



Health System Challenges for Critical Access Hospitals: Findings from a National Survey of CAH Executives

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BACKGROUND

Established by the Balanced Budget Act of 1997, the Critical Access Hospital (CAH) designation was created to help rural hospitals stay open by keeping essential health care services in rural areas. CAHs can have no more than 25 beds and must be: 1) at least 15 miles by secondary road or mountainous terrain OR 2) 35 miles by primary road from the nearest hospital OR 3) declared a “necessary provider” by the state’s governor. Long-term financial viability can be difficult because of low patient volume, the health and socio-economic status of rural residents, higher rates of uncompensated care, and many other factors beyond hospital control.^{1,2,3,4} CAHs receive cost-based reimbursement from Medicare for allowable costs for outpatient, inpatient, laboratory, and therapy services, as well as post-acute care in swing beds. However, the current reimbursement to CAHs was reduced from 101% to 99% of costs due to a sequester in place since 2013.⁵

The majority of unprofitable hospitals in the U.S. are rural hospitals. In 2018, approximately 30 percent of hospitals had negative total margins.⁶ Between January 2010 and December 2020, 134 rural hospitals closed and 33 percent of the hospitals were CAHs.⁷ Research prior to the COVID-19 pandemic predicted that approximately 27 percent of CAHs would be at a mid-high or high risk of financial distress in 2020, which increases their risk for closure.⁸

KEY FINDINGS

A survey of Critical Access Hospital (CAH) Chief Executive Officers identified the most pressing health system challenges for their hospitals:

- ◆ Uncompensated care and affordability of health insurance, particularly among executives of CAHs in states that have not expanded Medicaid.
- ◆ Patient and ambulance bypass that reduces hospital reimbursement and influences patient perceptions of quality.
- ◆ Uncertainty about the 340B program because access to medications and medication services has declined in many rural areas.

In addition, CAHs operate in areas where local infrastructure may be inadequate. Limited broadband service options and slower internet speeds are issues for rural areas, which could make it difficult for CAHs to participate in the health information exchange, hampering coordination of care.⁹ CAHs face barriers to building or purchasing health information technology in addition to maintaining electronic health information.¹⁰

Despite the numerous challenges of operating a CAH, there is little research examining the perspectives of CAH executives on potential community health care options if the CAH were to close. This brief presents a subset of results from a national survey (see Appendix for a description of the survey method) of CAH executive perspectives on pressing challenges.

The purpose of this brief is to provide rural health policy makers with a better understanding of the prevailing challenges of CAHs. The goal is for the information to assist in development of strategies and interventions to maintain CAH viability and access to health care by rural communities.

RESULTS

In total, 227 complete surveys were received. Table 1 describes the sample of survey respondents. After matching respondent data to identifiable hospital financial data, we dropped 14 observations that we were not able to match to hospital financial data. We also removed one observation that was a duplicate and incomplete response. Since all except 38 of the responses were from CAHs, we decided to drop non-CAHs, and to analyze and report only CAH responses. We were left with 174 CAH responses, which is approximately 13% of CAHs. Seventy-seven (44%) of these were found to be in a system.

Table 1. Critical Access Hospital Survey Respondents

Census Region	Number	Percent	State (of CAH) Medicaid Expansion Status	Number	Percent
Northeast	20	11%	Expanded	119	68%
Midwest	73	42%	Did not Expand	55	32%
South	38	22%	Total	174	100%
West	43	25%	Ownership Status	Number	Percent
Total	174	100%	Non-government, not-for-profit	112	64%
Management Type	Number	Percent	Government, non-federal	56	32%
Chief Executive Officer (CEO)	141	81%	Investor for-profit	6	3%
Other Senior Management	29	17%	Total	174	100%
Other	4	2%	System Status	Number	Percent
Total	174	100%	Not in a system	97	56%
			In a system	77	44%
			Total	174	100%

Health System Challenges

Table 2 shows the CAH executives’ responses to a question about health system challenges. More than 60 percent of respondents rated uncompensated care, affordability of health insurance, patient bypass, and prescription drug prices as high priority health system challenges.

Table 2. Health System Challenges

Please assess the priority of the following health system challenges	High Priority %	Medium Priority %	Low Priority %	Total Responses (n)
Uncompensated care (underinsured, uninsured, etc.)	65.9	31.1	2.9	170
Affordability of health insurance	63.9	29.6	6.5	169
Patient bypass (local patients traveling for care in hospitals beyond your community)	63.9	29.0	7.1	169
Prescription drug prices	60.7	33.3	6.0	168
Health information technology cost	50.6	42.9	6.5	170
Social barriers to care (transportation, health literacy, etc.)	39.6	49.1	11.2	169
Access to capital	37.3	34.3	28.4	169
Cyber threats	34.9	52.1	13.0	169
Prescription drug shortages	32.1	52.4	15.5	168

Source of Revenue

CAHs draw the bulk of their revenue from private payers, commercial insurance plans, public insurance plans (Medicare, Medicaid, and TRICARE) and federal and state payments to offset the cost of care provided to lower income patients. CAHs typically serve higher cost patient populations due to the socioeconomic and health challenges of rural areas. Rural areas have higher rates of unemployment and, as a result, the CAH patient mix has lower proportions of private or employer-sponsored health plans and higher proportions of public health plans or uninsured.^{11,12} Therefore, uncompensated care—hospital provided care that is not reimbursed through patient or insurer payment—is a concern for CAHs.¹³ Medicare reimbursement to CAHs for provided care covers reasonable costs,¹⁴ but often does not cover

additional costs required for the provision of services or allow for the realization of significant profit. CAH Medicare cost-based reimbursement covers outpatient, inpatient, laboratory, therapy, and swing bed services, and in some states, CAHs may also receive cost-based reimbursement from Medicaid.^{15,16} CMS Medicaid Disproportionate Share Hospital (DSH) payments require state Medicaid programs to make payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals.¹⁷ The 2010 Patient Protection and Affordable Care Act (PPACA) included a provision to reduce federal Medicaid DSH allotments to states. The provision calls for payment reductions in fiscal years 2020 through 2025, with a \$4 billion cut in fiscal 2020 and \$8 billion in each of the next four fiscal years.¹⁸ These proposed¹⁹ payment reductions could disproportionately impact rural hospitals as a larger share of nonelderly are covered by Medicaid in rural compared to urban areas.²⁰

“Costs continue to climb while reimbursement [from] Medicare [and] Medicaid lags. The proliferation of high-deductible plans is creating some challenges as folks delay preventive care and by and large wait until it is dire to show up in our [emergency room]. Overall, I feel that rural hospital and rural health care delivery are at a breaking point, [and] by extension[,] rural communities are under attack.”

Among our surveyed executives, lack of Medicaid expansion was expressed to be a contributor to health system challenges. Medicaid eligibility expansion to 138% of the federal poverty level for adults, a decision left up to states as a result of the PPACA and subsequent rulings, was set to be adopted in 37 states, including the District of Columbia when the survey data was collected.²¹ Approximately 36 percent of respondents who indicated uncompensated care and 29 percent who indicated health insurance affordability as high priority health system challenges were from states where Medicaid expansion had not taken place. Additionally, respondents from Medicaid expansion states expressed concern over 1115 Medicaid waivers with work requirements as they could impact enrollment and potentially increase hospital bad debt and the amount of self-pay patients. As of December 2020, eight states have approved 1115 Medicaid waiver work requirements and seven states have approvals pending.²²

“Reimbursement by Medicaid is below cost and accounts for 50% of our volume.”

High-deductible health plans may also contribute to uncompensated care. Since implementation of the PPACA, there has been an increase in private health plans with lower monthly premiums and higher deductible amounts, which are meant to limit out-of-pocket costs for the insured and to restrain overall health care costs, but may also be associated with increased deferred care, poorer outcomes, and more uncompensated care for hospitals.^{23,24,25} Rural residents are more likely to enroll in high-deductible health plans.²⁶

“With 64% of our business being Medicare/Medicaid we will never make our cost up without better payment from private insurances, hence, eliminating our abilities to add to our facility and bring new services.”

Patient Bypass

Patient bypass of a hospital occurs when residents seek care beyond their local hospital, and ambulance bypass occurs when emergency response and transportation teams transport a patient to a hospital beyond a local hospital.²⁷ Previous bypass studies identified that patients will bypass their CAH for their inpatient care needs.²⁸ CAH executive respondents perceived patient and ambulance bypass to be an area of high concern as there are implications for hospital reimbursement and influences on patient perceptions of quality.

“We are a primary care RHC so patients go to other facilities for specialty services. There are some, however, in the service area who travel to other facilities for primary care.”

“We have major health systems 45 minutes to the south and north. For those that can travel and have resources, many prefer large health systems to our small community hospital.”

“We can't be everything to everyone in our rural setting so we need targeted services to prevent the out-migration of services for those who socioeconomically can bypass us... it is difficult to tell when the changes in healthcare will be at our doors.”

Uncertainty of the 340B Drug Program

There is uncertainty in the permanence of the 340B program in rural areas where access to medications and medication services has declined. The 340B program provides a financial incentive for eligible rural facilities by requiring drug companies to sell them medicines at large discounts, reducing the potential for added uncompensated care costs, and this increases uninsured and underinsured patient access to necessary drugs.²⁹ According to the Government Accountability Office, hospitals participating in the 340B program are typically smaller, critical access, or other rural hospitals.³⁰

“Medicare D not having a cost-based settlement also puts the CAH program at risk.”

The increasing prices of prescription drugs and drug therapies can threaten care delivery in rural areas. Additionally, rural pharmacies face challenges with Medicare Part D, mainly as an out-of-network provider in addition to remuneration fees³¹ and maximum allowable costs.³²

These fees and either lower or delayed reimbursements limit the available cash flow of rural pharmacies and rural drug providers, which can impact service provision. The 340B program is perceived to be part of a solution as it allows for rural providers to meet the prescription drug needs of its patient population at manageable costs by providing 20 to 50 percent discounts on drug pricing.^{33,34}

“The 340B Program is personally responsible for keeping my guess would be, greater than 50% of CAHs open. If this program goes, rural medical deserts will form and there will be detrimental effects on the patients of rural America.”

SUMMARY

This survey data provides insight into some of the pressing health system challenges CAH executives faced before the COVID-19 pandemic (when this survey was undertaken). Three of the major challenges identified were: uncompensated care and affordability of health insurance, particularly among executives of CAHs in states that have not expanded Medicaid; patient and ambulance bypass that reduces hospital reimbursement and influences patient perceptions of quality, and; uncertainty about the 340B program because access to medications and medication services has declined in many rural areas. Medicaid DSH payments, Medicaid expansion, survival of the ACA, and potential reductions to private, state, and federal revenue sources were identified as other health system challenges that will affect CAHs.

Many of these health system challenges have and will increase the vulnerability of rural hospitals and the rural communities they serve from COVID-19:

- *Rural hospitals are more vulnerable to COVID-19.* Rural and urban acute care hospitals have lower revenue because elective procedures and some routine care are being canceled to ensure capacity for COVID-19 patients. Many also face higher expenses because of supplies, equipment, and staff required for COVID-19 patients. A hospital’s ability to get through periods of diminished cash flow depends on the amount of cash, marketable securities, and other assets that can be readily converted to cash. Many rural hospitals have low cash levels and may struggle to get through the current cash crunch.³⁵
- *Rural patients are more vulnerable to COVID-19.* People who are obese, live with diabetes, hypertension, asthma and other underlying health issues are more susceptible to COVID-19, and rural areas tend to have higher rates of these conditions.³⁶ In addition, insured patients have experienced increases in payment responsibilities since COVID-19: “Almost half of rural Americans can’t pay an unexpected expense of \$1,000 right away, much less deductibles and out-of-pocket medical costs that exceed those amounts. About 20 percent of rural residents say they can’t find doctors who accept their insurance, which means they have to cover the entire bill.”³⁷

In conclusion, the health system challenges identified in this survey are many, substantial, and long-standing. It is likely that these challenges will increase because of COVID-19, further jeopardizing the ability of CAHs to meet the needs of their community and threatening the long-term viability of many rural hospitals.

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APPENDIX: METHODS

We used an advisory panel to identify critical questions, determine how best to ask them, and to construct a survey of the appropriate length. Members of the panel are below.

1. Tammy Norville, Technical Assistance Director, National Organization of State Offices of Rural Health
2. Tim Putnam, President and CEO, Margaret Mary Community Health, Batesville Indiana
3. Aaron Saude, President and CEO, Bigfork Valley Hospital, Bigfork Minnesota
4. Pat Schou, Executive Director, Illinois Critical Access Hospital Network
5. Brock Slabach, Sr. Vice-President, Member Services, National Rural Health Association
6. John Supplitt, Senior Director, AHA Constituency Sections, American Hospital Association

The method consisted of the following steps: 1) using a literature review to construct a list of current operational and financial challenges facing rural hospitals; 2) advisory panel members ranked the importance of the challenges and an iterative process was used to select the challenges to be included in the survey; 3) survey questions were written, and imported into a web-based survey using Qualtrics (Qualtrics, Provo, UT), and revised for clarification and brevity. The web-based survey required several iterations to modify questions, clarify wording, and ensure it could be answered by a majority of respondents in less than 30 minutes. Probing questions based on responses to certain drop-down or multiple-choice questions were included on several questions, and; 4) a limited amount of hospital and respondent information was solicited for analytical purposes, such as the hospital zip code and the executive level of the respondent. Qualtrics was set to anonymize survey responses to avoid inadvertently storing any personally identifiable information including IP addresses. The informed consent detailed the criteria for participation; outlined the study's funding source, purpose, use of data, and investigator contact information; identified the risks, if any; and checked for understanding. Respondents were not be able to view any survey questions or participate without first acknowledging consent.

We did not have contact information for all rural hospital executives, so potential survey respondents were contacted using five methods: 1) Prompts for the web-based survey were built into the Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS). CAHMPAS users were notified about the opportunity to take the survey upon log-in. CAHMPAS is a web-based tool designed to give CAH executives, state Medicare Rural Hospital Flexibility (Flex) program coordinators, and federal staff the ability to explore the financial, quality, and community-benefit performance of CAHs. 2) the National Rural Health Association notified members and included the survey website in a regularly distributed newsletter email; 3) the National Organization of State Offices of Rural Health notified state offices of rural health and included the survey website in a regularly distributed newsletter email; 4) the Federal Office of Rural Health Policy notified selected persons and included the survey website in a communication, and; 5) the North Carolina Rural Health Research Program directly emailed several CEOs with whom they have had previous contact. We could not verify whether all rural hospital executives were exposed to the survey.

The survey opened on January 1, 2019 and closed on April 30, 2019. Respondents were asked a series of closed-ended and open-ended questions to describe their experiences and perspectives dealing with challenges associated with a variety topics, including staffing, value-based models and reimbursement, service lines, community health needs and infrastructure, and alternative models of care delivery. Online surveys, often solicited via email, have recently faced a dip in response rates due to survey spam and survey fatigue.³⁸ Survey research response rate trends and the possibility for self-selection bias have the potential to impact the results of this study. In total, 227 complete surveys were received. Survey responses were merged with CMS Healthcare Cost Report Information System (HCRIS) data to validate the limited amount of hospital information collected from survey respondents, such as hospital type, size, and state. Table 1 on page two describes the sample of survey respondents. After matching respondent data to identifiable hospital financial data, we dropped out 14 observations that we were not able to match to hospital financial data. We also removed one observation that was a duplicate and incomplete response. Since all but 38 observations were CAHs, we also dropped the 38 non-CAHs to analyze and report only CAH responses. We were left with 174 CAH responses which is approximately 13% of CAHs.

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