MODELING THE FRONTIER EXTENDED STAY CLINIC CONDITIONS OF PARTICIPATION AND REIMBURSEMENT METHODOLOGIES

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

This publication was funded by the Health Resources and Services Administration, Office of Rural Health Policy with the Mountain States Group, Inc. and Stroudwater Associates under contract 03H11626601D.

Table of Contents

Chapter 1 - Executive Summary

1. Introduction	**1 - 1**
2. Methods	**1 - 1**
3. Results	**1 - 2**
4. Conclusions	**1 - 3**

Chapter 2 - Geographic Location of Studied Clinics

1. Location Map	**2 - 1**

Chapter 3 - Data Collection and Analysis Reports

1. Project Overview	**3 - 1**
2. Assignment and Approach	**3 - 1**
3. Methodology	**3 - 2**
4. Sunshine Community Health Center, Talkeetna, Alaska	**3 - 3**
5. Cross Road Medical Center, Glennallen, Alaska	**3 - 11**
6. Dubois Medical Clinic, Dubois, Wyoming	**3 - 19**
7. Eureka Medical Clinic, Eureka, Nevada	**3 - 27**
8. Inter Island Medical Center, Friday Harbor, Washington	**3 - 35**

Chapter 4 - Prior Year FESC Studies

1. Alicia Roberts Medical Center, Klawock, Alaska	**4 - 1**
2. Iliuliuk Clinic, Dutch Harbor, Alaska	**4 - 12**

Chapter 1

Executive Summary

Introduction

The Frontier Extended Stay Clinic (FESC) is being considered as a new provider type. The purpose is to support expansion of services in remote and isolated primary care clinics so that these clinics can meet the needs of patients who need monitoring and observation for a limited period of time. Currently, these isolated facilities must either transfer patients at extraordinary cost or simply keep patients for observation without the benefit of a regulatory structure, licensure, or reimbursement. The design of this new provider type draws from four existing programs:

1. Rural Health Clinic (RHC) certification is used as the certification/licensure model.
2. Federally Qualified Health Center (FQHC) status is used as the basis for outpatient reimbursement. Most of the potential FESCs either are currently FQHCs or are eligible to seek that status.
3. Critical Access Hospital (CAH) licensure is used as the basis for the bed and length of stay limits, with modifications.
4. In addition, the observation bed service and reimbursement model is used as the basis for defining limiting parameters for the patient's stay in the facility for non-tribally operated FESCs and the all-inclusive Federally set rate used for the tribally operated FESCs. The services to be provided in these facilities are similar to outpatient office based services and hospital outpatient observation bed services.

Section 434 of the Medicare Modernization Act of 2003 (MMA) authorized the Center for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy (ORHP) to conduct a National demonstration program under which FESCs would be reimbursed as providers of Medicare services. Under this demonstration, Medicare payment would be provided to remote clinics providing observation-type services in cases where patients cannot or should not be transferred.

Methods

To date, seven medical clinics in four States have participated in the FESC financial modeling project funded by HRSA's Office of Rural Health Policy. Five FESC candidates were chosen for both a site visit and financial modeling while two additional sites were selected for the financial modeling only. Site visits were conducted at medical clinics in Dutch Harbor, Alaska; Prince of Wales Island, Alaska; Talkeetna, Alaska; Eureka, Nevada; and Dubois, Wyoming. In addition, financial analyses were conducted for clinics in Friday Harbor, Washington, and Glen Allen,

Alaska. All seven were located in medically underserved areas and were more than 75 miles away from any acute care hospital or CAH.

This project has developed a financial model that projects clinic financial performance under different Medicare clinic and hospital designations, including: 1) FQHC with capped cost-based Medicare and Medicaid office visit payments; 2) FESC that provides incremental reimbursement for observation stays; and 3) CAH with cost-based payments for Medicare and Medicaid as well as uncapped cost-based RHC office visits. One-year projections have been developed for each scenario based on fiscal year 2004 budgeted financial performance and discussions with management. Assumptions are generally held constant between the models with exceptions to account for the different reimbursement systems as well as incremental costs associated with both the CAH and the FESC to accommodate overnight occupancies.

Results

1. Preliminary results indicate that FESC would financially benefit those clinics that already care for patients overnight. The Iliuliuk Clinic in Dutch Harbor, Alaska, for example, frequently experiences severe weather that prohibits patient transfer for days. This requires medical observation in the clinics, which is currently not being reimbursed by either Medicare or private insurance providers. Other clinics in Alaska appear to be in similar circumstances, particularly those that are a great distance from medical centers in Anchorage and Fairbanks. In the lower 48 States, medical clinic candidates for FESC would be few in numbers -- probably less than ten-- and would experience limited financial benefits. The Friday Harbor, Washington and the Dubois, Wyoming clinics' financial gain would be marginal, at best. The Eureka, Nevada model would actually lose money, due to expensive modifications and equipment purchases and the additional staffing that would be necessary.

2. Quality of care in these facilities is an important consideration when assessing FESC potential. Several of the clinics visited in this study were prepared and eager to take on the additional medical responsibilities of FESC. At least one of the clinics was both unprepared and reluctant to assume additional responsibilities. The Dubois, Wyoming clinic, for example, was staffed by experienced emergency medical professionals eager to care for patients in observation beds, while the Eureka, Nevada clinic was staffed by relatively inexperienced medical professionals, with limited training and experience in

EMS. This disparity in capacity will make it important to develop quality guidelines for the FESC model.

3. Due to the limited number of potential FESCs as well as to the relatively small number of patients that would be kept overnight for observation, the overall cost to Medicare would be minimal. Further, the incremental FESC reimbursement is generally offset by reduced transportation costs and avoided hospitalizations.

Conclusion

The FESC model may have significant benefits for citizens and medical clinics in remote areas of Alaska, where it appears to be financially sustainable. In each of the four Alaska sites included in this financial modeling project, FESC reimbursement resulted in improved cash flow. This occurred as all but one of the clinics are already providing some level of observation services and are not being reimbursed. In the lower 48 States, a few FESCs may be practical in remote areas that are committed to expanding services and willing to take on additional staffing and equipment, but these clinics will probably experience little or no financial gain. Each of the three lower 48 sites reviewed as part of this study experienced little if any financial benefit from FESC reimbursement as the additional FESC reimbursement primarily offset the incremental costs of caring for the extended stay patients. Overall, because of the limited number of potential FESC sites throughout the country, the incremental costs of FESC being offset by reduced costs of avoided hospitalizations and transport, and the improved quality of care offered to patients in these remote areas when FESC type services have a new regulatory and licensing structure, support the case for the FESC demonstration program.

Chapter 2
Geographic Location of Studied Clinics

Location Map

Chapter 3
Data Collection and Analysis Reports

Project Overview

The FESC model is an operating model for which Section 434 of the MMA authorized CMS to conduct a demonstration program under which FESCs would be reimbursed as providers of Medicare services. Under this demonstration, Medicare payment would be provided for remote clinics providing observation-type services in cases where their patients cannot be transferred due to weather or other reasons.

Assignment and Approach

The goal of the project is to evaluate the financial merits of FESC for the participating organizations, the CMS demonstration representatives, and for other interested policy makers. FESC candidates were chosen for both a site visit and financial modeling, while additional sites were selected for the financial modeling only.

The consultants developed a financial model that projects financial performance for each clinic under different Medicare clinic and hospital designations, including: 1) FQHC with capped cost-based Medicare and Medicaid office visit payments; 2) FESC that provides incremental reimbursement for observation stays; and 3) CAH with cost-based payments for Medicare and Medicaid as well as uncapped cost-based RHC office visits. One-year projections have been developed for each scenario based on fiscal year 2004 budgeted financial performance and discussions with management. Assumptions are generally held constant between the models with exceptions to account for the different reimbursement systems as well as incremental costs associated with both the CAH and the FESC to accommodate overnight occupancies.

Specifically, this model:

1. Projects the facility-wide financial impact of conversion from capped cost-based Medicare/Medicaid office visits to cost-based Medicare/Medicaid reimbursement under each of the alternatives based on clinic data and projected changes in volume and revenue; and
2. Projects and includes the impact of the Balanced Budget Refinement Act (BBRA), Benefits Improvement and Protection Act (BIPA), and Medicare Modernization Act (MMA) changes including the Medicare Outpatient Prospective Payment System, allowable costs under CAH, and other clinic and hospital payment changes.

Methodology

The consultants have used internal data to model the financial impact of FQHC/RHC, FESC and CAH status at participating clinics. The consultants matched the financial models to each clinics' operating performance for fiscal year 2004 ("base year") using financial statements, operating statistics, and the period's preliminary FQHC cost report.

The consultants have not audited or attempted to confirm information for accuracy or completeness. Each clinic's staff reviewed all assumptions used in the model. The extent to which the financial analysis accurately predicts actual operating gains or losses depends on how closely the future operating environment matches the model's assumptions. The financial analysis cannot account for unforeseen regulatory or operational changes that may result in reimbursement or utilization changes.

Sunshine Community Health Center

Overview

The Sunshine Community Health Center (SCHC) is a nonprofit corporation and FQHC organized to provide comprehensive primary medical and dental care, mental health services, substance abuse counseling, and related health care services responsive to the needs of the Talkeetna Alaska community and the surrounding regions. SCHC is currently staffed with one physician and 2.7 full-time equivalent mid-level providers. SCHC's current operating budget is approximately $2.3 million per year with an approximately breakeven bottom line primarily due to significant FQHC grant funding that partially funds operations. Because SCHC is 75 miles from the nearest available hospital (Palmer, AK), management is interested in evaluating payment options that would allow it to be paid for local management of appropriate clinical conditions and avoid unnecessary transportation and associated costs. Primarily, SCHC is interested in evaluating the FESC model, relative to the current state (FQHC). A third model, CAH, is evaluated primarily to compare it to other locations selected as part of this project, but is not being considered at this time by SCHC management.

Current Status of Clinic Operations

SCHC is a FQHC providing local health care services to residents and visitors of the Upper Susitna Valley, AK with a population of approximately 6,000. The population expands significantly each summer due to tourism. SCHC provides access to primary care services, diagnostic (lab and X-ray) services, dental services, and behavioral health services to the community, and primarily to those persons who may lack access to these services because of financial, language, lifestyle, health status, or cultural barriers. SCHC is in the process of replacing its current facility, and the new facility will have an urgent care procedure room with a hospital stretcher for patients that require longer observation visits or who are unable to travel to hospitals in either Palmer or Anchorage due to weather or other complications. Further, SCHC only has funding to support the design of an emergency room wing addition.

Because SCHC is not operating as a hospital, it currently meets both the average length of stay requirements and the 25-acute care bed limit of a CAH and it is unlikely that these two CAH metrics will ever be an issue.

SCHC's fiscal year 2004 operating budget shows a breakeven financial position on net patient revenues of $853,000 and grant income and donations of approximately $1,486,000. During fiscal

year 2004, Medicare and Medicaid patients are budgeted to account for nine percent and 34 percent, respectively of all outpatient visits (measured by patient visits).

FQHC

Medicare office visit reimbursement is the lesser of actual costs per visit, adjusted for productivity screens, or an amount capped at approximately $92/visit. Medicaid office visit reimbursement is full costs per visit adjusted for the productivity screen. The FQHC cost-based rate is based on a simulated FQHC cost report that carves out non-FQHC-covered services from FQHC-covered services, and divides these costs of FQHC-covered services by FQHC visits. All other non-FQHC-covered services are reimbursed based on charges or a small discount off of charges. Operating expenses remain unchanged as this model represents status quo.

FESC

As discussed above, FESC has been authorized as a CMS demonstration program under Section 434 of the MMA in which remote clinics, providing observation-type services to Medicare patients would be reimbursed as providers of Medicare services. In its current form, FESCs would be organized similar to an FQHC and be paid as a FQHC would be paid for covered office visits and other ancillary/non-covered office visits. The key difference between the FESC and a FQHC is that the FESC would be reimbursed for "extended stays" as described below. Because the FESC is a CMS demonstration program only without a formally defined reimbursement system, revenue assumptions related to this model are those that are being proposed and not accepted as final.

SUNSHINE COMMUNITY HEALTH CENTER
ASSUMPTIONS
Fiscal Year Ending June 30, 2004

Assumptions

FESC Changes:	**Revenue**	**Salaries**	**Non-Salaries (excluding benefits)**
1) Additional Clinical Support Staff (added to Clinic)	**$ -**	**$ 40,000**	$ -
2) Additional Capital Costs to Support Extended Stay	**$ -**	**$ -**	
3) % Increase in Observation "Stays"		**0%**	
4) Observation Admissions per Month		**1.0**	
5) Average length of Observation Admission		**20.0**	
6) % of Clinic Visits that result in extended stay		**0.57%**	
7) Average length of extended clinic visit		**6.0**	
8) % Increase in Observation "Stays"		**0%**	
9) % of Observation Stays that would avoid Ambulance Trip		**25%**	
10) Employee Benefit %		**20%**	

These revenue assumptions primarily include FQHC-covered office visits reimbursable at the FQHC payment rate and extended stays exceeding 4 hours being reimbursed at a 24-hour per

diem of $2,400 (thus a 4-hour stay would be reimbursed $400). To derive the number of reimbursable observation days, the consultants discussed the current level of activity with the SCHC management team. Two types of extended stays were used for modeling purposes. The first is patients who enter SCHC and need extended observation (e.g., re-hydration, etc.). Management anticipates approximately one of these patients per month with an average length of stay of 20 hours. The second extended stay group is the patients require more complicated care that extends their office visit beyond 4 hours. Management anticipates approximately three of these visits per month with a 6 hour average length of stay. For all stays exceeding 4 hours, the total number of billed units (in increments of 4 hours) is added together and divided by six to determine billable "days." While not directly related to SCHC, a reduction in the number of ambulance trips and associated hospitalizations at area hospitals would occur, which ultimately reduces costs to patients and payers. The financial model assumes a 25 percent reduction in ambulance transfers for those patients treated in the observation beds. Finally, the model assumes that SCHC would have to increase clinical staffing by $40,000 (plus benefits) per year to cover the increased support required for maintaining 24-hour available observation services. FESC changes are summarized in the chart on the next page.

1) Observation Stays based on discussion with management. Average Observation stays were assumed to last 20 hours. Observation Billed units are determined by dividing each observation stay by 4 as observations stays will be billed in 4 hour increments
2) Observation Days are determined by dividing observation billed units by 6. The observations days are increased by 100% to accommodate increased use of services
3) Observation services are billed in 4 hours increments of $400 ($2,400 per day)
4) Observation revenue is carved out of Clinic Costs in determining the Clinic Cost per visit
5) Incremental costs associated with the FESC include $40,000 of clinical staffing plus associated employee benefits
6) Avoided program costs include reduced number of ambulance trips and assoicated hospitalizations at area hospitals (see below for assumptions)

CAH

A CAH is a limited-service hospital that is eligible for generally more favorable, cost-based Medicare, and in some States Medicaid reimbursement. The Alaska Medicaid program has adopted cost-based reimbursement for both inpatient and outpatient (part "A") services. To qualify for cost-based Medicare reimbursement, CAH status requires that a rural hospital have a bed limit of 25, with no more than 25 acute patients at one time and an <u>average</u> length of stay of less than 96 hours.

SUNSHINE COMMUNITY HEALTH CENTER
ASSUMPTIONS
Fiscal Year Ending June 30, 2004

Assumptions

CAH Changes:	Revenue	Salaries	Non-Salaries (excluding benefits)	Square Ft
1) Loss of CHC Grant	$ (1,263,674)	$ -	$ -	-
2) Reclass of Expense from Clinic to Emergency Room		$ 80,000		1,000
3) Add'l Annual Capital Costs ($15M/25 year depreciation)	$ -	$ -	$ 600,000	-
4) Additional Administrative Costs	$ -	$ 40,000	$ 40,000	
5) Incremental Adults and Pediatric Costs (3 Clinical)	$ -	$ 120,000	$ 20,000	1,000
6) % of Observation Visits Admitted		25%		
7) % reduction in "Observation" visits		-25%		
8) Average Length of Stay		3.00		
9) % of Observation Stays that would avoid Transportation		25%		
10) Employee Benefit %		20%		

A number of changes to the original FQHC model were necessary to incorporate CAH reimbursement. From the FQHC cost report, the consultants derived a "hospital" cost report using incremental expenses as well as reclassification entries to appropriately reflect the level of "inpatient" clinical care. These are noted in the above table. From observation days determined in the FESC model, it was assumed that 25 percent of these would be admitted into the hospital and reimbursed by Medicare and Medicaid on a cost basis, and all other payers at a case payment rate of $7,500. Twenty-five percent of current ambulance transports would be avoided- reducing both the patient and third party cost related to these services. For outpatient services, Medicare and Medicaid will reimburse SCHC on a cost basis (including RHC covered visits, which are not capped) while all other payers will pay a discount off of charges. A significant assumption is that the capital costs necessary to bring SCHC up to "code" would be approximately $15 million, with related annual depreciation costs of approximately $600,000. Further, staffing costs and non-staffing operating costs are increased by $160,000 and $60,000, respectively, to accommodate both increases in hospital clinical care as well as additional administrative expenses necessary to accommodate the incremental complexities of managing a hospital relative to an FQHC.

Results

Appended to this report are the projected Statements of Operations for the alternatives studied in the consultants' financial assessment. The results of the analysis are summarized in the tables below.

SUNSHINE COMMUNITY HEALTH CENTER COMPARISON OF FINANCIAL MODELS - PRO FORMA STATEMENT OF OPERATIONS Fiscal Year Ending June 30, 2004 *For Internal Purposes Only*					
REVENUE:	FQHC ***(I)***	FESC ***(II)***	CAH/RHC ***(III)***	FQHC vs. FESC ***(II - I)***	FQHC vs. CAH/RHC ***(III - I)***
Inpatient Revenue	$ -	$ -	$ 150,000	$ -	$ 150,000
Outpatient Revenue	944,000	990,000	1,323,000	46,000	379,000
Net Patient Revenue	944,000	990,000	1,473,000	46,000	529,000
Other Revenue	1,486,000	1,486,000	223,000	-	(1,263,000)
Total Revenue	2,430,000	2,476,000	1,696,000	46,000	(734,000)
EXPENSES:					
Total Expenses	2,346,000	2,394,000	3,198,000	48,000	852,000
Net Income (Loss)	84,000	82,000	(1,502,000)	(2,000)	(1,586,000)

The projected financial cost of converting to a FESC is approximately $2,000 and is primarily the result of the incremental FESC costs slightly exceeding the FESC reimbursement for extended stays. CAH status is projected to cost SCHC approximately $1.6 million relative to FQHC status. The negative impact relates directly to the increase in clinical, operating and capital costs without the "hospital" type volume to offset these costs as well as the loss of the FQHC grant income.

Medicare and Medicaid Payer Mix Impact

In order to evaluate the impact on each of these designations from both a Medicare and Medicaid perspective, the consultants' prepared separate financial summaries for each of these payers. The following chart demonstrates the impact to Medicare should any of these designations be adopted.

Medicare program costs are projected as follows:

SUNSHINE COMMUNITY HEALTH CENTER COMPARISON OF FINANCIAL MODELS - MEDICARE COST ONLY Fiscal Year Ending June 30, 2004 *For Internal Purposes Only*					
MEDICARE COST	FQHC ***(I)***	FESC ***(II)***	CAH/RHC ***(III)***	FQHC vs FESC ***(III - I)***	FQHC vs CAH/RHC ***(III - I)***
Inpatient Cost	$ -	$ -	$ 20,000	$ -	$ 20,000
Outpatient Cost	65,000	69,000	169,000	4,000	104,000
Net Patient Cost	65,000	69,000	189,000	4,000	124,000
Other Cost	46,000	42,000	42,000	(4,000)	(4,000)
Total Cost	111,000	111,000	231,000	-	120,000

Medicare costs for FESC are projected to equal the cost of FQHC as the marginally higher extended stay costs are offset by a reduction in ambulance transfers and the associated cost of

hospitalization services for patients once transported. Medicare costs for CAH are projected to be $120,000 greater for CAH and are related directly to Medicare reimbursing CAHs on a cost basis and SCHC increasing clinical, operating and capital costs as discussed above.

Medicaid program costs are projected as follows:

SUNSHINE COMMUNITY HEALTH CENTER
COMPARISON OF FINANCIAL MODELS - MEDICAID COST ONLY
Fiscal Year Ending June 30, 2004

For Internal Purposes Only

MEDICAID COST	FQHC ***(I)***	FESC ***(II)***	CAH/RHC ***(III)***	FQHC vs. FESC ***(II - I)***	FQHC vs. CAH/RHC ***(III - I)***
Inpatient Cost	$ -	$ -	$ 78,000	$ -	$ 78,000
Outpatient Cost	423,000	440,000	610,000	17,000	187,000
Net Patient Cost	423,000	440,000	688,000	17,000	265,000
Other Cost	170,000	154,000	154,000	(16,000)	(16,000)
Total Cost	593,000	594,000	842,000	1,000	249,000

Negligible Medicaid costs associated with the FESC model are similar to the Medicare findings and occur because the additional cost of FESC services is offset by the reduction in ambulance costs and the associated cost of hospitalizations.

Conclusions

While the FESC model does not provide a clear financial benefit to SCHC, clinical benefits related to patient care must be evaluated when considering the FESC option. The consultants recommend that SCHC continue to monitor FESC demonstration program developments at both the State and Federal level. Because CAH provides no financial benefit at this time, SCHC should not adopt this designation.

SUNSHINE COMMUNITY HEALTH CENTER
PRO FORMA STATEMENTS OF OPERATIONS
Fiscal Year Ending June 30, 2004

The Accompanying Assumptions are Integral to this Pro Forma

	FQHC	FESC	CAH/RHC
OPERATING REVENUE:			
Inpatient Revenue:			
General Acute	-	-	150,205
Total Inpatient Revenue	-	-	150,205
Outpatient Revenue:			
Clinic	666,419	667,403	767,912
Office Procedures	40,956	40,956	41,603
Injections/Immunizations	3,108	3,108	3,108
Radiology - Diagnostic	3,510	3,510	20,731
Laboratory	16,941	16,941	35,281
Drugs Charged to Patients	49,877	49,877	55,220
Emergency	-	-	176,766
Distinct Observation Bed Unit	-	45,600	59,688
Care Coordination	19,387	19,387	19,387
Dental Program	143,325	143,325	143,325
Total Outpatient Revenue	943,524	990,108	1,323,021
Net Patient Revenue	943,524	990,108	1,473,226
Other Operating Revenue:			
BPHC - CHC Grant	1,263,674	1,263,674	-
Oral Health	200,000	200,000	200,000
United Way	20,000	20,000	20,000
Interest Income	2,500	2,500	2,500
Other Non-Op. Rev (Fin. Stmnt.)	-	-	-
Total Other Operating Revenue	1,486,174	1,486,174	222,500
Total Operating Revenue	2,429,698	2,476,282	1,695,726
OPERATING EXPENSES:			
Salaries	1,416,423	1,456,423	1,576,423
Employee Benefits	334,101	342,101	366,101
Pro Fees, Supplies, & Other	574,554	574,554	628,554
Depreciation and amortization	8,000	8,000	614,000
Interest Expense	6,000	6,000	6,000
Provision for doubtful accounts	6,500	6,500	6,500
Total Operating Expenses	2,345,578	2,393,578	3,197,578
Net Operating Income	84,120	82,704	(1,501,852)

Appendix II - Base Year Assumptions

SUNSHINE COMMUNITY HEALTH CENTER
ASSUMPTIONS
Fiscal Year Ending June 30, 2004

Assumptions

Inpatient (CAH/RHC Model Only):		
Acute Cases:		
Acute - Medicare		**1**
Acute - Medicaid		**4**
Acute - Non Care/Caid		**7**
Number of Patient Days:		
Acute - Medicare		**3**
M'care HMO		**-**
% M'care SSI		**0%**
Acute - Medicaid		**12**
M'caid HMO		**-**
Acute - Non-Care/Caid		**21**
Average Per Case Payment Rate:		
Acute - Medicare	**	**N/A**
Acute - Medicaid	***	**N/A**
Acute - Non-Medicare	***	**$ 7,500**
** PPS payments		
*** Includes nursery est. at $500/day		
Average Per Day Payment Rate:		
Acute - Medicare		N/A
Acute - Medicaid		N/A
Acute - Non-Medicare		$ 2,500

Other Operating Revenue:	
BPHC - CHC Grant	**$ 1,263,674**
Oral Health	**$ 200,000**
United Way	**$ 20,000**
Interest Income	**$ 2,500**
Other Non-Op. Rev (Fin. Stmnt.)	**$ -**
Total	$ 1,486,174

Outpatient:	O/P Total
Medicare O/P Payer Mix:	**9.48%**
Medicaid O/P Payer Mix:	**34.00%**
Medicare Avg C/A (exc Pharm	**25.00%**
Medicaid Avg C/A (exc Pharm	**25.00%**
All other Avg C/A & Charity	**20.00%**
Clinic	
Patient Visits	**6,294**
Net Revenue Per	**$ 64.99**
RHC Payment Cap	**N/A**
FQHC Payment Cap	**$ 92.00**
Physician FTEs	**1.0**
Mid Level FTEs	**2.7**
Immunizations:	
Visits	**169**
Net revenue per*	**$ 25.00**
Medicare Costs Per Injectio	**$9.79**
Medicaid Costs Per Injectio	**$9.79**
Office Procedures:	
Procedures	**351**
Net revenue per*	$ 120.00
Medicare Fees Per Proc	**$ 112.50**
Medicaid Fees Per Proc	**$ 112.50**
Radiology - Diagnostic	
Procedures	**60**
Net revenue per*	$ 60.00
Medicare Fees Per Test	**$56**
Medicaid Fees Per Test	**$56**
Laboratory	
Test	**1,125**
Net revenue per*	**$ 40.00**
Medicare Net Rev Per	**$ 10.00**
Medicaid Net Rev Per	**$ 15.00**
M/C Fee charges	**$ -**
Drugs Charged to Patients	
O/P Scripts	**3,000**
Net revenue per*	$ 17.46
Medicare Fees Per Supply	**$ 13.10**
Medicaid Fees Per Supply	**$ 13.10**

Outpatient (cont.)	O/P Total
Emergency Room	
Visits	**-**
Incr CAH ER Visits	**500**
M/C Prof. Pmt.	$ 50
Net revenue per*	**$ 250**
Medicare Fees	**$ -**
Medicaid Fees	**$ -**
Distinct Observation Bed Unit	
Obs Adm per mnth	**1**
Avg Obs Hrs/Admis	**20.00**
% Clinic Extended visits	**0.57%**
Avg Obs Hrs/ER Admis	**6.00**
Net revenue per (roun	**$ 2,400**
Actual Days	**19**
Care Coordination:	
Visits	**500**
Net Revenue Per	$ 38.77
Medicare Fees Per Vi	**$ 38.77**
Medicaid Fees Per Vi	**$ 38.77**
Dental Program:	
Visits	**1,800**
Net Revenue Per	$ 79.63
Medicare Fees Per Vi	**N/A**
Medicaid Fees Per Vi	**$ 79.63**
Medivac Trips	
Number of Trips	**-**
Net Revenue Per	**$ 8,000**
Medicare Fees	**$ 8,000**
Medicaid Fees	**$ 8,000**

Other Program Effects:	
Reduced Ambulance Trips	
# of Trips/year	**130**
% Reduction	**25%**
Net Cost Per	**$ 500.00**
Medicare Costs	**$ 350.00**
Medicaid Costs	**$ 350.00**
Reduced Hospitalizations	
Net Cost Per	**$ 3,500**
Medicare Costs	**$ 3,500**
Medicaid Costs	**$ 3,500**

Cross Road Medical Center, Glennallen, Alaska

Overview

Glennallen, Alaska and the surrounding South Central Alaska local health care needs are served primarily by Cross Road Medical Center (CRMC), a recently designated Federally Qualified Health Center (FQHC) owned and operated by a non-profit faith-based organization. With the most accessible hospitals in Anchorage, nearly 200 miles away, CRMC meets a diverse need for health care services ranging from colds/flu to all forms of injuries, including lacerations, broken bones, and life-threatening trauma. CRMC is currently staffed with two physicians and a half time nurse practitioner. CRMC's current operating budget is approximately $2.5 million per year with an approximately breakeven bottom line primarily due to significant donor and missionary contributions that partially fund operations. Because CRMC actively serves patients on an observation basis, often overnight, and does not received incremental funding for these services, CRMC is interested in evaluating payment options that would offset the cost of these ongoing services. Primarily, CRMC is considering several different operating models including:

1. Status Quo (FQHC);
2. FESC; or
3. CAH.

Current Status of Clinic Operations

CRMC is a recently-designated FQHC providing all local health care needs for residents and visitors of the Copper River Basin of Alaska with a population of approximately 3,000. The population expands significantly each summer with tourists. CRMC provides access to primary care services, diagnostic (lab and X-ray) services, counseling services, urgent care services, a pharmacy and observation services. CRMC maintains four hospital-type beds for patients that require longer observation visits or are unable to travel to Anchorage due to weather of other complications. Extended stays are not recognized as reimbursable other than a complicated office visit.

Because CRMC is not operating as a hospital, it currently meets both the average length of stay requirements and the 25 acute-care bed limit of a CAH and it is unlikely that these two CAH metrics will ever be an issue.

CRMC's fiscal year 2004 (annualized 11 months year to date) financial statements, adjusted for full year FQHC 330 funding, show a net gain of approximately $130,000, on net patient revenues of $1.8 million and grant income and donations of approximately $.9 million. During fiscal year 2004, Medicare and Medicaid patients accounted for 15 percent and 25 percent, respectively of all outpatient visits (measured by charges).

FQHC

Medicare office visit reimbursement is the lower of actual costs per visit, adjusted for productivity screens, or an amount capped at approximately $92/visit. Medicaid office visit reimbursement is full costs per visit adjusted for the productivity screen. The FQHC cost-based rate is based on a simulated FQHC cost report that carves out non-FQHC-covered services from FQHC-covered services and divides these costs of FQHC-covered services by FQHC visits. For both the FQHC and FESC, emergency room visits and expenses are considered clinic activity. All other non-FQHC-covered services are reimbursed based on charges or a small discount off of charges. Operating expenses remain unchanged as this model represents status quo.

FESC

As discussed above, FESC has been authorized as a CMS demonstration program under Section 434 of the MMA in which remote clinics, providing observation-type services to Medicare patients, would be reimbursed as providers of Medicare services. In its current form, FESCs would be organized similar to an FQHC and be paid as a FQHC would be paid for covered office visits and other ancillary/non-covered office visits. The key difference between the FESC and a FQHC is that the FESC would be reimbursed for "extended stays" as described below. Because the FESC is a CMS demonstration program only without a formally defined reimbursement system, revenue assumptions related to this model are those that are being proposed and are not final.

CROSS ROAD MEDICAL CENTER
ASSUMPTIONS
Fiscal Year Ending March 31, 2004

Assumptions

FESC Changes:	**Revenue**	**Salaries**	**Non-Salaries (excluding benefits)**
1) Additional Clinical Support Staff (added to Clinic)	**$ -**	**$ 80,000**	**$ 40,000**
2) Additional Capital Costs to Support Extended Stay	**$ -**	**$ -**	
3) Average Patient Stay Hours per Observation Admissions		**20.00**	
4) % or Emergency Room Visits Exceeding 4 Hours		**7.0%**	
5) Average Patient Stay Hours per ER Observation Admission		**6.00**	
6) % Increase in Observation "Stays"		**25%**	
7) % of Observation Stays that would avoid Medivac		**10%**	
8) Employee Benefit %		**25%**	

These revenue assumptions primarily include FQHC-covered office visits reimbursable at the FQHC payment rate and extended stays exceeding 4 hours being reimbursed at a 24-hour per diem of $2,400 (thus a 4-hour stay would be reimbursed $400). To derive the number of reimbursable observation days, the consultants reviewed statistical logs for fiscal year 2004 (11 months YTD ended February 29, 2004) for actual patients admitted to observation as well as emergency room visits. Assumptions are made to determine the number of observation hours per observation and emergency room admission, and the percent of emergency room visits that exceed 4 hours. For all stays exceeding 4 hours, the total number of billed units (in increments of 4 hours) were added together and divided by six to determine billable "days." Billable observations days are increased by 50 percent to accommodate the growth in these services once they become reimbursable. While not directly related to CRMC, a reduction in the number of medevac patients would occur, which ultimately reduces costs to patients and payers. The financial model assumes a 25 percent reduction in medevac transfers and related hospitalizations. Finally, the model assumes that CRMC would have to increase clinical staffing by $80,000 (plus benefits) and other non-staffing costs by $40,000 per year to cover the increased clinical support of maintaining 24-hour available observation services. FESC changes are summarized in the chart below.

1) Observation Stays based on both observation admissions and a fraction of ER visits during FY 2004.
   The total observation hours on a per patient basis are divided by 4 (billing unit) to determine billable units.
2) Observation Days are determined by dividing observation billed units by 6. The observations days are increased by 50% to accommodate increases in services
3) Observation services are billed in 4 hours increments of $400 ($2,400 per day)
4) Observation revenue is carved out of Clinic Costs in determining the Clinic Cost per visit
5) Incremental costs associated with the FESC include $80,000 of clinical staffing plus associated employee benefits, and $40,000 of other expense offset by a slight reduction in medevac program costs

CAH

A CAH is a limited-service hospital that is eligible for generally more favorable, cost-based Medicare, and in some States Medicaid reimbursement. The Alaska Medicaid program has adopted cost-based reimbursement for both inpatient and outpatient (part "A") services. To qualify for cost-based Medicare reimbursement, CAH status requires that a rural hospital have a bed limit of 25, with no more than 25 acute patients at one time and an <u>average</u> length of stay of less than 96 hours.

CROSS ROAD MEDICAL CENTER
ASSUMPTIONS
Fiscal Year Ending March 31, 2004

Assumptions

CAH Changes:	Revenue	Salaries	Non-Salaries (excluding benefits)	Square Ft
1) Loss of CHC Grant	$ (576,000)	$ -	$ -	-
2) Reclass of Expense from Clinic to Emergency Room		$ -		1,000
3) Additional Annual Capital Costs ($15M/25 year Deprec)	$ -	$ -	$ 600,000	-
4) Additional Administrative Costs	$ -	$ 40,000	$ 40,000	
5) Incremental Adults and Pediatric Costs (3 Clinical)	$ -	$ 120,000	$ 40,000	1,000

6) % of Observation Visits Admitted	15%
7) % reduction in "Observation" visits	-25%
8) Average Length of Stay	3.00
9) % of Observation Stays that would avoid medevac	10%
10) Employee Benefit %	25%

A number of changes to the original FQHC model were necessary to incorporate CAH reimbursement. From the FQHC cost report, the consultants derived a "hospital" cost report using incremental expenses as well as reclass entries to appropriately reflect the level of "inpatient" clinical care. These are noted in the above table. From observation days determined in the FESC model, it was assumed that 15 percent of these would be admitted into the hospital and reimbursed by Medicare and Medicaid on a cost basis, and all other payers at a case payment rate of $7,500. Twenty-five percent of current medevac transports would be avoided reducing both the patient and third party cost related to these services. For outpatient services, Medicare and Medicaid will reimburse CRMC on a cost basis (including RHC covered visits, which are not capped) while all other payers will pay a discount off of charges. A significant assumption is that the capital costs necessary to bring CRMC up to "code" would be approximately $15 million with related annual depreciation costs of approximately $600,000. Further, staffing costs and non-staffing operating costs are increased by $160,000 and $60,000, respectively, to accommodate both increases in hospital clinical care as well as additional administrative expenses necessary to accommodate the incremental complexities of managing a hospital relative to an FQHC.

Results

Appended to this report are the projected Statements of Operations for the alternatives studied in the consultants' financial assessment. The results of the analysis are summarized in the tables below.

CROSS ROAD MEDICAL CENTER
COMPARISON OF FINANCIAL MODELS - PRO FORMA STATEMENT OF OPERATIONS
Fiscal Year Ending March 31, 2004

For Internal Purposes Only

REVENUE:	FQHC ***(I)***	FESC ***(II)***	CAH/RHC ***(III)***	FQHC vs. FESC ***(II - I)***	FQHC vs. CAH/RHC ***(III - I)***
Inpatient Revenue	$ -	$ -	$ 189,000	$ -	$ 189,000
Outpatient Revenue	1,747,000	2,046,000	2,120,000	299,000	373,000
Net Patient Revenue	1,747,000	2,046,000	2,309,000	299,000	562,000
Other Revenue	874,000	874,000	298,000	-	(576,000)
Total Revenue	2,621,000	2,920,000	2,607,000	299,000	(14,000)
EXPENSES:					
Total Expenses	2,488,000	2,628,000	3,368,000	140,000	880,000
Net Income (Loss)	133,000	292,000	(761,000)	159,000	(894,000)

The projected financial benefit of converting to a FESC is proximately $160,000 and is primarily the result of CRMC being reimbursed for extended stays that are currently being performed but not being reimbursed. CAH status is projected to cost CRMC approximately $895,000 relative to FQHC status. The negative impact relates directly to the increase in clinical, operating and capital costs without the "hospital" type volume to offset these costs.

Medicare and Medicaid Payer Mix Impact

In order to evaluate the impact on each of these designations from both a Medicare and Medicaid perspective, the consultants prepared separate financial summaries for each of these payers. The following chart demonstrates the impact to Medicare should any of these designations be adopted.

CROSS ROAD MEDICAL CENTER
COMPARISON OF FINANCIAL MODELS - MEDICARE COST ONLY
Fiscal Year Ending March 31, 2004

For Internal Purposes Only

MEDICARE COST	FQHC ***(I)***	FESC ***(II)***	CAH/RHC ***(III)***	FQHC vs FESC ***(III - I)***	FQHC vs CAH/RHC ***(III - I)***
Inpatient Cost	$ -	$ -	$ 17,000	$ -	$ 17,000
Outpatient Cost	101,000	135,000	157,000	34,000	56,000
Net Patient Cost	101,000	135,000	174,000	34,000	73,000
Other Cost	129,000	95,000	95,000	(34,000)	(34,000)
Total Cost	230,000	230,000	269,000	-	39,000

Medicare costs for FESC are projected to be equal to FQHC costs as marginally higher extended stay costs are offset by a reduction in medevac transfers and associated hospitalizations.

Medicare costs for CAH are projected to be $39,000 greater for CAH and are related directly to Medicare reimbursing CAHs on a cost basis and CRMC increasing clinical, operating and capital costs as discussed above.

Medicaid costs are projected as follows:

CROSS ROAD MEDICAL CENTER
COMPARISON OF FINANCIAL MODELS - MEDICAID COST ONLY
Fiscal Year Ending March 31, 2004

For Internal Purposes Only

MEDICAID COST	FQHC ***(I)***	FESC ***(II)***	CAH/RHC ***(III)***	FQHC vs. FESC ***(II - I)***	FQHC vs. CAH/RHC ***(III - I)***
Inpatient Cost	$ -	$ -	$ 30,000	$ -	$ 30,000
Outpatient Cost	225,000	282,000	290,000	57,000	65,000
Net Patient Cost	225,000	282,000	320,000	57,000	95,000
Other Program Cost	219,000	162,000	162,000	(57,000)	(57,000)
Total Cost	444,000	444,000	482,000	-	38,000

Medicaid costs associated with the FESC model are similar to the Medicare findings and occur because the lower projected cost-based office visits are offset by the new reimbursement for extended stays.

Conclusions

The FESC model provides clear financial benefit to CRMC reimbursing the organization for services currently being performed and not compensated for. The consultants recommended that CRMC continue to monitor FESC demonstration program developments at both the State and Federal level. Because CAH provides no financial benefit at this time, CRMC should not adopt this designation.

CROSS ROAD MEDICAL CENTER
PRO FORMA STATEMENTS OF OPERATIONS
Fiscal Year Ending March 31, 2004

The Accompanying Assumptions are Integral to this Pro Forma

	FQHC	FESC	CAH/RHC
REVENUE:			
Inpatient Revenue:			
General Acute	-	-	188,978
Total Inpatient Revenue	-	-	188,978
Outpatient Revenue:			
Clinic	446,357	400,312	467,115
Office Procedures	121,820	121,820	125,813
Injections/Immunizations	2,865	2,865	2,865
Radiology - Diagnostic	29,486	29,486	41,910
Laboratory	63,371	63,371	79,381
Medical Supplies Charged to Patients	73,462	73,462	69,331
Drugs Charged to Patients	1,009,481	1,009,481	1,009,481
Emergency	-	-	106,929
Medivac Services	-	-	-
Distinct Observation Bed Unit	-	345,000	216,694
Total Outpatient Revenue	1,746,842	2,045,797	2,119,519
Net Patient Revenue	1,746,842	2,045,797	2,308,497
Other Revenue:			
BPHC - CHC Grant	576,000	576,000	-
Other Grants	14,556	14,556	14,556
Donor Support	109,836	109,836	109,836
Housing Income	29,350	29,350	29,350
Missionary Service Support	109,023	109,023	109,023
Other Operating Income	34,582	34,582	34,582
Interest Income	388	388	388
Total Other Revenue	873,735	873,735	297,735
Total Revenue	2,620,577	2,919,533	2,606,232
EXPENSES:			
Salaries	763,221	843,221	923,221
Employee Benefits	196,193	216,193	236,193
Pro Fees, Supplies, & Other	1,390,983	1,430,983	1,467,549
Depreciation and amortization	70,066	70,066	673,500
Interest Expense	3,434	3,434	3,434
Provision for doubtful accounts	64,473	64,473	64,473
Total Expenses	2,488,370	2,628,370	3,368,370
Net Income (Loss)	132,207	291,162	(762,138)

Appendix II - Base Year Assumptions

CROSS ROAD MEDICAL CENTER
ASSUMPTIONS
Fiscal Year Ending March 31, 2004

Assumptions

Inpatient (CAH/RHC Model Only):		
Acute Cases:		
Acute - Medicare		**4**
Acute - Medicaid		**7**
Acute - Non Care/Caid		**19**
Number of Patient Days:		
Acute - Medicare		**12**
M'care HMO		**-**
% M'care SSI		**0%**
Acute - Medicaid		**21**
M'caid HMO		**-**
Acute - Non-Care/Caid		**57**
Average Per Case Payment Rate:		
Acute - Medicare	**	**N/A**
Acute - Medicaid	***	**N/A**
Acute - Non-Medicare	***	**$ 7,500**
** PPS payments		
*** Includes nursery est. at $500/day		
Average Per Day Payment Rate:		
Acute - Medicare		N/A
Acute - Medicaid		N/A
Acute - Non-Medicare		$ 2,500
Other Operating Revenue:		
BPHC - CHC Grant		**$ 576,000**
Other Grants		**$ 14,556**
Donor Support		**$ 109,836**
Housing Income		**$ 29,350**
Missionary Service Support		**$ 109,023**
Other Operating Income		**$ 34,582**
Interest Income		**$ 388**
Other Non-Op. Rev (Fin. Stmnt.)		**$ -**
Total		$ 873,735

Outpatient:	O/P Total
Medicare O/P Payer Mix:	**14.56%**
Medicaid O/P Payer Mix:	**24.78%**
Medicare Avg C/A (exc Pharm)	**63.74%**
Medicaid Avg C/A (exc Pharm)	**23.11%**
All other Avg C/A & Charity	**4.97%**
Clinic	
Patient Visits	**5,148**
Net Revenue Per	**$ 86.90**
RHC Payment Cap	**N/A**
FQHC Payment Cap	**$ 92.00**
MD FTEs	**2.00**
Mid Level FTEs	**0.50**
Office Procedures:	
Procedures	**883**
Net revenue per*	**$ 137.50**
Medicare Fees Per Proc	**$ 54.39**
Medicaid Fees Per Proc	**$ 115.34**
Injections/Immunizations:	
Visits	**150**
Net revenue per*	**$ 25.00**
Medicare Cost Per Injection	**$ 10.00**
Medicaid Cost Per Injection	**$ 10.00**
Radiology - Diagnostic	
Procedures	**480**
Net revenue per*	**$ 71.27**
Medicare Fees Per Test	**$ 27.20**
Medicaid Fees Per Test	**$ 57.67**
Laboratory	
Test	**2,169**
Net revenue per*	**$ 47.51**
Medicare Net Rev Per	**$ 18.13**
Medicaid Net Rev Per	**$ 38.45**
M/C Fee charges	**N/A**

Outpatient (cont.)	O/P Total
PT, OT, ST:	
Visits	**197**
Net revenue per*	**$ 88.61**
Medicare Fee tests	**$ 33.81**
Medicaid Fee tests	**$ 71.70**
M/C Fee charges	**N/A**
Medical Supplies Charged to Patients	
O/P supplies	**3,541**
Net revenue per*	**$ 47.51**
Medicare Fees Per Supply	**$ 18.13**
Medicaid Fees Per Supply	**$ 38.45**
Emergency Room	
Visits	**1,297**
M/C Prof. Pmt.	$ 50
Net revenue per*	**$ 48.43**
Medicare Fees	**$ 18.48**
Medicaid Fees	**$ 39.19**
Distinct Observation Bed Unit	
Avg Obs Hrs/Admis	**20.00**
% ER Extended visits	**7.00%**
Avg Obs Hrs/ER Admis	**6.00**
Actual Observation Days	**115**
Net revenue per (rountine)	**$ 2,400**
Drugs Charged to Patients	
O/P Scripts	**17,329**
Net revenue per*	$ 58.25
Medicare Fees Per Supply	**$ 58.25**
Medicaid Fees Per Supply	**$ 58.25**
Medivac Trips	
Number of Trips	**77**
Net Revenue Per	**$ 8,000**
Medicare Fees	**$ 8,000**
Medicaid Fees	**$ 8,000**

Dubois Medical Clinic, Dubois, Wyoming

Overview

Community Health Centers of Central Wyoming (CHCCW) assumed operations of the Dubois Medical Clinic (DMC) in September, 2003 from the Jackson Hospital and is now operating it as a Federally Qualified Health Center satellite location off of its main campus located in Casper, Wyoming. DMC, located in Dubois, Wyoming provides family medicine, urgent care and 24-hour emergency care, lab, x-ray, and other related services to the approximately 2,300 residents of Dubois and the surrounding region, as well as the significant number of tourist that frequent the area. DMC is currently staffed with a .6 FTE physician, a .4 FTE physician assistant, and one full time nurse practitioner. DMC's current operating budget is approximately $760,000 per year, with an approximately breakeven bottom line primarily on account of FQHC 330 (b) funding. Because DMC is approximately 80 miles from the nearest available hospital in Jackson, Wyoming, the clinic management is interested in evaluating payment options that would allow it to be paid for local management of appropriate clinical conditions to avoid the unnecessary transportation and associated cost. Primarily, DMC is interested in evaluating the FESC model, relative to the current state (e.g., FQHC). A third model, CAH, is evaluated primarily to compare it to other locations selected as part of this project, but is not being considered at this time by CHCCW management.

Current Status of Clinic Operations

DMC is one of two clinic sites owned and operated by CHCCW, a FQHC. DMC provides local health care services to residents and visitors of Dubois with a population of approximately 2,300. DMC provides access to primary care services, diagnostic (lab and X-ray) services, 24-hour urgent and emergency care, and other health related health education and management services to the community. Currently, DMC does not offer observation-type services to patients except on rare occasions. Extended stays are currently not recognized as reimbursable other than a complicated office visit.

DMC's fiscal year 2006 operating budget shows a breakeven financial position, on net patient revenues of $425,000 and grant income and donations of approximately $340,000. During fiscal year 2004, Medicare and Medicaid patients are budgeted to account for 29 percent and 14 percent, respectively, of all outpatient visits (measured by patient visits).

FQHC

Medicare office visit reimbursement is the lower of actual costs per visit, adjusted for productivity screens, or an amount capped at approximately $96/visit. Medicaid office visit reimbursement is full costs per visit adjusted for the productivity screen. The FQHC cost-based rate is based on a simulated FQHC cost report that carves out non-FQHC-covered services from FQHC-covered services, and divides these costs of FQHC-covered services by FQHC visits. All other non-FQHC-covered services are reimbursed based on charges or a small discount off of charges. Operating expenses remain unchanged, as this model represents status quo.

FESC

As discussed above, FESC has been authorized as a CMS demonstration program under Section 434 of the MMA in which remote clinics, providing observation-type services to Medicare patients, would be reimbursed as providers of Medicare services. In the current proposal, FESCs would be organized similar to an FQHC and be paid as a FQHC including covered office visits and other ancillary/non-covered office visits. The key difference between the FESC and a FQHC is that the FESC would be reimbursed for "extended stays" as described on the following page. Because the FESC is a CMS demonstration program only without a formally defined reimbursement system, revenue assumptions related to this model are those that are being proposed and not accepted as final.

Assumptions used for purposes of evaluating FESC are summarized as follows:

DUBOIS MEDICAL CLINIC
ASSUMPTIONS
Fiscal Year Ending March 31, 2006

Assumptions

FESC Changes:	Revenue	Salaries	Non-Salaries (excluding benefits)
1) Additional Clinical Support Staff (added to Clinic)	$ -	$ 60,000	$ -
2) Additional Capital Costs to Support Extended Stay	$ -	$ -	

3) Observation Admissions per Month	4.0
4) Average length (hours) of Observation Admission	20.0
5) % of Clinic Visits that result in extended stay	0.25%
6) Average length (hours) of extended clinic visit	6.0
7) % Increase in Observation "Stays"	0%
8) % of Observation Stays that would avoid ambulance	25%
9) Employee Benefit %	20%

Revenue assumptions primarily include FQHC-covered office visits reimbursable at the FQHC payment rate and extended stays exceeding 4 hours being reimbursed at a 24-hour per diem of $2,400 (thus a 4-hour stay would be reimbursed $400). To derive the number of reimbursable observation days, the consultants discussed the current level of activity with DMC's management team. Two types of extended stays were used for modeling purposes. The first is patients who enter DMC and need extended observation (e.g., re-hydration, etc.). Management anticipates approximately four of these patients per month with an average length of stay of 20 hours. The second extended stay group is patients requiring more complicated care that extends their office visit beyond 4 hours. Management anticipates approximately 1.25 of these visits per month, with a 6 hour average length of stay. For all stays exceeding 4 hours, the total number of billed units (in increments of 4 hours) is added together and divided by six to determine billable "days." While not directly related to DMC, a reduction in the number of ambulance trips and associated hospitalizations at area hospitals would occur, which ultimately reduces costs to patients and payers. The financial model assumes a 25 percent reduction in ambulance transfers for those patients treated in the observation beds. Finally, the model assumes that DMC would have to increase clinical staffing by $60,000 (plus benefits) per year to cover the increased support required for maintaining 24-hour available observation services. This support includes both nursing and lab technician costs. Additional FESC assumptions are summarized on the following page:

1) Observation Stays based on discussion with management. Average Observation stays were assumed to last 20 hours. Observation Billed units are determined by dividing each observation stay by 4 as observations stays will be billed in 4 hour increments
2) Observation Days are determined by dividing observation billed units by 6.
3) Observation services are billed in 4 hours increments of $400 ($2,400 per day)
4) Observation revenue is carved out of Clinic Costs in determining the Clinic Cost per visit

CAH

A CAH is a limited-service hospital that is eligible for generally more favorable, cost-based Medicare, and in some States Medicaid reimbursement. To qualify for cost-based Medicare reimbursement, CAH status requires that a rural hospital have a bed limit of 25, with no more than 25 acute patients at one time and an average length of stay of less than 96 hours.

DUBOIS MEDICAL CLINIC
ASSUMPTIONS
Fiscal Year Ending March 31, 2006

Assumptions

CAH Changes:	Revenue	Salaries	Non-Salaries (excluding benefits)	Square Ft
1) Loss of CHC Grant	$ (340,951)	$ -	$ -	-
2) Reclass of Expense from Clinic to Emergency Room		$ 80,000		1,000
3) Additional Annual Capital Costs ($15M/25 year Depreciation)	$ -	$ -	$ 600,000	-
4) Additional Administrative Costs	$ -	$ 40,000	$ 40,000	
5) Incremental Adults and Pediatric Costs (3 Clinical)	$ -	$ 120,000	$ 20,000	1,000
6) % of Observation Visits Admitted		25%		
7) % reduction in "Observation" visits		-25%		
8) Average Length of Stay		3.00		
9) % of Observation Stays that would avoid medevac		25%		
10) Employee Benefit %		20%		

A number of changes to the original FQHC model were necessary to incorporate CAH reimbursement. From the FQHC cost report, the consultants derived a "hospital" cost report using incremental expenses as well as reclassification entries to appropriately reflect the level of "inpatient" clinical care. These are noted in the above table. From observation days determined in the FESC model, it was assumed that 25 percent of these would be admitted into the hospital and reimbursed by Medicare and Medicaid on a cost basis, and all other payers at a case payment rate of $7,500. Twenty-five percent of current ambulance transports would be avoided, reducing both the patient and third party cost related to these services. For outpatient services, Medicare and Medicaid will reimburse DMC on a cost basis (including RHC covered visits, which are not capped) while all other payers will pay a discount off of charges. A significant assumption is that the capital costs necessary to bring DMC up to "code" would be approximately $15 million with related annual depreciation costs of approximately $600,000. Further, staffing costs and non-staffing operating costs are increased by $160,000 and $60,000, respectively, to accommodate both increases in hospital clinical care as well as additional administrative expenses necessary to accommodate the incremental complexities of managing a hospital relative to an FQHC.

Results

Appended to this report are the projected Statements of Operations for the alternatives studied in the consultants' financial assessment. The results of the analysis are summarized in the tables below.

DUBOIS MEDICAL CLINIC
COMPARISON OF FINANCIAL MODELS - PRO FORMA STATEMENT OF OPERATIONS
Fiscal Year Ending March 31, 2006

For Internal Purposes Only

REVENUE:	FQHC ***(I)***	FESC ***(II)***	CAH/RHC ***(III)***	FQHC vs. FESC ***(II - I)***	FQHC vs. CAH/RHC ***(III - I)***
Inpatient Revenue	$ -	$ -	$ 139,000	$ -	$ 139,000
Outpatient Revenue	424,000	525,000	796,000	101,000	372,000
Net Patient Revenue	424,000	525,000	935,000	101,000	511,000
Other Revenue	341,000	341,000	1,000	-	(340,000)
Total Revenue	765,000	866,000	936,000	101,000	171,000
EXPENSES:					
Total Expenses	760,000	832,000	1,612,000	72,000	852,000
Net Income (Loss)	5,000	34,000	(676,000)	29,000	(681,000)

The projected financial benefit of converting to a FESC is proximately $29,000 and is primarily the result of the incremental FESC reimbursement exceeding the incremental standby costs necessary for treating extended stay patients. CAH status is projected to cost DMC approximately $681,000 relative to FQHC status. The negative impact relates directly to the increase in clinical, operating and capital costs without the "hospital" type volume to offset these costs as well as the loss in FQHC 330(b) funding.

Medicare and Medicaid Payer Mix Impact

In order to evaluate the impact on each of these designations from both a Medicare and Medicaid perspective, the consultants prepared separate financial summaries for each of these payers. The following chart demonstrates the impact to Medicare should any of these designations be adopted.

Medicare program costs are projected as follows:

DUBOIS MEDICAL CLINIC
COMPARISON OF FINANCIAL MODELS - MEDICARE COST ONLY
Fiscal Year Ending March 31, 2006

For Internal Purposes Only

MEDICARE COST	FQHC (I)	FESC (II)	CAH/RHC (III)	FQHC vs FESC (III - I)	FQHC vs CAH/RHC (III - I)
Inpatient Cost	$ -	$ -	$ 51,000	$ -	$ 51,000
Outpatient Cost	134,000	165,000	312,000	31,000	178,000
Net Patient Cost	134,000	165,000	363,000	31,000	229,000
Other Cost	132,000	115,000	115,000	(17,000)	(17,000)
Total Cost	266,000	280,000	478,000	14,000	212,000

Medicare costs for FESC are projected to exceed the cost of FQHC as the higher extended stay costs are only partially offset by a reduction in ambulance transfers and the associated cost of hospitalization services for patients once transported. Medicare costs for CAH are projected to be $212,000 greater for CAH and are related directly to Medicare reimbursing CAHs on a cost basis and DMC increasing clinical, operating and capital costs as discussed above.

Medicaid program costs are projected as follows:

DUBOIS MEDICAL CLINIC
COMPARISON OF FINANCIAL MODELS - MEDICAID COST ONLY
Fiscal Year Ending March 31, 2006

For Internal Purposes Only

MEDICAID COST	FQHC (I)	FESC (II)	CAH/RHC (III)	FQHC vs. FESC (II - I)	FQHC vs. CAH/RHC (III - I)
Inpatient Cost	$ -	$ -	$ 21,000	$ -	$ 21,000
Outpatient Cost	99,000	109,000	177,000	10,000	78,000
Net Patient Cost	99,000	109,000	198,000	10,000	99,000
Other Cost	65,000	56,000	56,000	(9,000)	(9,000)
Total Cost	164,000	165,000	254,000	1,000	90,000

Negligible Medicaid costs associated with the FESC model are similar to the Medicare findings and occur because the additional cost of FESC services are only partially offset by the reduction in ambulance costs and the associated cost of hospitalizations.

Conclusions

The FESC model provides a clear financial benefit to DMC and would likely increase clinical benefits for patients in the Dubois area. The consultants recommended that DMC continue to monitor FESC demonstration program developments at both the State and Federal level. Because CAH provides no financial benefit at this time, DMC should not adopt this designation.

Appendix I – Financial Models

DUBOIS MEDICAL CLINIC
PRO FORMA STATEMENTS OF OPERATIONS
Fiscal Year Ending March 31, 2006

The Accompanying Assumptions are Integral to this Pro Forma

	FQHC	FESC	CAH/RHC
OPERATING REVENUE:			
Inpatient Revenue:			
General Acute	-	-	139,278
Total Inpatient Revenue	-	-	139,278
Outpatient Revenue:			
Clinic	421,270	416,645	539,880
Injections/Immunizations	2,769	2,769	2,769
Radiology - Diagnostic	-	-	-
Laboratory	-	-	-
Drugs Charged to Patients	-	-	-
Emergency	-	-	160,482
Distinct Observation Bed Unit	-	105,200	93,291
Care Coordination	-	-	-
Total Outpatient Revenue	424,039	524,614	796,422
Net Patient Revenue	424,039	524,614	935,700
Other Operating Revenue:			
BPHC - CHC Grant	340,951	340,951	-
Interest Income	500	500	500
Total Other Operating Revenue	341,451	341,451	500
Total Operating Revenue	765,490	866,065	936,200
OPERATING EXPENSES:			
Salaries	292,379	352,379	452,379
Employee Benefits	81,866	93,866	113,866
Pro Fees, Supplies, & Other	354,407	354,407	414,407
Depreciation and amortization	31,429	31,429	631,429
Interest Expense	-	-	-
Provision for doubtful accounts	-	-	-
Total Operating Expenses	760,081	832,081	1,612,081
Net Operating Income	5,410	33,984	(675,881)

Appendix II - Base Year Assumptions

DUBOIS MEDICAL CLINIC
ASSUMPTIONS
Fiscal Year Ending March 31, 2006

Assumptions

Inpatient (CAH/RHC Model Only):		
Acute Cases:		
Acute - Medicare		**5**
Acute - Medicaid		**2**
Acute - Non Care/Caid		**9**
Number of Patient Days:		
Acute - Medicare		**15**
M'care HMO		**-**
% M'care SSI		**0%**
Acute - Medicaid		**6**
M'caid HMO		**-**
Acute - Non-Care/Caid		**27**
Average Per Case Payment Rate:		
Acute - Medicare	**	**N/A**
Acute - Medicaid	***	**N/A**
Acute - Non-Medicare	***	**$ 7,500**
** PPS payments		
*** Includes nursery est. at $500/day		
Average Per Day Payment Rate:		
Acute - Medicare		N/A
Acute - Medicaid		N/A
Acute - Non-Medicare		$ 2,500

Other Operating Revenue:	
BPHC - CHC Grant	**$ 340,951**
BPHC - Frontier Grant	**$ -**
United Way	**$ -**
NWRPCA Grant	**$ -**
Interest Income	**$ 500**
Other Non-Op. Rev (Fin. Stmnt.)	**$ -**
Total	$ 341,451

Outpatient:	O/P Total
Medicare O/P Payer Mix:	**29.00%**
Medicaid O/P Payer Mix:	**14.00%**
Medicare Avg C/A (exc Pharm)	**20.00%**
Medicaid Avg C/A (exc Pharm)	**0.00%**
All other Avg C/A & Charity	**45.00%**
Clinic	
Patient Visits	**6,000**
Net Revenue Per	**$ 55.23**
RHC Payment Cap	**N/A**
FQHC Cap (Medicare Only)	**$ 96.00**
Physician FTEs	**0.6**
Mid Level FTEs	**1.4**
Immunizations:	
Visits	**150**
Net revenue per*	**$ 25.00**
Medicare Costs Per Injection	**$9.79**
Medicaid Costs Per Injection	**$9.79**
Radiology - Diagnostic	
Procedures	**-**
Net revenue per*	$ -
Medicare Fees Per Test	**$50**
Medicaid Fees Per Test	**$75**
Laboratory	
Test	**-**
Net revenue per*	**$ -**
Medicare Net Rev Per	**$ 10.00**
Medicaid Net Rev Per	**$ 15.00**
M/C Fee charges	**$ -**

Outpatient (cont.)	O/P Total
Emergency Room	
Visits	**-**
Incr CAH ER Visits	**500**
M/C Prof. Pmt.	$ 50
Net revenue per*	**$ 250**
Medicare Fees	**$ -**
Medicaid Fees	**$ -**
Distinct Observation Bed Unit	
Obs Adm per mnth	**4**
Avg Obs Hrs/Admis	**20.00**
% Clinic Extended visits	**0.25%**
Avg Obs Hrs/ER Admis	**6.00**
Net revenue per (roun	**$ 2,400**
Actual Days	**44**
Care Coordination:	
Visits	**-**
Net Revenue Per	$ -
Medicare Fees Per Vi	**$40**
Medicaid Fees Per Vi	**$40**
Drugs Charged to Patients	
O/P Scripts	**-**
Net revenue per*	$ -
Medicare Fees Per Su	**$ -**
Medicaid Fees Per Su	**$ -**

Other Program Effects:	
Ambulance Runs	
Number of Trips	**120**
% Reduction	**25%**
Net Revenue Per	**$ 500**
Medicare Fees	**$ 350**
Medicaid Fees	**$ 350**
Reduced Hospitalizations	
Net Cost Per	**$ 3,500**
Medicare Costs	**$ 3,500**
Medicaid Costs	**$ 3,500**

Eureka Medical Clinic, Eureka, Nevada

Overview

Nevada Health Centers, Inc. (NVHC) was founded in 1977 as Federally Qualified Health Centers (FQHC) and currently has 15 clinical sites throughout Nevada. Eureka Medical Clinic (EMC), located in Eureka County Nevada, opened its doors in 1987. EMC provides family medicine, women's health, pediatrics, occupational health, family planning, urgent care and 24-hour emergency care, lab, x-ray, and other related services to the 450 residents of Eureka and surrounding regions. EMC is currently staffed with one physician and one physician assistant. EMC's current operating budget is approximately $420,000 per year, with an approximately breakeven bottom line primarily due to in-kind donations and FQHC 330 funding. EMC, due primarily to its 75 miles distance from the nearest available hospital in Ely, Nevada, is interested in evaluating payment options that would allow it to be paid for local management of appropriate clinical conditions to avoid the unnecessary transportation and associated cost. Primarily, EMC is interested in evaluating the Frontier Extended Stay Clinic (FESC) model, relative to the current state (e.g., FQHC). A third model, Critical Access Hospital (CAH), is evaluated primarily to compare it to other locations selected as part of this project, but is not being considered at this time by NVHC management.

Current Status of Clinic Operations

EMC is one of 15 clinic sites owned and operated by NVHC, a FQHC. EMC provides local health care services to residents and visitors of Eureka, NV, with a population of approximately 450. EMC provides access to primary care services, diagnostic (lab and X-ray) services, 24-hour urgent and emergency care, and other health-related education and management to the community. Currently, EMC does not offer observation-type services to patients except on rare occasions. Extended stays are currently not recognized as reimbursable other than a complicated office visit.

EMC's fiscal year 2004 operating budget shows a breakeven financial position, on net patient revenues of $170,000 and grant income and donations of approximately $250,000. During fiscal year 2004, Medicare and Medicaid patients are budgeted to account for eight percent and 25 percent, respectively, of all outpatient visits (measured by patient visits).

FQHC

Medicare office visit reimbursement is the lower of actual costs per visit, adjusted for productivity screens, or an amount capped at approximately $92/visit. Medicaid office visit reimbursement is full costs per visit adjusted for the productivity screen. The FQHC cost-based rate is based on a simulated FQHC cost report that carves out non-FQHC-covered services from FQHC-covered services, and divides these costs of FQHC-covered services by FQHC visits. All other non-FQHC-covered services are reimbursed based on charges or a small discount off of charges. Operating expenses remain unchanged, as this model represents status quo.

FESC

As discussed above, FESC has been authorized as a CMS demonstration program under Section 434 of the MMA in which remote clinics, providing observation-type services to Medicare patients, would be reimbursed as providers of Medicare services. In the current proposal, FESCs would be organized similar to an FQHC and be paid as a FQHC would be paid for covered office visits and other ancillary/non-covered office visits. The key difference between the FESC and a FQHC is that the FESC would be reimbursed for "extended stays" as described below. Because the FESC is a CMS demonstration program only without a formally defined reimbursement system, revenue assumptions related to this model are those that are being proposed and not accepted as final.

Assumptions used for purposes of evaluating FESC are summarized as follows:

EUREKA MEDICAL CLINIC
ASSUMPTIONS
Fiscal Year Ending May 31, 2004

Assumptions

FESC Changes:	**Revenue**	**Salaries**	**Non-Salaries (excluding benefits)**
1) Additional Clinical Support Staff (added to Clinic)	**$ -**	**$ 40,000**	$ -
2) Additional Capital Costs to Support Extended Stay	**$ -**	**$ -**	
3) Observation Admissions per Month		**1.0**	
4) Average length of Observation Admission		**20.0**	
5) % of Clinic Visits that result in extended stay		**0.25%**	
6) Average lengh of extended clinic visit		**6.0**	
7) % Increase in Observation "Stays"		**0%**	
8) % of Observation Stays that would avoid Ambulance Transfer		**25%**	
9) Employee Benefit %		**20%**	

Revenue assumptions primarily include FQHC-covered office visits reimbursable at the FQHC payment rate and extended stays exceeding 4 hours being reimbursed at a 24-hour per diem of $2,400 (thus a 4-hour stay would be reimbursed $400). To derive the number of reimbursable observation days, the consultants discussed the current level of activity with EMC's management

team. Two types of extended stays were used for modeling purposes. The first is patients who enter EMC and need extended observation (e.g., re-hydration, etc.). Management anticipates approximately one of these patients per month with an average length of stay of 20 hours. The second extended stay group is patients requiring more complicated care that extends their office visit beyond 4 hours. Management anticipates approximately .6 of these visits per month, with a 6 hour average length of stay. For all stays exceeding 4 hours, the total number of billed units (in increments of 4 hours) is added together and divided by six to determine billable "days." While not directly related to EMC, a reduction in the number of ambulance trips and associated hospitalizations at area hospitals would occur, which ultimately reduces costs to patients and payers. The financial model assumes a 25 percent reduction in ambulance transfers for those patients treated in the observation beds. Finally, the model assumes that EMC would have to increase clinical staffing by $40,000 (plus benefits) per year to cover the increased support required for maintaining 24-hour available observation services. Additional FESC assumptions are summarized on the following page:

1) Observation Stays based on discussion with management. Average Observation stays were assumed to last 20 hours. Observation Billed units are determined by dividing each observation stay by 4 as observations stays will be billed in 4 hour increments
2) Observation Days are determined by dividing observation billed units by 6. The observations days are increased by 100% to accommodate increased use of services
3) Observation services are billed in 4 hours increments of $400 ($2,400 per day)
4) Observation revenue is carved out of Clinic Costs in determining the Clinic Cost per visit
5) Incremental costs associated with the FESC include $40,000 of clinical staffing plus associated employee benefits
6) Avoided program costs include reduced number of ambulance trips and assoicated hospitalizations at area hospitals (see below for assumptions)

CAH

A CAH is a limited-service hospital that is eligible for generally more favorable, cost-based Medicare, and in some States Medicaid reimbursement. To qualify for cost-based Medicare reimbursement, CAH status requires that a rural hospital have a bed limit of 25, with no more than 25 acute patients at one time and an <u>average</u> length of stay of less than 96 hours.

EUREKA MEDICAL CLINIC
ASSUMPTIONS
Fiscal Year Ending May 31, 2004

Assumptions

CAH Changes:	Revenue	Salaries	Non-Salaries (excluding benefits)	Square Ft
1) Loss of CHC Grant	$ -	$ -	$ -	-
2) Reclass of Expense from Clinic to Emergency Room		$ 40,000		1,000
3) Additional Annual Capital Costs ($15M/25 yr Depreciation)	$ -	$ -	$ 600,000	-
4) Additional Administrative Costs	$ -	$ 40,000	$ 40,000	
5) Incremental Adults and Pediatric Costs (3 Clinical)	$ -	$ 120,000	$ 20,000	1,000
6) % of Observation Visits Admitted		25%		
7) % reduction in "Observation" visits		-25%		
8) Average Length of Stay		3.00		
9) % of Observation Stays that would avoid ambulance transfer		25%		
10) Employee Benefit %		20%		

A number of changes to the original FQHC model were necessary to incorporate CAH reimbursement. From the FQHC cost report, the consultants derived a "hospital" cost report using incremental expenses as well as reclassification entries to appropriately reflect the level of "inpatient" clinical care. These are noted in the above table. From observation days determined in the FESC model, it was assumed that 25 percent of these would be admitted into the hospital and reimbursed by Medicare and Medicaid on a cost basis, and all other payers at a case payment rate of $7,500. Twenty-five percent of current ambulance transports would be avoided, reducing both the patient and third party cost related to these services. For outpatient services, Medicare and Medicaid will reimburse EMC on a cost basis (including RHC covered visits, which are not capped) while all other payers will pay a discount off of charges. A significant assumption is that the capital costs necessary to bring EMC up to "code" would be approximately $15 million with related annual depreciation costs of approximately $600,000. Further, staffing costs and non-staffing operating costs are increased by $160,000 and $60,000, respectively, to accommodate both increases in hospital clinical care as well as additional administrative expenses necessary to accommodate the incremental complexities of managing a hospital relative to an FQHC.

Results

Appended to this report are the projected Statements of Operations for the alternatives studied in the consultants' financial assessment. The results of the analysis are summarized in the tables below.

EUREKA MEDICAL CLINIC COMPARISON OF FINANCIAL MODELS - PRO FORMA STATEMENT OF OPERATIONS Fiscal Year Ending May 31, 2004 *For Internal Purposes Only*					
REVENUE:	FQHC ***(I)***	FESC ***(II)***	CAH/RHC ***(III)***	FQHC vs. FESC ***(II - I)***	FQHC vs. CAH/RHC ***(III - I)***
Inpatient Revenue	$ -	$ -	$ 63,000	$ -	$ 63,000
Outpatient Revenue	178,000	207,000	338,000	29,000	160,000
Net Patient Revenue	178,000	207,000	401,000	29,000	223,000
Other Revenue	248,000	248,000	248,000	-	-
Total Revenue	426,000	455,000	649,000	29,000	223,000
EXPENSES:					
Total Expenses	412,000	460,000	1,264,000	48,000	852,000
Net Income (Loss)	14,000	(5,000)	(615,000)	(19,000)	(629,000)

The projected financial cost of converting to a FESC is approximately $19,000 and is primarily the result of the incremental FESC costs exceeding the FESC reimbursement for extended stays. CAH status is projected to cost EMC approximately $429,000 relative to FQHC status. The negative impact relates directly to the increase in clinical, operating and capital costs without the "hospital" type volume to offset these costs.

Medicare and Medicaid Payer Mix Impact

In order to evaluate the impact on each of these designations from both a Medicare and Medicaid perspective, the consultants prepared separate financial summaries for each of these payers. The following chart demonstrates the impact to Medicare should any of these designations be adopted.

Medicare program costs are projected as follows:

EUREKA MEDICAL CLINIC COMPARISON OF FINANCIAL MODELS - MEDICARE COST ONLY Fiscal Year Ending May 31, 2004 *For Internal Purposes Only*					
MEDICARE COST	FQHC ***(I)***	FESC ***(II)***	CAH/RHC ***(III)***	FQHC vs FESC ***(III - I)***	FQHC vs CAH/RHC ***(III - I)***
Inpatient Cost	$ -	$ -	$ -	$ -	$ -
Outpatient Cost	22,000	24,000	49,000	2,000	27,000
Net Patient Cost	22,000	24,000	49,000	2,000	27,000
Other Cost	18,000	16,000	16,000	(2,000)	(2,000)
Total Cost	40,000	40,000	65,000	-	25,000

Medicare costs for FESC are projected to equal the cost of FQHC as the marginally higher extended stay costs are offset by a reduction in ambulance transfers and the associated cost of hospitalization services for patients once transported. Medicare costs for CAH are projected to be $25,000 greater for CAH and are related directly to Medicare reimbursing CAHs on a cost basis and EMC increasing clinical, operating and capital costs as discussed above.

Medicaid program costs are projected as follows:

EUREKA MEDICAL CLINIC
COMPARISON OF FINANCIAL MODELS - MEDICAID COST ONLY
Fiscal Year Ending May 31, 2004

For Internal Purposes Only

MEDICAID COST	FQHC (I)	FESC (II)	CAH/RHC (III)	FQHC vs. FESC (II - I)	FQHC vs. CAH/RHC (III - I)
Inpatient Cost	$ -	$ -	$ 33,000	$ -	$ 33,000
Outpatient Cost	75,000	83,000	151,000	8,000	76,000
Net Patient Cost	75,000	83,000	184,000	8,000	109,000
Other Cost	58,000	53,000	53,000	(5,000)	(5,000)
Total Cost	133,000	136,000	237,000	3,000	104,000

Negligible Medicaid costs associated with the FESC model are similar to the Medicare findings and occur because the additional cost of FESC services is offset by the reduction in ambulance costs and the associated cost of hospitalizations.

Conclusions

While the FESC model does not provide a clear financial benefit to EMC, clinical benefits related to patient care must be evaluated when considering the FESC option. The consultants recommended that EMC continue to monitor FESC demonstration program developments at both the State and Federal level. Because CAH provides no financial benefit at this time, EMC should not adopt this designation.

EUREKA MEDICAL CLINIC
PRO FORMA STATEMENTS OF OPERATIONS
Fiscal Year Ending May 31, 2004

The Accompanying Assumptions are Integral to this Pro Forma

	FQHC	FESC	CAH/RHC
OPERATING REVENUE:			
Inpatient Revenue:			
General Acute	-	-	63,460
Total Inpatient Revenue	-	-	63,460
Outpatient Revenue:			
Clinic	175,471	175,471	204,931
Injections/Immunizations	2,999	2,999	2,999
Radiology - Diagnostic	-	-	-
Laboratory	-	-	-
Drugs Charged to Patients	-	-	-
Emergency	-	-	82,598
Distinct Observation Bed Unit	-	28,800	47,552
Care Coordination	-	-	-
Total Outpatient Revenue	178,469	207,269	338,079
Net Patient Revenue	178,469	207,269	401,539
Other Operating Revenue:			
Contract Revenues	191,175	191,175	191,175
In-Kind Donations	56,400	56,400	56,400
Total Other Operating Revenue	247,575	247,575	247,575
Total Operating Revenue	426,044	454,844	649,114
OPERATING EXPENSES:			
Salaries	236,304	276,304	396,304
Employee Benefits	49,624	57,624	81,624
Pro Fees, Supplies, & Other	126,308	126,308	186,308
Depreciation and amortization	-	-	600,000
Interest Expense	-	-	-
Provision for doubtful accounts	-	-	-
Total Operating Expenses	412,236	460,236	1,264,236
Net Operating Income	13,808	(5,392)	(615,122)

Appendix II - Base Year Assumptions

EUREKA MEDICAL CLINIC
ASSUMPTIONS
Fiscal Year Ending May 31, 2004

Assumptions

Inpatient (CAH/RHC Model Only):			
Acute Cases:			
Acute - Medicare			-
Acute - Medicaid			1
Acute - Non Care/Caid			4
Number of Patient Days:			
Acute - Medicare			-
M'care HMO			-
% M'care SSI			0%
Acute - Medicaid			3
M'caid HMO			-
Acute - Non-Care/Caid			12
Average Per Case Payment Rate:			
Acute - Medicare	**		N/A
Acute - Medicaid	***		N/A
Acute - Non-Medicare	***	$	7,500
** PPS payments			
*** Includes nursery est. at $500/day			
Average Per Day Payment Rate:			
Acute - Medicare			N/A
Acute - Medicaid			N/A
Acute - Non-Medicare		$	2,500

Other Operating Revenue:		
Contract Revenues	$	191,175
In-Kind Donations	$	56,400
	$	-
	$	-
	$	-
Other Non-Op. Rev (Fin. Stmnt.)	$	-
Total	$	247,575

Outpatient:	O/P Total	
Medicare O/P Payer Mix:		7.94%
Medicaid O/P Payer Mix:		25.00%
Medicare Avg C/A (exc Pharm)		0.00%
Medicaid Avg C/A (exc Pharm)		0.00%
All other Avg C/A & Charity		50.00%
Clinic		
Patient Visits		2,864
Net Revenue Per	$	41.42
RHC Payment Cap		N/A
FQHC Payment Cap	$	92.00
Medicaid FQHC Pymt Cap	$	104.75
Physician FTEs		1.0
Mid Level FTEs		0.5
Immunizations:		
Visits		150
Net revenue per*	$	25.00
Medicare Costs Per Injection		$9.79
Medicaid Costs Per Injection		$9.79
Radiology - Diagnostic		
Procedures		-
Net revenue per*	$	-
Medicare Fees Per Test		$50
Medicaid Fees Per Test		$75
Laboratory		
Test		-
Net revenue per*	$	-
Medicare Net Rev Per	$	10.00
Medicaid Net Rev Per	$	15.00
M/C Fee charges	$	-

Outpatient (cont.)	O/P Total	
Emergency Room		
Visits		-
Incr CAH ER Visits		250
M/C Prof. Pmt.	$	50
Net revenue per*	$	250
Medicare Fees	$	-
Medicaid Fees	$	-
Distinct Observation Bed Unit		
Obs Adm per mnth		1
Avg Obs Hrs/Admis		20.00
% Clinic Extended visits		0.25%
Avg Obs Hrs/ER Admis		6.00
Net revenue per (roun	$	2,400
Actual Days		12
Care Coordination:		
Visits		-
Net Revenue Per	$	-
Medicare Fees Per Vi		$40
Medicaid Fees Per Vi		$40
Drugs Charged to Patients		
O/P Scripts		-
Net revenue per*	$	-
Medicare Fees Per Su	$	-
Medicaid Fees Per Su	$	-

Other Program Effects:		
Ambulance Runs		
Number of Trips		60
% Reduction		25%
Net Revenue Per	$	500
Medicare Fees	$	350
Medicaid Fees	$	350
Reduced Hospitalizations		
Net Cost Per	$	3,500
Medicare Costs	$	3,500
Medicaid Costs	$	3,500

Inter Island Medical Center, Friday Harbor, Washington

Overview

Inter Island Medical Center (IIMC), located in Friday Harbor on San Juan Island, a small island community off the northern coast of Washington, provides family medicine, urgent care, lab, X-ray, and other related services to the approximately 7,200 residents and additional visitors of San Juan Island. IIMC is currently staffed with four family practitioners and one nurse practitioner. IIMC's current operating budget is approximately $2.6 million per year, with an approximately breakeven bottom line primarily due to substantial tax revenue ($1.3 million) provided by the San Juan Island community. Because IIMC operates on an island, approximately 40 miles (by ferry commute) from the nearest hospitals in Bellingham, management is interested in evaluating payment options that would allow the clinic to be paid for the local management of appropriate clinical conditions to avoid the unnecessary transportation and associated cost. Primarily, IIMC is interested in evaluating the FESC model, relative to the current state (RHC). A third model, CAH, is evaluated primarily to compare it to other locations selected as part of this project, but is not being considered at this time by IIMC management.

Current Status of Clinic Operations

IIMC provides local health care services to residents and visitors of San Juan Island, Washington. IIMC provides access to primary care services, diagnostic (lab and X-ray) services, 24-hour urgent care, and other health-related education and management to the community. Currently, IIMC does not offer observation-type services to patients except on rare occasions. Extended stays are currently not recognized as reimbursable other than a complicated office visit.

IIMC's fiscal year 2004 operating budget shows a breakeven financial position, on net patient revenues of $1.4 million and tax revenue, grant income, and donations of approximately $1.3 million. During fiscal year 2004, Medicare and Medicaid patients are budgeted to account for 43 percent and eight percent, respectively, of all outpatient visits (measured by patient visits).

RHC

Medicare office visit reimbursement is the lower of actual costs per visit, adjusted for productivity screens, or an amount capped at approximately $68/visit. Medicaid office visit reimbursement is capped at $70/visit adjusted for the productivity screen. The RHC cost-based rate is based on a simulated RHC cost report that carves out non-RHC covered services from RHC covered services, and divides these costs of RHC covered services by RHC visits. All other

non-RHC covered services are reimbursed based on charges or a discount off of charges. Operating expenses remain unchanged, as this model represents status quo.

FESC

As discussed above, FESC has been authorized as a CMS demonstration program under Section 434 of the MMA in which remote clinics, providing observation-type services to Medicare patients, would be reimbursed as providers of Medicare services. In the current proposal, FESCs would be organized similar to an RHC and be paid as an RHC, including covered office visits and other ancillary/non-covered office visits. The key difference between the FESC and a RHC is that the FESC would be reimbursed for "extended stays" as described on the following page. Because the FESC is a CMS demonstration program only without a formally defined reimbursement system, revenue assumptions related to this model are proposed and not accepted as final.

Assumptions used for purposes of evaluating FESC are summarized as follows:

INTER ISLAND MEDICAL CENTER
ASSUMPTIONS
Fiscal Year Ending December 31, 2004

Assumptions

FESC Changes:	**Revenue**	**Salaries**	**Non-Salaries (excluding benefits)**
1) Additional Clinical Support Staff (added to Clinic)	$ -	$ 40,000	$ -
2) Additional Capital Costs to Support Extended Stay	$ -	$ -	
3) Observation Admissions per Month		4.0	
4) Average length (hours) of Observation Admission		20.0	
5) % of Clinic Visits that result in extended stay		0.25%	
6) Average length (hours) of extended clinic visit		6.0	
7) % Increase in Observation "Stays"		0%	
8) % of Observation Stays that would avoid ambulance		25%	
9) Employee Benefit %		20%	

Revenue assumptions primarily include RHC covered office visits reimbursable at the RHC payment rate and extended stays exceeding 4 hours being reimbursed at a 24-hour per diem of $2,400 (thus a 4-hour stay would be reimbursed $400). To derive the number of reimbursable observation days, the consultants discussed the current level of activity with IIMC's management team. Two types of extended stays were used for modeling purposes. The first is patients who enter IIMC and need extended observation (e.g., re-hydration, etc.). Management anticipates approximately four of these patients per month with an average length of stay of 20 hours. The second extended stay group is patients requiring more complicated care that extends their office visit beyond 4 hours. Management anticipates approximately four of these visits per month, with

a 6 hour average length of stay. For all stays exceeding 4 hours, the total number of billed units (in increments of 4 hours) is added together and divided by six to determine billable "days." While not directly related to IIMC, a reduction in the number of medevac trips and associated hospitalizations at area hospitals would occur, which ultimately reduces costs to patients and payers. The financial model assumes a 25 percent reduction in medevac transfers for those patients treated in the observation beds. Finally, the model assumes that IIMC would have to increase clinical staffing by $40,000 (plus benefits) per year to cover the increased support required for maintaining 24-hour available observation services. This support includes primarily nursing costs. Additional FESC assumptions are summarized on the following page:

1) Observation Stays based on discussion with management. Average Observation stays were assumed to last 20 hours. Observation Billed units are determined by dividing each observation stay by 4 as observations stays will be billed in 4 hour increments
2) Observation Days are determined by dividing observation billed units by 6.
3) Observation services are billed in 4 hours increments of $400 ($2,400 per day)
4) Observation revenue is carved out of Clinic Costs in determining the Clinic Cost per visit

CAH

A CAH is a limited-service hospital that is eligible for generally more favorable, cost-based Medicare, and in some States Medicaid reimbursement. To qualify for cost-based Medicare reimbursement, CAH status requires that a rural hospital have a bed limit of 25 and an <u>average</u> length of stay of less than 96 hours.

INTER ISLAND MEDICAL CENTER
ASSUMPTIONS
Fiscal Year Ending December 31, 2004

Assumptions

CAH Changes:	**Revenue**	**Salaries**	**Non-Salaries (excluding benefits)**	**Square Ft**
1) Reclass of Expense from Clinic to Emergency Room		$ 80,000		1,000
2) Additional Annual Capital Costs ($15M/25 year Depreciation)	$ -	$ -	$ 600,000	-
3) Additional Administrative Costs	$ -	$ 80,000	$ 80,000	
4) Incremental Adults and Pediatric Costs (3 Clinical)	$ -	$ 120,000	$ 40,000	7,500
5) % of Observation Visits Admitted		25%		
6) % reduction in "Observation" visits		-25%		
7) Average Length of Stay		3.00		
8) % of Observation Stays that would avoid medevac		25%		
9) Employee Benefit %		20%		

A number of changes to the original RHC model were necessary to incorporate CAH reimbursement. From the RHC cost report, the consultants derived a "hospital" cost report using incremental expenses as well as reclassification entries to appropriately reflect the level of "inpatient" clinical care. These are noted in the above table. From observation days determined in the FESC model, it was assumed that 25 percent of these would be admitted into the hospital

and reimbursed by Medicare and Medicaid on a cost basis, and all other payers at a case payment rate of $5,000. Twenty-five percent of current medevac transports would be avoided, reducing both the patient and third party cost related to these services. For outpatient services, Medicare will reimburse IIMC on a cost basis (including RHC covered visits, which are not capped), while all other payers will pay a discount off of charges. A significant assumption is that the capital costs necessary to bring IIMC up to "code" would be approximately $15 million, with related annual depreciation costs of approximately $600,000. Further, staffing costs and non-staffing operating costs are increased by $280,000 and $120,000, respectively, to accommodate both increases in hospital clinical care as well as additional administrative expenses necessary to accommodate the incremental complexities of managing a hospital relative to an RHC.

Results

Appended to this report are the projected Statements of Operations for the alternatives studied in the consultants' financial assessment. The results of the analysis are summarized in the tables below.

INTER ISLAND MEDICAL CENTER
COMPARISON OF FINANCIAL MODELS - PRO FORMA STATEMENT OF OPERATIONS
Fiscal Year Ending December 31, 2004

For Internal Purposes Only

REVENUE:	RHC ***(I)***	FESC ***(II)***	CAH/RHC ***(III)***	RHC vs. FESC ***(II - I)***	RHC vs. CAH/RHC ***(III - I)***
Inpatient Revenue	$ -	$ -	$ 249,000	$ -	$ 249,000
Outpatient Revenue	1,435,000	1,560,000	2,195,000	125,000	760,000
Net Patient Revenue	1,435,000	1,560,000	2,444,000	125,000	1,009,000
Other Revenue	1,271,000	1,271,000	1,271,000	-	-
Total Revenue	2,706,000	2,831,000	3,715,000	125,000	1,009,000
EXPENSES:					
Total Expenses	2,568,000	2,616,000	3,528,000	48,000	960,000
Net Income (Loss)	138,000	215,000	187,000	77,000	49,000

The projected financial benefit of converting to a FESC is proximately $77,000 and is primarily the result of the incremental FESC reimbursement exceeding the incremental standby costs necessary for treating extended stay patients. CAH status is projected to benefit IIMC approximately $49,000 relative to RHC status. The positive impact relates primarily to the incremental office visit reimbursement associated with Medicare reimbursing office visits for provider-based RHCs at a much higher, uncapped payment rate, offset by additional clinical, operating and capital costs.

Medicare and Medicaid Payer Mix Impact

In order to evaluate the impact on each of these designations from both a Medicare and Medicaid perspective, the consultants prepared separate financial summaries for each of these payers. The following chart demonstrates the impact to Medicare should any of these designations be adopted.

Medicare program costs are projected as follows:

INTER ISLAND MEDICAL CENTER
COMPARISON OF FINANCIAL MODELS - MEDICARE COST ONLY
Fiscal Year Ending December 31, 2004

For Internal Purposes Only

MEDICARE COST	RHC (I)	FESC (II)	CAH/RHC (III)	RHC vs FESC (III - I)	RHC vs CAH/RHC (III - I)
Inpatient Cost	$ -	$ -	$ 158,000	$ -	$ 158,000
Outpatient Cost	653,000	707,000	1,262,000	54,000	609,000
Net Patient Cost	653,000	707,000	1,420,000	54,000	767,000
Other Cost	1,086,000	1,041,000	1,017,000	(45,000)	(69,000)
Total Cost	1,739,000	1,748,000	2,437,000	9,000	698,000

Medicare costs for FESC are projected to exceed the cost of RHC by only $9,000 as the higher extended stay costs are only partially offset by a reduction in medevac transfers and the associated cost of hospitalization services for patients once transported. Medicare costs for CAH are projected to be $698,000 greater for CAH and are related directly to Medicare reimbursing CAHs on a cost basis and IIMC increasing clinical, operating and capital costs as discussed above.

Medicaid program costs are projected as follows:

INTER ISLAND MEDICAL CENTER
COMPARISON OF FINANCIAL MODELS - MEDICAID COST ONLY
Fiscal Year Ending December 31, 2004

For Internal Purposes Only

MEDICAID COST	RHC (I)	FESC (II)	CAH/RHC (III)	RHC vs. FESC (II - I)	FHC vs. CAH/RHC (III - I)
Inpatient Cost	$ -	$ -	$ 32,000	$ -	$ 32,000
Outpatient Cost	121,000	131,000	167,000	10,000	46,000
Net Patient Cost	121,000	131,000	199,000	10,000	78,000
Other Cost	210,000	201,000	197,000	(9,000)	(13,000)
Total Cost	331,000	332,000	396,000	1,000	65,000

Negligible Medicaid costs associated with the FESC model are similar to the Medicare findings and occur because the additional cost of FESC services are only partially offset by the reduction in medevac costs and the associated cost of hospitalizations.

Conclusions

The FESC model provides a clear financial benefit to IIMC and would likely increase clinical benefits for patients on San Juan Island. The consultants recommended that IIMC continue to monitor FESC demonstration program developments at both the State and Federal level. Because CAH provides only a limited benefit with substantial start up costs, IIMC should not consider this designation at this time.

INTER ISLAND MEDICAL CENTER
PRO FORMA STATEMENTS OF OPERATIONS
Fiscal Year Ending December 31, 2004

The Accompanying Assumptions are Integral to this Pro Forma

	RHC	FESC	CAH/RHC
OPERATING REVENUE:			
Inpatient Revenue:			
General Acute	-	-	249,033
Total Inpatient Revenue	-	-	249,033
Outpatient Revenue:			
Clinic	1,162,795	1,162,795	1,543,701
Injections/Immunizations	15,035	15,035	15,035
Radiology - Diagnostic	115,247	115,247	79,339
Laboratory	116,117	116,117	165,473
Drugs Charged to Patients	26,007	26,007	79,144
Emergency	-	-	162,709
Distinct Observation Bed Unit	-	124,400	149,823
Total Outpatient Revenue	1,435,202	1,559,602	2,195,224
Net Patient Revenue	1,435,202	1,559,602	2,444,257
Other Operating Revenue:			
Tax Revenues	1,256,400	1,256,400	1,256,400
Grants	14,644	14,644	14,644
Total Other Operating Revenue	1,271,044	1,271,044	1,271,044
Total Operating Revenue	2,706,246	2,830,646	3,715,301
OPERATING EXPENSES:			
Salaries	1,568,220	1,608,220	1,768,220
Employee Benefits	224,154	232,154	264,154
Pro Fees, Supplies, & Other	714,451	714,451	830,504
Depreciation and amortization	57,631	57,631	661,578
Interest Expense	3,947	3,947	3,947
Provision for doubtful accounts	-	-	-
Total Operating Expenses	2,568,403	2,616,403	3,528,403
Net Operating Income	137,843	214,243	186,898

Appendix II - Base Year Assumptions

INTER ISLAND MEDICAL CENTER
ASSUMPTIONS
Fiscal Year Ending December 31, 2004

Assumptions

Inpatient (CAH/RHC Model Only):			
Acute Cases:			
Acute - Medicare			**10**
Acute - Medicaid			**2**
Acute - Non Care/Caid			**12**
Number of Patient Days:			
Acute - Medicare			**30**
M'care HMO			**-**
% M'care SSI			**0%**
Acute - Medicaid			**6**
M'caid HMO			**-**
Acute - Non-Care/Caid			**36**
Average Per Case Payment Rate:			
Acute - Medicare	**		**N/A**
Acute - Medicaid	***		**N/A**
Acute - Non-Medicare	***	**$**	**5,000**
** PPS payments			
*** Includes nursery est. at $500/day			
Average Per Day Payment Rate:			
Acute - Medicare			N/A
Acute - Medicaid			N/A
Acute - Non-Medicare		$	1,667

Outpatient:	O/P Total	
Medicare O/P Payer Mix:		**43%**
Medicaid O/P Payer Mix:		**8%**
Medicare Avg C/A		**55%**
Medicaid Avg C/A		**60%**
All other Avg C/A & Charity		**30%**
Clinic		
Patient Visits		**19,041**
Net Revenue Per	**$**	**53.53**
RHC Medicare Cap	**$**	**68.00**
RHC Medicaid Cap	**$**	**70.00**
Physician FTEs		**3.2**
Mid Level FTEs		**1.0**
Immunizations:		
Visits		**1,962**
Net revenue per*	**$**	**9.44**
Medicare Costs Per Injection		**$6.07**
Medicaid Costs Per Injection		**$5.39**
Radiology - Diagnostic		
Procedures		**3,162**
Net revenue per*	$	44.88
Medicare Fees Per Test		**$29**
Medicaid Fees Per Test		**$26**
Laboratory		
Test		**13,501**
Net revenue per*	**$**	**11.75**
Medicare Net Rev Per	**$**	**7.55**
Medicaid Net Rev Per	**$**	**6.71**
M/C Fee charges	**$**	**-**

Outpatient (cont.)	O/P Total	
Emergency Room		
Visits		**-**
Incr CAH ER Visits		**500**
M/C Prof. Pmt.	$	50
Net revenue per*	**$**	**250**
Medicare Fees	**$**	**-**
Medicaid Fees	**$**	**-**
Distinct Observation Bed Unit		
Obs Adm per mnth		**4**
Avg Obs Hrs/Admis		**20.00**
% Clinic Extended visits		**0.25%**
Avg Obs Hrs/ER Admis		**6.00**
Net revenue per (roun	**$**	**2,400**
Actual Days		**52**
Drugs Charged to Patients		
O/P Scripts		**4,330**
Net revenue per*	$	7.71
Medicare Fees Per Su	**$**	**4.96**
Medicaid Fees Per Su	**$**	**4.41**

Other Program Effects:		
Medevac Transfers		
Number of Trips		**250**
% Reduction		**25%**
Net Cost Per	**$**	**5,000**
Medicare Fees	**$**	**5,000**
Medicaid Fees	**$**	**5,000**
Reduced Hospitalizations		
Net Cost Per	**$**	**5,500**
Medicare Costs	**$**	**5,500**
Medicaid Costs	**$**	**5,500**

Other Operating Revenue:		
Tax Revenues	**$**	**1,256,400**
Grants	**$**	**14,644**
United Way	**$**	**-**
NWRPCA Grant	**$**	**-**
Interest Income	**$**	**-**
Other Non-Op. Rev (Fin. Stmnt.)	**$**	**-**
Total	$	1,271,044

Chapter 4
Prior Year FESC Studies

Alicia Roberts Medical Center, Klawock, Alaska

Overview

The Alicia Roberts Medical Center (ARMC) is a health center serving the needs of the residents of the Prince of Wales Island. ARMC is owned and operated by Southeast Alaska Regional Health Consortium (SEARHC), a regional tribally owned consortium that provides comprehensive health services to rural communities throughout Southeast Alaska. SEARHC provides health services to approximately 12,500 Alaska Natives and 6,000 non-natives in the small isolated communities of Southeast Alaska. SEARHC was established in 1975 by the Native peoples of Southeast Alaska and represents 18 Alaska villages including Tlingit, Haida, and Tsimpshian peoples. SEARHC is incorporated as a non-profit and operates a 60 bed general acute hospital in Sitka, larger health centers in Juneau, Haines and Klawock, and smaller village clinics staffed with community health aides and mid-level providers in the smaller communities of the region.

The Prince of Wales Island is about the size of Delaware and is the third largest island in the United States. It has a population of approximately 5,000. It is located 600 miles north of Seattle and has a network of roads on the island, but the island can only be reached by float plane or ferry. ARMC is the main primary-care facility for the island, and the only one with 24-hour emergency care services staffed by physicians or mid-level providers. In May 2000, the ARMC became the only emergency provider on the island. With a hospital only accessible by float plane or by sea, ARMC meets a diverse need for health care services ranging from colds/flu to all forms of injuries, including lacerations, broken bones, and life-threatening trauma. ARMC is currently staffed with five primary care providers, two clinical nurses, three health aides, a pharmacist and other supportive ancillary personnel. The clinic's current operating budget for medical services is approximately $2.9 million per year. The health center receives support from the Indian Health Service under a compact with SEARHC in addition to support from HRSA through an FQHC grant under Section 330 of the Public Health Service Act. Because of isolation and dependence of the Prince of Wales population on ARMC for emergency services, and the demand of non-IHS beneficiary population for these services, ARMC was also considered a likely candidate for consideration and evaluation of the FESC model.

ARMC has provided the attached evaluation of the financial feasibility of the extended stay model in comparison to a CAH and the current OMB/IHS provider based model with no changes.

Financial Model

This model has been developed in conjunction with the model developed by the consultants for Iliuliuk Clinic in Dutch Harbor for the FESC project. It was developed based on a proposed Medicare Demonstration Program that would reimburse FESCs meeting predefined criteria, for extended stays, while continuing to reimburse the other visits to the facility under the IHS/OMB provider based rate system. One-year projections have been developed for CAH and FESC scenarios based on fiscal year 2003 budget information. Assumptions are generally held constant between the models with exceptions to account for the different reimbursement systems, as well as incremental costs associated with both CAH and FESC to accommodate overnight occupancies.

Results

As documented below, FESC status allows ARMC to recover the additional costs of providing extended stay services. The model does require SEARHC to allocate additional IHS revenue in support of these services, but it does not take into account the avoided costs for IHS beneficiaries that will be saved by avoided hospitalization in Ketchikan and Sitka. Overall, SEARHC expects these costs to be material, to offset the required allocation of IHS revenue to ARMC, and to marginally improve overall financial performance relative to status quo. FESC will also clearly improve reimbursement for these services from non-beneficiaries.

CAH status has a significant negative impact on the financial performance of ARMC and of SEARHC.

ALICIA ROBERTS MEDICAL CENTER
COMPARISON OF FINANCIAL MODELS - PRO FORMA STATEMENT OF OPERATIONS
FISCAL YEAR 2003

For Internal Purposes Only

	IHS/OMB	FESC	CAH/OMB	OMB vs. FESC	OMB vs. CAH/OMB
REVENUE:	***(I)***	***(II)***	***(III)***	***(II - I)***	***(III - I)***
Inpatient Revenue	$ -	$ -	$ 286,000	$ -	$ 286,000
Outpatient Revenue	2,900,000	3,112,000	2,965,000	212,000	2,965,000
Net Patient Revenue	2,900,000	3,112,000	3,251,000	212,000	3,251,000
Other Revenue	-	-	-	-	-
Total Revenue	2,900,000	3,112,000	3,251,000	212,000	3,251,000
OPERATING EXPENSES:					
Operating Expenses	2,900,000	3,109,000	3,884,000	209,000	3,884,000
Net Operating Income (Loss)	-	3,000	(633,000)	3,000	(633,000)
NON OPERATING REVENUE (EXPENSE)					
Non-Operating Revenue	-	-	-	-	-
NET CHANGE IN ASSETS	$ -	$ 3,000	$ (633,000)	$ 3,000	$ (633,000)

Next Steps

Mather and Associates recommends that SEARHC and ARMC participate in the FESC program on a demonstration basis. Several challenges will be present in the development of this program that should be carefully evaluated as part of the demonstration project. The financial model attached is based on a utilization rate of approximately 73 observation beds per year. This estimate is based on current utilization trends in the ER and for medevacs coupled with the current provider's estimate of demand for this service. The demand for this service must be validated during the demonstration period. Training and recruitment of professionals necessary to support the project must also be evaluated, as access to an intermittent professional workforce will be more difficult in the isolated rural setting of Klawock than in more urban settings.

At this point, the significant cost of capital ($15 million or higher) necessary to improve the facility to meet "hospital" code precludes SEARHC from considering CAH as a financially viable operating model. However, as the CAH model continues to evolve, and the Prince of Wales Island experiences changes in demographic, economic and/or other social conditions, or if SEARHC is able to receive future capital funding to reduce debt service associated with the $15 million hospital facility (e.g., Denali Commission, Rasmuson Foundation, etc.), CAH may become a more financially viable model in the future.

Assignment and Approach

SEARHC engaged Mather and Associates under a subcontract with the consultants in August 2002 to consider Frontier Extended Stay Clinic and Critical Access Hospital alternatives and to determine whether the clinic would benefit financially from converting to CAH or FESC. This document summarizes the projected financial impact of converting to each of these alternatives and primarily discusses financial issues. Specifically, this model utilizes current clinic utilization and projected utilization for the observation units and inpatient bed days (CAH) to:

1. Project the financial impact of adding a reimbursement rate for observation days for the FESC designation on to the OMB/IHS provider based reimbursement rate system.

2. Project the financial impacts of additional costs and reimbursements of inpatient services and observation units for a CAH.

Current Status of Clinic Operations

ARMC is an affiliated provider-based IHS supported facility providing all on-island health care needs for residents and visitors of Prince of Wales Island, Alaska, with a population of approximately 5,000. ARMC provides access to primary care services, diagnostic (lab and X-ray) services, mental health counseling services and urgent and emergency care services. ARMC is currently providing for facility improvements that include two hospital-type beds for patients who require longer observation visits or who are unable to get off the island due to weather or other complications. Extended stays are not currently recognized as reimbursable other than a complicated office visit.

Because ARMC is not operating as a hospital, it currently meets both the average length of stay requirements and the 15 acute-care bed limit of a CAH, and it is unlikely that these two CAH metrics will ever be an issue.

During fiscal year 2002, Medicare and Medicaid patients accounted for nine percent and 14 percent, respectively, of all outpatient visits (measured by charges).

Evaluation

Methodology

ARMC internal data has been used to model the financial impact of FESC and CAH status. The financial models were developed with ARMC's operating performance for fiscal year 2002 ("base year") using financial statements and operating statistics. For fiscal year 2003, the operating statistics from 2002 were projected forward and budgeted changes to the projected financial performance were incorporated. On the basis of this information, three separate pro forma Statements of Operations (i.e., OMB/IHS, FESC and CAH) were prepared. Comparing these scenarios indicates the benefit of Medicare designation changes specific to ARMC's operations.

SEARHC staff reviewed all assumptions and data used in the model, however, they have not been audited for accuracy or completeness. The extent to which the financial analysis accurately predicts actual operating gains or losses depends on how closely the future operating environment matches the model's assumptions. The model is particularly sensitive to utilization of the FESC for extended stay days and the variability and level of the operational costs associated with these days.

Financial Model Assumptions:

To the extent possible and consistent with the rate methodologies utilized and the operating characteristics of the facility, the assumptions for ARMC are consistent with the assumptions utilized for Iliuliuk Clinic. It is important to understand the key assumptions used in the projections.

The operating assumptions between the three alternatives are the same with certain exceptions only as necessary. By keeping assumptions constant between models, any differences resulting from the analysis are reflective of the varying reimbursement and/or operating models.

IHS/OMB Provider Based Reimbursement (FQHC)

ARMC receives IHS funding to support care for IHS beneficiaries under a Self Determination Compact under Title V of the PL 93-638. In addition, ARMC is a FQHC receives grant funds under Section 330 of the Public Health Service (PHS) Act. Once such grant funding is received, it is available on an annual basis to support general operating deficits. In addition, ARMC is a tribally operated provider based facility that is eligible for the IHS/OMB negotiated provider

based all-inclusive outpatient reimbursement. Under this reimbursement methodology a Medicare office visit is reimbursed at the approved all-inclusive rate of $364 per visit plus professional fees. Medicaid office visit reimbursement is computed at the all-inclusive rate of $374 per visit. Operating expenses remain unchanged from fiscal year 2003 budgeted amounts as this model represents status quo.

FESC

As discussed above, the FESC is currently a proposal to CMS to initiate a Medicare Demonstration Program. In the current proposal, ARMC would continue to receive reimbursement for services under the IHS/OMB negotiated rate for all services, except the "observation units" for extended stays. Thus, the key difference between the FESC and the current practice is that the FESC would be reimbursed for "extended stays" as described below. Because FESC designation is only a demonstration proposal to CMS, revenue assumptions related to this model are those that are being proposed and not finally accepted.

These revenue assumptions primarily include FQHC-covered office visits reimbursable at the IHS/OMB all-inclusive payment rate; extended stays exceeding 4 hours are being reimbursed at a 24-hour per diem of $4,000 (thus a 4-hour stay would be reimbursed $667). To derive the number of reimbursable observation days, ER statistics for fiscal year 2002 were reviewed to determine the number of ER visits and medevacs. The length of observation stays was projected by ARMC professional providers, who provided estimates of the length of stay for medevac and non-medevac encounters. For these stays, the total number of billed units (in increments of 4 hours) was added together and divided by six to determine billable "days." Further, revenue and expenses for a number of medevac patients no longer exists when patients have longer access to health care services provided by FESC. The financial model assumes a 25 percent reduction in medevac revenue and expense to consider this. Finally, the model assumes that ARMC would have to increase clinical staffing by $94,000 (plus benefits) per year to cover the increased clinical support of maintaining 24-hour available observation services.

CAH

A CAH is a limited-service hospital that is generally eligible for more favorable, cost-based Medicare and, in some States, Medicaid reimbursement. The Alaska Medicaid Program has adopted cost-based reimbursement for inpatient services. Tribally operated programs continue outpatient reimbursement at the OMB/IHS approved all-inclusive rate. To qualify for CAH

status, a rural hospital has 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.

ARMC Assumptions

CAH Changes:	Salaries	Non-Salaries
1) Additional Annual Capital Costs ($15M/25 year Depreciation)	$ -	$ 600,000
2) Additional Staffing Costs for FESC changes	$ 93,526	$ 81,783
3) Add Incremental Costs for CAH	$ 61,840	$ 19,040
4) Incremental Adults and Pediatric Costs-	$ 155,366	$ 100,823

A number of changes to the original model were necessary to incorporate CAH reimbursement. A derived "hospital" cost report was developed using incremental expenses for CAH to reflect the appropriate level of "inpatient" clinical care. These are noted in the above table. From observation days determined in the FESC model, it was assumed that 50 percent of these would be admitted into the hospital and reimbursed by Medicare and Medicaid on a cost basis, and all other payers at a case payment rate of $7,500 for a 3-day stay. Up to 25 percent of both observation stays and inpatient admissions would avoid medevac transport, thus reducing both the revenue and expense related to these services. For outpatient services, Medicare and Medicaid will reimburse ARMC at the IHS/OMB approved all-inclusive rate, while all other payers will pay off of charges. A significant assumption consistent with the assumption made for Iliuliuk Clinic is that the capital costs necessary to bring ARMC up to "code" would be approximately $15 million with related annual depreciation costs of approximately $600,000. Further, staffing costs and non-staffing operating costs are increased by $155,000 and $100,000, respectively, to accommodate both increases in hospital clinical care as well as additional administrative expenses necessary to accommodate the incremental complexities of managing a hospital relative to a RHC.

Results

Appended to this report is the full financial analysis for the alternatives studied in this financial assessment. The results of the analysis are summarized in the table below.

ALICIA ROBERTS MEDICAL CENTER
COMPARISON OF FINANCIAL MODELS - PRO FORMA STATEMENT OF OPERATIONS
FISCAL YEAR 2003

For Internal Purposes Only

	IHS/OMB (I)	FESC (II)	CAH/OMB (III)	OMB vs. FESC (II - I)	OMB vs. CAH/OMB (III - I)
REVENUE:					
Inpatient Revenue	$ -	$ -	$ 286,000	$ -	$ 286,000
Outpatient Revenue	2,900,000	3,112,000	2,965,000	212,000	2,965,000
Net Patient Revenue	2,900,000	3,112,000	3,251,000	212,000	3,251,000
Other Revenue	-	-	-	-	-
Total Revenue	2,900,000	3,112,000	3,251,000	212,000	3,251,000
OPERATING EXPENSES:					
Operating Expenses	2,900,000	3,109,000	3,884,000	209,000	3,884,000
Net Operating Income (Loss)	-	3,000	(633,000)	3,000	(633,000)
NON OPERATING REVENUE (EXPENSE)					
Non-Operating Revenue	-	-	-	-	-
NET CHANGE IN ASSETS	$ -	$ 3,000	$ (633,000)	$ 3,000	$ (633,000)

The projected financial benefit derived from FESC is $3,000. This benefit is primarily the result of ARMC being reimbursed for extended stays that are currently being performed, but not being reimbursed. This estimate relies on SEARHC reallocating some IHS contract funds to support the extended stays for IHS beneficiaries, but does not account for avoided costs by these beneficiaries in the SEARHC hospital in Sitka or in IHS contract care funds. CAH status is projected to cost ARMC approximately $633,000 relative to current status. The negative impact relates directly to the increase in clinical, operating and capital costs without the "hospital" type volume to offset these costs.

Medicare and Medicaid Payer Mix Impact

In order to evaluate the impact on each of these designations from a Medicare prospective, a separate financial summary was prepared. The following chart demonstrates the impact to Medicare, should any of these designations be adopted.

ALICIA ROBERTS MEDICAL CENTER
COMPARISON OF FINANCIAL MODELS - MEDICARE COST ONLY
Fiscal Year 2003

For Internal Purposes Only

	Fiscal Year 2003				
	IHS/OMB (I)	FESC (II)	CAH/OMB (III)	OMB vs. FESC (II - I)	OMB vs. CAH/OMB (III - I)
MEDICARE COST					
Inpatient Cost			24,976	$ -	$ 24,976
Outpatient Cost	253,253	271,767	258,930	18,514	5,676
Net Patient Cost	253,253	271,767	283,906	18,514	30,652
Other Cost				-	-
Total Cost	253,253	271,767	283,906	18,514	30,652

Because Medicare represents only a small portion of ARMC's total business, the amounts below are relatively low. Medicare costs for FESC are projected to be $19,000 greater than they are currently and $30,000 greater for CAH. The significantly higher Medicare costs associated with CAH are related directly to Medicare reimbursing CAHs on a cost basis and ARMC increasing clinical, operating and capital costs as discussed above.

ALICIA ROBERTS MEDICAL CENTER
COMPARISON OF FINANCIAL MODELS - MEDICAID COST ONLY
Fiscal Year 2003

For Internal Purposes Only

	Fiscal Year 2003				
MEDICARE COST	IHS/OMB ***(I)***	FESC ***(II)***	CAH/OMB ***(III)***	OMB vs. FESC ***(II - I)***	OMB vs. CAH/OMB ***(III - I)***
Inpatient Cost			40,923	$ -	$ 40,923
Outpatient Cost	414,957	445,291	424,257	30,335	9,301
Net Patient Cost	414,957	445,291	465,181	30,335	50,224
Other Cost				-	-
Total Cost	414,957	445,291	465,181	30,335	50,224

Medicaid costs are projected to be about $30,000 higher for FESC than current Medicaid costs. CAH implementation would raise the additional costs for Medicaid to over $50,000.

Conclusions

ARMC will in all probability incur some benefit from the adoption of the new Frontier Extended Stay Clinic model. Implementation of this model is dependent on several operational issues that cannot be assessed in a financial model. Acquiring necessary professional staff and supporting existing staff in isolated remote settings must be a focus of any demonstration project. In addition, the model, as presented, is sensitive to the expected utilization of the observation stay services, and more experience is needed by SEARHC to determine the probable level of utilization.

Lastly, the model will require that SEARHC will need to identify alternative resources to support the care of IHS beneficiaries and other under or uninsured recipients of FESC services. The provision of extended stay services at ARMC must allow these costs for ARMC patients to be avoided in these other health care programs, or the SEARHC board must decide whether the improvements in the quality of care for ARMC patients is worth the additional costs.

Appendix I – Financial Models

ALICIA ROBERTS MEDICAL CENTER
PRO FORMA STATEMENTS OF OPERATIONS
Fiscal Year 2003

The Accompanying Assumptions are Integral to this Pro Forma

	IHS/OMB	FESC	CAH/OMB
OPERATING REVENUE:			
Inpatient Revenue:			
General Acute (M&M)	-	-	68,090
General Acute (IHS revenue required)			217,500
Total Inpatient Revenue	-	-	285,590
Outpatient Revenue:			
Clinic	1,410,452	1,410,452	1,410,452
Office Procedures	111,582	111,582	111,582
Injections/Immunizations	25,641	25,641	25,641
Radiology	121,809	121,809	121,809
Lab	47,156	47,156	47,156
Medical Supplies Charged to Patients	6,601	6,601	6,601
Drugs	642,937	642,937	642,937
Medivac Services	533,368	533,368	533,368
Less Medivac Servcies (FESC & CAH)		(80,699)	(80,699)
Observation Extended Stay Unit (All revenue except IHS)	-	144,357	72,178
Observation Extended Stay Unit (IHS revenue required)		148,563	74,282
Total Outpatient Revenue	2,899,545	3,111,766	2,965,306
Net Patient Revenue*	2,899,545	3,111,766	3,250,895
Additional IHS earned revenue (extended stay and CAH)		-	-
Total Operating Revenue	2,899,545	3,111,766	3,250,895
OPERATING EXPENSES:			
Salaries	1,355,118	1,438,599	1,532,125
Benefits, Supplies, & Other	875,375	921,538	940,577
Adminstrative and IDC expenses	591,081	626,701	656,531
Depreciation and amortization	77,971	77,971	677,971
Provision for doubtful accounts (non beneficiaries)		44,652	76,745
Total Operating Expenses	2,899,545	3,109,461	3,883,949
Net Operating Income	0	2,305	(633,054)
NON-OPERATING REVENUE (EXPENSE):			
	-		
	-	-	-
CHANGE IN NET ASSETS	0	2,305	(633,054)

Appendix II - Base Year Assumptions

ASSUMPTIONS
Fiscal Year Ending June 30, 2003
Assumptions

Inpatient (CAH/RHC Model Only):					**Outpatient:**		
Acute Cases:					Medicare O/P Payer Mix:		9%
Acute - Medicare			3		Medicaid O/P Payer Mix:		14%
Acute - Medicaid			5		Private Insurance O/P mix		18%
Acute - Non Care/Caid			29		Direct Payment - non ben		19%
					IHS beneficiary pay		40%
Number of Patient Days:							
Acute - Medicare			9				
Acute - Medicaid			15		Medicare visit rate		364
Acute - Non-Care/Caid			87		Medicaid vist rate		374
					Avg. Medicare Pro fee		$65
					Medivac Trips		
Average Per Case Payment Rate:					Number of Trips		110
Acute - Medicare	**		N/A		Net Revenue Per	$	4,408
Acute - Medicaid	***		N/A				
Acute - Non-Medicare	***	$	7,500				
					Extended Stay Observation Days		
Average Per Day Payment Rate:					Actual Days		73
Acute - Medicare					Medicare %		9%
					Net revenue per (rountine)	$	4,000
Acute - Medicaid							
Acute - Non-benficiary		$	2,500				
					% Inc. Observation "Stays"		0%
					% of avoided Medivacs		25%
Employee Benefit %			29%		# avoided Medivacs		18
Payment rate w/o IHS payment for extended care					Clinic		
Medicaid			100%		Patient Visits		7,113
Medicare			80%		Net Revenue Per	$	180.27
Private Insurance			50%		Care/Caid Payer %		23%
Non Beneficiary Pay			20%				

Iliuliuk Clinic, Dutch Harbor, Alaska

Overview

The City of Unalaska's local health care needs are served primarily by IFHS, a 19,955 square foot independent Rural Health Clinic (RHC) owned and operated by a non-profit corporation. With the most accessible hospitals in Anchorage, over 800 miles away, IFHS meets a diverse need for health care services ranging from colds/flu to all forms of injuries, including lacerations, broken bones, and life-threatening trauma. IFHS is currently staffed with three practitioners, with additional physician support during fishing seasons in January-April and July-October. The clinic's current operating budget is approximately $2.6 million per year with an ongoing operating deficit of approximately $250,000. IFHS has enough capital to support itself for approximately 18-24 months at the current rate of losses. Because of the ongoing losses and need to generate a future positive (or at least breakeven) bottom-line, IFHS is considering several different operating models including:

1. Status Quo (RHC)
2. FQHC;
3. CAH; and
4. FESC

IFHS has received two separate grants to help evaluate its options. The first grant is focused on obtaining facility-planning information necessary to explore option three. The second grant relates to evaluating the financial feasibility of each of the above options.

Financial Model

The consultants have developed a financial model that projects IFHS financial performance under different Medicare clinic and hospital designations including: 1) RHC with capped cost-based Medicare and Medicaid office visit payments; 2) FQHC with higher capped cost-based Medicare and Medicaid office visit payments; and 3) CAH with cost-based payments for Medicare and Medicaid as well as uncapped cost-based RHC office visits. In addition, a fourth model was developed based on a proposed Medicare Demonstration program that would reimburse FESC meeting predefined criteria for extended stays as well as capped cost-based office visits for Medicare and Medicaid. One-year projections have been developed for each scenario based on fiscal year 2003 budget information. Assumptions are generally held constant between the

models with exceptions to account for the different reimbursement systems as well as incremental costs associated with both the CAH and the FESC to accommodate overnight occupancies.

Results

As documented below, FQHC status marginally improves financial performance relative to status quo (RHC); FESC provides additional benefit; while CAH status has a significant negative impact on the financial performance of IFHS.

ILIULIUK FAMILY & HEALTH SERVICES
COMPARISON OF FINANCIAL MODELS - PRO FORMA STATEMENT OF OPERATIONS
FISCAL YEAR ENDING JUNE 30, 2003

For Internal Purposes Only

	Fiscal Year Ending June 30, 2003						
REVENUE:	RHC ***(I)***	FQHC ***(II)***	FESC ***(III)***	CAH/RHC ***(IV)***	RHC vs. FQHC ***(II - I)***	RHC vs. FESC ***(III - I)***	RHC vs. CAH/RHC ***(IV - I)***
Inpatient Revenue	$ -	$ -	$ -	$ 264,000	$ -	$ -	$ 264,000
Outpatient Revenue	3,192,000	3,195,000	3,314,000	3,227,000	3,000	122,000	35,000
Net Patient Revenue	3,192,000	3,195,000	3,314,000	3,491,000	3,000	122,000	299,000
Other Revenue	-	-	-	-	-	-	-
Total Revenue	3,192,000	3,195,000	3,314,000	3,491,000	3,000	122,000	299,000
OPERATING EXPENSES:							
Operating Expenses	3,389,000	3,389,000	3,473,000	4,226,000	-	84,000	837,000
Net Operating Income (Loss)	(197,000)	(194,000)	(159,000)	(735,000)	3,000	38,000	(538,000)
NON OPERATING REVENUE (EXPENSE)							
Non-Operating Revenue	344,000	344,000	344,000	344,000	-	-	-
NET CHANGE IN ASSETS	$ 147,000	$ 150,000	$ 185,000	$ (391,000)	$ 3,000	$ 38,000	$ (538,000)

Next Steps

The consultants recommend that IFHS move forward with its FQHC application. In addition, they recommended that IFHS continue to monitor FESC demonstration program developments. At this point, the significant cost of capital ($15 million projected) necessary to improve the facility to meet "hospital" code precludes IFHS from considering CAH as a financially viable operating model. However, as the CAH model continues to evolve, and the city of Unalaska experiences changes in demographic, economic and/or other social conditions, CAH may become a more financially viable model in the future.

Assignment and Approach

IFHS engaged the consultants in April 2002 to consider Medicare payment alternatives and determine whether the clinic would benefit financially from converting to FQHC, CAH or FESC. This document summarizes the projected financial impact of converting to each of these alternatives and primarily discusses financial issues. Specifically, this model:

1. Projects the facility-wide financial impact of conversion from capped cost-based Medicare/Medicaid office visits to cost-based Medicare/Medicaid reimbursement under each of the alternatives based on clinic data and projected changes in volume and revenue; and

2. Projects and includes the impact of BBRA and BIPA changes including the Medicare Outpatient Prospective Payment System, allowable costs under CAH, and other clinic and hospital payment changes.

Current Status of Clinic Operations

IFHS is an independent RHC providing all on-island health care needs for residents and visitors of Unalaska, AK with a population of approximately 4,300. The population nearly doubles each year during two 8 to 10 week (some as long as 12 week) fishing seasons. IFHS provides access to primary care services, diagnostic (lab and X-ray) services, mental health counseling services and urgent care services. IFHS maintains one hospital-type bed for patients who require longer observation visits or are unable to get to Anchorage due to weather of other complications. Extended stays are not recognized as reimbursable other than a complicated office visit.

Because IFHS is not operating as a hospital, it currently meets both the average length of stay requirements and 15-acute care bed limit of a CAH and it is unlikely that these two CAH metrics will ever be an issue.

The fiscal year 2001 financial statements for IFHS showed a net loss of approximately $216,000, on net patient revenues of $2.6 million. During fiscal year 2002, IFHS's showed a net gain of $43,000 on net patient revenue of $3.1 million. During fiscal year 2002, Medicare and Medicaid patients accounted for 1.7 percent and 2.9 percent, respectively of all outpatient visits (measured by charges).

Evaluation

Methodology

The consultants used IFHS internal data to model the financial impact of RHC, FQHC, FESC and CAH status. The consultants matched the financial models to IFHS's operating performance for fiscal year 2002 ("base year") using financial statements, operating statistics, and the period's RHC cost report. For fiscal year 2003, the consultants annualized the operating statistics from

2002 (through February) and incorporated budgeted changes to the projected financial performance. On the basis of this information, the consultants prepared four separate pro forma Statements of Operations (i.e., RHC, FQHC, FESC and CAH with cost-based Medicaid). A comparison of these scenarios indicates the benefit of both Medicare designation changes and Medicare/Medicaid cost-based reimbursement, specific to IFHS's operations.

The consultants have not audited or attempted to confirm information for accuracy or completeness. IFHS staff reviewed all assumptions used in the model. The extent to which the financial analysis accurately predicts actual operating gains or losses depends on how closely the future operating environment matches the model's assumptions. The financial analysis cannot account for unforeseen regulatory or operational changes that may result in reimbursement or utilization changes.

Financial Model Assumptions

Prior to discussing the results of the analysis, it is important to understand the key assumptions used in the projections. Assumptions fall into three primary categories:

1. Revenue changes derived from the different clinic and hospital designations (Medicare, Medicaid, and non-Medicare/Medicaid);
2. Operating expenses and projected rates of inflation; and
3. Medicare and Medicaid program changes.

The operating assumptions between the four alternatives are the same with certain exceptions only as necessary. By keeping assumptions constant between models, any differences resulting from the analysis are reflective of the varying reimbursement and/or operating models.

RHC

Medicare office visit reimbursement is capped at approximately $66/visit. Medicaid office visit reimbursement is approximately $147/visit representing the fully allocated cost of an office visit. The full cost-based rate is based on a simulated RHC cost report that carves out non-RHC-covered services from RHC covered services and divides these costs of RHC-covered services by RHC visits. All other non-RHC-covered services are reimbursed based on charges or a small discount off of charges. Operating expenses remain unchanged from fiscal year 2003 budgeted amounts since this model represents status quo.

FQHC

The financial model compares IFHS as an RHC to IFHS as a FQHC "Look-Alike". An FQHC Look-Alike is organized and operated as an FQHC with its covered office visits being reimbursed by Medicare on a cost basis up to an $86 cap and by Medicaid at its full cost. The FQHC Look-Alike also allows providers access to the Federal 340(B) Discount Pharmacy Program. This program allows entities to purchase prescription drugs at substantially reduced prices and resell those items to users of the entities' services.

ILIULIUK FAMILY & HEALTH SERVICES ASSUMPTIONS Fiscal Year Ending June 30, 2003	
Assumptions	
FQHC Changes:	
1) Increase in Medicare payment cap	**$ 20.00**

The primary difference between a FQHC and a FQHC Look-Alike is that FQHCs receive grant funding under Section 330 of the PHS Act. An additional difference between the FQHC and the Look-Alike is that FQHCs are eligible for professional malpractice through the Federal Tort Claims Act. This can dramatically reduce professional liability insurance premiums.

FESC

As discussed above, the FESC is currently a proposal to CMS to initiate a Medicare Demonstration Program. In the current proposal, FESCs would be organized similar to an FQHC and be paid as a FQHC would be paid for covered office visits and other ancillary/non-covered office visits. The key difference between the FESC and a FQHC/FQHC Look-Alike is that the FESC would be reimbursed for "extended stays" as described below. Because the FESC designation is only a demonstration proposal to CMS, revenue assumptions related to this model are those that are being proposed and are not final.

ILIULIUK FAMILY & HEALTH SERVICES ASSUMPTIONS Fiscal Year Ending June 30, 2003		
Assumptions		
FESC Changes:	**Salaries**	**Non-Salaries (excluding benefits)**
1) Additional Clinical Support Staff (added to Clinic)	**$ 80,000**	$ -
2) Additional Capital Costs to Support Extended Stay	**$ -**	
3) % Increase in Observation "Stays"	**100%**	
4) % of Observation Stays that would avoid Medivac	**25%**	
5) Employee Benefit %	**20%**	

These revenue assumptions primarily include FQHC-covered office visits reimbursable at the FQHC payment rate (i.e., $86/visit); and extended stays exceeding 4 hours being reimbursed at a 24-hour per diem of $4,000 (thus a 4-hour stay would be reimbursed $667). To derive the number of reimbursable observation days, the consultants reviewed ER logs for fiscal year 2002 (through April 30) to determine the number of ER visits that lasted more than 4 hours. For these stays, the total number of billed units (in increments of 4 hours) was added together and divided by six to determine billable "days." Billable observation days were doubled to accommodate the growth in these services once they become reimbursable. Further, revenue and expenses for a number of medevac patients no longer exists when patients have longer access to health care services provided by the FESC. The financial model assumes a 25 percent reduction in medevac revenue and expense to consider this. Finally, the model assumes that IFHS would have to increase clinical staffing by $80,000 (plus benefits) per year to cover the increased clinical support of maintaining 24-hour available observation services. These changes are summarized in the chart below.

1) Observation Stays based on all ER visits during FY 6/30/02 that exceeded 4 yours (source FY 2002 ER Log Book). For ER stays that exceeded 4 hours, the total ER hours on a per patient basis are divided by 4 (billing unit) to determine billable units.
2) Observation Days are determined by dividing observation billed units by 6. The observations days are increased by 100% to accommodate increased use of services
3) Observation services are billed in 4 hours increments of $670 ($4,000 per day)
4) Observation revenue is carved out of Clinic Costs in determining the Clinic Cost per visit
5) Incremental costs associated with the FESC include $80,000 of clinical staffing plus associated employee benefits, offset by a slight reduction in Medivac costs

CAH

A CAH is a limited-service hospital that is eligible for generally more favorable, cost-based Medicare, and in some States Medicaid reimbursement. The Alaska Medicaid program has adopted cost-based reimbursement for both inpatient and outpatient services. To qualify for CAH

status a rural hospital must have a bed limit of 25 and an average length of stay of less than 96 hours.

ILIULIUK FAMILY & HEALTH SERVICES
ASSUMPTIONS
Fiscal Year Ending June 30, 2003

Assumptions

CAH Changes:	Salaries	Non-Salaries (excluding benefits)	Square Ft
1) Reclass of Expense from Clinic to Emergency Room	$ 150,000	$ -	1,000
2) Additional Annual Capital Costs ($15M/25 year Depreciation)	$ -	$ 600,000	-
3) Additional Administrative Costs	$ 40,000	$ 40,000	
4) Incremental Adults and Pediatric Costs (3 Clinical)	$ 120,000	$ 20,000	1,000
5) % of Observation Visits Admitted	50%		
6) % reduction in "Observation" visits	-50%		
7) Average Length of Stay	3.00		
8) % of Observation Stays that would avoid medevac	25%		
9)Employee Benefit %	20%		

A number of changes to the original RHC model were necessary to incorporate CAH reimbursement. From the RHC cost report, the consultants derived a "hospital" cost report using incremental expenses as well as reclass entries to appropriately reflect the level of "inpatient" clinical care. These are noted in the above table. From observation days determined in the FESC model, it was assumed that half of these would be admitted into the hospital and reimbursed by Medicare and Medicaid on a cost basis, and all other payers at a case payment rate of $7,500. Twenty-five percent of both observation stays and inpatient admissions would avoid medevac transport thus reducing both the revenue and expense related to these services. For outpatient services, Medicare and Medicaid will reimburse IFHS on a cost basis (including RHC covered visits, which are no longer capped) while all other payers will pay a discount off of charges. A significant assumption is that the capital costs necessary to bring IFHS up to "code" would be approximately $15 million with related annual depreciation costs of approximately $600,000. Further, staffing costs and non-staffing operating costs are increased by $160,000 and $60,000, respectively, to accommodate both increases in hospital clinical care as well as additional administrative expenses necessary to accommodate the incremental complexities of managing a hospital relative to a RHC.

Results

Appended to this report are the projected Statements of Operations for the alternatives studied in the consultants' financial assessment. The results of the analysis are summarized in the tables below.

ILIULIUK FAMILY & HEALTH SERVICES
COMPARISON OF FINANCIAL MODELS - PRO FORMA STATEMENT OF OPERATIONS
FISCAL YEAR ENDING JUNE 30, 2003

For Internal Purposes Only

	Fiscal Year Ending June 30, 2003						
REVENUE:	RHC ***(I)***	FQHC ***(II)***	FESC ***(III)***	CAH/RHC ***(IV)***	RHC vs. FQHC ***(II - I)***	RHC vs. FESC ***(III - I)***	RHC vs. CAH/RHC ***(IV - I)***
Inpatient Revenue	$ -	$ -	$ -	$ 264,000	$ -	$ -	$ 264,000
Outpatient Revenue	3,192,000	3,195,000	3,314,000	3,227,000	3,000	122,000	35,000
Net Patient Revenue	3,192,000	3,195,000	3,314,000	3,491,000	3,000	122,000	299,000
Other Revenue	-	-	-	-	-	-	-
Total Revenue	3,192,000	3,195,000	3,314,000	3,491,000	3,000	122,000	299,000
OPERATING EXPENSES:							
Operating Expenses	3,389,000	3,389,000	3,473,000	4,226,000	-	84,000	837,000
Net Operating Income (Loss)	(197,000)	(194,000)	(159,000)	(735,000)	3,000	38,000	(538,000)
NON OPERATING REVENUE (EXPENSE)							
Non-Operating Revenue	344,000	344,000	344,000	344,000	-	-	-
NET CHANGE IN ASSETS	$ 147,000	$ 150,000	$ 185,000	$ (391,000)	$ 3,000	$ 38,000	$ (538,000)

The projected financial benefit of converting to a FQHC Look-Alike is approximately $3,000 and is comprised solely of the increased cap on Medicare office visit payment rate. Other FQHC benefits including PHS grant funding, discount drugs, and potentially lower malpractice insurance premiums were not taken into account in the model. There is an additional benefit that is projected to total $38,000 derived from FESC. This benefit is primarily the result of IFHS being reimbursed for extended stays that are currently being performed but not being reimbursed. CAH status is projected to cost IFHS approximately $538,000 relative to RHC status. The negative impact relates directly to the increase in clinical, operating and capital costs without the "hospital" type volume to offset these costs.

Medicare and Medicaid Payer Mix Impact

ILIULIUK FAMILY & HEALTH SERVICES
COMPARISON OF FINANCIAL MODELS - MEDICARE COST ONLY
Fiscal Year Ending June 30, 2003

For Internal Purposes Only

	Fiscal Year Ending June 30, 2003						
MEDICARE COST	RHC ***(I)***	FQHC ***(II)***	FESC ***(III)***	CAH/RHC ***(IV)***	RHC vs. FQHC ***(II - I)***	RHC vs. FESC ***(III - I)***	RHC vs. CAH/RHC ***(IV - I)***
Inpatient Cost	$ -	$ -	$ -	$ 12,000	$ -	$ -	$ 12,000
Outpatient Cost	32,000	35,000	38,000	59,000	3,000	6,000	27,000
Net Patient Cost	32,000	35,000	38,000	71,000	3,000	6,000	39,000
Other Cost	-	-	-	-	-	-	-
Total Cost	32,000	35,000	38,000	71,000	3,000	6,000	39,000

In order to evaluate the impact on each of these designations from both a Medicare and Medicaid perspective, the consultants prepared separate financial summaries for each of these payers. The following chart demonstrates the impact to Medicare should any of these designations be adopted.

Because Medicare represents only a small portion of IFHS's total business, the amounts below are relatively low. Medicare costs for FQHC are projected to be $3,000 greater than RHC; $6,000 greater for FESC; and $39,000 greater for CAH. The significantly higher Medicare costs associated with CAH related directly to Medicare reimbursing CAHs on a cost basis and IFHS increasing clinical, operating and capital costs as discussed above.

Medicaid costs are projected as follows:

ILIULIUK FAMILY & HEALTH SERVICES
COMPARISON OF FINANCIAL MODELS - MEDICAID COST ONLY
Fiscal Year Ending June 30, 2003

For Internal Purposes Only

	Fiscal Year Ending June 30, 2003						
MEDICAID COST	RHC ***(I)***	FQHC ***(II)***	FESC ***(III)***	CAH/RHC ***(IV)***	RHC vs. FQHC ***(II - I)***	RHC vs. FESC ***(III - I)***	RHC vs. CAH/RHC ***(IV - I)***
Inpatient Cost	$ -	$ -	$ -	$ 12,000	$ -	$ -	$ 12,000
Outpatient Cost	85,000	85,000	85,000	103,000	-	-	18,000
Net Patient Cost	85,000	85,000	85,000	115,000	-	-	30,000
Other Cost	-	-	-	-	-	-	-
Total Cost	85,000	85,000	85,000	115,000	-	-	30,000

Medicaid costs associated with the RHC and FQHC options are identical as Alaska Medicaid pays RHCs and FQHCs an uncapped cost-based payment rate for covered office visits. The Medicaid costs for the FESC model are also similar but occur because the lower projected cost-based office visits are offset by the new reimbursement for extended stays.

Conclusions

When comparing the RHC option with the other options, there is clear financial advantage to FQHC. Because this model currently exists and IFHS currently meets a majority of the FQHC operating criteria, IFHS should move forward with this designation. It is important to note again that the FQHC financial model did not incorporate any of the addition benefits that can be derived from FQHC status including grant proceeds and the 340B discount drug program. Because FESC provides additional benefit, IFHS should consider this model if and when the CMS demonstration program is created. Because CAH provides no financial benefit at this time, IFHS should not adopt this designation. In the future, IFHS may want to reconsider CAH to the extent that changes occur in the economic, demographic or social characteristics of the city of Unalaska or to the extent that additional non-traditional funds are made available to IFHS to support the added infrastructure of a CAH.

Appendix I – Financial Models

ILIULIUK FAMILY & HEALTH SERVICES
PRO FORMA STATEMENTS OF OPERATIONS
Fiscal Year Ending June 30, 2003

The Accompanying Assumptions are Integral to this Pro Forma

	RHC	FQHC	FESC	CAH/RHC
OPERATING REVENUE:				
Inpatient Revenue:				
General Acute	-	-	-	264,411
Total Inpatient Revenue	-	-	-	264,411
Outpatient Revenue:				
Clinic	792,764	795,597	791,343	806,183
Office Procedures	407,962	407,962	407,962	412,874
Injections/Immunizations	64,306	64,306	64,306	64,306
Radiology - Diagnostic	360,762	360,762	360,762	354,846
Laboratory	486,523	486,523	486,523	502,694
Medical Supplies Charged to Patients	63,259	63,259	63,259	63,893
Drugs Charged to Patients	581,212	581,212	581,212	582,175
Emergency	89,182	89,182	89,182	100,215
Ambulance	60,605	60,605	60,605	59,605
Medivac Services	253,436	253,436	161,193	142,755
Distinct Observation Bed Unit	-	-	216,000	105,554
Mental Health Counseling	32,008	32,008	32,008	32,008
Total Outpatient Revenue	3,192,018	3,194,851	3,314,354	3,227,109
Net Patient Revenue	3,192,018	3,194,851	3,314,354	3,491,520
Other Operating Revenue	-	-	-	-
Total Operating Revenue	3,192,018	3,194,851	3,314,354	3,491,520
OPERATING EXPENSES:				
Salaries	1,360,887	1,360,887	1,440,887	1,520,887
Benefits, Supplies, & Other	1,565,060	1,565,060	1,568,649	1,642,580
Depreciation and amortization	225,012	225,012	225,012	825,012
Provision for doubtful accounts	238,000	238,000	238,000	238,000
Total Operating Expenses	3,388,959	3,388,959	3,472,548	4,226,480
Net Operating Income	(196,941)	(194,109)	(158,194)	(734,960)
NON-OPERATING REVENUE (EXPENSE):				
City of Unalaska Grants	140,000	140,000	140,000	140,000
State of Alaska Grant	95,500	95,500	95,500	95,500
Interest Income	20,000	20,000	20,000	20,000
Other Non-Operating Revenue	88,876	88,876	88,876	88,876
Total Non-Operating Revenue (Expense)	344,376	344,376	344,376	344,376
CHANGE IN NET ASSETS	147,435	150,267	186,182	(390,584)

Appendix II - Base Year Assumptions

ILIULIUK FAMILY & HEALTH SERVICES
ASSUMPTIONS
Fiscal Year Ending June 30, 2003

Assumptions

Inpatient (CAH/RHC Model Only):	
Acute Cases:	
Acute - Medicare	**2**
Acute - Medicaid	**2**
Acute - Non Care/Caid	**32**
Number of Patient Days:	
Acute - Medicare	**6**
M'care HMO	**-**
% M'care SSI	**0%**
Acute - Medicaid	**6**
M'caid HMO	**-**
Acute - Non-Care/Caid	**96**
Average Per Case Payment Rate:	
Acute - Medicare **	**N/A**
Acute - Medicaid ***	**N/A**
Acute - Non-Medic ***	**$ 7,500**
** PPS payments	
*** Includes nursery est. at $500/day	
Average Per Day Payment Rate:	
Acute - Medicare	N/A
Acute - Medicaid	N/A
Acute - Non-Medicare	$ 2,500
Transitional Care Days	
Swing Beds:	
Medicare SNF	-
All Other SNF	-
Distinct Part:	
Medicare SNF	-
All Other SNF	-
Transitional Care Payment	
Swing Beds:	
Medicare SNF	**$ -**
All Other SNF	**$ -**
All Other Ancillary	**$ -**
Distinct Part:	
Medicare SNF	$ -
All Other SNF	$ -
All Other Ancillary	$ -
Other Non-Operating Revenue:	
City of Unalaska Grant	**$ 140,000**
State of Alaska	**$ 95,500**
Interest Income	**$ 20,000**
Other Non-Op. Rev (Fin. St	**$ 88,876**
Total	$ 344,376

Outpatient:	O/P Total
Medicare O/P Payer Mix:	**1.67%**
(unless otherwise noted)	
Medicaid O/P Payer Mix:	**2.94%**
Office Procedures:	
Procedures	**4,761**
Net revenue per*	$ 85.94
Medicare Fees Per Proc	**$50**
Medicaid Fees Per Proc	**$50**
Radiology - Diagnostic	
Procedures	**3,499**
Net revenue per*	$ 104.46
Medicare Fees Per Test	**$50**
Medicaid Fees Per Test	**$75**
Laboratory	
Test	**9,418**
Net revenue per*	**$ 55.22**
Medicare Net Rev Per	**$ 10.00**
Medicaid Net Rev Per	**$ 15.00**
M/C Fee charges	**$ -**
PT, OT, ST:	
Visits	**-**
Net revenue per*	$ -
Medicare Fee tests	**-**
Net revenue per	$ -
M/C Fee charges	**$ -**
Medivac Trips	
Number of Trips	**37**
Net Revenue Per	**$ 6,936**
Medicare Fees	**$ 5,000**
Medicaid Fees	**$ 4,500**
Medical Supplies Charged to Patients	
O/P supplies	**1,739**
Net revenue per*	$ 39.15
Medicare Fees Per Supply	**$10**
Medicaid Fees Per Supply	**$15**
Drugs Charged to Patients	
O/P Scripts	**38,066**
Net revenue per*	$ 15.37
Medicare Fees Per Supply	**$10**
Medicaid Fees Per Supply	**$15**

Outpatient (cont.)	O/P Total
Emergency Room	
Visits	**595**
M/C Prof. Pmt.	$ 50
Net revenue per*	**$ 150**
Medicare Fees	**$ 150**
Medicaid Fees	**$ 150**
Distinct Observation Bed Unit	
Actual Days	**27**
Medicare %	**2%**
Net revenue per (rountine)	**$ 4,000**
Ambulance Trips	
Number of Trips	**215**
Net Revenue Per	**$ 291.75**
Medicare Fees	**$ 250.00**
Medicaid Fees	**$ 275.00**
Clinic	
Patient Visits	**8,498**
Net Revenue Per	**$ 92.09**
Care/Caid Payer %	**2%**
RHC Payment Cap	**$ 66.00**
FQHC Payment Cap	**$ 86.00**
Injections/Immunizations:	
Visits	**2,737**
Net revenue per*	$ 23.66
Medicare Fees Per Injection	**$20**
Medicaid Fees Per Injection	**$20**
Counseling:	
Visits	**672**
Net Revenue Per	$ 48.00
Medicare Fees Per Visit	**$40**
Medicaid Fees Per Visit	**$40**