

Overview of Children's Hospital of The King's Daughters and Impact of Federal Health Care Reform

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**Children's Hospital
of The King's Daughters**

Overview of CHKD Health System

- The King's Daughters, founding organization dating to 1896
- CHKD established in 1961 at current site
- Only freestanding Children's Hospital in Virginia and one of only 43 in nation
- Primary through tertiary care
- Three major Health and Surgery Centers
 - Newport News (2004)
 - Virginia Beach (2008)
 - Chesapeake (2009)
- Smaller outpatient facilities in Norfolk, Suffolk, Virginia Beach and Williamsburg

Our Physicians

- CHKD Medical Group – region’s largest pediatric group with practices in 24 locations
- CHKD Surgical Group – employs every board- and fellowship-trained pediatric surgeon in the region (Neurosurgery, Orthopedics and Sports Medicine, Urology, Plastic, Cardiac and General Surgery)
- Every pediatric subspecialist exclusively contracted to CHKD
- Residents from all regional teaching programs, including Portsmouth Naval Hospital
- 500-member professional staff

About CHKD

- Regional referral center for all pediatric specialty and subspecialty care for southeastern Virginia, the Eastern Shore, and northeastern NC
- Nearly every child needing hospitalization comes to CHKD
 - all other facilities closed their inpatient pediatric units
- COPN approval for 212 beds and staffed for 197
- Facility built in 1961, expanded in 1979, eight-story tower added in 1994
 - ***New building is now old and too small!***

A Litany of “Only’s”

- **Pediatric Intensive Care Unit** – 18 beds and key to cardiac surgery and Nuss Procedure patients, 24-hour in-house intensivist coverage
- **Neonatal Intensive Care Unit** – region’s only Level IV NICU, 62 beds plus another 7 step-down, 56% Medicaid

More than 40% of our beds are in an Intensive Care Unit

- **Pediatric Emergency Center** – 50,000 visits last year in space designed for 25,000 and 60% Medicaid
- **Pediatric Surgery Center** – more than 13,000 cases, 85% on outpatient basis
- **Transitional Care Unit** – 15-bed unit, 65% Medicaid, 100% occupancy
- **Neonatal and Pediatric Transport** – 4 rolling intensive care units with 96 transports per month/1,200 annually

The Litany, Continued ...

- **Cardiac Surgery** – 160 cases annually and growing with surgeon recruited from Cleveland Clinic
- **Cancer and Blood Disorders** – 75 new diagnoses each year plus several hundred in ongoing treatment or follow-up using national protocols and research – the best care close to home
- **Child Abuse** – more than 1,000 cases annually, extensive collaboration with law enforcement, social services, Commonwealth's Attorneys

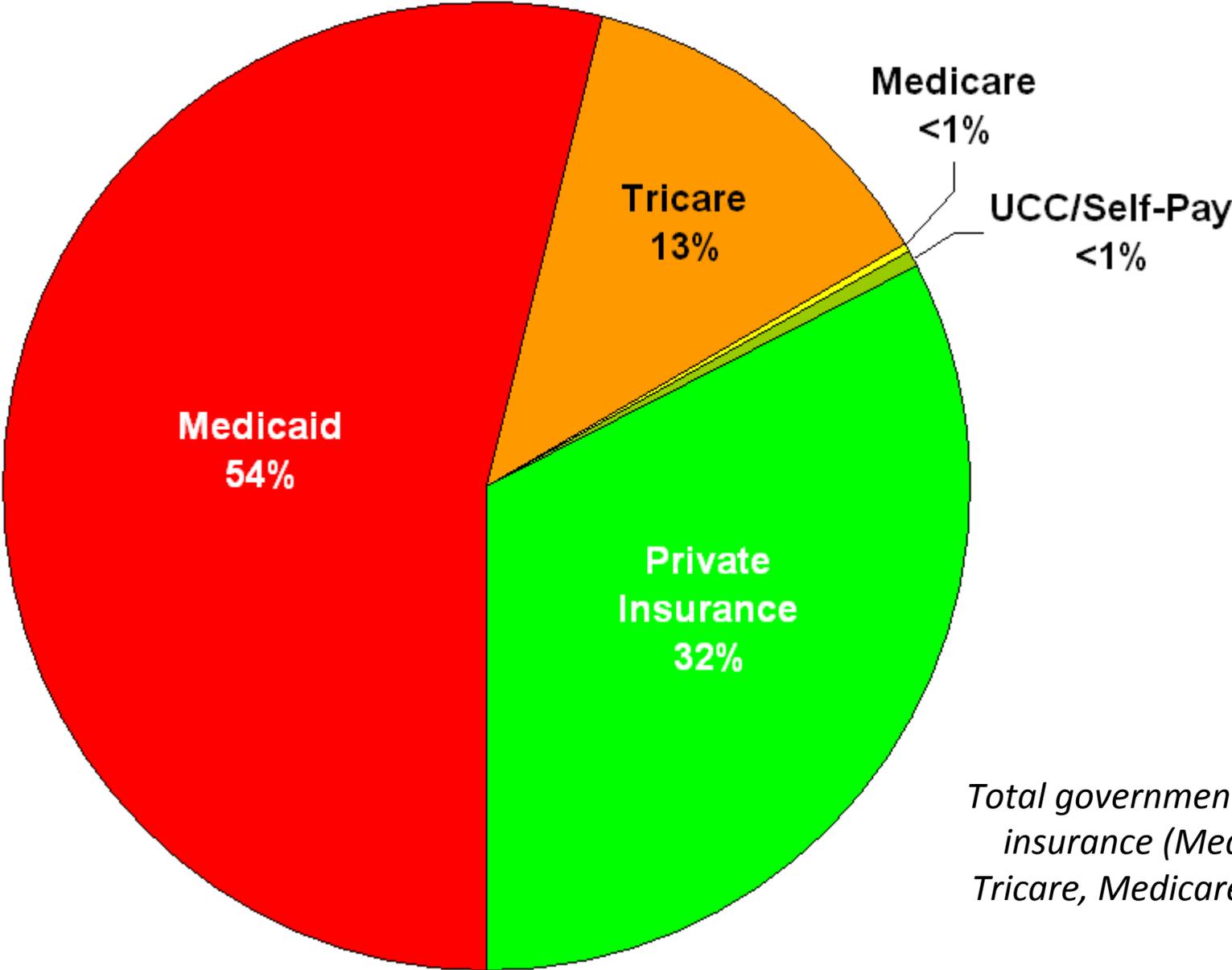
(mission-driven program operating at \$800,000 loss)

- **Childhood Obesity** – one of first programs in U.S., established in 2001, *little to no coverage by insurance*
- **50+ pediatric subspecialties** – 132,000 outpatient visits annually

The Uniqueness of CHKD

- Nurse-to-patient ratios
- Children are not small adults
 - 55% of inpatients < 5 years of age
- Training requirements
- Social Work
- Child Life
- School Teachers
- Buddy Brigade
- Chaplaincy Services
- Community Outreach

CHKD FY10 (through May 31) Patient Days by Insurer

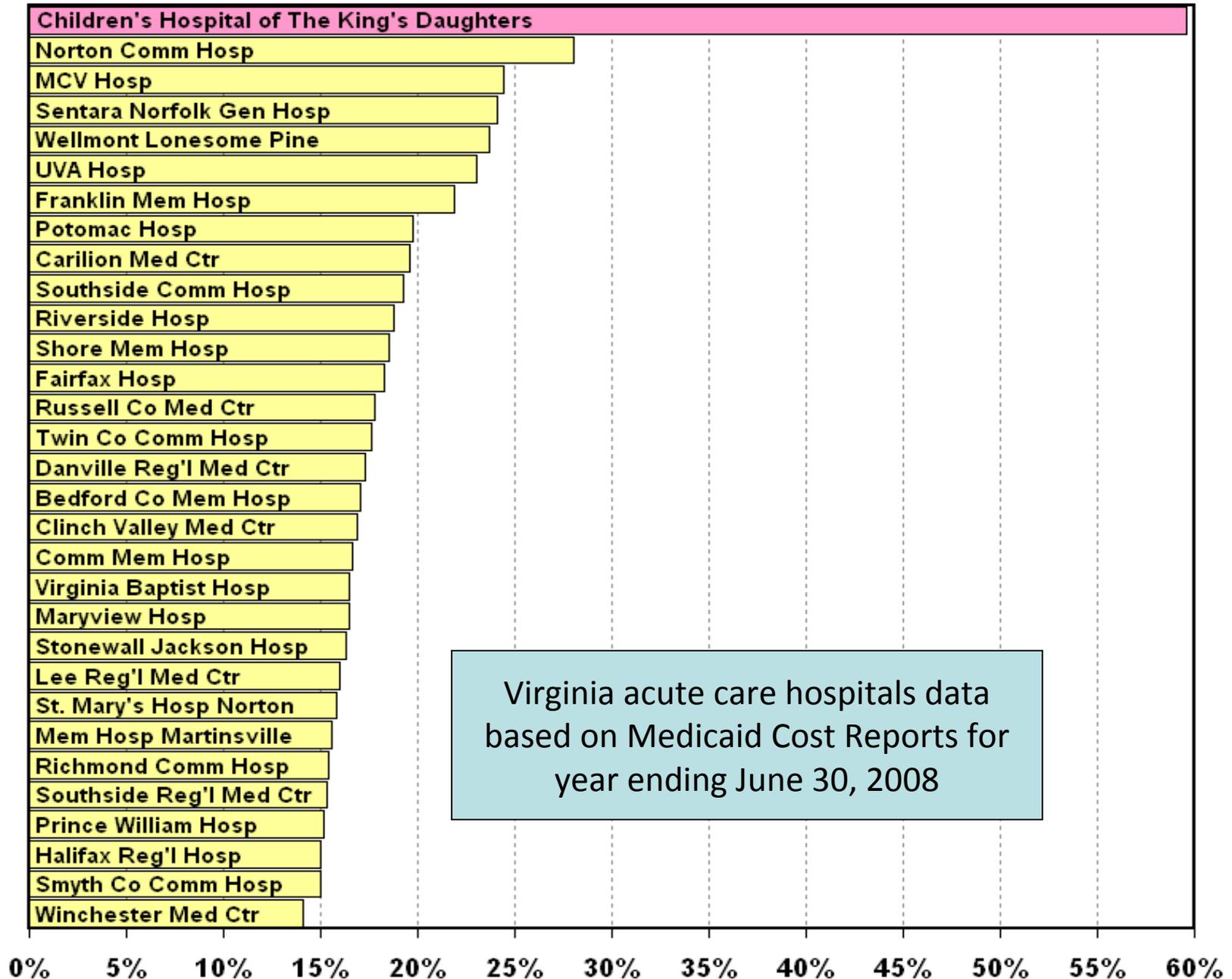


Total government-funded insurance (Medicaid, Tricare, Medicare) = 67%

Medicaid at CHKD

- Highest percentage of Medicaid inpatient days of any provider
 - 54% at CHKD (up from 53% during 2010 legislative session)
 - Facility with 2nd highest utilization is at 28%
- Medicaid comprises:
 - 56% of NICU days
 - 60% of ER visits
 - 65% of Transitional Care Unit days

Virginia Acute Care Hospitals That Qualify for DSH Payments Percentage of Inpatient Days Reimbursed by Medicaid



Medicaid Reimbursement

- Inpatient payment rates
 - Flat since '09
- FY 10: 72% of cost*
- FY11: 68% of cost*
- FY12: 64% of cost*

** projected and based on VHHA analysis for all hospitals*

Disproportionate Share Hospital Payments

- Federal \$ matched by state
- Allocated by category
 - Type I – state teaching hospitals
 - Type II – all other acute care hospitals
- Eligibility threshold – 14% (down from 15% currently)
- Two payment tiers for Type II Hospitals
 - <21% utilization
 - >21%
- CHKD DSH Payments
 - \$19.3 million FY10
 - \$18.7 million FY11
 - (\$600,000)

Neonatal Intensive Care Unit (NICU) Indirect Medical Education (IME)

- Established in FY05 by legislation as mechanism intended to compensate for high Medicaid utilization NICUs
- Restored for CHKD by Governor's amendments with legislative approval
 - \$1.3 million FY10
 - \$1.9 million FY11
 - \$600,000

Uncompensated Care/Charity Care at Children's Hospitals

- Due to federally supported coverage and expansions, children's hospitals generate **very low** levels of charity care (<1% at CHKD).
- The true measure of charity care at Children's Hospitals is the **Medicaid shortfall** – the difference between cost of care and payment for care.
- True Medicaid shortfall should include costs not recognized by Medicaid, including availability of unique clinical services, research, unique support services and community benefit – totaling \$27 million in FY09 at CHKD.

Another Way to Look at it: The Simple Math

- Last year, it cost \$240 million to run CHKD.
- Even if we were only 50% Medicaid, Medicaid-associated costs would be around \$120 million.
- We got paid \$60 million through Medicaid reimbursements.
- Plus around \$30 million between DSH, GME, IME and NICU IME
- **Leaving, a \$30 million Medicaid shortfall.**

CHKD Financial Environment

- Breakeven FY08
- 1.5 % Operating margin FY09
 - 137 positions eliminated
 - Expenses cut by \$6.5 million
 - Lost \$40 million from Foundation
 - No COLA or retirement contributions
 - Freeze on major capital and renovations
- 7.9 % Operating Margin FY10*
 - Reflects full-year effect of cost-saving measures and **not sustainable**
- 5 % Operating Margin FY11*
 - Add positions to eliminate service-line waiting lists (e.g. therapies)
 - Lift two-year pay freeze
 - Rebuild Foundation
 - Absorb \$2 million increase in health insurance costs
 - Initiate stalled capital (bed expansion, clinical growth by patient demand)
 - Address Medicaid Managed Care Plans' demand for price roll back

*projected

With 67% of CHKD's Inpatients Covered by Government-Sponsored Insurance...

54% Medicaid + 13% Tricare = 67%

CHKD can't recover enough revenue from other payers to offset losses.

And, CHKD is not part of a larger adult health system – pediatrics is our only service line!

With our unique circumstances and mission as a teaching hospital, does CHKD resemble the state's Type I hospitals, like VCU and UVA, more than it does Type II hospitals?

Federal Health Care Reform

- Prohibition on exclusions for pre-existing conditions
- Plans must provide dependent coverage until age 26
- Prohibition on lifetime limits (now) and on annual limits (2014)
- **Significant cuts to DSH program!**

Federal Health Care Reform and DSH Unintended Consequences

- \$14.1 billion cut to Medicaid DSH funding in 2014-19, with bulk coming in out-years. Additional \$4 billion cut in 2020.
- Based on assumption that coverage expansions will reduce the need for DSH over time.
- CHKD, like other children's hospitals, does not expect significant gains from coverage expansions.
- CHKD will continue to rely on DSH to supplement Medicaid reimbursement ***which does not cover the cost of providing care.***

Facilities like CHKD face “falling through the cracks”

- Only 32% of CHKD’s inpatients are covered by commercial insurance.
- CHKD is disproportionate among the disproportionate. Cannot expect private sector to offset Medicaid losses.
- Health Care Reform theory that expanded coverage will offset need for DSH is a non concept for CHKD and most children’s hospitals – children are already beneficiaries of universal coverage that does not cover provider costs.

DSH is essential to the future of CHKD!

DSH Policy

- The state determines:
 - total amount of state funds spent on DSH program
 - criteria (in addition to federal requirements) for determining hospital eligibility
 - formula for determining amount of DSH payments to each hospital
 - distribution of payments among eligible hospitals
 - conditions on hospitals that receive DSH funding

DSH Policy Considerations

- DSH is intended to provide financial assistance to hospitals that serve a large number of Medicaid patients.
- But what exactly is “a large number”? Is it 14% or is it 54%?
- How do we protect our safety net providers like CHKD?
- Should DSH eligibility take into account those who benefit from health care reform and those who will lose?
- Is there a long-term policy solution that prevents the necessity for continued short-term fixes?

DSH Policy Considerations

- Raise the eligibility floor from 14%?
- Adjust the tiers?
- Add a third tier above the current 21% high-water mark?
- Establish a Type III Hospital Category for freestanding children's hospitals (use federal definitions that authorize inclusion in CHGME and 340B programs)?
- Establish a Type IA Hospital category that recognizes high Medicaid utilization and teaching status?

Medicaid Payment Rate Policy Considerations

- Establish pilot program at CHKD for managing pediatric care?
- Establish payment rate tier for high Medicaid providers?
- Establish payment rate tier for freestanding Children's Hospitals?

The Bottom Line

- CHKD will rely on strong advocacy at the federal and state levels to ensure DSH cuts are directed at those providers expecting to benefit from coverage expansions.
- And, strong state advocacy will be critical to ensure scarce DSH funding is preserved and directed to safety net hospitals like CHKD with ongoing and critical needs.

Goals for CHKD and Virginia's Legislature

- Collaboration
- Partnership
- Transparency
- Shared goals and vision
- Protection of our children's future and Commonwealth

Thank You for Your Time!

- Questions?