NC Rural Health Research and Policy Analysis Program
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill

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THE ROLE OF CAH STATUS IN MITIGATING THE EFFECTS OF NEW PROSPECTIVE PAYMENT SYSTEMS UNDER MEDICARE

Kathleen Dalton, Ph.D., Rebecca T. Slifkin, Ph.D., Hilda A. Howard, B.S.

This Findings Brief examines rural hospitals that potentially qualify as Critical Access Hospitals (CAH), and identifies facilities at substantial financial risk as a result of Medicare's expansion of prospective payment systems (PPS) to non-acute settings. Almost 30% of all rural hospitals were identified as potential CAHs. Potential CAH facilities are exposed to greater-than-expected risk from the new payment systems based on their relative participation rates in the affected non-acute services and/or on poor financial ratios. We estimate that just over one half of this group would derive reimbursement benefit from conversion to CAH status.

BACKGROUND

The Balanced Budget Act of 1997 (BBA-97) contained a number of provisions that affect rural hospitals. Of particular importance is the expansion of Medicare's prospective payment systems to non-acute-care services, and the Medicare Rural Hospital Flexibility Program, which created a new limited service inpatient facility, the Critical Access Hospital (CAH). The Balanced Budget Refinement Act of 1999(BBRA) subsequently delayed implementation of some of the non-acute care reductions, and protected small rural hospitals from additional losses attributable to outpatient PPS for a period of three years.

Conversion to a CAH places certain limitations on a hospital, including restricting average inpatient stays to 96 hours or less and operating only a small number of beds. Hospitals can only qualify for this status if they are in a non-metropolitan county and are either remote from the nearest full service hospital or designated a necessary provider by their state. This Findings Brief identifies potential CAHs and examines their exposure to financial risk as a result of Medicare's expansion of prospective payment systems to outpatient, home health and skilled nursing services. HCFA recently estimated that outpatient PPS would reduce Part B payments to under 50-bed, rural hospitals by 13.8%, and the biggest projected reductions appeared to be in the regions with the highest dependence on Medicare payments. The BBRA provisions delay, but do not eliminate, these reductions. CAH status allows the hospital to receive cost-based reimbursement from Medicare for hospital inpatient and outpatient Part B services. Although payment for home and skilled nursing services is not affected, reimbursement relief offered by CAH status for the in- and outpatient care should improve facilities' ability to absorb payment reductions in the other non-acute areas.

IDENTIFYING POTENTIAL CRITICAL ACCESS HOSPITALS

Potential CAH were identified from 1996 Medicare cost reports (PPS Year 13) based on criteria that blended the mandatory requirements as delineated in the BBA-97 with state-reported optional criteria for necessary providers.[1] Among the 769 potential CAH facilities identified, 41% were already sole community hospitals (SCH), and qualified for some cost-based adjustments to their inpatient prospective payment rates. Another 4% were Rural Primary Care or Medical Assistance Facility sites, where both inpatient and outpatient Medicare services are paid under rules of retrospective cost-based reimbursement.

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[1] See Dalton, K.; Howard, H; Slifkin, R. "At-Risk Hospitals: The Role of Critical Access Hospital Status in Mitigating the Effects of New Prospective Payment Systems Under Medicare." December 1999. NC RHRP Working Paper Series, No. 67, for details. With the passage of the BBRA in November 1999, 35 for-profit hospitals would also have met the criteria for eligibility. These hospitals are not included in the analysis because for-profit institutions were precluded from participating at the time that this study was conducted.

The West Central and Mountain regions combined accounted for 69% of potential CAHs, though they account for only 35% of all hospitals nationally. Thirty-five percent of potential CAHs are located in counties adjacent to metropolitan areas, most with towns of less than 10,000 people. Thirty-four percent are located in non-adjacent counties having towns with populations between 2,500 and 10,000, and 26% are located in non-adjacent counties with no population centers greater than 2,500. Twenty-nine percent of counties with potential CAHs had six or fewer people per square mile.

SERVICE DELIVERY AND FINANCIAL CHARACTERISTICS OF POTENTIAL CRITICAL ACCESS HOSPITALS

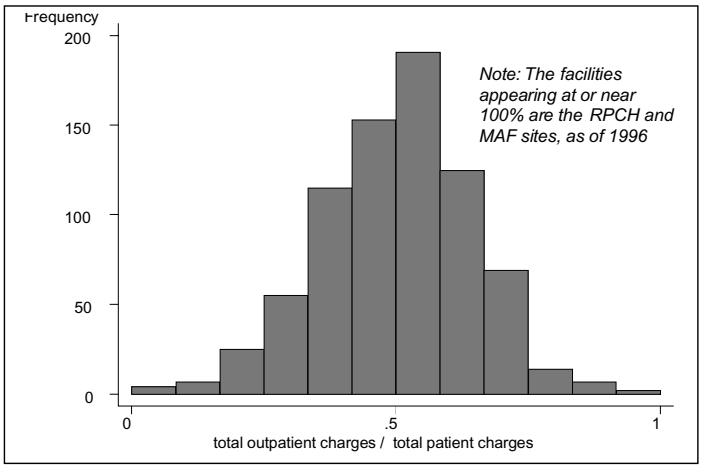
Reliance on Non-Acute Services: Outpatient charges averaged 50% of total patient charges for potential CAH facilities (Figure 1), compared to 45% in other rural hospitals and 36% in urban hospitals. Medicare outpatient Part B payments averaged 9% of each hospital's total net patient service revenue (Figure 1), as compared with 8% for other rural facilities and 6% for urban hospitals.

More than 55% of all potential CAHs (426 hospitals) operated certified home health agencies (HHA). Reported HHA charges averaged 11% of total patient charges among those that participated in home care. By region, home services ranged in importance from 7% to 20% of business. Many states in the New England and the north and south Atlantic regions had no potential CAHs participating in home care, while in the western and mountain states, participation rates were above 50%.

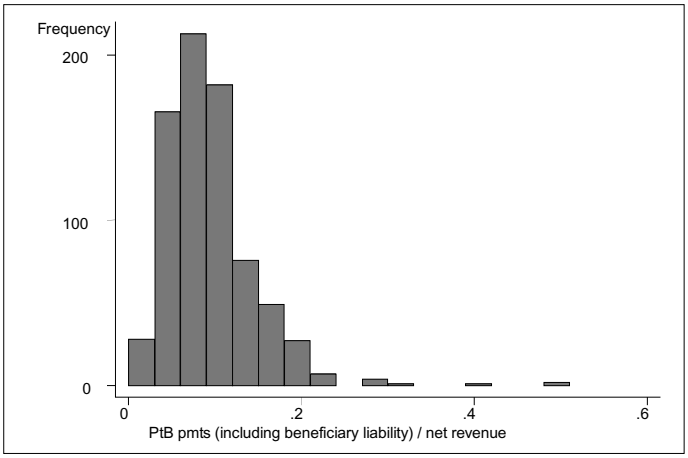
Twenty-seven percent of potential CAHs also operated licensed skilled or intermediate care beds, and 86% were authorized for swing beds. Acute unit occupancy averaged 26% among those with swing beds, compared to 20% among those without. Swing days accounted for over one fourth of the care provided on the acute units of potential CAH sites with swing-bed authorization. A significant subset of potential CAHs is heavily dependent on lower levels of convalescent care, to the point where it may be more reasonable to consider these institutions as extended care facilities with some additional, limited, acute care capacity. Potential CAHs were less dependent on Medicare-certified skilled nursing units, however, than were other rural or urban hospitals.

Figure 1: Potential CAH's Reliance on Outpatient Activities

Distribution of Outpatient Charges as a Proportion of Total Charges Among Potential CAH Facilities



Distribution of Payments for Medicare Part B Services as a Proportion of Net Revenue, Among Potential CAH Facilities



Source: Hospital Cost Report Information System Minimum Data Set, Health Care Financing Administration.

Inpatient PPS Payments: CAHs are exempt from prospective payment for inpatient and hospital-based outpatient services and are paid, instead, under retrospective cost reimbursement. Among potential CAHs that were receiving inpatient PPS payments in 1996 (732 facilities) Medicare patients accounted for 56% of total acute-care discharges, compared to 49% in other rural hospitals and 39% in urban hospitals. However, inpatient PPS payments accounted for only 24% of their net patient revenues from all sources, compared to 28% for other rural hospitals and 30% for urban hospitals.

Examination of PPS payment-to-cost ratios shows that thirty-one percent of potential CAHs were paid at or below cost in PPS 13 (Table 1). Although the comparable figure for urban hospitals is only 20%, potential CAH facilities as a group were not significantly more disadvantaged with respect to PPS payments than other rural facilities. This is attributable to the high number (315) that are already eligible for payment adjustments as SCH. SCHs are allowed the option of being paid under the PPS rules based on a national standardized payment amount per discharge, or based on their own updated historical cost per case-mix-adjusted discharge. An SCH may choose whichever method results in higher payments, each year. Payment-to-cost ratios averaged 1.16 among facilities eligible for both CAH and SCH status, compared to an average of 1.06 for those eligible only for CAH. Even with these special adjustments, however, 23% of SCHs in 1996 had PPS payment ratios below 1.0.

Other Financial Ratios: As compared with other rural hospitals, a substantially greater percent of potential CAHs had operating ratios (net patient revenues divided by operating expenses) below 1.0. Seventy percent of potential CAHs fail to recover accrued costs with income earned during the accounting period, despite the fact that many of these facilities had healthy inpatient margins. Potential CAHs in the

western states tend to have higher PPS margins, yet they also have the lowest average operating margins (Figure 2). Although nearly half of the potential CAH facilities that operated at a loss appeared to have access to other (non-operating) sources of support that were sufficient to cover their total expenses, 33% of all potential CAHs still reported total revenues (operating plus non-operating) that were less than their annual expenses.

WHO WILL BENEFIT FINANCIALLY FROM CONVERSION?

Facilities with PPS payments that substantially exceeded cost in 1996 are unlikely to receive financial benefits from CAH cost reimbursement provisions, regardless of the possible protection from reductions in outpatient payments. Due to other payment reductions included in BBA-97, many of the CAHs that experienced moderately positive PPS payment ratios in 1996 may find themselves facing PPS losses by 1999 or 2000. We use a 1996 PPS ratio of 1.1 as a conservative cut-point to identify facilities that are likely to have ratios at or below 1.0 by the year 2000. On the map in Figure 3, potential CAH have been categorized according to whether their 1996 PPS ratios were above or below 1.1, to identify those that, based solely on the status of their inpatient Medicare business, might benefit from CAH conversion. Of the 732 potential CAHs paid under PPS in 1996, 18 had already converted to CAH status by August of 1999. Of the remaining 714, 51% had PPS payment ratios in 1996 that were below 1.1. This is the group of hospitals where conversion to CAH status might be a viable financial strategy, if they are unable to respond to the new prospective payment systems through lower unit costs.

Table 1: Financial Ratios

(Means are un-weighted averages across all hospitals with complete margin data)

	Potential CAH Facilities	Other Non-MSA Hospitals	Urban Hospitals
Mean PPS Payment Ratio: (Total PPS Pt A Payments ÷ PPS Expenses)	1.11	1.12	1.17
Percent of hospitals with ratios:			
Less than 0.9	17%	12%	7%
Between 0.9 and 1.0	13%	18%	13%
Between 1.0 and 1.1	20%	20%	19%
Greater than 1.1	46%	47%	59%
N/A, or Incomplete margin data	5%	2%	2%
Mean Operating Ratio: (Net Patient Revenue ÷ Operating Expenses)	0.93	1.01	1.00
Percent of hospitals with ratios:			
Less than 0.9	30%	10%	13%
Between 0.9 and 1.0	40%	32%	34%
Between 1.0 and 1.1	11%	43%	36%
Greater than 1.1	6%	12%	14%
Incomplete margin data	2%	2%	3%
Mean Total Revenue Ratio: (Total Net Revenue ÷ Total Expenses)	1.03	1.06	1.06
Percent of hospitals with ratios:			
Less than 0.9	5%	3%	6%
Between 0.9 and 1.0	28%	15%	15%
Between 1.0 and 1.1	48%	52%	48%
Greater than 1.1	17%	26%	25%
	3%	4%	6%

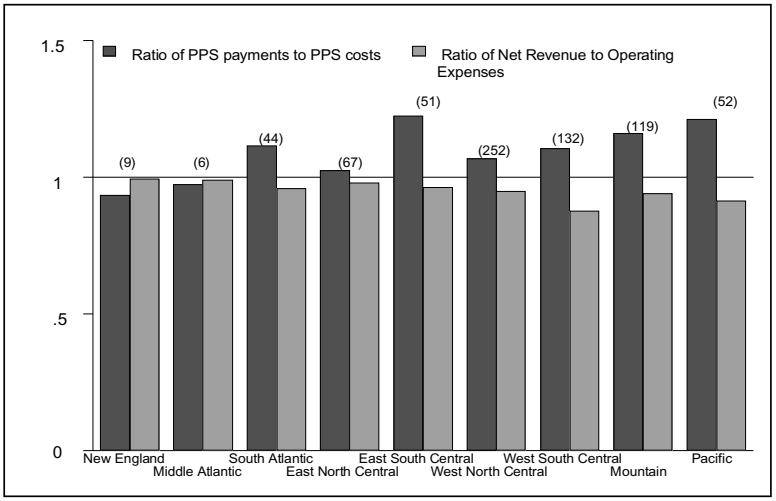
SUMMARY AND CONCLUSIONS

Low-volume rural hospitals are at greater financial risk than other hospitals from proposed changes to Medicare payment for non-acute services. There are significant numbers of rural hospitals that rely heavily on income from non-acute services, and/or are already unable to cover operating expenses with net patient revenue, for which any further reductions in non-acute payment could pose significant hardship.

Designation as a Critical Access Hospital exempts a hospital from the limitations on hospital-based non-acute care, by allowing it to receive reimbursement based on reasonable costs. The reimbursement provisions of the Rural Health Flexibility Program, however, apply to both inpatient and outpatient care. We estimate that only one-half of potential CAHs might improve their Medicare payments under cost reimbursement. Among the remaining potential CAHs, prospective payments for inpatient acute services are likely to continue to exceed costs. Evidence from the financial ratios in this group of hospitals shows that the Medicare inpatient PPS surpluses make important contributions to the hospitals' overall financial stability. If the loss of inpatient margins outweighs the reimbursement advantages from cost-based outpatient payments, then conversion to CAH status cannot offer any financial advantage.

Figure 2: Comparing Financial ratios by Region

Figures in parentheses represent the number of facilities contributing to that average.



Source: Hospital Cost Report Information System Minimum Data Set, Health Care Financing Administration.

There are many small rural hospitals that are eligible for both sole community status and CAH designation. Many of these hospitals were able to earn a surplus from inpatient PPS payments because of special payment provisions for sole community hospitals. Whether the Rural Hospital Flexibility Program will benefit this subgroup depends on whether the institution decides that accepting the CAH designation is consistent with its mission, as well as whether the relief from outpatient prospective payment offered under this designation outweighs the benefits currently received from their inpatient PPS payment arrangements. For the institutions that decide conversion to CAH is consistent with their mission, the Rural Hospital Flexibility Program would be strengthened if these hospitals had the option to retain the inpatient PPS reimbursement rules applicable to SCH status. Many SCH may choose not to convert to CAH status, even though our data reveal that many of these institutions are at risk from non-acute care PPS. Relief could be given to these hospitals either by extending the cost-based outpatient provisions to all SCH, or by revising the inpatient rules for CAH facilities that qualify for more than one special rural designation.

Critical Access Hospitals are limited service inpatient facilities. Conversion to this status is a strategic decision that should be made in the context of clinical and community needs as well as financial objectives. This Findings Brief restricts analyses to the financial basis on which the decision might be made, but the reimbursement implications are only one component of a complex decision. Many rural facilities may find ways to reduce their unit costs, or may be able to respond to the challenges of expanded prospective payment systems with other strategies.

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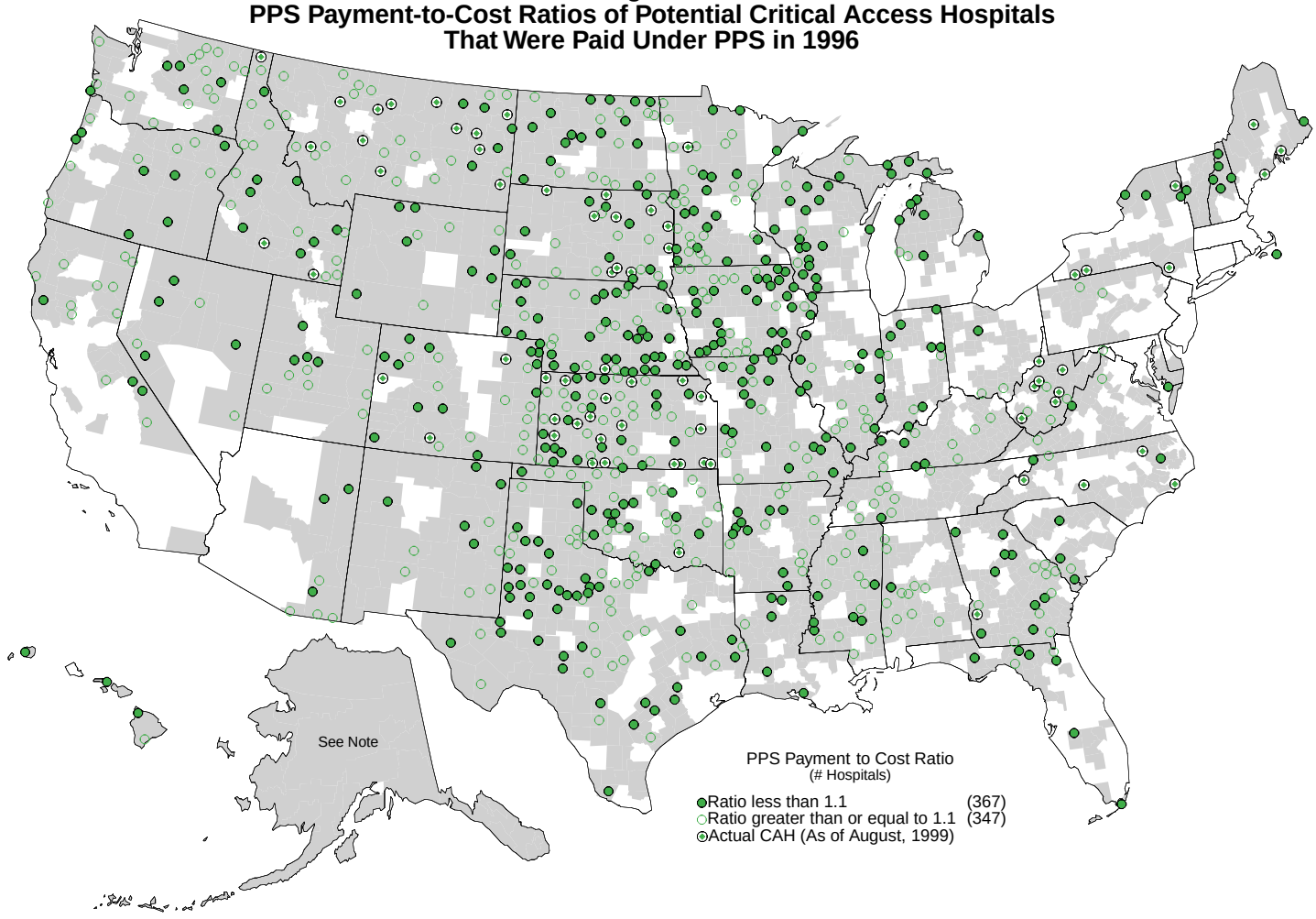
Figure 3
PPS Payment-to-Cost Ratios of Potential Critical Access Hospitals That Were Paid Under PPS in 1996



Source: Health Care Financing Administration; Hospital Cost Report Information System Minimum Data Set, PPS 13, 1996.

Produced By: North Carolina Rural Health Research Program, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

*Note: Nonmetropolitan Counties are shown in grey. Metropolitan Counties are aggregated into white areas on the map.

Potential CAHs could not be identified in Alaska due to Area Resource File limitations.

North Carolina Rural Health Research and Policy Analysis Program
Cecil G. Sheps Center for Health Services Research
CB# 7590, 725 Airport Road
University of North Carolina at Chapel Hill
Chapel Hill, NC 27599-7590
http://www.shepscenter.unc.edu/research_programs/Rural_Program/