Full of Patients but Low on Cash: Managing Conflicts between Health-Care Needs and Budget Woes

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RURAL HEALTH CHALLENGES 2016

GEORGIA STATE UNIVERSITY COLLEGE OF LAW
“TOWER TO TRENCHES”
SEPTEMBER 30, 2016
Rural is Different – Not Worse

- Rural areas score higher than urban areas on appropriate provision of preventive services related to breast exams, family history of cancer, flu immunization...

- Hospitals in rural area have significantly higher ratings on HCAHPS measures than those located in urban areas

- Rural hospitals match urban hospitals on performance at a lower price

Stats courtesy of Alan Morgan, CEO of National Rural Health Association

- Sample rural GA hospital versus statewide averages (HCAHPS):
  - Pain control: 86% satisfied vs. 71% state average
  - Physician communication: 95% satisfied vs. 83% state average
  - 82% gave hospital a score of 9 or 10 vs. 71% state average
Half of Americans live in the red counties, half live in the orange counties...

dadaviz.com via @conradhackett
WHAT’SAILING RURAL HEALTHCARE?

• More likely to report fair to poor health
  • Rural counties 19.5%
  • Urban counties 15.6%

• Higher obesity rates: Rural counties 27.4% vs. urban counties 23.9%
  Stats courtesy of National Rural Health Association

• More chronic disease:
  • Sample rural hospital vs. GA state averages:
    • 26% higher cardiovascular disease mortality
    • 16% higher cancer mortality

• 1/5 of Americans live in rural areas, but 1/10 of physicians practice there (The Atlantic, Aug. 28, 2014)
Recent legislation including the Affordable Care Act has placed many burdens on hospitals

- Medicare / Medicaid reimbursements cuts
  - E.g. sequestration (2-percent Medicare cut in 2013)
  - Current and looming safety-net care cuts
    - Medicare disproportionate share program cuts under way
    - Medicaid disproportionate share program cuts begin in 2018
- Overall, CBO projects **10.4% decline** in Medicare reimbursement by 2020

- Payments withheld under quality programs
  - “Stick and carrot” incentive programs – chance to gain back
  - Hospital readmissions (up to 3% cut)
  - Hospital Value-Based Purchasing (up to 2% cut)
  - Hospital-Acquired Condition program (1% cut)
What’s Ailing Rural Healthcare?

Insurance changes

• Even among newly insured, higher deductibles have led to increased uncompensated care
  • One half of all non-elderly, non-poor households do not have enough liquid assets to meet deductibles over $2,500

Source: Kaiser Family Foundation

• Insurer exits have caused limited competition in the individual market
  • In 2017, one fourth of U.S. counties will be served by only one insurer in the individual marketplace

• Medicaid’s expansion has been so bungled it gets its own slide…
WHAT’S AILING RURAL HEALTHCARE?

MEDICAID EXPANSION WAS INTENDED TO OFFSET ACA’S CUTS:
MORE PAYING PATIENTS,
LESS UNCOMPENSATED CARE.
BUT....

- U.S. Supreme Court made expansion optional
- 23 states, including Georgia, have declined
- Georgia’s Medicaid program remains closed off to all childless adults, and parents making more than 40% of federal poverty level ($8,000 annually = too wealthy for Medicaid)
CONSEQUENCES OF CLOSURE

ACCESS TO CARE

• Increased travel time to nearest hospital – costly during emergencies

• Travel limitations for poor and elderly populations

• Pungo Hospital, Bellhaven, NC
  • Closed in 2014; 20,000 people now in counties without ER
  • Six days after closing, 48-year-old woman died of heart attack waiting for helicopter
  • “If someone has a stroke, and we can’t get a CT on them to administer treatment, or if they have trauma and they can’t get fluid replacements, they’re going to die.” - Belhaven physician Mark Beamer

Sources: Kaiser Health News, Charlotte Observer
CONSEQUENCES OF CLOSURE

ACCESS TO CARE

• North Georgia Medical Center, Ellijay, GA

• Closed in 2016

• “[Physician’s offices] have been treated like an emergency room…We have people walking in with open knees requiring stitching, and people are coming in weak and fragile and passing out in the waiting room.”

Source: Times Courier
CONSEQUENCES OF CLOSURE

ACCESS TO CARE
CONSEQUENCES OF CLOSURE

ECONOMIC IMPACT

• Three years after a rural hospital community closes, it costs about $1000 in per capita income

• On average, 14% of total employment in rural areas is attributed to the health sector.

• One rural physician generates an average of 23 jobs in the local economy

Sources: National Rural Health Association; Rural Health Works; Mark Holmes, UNC Professor
CONSEQUENCES OF CLOSURE

ECONOMIC IMPACT

• Hancock Memorial Hospital, Sparta, GA

• Closed in 2001

• “When [trying] to recruit a new industrial employer, one of the first things they ask is, ‘Do you have a hospital?’” – Hancock County Commission Chair Sistie Hudson

• Source: “When Rural Hospitals Close, Towns Struggle to Stay Open” – Marketplace, 2014
SEARCHING FOR A SOLUTION

- Affiliations
- Mergers & Acquisitions
- Management Relationships
- County Support
- State Legislation (e.g. tax credit)
- Creative Revenue Streams
Rural Hospital Mergers, 2005-12

- Number of Mergers and Acquisitions

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WHY TELEHEALTH’S TIME IS HERE

• E-visits increased by **400%** between 2012 and 2014\(^1\) – still rising

• Rural communities dwindling -- telemedicine can extend access to specialty services to underserved areas

• Rise of direct-to-consumer health puts increased pressure on institutional providers to maintain market share

• Technological advancements make telemedicine more affordable than ever

• Shift to value-based care places greater emphasis on routine, convenient, preventive care

A MOVE TOWARD MOBILE

What Options Consumers Would Select for Middle-of-the-Night Care

- Video Visits: 44%
- 24 Hour Nurse Line: 21%
- Online Symptom Checker: 17%
- Ambulance: 9%
- Other: 5%
- ER: 4%

Source: Kaufman Hall & Associates
Financial Pressures for Safety Net Health Systems
Safety Net Health Systems

• A safety net health system includes “hospitals or medical centers and their affiliated facilities and practices that serve high proportions of low-income, medically vulnerable patients, as indicated by having the highest shares of Medicaid and uninsured patients and lowest shares of privately insured patients compared with all hospitals in the country.”

• Generally offer special health care (infectious disease, sickle cell, trauma) and social services that other hospital systems do not

• Offer services required by State and local governments and communities, even if adequate revenue streams do not exist to support these service lines

DSH payments

• Safety net systems benefit from Disproportionate Share Hospital (DSH) payments, made by state Medicaid programs to hospitals that serve a large number of Medicaid and uninsured patients

• DSH payments include, in addition to uncompensated care, the difference (if any) between Medicaid payments and the cost of providing services to Medicaid patients

• About half of all US hospitals receive DSH payments
Pressures on Safety Net Systems

Health reform has had a direct impact on safety nets due to the potential for reduced funding from:

– Federal reductions in Medicare and Medicaid DSH payments as funds are shifted to pay for new insurance coverage;

– New performance accountability requirements that appear to disadvantage safety-net hospitals, such as penalties for all-cause readmission rates

– Higher numbers of Medicaid patients as Medicaid coverage is expanded, in most cases with inadequate reimbursement rates.

Effect of ACA

• Currently, effects of ACA on levels of uncompensated care are not fully known - early reports suggest that there may be a decline in unpaid costs in states that have expanded Medicaid

• Difference between the cost of providing care for Medicaid patients and the Medicaid reimbursement may be increasing

• Reduction in DSH payments planned, but has been delayed until 2018. CMS has proposed a new formula for DSH payments in a recently released rule.

Medicaid and CHIP Payment and Access Commission (MACPAC), Report to Congress on Medicaid Disproportionate Share Hospital Payments, February 2016
AHRQ Study

• Study of 8 safety net hospital systems in fall of 2012 and spring of 2013 to see how these systems were addressing the funding pressures

• Changing business strategies
  – Market dominance in geographic area
  – Outreach to new markets and patients
  – Redesigning patient care delivery