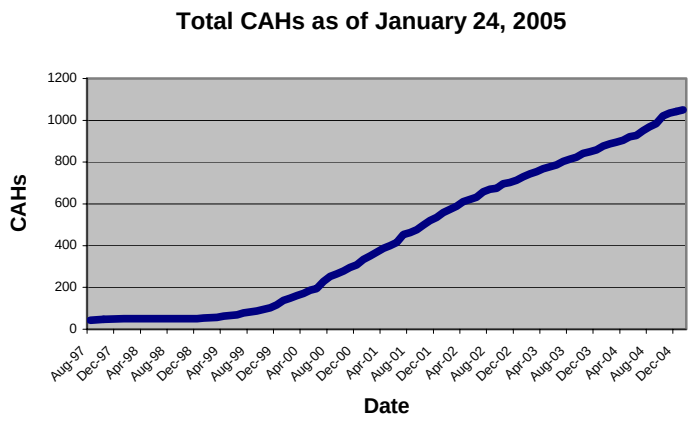
Critical Access Hospital Growth

American Hospital Association

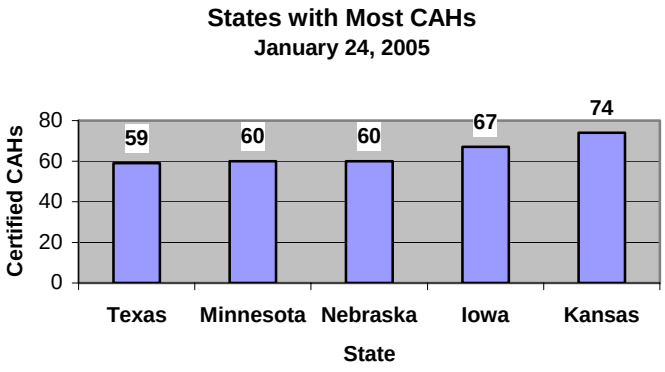
Figure 1



According to a report from CMS using the OSCAR database, as of January 24, 2005, there were 1,050 CAHs (figure 1). This represents 21 percent of the 4,895 community hospitals in the United States or 48 percent of the 2,166 rural community hospitals in the U. S.

Growth of CAHs across the country has been uneven. There are now CAHs in 45 states, and 5 including Kansas (74), Iowa (67), Nebraska (60), Minnesota (60), and Texas (59), account for 30 percent of all CAHs (figure 2). Conversely, the 16 states with the fewest CAHs (figure 3) account for only 108 or 10 percent of all CAHs in the U.S. A map with the location of CAHs as of November 9, 2004 appears below.

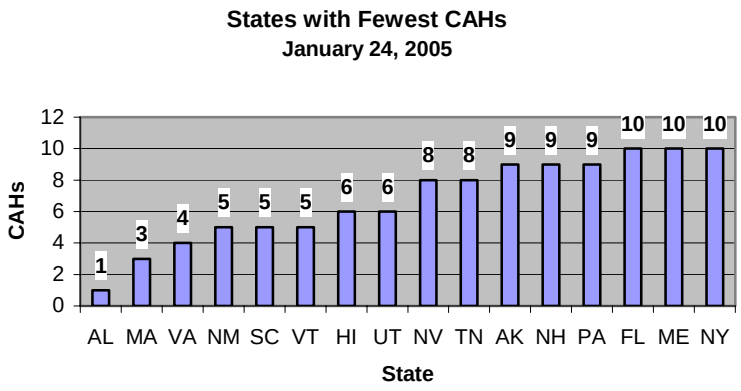
Figure 2



Since December of 1999, growth of CAHs has been gradual yet consistent, but that has not always been the case. After the initial conversion of rural primary care hospitals and medical assistance facilities in August 1997, the program was dormant as hospitals awaited the outcome of their 1998 cost reports, their first under the BBA. In October 1998, Congress appropriated $25 million in the first of 7 years of support for the Medicare Rural Hospital Flexibility Program, which funded an infrastructure at the state level to support interested hospitals and communities weigh the pros and cons of CAH conversion.

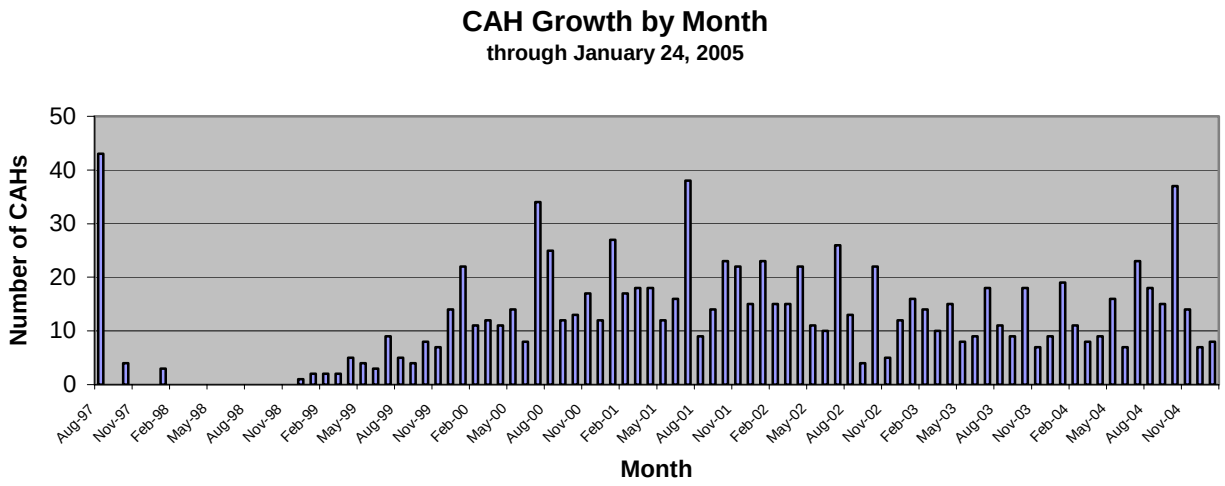
Conversions started again in earnest in December 1998 (figure 4). In addition, legislation passed by Congress through the years offered new incentives for hospitals to convert to CAHs. In November 1999, Congress passed the BBRA, which expanded eligibility to include investor-owned hospitals, and modified length-of-stay requirements to an average of 96 hours. In December 2000, BIPA offered new incentives to convert by exempting CAH swing-beds from SNF PPS and effective retroactive to the BBRA, eliminated beneficiary coinsurance for clinical diagnostic lab tests. In December 2003, the Medicare Modernization Act (MMA) of 2003 provided additional incentives by permitting a CAH to operate up to 25 inpatient beds for either acute or long-term care. Also, the MMA set a deadline of December 31, 2005 by which state designated necessary providers must convert to CAH. These and other provisions in the MMA spawned a new round of conversions and a boom in growth in 2004.

Figure 3

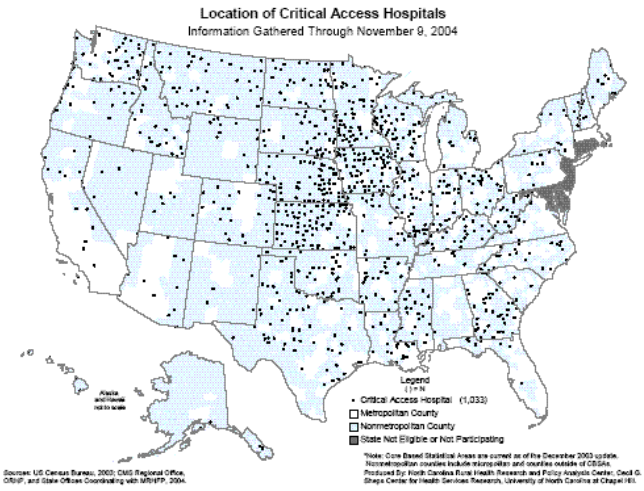


In September 2003, the General Accounting Office (GAO) released a study, *Modest Eligibility Expansion for Critical Access Hospital Program Should Be Considered*. Using 1999 Medicare claims data, GAO found 129 potential CAHs that likely would have been able to meet the CAH census limit of no more than 15 acute care patients at any given time if not for a seasonal increase in their patient census. Seasonal increases in patient census were common among the hospitals GAO studied, generally occurring during the winter flu and pneumonia season.

Figure 4



As a result of their findings, the GAO suggested that the Congress might wish to consider allowing hospitals with a DPU to convert to CAH status. The GAO also suggested that Congress might wish to consider changing the CAH limit on acute care patient census from an absolute limit of 15 patients to an annual average of 15 patients. The Department of Health and Human Services said that these modifications to CAH eligibility criteria would provide the needed flexibility for some additional facilities to consider conversion to CAH status, and emphasized the importance of maintaining financial incentives for efficiency as well as health and safety standards.



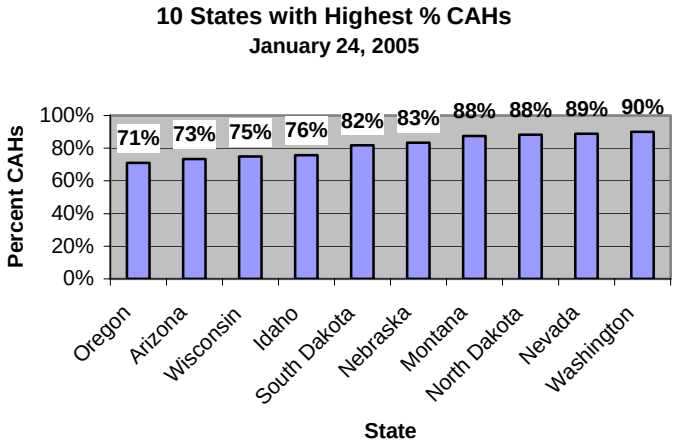
The MMA accomplished this and more. The MMA allows CAHs to establish distinct part psych and rehab units of up to 10 beds, which do not count against the inpatient bed limit. It also permits a CAH to operate up to 25 inpatient acute care or swing beds in any combination. By revising the CAH bed criteria, Congress acted to relieve the pressures of CAHs from managing their patient census during the winter flu and pneumonia season as well as during periods of seasonal fluctuation in their area's population. In addition Congress has encouraged hospitals to continue their broad missions of providing essential mental health and rehab services to their communities. It is expected that these changes will result in more efficient and effective management of patient care by CAHs and will promote further growth in the number of CAHs.

Complicating a hospital's decision toward conversion; however, is a policy created by CMS in May 2004 that counts observation beds against the 25-inpatient bed limit available to a CAH as established under the MMA. Previous CMS policy counted inpatient beds set-up and staffed. By including observation beds CMS negates in part the increased flexibility afforded to CAHs as created by Congress in the MMA and places CAHs in a precarious position of having to care for patients during seasonal peaks of influenza when there presently is insufficient doses of vaccine to meet demand.

As of January 24, several states are rapidly approaching a saturation point regarding further growth of CAHs. Figure 5 shows the 10 states with the highest percentage of CAHs to total rural community hospitals. All are above 70 percent and all except Wisconsin are west of the Mississippi. The prospect in these states of further conversions to CAH is slim.

Conversely, figure 6 shows the ten states with the lowest percentage of CAHs to total rural community hospitals. Some are relatively urban states, but several are largely rural. All but two are east of the Mississippi. Note that original EACH/RPCH states are represented in each set of 10. While the prospects of further growth in these states are sizeable, the opportunity to do so is rapidly coming to an end.

Figure 5



There is no single reason why some states adopted the CAH program early and others much later. In fact the reasons can be very complex. However, whether it is on an institutional basis or a state basis arriving late to the program will have its consequences. The MMA includes a provision that will eliminate states' ability to identify necessary providers effective January 1, 2006. As of that date in order to qualify as a CAH a hospital must meet the federal mileage guidelines (35 and 15) from the nearest hospital. In effect this will bring an abrupt and virtually complete halt to the growth of CAHs in the U.S.

Figure 6