Protecting Critical Access Hospital Stability

Policy Solutions

The stability of the rural health safety net is tenuous. Critical access hospitals (CAHs) across the country are struggling to maintain services in their rural communities. Policy intervention is needed to stabilize CAHs:

Removal of Unnecessary Regulatory Burdens

- The Administration should extend the COVID-19 flexibilities for rural hospitals through permanently removing the Condition of Payment requirements that Critical Access Hospitals length of stay be limited to 96 hours.
- The 35-mile standard currently required for cost-based reimbursement for CAH ambulance services should be eliminated.
- The ability of states to designate necessary providers as a means of meeting the CAH location requirements should be reinstated with appropriate qualifying criteria.

Increase Medicare Payments to CAHs

- Increasing or eliminating bad debt reimbursement would disproportionately affect rural hospitals that treat high numbers of low-income Medicare beneficiaries. Rural hospitals have Medicare bad debt percentages that are 60 percent higher than urban hospitals, on average. As such, the bad debt a rural hospital is liable for should be reduced from 30 percent to 15 percent or less. According to Chartis, current bad debt policy could have a $117 million impact and result in nearly 2,500 jobs lost for CAHs nationwide.
- In 2011, Congress passed legislation instituting a two percent sequestration reduction to all Medicare fee-for-service payments through 2031. Reductions in Medicare reimbursement due to sequestration, in addition to reductions in bad debt payments, impact the financial profitability of rural hospitals. This policy has a disproportionate impact on cost-based providers, such as CAHs, who are paid below their actual costs due to sequestration. According to Chartis, current Medicare sequestration policy could have a $139 million impact and result in nearly 2,800 jobs lost for CAHs nationwide.
- Change the cost report for Critical Access Hospitals so that a CAH is not penalized with a loss in Medicare reimbursed overhead when it incurs expenses for services not covered by Medicare that address social determinants of health (e.g., childcare or housing.)

Strengthen Supportive Programs

- Strengthen and support the 340B Drug Pricing Program, which provides discounts to safety net rural CAHs.
- Test new delivery and payment models for rural hospitals that promote financial sustainable access.
- Through the Medicare Advantage Program, incent insurers to cooperate with CAHS rather than undermine them. Enforce Medicare Advantage plans to pay settlement as with traditional Medicare and not allow plans to pay CAH rates longer than six-month intervials requiring annual settlement of reasonable expenses.

Recommended Action

- Support H.R. 6400, Save America's Rural Hospitals Act to improve and expand access to health care through sustaining CAHs. Provisions in this important legislation include the removal of the 96-hour rule, elimination of Medicare sequestration for rural hospitals, and
- Support H.R.1639/ S.644: Rural Hospital Closure Relief Act of 2021 to reinstate necessary provider status and allow additional hospitals to qualify as CAHs.
- Support H.R.5660, the Fairness for Rural Medicare Beneficiaries Act of 2021, to adjust coinsurance requirements for outpatient CAH services under Medicare.

Overview

The CAH Medicare designation was created in 1997 to reduce the financial vulnerability of rural hospitals and improve access to healthcare by maintaining essential services in rural communities. CAHs can have no more than twenty-five inpatient beds, must be located more than thirty-five miles from another acute care hospital (unless approved as a necessary provider of health services prior to 2006), maintain an annual average length of stay of 96 hours or less for acute care patients, offer outpatient services, and provide 24/7 emergency care

services. In statute, CAHs receive 101 percent cost-based reimbursement for both inpatient and outpatient services. However, due to the Budget Control Act's provision implementing Medicare sequestration, CAHs receive just 99 percent of allowable costs. Sequestration policies are currently in effect through 2031.

Since 2010, 138 rural hospitals closed, 64 of which were CAHs.[i] Long-term financial viability of CAHs is difficult because of low patient volume, lower than cost reimbursement, the health and socio-economic status of rural residents, higher rates of uncompensated care, challenging payer mix, and many other factors beyond hospital control.[ii,iii,iv,v] CAH closures are of great concern because they are often located further away from other hospitals. The median distance between a CAH and 1) the next closest hospital or 2) the next closest hospital with one hundred or more acute care beds is 18.6 miles and 36.5 miles, respectively, compared to 17.1 miles and 28.9 miles, respectively, for other rural hospitals.[vi] In addition, CAHs in very rural and geographically isolated areas often provide primary care as well as emergency, diagnostic, and outpatient services.[vii] With millions of Americans dependent on CAHs, it is imperative that policy be put in place to prevent their closures.

Affordability of Providing Care

Hospital provided care that is not reimbursed through patient or insurer payment is a foremost concern for CAHs.[viii] While CAHs typically serve higher cost patient populations due to the socioeconomic and health challenges of rural areas, they also serve a higher proportion of uninsured peoples and public insurance plan enrollees.[ix,x] For these reasons, CAHs report higher rates of uncompensated care and unrecoverable debt.[ii] From 2011 to 2017, nonprofit and profit CAHs experienced 13% and 88% decreases in profits, respectively, [xi] with nearly 20% of CAHs were at high or immediate risk of closure in 2020.[xii]

Public insurance expansion and increased reimbursement are critical to CAH viability. Currently, Medicare reimbursement to CAHs covers reasonable costs, but often does not cover additional costs required for the provision of services or allow for the realization of the operating margins needed to keep the doors open. CAHs make up 64% of all rural hospitals but only make up 37% of rural Medicare payments (Figure 1). From 2011 to 2017, rural hospital financial viability deteriorated significantly in states that did not expand eligibility for Medicaid.[xi] High-deductible health plans have been associated with increased deferred care, poorer outcomes, and more uncompensated care for hospitals may also contribute to uncompensated care.[xiii,xiv,xv] Rural residents are more likely to enroll in high-deductible health plans, placing a disproportionate uncompensated cost burden on CAHs.[xvi]

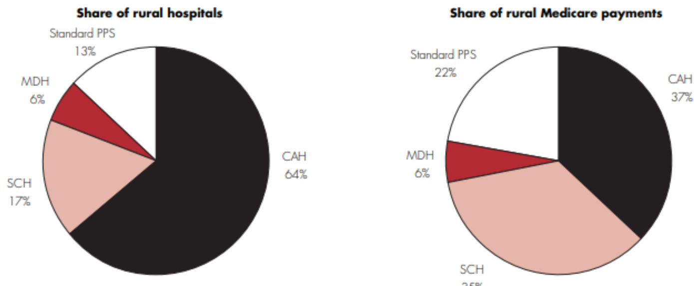

Figure 1. SCH (sole community hospital), MDH (Medicare-dependent hospital), PPS (prospective payment system). MedPac,

Infrastructure and System Challenges

CAHs operate in areas that are often located away from other health care facilities and where local infrastructure may be inadequate. For example, 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 and hampering coordination of care.[xvii] Recruitment and retention of health care professionals is an ongoing challenge for CAHs, with more than 60 percent of health professional shortage areas (HPSA) located in rural areas. Rural hospitals had increasing low or negative operating margins in 2020 while health insurers had unprecedented high profits. Some insurers have chosen this time to become extremely aggressive in undermining local rural hospitals. CAHs are small hospitals but they are anchor institutions for community and economic development-critical to much of rural America with shrinking economies. Finally, many rural hospitals need to update their facilities to align with community needs, yet lack of access to capital and narrow financial margins limit their ability to secure the necessary funds.

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