Big changes ahead for CAH program?

Policymakers in Washington, DC, are considering major changes to the critical access hospital (CAH) program – changes that could mean a loss of CAH status to facilities like 25-bed Samaritan Lebanon (NE) Community Hospital.

Samaritan Lebanon is less than 20 miles from the nearest hospital – too close to keep its CAH designation under some proposals offered in an effort to reduce Medicare costs. Congress created the program in 1997, after a wave of rural hospital closures, to make sure Americans in isolated areas would still have access to health care. For that reason, hospitals designated as CAHs and with no more than 25 beds are reimbursed under Medicare based on their actual costs to provide care, rather than through a prospective payment system (PPS).

“Policymakers recognized that [CAHs] were more at risk because they didn’t have the volume of activity to support their operations,” said Larry Mullins, CEO of Samaritan Health Services, which is Samaritan Lebanon Community’s parent company. “Prior to being designated critical access, the hospital was struggling.” He said Medicare accounts for more than 65% of the hospital’s revenue.

But what federal policymakers give they can take away, as the Obama administration, the Medicare Payment Advisory Commission, the Congressional Budget Office and, most recently, the Department of Health and Human Services Office of the Inspector General (OIG) have proposed doing to the CAH program.

While CAHs are supposed to be at least 35 miles away from another hospital in rural areas, states were allowed to waive distance requirements and designate small hospitals as “necessary providers” if it was felt that they were offering services that would not be available in the area otherwise. When that provision of the law was eliminated in 2006, hospitals that had already been granted an exemption were allowed to remain in the program.

As a cost-saving move, OIG in August recommended the Centers for Medicare & Medicaid Services (CMS) decertify CAHs that were 15 or fewer miles from other nearby hospitals in 2011.

For Samaritan Lebanon, and other CAHs, Mullins said the “result would not only jeopardize access to vital health services, but also the jobs of hundreds of health professionals, because the hospitals are among the largest employers in these communities.”

OIG’s proposal and budget proposals that call for both tighter distance requirements and reducing CAH payments would force many of the nation’s smallest hospitals to close and cause patients to lose their access to essential medical services, CAH administrators said.

Cutbacks in the CAH program “probably means drastic changes in programs we offer in the community … the wellness initiatives … the education initiatives that we have going on in the community,” said John Russell, CEO of 25-bed Columbus Community Hospital in south-central Wisconsin. The hospital was granted “necessary provider” status in 2006. Russell attended the AHA’s Oct. 29 “Advocacy Day” event, and took his case for protecting CAHs to Capitol Hill (see related story on page 1).

William Newton Hospital, a 25-bed hospital in Winfield, KS, is another vulnerable CAH. Hospital administrator J. Ben Quinton said CAHs must speak up on the issue and “work with their senators and representatives and the AHA” to preserve their CAH status.

Another thorny issue confronting CAHs is CMS’ controversial policy that requires a supervising physician or non-physician practitioner (NPP) to be immediately available whenever a Medicare patient receives outpatient therapeutic services. The policy, on hold since 2009, takes

Continued on next page
effect in January for CAHs and other rural hospitals with no more than 100 beds.

The agency in 2009 characterized the direct supervision requirement as a “restatement and clarification” of existing outpatient payment policy that had been in place since 2001 – a move that put hospitals at increased risk for unwarranted enforcement actions.

The AHA and CAH administrators said the policy would essentially require the round-the-clock presence of physicians and NPPs. Many say they can neither find nor afford the medical staff to meet that requirement.


The legislation would require CMS to allow a default setting of general supervision, rather than direct supervision, for outpatient therapy services and create an advisory panel to establish an exceptions process for risky and complex outpatient services. The legislation also would create a special rule for CAHs that recognizes their unique size and Medicare conditions of participation; and would hold hospitals and CAHs harmless from civil or criminal action for failing to meet the “direct supervision” requirements applied to services provided since 2001.

“The critical access hospital program was created to ensure that people in rural communities have access to health care service within a reasonable time,” said Keith Heuser, administrator of 19-bed Mercy Hospital in Valley City, ND. He said the rural therapy bill “offers appropriate protections and gives us the latitude we need to continue to ensure that people in our community have access to care.”

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**In Critical Condition:**

**The Fragile State of Critical Access Hospitals**

<table>
<thead>
<tr>
<th>BRIDGING GAPS IN ACCESS TO CARE</th>
<th>1,330 CAH LOCATIONS</th>
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</thead>
<tbody>
<tr>
<td><strong>ANNUAL SERVICES PROVIDED TO PATIENTS</strong></td>
<td><strong>19.3%</strong> of the U.S. population resides in rural areas, as of the U.S. Census Bureau’s 2010 Census.</td>
</tr>
<tr>
<td>7 MILLION patients treated in CAH emergency departments.</td>
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<tr>
<td>38 MILLION outpatient visits to CAHs.</td>
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<tr>
<td>900,000 patients admitted to CAHs.</td>
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<td>86,000 babies delivered at CAHs.</td>
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**DElicate LIfelines**

CAHs’ small size means that they can only focus on providing the most essential medical services, in contrast to high-volume hospitals that have more resources and flexibility to offer a wider range of services. CAHs simply don’t have the same economies of scale as their larger counterparts.

More than 60% of their revenue comes from government payers, such that any payment reductions to Medicare or Medicaid would have an immense impact on CAHs’ ability to provide access to beneficiaries in rural communities.

**CAH PERCENTAGE OF GROSS REVENUE, BY PAYER:**

- **47.3%** Medicare
- **35.9%** Private
- **15.5%** Medicaid
- **1.3%** Other Government

**A SPECIAL MEDICARE PAYMENT STRUCTURE**

CAHs survive in large part due to a federal reimbursement structure that provides them funding of 1% above the cost of providing care.

**MEdICARE MARGINS, BY SERVICE AND HOSPITAL TYPE:**

- **-4%** Inpatient
- **1%** Outpatient

**MANY CAHs STILL STRUGGLE**

Although Medicare pays CAHs 1% above the cost of providing care, CAH revenues from other payers often don’t cover costs, illustrating why adequate Medicare payments must continue in order for CAHs to be able to provide care for rural populations.

**PERCENTAGE OF CAHs WITH NEGATIVE ALL-PAYER MARGINS:**

- **38.1%** Negative Operating Revenue
- **30.6%** Negative Total Margin

CAHs make up nearly 30% of acute care hospitals...

...but receive less than 8% of total Medicare payments to hospitals.

**Sources:** American Hospital Association | United States Census Bureau

Data on services and payment from 2011.