

Webinar Transcript

Change in Profitability and Financial Distress of CAHs from Loss of Cost-Based Reimbursement

Presented by Mark Holmes on October 31, 2014

{Shawnda Schroeder:}

Thank you and good afternoon. This Rural Health Research Gateway webinar is entitled “Change and Profitability and Financial Distress of CAHs for Loss of Cost-based Reimbursement.” It was hosted in September by Dr. Mark Holmes and Dr. George Pink. Thank you to Mark for agreeing to share this presentation again today. Following the presentation this webinar will be posted on the Rural Health Research Gateway website. The Rural Health Research Gateway is a website that provides free access to publications and projects funded through the Federal Office of Rural Health Policy. It is part of the rural health research centers and analysis initiatives grant program. You can find the gateway website at www.ruralhealthresearch.org. You can also join the gateway alerts to receive periodic email updates when new publications become available. It includes the archive of today's webinar. To join the gateway alerts you can access the website on the left-hand side of your screen today at the bottom.

The lines are muted so I encourage you to use the question and answer chat box at the bottom of your screen. We will use this at the end of the presentation to present questions to Mark. I will read the questions and Mark will answer as many as time allows for. If there are remaining questions at the end of the conference we will send them with answers through email. Thank you for joining us today and now, I would like to introduce our presenter. Dr. Mark Holmes, PhD is an associate professor and associate chair for research in the Department of Health Policy and Management and the University of North Carolina School of Global Public Health. He is the director of the North Carolina Rural Health Research and Policy Analysis Center. He is senior research fellow and co-director of the program on health care economics and finance at the Center for Health Services Research. Welcome, Mark. I'm going to turn the line over to you.

{Mark Holmes:}

Thank you everyone for participating today on Halloween. Some of these numbers may be a little bit scary, but it's important for us to go through them and talk about some of the things that we've been doing at UNC and with the Flex Monitoring Team.

A brief overview of today, what I want to spend the next hour talking about is giving a little bit of the policy context, talking about where we are today. Talking about the status quo in terms of profitability by hospital type and looking at variation across the country. Then, getting into the real meat. I will cover effects of a limit in cost-based reimbursement overall across critical access hospitals looking at regional differences, focusing also on the effect on beneficiaries, which is an important consideration. I will talk about closures and related studies to wrap up and then the Q&A.

First, let's talk about policy context. There have been multiple proposals, some formal, some informal to cut Medicare reimbursement to critical access hospitals. The President's budget, Congressional Budget Office, Office of Inspector General and MedPAC have proposed different approaches. Sometimes trimming payments by one percentage point, maybe eliminating CAH designations less than 10 miles from the nearest hospital and eliminating the program altogether or removing the necessary provider. The permanent exemption was the Office of Inspector General's idea. I have heard a lot of various proposals looking at changes to how the critical access hospital program is implemented. Based on that, we wanted to take a step back and look at the profitability of rural hospitals, in general. You will see that for every one of these studies we talk about, we include the citations. It's a direct link. They are also linked from Gateway's website and at the very end there is a shorter web link that will get you to the main page where you can access these, if you are interested in more detail.

This chart shows the total margin distribution by hospital type in 2012. Rural-PPS on the far left, critical access hospitals, Medicare dependent hospitals, sole community hospitals, rural referral centers and urban prospective payment hospitals. What you can see from the chart is the different colors represent the distribution of total margin. Where rural-PPS has generally the lowest. You see the median is above 0%. Then, it goes from left to right. Urban prospective payment has the highest median total margin.

If we look at these trends over time, we can see that this is generally consistent with the data we saw on the previous slide. Rural-PPS having the lowest margins, urban-PPS having highest ones. You see a general upward trend from 2010 to 2012 in most categories. One exception might be rural referral centers. For most of these categories we see profitability increasing from 2010 through 2011 through 2012 and that's consistent with the recovery from the recession. In terms of operating margin, the chart looks generally the same. You will note that with a fine eye you can see it is a little bit lower. Operating margins tend to be lower than total margin. Consistent with the previous slide, rural-PPS, critical access and Medicare dependent tend to be among the lower groups. Sole community hospital in between with rural referral centers and urban payments being higher margin medians. What does this tell us? The study tells us that urban hospitals paid under PPS and the rural referral centers consistently had the highest profitability compared to other hospitals with other payment classifications. Rural hospitals, particularly those paid under PPS and critical access hospitals have the lowest profitability and we saw a general upward trend from 2010 in 2012.

So, looking at the status quo, let's look at the geographic variation. How does profitability vary across the country? This chart is a little bit difficult to read in terms of left to right, but we see the different divisions of the country. New England, mid-Atlantic, East North Central and so on from left to right. Same general format as the previous slides, with breaking the distribution of profitability into four categories. Bottom quarter, light green is the second lowest quarter, dark blue is second-highest quarter and light blue is highest quarter. You can see that there is considerable variation across the country in terms of how total margin is distributed. For example, West South Central having some of the higher total margin and others being much lower. Mid-Atlantic, for example, having a lower operating margins, generally. We see the West

South Central and Pacific going with very low operating margins for some of the ones on the bottom and operating margin negative 120%, which would be quite unusual. But, sometimes the data presents in that manner.

So, profitability of CAHs varies across the states and divisions. In general, CAHs in Hawaii, Georgia and Kansas have the lowest total margin and operating margin. CAHs in the South, South Atlantic and East South Central had lowest total margin, operating margin. Whereas those in the East North Central have the highest total margin and highest operating margin. A wide variability in terms of possibility across the country and we'll see more of that as we dive into the data a little bit more. The implication of that, in the fourth bullet, is that if the CAHs program is decertified or there are changes to it and loss of cost-based reimbursement, they will reduce hospital profitability with that potential for wide variation by state and region. Some states and regions maybe only minorly affected where others would be majorly affected depending on where they are with their current finances.

That review is where we are today. Now, I would like to get into the real interest of this webinar: what would happen regarding eliminating cost-based reimbursement. This is the brief that will be driving the change in profitability and financial distress from loss of cost-based reimbursement. We will take a step back and talk about what we mean by financial distress. Back in 2011, the Flex Monitoring Team developed a financial distress model that used key characteristics of the critical access hospital today to model what the financial status would look like in two years. So, the kinds of elements that went into the projection are the current profitability, reinvestment of the CAH to the degree in which it reinvested its earnings. The size of hospital, but also incorporated key characteristics of the market in which the hospital is situated. The competition, how far to the nearest hospital. The socioeconomic status of the community. A poor community or relatively higher income community. What is the size of the market? How many people live in the area that is served by the critical access hospital? By taking these kinds of variables, we took in and modeled the hospitals in terms of the risk of financial distress within two years. High, mid-high, mid-low and low. What outcomes being associated with those, for example, things like a decline in the fund balance or decline in equity.

Three consecutive years of negative operating margin. A closure, substantial decline in equity over a number of years. That's the general tool we use. Stepping back again to how we might think about giving the policy context, we looked at various approaches that have been taken to look at how much more critical access hospitals get because they are reimbursed under cost-based systems, relative to a prospective payment system. Medicare Payment Advisory Commission, the CBO, and the Office of the Inspector General came up with different estimates for how the average hospital is effective in terms of the difference between what it gets from Medicare under cost-based versus what it would get under prospective payment. In general, they range from about 17% to about 30%. The model what would happen to critical access hospitals if Medicare revenue were reduced from 20% and what would happen if it reduced 30%. This being the current approach for modeling what happens to a hospital if it were to revert to prospective payment. This approach takes some fundamental assumptions. One of them, and the key one, is everything else about the hospital remains the same. They're doing the same number of visits,

same number of outpatient procedures and visits and inpatient stays. Everything else remains the same. It is just a change in how it's reimbursed. That's a pretty notable assumption, because we know hospitals would likely respond to a change in payment like this. But, it's a useful starting point to think about what would happen. I just want to point out that this 20% to 30% we came up with what others have estimated, some people have whispered in different conferences that's it may actually be larger than this. I would be really interested: both George and I would welcome feedback. We've had a couple of CEOs and CFOs say we ran the model and it would have been a 22% change or would in an 18% change last year. Those kinds of data points would be really helpful to us. If you have the ability and are so inclined, we would love that kind of feedback to help us understand whether this 20% to 30% is reasonable or would be bigger than this. We haven't had many people say that they expect it to be smaller than this.

Next slide. I will walk you through and explain what's going on. This is a box plot. The green box and whiskers represent the distribution of operating margin for 2011, which is a couple of years ago. Distribution of operating margin based on distance to nearest hospital. The far left group is less than 10 miles. We see the status quo under current cost-based conditions, the middle horizontal line in the middle represents the median. Top of the box on the lower box represents 75th and 25th percentile. We see just over half of hospitals less than 10 miles from the next nearest acute facility, have an operating margin that's positive. If we call the top of that box about 5%, 6%, we would say 25% of the hospitals have an operating margin above the 6% operating margin range where is 25% or below the bottom part of that box, negative 4%, something in that range. We look at the green boxes and walk our way through it. The hospitals that are less than 10 or tend to 15 miles from the nearest hospital have slightly higher operating margin than the rest of the hospitals. In particular, those critical access hospitals 25 miles to 35 miles from the next closest hospital have the lowest median operating margin. We can see that over half of critical access hospitals 25 miles to 35 miles from the nearest other acute facility have a negative operating margin. On the far right, it represents a total of all critical access hospitals. As we work our way through the colors, the dark blue box represents what would happen to operating margin with the reduction to Medicare reimbursement. You can see that the box shifts quite dramatically by approximately six percentage points. The median for the less than 10 is probably 1% to 2% on the far left and probably negative 4% in the dark blue box. Overall, we see the dark blue box sliding down considerably at every distance point. The light blue box, which might represent Carolina blue, is a 30% reduction. We see that for most of those, for every single distance hospital with the exception of 10 to 15 miles, over 75% of hospitals would have a negative operating margin with a 30% reduction in Medicare reimbursement. So, this kind of change going from cost-based to prospective payment, on average, it means about a 30% reduction in Medicare reimbursement, would have major effects on operating margin for hospitals across the distance, across all distance levels. Again, we see that 25 to 35-mile range being probably the ones most at risk- most likely to be a negative operating margin.

Now, we can also use this approach to model the financial distress. If you remember, which of the current conditions for the hospital and modeled and put each hospital into one of four buckets, if you will, in terms of the risk of financial distress in the next two years. What we've

done is starting with SQ (the status quo) we looked at the distribution. Let's start with "total" on the far right. Currently about 10% of critical access hospitals are in the highest risk, the black bar of financial distress. Another 11% are in the blue, the mid-risk. 13 from mid-low and 64% in the lowest risk. If you look across distance first looking at the status quo, those hospitals, the critical access hospitals, but closest to other hospitals have the lowest probability of financial distress. Only 6% are in the highest category of risk for financial distress. When you look at the other categories, 10, 11, nine and nine.

Again, what happens as we change our reimbursement structure to transition from cost-based to prospective payment? If it entails a 20% reduction, focusing on the less than 10 miles, rather than 6% of critical access hospitals being at high risk of financial distress, it increases to 21%. Over triple the rate. That happens across the board going from 10 to 17 and those are 10 to 15 miles from 11% to 19%. Those in 15 to 25-mile range and so on based on distance. If we were to go to 30% reduction given that some estimates have put that's what the conversion is from cost-based to prospective payment would mean, then the proportion of critical access hospitals less than 10 miles from the nearest acute facility -- the proportion of those that are in the highest risk of financial stress goes from six under status quo to about 25% under this reduction. An across-the-board change for all of these. You'll notice that some types of hospitals in terms of distance are more affected than others. Those are 10 to 15 miles at the rate that doubles from 10% to 19%. But the closest ones increased by fourfold. 25 to 35 triples. There are differing effects depending on how far the critical access hospital is from the next nearest facility. When you talk about proposals that rollback cost-based for a subsection of critical access hospitals, for example those within 10 miles or those that would only qualify under the necessary provider provisioned, 25 to 35 miles, depending on the topography in the region, you can see varying effects in terms of how they would respond and the impact on them in terms of the distress.

Reviewing the key findings and 20% to 30% reduction, the percentages of critical access hospitals with negative operating margin are projected to be 72% and 80%, respectively. The effect of distribution is largely independent of the distance to the nearest hospital. In general, the rule of thumb, the operating margin fell. For 20% reduction in Medicare revenue, again, the one estimate for convergence from cost-based to PPS, about 40% of hospitals that are 25 miles to 35 miles from the nearest and about 36% of those greater than 35 miles. Those that are farthest away on the nearest facility would be high or mid-high risk of financial distress.

In this talk we don't get into the different risk levels, but I refer you to the brief cited at the beginning of this section which talks about what this risk entails and what proportion of hospitals in a high risk category have a negative operating margin within two years or have a negative equity within two years. That's a good source to understand these different risk levels and what they mean in terms of practical effects. From a 30% reduction to Medicare revenue, nearly half of hospitals that are over 25 miles from the nearest acute facility, would be high or mid-high risk of financial distress. These would have major effects, particularly among those more distant from the next nearest facility in terms of the risk of financial distress. Just like we did with the status quo, we wanted to look at how these types of changes would have affects regionally.

Recognizing that if you've seen one critical access hospital, you've seen one critical access hospital. There is a wide variation in what these facilities look like across the country, depending on the structure, state policies, how Medicare reimburses or the uninsured rate, and lots of other drivers.

Here, we look at the same exercise, but we look by geographic location. In very small type is the nine divisions of the country. East North Central, East South Central, Middle Atlantic, Mountain, New England, Pacific... I'm going to deviate from the order so that we can get ourselves a little oriented. So that you understand what we are talking about when we talk about these divisions, I will leave this slide up for little bit. North Central is the Big 10 country, the West South Central and East South Central being SEC--- big games this weekend. I'm thinking football centric and how the country is divided up. This might be helpful to you understand what I'm talking about when I talk about these different census divisions.

Let's go back to the chart we just left. How does the financial distress vary across the country? If you look at some of these regions, the financial distress is very low under status quo. In some regions of the country, critical access hospitals, in general, are very low risk of having some type of financial distress occurring within the next two years. Contrast that with other parts of the country such as South Atlantic, under current conditions, one quarter of critical access hospitals are at high risk of financial distress within the next two years. In the West South Central, 21%. In Middle Atlantic, 16%. In Pacific, 18%. A wide variety distributions ranging currently from 2% in high-risk in the East North Central to 23% in the South Atlantic. What happens as we march through the different models and say let's reduce Medicare reimbursement by 20% or 30%? Let's start with New England. You can see that in New England, as the reimbursement gets cut, is affected very little. In fact, no change in terms of proportion that are at high-risk of financial distress. You see some turning to mid-high and increases from 5% to 15%. Overall, if we focus on the black bar, the critical access hospital with the financial distress-- that proportion is largely independent of the Medicare reimbursement level. If we move to the East North Central, Minnesota to Kansas, 2% to 10%. An increase by eight percentage points in terms of number of critical access hospitals that would be at high risk. As we look at other divisions, we've seen much larger effects. For example, the East South Central going from 11% at high-risk to 42%. South Atlantic from 23% to 46%. West South Central, 21% to 47%. Again, we are seeing in some divisions, with a 30% reduction, nearly half of critical access hospitals would be at high-risk of financial distress within the next two years.

This chart is easier to see as we break them into regions rather than divisions but is consistent with the same story. The one region that jumps out at you more than the others is the South. Historically it's had lower profitability, higher levels of financial distress for rural hospitals, in particular, and has manifested under current conditions with 19% being at high-risk. 30% reduction, again, nearly half of critical access hospitals would be high risk of financial distress within two years.

The Midwest and Northeast are generally much healthier, financially. Critical access hospitals -- the Northeast, again, in terms of percent at high-risk, being very modestly affected by the different payment policies. See the numbers with low-risk going from 81 to 50. It is making a

difference, but the ones we are concerned about in the black bar region, the number does not really change that much in the Northeast. To a lesser extent in the Midwest. Somewhat in the West. It's really the South that received a marked change. I do want to point out that we are talking about averages and trends and that it's an amalgamation of individual hospitals, which is what people really depend on. We are trying to look at overall pictures and how the trend is set up nationally.

Here's the census division set up again that we talked about. So, now we represent the same data in a map context. Here, we have a map of the country with darker colors representing areas of the country with a higher proportion at high-risk of financial distress. If you look to the far right there are four census divisions that have 2% to 9% of critical access hospitals in the highest risk of financial distress and zero divisions have 30% of critical access hospitals in that higher risk category. What happens if we go from no reduction in Medicare reimbursement to a 20% reduction? Now, we've seen all three divisions in the South move into that range where over 30% of the hospitals -- critical access hospitals-- are in highest risk and we start to see the colors change across the country. I'm going to click back so you can appreciate the difference from the status quo to here's what happens with a 20% reduction. Again, the Midwest and the East North Central and New England are in the same color in both of these scenarios. As we march on, you see that even the East North Central moves into that higher bracket.

Here's what the country looks like in terms of percent of critical access hospitals under high-risk under 30% reduction. Many more darker colors, particularly around the South in Texas up to Delaware. Again, I'm going to click back so we can see the animation, as we move from status quo to 20% reduction to 30% reduction. We can do the same thing not looking at high-risk, but mid and high risk, or the level we are concerned about which is in the mid high-risk. We do the same type of exercise. Here the darkest colors that represent those divisions with the highest proportion of critical access hospitals at high or mid-high risk. We march through from status quo, current conditions, to a 20% reduction to a 30% reduction. In this case, all parts of the country are affected, moving in terms of the proportion of the critical access hospitals in the country that become in the higher risk of financial distress. Again, doing that one more time. We really like these maps. I'm going to leverage them. Going from status quo to 20% to 30% and we roll it across the country. Terms of key findings of that exercise, again, the CAHs in the South have the sharpest increase in risk. If a 30% reduction would be what it means to convert from cost-base to PPS, nearly half of CAHs in the South would be at highest risk of financial distress and all three divisions and the South would have a financial distress for acute financial pressure. New England and East North Central, which start off from a much better and stronger financial position with little change in the risk of financial distress. Again, overall trends, on average.

What would it mean to increase financial distress? There would be an increase in the number of critical access hospitals experiencing insolvency. This is when an organization can no longer meet its financial obligations and lenders can't make the payments on the debt. That would lead to reorganization bankruptcy, chapter 13. If they can't make that work, moved to liquidation bankruptcy or chapter 7. You can tell that this is a slide George wrote. As an economist, I think of this as being more likely to close as the liquidation chapter 7 would generally be closure.

From an organizational implication, it can mean a lot of different things as we see increased financial distress. It can be a merger with another hospital, acquired by a hospital or a holding company as we've seen happen in some critical access hospitals across the country. The facility converts to a different function. It can convert to a long-term care facility or a federally qualified health center or clinic. It could affiliate with a system or network or alliance. It could lease hospitals to another hospital or maybe sign a management contract or ultimately lead to closure.

For the last minutes we've been focused on the finances of the hospital. These changes affect beneficiaries, as well. In particular, Medicare beneficiaries as they experience these types of changes. We wanted to look at what would happen for beneficiaries in terms of the travel time if some of these financially vulnerable critical access hospitals were to close. The general design was to take critical access hospitals across the country, find those that look financial really vulnerable, model them as closed, and see how much farther beneficiaries have to travel in order to get their acute care. In this chart and I will walk you through it, the far left is the status quo. As a backup, we start off and identified 93 hospitals that met the standard for being financially vulnerable. It was based on a combination of the current profitability, trends over time, size, some of the things we know are associated with the financial strength and we identified, mentioned, 93 of the critical access hospitals. For every rural zip code in the country, we calculated the distance between the middle of the zip code and the closest hospital and we "closed" 93 critical access hospitals and repeated the exercise with the idea that if the 93 hospitals were closed, the beneficiary living in the zip codes would have to go to the next closest facility for their care. We wanted to know how much farther that distance might be. We identified 490 zip codes with the population of 1.4 million people that would be affected by a change in distance to nearest facility if one of these 93 critical access hospitals closed. Starting from the status quo, among these 490 zip codes, the average distance to the nearest critical access hospital was 9.9 miles. The median, the distance such that half the people would go more than it, half would go less than it, was 9.4. Then, we said let's close these 93 hospitals and now how far is the average distance? The median was 16.6 and the range was from 2.1 miles to 52 miles. The impact on beneficiaries and the average -- the resident who lived in this area that would be affected by a closure of the critical access hospital-- the average resident would have to travel 7.9, nearly 8 miles farther. Some people saw no change if they had two hospitals in the same zip code or 38.4-mile average distance.

Every time I look at this table I look at this and I say, 7.9 miles being the average. I think we haven't come up with a good way to really explain what that 8 miles really means. It doesn't sound like much. But, as everyone knows, when you are talking about a really traumatic event or the Golden Hour after some kind of emergency condition, that 7.9 miles can have a major effect on outcomes for the resident and plus, 7.9 miles doesn't mean 7.9 minutes based on travel time and through the mountains or through whether. So, we have to come up with a better way of explaining the 7.9 miles and really making it meaningful so that we all understand what the distance really means.

In terms of what the next nearest hospital would be if one of these 93 critical access hospitals closed, what would be the next nearest facility? 40% of them would still be another critical

access hospital. 20% would be a rural PPS. 15% would be rural referral centers and 10% would be urban PPS. Sometimes people say, if it closes that means maybe they will go to another facility or something different. For the most part, they go to another critical access hospital.

Where is the next closest hospital? 19% are in the same county. 70% would be in a different county or same state and green bar represents those that would be in a different state: 11%. That 11% may be important if we have different licensure rules or if I am a commercial insurer and out-of-network once I cross the state border. Nearly three quarters would remain in the same state, just a different county in the state.

What are the findings and implications? Residents would have to travel an average of nearly 8 miles farther. 40% of them would see a driving distance increase of less than 5 miles. For 31% of the zip code areas, the increased driving distance would be 10 miles or more. The new nearest hospital would not be a CAH for the majority of affected zip codes and 70% would be in a different county but in the same state. Another 11% would be in a different state.

Eliminating the CAH payment classification would have considerable adverse financial consequences on the hospitals: between 36% and 45% of the hospitals would be at high or mid-high risk of financial distress, challenging their ability to remain financially viable in the long run.

These effects would not be the same across the country. There would be different financial effects with the South seeing much, much larger effects than other parts of the country. Hospitals that are closer to other facilities would see different kinds of changes than hospitals farther from other facilities. Understanding what's happening for the average can be very different picture. Looking at different categories or different slices of the country in terms of those hospitals can be different.

Substantial reduction of financial support could lead to a renewal of the high closure rate of the 80s and 1990s with deleterious effects on the health and well-being of these communities. You know there are economic development effects for the communities that are seeing these kinds of closures. The critical access hospital program, from 1996, the large impetus was the rapid number of closures occurring in the 80s and 90s after the advent of prospective payment. The critical access status has stemmed a large number of closures. We saw the closure rate pick up again and what would happen if we move back to what we saw before?

For talking about these high closure rates, that leads to our next project. There are related studies that I want to mention briefly in the last couple of minutes. You may know that through partnership with lots of other institutions including the National Rural Health Association, we've been collecting data on hospital closures across the country. The current count I've seen from January 2010 through today is 42. There's a website you can go to. It's bit.ly/ruralclosures.

You can drill down on rural areas and click on them and see when they closed and the kind of hospitals they were, what they are now. What we really hope to get out of this is a portal and a way to gather information. A lot of times when rural hospitals close, it takes a while to discover that. We are searching websites, searching news outlets, working with CMS on a quarterly basis

to get the most current list of hospitals. We hope to spread the word about this as a resource and a way to collect and gather information from the public. If you know of one that's happening in your community or in your state, there is a feature where you can send an email and tell us. We would love to get that feedback. If you are interested, there's lots of data on how these hospitals are closing and a lot more information is on that website.

Finally, I want to mention a couple of other products that may be of interest to people on this webinar. This map shows enrollment in the federally facilitated marketplace. You may know that recently the assistant secretary for planning and evaluation released zip code level data on the number of people who selected a plan in the Federal Marketplaces. The model has the number of eligible in each community and we have a heat map showing what parts of the country a greater percentage of those eligible are selecting a plan. If you look at this map, one thing that jumps out at you is how the urban colors tend to be hotter than the rural colors. That is because enrollment tends to be higher in the metropolitan areas than it does in the non-metro and rural areas. We are undergoing work now to understand why that is. Does it have something to do with the availability of Federally Qualified Health Centers which are tasked with recruiting people? Does it have something to do with the populations in these areas? Does it have something to do with other factors? There's some discussion on that topic in our brief. We have a brief on mergers and acquisitions among critical access hospitals in particular. What predicts what kinds of hospitals merge and acquire? What happens after hospitals merge or become acquired?

We have another brief that looks at Medicaid expansion given that the states could make decisions about Medicaid expansion. What does it mean in terms of the rural-urban disparity in terms of insurance coverage? What kinds of states are choosing to expand? What kind of states choose not to expand? Are rural populations over or underrepresented in those kinds of places?

For those of you who know about the critical access hospital financial indicator report, those letters were in the mail a couple of weeks ago. If you've been paying attention, hopefully you've got that report. If you expected it and didn't get it, it probably got thrown out in your mail room somewhere. If you go to the Flex Monitoring Team website you can find our email and get that report. Later this year we will start a pilot program for community benefit and market variables, as well as for these critical access hospital reports.

Coming soon, we have a chart book on the 21st century rural hospital. Rural hospitals vary dramatically in terms of size and we've noticed there's a lot of misconceptions out there about what they look like and what they do. We put together a chart book that talks about what the typical 21st century hospital does. Of course, there's no such thing as a typical one. We provide typical hospitals because there are examples of things that rural hospitals are doing.

This is information in terms of ways to contact us. The website is up there. The email address. We are on Twitter. We would love followers on Twitter. We have a wide variety of team members and you can contact anyone of us. All of the contact information is available on the website. Email and Twitter are great ways to get a hold of us. I believe that's it. I think Shawnda can take back over now.

{Shawnda Schroeder:}

Thank you, Mark. If you have any questions, type them into the box now and we will relay them to mark on your behalf. I am not seeing any questions. {the questions were hidden on Shawnda's screen, unfortunately} I do want to thank Mark for presenting today and thank all of you for joining us. If you want an archive of this presentation, it will be housed on the Rural Health Research Gateway website. We would encourage you to sign up for the research alerts. I thank you for your time this afternoon and wish you a happy Halloween.

Questions:

1. Total Margins include investments which are important for reserves.
2. What's an "outlier value" and how was it determined?
3. Do you have the 'high risk of financial distress' data broken-out by State?
4. At 30 mph 8 miles means about 16 to 17 minutes travel time.
5. What is a Rural Referral Center? Is it a type of hospital?
6. Consider the age brackets and poverty levels of these areas when looking at the implications for closures or changes from CAH to PPS. Additionally, look at the implications on economics of the local communities when this change occurs. In our county, the hospital is the largest non-governmental employer in the community.
7. Do you have any advice for doing an analysis of the impact on a single facility?
8. Does the staffing mix (MD, PA, APRN) have any relationship to fragility of the CAH?
9. Are most of your datasets publicly available? If so can you direct us where to obtain data?
10. Has there been any modeling regarding 15 bed or less?
11. What is a Rural Referral Center? Is it a type of hospital?
12. Many CAHs have dropped OB to improve profitability. Was this factored into projections?