Georgia Hospital Association

House Rural Development Council

Report from Georgia Hospital Association

Chuck Adams, Executive Vice President

House Rural Development Council

- What resources does GHA provide rural hospitals?
- What practices can help improve financial stability?
- What can the state do to assist?

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Rural Hospital Economic Impact

CY 2015	Georgia's 63 Rural Hospitals	Average per Rural Hospital
Full-Time Hospital Jobs	15,000	240
Georgia Full-Time Jobs Created	36,000	570
Direct Expenditures	$1.4 billion	$21 million
Community Benefit	$123 million	$2.0 million

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Education and Resources

- Quality and Safety
  - GHA receives and administers more than $3 million dollars a year of Federal, State, and Private Partnership Funding to help educate and train our Rural Hospitals
    - SHIP Grant – 19 Hospitals - $171,000
    - Flex Grant – 30 Hospitals - $172,000
    - HIIN Grant – 55 Hospital - $880,000
    - LEAN Training – 8 Hospitals -$80,000
    - All of these programs are helping our hospitals reduce readmissions, reduce hospital acquired infections and increase HCAHPS scores….all of which have a positive financial result in reimbursement.
    - Emergency Preparedness – 55 Hospitals - $1,000,000
  - Average per Rural Hospital = $73,000/year

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Education and Resources

- Education
  - GHA offers continuous 340b education and support
  - GHA offers education on obtaining certification as a Remote Treatment Stroke Center
  - GHA provides reports on Value Based Purchasing, Hospital Acquired Conditions and other CMS Quality Measures which help quantify the net impact of Medicare policy changes
  - GHA works with DPH to ensure all of our Rural Hospitals have access and participate in the Regional Healthcare Coalitions to help plan and prepare for disasters to assist them in a state of emergency
- Resources
  - Center for Rural Health – Operational focused education specifically for Rural Hospitals
  - Strategic planning assistance through the Georgia Discharge Data system, market share reports and Board presentations
  - Advocacy – Federal and State

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Education and Resources

- Rural Behavioral Health Environmental Scan
  - GHA received funding from the SORH to conduct this scan and presented its findings at the recent CRH annual meeting
  - GHA conducted a scan of all available behavioral health resources in rural markets(hospitals, CSB's, FQHC's, Regional DBHDD's) designed to:
    - Provide an overview of behavioral health population characteristics and status of behavioral health care access in rural Georgia
    - Identify the key programs and organizations involved in these issues
    - Highlight gaps in information or resources
    - Present measures that can help assess the status of the issues and advance solutions to behavioral health access to care

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Education and Resources

- Rural Behavioral Health Environmental Scan Findings
  - There is a large knowledge gap of services provided in every region
  - There is an undersupply of behavioral health providers in rural markets
  - Rural patients and view the rural ED as a safety net provider of behavioral services
  - Patients are willing to be seen in rural facilities if beds are available
  - Patients will continue to look at their rural hospital as the provider of emergency services, both mental and/or physical
  - The behavioral issues in rural markets are not due to an influx of volume, but rather a disruption of normal workflow and placement options
  - Proximity and availability appeared to be a driver of ED utilization
  - Inconsistency in collaboration with other providers
  - Inconsistent CSB proximities to rural hospitals

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Education and Resources

- Rural Behavioral Health Scan Opportunities
  - Increased awareness and collaboration of providers
  - Psychiatrist practice start up funding
  - Use of a Telepsych “bunker approach”
  - Increase in In-patient Psych beds and Geri Psych programs - funding

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Financial Stability

- Operational Efficiency
  - Revenue Cycle Management
  - Proper staffing ratios
  - 340b savings
- Service Line Enhancements
  - Swing Bed
  - Geri-psych
  - Out patient imaging

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Financial Stability

- Affiliations
  - Collaboration
  - Partnership
  - Shared Services
- Workforce
  - FP, Mid level, Specialists

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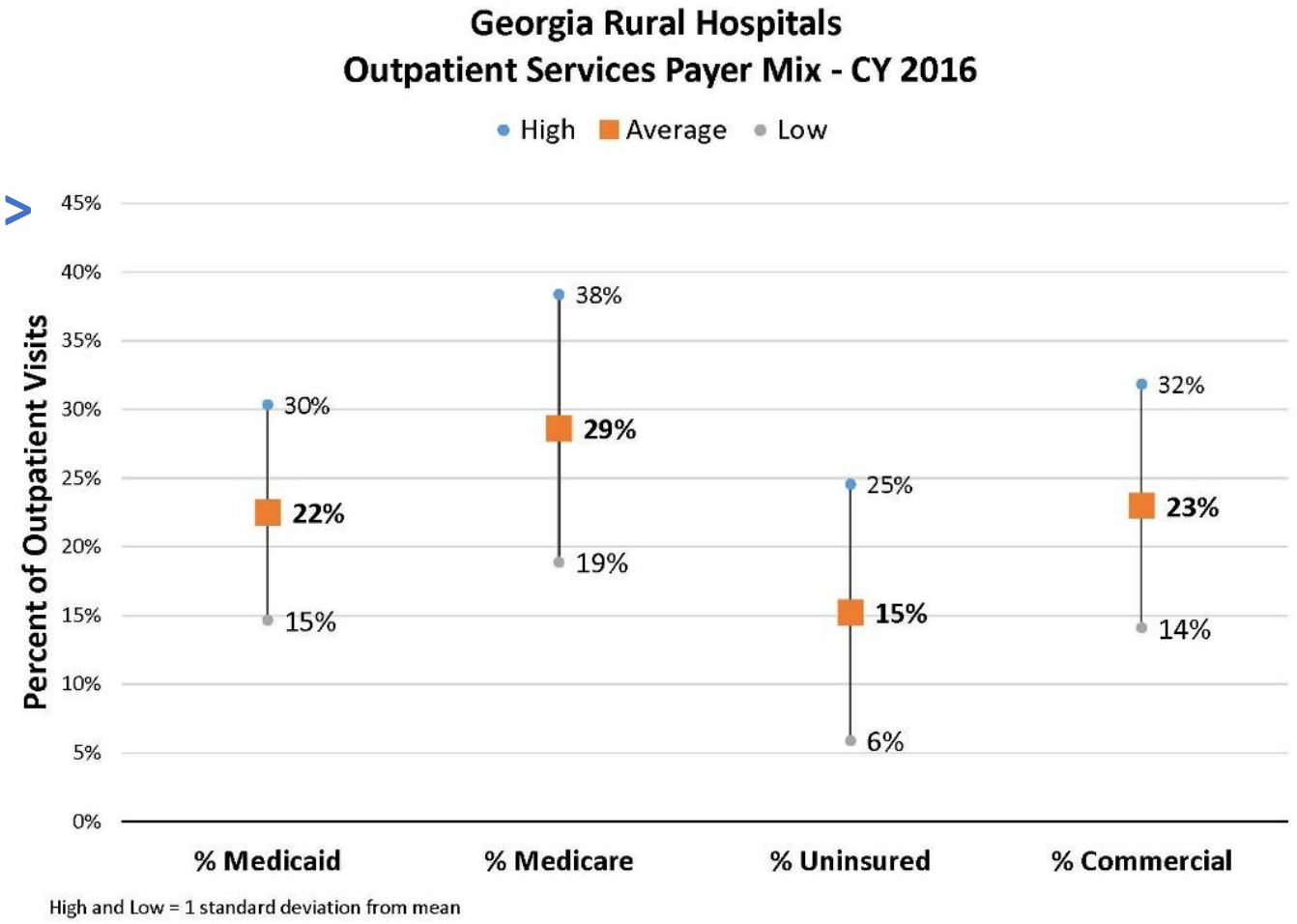
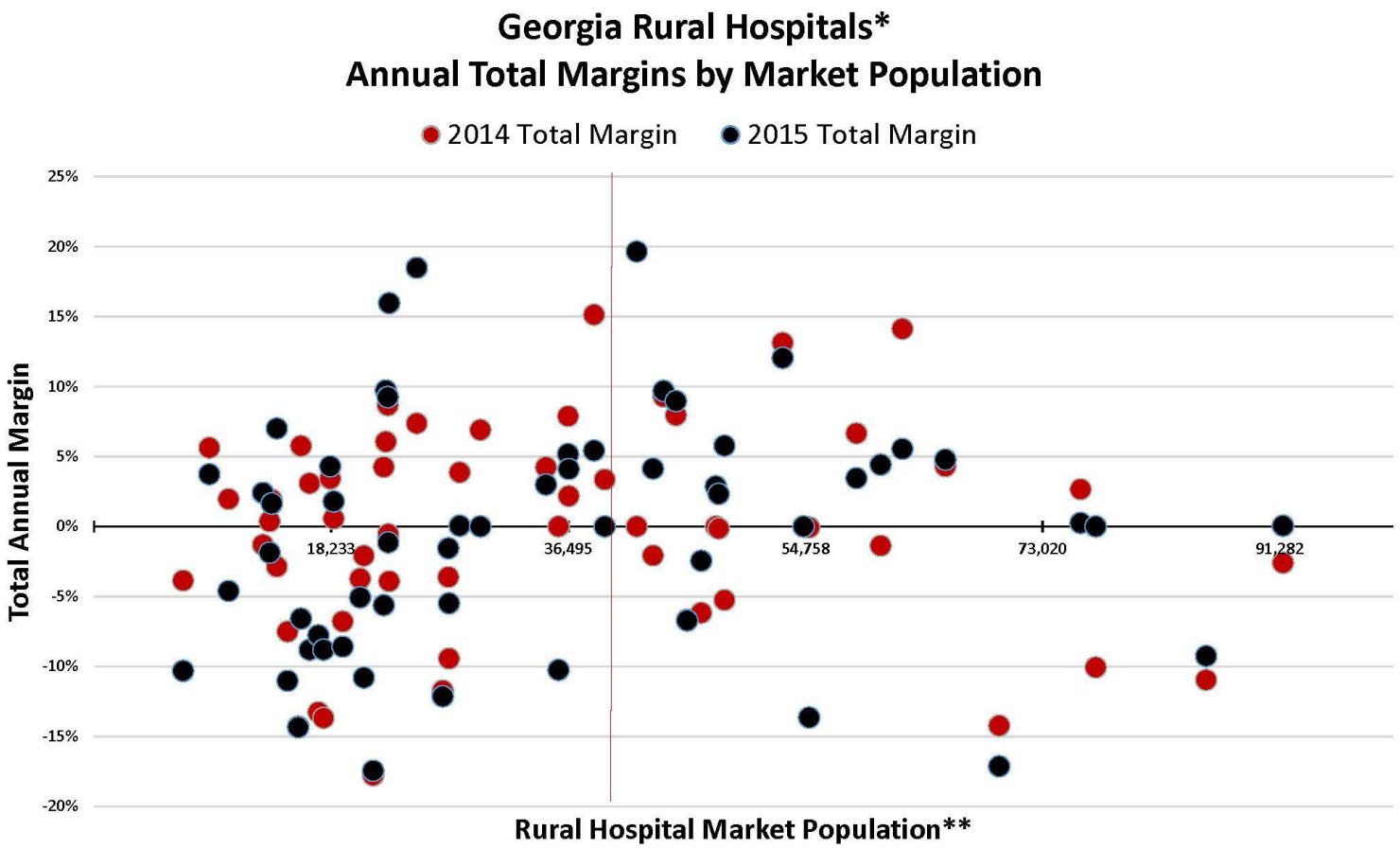
What Can the State Do?

- These factors **vary** by rural hospital and cumulatively affect stability:
  - Competition
  - Demographics
  - **Payer Mix ---------->**
  - Affiliations
  - Service Lines
  - County and/or City Support
  - Stand Alone vs System
  - Age of Physical Plant
  - Long Term Debt



What Can the State Do?



Rural hospitals in counties less than 35,000 (1990 census) with market populations less than 100,000
**Market population includes counties where 75% of the hospital's patients reside

Market Population size isn't solely an indicator of financial success

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What Can the State Do?

- There are three **needs** that are the same for all rural hospitals:
  1. Coverage for the Uninsured
  2. Sufficient Payment for Non-Emergent Use of the Emergency Room
  3. Regulatory Stability

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Coverage for the Uninsured

Rural Hospitals	Medicaid	Uninsured	Total
Total Patient Visits/Admissions	284,000	206,000	490,000
Total Uncompensated Care (UCC)	$41 million	$82 million	$123 million
Average UCC per Hospital	$620 thousand	$1.2 million	$2 million
Average Loss/Patient	$143	$400	$250
Staff Equivalent for UCC*	12 FTEs	25 FTEs	37 FTEs

* Based on average salary and benefits of $50,000 (2015 average for GA rural hospitals)

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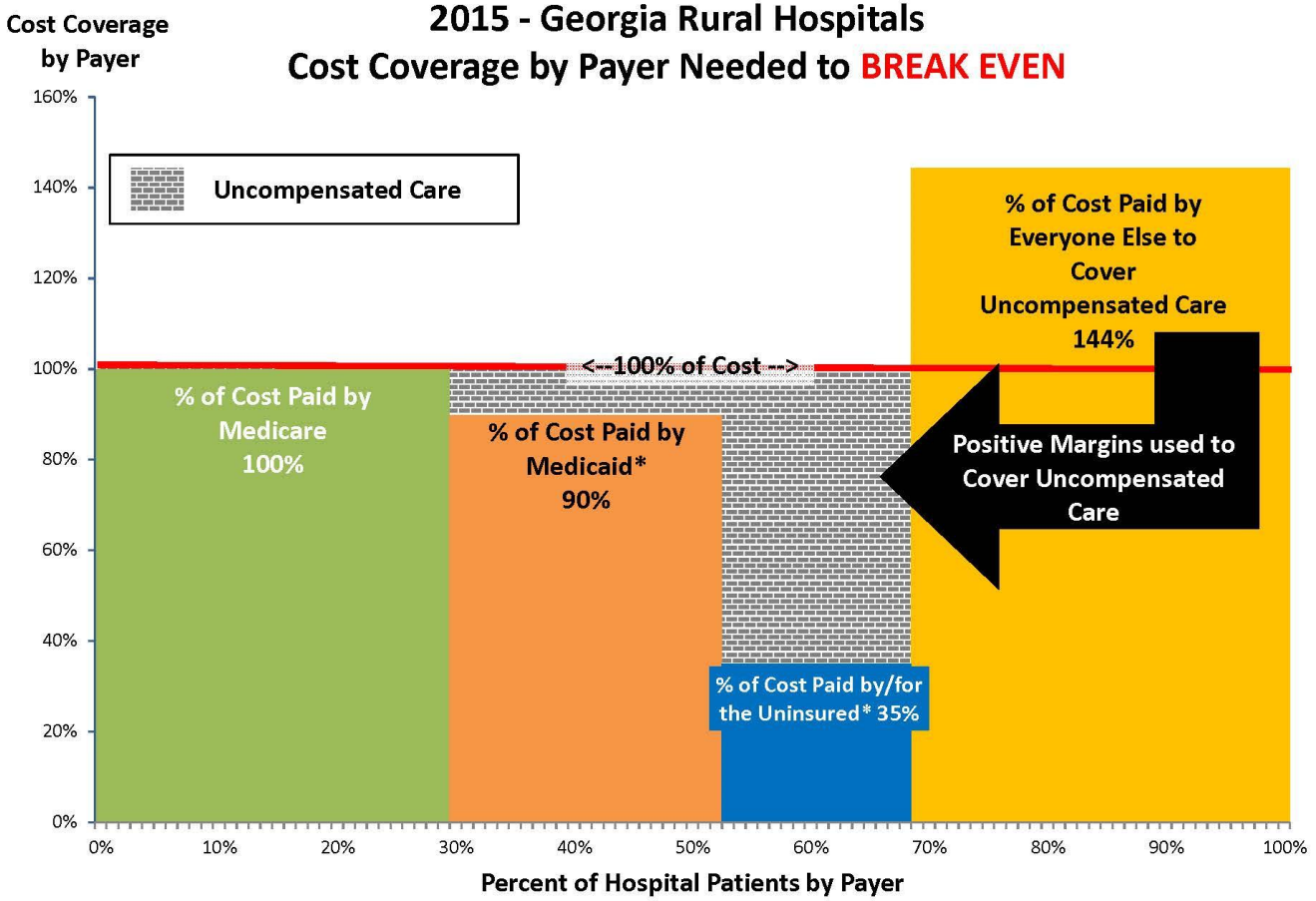
Coverage Gap



* considers DSH and Medicaid supplemental payments
Rural defined as hospitals in counties with less than 35,000 (1990 census).

Rural Hospitals have to negotiate with commercial payers and seek almost **1.5 times their cost** for insured patients to cover their uncompensated care from the uninsured and Medicaid.

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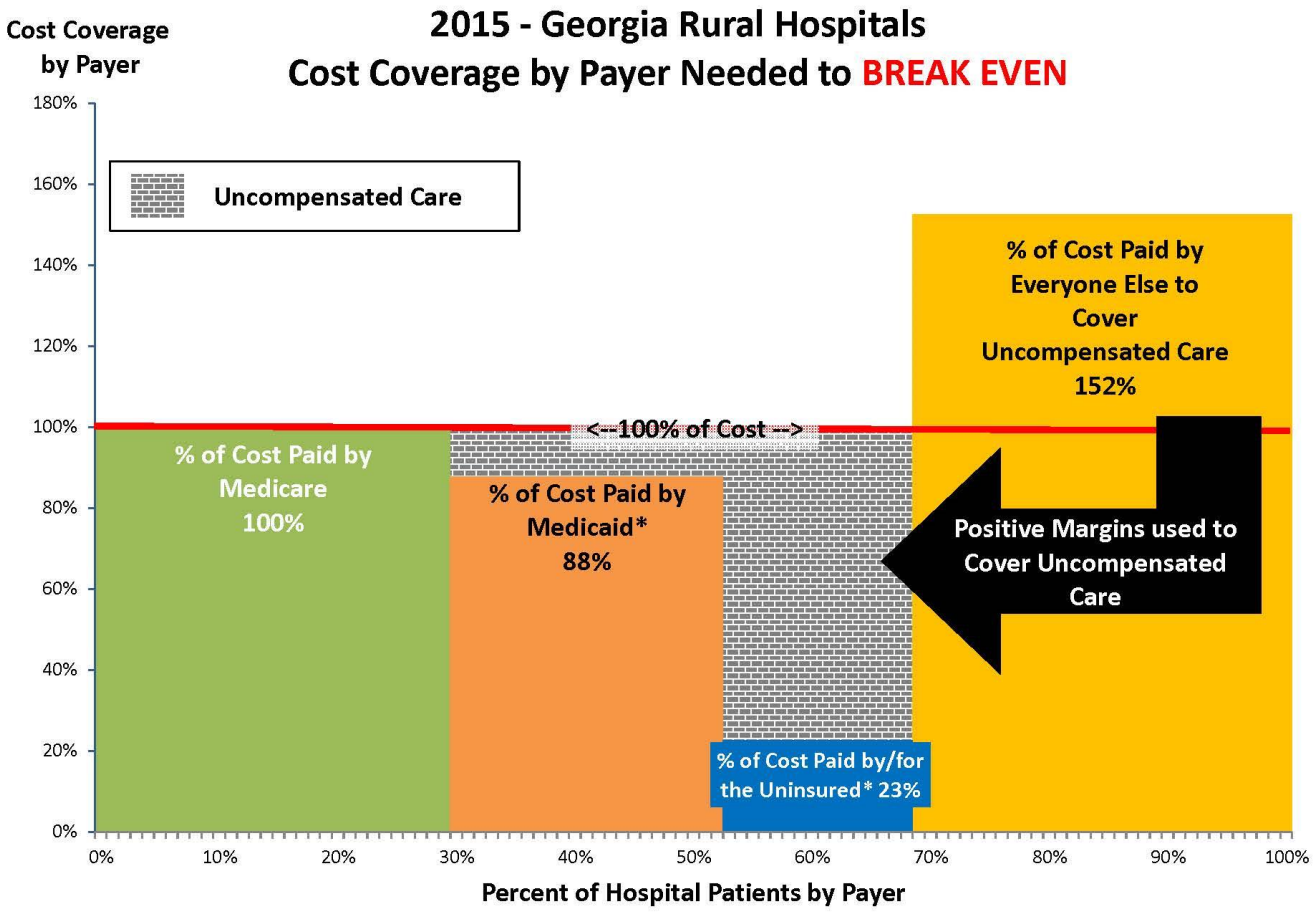
Coverage Gap with DSH Cuts



* considers DSH (with 2026 ACA cuts) and Medicaid supplemental payments
Rural defined as hospitals in counties with less than 35,000 (1990 census).

Rural Hospitals	Total
Future Maximum Medicaid DSH Cuts (escalating to 47% in FY 2026)	-$23 million
Average Cut per Hospital	$360 thousand
Average Cut per Patient	$47
FTE Equivalent per Hospital	7 FTEs

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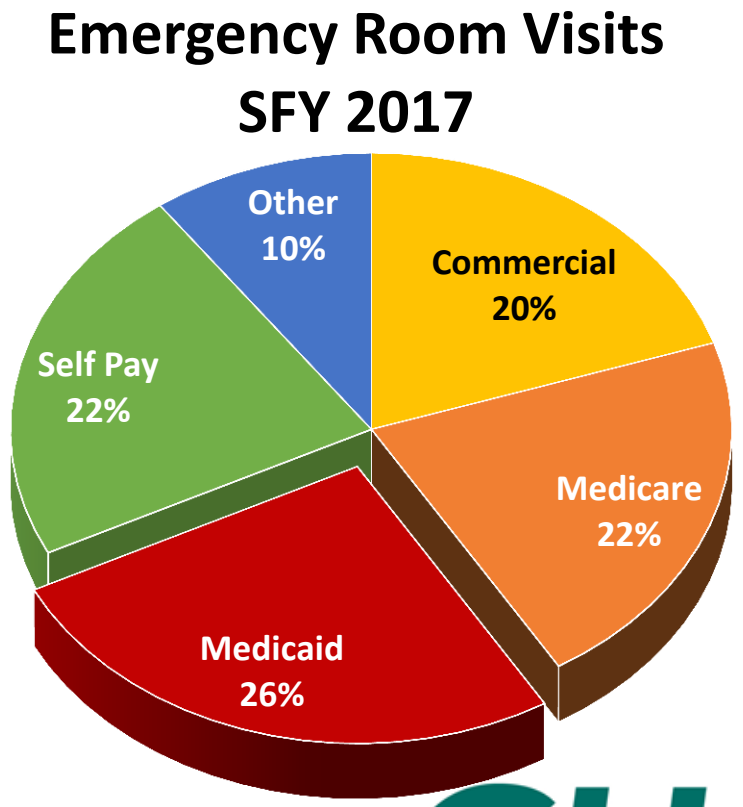
Non-Emergent Use of the Emergency Room

EMTALA requires hospitals to provide care to anyone needing emergency treatment, including a medical screening examination to determine whether an emergency exists

- Medicaid pays hospitals **$50** for non-emergent ER visits*

Compare to:

- Medicaid's physician fee schedule for New Patient Office Visits range from **$35 to $137** depending on visit complexity



* Does not include professional fees

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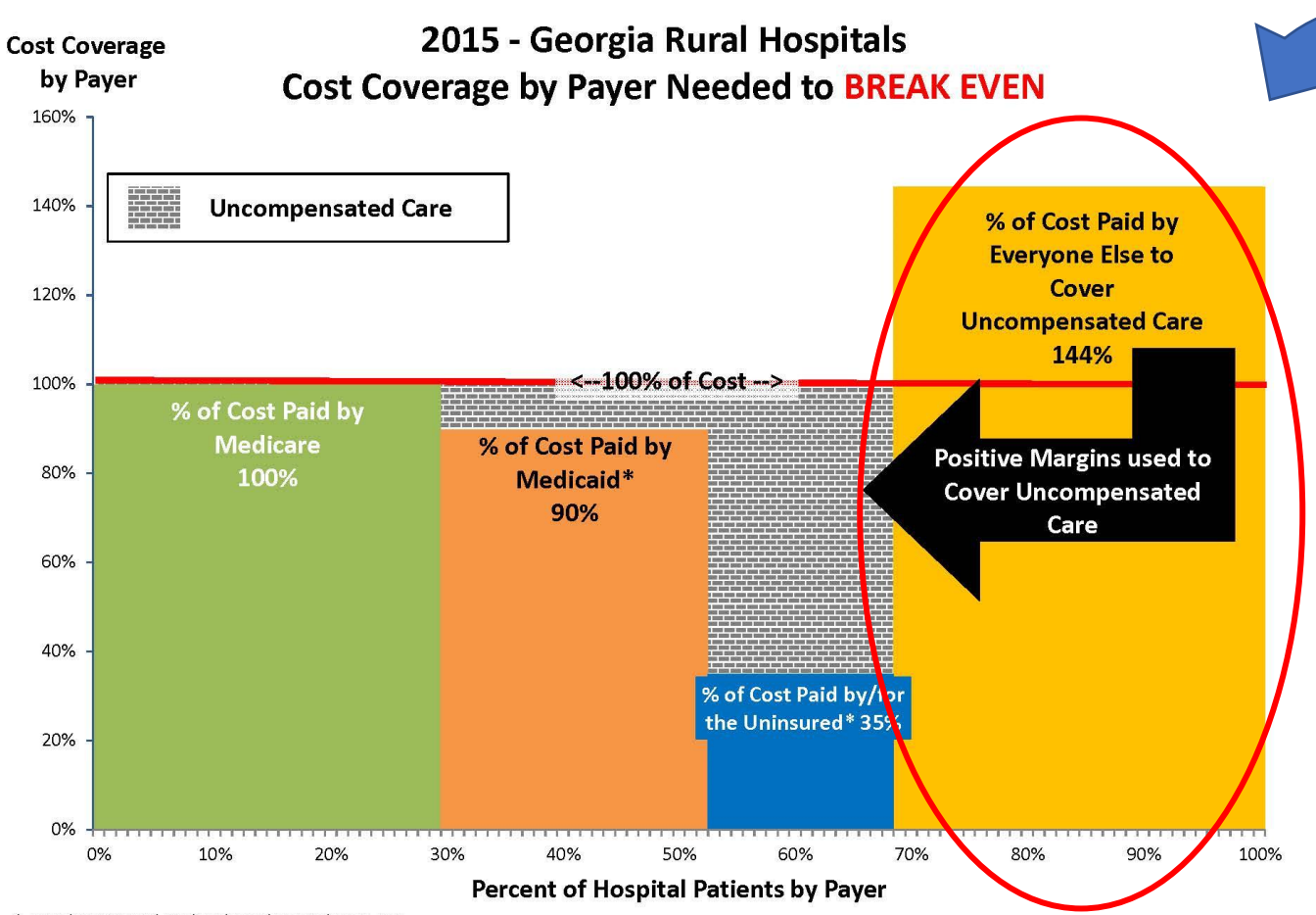
Regulatory Stability



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Protect CON to preserve the "profitable" service lines

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Questions

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