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# The Effect of Critical Access Hospitals and Healthcare Requirements on Small Communities

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**The Effect of Critical Access Hospitals and Healthcare Requirements on Small  
Communities.**

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**BIS 437**

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## **Abstract**

This paper explores various articles about how critical access hospitals are an important part of the community they reside in, along with the effects of healthcare requirements to these hospitals and their patients. We will discuss pros and cons of critical access hospitals in rural communities versus urban city hospitals. This paper will discuss ethics, reimbursement, profit versus not-for-profit facilities, revenue cycle, outsourcing versus in house billing, how the government affects healthcare, ethical values of the hospital and its staff, and overall education about critical access hospitals including just what it takes to keep them going that will help patients understand how important these small, “Band-Aid” hospitals actually mean to their community and why they need to continue supporting them. A majority of the information in this paper is from personal knowledge as I have worked deeply in this field for over 3 years along with degrees and certificates backing up my knowledge.

## **The Effects of Critical Access Hospitals and Healthcare Requirements on Rural Communities**

### **Introduction**

Small but mighty, critical access hospitals make a difference in rural communities. From stabilizing critical patients in the emergency department to having a loved one in the swing bed program so they can be close to home and family after a hip replacement or surgery. We normally take these rural community hospitals for granted. Little do many people realize these hospitals rely on the community they serve just as much as the community relies on the hospital. There is a lot of controversy about the quality of these small facilities also, and I feel explanations and justification goes a long way. Patients and community members need to be educated as to why things happen the way they do before they jump the gun and are upset or complaining to the CEO about something they just don't understand. Small rural critical access hospitals are closing by the dozens all over the united states each year, and this puts the healthcare of the community the hospital resides in, in jeopardy. Insurance, billing, certain services, accessibility, specialties, and ethical decisions of board members or physicians are all very important in running and making a rural hospital successful. In a rural community with just

a few thousand people who you are, and who you know unfortunately makes a difference. Ethically this doesn't seem right, but there *are* reasons and standards behind everything. Patients in small hospitals have a higher satisfaction rate than bigger city hospitals because the care is usually more personal, and there is more time to focus on the patient and the treatment plan (Harris, et. al 2010). A lot of decisions have to be made about the care of the patients, which is number one priority, charges, purchases, equipment, contracts, what services to offer, and more. Patients sometimes can be one track minded when they see a small single level hospital, with just 4 nurses total on a shift between the Emergency room and the inpatient "med-surg" area, only two lab technicians, and two radiology techs for the day. People think, well how hard could it be to manage something so small? When a large hospital makes a mistake, patients tend to overlook it more so because they have the mind set of thinking that that place has a lot going on or the mistakes get caught and erased before the patient finds out because there is more staff to filter through and trying to secure physicians is a challenge in rural areas. When a larger urban hospital does something, recognizable enough to either complain about or award. patients tend to think, "Oh, it's because they have a lot more money, resources and smarter staff that know more to succeed." I can see both sides of the matter and I'm not saying all is false. Empathy plays a large part in this paper, just like having empathy for the stressed-out cashier at Walmart who wasn't all that nice, have an open mind and be considerate before making judgement on these facilities. Working in a tiny town, where there are elderly, and traditions do not get broken, along with the theory that change is bad, justification needs to be given on behalf of these hospitals. Let's just take a look into what it takes to function as a small rural community, not-for-profit hospital, compare and contrast pros and cons, and also see how similar these hospitals can be compared to an urban hospital. Keep in mind every town has "local celebrities" or very

important people, political factors, and small-town activities like gossip. Healthcare workers are very diverse and often isolated by the nature of their job and they tend to benefit from being closely-nit with the community they practice in.

### **To be profit or not-for-profit?**

There is only one big difference between not-for-profit and for profit. For-profit hospitals pay property and income taxes while nonprofit hospitals do not. Nonprofit hospitals are viewed the same way as charities are by the Internal Revenue Service's (IRS) standards, as long as they are actively complying with the set guidelines for nonprofit organizations like providing certain benefits to the community. In a hospital's case, the government sees not-for-profit hospitals as a huge benefit because hospitals are supplying a need and goof service to the people so the government does not have to try to provide it for their citizens. Not-for-profits do not pay federal income taxes or state and local property taxes. For-profit hospitals are either owned by investors or shareholders of a much larger company or one individual person. People may think that nonprofit hospitals provide more uncompensated care than for-profit hospitals do. Regardless of what we might think, for-profit hospitals actually serve higher poverty populations and they tend to have more resources for charity care or write-offs mainly because they have the funds to do it bringing in profit there is more room to adjust in this area. It is important for patients to understand that there is no difference in the environment, efficiency of the way things operate, or quality of care between nonprofit and for-profit hospitals. Both nonprofit and for-profit facilities can be found on lists of the best and worst hospitals in the country. For the 2016-2017 year, the

Mayo Clinic in Rochester, Minnesota, is number one (Sherry, S. "U.S. News & World Report Announces the 2016–17 Best Hospitals" August 2, 2016). The Mayo Clinic is a not-for-profit organization. There is no reason to believe that the quality and management of a hospital is associated by its tax status. For-profit hospitals have a larger need for raising their capital that nonprofits do not have. Nonprofits have the benefit of not paying certain taxes, and they fall in a category where they usually qualify for more grants and state and federal help. Whether a hospital is nonprofit or for-profit it should always have the best interest of its patients and staff so that they can understand how the hospital operates and where the resources go to benefit the community.

### **What is a Critical Access Hospital?**

Critical Access is a label, or designation given to particular rural hospitals by the Center for Medicare and Medicaid Services (CMS). Congress created the designation and the 1997 Balanced Budget Act in response to the increased number of hospital closures in the 1980s and early 1990s (cms.gov. 2015). According to the authors of the Rural Health Information Hub, critical access was "designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities." (2015). Rural hospitals are divided by the size of the Prospective Payment System which is the number of beds the facility has available to patients, so this really focuses on inpatient and swing bed stays. Medicare payment classifications can be Critical Access Hospitals, Medicare Dependent Hospitals, Sole Community Hospitals, and Rural Referral Centers. Overall, the profitability of rural hospitals has decreased while the profitability of urban hospitals has increased between

2012 and 2014, furthering the gap between both rural and urban hospitals. The Rural Prospective Payment System hospitals with 26-50 beds (not necessarily critical access hospitals) and Medicare Dependent Hospitals had the lowest profitability compared to other hospitals. (Sharita R. "2012-14 Profitability of Urban and Rural Hospitals by Medicare Payment Classification" March 2016). Keeping access to healthcare while trying to improve essential and necessary services needed in these rural communities is accomplished through cost-based Medicare reimbursement for these facilities. There are requirements and restrictions in place determining what types of hospitals are eligible for the critical access hospital designation. The major eligibility requirements for critical access hospitals are that they must have 25 or less acute care inpatient beds available, the hospital must maintain an annual average length of stay of 96 hours or less for acute care patients, (which are inpatients not swing bed), the physical location of the hospital must be located farther than 35 miles from the next closest hospital, with some exceptions including rough terrain, and the facility must also provide 24/7 emergency services. Critical access hospitals have the option to be for-profit, or not-for-profit. This obviously effects the financial status of the facility and there are pros and cons to being not-for-profit or for-profit. Usually the combination of critical access and not-for-profit are eligible for a larger variety of grants and government help and not having to pay the property and other various taxes helps also. Training for staff is usually limited for rural areas. If staff wants to attend trainings they usually have to travel fairly far, and this causes much more expense on the hospital. Rural healthcare worker's access to training is often more limited than that of an urban area so when training is offered to the rural worker it tends to be more beneficial and taken more seriously than that of someone who gets training constantly. Once you hear things so many times you tend to decrease its importance and it can result in a slack in performance because it becomes very

repetitive and its importance decreases. The workers who cannot receive training as needed can appreciate training offered much more. Rural areas have to participate in many virtual trainings and WebEx's online because the cost for travel is not something that can be expensed often in the strict budgets of a critical access or not-for-profit hospital. This makes a huge difference and makes the hospital at a slight disadvantage for up-to-date trainings and information.

### **Impacts of a Critical Access Hospital on a Rural Community**

In a study of data collected from 2012 to 2016, representing 91 CAHs across 18 states it was discussed the direct impacts, like employee benefits and wages, as well as secondary benefits such as construction activity, renovations, or add-ons. and retail spending. The information gathered projects the need for the rural and critical access hospitals to share their specific economic impacts to their rural communities to help them better understand and let the patients know the hospital isn't hiding anything from them. Critical access hospitals are responsible for a number of full- and part-time jobs and the wages, salaries, and benefits, like retirement, and insurance. Research findings from the National Health Information Center specify that typically ten to fifteen percent of the careers in a rural community are focused in or around health care and that typically rural hospitals are one of the top employers in the rural community. The employment and the resulting wages, salaries, and benefits from a critical access hospital are critical to the rural community economy (Dokeson, G. et al. "Economic Impact of a Critical Access Hospital on a Rural Community" October 2015). Health care is important to local economies in order to retain/and recruit the elderly (including retirees) to live in the local community. Health services and safety services are the most important concerns of

the elderly in choosing where to live or retire to. The elderly are the largest users of health care and have had the largest growth in the past several years. Now that the average life expectancy is much longer than it was even just 10 years ago, the elderly turns to their healthcare professionals to keep them going. Healthcare is important for retaining or recruiting business and growth to the local community. Decisions for industrial and business locations are significantly influenced by the availability of quality education services and healthcare services. Critical access hospitals are a key part of the rural community health care system and the economics of that community.

When residents obtain healthcare outside their own community, no spending occurs in local healthcare or their local economy and not bringing the dollars made back into circulation to the community. Dollars spent outside the community also reduce the local tax bases. A Critical access hospital or rural community can use the economic impact study to educate local residents and possible patients on the importance of utilizing their local health care and on the importance of "re-capturing" the healthcare dollars that are leaving the local community. According to a recent study by the National Center of Rural Health Works, critical access hospitals generate on average of \$1.8 million in taxable retail sales in the rural community. "This means that of the average labor income impact of \$7.1 million, an average of \$1.8 million is spent on taxable retail" (2015). There are also policy issues that involve providing access to health care, and services to rural communities. The impact of a critical access hospital may be useful in processing access to healthcare policy issues. These issues can arise at the local, county, state, or even national level. Critical Access Hospitals significant importance to their local communities and local economies is shown through economic impact studies. These studies really push local utilization of health care resources, they strive to ensure the quality of their local healthcare services, and focus on demonstrating the importance of healthcare to the local economy.

Knowing the economic impact of a critical access hospital can assist policy-makers/politicians, and other government officials in making future decisions along with voters. The political issues arising now with healthcare are very unstable and no one really knows where healthcare is headed. Why can't we just resort to free healthcare like Canada? Easy answer, the U.S government is so much debt they would never be able to cycle out enough money to pay back the current debt. Education and knowledge is the most important key for patients, public administrators, and politicians.

## **What is Medicare?**

Medicare is federal health insurance for people who are 65 or older, for certain younger people with disabilities, and for people with End-Stage Renal Disease sometimes referred to as ESRD. (medicare.gov 2016) Medicare is split up into four parts. Part A, Part B, Part C, and Part D. Part A covers inpatient hospital stays, care in a skilled nursing facility, swing bed stays, hospice care, and some home health care. Part A is free to the person if they worked and paid in most of their life to Medicare. Part B covers outpatient services. As long as lab work is medically necessary it is covered 100%. Most places have software that can run your lab test against the diagnosis code your physician gave you, and it can deem the test medically necessary or not based on the diagnosis code that will be billed. All other outpatient services such as X-rays, CT scans, Physical Therapy, Emergency Room Visits, Office Visits, observation hospital stays, etc. Medicare pays 80%, and leaves the patient with 20% to pay out of their own pocket. Part B does not, however, cover self-administered drugs. Medicare wants you to take out a part D (prescription drug coverage policy) for these medications. If your hospital has an in-house

pharmacy, then you can file your part D on the same claim directly with your emergency room or observation visit because the pharmacy should share the same tax ID and national provider Identification (NPI) as the hospital and be able to include those medications on the claim. Most critical access hospitals do not have an in-house pharmacy, because there is usually a local pharmacy available and it is not beneficial enough for the hospital to operate one. It then becomes the patient's responsibility to file their own claim with their Medicare part D insurance and most providers will provide the patient with the materials needed to. Patients can contact their part D prescription drug coverage company for a paper claim form, or some companies allow you to enter the claim online. There is a lot of confusion about being an inpatient or an outpatient when in observation. I have found this is something that Medicare needs to clarify and make in bold print, instead of fine print if you will. This is also up to the admitting physician's language. I have learned a lot of physicians are not aware of the importance of this language. For instance, the doctor walks into a patient's room and states that he is going to admit them for observation. The patients assume that they're being admitted, when really, they are not admitted to the hospital, they are staying overnight as an outpatient to be observed. When a physician decides to admit or keep a patient for observation the normal process is for a case manager to be notified and they will perform an assessment on the patient to see which level of care is best for the patient and if an authorization from insurance is required. To prevent fraud, insurances, especially Medicare puts these assessments in place to make sure the hospital does not try to put someone into inpatient or swing bed that should be a lower level of care just to get paid more. Critical access hospitals get paid most on their inpatient and swing bed accounts. They get paid a certain flat rate per day based on previous years audits of cost, regardless if the charges were lower or higher. If you are ever unsure of your status in the hospital, just ask you do not want a

surprise when you receive a bill. As mentioned above Part D is prescription drug coverage. Patients get pretty irate when they receive bills for medicines they could have taken over the counter or brought from home. Self-administered drugs are medications, ointments, and eye drops that could be purchased without a prescription at a drug store, *or* anything taken by mouth while in outpatient observation or emergency room visit. These are drugs like daily vitamins, nausea medicine like Zofran, Tylenol, or lidocaine patches, most pharmacist employees by the hospital will not allow patients to bring their own medication for any reason or at least without a fee, but you can try to get them approved by that pharmacist in special circumstances like rare medications the hospital may not have on hand. A small rural hospital will not have the quantity or variety of pharmaceuticals available like a large urban hospital may have. In August of 2016, The Center for Medicare and Medicaid Services (CMS) released a new form that all hospitals had to present to outpatient Medicare patients being treated in observation. This form is called the Medicare Outpatient Observation Notice (MOON). This form does just as the title describes it, Medicare had been receiving complaints about the self-administered drugs and 20% co-insurance being left behind after observation visits. A person can be in observation up to 72 hours as an outpatient, which will be billed under the patient's Medicare Part B plan. Most Medicare patients are not aware of this. A large balance can be accrued in 72 hours, and the patient portion is 20% of total charges along with any self-administered drugs given along with deductible amounts if that has not been met. Granted larger, urban hospital's that actually make a profit most of the time, write off these self-administered drugs as a courteous jester for the patients as a Medicare non-covered charge. This not something most rural, not for profit hospitals would do because of the impact it would make from losing the money. Most items that are legally billable to Medicare patient's hospitals will bill to the patient. Writing off charges that

billable to the patient makes it hard to explain why we are billing them for charges that have been excluded from their balance before. I have been told that I was a liar, and called many names after explaining self-administered drug balances to patients. Patients are encouraged to pay these non-covered drug charges because that is raw money for the hospital and a smarter business move to collect revenue from Medicare patients that also may have secondary insurances and normally do not have to pay anything to facilities. Medicare is life to critical access hospitals. Without Medicare's payments and support critical access hospitals would not make it as most small rural communities have a larger elderly population have Medicare as primary insurance.

## **Reimbursement**

Critical access hospitals are paid by Medicare costs fee basis versus the perspective payment system that other facilities opt for. The Prospective Payment System (PPS) is a method of reimbursement in which Medicare's payment is made based upon a predetermined, fixed amount and fee basis. Medicare has an addendum available to patients and facilities on their website; [www.cms.gov](http://www.cms.gov), this is updated every few months and tells you how much Medicare will allow and pay for CPT codes. The most popular Addendums are Addendum A and Addendum B. Addendum A for inpatient charges associated with Medicare part A, and Addendum B for outpatient charges associated with Medicare part B. The payment amount for a particular service is based on the classification system of that service (for example, diagnosis-related groups (DRG) for inpatient hospital services) (cms.gov, 2015). Critical access hospitals can choose to be paid by the Prospective Payment System using DRGs and Fee Schedules on certain ancillary

services and not others. Most facilities do choose to participate in splitting out the charges like this, but it makes even more work when tracking charges and preparing required periodic Medicare reports. Critical access hospitals are usually paid 101% of costs of operation for that particular service. But this does not necessarily mean that the hospital is profiting in anyway. The final settlement for each fiscal year is based on the Medicare cost report and credit reports filed after the company completes their audits. Inpatient and Swing Bed stays are paid on an interim basis using a per diem rate for routine and ancillary costs, in other words each day in the hospital as an inpatient or swing bed stay is still paid at 101% of cost. No matter the actual cost of that day, Medicare will reimburse one rate. If you only bill an updated charge of \$1,000.00 per day for a swing bed stay, but based on the last year's credit and cost report audits you are to be paid \$1,200.00 a day regardless of the updated charge so you are receiving more money than what you are billing for. If you spend this money and do not prepare for the takeback of this money, the facility will be in financial stress because Medicare wants their money within 30 days on a normal basis. The cost payment system has its pros and cons, because the payments continue at the same rate until it is audited, and this can cause big problems. At the hospital I am employed at we have projected a 1.3 million dollar take backs or overpayment, and will have to repay this money back immediately or they hold any current payments being made which will practically stop your revenue because critical access hospitals rely on Medicare payments to pay the bills. This is what happens when management positions continue to take a turn over and no one is on the same page. A take back or overpayment can come about when the auditor for Medicare decides that the cost was not great enough and reflected as a high cost based on the claims submitted. Something like this can shut the doors on a critical access hospital if they are not approved for an extension/payment plan with Medicare. When Medicare pays based on costs,

but a facility does not reflect those costs, Medicare gives you a very short time to settle up.

Critical access hospitals rely on Medicare's payments to keep the doors open because they pay at the least within two weeks of filing of claim. But I personally feel like this could be a defect in the system because if Medicare is just paying whatever comes in on claims and not thoroughly checking for claim edits or errors, you will most certainly have overpayments. During the late 1980s to 1990s, around 400 hospitals across the U.S. closed because they experienced a large amount of financial losses from the Perspective Payment System. Medicare pays on the same services from critical access hospitals to other acute care hospitals (medicare.gov, 2012).

According to the Critical Access Hospital Finance 101 Manual, critical access hospital payments are based on each critical access hospital's costs and a share of those costs that are allocated to Medicare patients reflected by the claims submitted to Medicare as mentioned above. Critical access hospitals receive cost based reimbursement for inpatient and outpatient services provided to Medicare and most Medicaid patients. Cost based reimbursement provides a significant financial advantage to critical access hospitals by paying them at 101% of costs on all patients using the hospital's services that have Medicare as insurance (2012). There is a downside to this system though too. As mentioned above, to reiterate, take those swing bed accounts for instance, a hospital may be paid \$1,200 per diem. The cost for this stay per day may not actually be that much, so the hospital has to show the cost of operation is actually \$1,200 a day or more per account that was paid out for swing beds that day. Otherwise Medicare will request a "takeback" or "payback" after their yearly audit or cost reports are due. This is why the cost reports and credit balance reports are so important. But hospitals are allowed to account for employee wages, equipment costs, supplies, and so on into this balance. Larger hospitals have a larger cost because their employees get paid much more and their equipment may be newer and up to date.

Hospitals and health systems like long term care facilities, dialysis centers, home health and others, including those serving rural communities, are greatly rising the use of population health strategies as they attempt to move toward reliable healthcare delivery models and financing. As they are seeking to re-vamp their community benefit activities to improve the health of their local communities, representing their accountability to the local invested stakeholders. Your stakeholders are more than likely going to be made up of board members, most critical access hospitals are owned by the county they reside in and different people or politicians in the county make up the board members and chairmen. Different populations and health strategies of regionally diverse critical access hospitals identify challenges, opportunities and lessons that could inform and motivate the efforts of other critical access hospitals and state flex programs that participate. In other words, every hospital works off each other's stats when dealing with Medicare. Board members need to be active in the hospital and community to be a voice for the facility. Medicare takes all the critical access hospitals, and compares the charges, the services, commercial reimbursement etc. and breaks it up by geographic location to determine future goals to set for those hospitals.

## **Medicare Flex Program and Grants**

The Medicare Rural Hospital Flexibility Program (Flex Program) was also created by the Balanced Budget Act (BBA) of 1997, with the objective of supporting the new and existing critical access hospitals. The Federal Office of Rural Health Policy (FORHP) funds the Flex Program (Morgan, T. [www.ruralcenter.org](http://www.ruralcenter.org) Flex Program, 2017). Issues for a critical access hospital defined under the Flex Program include: payment/reimbursement and financial

information, regulations and information regarding critical access hospitals status and the Flex Program, key organizations in the field, various funding opportunities, and the challenges of operation. (Rural Health Information Hub, 2015). The Flex Program provides technical support and information to help hospitals realize their unique needs of being a rural hospital. The hospital can use the following programs to help identify these needs: The State Office of Rural Health Programs, Medicare Rural Hospital Flexibility Grant, Small Rural Hospital Improvement Program (SHIP) Grant, (which I have had personal experience applying for,) and the Rural Quality Improvement Technical Assistance Cooperative Agreement, along with a number of regional sources in each area that offer grants hospitals can apply for online. Flexible funding motivates the development of cooperative systems of care in rural areas, combining together critical access hospitals, emergency medical service (EMS) providers, clinics and health practitioners to increase the efficiency and quality of care. The Flex Program also requires states to develop their own rural health plans and funds their efforts to implement community-level outreach. The Flex Program includes help and support for five program areas including Quality improvement, designation of critical access hospital which is required if requested, financial operation improvement, and two optional choices, population health management and emergency medical services integration, and the integration of innovative healthcare models (National Rural Health Resource Center, Flex Program, 2017). This is a very important program for critical access hospitals and rural facilities because this money only goes toward important matters when running a hospital or business in rural communities. The (SHIP) grant that our hospital applies for every year goes toward strengthening our meaningful use program, was used to help convert medical records and our coders from ICD-9 to ICD-10 coding, software, and training, along with physical improvements needed for our facility like new flooring, paint, and furniture. You must

describe in detail how the money is going to be put to use to help better your facility or else they will deny the grant. The grant is very easy to apply for though, and it is simply a form that needs to be filled out and proof of implementation needs to be sent after the grant is approved. There are many websites and resources available to help a facility find other grants that they qualify for and they also have people to help you apply for these grants normally at no costs to the facility. The main thing to pay attention to when applying for a grant online is to make sure it is creditable, and for your state. Many grants are at the state level and the state of Pennsylvania for example will have no interest in funding a facility in the state of Kentucky.

## **Staffing**

Staffing a small hospital is something most people would assume is an easy task. In my facility there are a handful of people who have been there over 30 years! Most hospitals have initiatives for their employees to keep them around. Employee retention varies by facility. Having a good environment and diverse culture makes employee retention much easier. It can be looked at two ways, rural areas have less people, and less places to work so whether you like it or not you stay at a place because you have to, or you can also look at it as an opportunity to recruit local community residents and help them have a sense of giving back to their community by creating and retaining dollars paid out and spent in their own area. In many rural or just simply small facilities one person may have many jobs to keep down on employment costs, wages, and having to provide benefits but it also can put stress on the employees who have more than one title. For instance, I am financial counselor only by title, I counsel patients, assist patients with insurance, am taking responsibility of all of the Cashier duties which includes all

patient complaints about billing issues and taking payments, along with being in charge of emergency room, inpatient, swing bed, surgery, radiology and laboratory daily charges because the facility will not hire anyone else. I am a registration clerk, an emergency room registration clerk, help out in medical records when needed, billing specialist, and personal assistant to my supervisor. I bounce from one desk to another, to another, all day long and I most certainly do not get compensated for all my skills. On the down side, recruiting local employees can cause major problems with HIPAA violations. I see it almost every day, "oh so and so came into the ER again today for an anxiety attack or what not." Being in a rural community people are more apt to know one another and you have major HIPAA issues, but staffing local people helps the community and the employees. I have so many patients that have gotten so used to dealing with me and they know I will do my best to help them have a great experience or get their issue taken care of they insist on only speaking with me, which makes me feel like I am an asset to the facility. I know a lot of the patients that come in on a personal level and it does make it harder on me because they expect our personal relationship to get them out of bills, or get them discounts, and ethically along with lawfully I just cannot do that. Another issue I see with staffing these small facilities are the Physicians. According to Nicole Fisher with Forbes magazine, 25% of physicians are not born in the United States (2016). Let's just face it, not many doctors come from super small rural towns. The foreign physicians are qualified to be at the best of the best hospitals mostly in large cities so rural hospitals may have to use a recruiting company to staff their facility. Even these doctors normally travel over 45 miles to work their shift, but their being compensated for that because they are actually employed by an outside company that the hospital has to pay. Hospitals can pay up to \$30,000 a month for this service. This also doesn't mean that the doctors are not good, but you do not get to choose who the company sends you, and if you

have a few bad physicians this can hurt your facility. This more commonly happens with emergency room doctors. The patients also notice that a new doctor is there every time they present to the emergency room and they respond negatively to having someone new see them every time. On the other hand, that leads to the issue of emergency room abusers if they are in the emergency room enough to realize the same doctors are not there all the time. Not being able to hire and keep particular physicians may make the appearance of the facility look unstable.

## **Accounts Receivable**

If you were trying to apply for a job at a hospital in the revenue or business office, a good way to see how decent your point of collections staff, and billers are you can take a look at the days in “AR” accounts receivable. This is the turnaround time of money going out the door to money coming in. If you have a self-pay, or private pay patient that pays at the time of service, the accounts receivable day is 0. If a claim is having trouble getting billed out, or there are multiple rejections and appeals are having to be done the Account receivable days may be well over 100. Each month a report should be ran to obtain the average accounts receivable days. A good average amount of days in accounts receivable is 35 days or less. So, this means you’re having a lot of money going out, but not coming in as quick. This helps hospitals make the decision to have a company do their billing instead of doing it in house, or helps see how efficient the company they have already is. Patients do not like to receive statements from somewhere across country, but if the hospital can hire a company to bill out and bring money back in the door quicker it is a good business decision, it is just an adjustment for the patients. Luckily, at our facility myself and one more person was a part of the billing team before we

decided to outsource so we can still help patients on site. Outsourcing billing can be a headache, or a relief, sometimes both. Large and small hospitals or rural clinics and other facilities can choose to outsource. Processes are normally sped up when an outsourced company takes over certain tasks because you have a team dedicated to that one task. I know that outsourcing was a blessing for our facility because we only had two billers, and one coder and this made it very hard to keep up with the volume we had coming in and needing to get correct claims out the door. Outsourced billing companies should stay up to date on all changes happening pertaining to how claims need to be billed for certain insurance companies. Like Anthem, for example, they have different forms for different types of services making it extremely hard to remember which one needs to be billed on what form and to where. Having a group of people specifically for that makes billing much easier. People in a small town tend to have hard feelings against outsourced companies, patients don't understand why they were seen in Cadiz, Kentucky but are being billed from Mobile, Alabama. It is something that a lot of facilities turn to now and soon it will be the norm.

## **Medicaid**

What is Medicaid? Medicaid is funded jointly by state and federal level insurance programs. This insurance is awarded to low-income and "needy" people. It covers children normally under 18, elderly, blind, and/or disabled and other people who are eligible to receive federally assisted income based on certain circumstances. There are different types of Medicaid offered, the elderly usually qualifies for QMB Medicaid. This does not help with health care until you have met a certain predetermined amount based on your income. QMB is focused on

helping elderly patients pay their Medicare premiums, but if determined, by income there is a separate QMB plan patients can receive to have their premiums and their healthcare paid for in full by full Medicaid benefits normally considered ZQMB. Pregnant mothers normally single mothers, always receive Medicaid based on that status and their income. CHIP is the insurance for children who are eligible for Medicaid but instead of having no co-pays like full Medicaid, CHIP can apply certain co-pays for the patient. Patients can apply for this insurance at the local Department of Community Based Services, some hospitals, or by calling Medicaid directly. Medicaid is launching an online portal to detect eligibility and assign Medicaid to patients that qualify without having to manually call in. This will take the load off of Food Stamp offices, Social Security Offices and the local Department of Community Based Services locations because hospitals can more easily sign up their uninsured patients along with anyone who is an agent or broker for HealthCare.gov. Medicaid patients are required to renew their income verifications, household size, and employment status every year sometimes more often. It is easy to abuse Medicaid because anyone with Medicaid is exempt from being billed any balance. Its free healthcare for those who cannot afford it.

## **Abusing Medicaid**

These “frequent flyers”, as some may call them are normally Medicaid patients. Not to be stereotypical but having free healthcare tends to set an ambiance that you can go wherever you want for health care for every little problem. Where people with regular commercial insurance may try to hold off on going to see a doctor because they know they will have to pay for it. The biggest problem is the emergency room is patients who do not want to wait for a primary care

provider or who just do not know better, and come to the emergency room for common cold symptoms, stomach aches, and very minor diagnoses. This ties up emergency room resources if a critical patient was to present to the emergency rooms. Being in a small facility the emergency rooms are not very big, normally rural facilities just have three or four rooms, where a larger facility may ten or more. You may say, who cares as long as the facility gets paid? But that is if Medicaid pays on every CPT code and determines the visit medically necessary. More often than not, Medicaid, or the MCO assigned to you through Medicaid is very particular when it comes to medically necessity. Most MCO's make patient's get their CT scans, MRI's and ultrasounds pre-certified before they are performed to make sure they are medically necessary. As a hospital we have to rely on the patient's provider to get that pre-certification but can obtain one if necessary. If one slips through or the insurance company changes their protocol, the hospital has to eat that cost if that is not approved or caught in time to file for a preauthorization or a retro-authorization. A retro-authorization is an authorization that is approved after the service was already performed. Some insurances allow the facility to get a retro-authorization and they will determine if it is medically necessary enough to pay for the service. A big problem with Medicaid insurances and hospitals are emergency room visits. Medicaid patients were too accustomed to coming to the emergency room for non-emergent symptoms. I feel this is partly because in rural areas the options for healthcare is limited. Primary care physicians are hard to come by and the ones available can stay booked up. Out of daily office hours, the next closest urgent care or after-hours clinic may be more than thirty miles away, so why not just go to the closest emergency room? Some hospitals were experiencing high volumes of fifty-dollar triage accounts from certain insurance companies. It has recently just past congress that insurance companies cannot follow the fifty-dollar triage processes anymore. This process ended early

2017, but hospitals urban and critical access are still reaping repercussions, filing appeals and trying to get paid for previous fifty-dollar triage accounts. Turns out, the MCO's made up their own rules and erected the idea of the fifty-dollar triages against the rules of the state Medicaid policies, and it has just now come a large enough of an issue that the state of Kentucky and a few other states have put an end to it. A fifty-dollar triage account is where the patient presented to the emergency room for a non-medically necessary complaint and the insurance company only pays fifty dollars. Fifty dollars for an emergency room visit is very cheap and most certainly under cost. This is a burden for the facility because resources are being used, and the patient is being treated all for hardly nothing. Good for the patient, not so good for the facility. The insurance companies that do this see this as a benefit to the facility to give them fifty-dollars just for walking in the door. Most hospitals have a Utilization Review team (UR) to determine what amount should be appealed and what amount should be written off. It is not always a negative thing to "write off" balances with some facilities showing you have a larger loss than gain means Medicare may not take back so much money when the audit comes around. Some facilities have implemented the fast track or medical screening process. The fast tracking or medical screening process consist of allowing the patient to be signed in and triaged before an emergency room charge is applied. The nurse will obtain vitals and document chief complaint, then the physician will "screen" the patient to see if the patient's complaint is actually a medical emergency. If the patient has been deemed non-emergent and they still would like to be seen, there is a \$150 fee that must be paid at time of service whether the patient is a Medicaid patient or not. This process was implemented in my facility and the process has been hard on our patients. Our patients that frequently visit the emergency room are now being asked to schedule visits with their primary care providers and if they do not have a provider we will offer to schedule them a visit with

someone from our rural clinic. Slowly, the outcome should be to make our patients familiar with the process that should be taken when they need to be seen for non-emergent complaints and this is also a way to expand business with the rural health clinic. Seems against the rules doesn't it? This process is actually in compliance with Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA was enacted in 1986 under the Social Security Act and passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. EMTALA was created to address major concerns from patients that hospitals were denying emergency care to indigent and under insured patients. It requires hospitals and ambulance services to provide care to anyone needing emergency healthcare treatment regardless of ability to pay, what type of insurance they may have, or their legal status. You may have heard this called the "anti- dumping Act" because originally physicians were referring patients that were un-insured or underinsured to other facilities for care after a very simple and inadequate exam. Hence dumping the patient on someone else to eat the cost. In most emergency rooms the doctors or nurses have no idea about insurance, or what they insurance is going to pay, this staff is more clinical and worried about saving you, or if anything stabilizing you. This Act was set in place, so no one was discriminated against or turned away if they had bad or no insurance. Some patients that know they will get turned away in the office because of outstanding balances also use the emergency room to get treated because you can't be turned away.

### **Audits, Reporting and Regulations.**

Critical access hospitals have regulations to follow and affiliates to report to just like any other hospital. If a hospital is not accredited by the Joint Commission, it will be audited by the

Office of Inspector General (OIG). Office of Inspector General was formed in 1976, as a part of the U.S. Department of Health & Human Services (HHS) has been at the forefront of the Nation's efforts to fight waste, fraud, and abuse in Medicare, Medicaid and more than 100 other HHS programs. Daniel R. Levinson has lead the Office of Inspector General since September 8, 2004. (2016) A group of auditors will come unannounced once a year to audit policies and procedures, cost reports, insurance claims, safety, complaints, and EMTALA. According to cms.gov the definition of EMTALA is an Emergency Medical Treatment and Labor Act (EMTALA) that requires hospitals with emergency departments to provide a medical screening exam to any individual who presents to the emergency department and requests to be seen, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition. The term "hospital" includes critical access hospitals. The requirements of EMTALA apply to all individuals (not just Medicare beneficiaries) who try to gain access to a hospital for emergency care (Certification and Compliance for The Emergency Medical Treatment and Labor Act (EMTALA) 2015). My facility has just implemented a policy where we medically screen patients to determine whether they are an actual emergency. A lot of critical access hospitals are going to this method because of the limited space in the emergency room. In my facility, we have three emergency rooms and one triage room. Since critical access hospitals are in rural areas, these areas usually consist of elderly or low-income residents. Patients on Medicaid have a tendency to abuse the emergency room. The medical screening process keeps the common cold symptoms and upset stomachs out of the emergency rooms, so they are left open for real emergencies. Our compliance officer had to conduct a lot of research not to break any rules or regulations because there are very thin lines that can and can't be crossed. Once a patient presents to the emergency room they are seen and screened to be

determined if the visit is medically necessary. If not, we can schedule an appointment for the patient at our Primary Care/walk-in clinic or we charge everyone even Medicaid patients, yes, (that's legal) \$150 to stay and be treated when not medically necessary conditions are present. \$150 is what we as a facility chose to make the amount, this amount is not set or specified to be a certain amount by EMTALA. This has helped tremendously to eliminate wasted resources and long wait times which leads to better patient satisfaction scores. In rural communities someone in a high position will hear about "Oh, my mom broke her hip and had to sit in the waiting room for over an hour!" This does not look good, but cannot be prevented when the emergency rooms are full. MEPS is the Medical Expenditure Panel Survey which has been conducted by the Agency for Healthcare Research and Quality (AHRQ) each year since 1996. MEPS is a set of large-scale surveys of families and individuals, their medical providers, and their employers across the United States. MEPS collects data on specific health services, including frequency of use, costs, and sources of payment for services, and on the cost and scope of health insurance covering U.S. workers. (2017) It is a requirement for meaningful use data to report to Medicare. CMS published a final rule in October 2015 that specified criteria eligible professionals (EPs), eligible hospitals, and critical access hospitals have to meet in order to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Zhan C, Sangl J, Bierman AS, et al. Potentially inappropriate medication use in the community-dwelling elderly: findings from the 1996 Medical Expenditure Panel survey. JAMA 2001 Dec 12;286(22):2823-29). Any incentives offered to the hospitals or providers are usually worth taking from 2003 to 2009, the wait time in U.S. emergency departments increased 25%, from 46.5 minutes to 58.1 minutes. Wait times were longer in emergency departments that went on ambulance diversion or boarded admitted patients in hallways and in other spaces (Hing, E. et al, Wait Time for Treatment in

Hospital Emergency Departments: 2009, August 2012). Diversion happens when a hospital cannot take any more patients, they have the ambulance or serious cases diverted to another facility for care. Office of Inspector General was formed in 1976, as a part of the U.S. Department of Health & Human Services (HHS) has been at the forefront of the Nation's efforts to fight waste, fraud, and abuse in Medicare, Medicaid and more than 100 other HHS programs. Daniel R. Levinson has lead the Office of Inspector General since September 8, 2004. (2016) A group of auditors will come unannounced once a year to audit policies and procedures, cost reports, insurance claims, safety, complaints, and EMTALA. The requirements of EMTALA apply to all individuals (not just Medicare beneficiaries) who try to gain access to a hospital for emergency care. This has helped tremendously eliminate wasted resources and long wait times which leads to better patient satisfaction scores. MEPS is the Medical Expenditure Panel Survey which has been conducted by the Agency for Healthcare Research and Quality (AHRQ) each year since 1996. MEPS is a set of large-scale surveys of families and individuals, their medical providers, and their employers across the United States. MEPS collects data on specific health services, including frequency of use, costs, and sources of payment for services, and on the cost and scope of health insurance covering U.S. workers. (2017) It is a requirement for meaningful use data to report to Medicare. CMS published a final rule in October 2015 that specified criteria eligible professionals (EPs), eligible hospitals, and critical access hospitals have to meet in order to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Any incentives offered to the hospitals or providers are usually worth taking. Compliance officers, department directors, and Chief Financial Officers can also conduct internal audits. Emergency room staff may have an audit on their charts to see if their documentation is substantial. I personally conduct more of a review every day of charges for

different departments to make sure they are correctly placed on the patient's account and will be allowed when billing the claim.

### **Commercial Insurance**

Commercial insurance is what most facilities consider any other insurance than Medicare or Medicaid. Facilities must obtain contracts with these insurances in order to get paid a better rate. Some examples of these commercial insurances are Anthem Blue Cross and Blue Shield, Humana, United Health Care, and Aetna. There are also many more. Also not to be confused with Medicare replacement plans of Anthem Medicare replacement, Humana Gold Choice, United Healthcare Medicare replacement and more Medicare part C plans that regular commercial companies have bought into. If a facility obtains a contract with that insurance company that means they are "in network". Being in network is more beneficial for both the facility and the patient. The patient has a better contractual agreement and more paid out to that facility, so the patient has less responsibility to their deductible and co-insurance or out of network/out of pocket costs. This helps the facility because people will receive healthcare where their insurance is in network to pay less. Being in network with a company brings in more business. Medicare and Medicaid also obtain contracts but are much more limited to any negotiation. Each insurance company specifies a set amount on what they are going to pay for each type of service sometimes down to the CPT and procedure code. Hospitals should do the research ahead of time to know what percentage of the insurer's business comes from the hospital. Payors should have the numbers together and know what they're talking about. You'll be at a major disadvantage if you don't take the time to compare contracts to each other." Says

Kyle Kobe from Equation, a healthcare consulting firm (2011). Negotiating is a very important aspect that can affect the revenue cycle. Questionable or vague clauses that involve legal issues or payment procedures like the appeals process should be dissected and explained so later disputes do not cost the hospital money. Every aspect needs to be looked over before signing a contract. Sometimes no terms can be met between the payor and facility, so the agreement is never signed. From my own personal experience, I have noticed that contracts are usually as vague as possible to begin with to deceive the facility. Identify the core services in which the organization provides higher patient care than competitors, which is to drive operational efficiency, regardless of the health care payment mechanisms. After evolving the capacity to deliver value-based care, proactively approach payers for value-based payment contracts. Then, begin to demonstrate the value of the health care you deliver. The current payment system (fee-for-service and cost-based reimbursement) rewards health care service volume, not value which is not efficient to continue. The idea where the CEO stated that she was re-signing contracts requesting a different strategy. “the team proactively approached the payers requesting a value-based payment contract, noting that SPMC was investing in value-based care that will eventually lead to lower payer costs.” I would really like to know also where the staff and resources come from to have teams and committees in rural hospitals. All the critical access hospitals I have been in contact with do not have the staff to have teams and councils to focus on payer agreements and contracts. Most of the time the Revenue Cycle Director facilitates this, as they are most familiar with what facilities need to get paid. Each facility is different, but if possible, these committees would be a great part of the organization. I feel like having just a regular insurance committee composed of billers, and revenue cycle management along with the chief financial officer would be extremely beneficial. Patients have recently started presenting to us that their

insurance company is offering incentives for direct reimbursement if the patient does not present to certain facilities for services. For example, a local primary care facility called Blue Cross and Blue Shield commercial insurance to get a precertification number for the patient to have an MRI at our hospital. The precertification number was authorized, and the patient was on their way across the street to us when the patient received a call from their insurance company offering a \$200 incentive just to go to another facility like a free-standing imaging facility instead of our hospital for the MRI because it would be that much cheaper. Unfortunately, this is legal, and we did not have time to do anything about it, but the patient said to them that she was not going anywhere else, our facility is close for her and where she chooses to go for her services. But it concerned us as a facility, if we had a committee, this issue could be addressed, and time could be set aside to file a complaint because this is the only thing that can be done in the hospital's defense or contact the representative of Blue Cross and Blue Shield for our region and complain directly. I can most certainly see where a committee would be beneficial.

## **Technology in Healthcare**

Patient Portals, text messaging bills, and Online bill pay and updates, it is a constant movement towards being technologically advanced to keep up with the ever-evolving technology that the world is used to now. It is a requirement now to have a patient portal and to ask patients if they would like to be part of the patient portal the facility provides, so they can get their medical records online, saving time and resources for employees and patients. I feel like the statement made by Vaishali Patel and her co-authors in the article Electronic Capabilities for Patient Engagement among U.S. Non-Federal Acute Care Hospitals: 2012-2015 that "Large and

medium hospitals provide patients with the capability to electronically view and download health information at significantly higher rates than small hospitals and Critical Access Hospitals.” Is a bold statement to make, because we are a critical access hospital and we are now required to have an “app” or mobile phone application so patients can look up their records, receive appointment reminders, and pay their bills all conveniently from their mobile device. It is required by the meaningful use requirement law to have these options available. The health information management department is usually over the patient portal and meaningful use. Patients can get on their patient portal if they provide an email address to the provider and view test results, retrieve medical records, and pay their balances. There are some companies that actually have implemented a text message statement. Louisville Radiology Imaging Consultants provide their patients with a text message as the first attempt of payment, then a phone call, a mailed notice for collections, and last, the balance gets turned over to a collection agency. This has taken technology too far, there are several patient complaints about not receiving their text message because they do not use a cellular device. Elderly patients do not like to participate in this as much because this is not something they are used to, and may not be aware of how to use a cellular device or smart phone to understand their billing process. I am only 25 but I feel this is absurd to informally send a patient a text message to pay their bill. Technology advancements *can* be a huge advantage in some cases, but there is a line that should be drawn when you are tampering with a patient’s credit.

Mechanical technology is also a benefit to the facility. By having up to date machines and devices this can attract patients to your facility. Rural hospitals have a harder time obtaining new equipment because of the cost and training that is associated with newer equipment. But rural health care facilities can be eligible for grants to help upgrade their equipment as long as it

benefits the patients, if not some facilities spend a large portion of their budget fixing machines, and experience patient diversion or cancelations costing the facility revenue. Some machinery upgrades like new 3-D breast imaging for mammograms have a new CPT code that is eligible to be billed differently than a regular 2-D mammogram image, because of the higher more advanced imaging you can bill a higher charge for this by factoring in the cost of the equipment, training, and technicians to run the machine. Along with being able to attract patients, bill more, your cost goes up and depreciation will go up and help you too in the long run.

## **Separating Clinical Practices and the Business Office**

The business office and clinical areas of the hospital are two very different departments of the facility. I encourage patients to realize that doctors especially in the emergency room rarely are concerned with a patient's insurance or what they are going to owe when the visit is over. People are supposed to present to the emergency room for emergencies and that doctor is only worried about saving your life. If you present to the emergency room with a hacking cough in the middle of the night, they are more than likely do chest X-rays and lab work which can be expensive because you felt like it was bad enough to come to the emergency department for treatment. You can expect a high bill for this, but the doctor cannot tell you what you will owe or how much your insurance company will pay. As a matter of fact, the business office can only give you a rough estimate of what your insurance will pay because everyone has a slightly different plan and it is almost impossible to pinpoint what an insurance company will leave as patient responsibility. As a financial counselor I get all the complaints about billing. A complaint I hear all too often is that the nurse or doctor said I would not be charged for this service, or this

medicine. If a doctor does not put this in his notes, or does not instruct someone to take off charges if there is a mix-up or something that may occur as the facility's fault, the charge will go on and get billed out. Clinical staff are not trained and even though they are doctors and nurses and know many things to help you, very rarely can they give you financial advice or tell you what you will and will not be charged for. The same goes for the business office trying to help a patient with a clinical question. The business office tends to be more into the clinical world for minor things and diagnoses in order to bill properly, but I hear patients asking the registration clerks if they should wait to have lab work, or if it is really necessary to have a certain test done. The physician ordering the test would not have ordered it for you unless it was necessary. It is courteous to be mindful of this when asking questions to clinical and business office staff.

### **Services Offered in Rural Healthcare hospitals**

Many of the same services are offered in critical access hospitals are also offered in urban hospitals. The only difference is the scale of the services. Rural hospitals will have a much smaller volume than a larger urban hospital. If a patient is in house already like the being in the emergency department and the emergency room doctor states, "you need to be admitted or kept for observation" is when the process of admitting starts. The level of care in which are placed is normally determined by a case manager. Insurance companies also have their own set of standards for each level of care and what they will pay for each level of care. This eliminates the abuse of insurance fraud. If critical access hospitals get paid a per diem rate for inpatient and swing bed stays it would be beneficial to have nothing but inpatient and swing bed patients. But by having to follow the correct level of care based on medical necessity each insurance provider

sets they will only pay for the level of care that is proven medically necessary. So, there would be no point to put someone who only qualifies for an outpatient observation stay in swing bed because they do not meet criteria and the facility will not be paid for the stay. The doctor should send over diagnoses and nursing notes for the case manager to determine the exact level of care the patient's criteria calls for. The case manager will then contact the hospitalist on call and inform them of the patient coming and give report. There is also another way to be admitted to the hospital and how the doctor chooses which care you need. A patient can present to a doctor's office for a problem and if the problem is severe enough, if the doctor has admitting privileges to that facility they can directly admit them to the level of care they need to be at without having to send them to the emergency department. This is called a direct admit, normally that doctor will round on that patient as needed instead of turning them over to a hospitalist's care. A hospitalist is someone who acts as the physician for the hospital. In larger hospitals they have a hospitalist on every shift, where in small critical access hospitals it is not necessary to have a hospitalist on every shift because there is usually no call for it. Critical access hospitals can go days without an admission. Once the determination for an admission has been set a patient will be placed into one of three levels of care, observation, inpatient or swing bed. Hospitals urban or rural can also offer other outpatient services like physical therapy, occupational therapy, speech therapy, cardiac rehab and pulmonary rehab.

### **Swing Bed Program**

The swing bed program concept is only 35 years old. In a swing-bed program, a patient being treated for an acute condition could remain in the hospital for follow-up long-term care

rather than be discharged to a long-term care facility or nursing home. She or he would usually stay in the same bed, but the type of care would be different, and the business office would bill for it differently. In March 2015, the Office of the Inspector General (OIG) issued a report studying the swing bed program. The OIG stated that Medicare could save a significant amount of money if it created a site-neutral policy between freestanding Skilled Nursing Facility (SNF) reimbursement rates and Swing Beds. When billing a patient's swing bed stay the level of care can never move backward. Swing bed is the highest care, even though physical care is less than that of inpatient, the swing bed stay will result in longer days in house. Then inpatient is second lowest, then observation. A patient can never change a level of care from swing bed to inpatient, only inpatient to swing bed and sometimes you will have patients going from emergency room to observation, to inpatient, then after three days if medically necessary they go to swing bed program. These accounts can be up in the \$50,000 range based on average length of stay, they can be much larger based on days and how critical the patient is. If a critical access hospital has a Swing Bed program that is usually a big money maker for the facility for present time, but if costs are not adjusted as mentioned above it can actually cause the facility to lose money. Perfecting the process for Swing Bed admissions, billing, and discharges the hospital could bring in a bigger profit margin, and help patient satisfaction scores. Hospitals are not required to have swing bed programs but are usually beneficial to both critical access and larger hospitals.

## **Inpatients**

You're an inpatient beginning when you are formally admitted to the hospital with a doctor's written or verbal order. The day before you're discharged is your last inpatient day. The

decision for inpatient hospital admission is a complex medical decision based on your doctor's judgment and your need for medically necessary hospital care. An inpatient admission is usually acceptable when you are expected to require 2 or more midnights of medically necessary hospital care, but your doctor must give a written order for this admission, and the hospital must formally admit you in their system and report it to the insurance carrier in order for you to become an inpatient. Medicare Part A (Hospital/inpatient Insurance) covers inpatient hospital services. Generally, this means you pay a one-time deductible for all of your hospital services for the first 60 days you're in a hospital. Medicare Part B (Medical/outpatient Insurance) covers most of your doctor services/visits to your room to check on you, when you're an inpatient. For instance, when the physician rounds on you it is sort of like an office visit but usually cheaper. Medicare patients pay 20% of the Medicare-approved amount for doctor services after paying the Part B deductible. If you do not have a three-day inpatient hospital stay and you need care after your discharge from a hospital, since you would not qualify for the swing bed program, you should ask the doctor or the case manager if you can get care in other settings (like home health care) or if any other programs (like Medicaid or Veterans' benefits) can cover your skilled nursing care. Because of the importance of the three-day stay, most physicians will make sure you stay three days in one facility because it is very confusing if you do not, it also benefits the facility to have you there as long as possible. Commercial insurances and Medicare replacement plans do not normally require three-day stays as an inpatient to become eligible for the swing bed program. It is important to check your benefits with your insurance company also instead of relying on someone else to check them for you whether it is supposed to be their job or not.

## Observation

You are considered outpatient if you are in the emergency department receiving services, placed in observation for up to 72 hours, are having an outpatient surgery, coming to the facility for X-rays, lab tests, or any other hospital services that the doctor has not written an order to formally admit you to a hospital as an inpatient. In these cases, you are considered an outpatient even if you spend the night at the hospital like in observation. Observation is just as it sounds, the doctor has decided to observe your health and behavior then decide if it is necessary to admit you to the hospital or send you home with a referral or instructions to follow up with a primary care physician or specialist. As mentioned above, if you are filing Medicare and receive any drugs by mouth or ointments/drops Medicare will not pay for them if there is not an inhouse pharmacy. In urban hospitals there is usually an in-house pharmacy that will fill medication and file the patient's drug prescription plan. The bad thing about this is that Part D only reimburses the medication as a pharmacy would file it. The patient has to pay for their medications out of pocket in full before the prescription drug plan will process the claim you have to file yourself online or by paper claim. Patients are usually not very understanding when they get a \$300 bill for medications, and they file their claim with part D, and they are only reimbursed a small portion. This is where patients with Medicare need make sure they are fully aware of their benefits and the facility needs to make sure they are explaining the status of the patient efficiently and answering any questions the patient may have. Due to both parties lacking on this,

Medicare came out with the Medicare Outpatient Observation Notice (MOON) form that is required to be given to patients as soon patients enter observation status and have them sign off that they have received and read the form to reduce the amount of complaints towards Medicare and hospitals from patients that stated they were not aware they were being treated as an outpatient.

### **Physical, Occupational, and Speech Therapy**

According to medicinenet.com (2017) physical therapy is described as “A branch of rehabilitative health that uses specially designed exercises and equipment to help patients regain or improve their physical abilities. Physical therapy is appropriate for many types of patients, from infants born with musculoskeletal birth defects, to adults suffering from sciatica or the after effects of injury or surgery, to elderly post stroke patients.” Merriam Webster’s definition of occupational therapy is “therapy based on engagement in meaningful activities of daily life (such as self-care skills, education, work, or social interaction) specially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning” (2017). Speech therapy is where someone who has lost their speech does therapy to regain their speech and language and speak more clearly. Most of the time each of these services require a referral from another physician to see the therapist for an evaluation and to make sure the patient’s insurance will cover the services. If a Medicare patient has any of these therapy services, the patient is restricted to a certain number of therapy visits. Once a patient has met the annual Medicare Part B deductible which is around \$183 in 2017. Medicare pays up to 80 percent, around \$1,584 of the Medicare-approved amount for each service and the patient will be

responsible for the remaining 20 percent. Once the limit has been reached, the patient will have to pay 100 percent of the full cost of the services. If you are approaching the limit and need more therapy, your doctor can tell Medicare that it's medically necessary for you to continue. If you need a lot of care after you have reached the therapy cap, your provider may need to get pre-approval from Medicare for your care to continue ([www.medicareinteractive.org](http://www.medicareinteractive.org), Amount of Medicare Coverage for Outpatient Physical, Occupational and Speech therapy (2017)). These services can be offered inpatient and outpatient. Most urban facilities have their own therapist available which reduce cost. Rural hospitals may hire out companies that provide therapist and equipment. When this option is selected the therapy, costs are usually a bit higher and the patient may have a higher portion to pay out of pocket depending on what insurance the patient has.

### **Cardiac and Pulmonary Rehabilitation**

Cardiac and pulmonary rehabilitation go hand in hand. Either of these rehabilitation programs can be offered as inpatient during a hospital stay or offered as outpatient services. Cardiac rehab is for patients who have had some sort of heart disease or condition affecting the cardiac system. This can also include nutritional programs like weight loss programs, management with diet and medications, control of blood pressures, stress management and diabetic management. Pulmonary rehab obviously is associated with the pulmonary/respiratory system like lung function. People with COPD, heavy smokers, anyone who needs oxygen or has trouble breathing in general may be a good candidate for pulmonary rehab. Both types of rehabilitation require referrals from physicians to start the program. These types of therapy monitor patients using treadmills, and other "exercise machines" with the use of

electrocardiogram monitors. Depending on facility some can monitor continuously, bigger hospitals have the equipment to do this, and some facilities monitor before and after the exercise period. There is a billing difference based on machines and electrocardiogram usage. An electrocardiogram (EKG) measures your heart's electrical activity. These programs can run around \$36,000 for the normal 17 treatments.

### **Behavioral Health Services**

Some facilities offer behavioral health or at the least have a referral program. Behavioral health patients can start their journey in the emergency room. Some facilities are not large enough to have on call therapist 24/7 and some facilities have to use technology to perform a psych screening on patients that present to the emergency room with drug overdoses or suicidal thoughts and attempts. In our facility we use an iPad and FaceTime with a nearby facility to determine if the patient is a good candidate for their hospital or program immediately, normally these patients do not need to be released back home. If they are released back home, or are seen and referred by a primary care provider, most facilities will assist the patient in making an appointment for therapy sessions with the behavioral health services offered. The best practice is to accept patients with a primary and secondary insurance. Over time, not to be stereotypical, but normally these patients do not pay their bills, or are not in good enough health to realize they have bills to pay. But “ethically” where do you draw the line and say well we can’t treat you anymore because you do not pay your bills. This is where a lot of people have conflicts. As a business you cannot continue to lose money. The more money sitting in your accounts receivable the worse off you are. This is why each facility needs to have a financial policy, collections

policy, and financial assistance policy and strictly enforce them all. Normally when a patient signs consent for treatment there is also a clause in there stating that the patient agrees to be financially responsible for the balance of any. This is also where you get into ethical decisions in healthcare.

### **Rural Healthcare Clinical and Organizational Ethics/Bioethics**

According to Wikipedia the definition of ethics is “moral philosophy that is a branch of philosophy that involves systematizing, defending, and recommending concepts of right and wrong conduct” (2015). In layman’s terms, think of it as the golden rule. You cannot strictly define ethics but to treat others the way you would want to be treated is a good start. When a sweet little old lady comes to you to set up payments on her bill and she offers you \$5.00 and states that all she can pay and she goes into the spill about how she is on a fixed income and she comes up with many other reasons why she cannot meet the normal standard payment plan.

What do you do? Per your policy you have to inform her that you cannot set her up on a payment plan for \$5.00 to keep her account from aging into collections. She can make those payments but they will still turn her over to collections because the minimum payment plan is \$20 per hospital policy. This is an example of what I run into as financial counselor for my local hospital. I know deep down in my heart that these people cannot pay, and I can also tell the people who are lying, and it breaks my heart to turn these people away and eventually send them to collections. Now, if they have Medicare and are making an attempt to pay something each month you are not permitted to send that person to a collection agency. But if a person on Medicare has not made a payment at all, and is not making a good attempt to stay in good standing you can send the

patient to collections. This is why it's important to know the facts, then incorporate your ethics. Federal regulations now require hospitals that get Medicare and Medicaid funding for inpatient services to "address" ethical issues or organizational, clinical, administrative, and financial processes. The Joint Commission addresses standards for federal regulations, and most rural critical access hospitals are not accredited with the Joint Commission. You will find many larger urban hospitals including teaching hospitals are usually accredited by the Joint Commission to be considered a higher standard of care. A good committee to have in a healthcare organization is a healthcare ethics committee. Larger hospitals may be able to have a separate committee for this, unfortunately rural hospitals do not normally have the staff, time, or resources to form this type of committee, so they rely on patient feedback from experiences, and particular issues or circumstances as they come up. I feel like the highest conflict in healthcare is the fact that facilities are still a business and they have to make money, but they also "ethically" *should* have the patient's health and quality of care at best interest. It is very rarely that administrators or board members are trained in organizational ethics, they just consider it to be financially solvent Cook, A.F. & Hoas, H. HEC Forum (2000) 12: 331. <https://doi.org/10.1023/A:1008941503847>). From my own personal experiences board members seem to be mainly concerned with the hospitals finances and not the ethical values or issues of the hospital. In a small rural community board members want to make sure that their friends and families are taken care of. So, you are privileged or think you are if you know someone tied in close to the hospital. I see this happen every day our case manager is working things out to try and get a "special" family member into the swing-bed program just so they can be close home. So, and so always knows someone, same as the hiring process someone on the board always has a friend or relative that needs a job. That is another issue, but we will continue with the one at hand. It doesn't matter if their insurance is

not going to pay anything the board member, chief executive officer or directors just want their way and the rules and good ethics are set aside. This a good example of bad ethics. I'm all for being able to have benefits wherever you work, but, don't abuse it, and at least use treat everyone equally. When it comes to wanting a loved one near you in your home town it doesn't matter if their insurance is or is not going to pay for it, you are doing them a favor and your putting that want over the best interest of the hospital. A study of every critical access hospital in New Hampshire resulted in small but obvious results. This team conducted telephone interviews of all 13 chief executive officers (CEOs) of the critical access hospitals in New Hampshire. All the chief executive officers in the study indicated that they have experienced ethical conflicts in their facility. Per the average of these thirteen, the three most popular issues were with organizational and professional staff relationships, clinical care, and reimbursements. All chief executive officers indicated that "they would like to have additional ethics resources to address these conflicts." This study verified that chief executive officers encounter plenty of ethical conflicts and really need additional resources in ethics to address their problems (J Healthcare Management. 2009 Jul-Aug;54(4):273-83; discussion 283-4 2017). This shows where our ethics need to come in treat everyone fairly, and how you would expect to be treated. Organizational ethics might be easier than clinical ethics sometimes because organizational ethics is something I consider to be a given, a set of norms (or should be), people need to know what to do and how to act when in a professional environment.

Clinical ethics on the other hand is a completely different situation and is normally the focus of end-of-life care and decisions. Ethics committees, if you are fortunate enough to have one, and advance directives, have not actually improved end-of-life care or reduced end-of-life treatment conflicts. In an emergency it may not make a difference, but if you have a choice you can take

into consideration that a larger hospital may have an ethics committee and their staff is properly trained to handle end-of-life situations. The small rural hospital can be more trained on ethical situations because of the rural setting, it just depends, and no facility is the same. A local resident may choose to present to their local hospital because they know who is on call or know that they will be taken care because staff is familiar with them and the patient feels comfortable presenting there instead of somewhere else.

For example, you have an elderly patient present to the emergency room of a critical access hospital who is in the emergency room and has coded several times. Staff is working hard to intubate and stabilize her. Once a person has flat lined or their heart has stopped beating for six minutes the person can be pronounced deceased. Did the physician check for an advance directive before starting the process to revive the patient? On a personal level the physician may feel like they need to try and save everyone even if they stated they do not want to be saved and making them comfortable just isn't enough. Just because the physician is entitled to do his or her job, the patient may not have wanted to be revived regardless of the patient's family wishes or the physicians personal aspect on the situation. This patient's family is in the emergency room and they're hysterical, screaming, and crying trying to get into the room. The doctor walks out of the room after stabilizing the patient and states to the nurse "she won't make it out of here, don't bother calling the helicopter." He did not show one bit of empathy or sympathy and compassion for this family standing there listening to the words he was saying to the nurse. Some doctors finally callus their feelings because they know this is their job and a person dying is going to happen often. But as good practice the doctor should still be compassionate acting if anything to the patient's family in this situation and reassuring whether the patient was a child or an elderly person who has lived their life. Another example could be making the decision to not use an

intubation kit because it is the last one and what if you have another critical patient like a child or younger adult come in and need it, so the doctor chooses to only perform CPR and possibly endanger this elderly patient by letting her die because he didn't intubate when needed. Ethical decisions in a clinical setting have to be made very quickly sometimes and if you practice good ethics on a daily basis the decisions become more like second nature.

Reimbursement ethics is something I am very familiar with. Taking into consideration that charges fall into this category too. In today's organizations, health care and human services are influenced by different complex business models and sometimes it takes trial and error to find the best model for your facility. Labor and supplies account for a large percentage of health care and human services costs, so efforts to keep escalating expenses down is to have emphasized productivity as an essential tool to positively help a facility's net revenue. Increasing costs, along with the slacking reimbursement and emphasis on efficiency for patients and the facility, produce a dramatic challenge when performing a charge master audit, or simply making prices for new charges. Most critical access hospitals take a CPT procedure code and look at the allowed amount to charge per Medicare, per the updated addendums provided on Medicare's website. This can be a severe disadvantage to people who do not have Medicare and their commercial insurance will not process those amounts side by side Medicare's standards. The facility also has a percentage they mark up on these suggested prices to make up for contractual discounts and to hopefully obtain more money from other insurance carriers and patients also this is a legal way to increase cost by factoring in the other items besides equipment and supplies used like time and wages for the employees performing the service. I am required make many choices on a daily basis, what is actually considered right and wrong when reimbursing patients and reflecting it on the patients accounts through insurance adjustments and write offs. A job duty of mine is to

prepare refunds for patients something I come across frequently is having to determine who to give checks to first, normally I go oldest to newest. But when a patient is aware they have overpaid and are due a refund, do I cut their checks first because they are aware and if we immediately give the money back, the patient has less hard feelings than when we have to wait to disperse checks. I also have been informed to wait to reimburse insurance companies and reimburse patients first. Which on a regular basis I agree with, I run into the question of is this really ethical? If the hospital has no money to cut patient's checks or insurance, insurance needs to be on the back burner because they should have processed their claim correctly unless it was billed incorrectly by our facility. Then what do you do? It would our fault then and the insurance company would be entitled to their refund or some insurance companies will recoup their money on future remits which helps a lot. Is this method ethically correct or is it just my opinion, are my own ethics influencing my work ethics? I also encounter patient's that have no insurance. I feel like the facility should still offer a discount or incentive for private pay patients because I understand not being able to afford insurance. When a person does have insurance, they are entitled to the contractual discount the facility has with that insurance. So normally the patient would never pay full amount even if their insurance did not pay anything on the claim. Why penalize people more who do not have insurance and make them pay full price or the price we made up because we added a percentage of mark up onto the physical costs. I find myself more of a patient advocate when it comes to this situation because I have empathy and understand. Most facilities offer a discount or a private pay price that is a certain percent off the total charges as an incentive for the patient to pay the bill and revisit the facility if needed. In recent research I performed myself for my facility I called surrounding hospitals in the area, some critical access and some larger hospitals that are not for profit still. I found out that the larger hospitals offered

up to a sixty percent discount on the total balance for private pay patients whether they paid in full or not. I also found out that the small critical access hospitals gave up to a thirty percent discount but required the patient to pay in full or else they would have to pay one hundred percent of the charges. I disagree with this. Patients that are able to have insurance still have large balances, and sometimes it is better not to file any insurance and pay for the balance upfront and get a discount. Patients without insurance do not have the ability (normally) to pay for insurance they are already being penalized by the government putting them more in debt because they cannot afford insurance. Hospitals shouldn't penalize patients too. Let's give them a small discount and let allow them to set up a payment plan. I know that this endangers the money sitting in accounts receivable, but the patients are more satisfied this way and they do not feel forced into an uncomfortable financial situation where they may make the decision not to return to your facility for services because of this experience. Ethically what is going to be considered the best option? You cannot let patients abuse you, and put your facility in danger but is it correct to over-charge these patients because they do not have insurance or are unable to pay a balance in full. You must take into consideration the majority of society is used to making payments, because it fits their budget better than forking out a large amount of money at once because many people are losing their ability to handle their finances. Do we blame them for this or blame society? Most of our morals and ethics come from our parents or someone who taught us many things, and as the generations keep going something gets lost or forgotten as the time progresses. It is ultimately up to the financial department or revenue cycle manager to determine the protocol, but this person needs to take reimbursement ethics into consideration.

## **Conclusion**

In conclusion, it is up to the patient, their experiences, and availability on whether the patient should or should not present to a rural, or critical access hospital before going to a larger hospital. As discussed, the care can be very proficient, or poor in either place. Take time to know your hospital and employees and don't act like another account number. Just as the staff should not treat you like you one. Patients of retirement communities like mine, and small rural areas should have a better understanding of how important their local hospital is. It is important to let patients know the status of the hospital so that they will be more understanding and supportive than always assuming facilities are out to make money when most are just trying to keep the doors open to serve their community, I personally experience comments that our hospital should be more active in the community and inform their patients (the community) of major changes or information. Your health is important, your community is important, and healthcare in your community makes a huge difference. Please consider the information discussed, and do your own research on your local hospital. It's not always about the money. It's about the people, the patients, and keeping being able to keep a community healthy.

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