





*We care about Iowa's health*

**Mission:** The Iowa Hospital Association is the organization that represents Iowa hospitals and supports them in achieving their missions and goals.

**Vision:** To be Iowa's most trusted, respected and influential leader in health policy and advocacy, and a valued resource for information and education.

**Values:** Integrity — Leadership — Innovation — Engagement



The mission of every Iowa hospital is simple – to serve as the primary guardian of health in the community it serves. In an effort to support Iowa hospitals in achieving their missions and goals, IHA is proud to release the first edition of *Hospitals 101*.

Hospitals serve both a critical and unique role as the health care safety net. They are open 24/7 and ready to provide care in all kinds of emergency situations. Inherently, the system that exists to fulfill this critical mission is quite intricate; hospitals must skillfully navigate a maze of third-party payers and government regulations that grows in size and complexity each year.

In developing this resource guide, IHA hopes to provide its readers a high-level look into the details of our health care delivery system, including financial utilization, economic impact and community benefit, workforce statistics, state and federal regulations and much more. It is also designed to educate legislative leaders and hospital trustees, who are charged with making critical decisions about a system that is so vital, not only to the physical wellness of their constituents, but also the economic health of their communities.

On behalf of the Iowa Hospital Association Board of Trustees and staff, thank you for your continued support of Iowa's hospitals and the patients and communities they serve.

Sincerely,

Kirk Norris,  
President and CEO  
Iowa Hospital Association

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# Iowa Hospital Fast Facts



Iowa's hospitals are vital to meeting the health care needs of the communities they serve by providing a wide range of acute care and diagnostic services, supporting public health needs and offering many other community services, including financial assistance to promote the health and well-being of the community. While many of these services are also delivered by other health care providers, three things make the role of the hospital unique:

## 24/7 Access to Care

The provision of health care services, including specialized resources, 24 hours a day, seven days a week, 365 days a year.

## Iowa's Health Care Safety Net

Caring for all patients who seek emergency care, regardless of ability to pay.

## Disaster Preparedness and Response

Ensuring that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions.

## *Iowa's 118 Community Hospitals*

82 - Critical Access Hospitals

22 - Urban Hospitals

8 - Rural Hospitals

6 - Rural Referral Hospitals



**72,000**  
Iowa Jobs

**\$4.5 BILLION**  
Salaries and Benefits



## Patient Utilization

Inpatient Hospital  
Admissions

314,553

Outpatient Hospital  
Visits

11,436,313

## Uncompensated Care

Financial Assistance and  
Charity Care

(\$194,676,551)

Bad Debt

(\$270,261,292)

The critical role of hospitals, while often taken for granted, represents an essential component of our state's health and public safety infrastructure. While many of these roles are not explicitly funded, hospitals build these costs into their overall cost structure and support initiatives by dedicating certain revenues received from providing direct patient care.

# Hospital Classifications

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## Not-for-Profit Hospitals

Nearly all Iowa hospitals are “not-for-profit,” meaning the hospital can demonstrate that no part of its net earnings is given to a shareholder or individual. A not-for-profit hospital is a community facility that operates under religious or voluntary auspices and is exempt from most federal and state taxes due to its charitable status. Despite this exemption, it is important to note that a not-for-profit hospital is not exempt from employment taxes (e.g., Social Security and Medicare taxes). The term non-profit does not mean that the hospital does not make a profit. Rather, the term means that profits of the hospital are returned to the control of the hospital for operations rather than to shareholders.

## Public Hospitals

Public hospitals are hospitals established by a government and fall into four categories: Federal, state, county or municipal government. Public hospitals have specific chapters of the Iowa Code (Chapters 35, 145A, 263, 263A, 347, 347A and 348) they must follow and are subject to laws aimed at governmental transparency such as open meetings and open records laws and have publicly elected trustees.

## Teaching Hospitals

In addition to treating patients, teaching hospitals are training sites for physicians and other health professionals. These hospitals are affiliated with medical schools, which means patients have access to highly skilled specialists who teach at the school and are familiar with current technology and innovative delivery system models.

## Health System Affiliated Hospitals

Hospitals are often owned, managed or affiliated with corporate health systems. Health systems are comprised of a variety of diverse types of hospitals. Additionally, a health system may also own or operate other lines of business, like a skilled nursing facility, pharmacy or physician practice.

## Specialized Hospitals

These are defined by the Iowa Department of Inspections and Appeals and are licensed, acute-care hospitals that provide specialized care and treatment of persons with chronic or long-term illness, injury or infirmity.



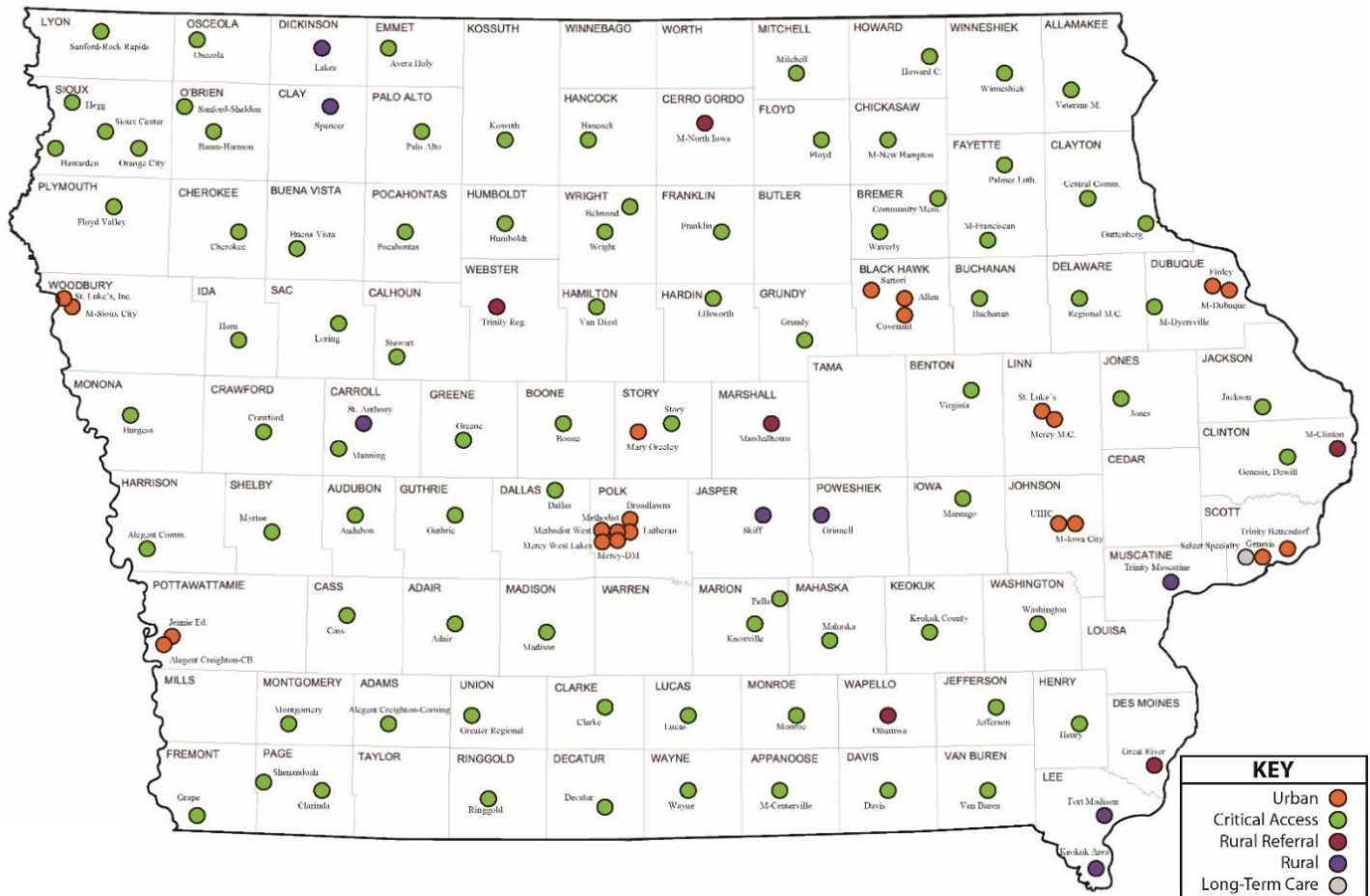
Above: Lakes Regional Healthcare, Spirit Lake.



Above: Mary Greeley Medical Center, Ames.

# Types of Hospitals

Iowa law defines a hospital pursuant to Iowa Code section 135B; however, specific hospital classifications are defined by rules promulgated by state and federal law.



## Urban Hospitals

Urban hospitals are the largest hospitals in Iowa and are typically located in major cities across the state. These hospitals are reimbursed under the Prospective Payment System (PPS), a method of reimbursement in which payment is made based on a predetermined, fixed amount regardless of the actual cost incurred.

## Critical Access Hospitals

Established under the Balanced Budget Act of 1997, Critical Access Hospitals (CAHs) are located in rural areas and can have no more than 25 inpatient beds. Because of their small size and rural locations, CAHs receive "cost-based" reimbursement intended to improve their financial performance and maintain access to hospital inpatient and outpatient services in rural areas.

## Rural Referral Centers

Rural Referral Centers (RRCs) are high-volume acute care rural hospitals that treat a large number of complicated cases. RRCs must have at least 275 available beds and must also demonstrate that at least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital.

## Rural Hospitals

Rural hospitals are mid-sized hospitals located in smaller Iowa communities. Larger than CAHs, rural hospitals provide access to emergency department services, inpatient care, outpatient care, long-term care and care coordination services.

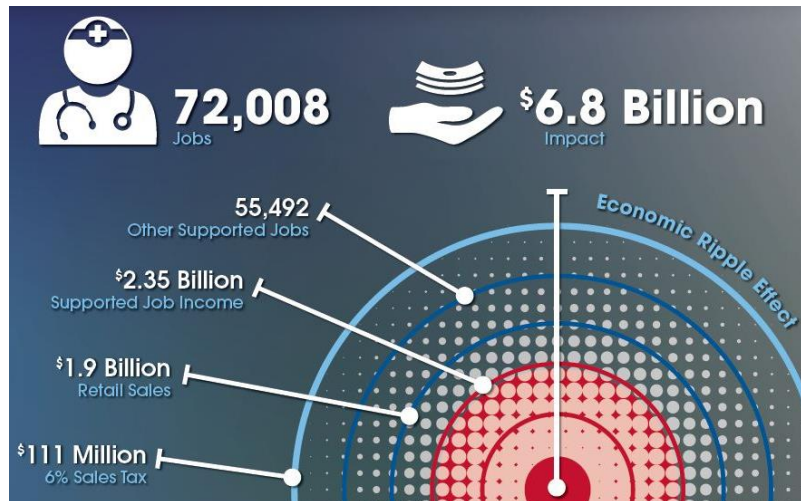
## Long-Term Acute Care Hospitals

Long-term acute care hospitals provide extended medical and rehabilitative care for patients who suffer from multiple acute or chronic conditions. A long-term care acute care hospital must meet the requirements for a general hospital, including emergency services directly or by contract.

# The Economic Impact of Iowa's Hospitals

A hospital is an asset to any community or region. It provides communities with easy access to a broad spectrum of essential health care services such as primary care, surgery, laboratory services, emergency care, mental health services, hospice and diagnostic technology.

Hospitals are also essential in another way - as economic engines that are among the largest employers in their communities and for the state as a whole.



Source: IHA 2017 Economic Impact Report

## Multiplying the Benefit

The needs of hospitals and their employees creates a "multiplier" effect that supports thousands of additional jobs.

The economic impact of hospitals extends beyond the people they hire and the salaries paid.

In total, more than **127,500 jobs** are supported by hospitals, creating an overall impact that is worth nearly **\$6.8 billion** to Iowa's economy.

## \$4.5 Billion in Salaries and Benefits

Hospitals are essential to local and state economic development, as many companies wishing to relocate or expand need access to high-quality health care services.

Iowa's hospitals not only provide jobs, they create jobs by purchasing goods and services from other businesses.

Iowa hospitals provide more than **72,000 jobs** that pay more than **\$4.5 billion** in salaries and benefits. Most Iowa hospitals are among the largest employers in their counties.

## Supporting Communities

Hospitals have a tremendous impact on their local businesses and communities.

Retail sales generated by hospitals and their employees amount to more than **\$1.9 billion**, according to IHA's study. In turn, that retail activity generates sales tax, a major revenue source for government, exceeding **\$111 million**.

## A Healthy Health Care Industry

While hospitals are by far the greatest economic contributor to Iowa's health care industry, other health care sectors also have significant impact.

Physicians and dentists, for example, provide more than **45,000 jobs** with an economic impact of **\$5.1 billion**.

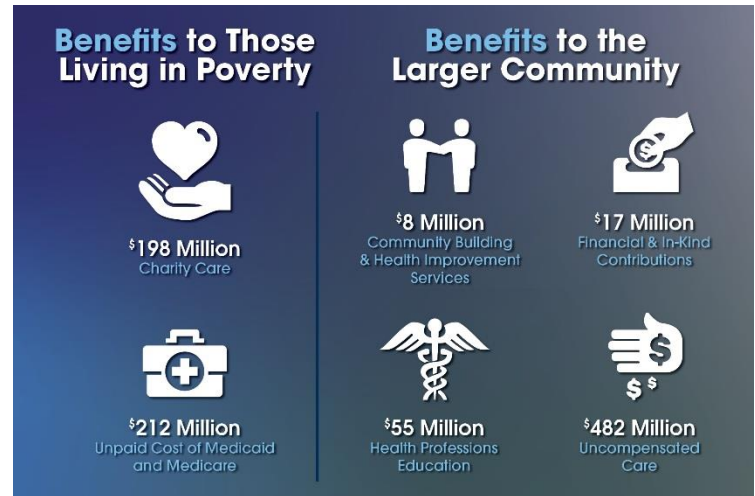
Nursing homes and other residential care providers provide more than **57,000 jobs** and add more than **\$1.9 billion** to the economy.



# Community Benefit Programs and Services

Hospitals provide treatment or health education by improving access to health care services, enhancing the health of the overall community, advancing medical knowledge and relieving or reducing the burden of other efforts. These benefits include classes, screenings, immunizations, counseling, scholarships, research and in-kind contributions to other community groups. Many of these services simply would not exist without hospital resources and leadership.

Additionally, hospitals must make up for losses created when people cannot pay for their care as well as payment shortfalls from private and public payors.



Source: IHA 2017 Community Benefit Report, reflecting 2015 data.

## Definitions:

Charity Care:	Bad Debt:	Medicare Losses:	Medicaid Losses:	Subsidized Services:
Services provided for free or at reduced prices to low income patients.	Services for which the hospital expects but does not collect payment.	Care for the elderly not reimbursed by Medicare.	Care for low-income patients not reimbursed by Medicaid.	Clinical programs provided despite a financial loss.

Because health is about more than the absence of sickness or disease, Iowa's hospitals offer community benefits in the form of charity care and free and reduced-cost services. These community benefit programs are designed to address specific community health needs.

<b>Community Health Improvement</b>	Carried out to improve community health, extends beyond patient care activities and is usually subsidized by the health care organization.
<b>Research</b>	Includes clinical and community health research as well as studies on health care delivery shared with the public.
<b>Financial and In-Kind Contributions</b>	Includes funds and in-kind services donated to individuals not affiliated with the organization or to community groups and other not-for-profit organizations.
<b>Professional Education</b>	Includes lectures, presentations and other programs and activities apart from clinical or diagnostic services.
<b>Community-Building Activities</b>	Includes programs that address the root causes of health problems, such as poverty, homelessness and environmental problems.
<b>Community Benefit Operations</b>	Includes costs associated with assigned staff and community health needs assessment as well as other costs associated with community benefit strategy and operations.



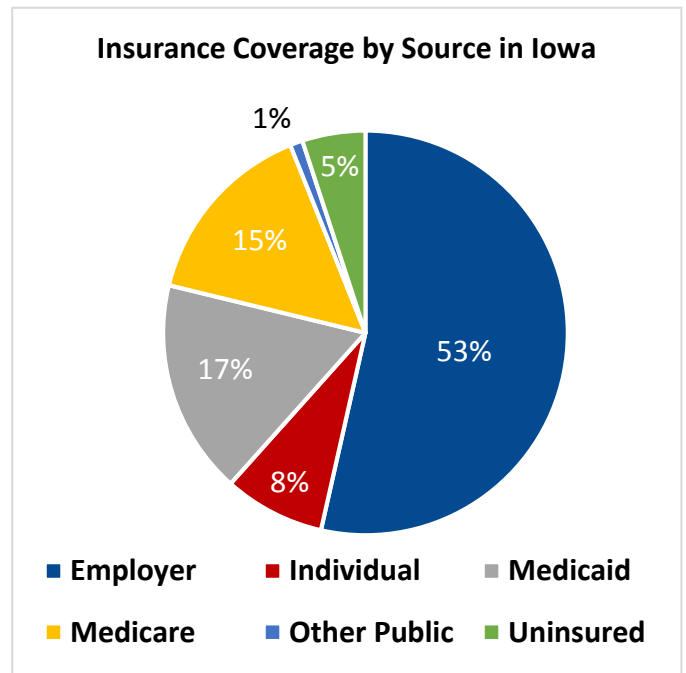
# Reimbursement Basics

Most Iowa hospitals depend heavily on payments for services provided to patients insured by governmental programs. For example, the Medicare and Medicaid programs account for more than half of the typical hospital's net patient revenue.

Hospitals and health systems are reimbursed for services provided through the following primary methods:

- Medicare
- Medicaid
- Individual/Employer Sponsored Insurance
- Self-pay/Uninsured
- Veteran's Administration/Other Public

In large part due to state and federal budget limitations and deficits, adequate, stable and predictable financing is one of the most critical issues facing hospitals today.



According to data collected by the American Hospital Association, the majority of hospitals lose money on both Medicare and Medicaid patients. This issue is compounded for hospitals - while they are struggling with Medicare and Medicaid reimbursement, demographic changes are resulting in a significant growth in enrollment in both programs.

## Medicare

Medicare is a federal health insurance program for people 65 years of age and older, some people with disabilities under age 65 and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant). Medicare has four parts:

### Part A - Hospital Insurance

- Most beneficiaries do not have to pay for Part A. It helps pay for care in hospitals, skilled nursing facilities, hospice care and some home health care.

### Part B - Medical Insurance

- Most beneficiaries pay a monthly premium to access doctors' services, outpatient hospital care and some other medical services that Part A does not cover, such as the services of physical and occupational therapists and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

### Part C - Medicare Advantage

- Medicare managed care program for health maintenance organizations and Medicare Advantage preferred provider organizations.

### Part D - Prescription Pharmaceuticals

- Prescription drug program for seniors.

## How is Medicare Funded?

The Medicare program is funded by a combination of contributions made by employers and their employees, premiums paid by Medicare participants and federal funds. More than 570,000 (18 percent) of Iowans had Medicare coverage in 2015.

Medicare is overseen at the federal level by the Centers for Medicare & Medicaid Services (CMS) and is administered through insurance contractors known as Medicare Administrative Contractors (MACs). The MAC for Iowa is Wisconsin Physicians Service Insurance Corporation (WPS).

## How Medicare Pays Hospitals

For Prospective Payment System (PPS) hospitals, Medicare pays predetermined, non-negotiable fixed amounts for hospital services based on the patient's diagnosis and treatment. For inpatient services, this is known as a diagnosis-related group (DRG). For outpatient services, Medicare uses Ambulatory Payment Classifications (APCs). Services in each APC are similar clinically and require the use of similar resources.

Medicare payments vary among geographic regions to reflect local wage rates. For example, PPS hospitals in Iowa's rural areas receive lower payment rates from Medicare than urban hospitals. Likewise, rural states like Iowa receive lower payment rates from Medicare compared to larger or more urban states, generally due to higher wages paid in those states.

## How Medicare Pays Critical Access Hospitals

Inpatient and swing bed services at Critical Access Hospitals (CAHs) are paid based on 101 percent<sup>1</sup> of average cost per day for inpatient services (as computed in the Medicare cost report, an annual systematic method of cost accounting and reporting used to determine allowable cost). The services are paid on an interim basis using a per diem rate for routine and ancillary costs, final settlement for each fiscal year is based on the filed Medicare cost report after the intermediary completes their audit. Cost-based payment requires a settlement process at the end of each CAH's fiscal year that reconciles the cost of providing Medicare services to the interim payments made throughout the year.

Services often tied to a CAH that are not cost-based reimbursed:

- Freestanding clinics
- Professional component physician and non-physician practitioners
- Hospital-based home health agencies
- Hospital-based skilled nursing facilities
- Ambulance services (if not the only local provider)
- Distinct part psych and rehab units
- Reference labs

## Critical Access Hospital Swing Beds

"Swing Bed" is a term used to describe the use of an inpatient hospital bed for either acute or skilled level of care – Rural hospitals with fewer than 100 beds can apply with the Centers for Medicare & Medicaid Services. CAH swing beds are reimbursed using a cost-based methodology. CAH swing beds are treated as a Skilled Nursing Facility (SNF) and are subject to SNF Medicare Part A coverage, deductible, coinsurance as well as physician certification/recertification provisions to maintain medical necessity of continued swing bed use. Prior to a swing bed admission, patients must have a prior qualifying inpatient hospital stay of at least three days.

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<sup>1</sup> Due to federal "sequestration" cuts, Critical Access Hospitals are effectively reimbursed at 99 percent of cost.

## Quality-Based Reporting Programs Under Medicare

### Medicare Value-Based Purchasing

The Affordable Care Act (ACA) of 2010 mandated the implementation of an inpatient hospital value-based purchasing (VBP) program. VBP is a pay-for-performance program that links Medicare payment to quality performance. Data reported by hospitals is grouped into performance domains and hospitals can earn points and an overall score. The score serves as the basis for determining VBP payments. Critical Access Hospitals (CAHs) and small hospitals with insufficient numbers of measures and/or cases are excluded from the program.

### Hospital Readmission Reduction Program

The Readmission Reduction Program (RRP) adjusts Medicare inpatient payments based on hospital readmission rates for several conditions. This program is punitive only and does not give hospitals credit for improvement over time. The Centers for Medicare & Medicaid Services (CMS) compares hospital-specific readmission rates to national rates and then adjusts hospital payments based on the volume of readmissions that exceed pre-determined benchmarks.

### Hospital Acquired Condition Reduction Program

The Hospital Acquired Condition (HAC) Reduction Program sets payment penalties each year for hospitals with the lowest performance of HAC rates for the country. The HAC reduction program is punitive only and does not give hospitals credit for improvement over time. Scores for similar measures are combined into domain scores used to determine hospital rankings and assigns payment penalties. The HAC payment penalty is set at one percent of total Medicare fee-for-service (FFS) revenue.

## Medicaid

Medicaid is a jointly funded state and federal health insurance program available to certain low-income individuals and families who fit an eligibility group that is recognized by federal and state law. Each state has its own guidelines regarding eligibility and services. Specific requirements often include age, whether the recipient is pregnant, disabled, blind or aged, whether he/she is a US citizen or a lawfully admitted immigrant. The rules for counting income and resources vary from state to state and from group to group.

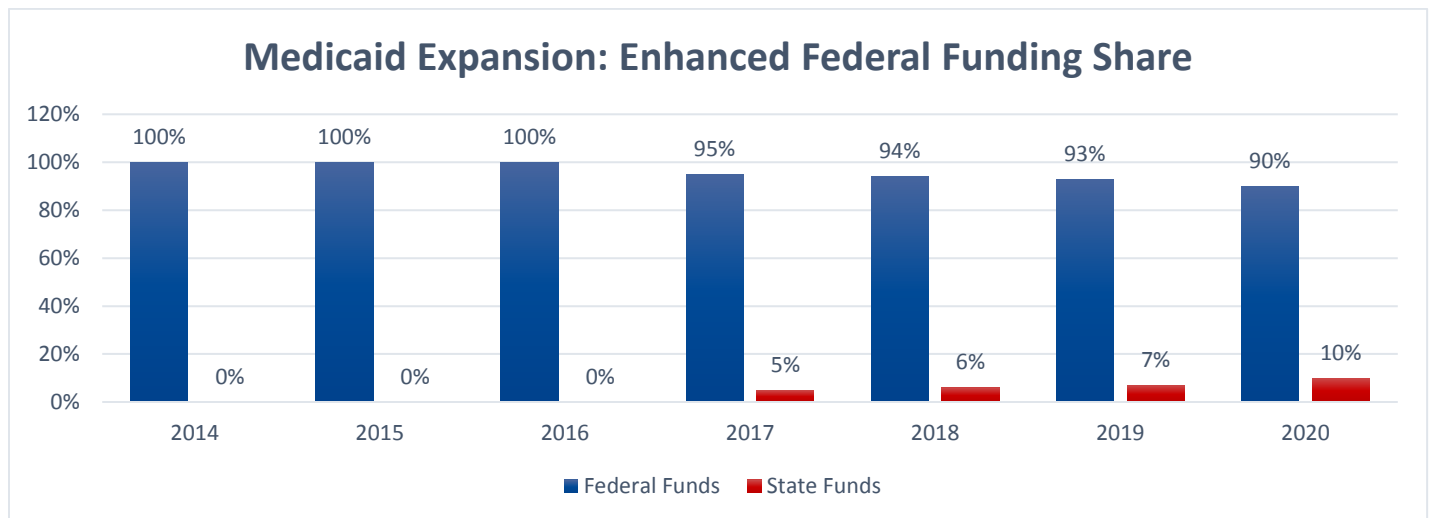
The Medicaid program is operated by the states and overseen at the federal level by the Centers for Medicare & Medicaid Services (CMS). Iowa's Medicaid program is administered by the Iowa Medicaid Enterprise within the Iowa Department of Human Services.

### Medicaid Expansion

Hospitals across the nation supported passage of the Affordable Care Act (ACA) in 2010 as a means of providing health insurance to millions of Americans with little or no ability to afford coverage. In June 2012, the United States Supreme Court upheld almost all of the provisions of the ACA, including the legality of mandating all citizens to purchase health insurance coverage.

In its ruling, the Supreme Court rejected only one provision of the law: the federal government's ability to withhold existing Medicaid support to states that do not expand Medicaid coverage to adults ages 19-64 who are at or below 133 percent of the federal poverty level (FPL). In Iowa, this population is estimated to be around 150,000 people.

The Iowa General Assembly implemented Medicaid expansion through the Iowa Health and Wellness Plan, which became effective on January 1, 2014. Iowa receives significantly enhanced federal matching funds under ACA used to cover this population.



## How Medicaid Pays Hospitals

Similar to Medicare, Iowa Medicaid covers both inpatient and outpatient hospital services under two different payment arrangements: fee-for-service (FFS) and through managed care organizations (MCOs).

### Fee-For-Service

Under the FFS arrangement, a hospital bills the state directly for each covered service provided to a Medicaid patient and is paid based on uniform and predetermined Medicaid payment policies as established based on funding appropriated from the Iowa General Assembly and hospital-specific calculations performed by the Iowa Medicaid Enterprise. Following the transition to Medicaid managed care, the state has significantly reduced the volume of claims processed using FFS methodology.

### Managed Care

Under the MCOs, Iowa Medicaid pays a fixed monthly payment to each MCO based on the number of any type of Medicaid members enrolled in the MCO's plan. The MCO is then responsible for paying providers, including hospitals, for covered services provided to the MCO's enrolled members. The hospital bills the MCO for services based on contractual payment terms that have been negotiated between the hospital and the MCOs for the hospital to participate in the MCO's provider network.

MCOs can require hospitals to receive authorization to provide non-emergent services, which, if not obtained can lead to claim denials. Further, MCOs review claims that have already been paid and can recoup money from hospitals.

Because MCOs negotiate with each hospital, payment methodologies for inpatient and outpatient services vary by hospital. The percentage of cost paid by the MCOs has been historically lower than FFS. The MCOs, being for-profit entities, must cover not only payments to providers for medical services, but also their administrative costs and profit for their shareholders.



## Medicaid Rate Rebasing

Inpatient and outpatient hospital base rate rebasing occurs every three years and is an important mechanism to ensure that individual hospital costs and patient mixes are accurately reflected in the Medicaid payment system. Unless adequately funded, rebasing occurs in a “budget neutral” manner, meaning that some hospital base rates will increase while others decrease, creating “winners” and “losers.”

## Critical Access Hospital Reimbursement under Medicaid

Following the state’s transition to Medicaid managed care in April 2016, Iowa’s Critical Access Hospitals (CAHs) were transitioned to a non-cost-based reimbursement system whereby CAHs must negotiate their payment rates with each MCO. While the state has provided “rate floor” protections, meaning that the payment rates cannot fall below the rate that was being paid prior to the implementation of managed care, this has caused significant disruption for CAH finances as the cost-settlement process under cost-based reimbursement is a key benefit of the CAH program that has been eliminated.

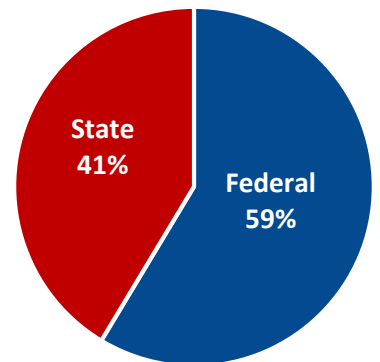
## How is Medicaid Funded?

Medicaid is jointly funded by the federal and state governments. Generally, for each “state-dollar” paid to providers serving Medicaid patients, the federal government provides a near two-for-one match in Iowa.

### Federal Medical Assistance Percentage

The federal share is called the Federal Medical Assistance Percentage (FMAP) and the exact amount is determined annually by the Centers for Medicare & Medicaid Services (CMS) based on each state’s per-capita income; the lower the per-capita income, the higher the FMAP. For federal fiscal year 2017, Iowa’s FMAP was 58.5 percent.

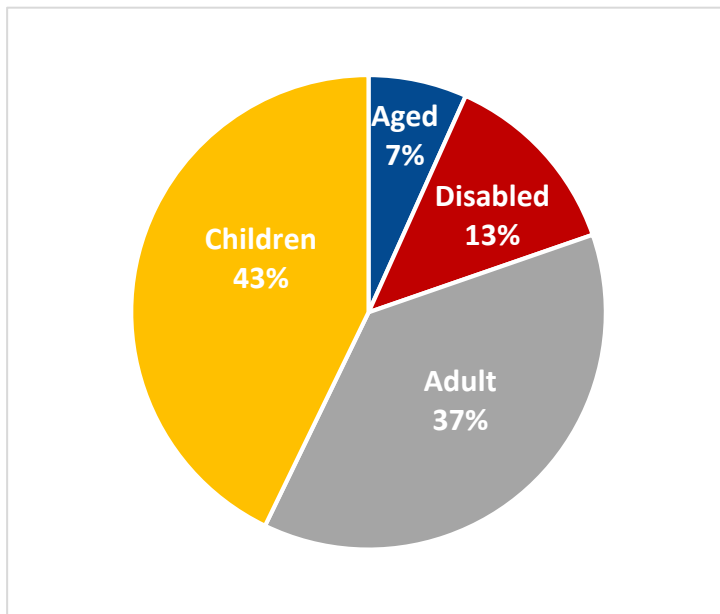
As of January 2014, states like Iowa that elected to expand Medicaid coverage up to 133 percent of the federal poverty level received 100 percent FMAP for the expansion population’s expenditures through 2016. Beginning in 2017, the FMAP will be reduced for this population each year, reaching 90 percent by 2020 and remaining at that level unless changed by Congress.



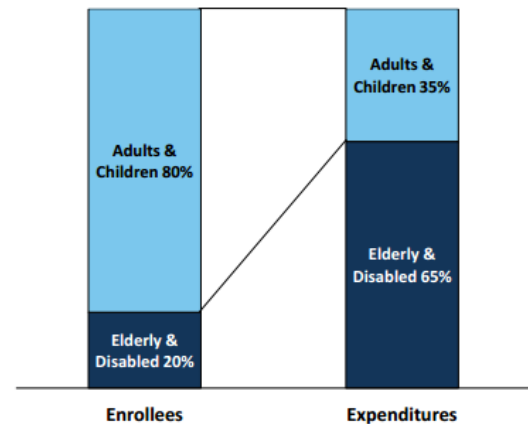
### State Share

The state share is made available through the General Assembly’s annual appropriation made primarily through the Health and Human Services appropriations bill. Most state appropriations for Medicaid come from general state funds; however, a portion of the state share is paid for by fees or payments made to the state from hospitals through a “provider assessment” used to draw down additional federal dollars to enhance payments.

## Medicaid Enrollees



**In 2014, most Medicaid beneficiaries in IA were children and adults, but most spending was for the elderly and people with disabilities.**



## Medicaid Upper Payment Limit Payments - Hospital Provider Assessment

Due to declining state revenues, several states have turned to health care provider assessments as a means of generating greater federal financial participation in state Medicaid programs. These proposals, which must be approved by the federal government, assess health care providers as a means of raising the state share of Medicaid expenditures.

Prospective Payment System (PPS) hospitals qualify for supplemental payments to help subsidize regular Medicaid payments that are less than cost. These payments are paid in addition to regular Medicaid payments and are often referred to as Upper Payment Limit (UPL) payments, where the maximum that Medicaid can pay (i.e., the UPL) is either cost or what Medicare would have paid for a service provided to a Medicaid patient.

Under these plans, states then raise Medicaid payments to the affected providers as a means of supporting care to the state's Medicaid population. However, disparities arise because hospitals do not serve an equal number of Medicaid beneficiaries. This means that some hospitals that serve a higher number of Medicaid patients may actually see payment increases in excess of their assessments while other hospitals that see fewer Medicaid patients could in fact lose money under these proposals. That is a significant issue when hospitals are experiencing increased cost pressures and growing charity care needs.

Iowa's provider assessment generates approximately \$34 million in increased reimbursement for Iowa's PPS hospitals. Iowa Code Chapter 249M governs Iowa's hospital provider assessment.

## hawk-i/ Children's Health Insurance Program

The Healthy and Well Kids in Iowa (hawk-i) program offers health coverage for uninsured children of working families. As of July 2017, more than 43,000 children were enrolled in the hawk-i program.

## Private Health Insurance

Approximately 60 percent of Iowans receive health insurance through an individual or employer-sponsored health insurance plan. As a requirement of the 2010 Patient Protection and Affordable Care Act (ACA), most US citizens and legal residents were required to have health insurance beginning in 2014 until the provision was repealed in 2017. In Iowa, residents can purchase insurance coverage through the Health Insurance Marketplace, [healthcare.gov](http://healthcare.gov).

### Iowa Insurance Division

The Iowa Insurance Division supervises all insurance business transacted in the state. The Insurance Commissioner oversees companies and individuals in the sale of insurance in Iowa and has general control over all aspects of their business, from the forms they use to the rates they charge. The Insurance Division also has statutory authority over many activities related to the sale of securities and other regulated products in the state.



### Individual Insurance Market

As of March 2017, nearly 52,000 Iowans were enrolled in a Marketplace insurance plan while an approximately 20,000 additional Iowans purchase individual health insurance plans directly from insurers. In total, there are more than 72,000 Iowans who rely on the individual health insurance market for their coverage.

Individuals or families with incomes between 100 percent and 400 percent of the federal poverty level who purchase coverage through the Health Insurance Marketplace are eligible for tax credits, which will help offset their premium costs. Nearly 90 percent of Iowans purchasing health insurance through the Marketplace qualified for federal premium tax credits and more than half qualify for "cost-sharing" reduction assistance, another form of premium subsidy made available through the federal government.

### Uninsured Patients

Patients that are not covered by either Medicare or Medicaid or by an insurance company are generally classified as "self-pay." Self-pay patients are subject to the hospital's usual and customary charges from the services they receive. Oftentimes, these individuals lack sufficient financial means to pay for the services received. Hospitals will have policies and procedures in place that address billing, financial assistance and collection practices consistent with their mission for these patients.

### Patient Billing



While the format of a hospital bill may vary by hospital, the elements of the bill are universal. A hospital bill will begin with the amounts the hospital charges for the services that were rendered. Patients who have insurance that has made a payment on the claim will likely see an adjustment reflecting the difference in the hospital's charges and the amount the insurance company has negotiated for the services rendered. This is known as a contractual adjustment and is the base amount used to determine the patient's cost sharing. Patients who qualify for the hospital's indigent or charity care programs would see similar adjustments showing the value of the financial aid being provided. Any residual amount left after considering these adjustments would typically be the amount owed by the patient. These amounts may comprise a combination of deductible, coinsurance, co-payments and non-covered charges due as determined by the patient's insurance plan.

# Regulatory Requirements

Hospitals are subject to many state and federal laws and regulations. Some of the most important regulatory basics include:

## Federal

### Department of Health and Human Services



The United States Department of Health and Human Services (HHS) is a cabinet-level department of the executive branch charged with protecting the health of all Americans and providing essential human services.

HHS includes more than 300 programs, including research, disease prevention, food and drug safety, Medicare and Medicaid, prevention of child abuse and domestic violence, services for older Americans and health services for Native Americans.

Due to the large number of programs under the Department's umbrella, HHS has many operating divisions, divided into two sections:

#### Public Health Service Operating Divisions

- National Institutes of Health (NIH)
- Food and Drug Administration (FDA)
- Centers for Disease Control and Prevention (CDC)
- Indian Health Service (IHS)
- Health Resources and Services Administration (HRSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

#### Human Services Operating Divisions

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Medicare & Medicaid Services (CMS)
- Administration for Children and Families (ACF)
- Administration on Aging (AoA)
- US Public Health Service Commissioned Corps

### HHS Office of Inspector General

HHS and Congress established the HHS Office of Inspector General (OIG) in 1976 to promote efficiency and identify and eliminate waste, fraud and abuse in the Department's operations. OIG addresses these issues through nationwide audits, investigations and inspections. Part of reducing fraud includes investigating violations of the Medicare and Medicaid anti-kickback statute, which penalizes anyone who knowingly and willfully solicits, receives, offers or pays anything of value as an inducement in return for referring a patient or recommending, purchasing, leasing or ordering any facility, good or service payable under Medicare or Medicaid. This carries criminal penalties as well as exclusion from participation in the Medicare and Medicaid programs.

### Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the HHS. CMS is responsible for the implementation, oversight and/or regulation of:

- Medicare
- Medicaid
- State Children's Health Insurance Program (S-CHIP; or *hawk-i* in Iowa) in collaboration with the Health Resources and Services Administration
- All laboratory testing (except research) performed on humans in the US, based on the Clinical Laboratory Improvement Amendments of 1988 (CLIA)



- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

As a part of running the Medicare and Medicaid programs, CMS:

- Establishes reimbursement policies and payment methodologies.
- Assures the programs are properly run to avoid fraud and abuse.
- Conducts research on the effectiveness of methods for health care management, treatment and financing.
- Assesses the quality of health care facilities receiving Medicare and Medicaid funds, taking appropriate actions if necessary.

CMS is comprised of four centers that support the organization's functions:

<b>The Center for Medicare Management</b>	Focus on management of traditional fee-for-service (FFS) reimbursement, including the development of payment policies and management of Medicare FFS contractors.
<b>The Center for Beneficiary Choices</b>	Focus on providing information for beneficiaries regarding Medicare plans as well as management of Medicare+Choice plans, consumer research, demonstrations, grievance and appeals.
<b>The Center for Medicaid and State Operations</b>	Emphasize programs administered by the states, including Medicaid, insurance regulation functions, survey and certification.
<b>The Center for Medicaid and Medicare Innovation</b>	Supports the development and testing of innovative health care payment and service delivery models.

## Medicare and Medicaid Conditions of Participation

Conditions of Participation (CoPs) are the minimum health and safety standards that health care organizations must meet in order to be Medicare and Medicaid certified. The requirements are developed by CMS and address a wide range of topics, from medical records to medications to smoke alarms and hand washing procedures. Hospitals must meet or exceed CMS requirements to participate in Medicare and Medicaid.

## Federal Trade Commission and the Department of Justice

The Federal Trade Commission Act of 1914 created the Federal Trade Commission (FTC), an independent administrative agency with the power to study, issue findings and judicially enforce findings regarding "unfair methods of competition" and "unfair or deceptive acts." The FTC and the US Department of Justice (DOJ) enforce the Sherman Antitrust Act of 1890 and the Clayton Act of 1914 (a supplement to the Sherman Act), which carry both civil and criminal penalties.



Antitrust litigation and enforcement in the health care field was minimal or nonexistent prior to 1975. It has emerged as a major legal issue since then, as the number of health care professionals and alternative delivery systems increased and the health care field became more complex.

# State

## Certificate of Need

Iowa's Certificate of Need (CON) program was first enacted in 1977 for the express purpose of providing for the orderly and economic development of new health care services, avoiding the unnecessary duplication of services and for controlling the growth of overall health care costs. Thirty-five states have some form of operational CON law.

Iowa's CON statute is administered by the State Health Facilities Council, a five-member council of citizens appointed by the governor and confirmed by the Senate for six-year terms. The Council evaluates the need for new or changed institutional health care services in communities across the state and reviews applications to ensure access, quality and community input. The health services reviewed include:

- Cardiac catheterization services
- Open heart surgery services
- Organ transplantation services
- Radiation therapy services
- Establishing a new hospital or adding inpatient hospital beds
- Establishing a new nursing facility or adding nursing facility beds
- Establishing an outpatient surgery facility (also known as an ambulatory surgery center)
- Expenditures over \$1.5 million

The Council provides a CON to a provider seeking an institutional health service when a true community need has been demonstrated. For more information, see Iowa Code Chapter 135, Division VI.

Iowa's CON law plays an essential role in supporting the continued availability of unprofitable but essential services provided by hospitals 24 hours a day, seven days a week, such as emergency services, trauma services, intensive care services, neonatal intensive care services and the most complex inpatient surgical services. Iowa's CON program is one of the key reasons Iowa has a vibrant hospital system that provides access to critical health care services in all parts of the state.

## Health Care Facility Licensure and Regulation

The Iowa Department of Inspections and Appeals (DIA) is the state agency responsible for licensing and inspecting many of Iowa's health care facilities, including hospitals, long-term care facilities, hospices and rural health clinics. DIA's Health Facilities Division surveys hospitals for compliance with both state licensure requirements and Medicare and Medicaid Conditions of Participation (CoPs). If problems are discovered during an inspection, the Division can initiate corrective and/or disciplinary action to assure a facility's compliance with state and federal rules. Hospitals that have accreditation by The Joint Commission are deemed by DIA and the Centers for Medicare & Medicaid Services (CMS) to be in compliance with the state licensure requirements and Medicare's CoPs. Additionally, the Division staffs the state's Hospital Licensing Board. The Board advises the Division and DIA on issues impacting the administration of hospitals in Iowa. Iowa Code Chapter 135B governs the licensure and regulation of hospitals.

# Health Care Workforce

## Iowa's Shortage of Nurses

The majority of hospitals across the state are facing a nursing shortage. There are approximately 46,000 nurses in Iowa and of those only 48 percent of them work in the hospital setting. The other 52 percent of nurses work in clinics, long-term care facilities, home health or other settings.



Both rural and urban hospitals in Iowa are struggling to recruit and retain nurses. The

2016 IHA Turnover Survey showed that the state average nursing turnover rate is 10.4 percent in hospitals. Data provided by the Iowa Board of Nursing shows that 21 percent of nurses in the state are eligible to retire now and 44 percent of the nursing workforce is 50 years of age or older. This means in the years to come Iowa may have an increasing number of nursing positions to fill due to a high numbers of retirements.

To help grow the nursing workforce, more nursing faculty is needed. The Iowa Board of Nursing data shows there are currently 48 nurse educator positions open with 54 percent of those positions being full-time. There are 94 nursing faculty across the state that intend to retire in the next two years.

The Iowa Workforce Development Center website provides statewide projections for occupations. See the table below for the 2014-2024 statewide projections and annual openings for registered nurses, nurse practitioners and licensed practical nurses.

<b>Long-Term (2014-2024) Statewide Occupational Projections</b>				
<b>Occupational Title</b>	<b>Base Estimated Employment</b>	<b>Projected Estimated Employment</b>	<b>Annual Growth Rate</b>	<b>Total Annual Openings</b>
Registered Nurses	32,025	37,260	1.6%	1,280
Nurse Practitioners	835	1,070	2.8%	45
Licensed Practical and Licensed Vocational Nurses	7,585	8,370	1.0%	295

## Iowa's Shortage of Physicians

Iowans' access to physician care is limited relative to citizens of other states. According to the American Association of Medical Colleges 2015 State Physician Workforce Data Book, Iowa ranked 43<sup>rd</sup> in the nation in the number of active physicians per 100,000 population.

Physician workforce shortages can threaten a hospital's ability to provide a full spectrum of care to its community. In Iowa, physician shortages have a large impact on primary care in rural communities, however, shortages in specialty and subspecialty areas impact the entire state. According to information published by the Iowa Medical Society in 2015, Iowa ranks in comparison with other states and the District of Columbia for the specialties listed. The table shows the number of individuals per one physician in the state of Iowa, and the ranking of "1" is the most favorable and "51" is the least favorable.

Specialty	Individuals per Physician	Rank
Child & Adolescent Psychiatry	59,468	41
Emergency Medicine	14,656	51
Family Medicine/General Practice	1,806	6
General Surgery	9,604	42
Internal Medicine	3,235	46
Pediatrics	26,890	15
Psychiatry	103,078	50
Surgery	56,224	48

Hospitals play a significant role in physician recruitment and retention. In more rural areas, the hospital often does the physician recruiting for an entire community. Hospitals actively work with residency programs and medical schools to identify new physicians who can replace current physicians as they retire or move or to add capacity to a growing patient community. It is also becoming more common for a hospital to hire a private-practicing physician as an employee of the hospital. In many cases, this action is the only way a hospital can help to maintain necessary physician services for the community.

## Iowa's Shortage of Mental Health Professionals

Mental health professionals are needed to ensure that patients have access to appropriate and timely treatment and that the mental health system of services and supports operates seamlessly. Much of the US struggles with a mental health workforce shortage, but unfortunately, Iowa ranks poorly even among other states.

In addition to Iowa's rankings for adult and child psychiatrists, Iowa ranks low for its overall mental health professional workforce. In a 2015 report, Iowa was ranked 44<sup>th</sup> in the nation for mental health workforce availability with a ratio of one mental health professional to every 1,144 Iowans. The growing need for a mental health workforce is evident throughout Iowa, but is particularly notable in rural communities.

## Practitioner Licensure and Credentialing

Licensure of individual health care providers such as physicians, nurses and physician assistants, is a function of the state. In Iowa, most health care providers are licensed through the Iowa Department of Public Health (IDPH) and the Bureau of Professional Licensure, which coordinates 19 licensure boards regulating the activities of more than 30 health professions.

The Board of Medicine, Board of Nursing, Board of Pharmacy and Board of Dentistry are stand-alone licensure boards in Iowa that are housed outside of the Bureau of Professional Licensure. Licensure boards are partially funded by fees paid by the licensees. In addition to licensure and the investigation of complaints, each board makes rules and policies for the profession. IDPH also regulates all substance abuse programs in Iowa.





## Physician Credentialing

Credentialing is the basis for appointing health care professionals to the staff of a hospital or other health care organizations. The process of credentialing is used by hospitals to ensure the qualifications of licensed physicians or other health care providers. Credentialing includes an evaluation of the provider's education, training, experience, competence and judgment as well as his or her scope of practice. A credentialed staff member is permitted to perform certain clinical duties within the organization. Specific clinical duties are defined by the institution's medical staff.

Credentialing is also performed by health plans before facilities and providers are accepted into a plan's provider network. Many hospitals and health systems that have a large number of employed providers and their Physician Hospital Organizations (PHOs) prefer to have "delegated credentialing" contracts with the plans in which they participate in order to simplify the process of adding providers to a plan's network. Delegated credentialing usually requires that the hospital, health system or PHO contractually agree to perform the components described above for hospital credentialing as well as other activities required by the National Committee for Quality Assurance and the plan.

## Iowa Hospital Education and Research Foundation

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IHA established the Iowa Hospital Education and Research Foundation (IHERF) Health Care Careers Scholarship Program in 2004 to help address the ongoing shortage of health care professionals and encourage young Iowans to establish or continue their careers with Iowa hospitals. In exchange for financial support, each award recipient must be willing to commit to working one year in an Iowa hospital for each year of scholarship award.

With the help of hospitals throughout the state, IHERF awarded \$110,000 in scholarships in 2017 to 34 college students from all parts of Iowa. The students, who are all studying in health care fields, each received \$3,500 for the academic year and each student is eligible for an additional \$3,500 award. Beginning in 2018, IHERF will increase the amount of scholarships awarded to 50 students.

The first scholarships were awarded in 2005 and since then:

- Nearly **400 students** have benefited from the program
- More than **\$1 million** in direct support has been provided to students through the program
- More than **200 past scholarship recipients** are working in hospitals across the state.

# Emergency Care

In the event of a medical emergency, hospitals are often the first place people go. In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of citizenship, legal status or ability to pay.

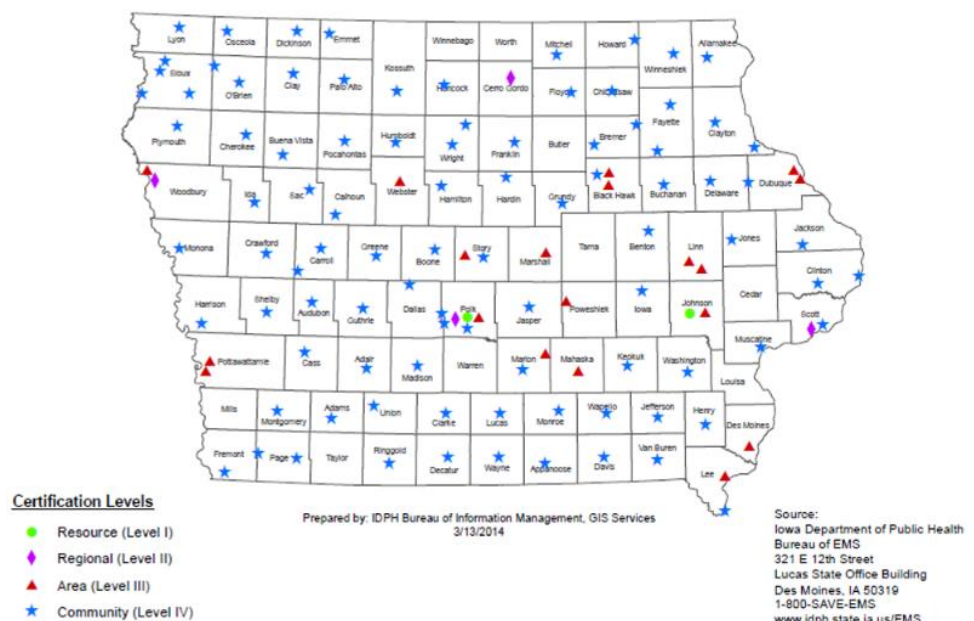
Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition including active labor, regardless of an individual's ability to pay. Hospitals are required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

The enforcement of EMTALA is a complaint-driven process. The investigation of a hospital's policies, procedures and processes and any subsequent sanctions are initiated by a complaint. If the results of a complaint investigation indicate that a hospital violated one or more of the "anti-dumping" provisions, a hospital may be subject to termination of its provider agreement and/or the imposition of civil monetary penalties. Civil monetary penalties may be imposed against hospitals or individual physicians.

## Trauma Care

Traumatic injury is a serious problem in Iowa and is the leading cause of death of younger Iowans. The death and Disabilities associated with traumatic injury contribute to significant medical expenses and lost work and adversely affects the productivity of Iowans.

Iowa has an inclusive trauma system which means all 118 hospitals are required by Iowa Code to be a designated trauma center. Iowa hospital trauma levels are self-designated. There are four trauma level designations: Level I, Level II, Level III and Level IV. The designation levels are categorized by the hospital's capacity to provide trauma services.



The standards and verification process are established by rule and may vary as appropriate by level capacity. Upon verification and the issuance of a certificate of verification, a hospital agrees to maintain a level of commitment and resources sufficient to meet the responsibility and standards of their verified trauma designation.

The Iowa Department of Public Health (IDPH) maintains a statewide trauma reporting system in which the Trauma System Advisory Council and IDPH monitor the effectiveness of the statewide trauma system.

Trauma triage and transfer protocols are used to assist personnel from each service program and trauma care facility. The triage and transfer protocols do not preclude service programs or trauma care facilities from making emergency revisions when an incident overburdens medical care resources. Hospital statewide diversion criteria have not been established, although hospitals have locally developed diversion plans. Trauma education is required for physicians, physician assistants, advanced registered nurse practitioners, registered nurses and licensed practical nurses who are identified as trauma team members by a trauma care facility.

# Program Integrity

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Like all health care providers, hospitals are subject to billing and payment scrutiny by the administrators of the Medicare and Medicaid programs as well as by commercial insurers. The following sections discuss some of these federal and state efforts.

## Federal Medicaid Integrity Program

Section 1936 of the Social Security Act requires the Secretary of Health and Human Services to establish a Comprehensive Medicaid Integrity Plan to safeguard the integrity of the Medicaid program. Under the current plan for fiscal years 2014 through 2018, the agency plans to expand the use of Medicaid data, provide additional program integrity resources to state Medicaid programs and streamline the federal program integrity contractors.

## Medicare and Medicaid Audit Contractors

In the Tax Relief and Health Care Act of 2006, Congress required the Centers for Medicare & Medicaid Services (CMS) to establish a national Recovery Audit Contractor (RAC) program to be in place by January 1, 2010. The goal of the recovery audit program is to identify overpayments made on claims of health care services provided to Medicare beneficiaries and to identify underpayments by Medicare to providers. Medicare RACs are paid on a contingency fee basis - a fact many providers believe creates perverse incentives to aggressively deny claims.

The Medicare RAC is just one of many entities with the authority to audit Medicare claims. Others include Medicare Administrative Contractors (MACs), Zone Program Integrity Contractors (ZPICs), Comprehensive Error Rate Testing (CERT) Contractors, Supplemental Medical Review Contractors (SMRCs) and the US Department of Health and Human Services Office of Inspector General (OIG).

In 2010, as part of the Patient Protection and Affordable Care Act (ACA), Congress expanded the RAC program to Medicaid. It is important to note that Medicaid RACs supplement, rather than replace, other auditors, even though all are charged with reviewing Medicaid claims to identify overpayments. This level of seemingly parallel oversight adds to the administrative costs hospitals incur to demonstrate regulatory compliance to multiple entities.

# Quality and Patient Safety

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Providing safe, high-quality and patient-centered care is the top priority for Iowa hospitals. Iowa hospitals are always working to raise the quality of care they provide and ensure patient safety. Hospitals spend a great deal of time identifying, improving and monitoring the quality of care patients receive.

IHA, in conjunction with the Iowa Medical Society (IMS), co-founded the Iowa Healthcare Collaborative (IHC) in the mid-2000s. IHC is a nationally recognized leader in engagement and quality/patient safety endeavors since that time. In recent years, IHC efforts have focused on the Hospital Innovation Improvement Network (HIIN).



Participating hospitals are asked to reduce patient harm by 20 percent for:

- Hospital-acquired infections (clostridium difficile, catheter-associated urinary tract infections, central line-associated blood stream infections, surgical site infections, ventilator-associated infections)
- Adverse drug events
- Falls and immobility
- Pressure ulcers
- Deep venous thromboembolism (blood clots)
- Reduce readmissions (by 12 percent)

Performance results from monthly HIIN reporting helps hospitals analyze near-real-time performance on key metrics. Comparative information demonstrates gaps in performance to allow hospitals to focus improvement in areas important to their patients and families.

## **Quality Improvement Organization Contractor - KEPRO**

KEPRO is the Quality Improvement Organization (QIO) in Iowa. The QIO program was established by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 to promote the quality, medical necessity and appropriateness of services reimbursed through Medicare and Medicaid.

The federal government hires QIOs to review the care provided to Medicare and Medicaid patients who use government-approved criteria to measure whether services were used appropriately. Sometimes the care is pre-certified and in other cases the care is reviewed after the patient is discharged. Each QIO may use a slightly different process, but all QIOs share the common goals to:

- Support improved quality of care for beneficiaries.
- Protect the integrity of the Medicare Trust Fund.
- Protect beneficiaries by expeditiously addressing individual complaints.

## **Reporting Requirements**

Iowa hospitals are required through federal or state legislation to report to the following 13 registries: state health registry of Iowa, congenital and inherited disorders, Iowa trauma registry, birth registry, death registry, fetal death registry, reportable disease registry (includes 54 reportable diseases), HIV, immunization registry, newborn screening (hearing and congenital disorders), pesticide exposure incidents, brain injury registry and stroke registry. Registry is defined as a dataset where every occurrence within the state is reported.

The reporting requirements for Iowa hospitals related to quality and patient safety also include submitting data to the Centers for Medicare & Medicaid Services (CMS) through the Inpatient Quality Reporting (IQR), Outpatient Quality Reporting (OQR), the National Healthcare Safety Network (NHSN) at the Centers for Disease Control and Prevention (CDC) and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) programs. Reimbursement for Iowa hospitals are determined by individual hospital performance as compared to other hospitals throughout the country. Programs include Value-Based Purchasing (VBP), Hospital Readmission Reduction Program (HRRP) and Hospital-Acquired Condition Reduction Program (HACRP).



# HIPAA and the HITECH Act

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The Health Insurance Portability and Accountability Act (HIPAA) is a federal law passed in 1996 that was originally intended to protect health insurance coverage for workers and their families when they change or lose their jobs and to provide for the development of national standards for electronic health care transactions. However, the law also contained a provision regarding privacy and security of health care data that led to the development of extensive rules that now govern how “covered entities,” including hospitals, may use and disclose a patient’s health information. For example, a hospital may use or disclose a patient’s health information to enable providers to treat the patient, to obtain payment for services and for certain purposes of the hospital’s own operations, such as its quality and patient safety initiatives.

HIPAA requires hospitals to use and disclose only the minimum amount of health information necessary to accomplish the intended purpose and to create safeguards to ensure the privacy and security of health information. HIPAA also created new rights for patients, such as the right to request restrictions on how their health information is used and disclosed and the right to receive an account from hospitals of certain types of disclosures of their health information.

In 2009, Congress passed a new law, the Health Information Technology for Economic and Clinical Health Act (HITECH), which significantly expanded the HIPAA privacy and security requirements. For example, the HITECH Act requires hospitals to inform patients when there is a security breach involving their unsecured health information and more directly regulates subcontractors or “business associates” that handle protected health information.

## HITECH/Electronic Health Records

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An Electronic Health Record (EHR) is an electronic version of a patient’s medical history. It may include all of the key administrative clinical data relevant to that person’s care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates access to information and has the potential to streamline the clinician's workflow. The EHR also has the ability to support other care-related activities, directly or indirectly, through various interfaces, including evidence-based decision support, quality management and outcomes reporting.

EHRs are the next step in the continued progress of health care that can strengthen the relationship between patients and clinicians. The data and the timeliness and availability of it will enable providers to make better decisions and provide better care. For example, the EHR can improve patient care by:

- Making health information available.
- Reducing duplication of tests and delays in treatment.
- Ensuring patients are well informed to make better decisions.
- Reducing medical errors by improving the accuracy and clarity of medical records.

In 2009, Congress passed a new law, the Health Information Technology for Economic and Clinical Health (HITECH) Act. In one of its many provisions, the HITECH Act made federal incentive payments available to doctors and hospitals when they adopt EHRs and demonstrate use that can improve quality, safety and effectiveness of care. These funds were first available to eligible providers serving Medicare and Medicaid patients in September 2011 and will continue through 2021.

Many hospitals will use these payments to help cover the cost of their investment in EHR technology and its meaningful use. Beginning in 2015, hospitals that are not meaningful users of EHR technology are subject to reductions in their Medicare payments.