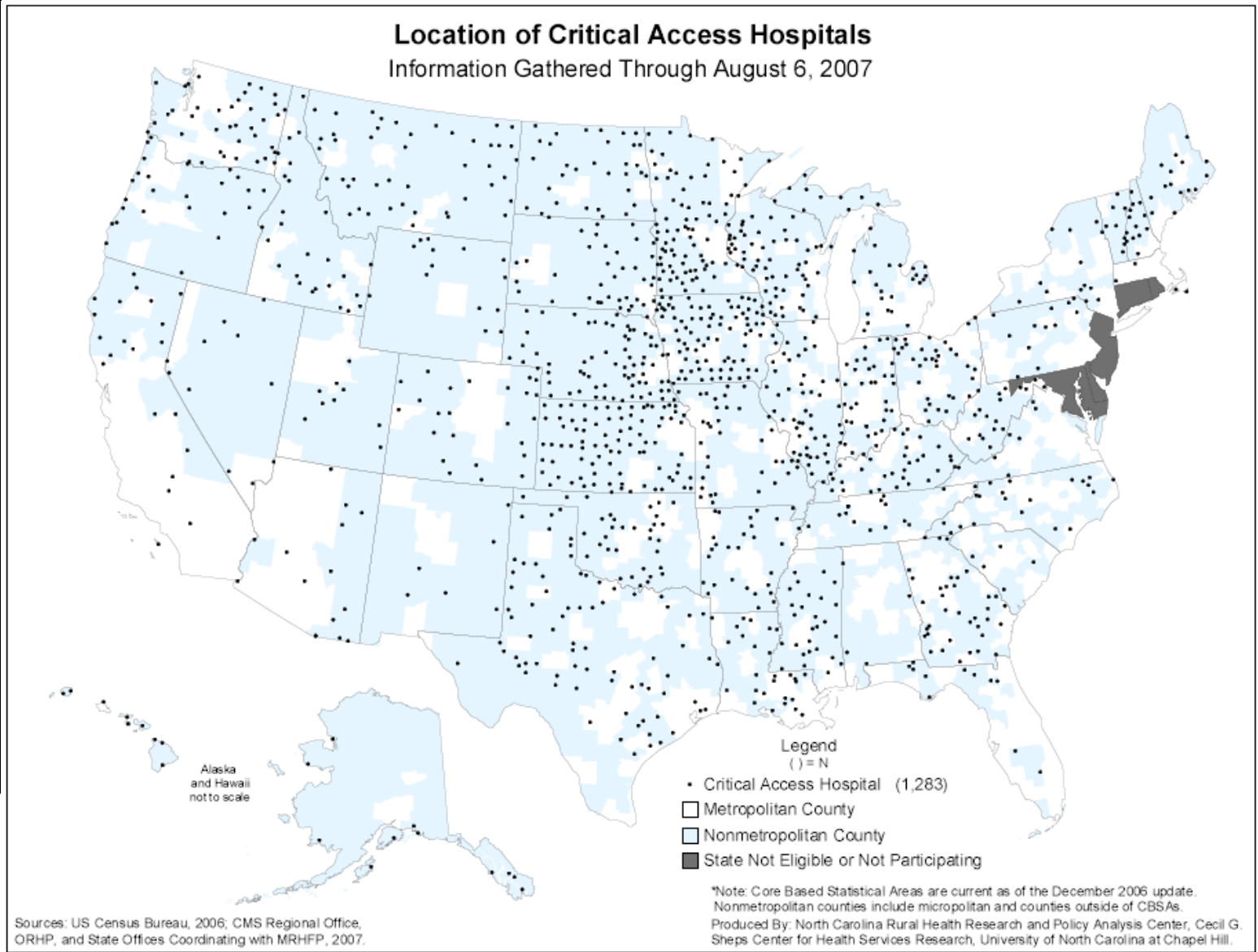
Presented by
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Stroudwater Associates

Stroudwater Associates

- National health care consulting firm
 - Total of 24 consultants with offices in Portland ME, Atlanta GA, and Phoenix AZ
 - 8 consultants with focus on small and rural hospitals
 - Rural consultants include physician, nurses, MBAs, CPA, and MHSA
- Lead consulting firm working with Hawaii Department of Health's Office of Rural Health
 - Project began May 2001
 - Have worked with every CAH in Hawaii
 - In Maui County – Kula Hospital, Molokai General Hospital, and Lanai Community Hospital
- Active in working with CAHs planning and developing new facilities
- Worked with Department of Housing and Urban Development (HUD) to facilitate access to capital for CAHs via "Section 242" loan guarantees
- Lead consulting firm in the Mississippi Rural Hospital Performance Improvement Program
- State and National presentations regarding Rural Hospital Performance Improvement, CAH Replacement Study and Master Facility Planning, CAH Feasibility, Balanced Scorecard, and Rural Quality Improvement

Critical Access Hospital Program

- CAH Program
- Hawaii Realities
- Maui Opportunity
- Discussion



CAH Program Overview

- Hospital providers are challenged to maintain access to high quality medical care while facing cuts in Medicare reimbursements.
- One true benefit to small, rural hospitals derived from the Balanced Budget Act (BBA) was the establishment of the Medicare Rural Hospital Flexibility Program (MRHFP).
- A feature of the MRHFP was the creation of the CAH – a hospital that is eligible for generally more favorable, cost-based Medicare reimbursement.
- Historically, to qualify for cost-based Medicare reimbursement, CAH status required that a hospital be classified as rural, have a bed limit of 25, with no more than 15 acute patients at one time and an average length of stay of less than 96 hours.

CAH Program Overview (cont.)

- The Balanced Budget Refinement Act (BBRA) was passed in 1999 and the Medicare Benefits Improvement and Protection Act (BIPA) was passed in 2000
 - BBRA and BIPA increased the benefit of the CAH program by making the rules less clinically restrictive and expanding the definition of costs that are considered allowable.
- The Medicare Modernization Act (MMA) was passed in November 2003. CAH Improvements include:
 - *101% of Costs – 1/1/04*
 - *Up to 25 Acute Beds – 1/1/04*
 - *Up to 10-Bed psych and/or rehab unit – 10/1/04*
 - *On-Call cost reimbursement for PAs, NPs, and Clinical Nurse Specialists – 1/1/05*
 - *CAHs able to receive PIPs – 7/1/04*
 - ***Necessary Provider status eliminated after 1/1/06***

CAH Designation

- Prior hospital status (non-profit, public, or for-profit)
- Location in a rural area defined as:
 - Outside MSA, or within a rural census tract if in MSA
 - Not classified as an urban hospital by HCFA or Medicare Geographic Classification Review Board
 - Located more than 35 miles, or 15 miles in mountainous terrain or secondary roads, from a hospital or another CAH unless certified by the State as a necessary provider
 - Necessary Provider option sunset on December 31, 2005
 - 9/7/07 change in CAH Interpretive Guidelines tightening definition of primary roads
 - In general, Primary Road must be Federal Highway or State Highway with 4 lanes to meet new definition
- Makes available 24 hour emergency care “determined by the State as adequate” to ensure access to emergency services

CAH Designation (continued)

- Network agreement with referral hospital
- Has no more than 25 total beds, including swing beds, with acute beds historically limited to 15 at any given time, now 25 (MMA)
 - Swing Beds may be used for patients who have had acute stays of 3 days or longer
- Average annual acute LOS may not exceed 96 hours

CAH Reimbursement

- Payment for Medicare inpatient and Part "A" outpatient services on the basis of "reasonable cost"
 - Does not consider:
 - Inpatient perspective payment (DRGs)
 - Swing bed perspective payment (RUGs)
 - Outpatient perspective payment (APCs)
 - Lessor of Cost or Charges (LCC)
 - Reasonable Compensation Equivalents limits (RCE)
 - Therapy (Physical, Occupational, Speech) fee schedule
 - Outpatient lab fee schedule

- Many States have extended CAH reimbursement rules to their Medicaid programs
 - Hawaii State Medicaid program pays CAHs based on costs

- Many Medicare Advantage Plans pay CAHs based on costs
 - HMSA 65C+ pays costs based on costs

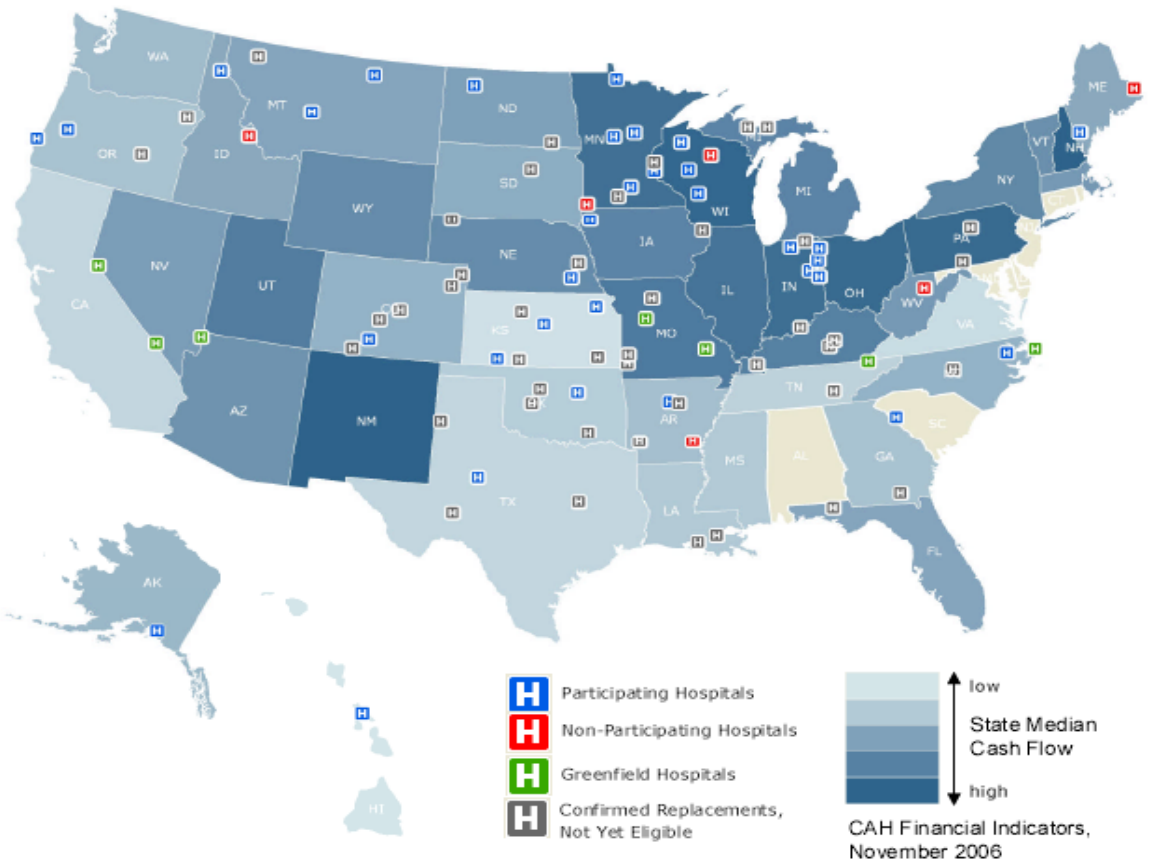
CAH Reimbursement (cont.)

- How CAH status lowers risk for rural hospitals
 - Inpatient and outpatient (non-professional) costs paid on cost-based reimbursement for Medicare and (some states) Medicaid
 - High Medicare and Medicaid occupancy rates
 - Focus on outpatient services
 - Often opportunity for margin as a CAH
 - However, CAHs in Hawaii struggle to generate margin on outpatient services due to relatively low reimbursement rates from primary third party payer
- Many CAHs are investing in capital projects with cost-based depreciation and interest

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Overview Prior Findings 2007 Findings Conclusions
 All Replacements, Including Construction in Progress (n=90)



Candidate Hospitals

- Atoka Memorial Hospital (OK)
- Barton County Hospital (MO)
- Baptist Heber Springs (AR)
- Bell Memorial Hospital (MI)
- Casey County Hospital (KY)
- Chadron Community Hospital (NE)
- Chatham Hospital (NC)
- Clinch County (GA)
- Comanche County Hospital (KS)
- Doctor's Hospital-Bonifay (FL)
- Faulk County Hospital (SD)
- Fort Logan (KY)
- Franklin Hospital (LA)
- Fulton County (PA)
- Harney District Hospital (OR)
- Harrison County Hospital (IN)
- Heart of the Rockies RMC (CO)
- Howard Memorial Hospital (AR)
- Jersey Shore Hospital (PA)
- Limestone Medical Center (TX)
- Marshall County Hospital (KY)
- McCune-Brooks Hospital (MO)
- Melissa Memorial Hospital (CO)
- Mid West Regional-Galena (IL)
- Munising Memorial (MI)
- North Valley Hospital (MT)
- Oakes Community Hospital (ND)
- Okeene Municipal (OK)
- Osceola Medical Center (WI)
- Pagosa Mountain Hospital (CO)
- Parkview LaGrange Hospital (IN)
- Parmer County Hospital (TX)
- Pecos County Hospital (TX)
- Pershing Memorial Hospital (MO)
- Pikes Peak Regional Med. Ctr. (CO)
- Rhea Medical Center (TN)
- Rooks County Health Center (KS)
- Saint James Health Services (MN)
- Saunders Medical Center (NE)
- St. James Parish Hospital (LA)
- St. Lukes Community (MT)
- Wallowa County Health Care (OR)
- Weatherford Regional Hospital (OK)
- Wilson County Hospital (KS)
- Yuma Hospital District (CO)

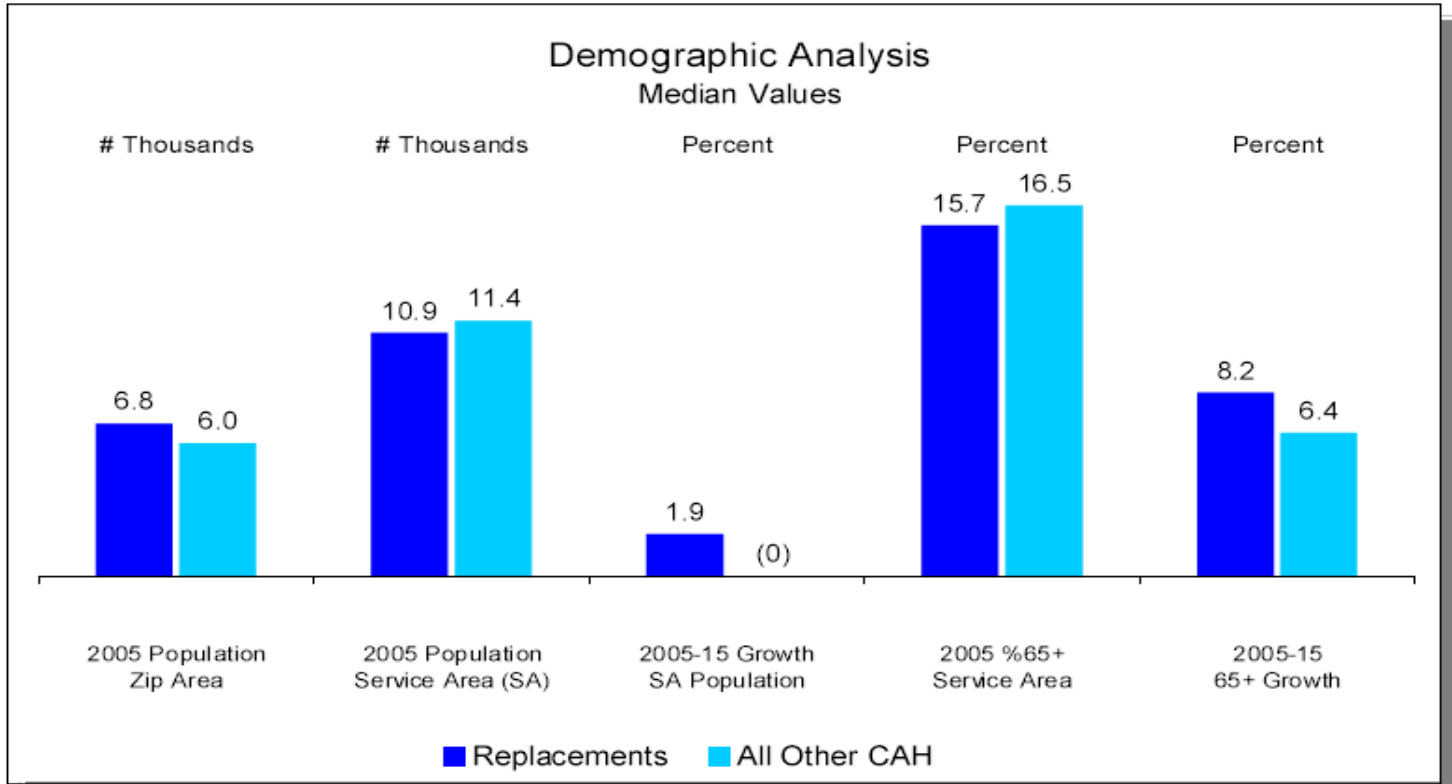
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CAH Characteristics



- Overview
- Prior Findings
- 2007 Findings
- Conclusions
- Report

Demographics and Service Area



- CAH Program
- Hawaii Realities**
- Maui Opportunity
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Hawaii CAH Realities

State	Total Margin	Cash Flow Margin	Return on Equity
	%	%	%
US	2.63	4.73	5.87
AK	-2.88	0.98	-3.43
AR	0.32	-0.01	6.80
AZ	3.93	3.24	11.21
CA	3.47	-0.78	10.66
CO	3.79	3.78	5.47
FL	-0.88	-0.78	-15.60
GA	0.85	2.65	12.14
HI	-10.16	-17.89	-19.97
IA	5.75	7.02	5.81
ID	3.14	5.46	4.03
IL	4.75	7.87	9.76
IN	2.13	7.25	3.67
KS	-0.71	-6.38	-0.51
KY	2.42	7.51	7.75
LA	0.66	2.71	0.89
ME	1.91	4.59	5.46
MI	1.16	3.54	4.56
MN	3.06	8.10	7.23
MO	3.03	5.16	9.31
MS	-2.70	0.84	-4.67

State	Total Margin	Cash Flow Margin	Return on Equity
MT	2.86	2.28	5.46
NC	1.84	2.63	6.77
ND	0.06	2.27	0.34
NE	4.24	7.80	6.63
NH	2.65	7.31	3.82
NM	4.77	7.40	12.54
NV	9.95	4.15	13.44
NY	3.29	6.87	7.24
OH	3.75	8.05	8.69
OK	4.47	1.52	12.15
OR	2.25	2.28	10.02
PA	1.53	5.59	7.10
SD	-0.31	4.34	0.39
TN	-2.03	1.20	-5.41
TX	2.86	-0.29	7.70
UT	5.70	4.78	17.10
WA	3.86	4.57	6.56
WI	5.83	10.52	11.30
WV	1.08	3.82	4.45
WY	5.24	5.95	8.97

Hawaii CAH Realities (continued)

- Common Findings/Challenges
 - Relatively low volume in most CAHs results in high unit costs
 - Third party payers generally result in losses on a fully allocated cost basis
 - High labor costs resulting from collective bargaining agreements further increase costs
 - Cost-based Medicare, Medicaid, and HMSA 65C+ reduce CAH losses significantly
 - For most CAHs, operating losses are primarily the result of high unit costs, third party reimbursement, clinics, and costs associated with bad debt
 - Hawai`i facilities, with some exceptions, are in desperate need of updating

Maui County Opportunity

- Lahina area likely meets Federal distance criteria for CAH designation
 - No 4-lane roads between Lahina and closest hospital
- Community size is likely above CAH averages and growing
 - Need to more formally evaluate
- CAH status and cost-based reimbursement would likely be beneficial to cover high capital costs, labor costs, and start-up operations
 - CAH Bed-size limitations should not negatively impact potential new hospital
 - Feasibility study should be completed to assess
- Requirement of “prior hospital status” would require new hospital to open as acute care hospital and then convert to CAH status
- Facility projects in Hawaii are expensive relative to mainland projects
 - Capital sources necessary to be identified

Discussion