Critical Access Hospitals

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Congressional mandates

- Report on several rural aspects of the MMA, due in December 2006
- Interim report on the Critical Access Hospital (CAH) provisions in the MMA, due in June 2005

Tasks for this meeting

- Review current status of the CAH program
- Discuss how CAH conversions have increased Medicare payments to converting hospitals
- Show that profit margins have increased at converting hospitals
- Discuss policy issues

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Who can be a CAH?

4 day LOS +	distance rule +	Rural +	Bed size =	Eligible
Not binding (CAHs use swing beds)	Almost never binding (states waive 35/15 mile rule)	States can declare towns rural	Firm 25 bed limit	

CAHs must also have an emergency room with a physician or midlevel provider on-call 24 hours a day; in rare cases a nurse can be the on-call provider.

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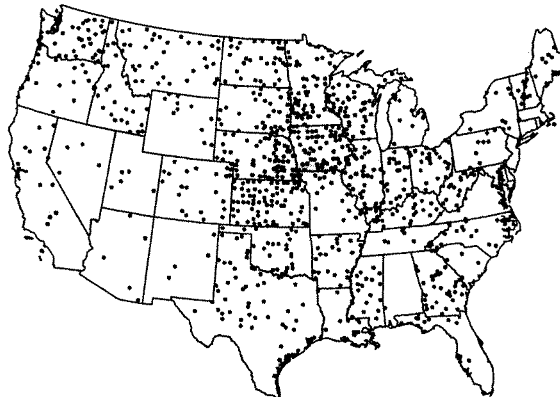
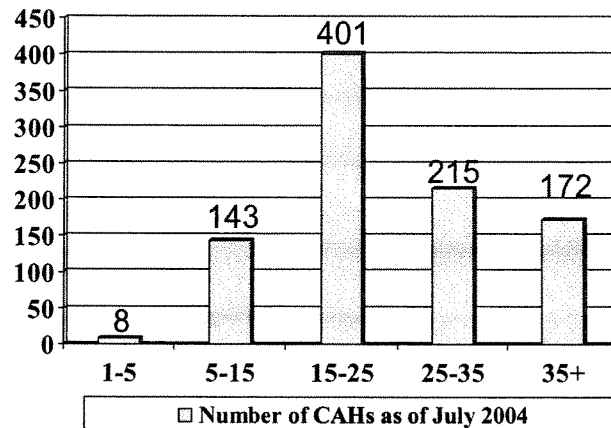
Location of Critical Access Hospitals, as of Jan 1, 2000

Location of Critical Access Hospitals, as of Nov 1, 2004



Distance to the nearest hospital (in road miles)



Why convert to CAH status?

Medicare payments = 101% of costs

- Outpatient
  - On-call payments for physicians
  - Laboratory payments
- Post-acute care in swing beds
- Inpatient

Outpatient payments per CAH grow rapidly

	Payments per hospital in 1998	Payments per hospital in 2003	Growth over five years
CAHs (n=498)	$528,000	$1,061,000	101%
Comparison hospitals (n=551)	$786,000	$1,038,000	32%

Note: payments are not adjusted for inflation

Swing bed payments grow rapidly

	1998 payments	2003 payments	Growth
CAH payment per day	$259	$1,016*	$741*
Comparison group payment per day	262	270	4*
Swing bed payments per CAH	117,000	580,000	463,000
Swing bed payments per comparison hospital	134,000	122,000	-12,000

* When swing bed days increase, costs allocated to acute days decrease; therefore, total payments to the hospital will not increase by $1,016 per day. The growth in payment per day is for hospitals with swing beds in both 1998 and 2003.

Charity care leads to lower Medicare reimbursement

Without a 5-day charity admission	Fixed routine costs: $1,000,000 Total inpatient days: 1,995 Medicare days: 1,200 Pmt=$1mm*(1,200/1,995)=$601,534
With a 5-day charity admission	Fixed routine costs: $1,000,000 Total inpatient days: 2,000 Medicare days: 1,200 Pmt=$1mm*(1,200/2,000)=$600,000
Result	Medicare payments fall by $1,534

Changes in service offerings follow financial incentives

Percentage of CAHs expanding specific services

- imaging, 40%
- laboratory, 20%
- rehabilitation, 19%
- emergency department, 14%

Percentage of CAHs dropping specific services

- obstetrics, 6%
- home health, 11%
- SNF, 4%

Sources: University of Minnesota and Medicare cost reports

Total cost-based payments per CAHs grow rapidly

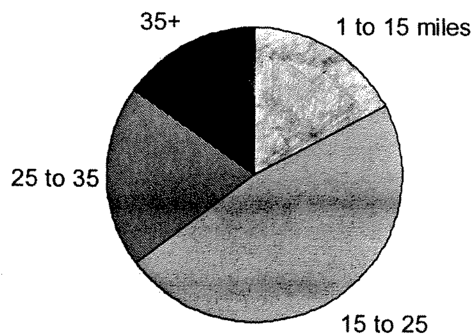
	Payments in 1998	Payments in 2003	Growth over 5 years
CAHs (n=498)	$1,900,000	$3,000,000	57%
Comparison hospitals (n=551)	$3,300,000	$3,900,000	17%

Note: Payments include inpatient, outpatient and swing bed payments. Lab payments are excluded. Payment are not adjusted for inflation.

Converters turn profitable

	All-payer Margin In 1998	All-payer Margin in 2003	Change
CAHs (n=498)	-1.2%	2.2%	3.4%
Comparison hospitals (n=551)	2.2%	-0.2%	-2.4%

Medicare CAH cost-based payments
(by distance to the nearest hospital)



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Key issues in cost-based payment

- Should the requirement that CAHs be 15 miles from other hospitals be extended to current CAHs?
- Should Medicare pay hospitals more for post-acute patients in swing beds than for patients in SNFs?
- Should we base CAH profit on costs or on equity?

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An alternative to cost-based payment

Pay small isolated rural hospitals a fixed amount (e.g. $500,000) to provide emergency services, plus regular Medicare payment rates for all services

- Increased incentive to control costs
- Providing charity care will no longer result in reduced Medicare payments
- Payments would be less volatile
- Decreased incentive to increase volume

Four discussion topics

- Require all CAHs to be 15 miles from other hospitals?
- Set CAH post acute care rates equal to those for local SNFs?
- Pay a return on equity rather than a return on cost?
- Change to a fixed subsidy rather than cost-based reimbursement?