The Critical Access Hospital Modernization Act

Utilizing Critical Access Hospital Infrastructure to Provide Critical Services to Rural Communities

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Acronyms

ALOS	Average Length of Stay
CAH	Critical Access Hospital
CAHMA	Critical Access Hospital Modernization Act
CBR	Cost-based reimburse
CMS	Centers for Medicare and Medicaid Services
CoP	Conditions of Participation, Medicare
MAF	Medical Assistance Facilities
MAT	Medication Assisted Treatment
MCR	Medicare Cost Report
SNF	Skilled Nursing Facility

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I. THE PROBLEM

The medical needs of rural communities have changed in the past 22 years, but the eligible services defined by Medicare for critical access hospitals (CAHs) and the cost report payment methodology have not changed. Critical access hospitals receive cost-based reimbursement, including indirect costs (overhead), for eligible services. Home health, hospice, and behavioral health services such as acute mental health and substance use disorder treatment are not CAH Medicare cost report eligible services. Given the healthcare business environment in the 1990s, these exclusions are understandable, but this is no longer the case, as most private providers of these services have consolidated their business footprint into urban and suburban areas and are leaving rural communities. Critical access hospitals face the difficult decision of trying to operate these services to meet the healthcare needs of their community while being financially dis-incentivized to provide these services.

Need for Behavioral Health and Addiction Services

The opioid crisis disproportionately impacts rural communities. Social determinant risk factors such as lower educational attainment, unemployment rates, high-risk behaviors, isolation, and poverty contribute to rural communities being disproportionately affected by addiction.[1] A second factor increasing the rural-urban disparities is the lack of access to care. Individuals in rural locations experience behavioral health and substance use disorders at rates that are similar to those of their urban counterpart.[2,3] Despite having a similar need for services, only about 3 percent of all opioid treatment programs are situated in rural areas[4,5]. Although CAHs can provide medication assisted treatment in a primary care setting, there is a need for more intensive outpatient programs and full-fledged evaluation and treatment centers that provide both inpatient and intensive outpatient services. The lack of access to care is factor contributing to the opioid overdose deaths in rural communities surpassing urban areas by 45%.[6]

Case example:

In 2017, Jefferson Healthcare, a critical access hospital that serves East Jefferson County on the Olympic Peninsula in Washington State, explored the possibility of acquiring the struggling community mental health agency. The Medicare Cost Report (MCR) impact from adding a non-CAH cost-report eligible into Jefferson Healthcare's service line was between $411,000 and $550,000 and was determined to not be sustainable long term. This has limited Jefferson Healthcare's ability to partner with the mental health agency to serve the mental health and substance abuse disorder needs of their community.

Need for Home Health and Hospice Services

Home health services lead to better health outcomes and lower healthcare spending. Researchers have noted that a decrease in home health services would lead to an increase of expensive and often inappropriate treatment, including nursing home placement, hospitalization and readmissions, and/or emergency room use.[7,8] Hospice is the provision of palliative care, or comfort care, to patients who have a prognosis of less than six months. Both services are essential to rural communities since on average rural communities are older and

sicker than urban communities. Medicare currently views Home Health and hospice as a non-cost report eligible services, which means that CAHs that do provide these services to patients incur an MCR financial penalty.

Case example:
Jefferson Healthcare currently provides both home health and hospice services to the community. Each service line has an annual expense of approximately two million dollars. Because these are non-cost report eligible services, Jefferson Healthcare loses roughly $300,000 annually on the cost report.

Need for Skilled Nursing Services

Skilled nursing facilitates (SNF) provide 24-hour medical attention for medically vulnerable residents. SNFs are commonly used for short-term stays following surgeries or other procedures. Although a critical component of a community's health system, SNFs are not eligible services for cost-based reimbursement at CAHs.

Case example:
Forks Community Hospital in Washington State operates an SNF from their CAH licensure. The program has approximately a $150,000 annual deficit; the additional cost report penalty is almost $400,000, which is nearly half of the overall program revenue and puts the SNF at a half-million-dollar deficit. Forks Community Hospital continues to provide this service to the community because privately owned and operate SNFs have begun declining due to untenable finances, and aging rural communities have few other options.

II. CRITICAL ACCESS HOSPITAL BACKGROUND

Overview

Congress created the critical access designation through the Balanced Budget Act of 1997. A critical access hospital is a designation by the federal government which indicates the hospital has met certain conditions, referred to as the Medicare Conditions of Participation (CoP). Requirements for this designation include having 25 or fewer inpatient beds; offering 24/7 emergency care; be located further than 35 miles from the nearest hospital, or 15 miles on a secondary road; and, maintain an average length of stay (ALOS) for inpatient admissions of 96 hours or less. With over 1,300 critical access hospitals currently in operation, CAHs make up more than two-thirds of all rural community hospitals.[7]

Eligible Services and Cost-Based Reimbursement Model
The model for CAHs emerged from a federally-funded demonstration of what was termed 'Medical Assistance Facilities' (MAFs) in Montana. During the demonstration, one key question was the type of services that are appropriate to provide within a medical system located in a rural community. Despite early concerns that rural MAFs would attempt to provide highly specialized care to a community in order to maximize reimbursement, the pilot proved that rural medical systems self-regulated the types of services provided, primarily based on the type

of workforce that was able to be recruited to the areas and ability to ensure clinical competencies and the delivery of high quality care. However, when designing CAHs during the 1997 Balanced Budget Act, legislators were interested in placing boundaries around the types of services that could be provided by a CAH to the community. This led to the development of a list of services that are eligible to receive cost-based reimbursement on the Medicare cost report. Eligible services, or services that are incentivized on the CAH MCR, include emergency department services, inpatient unit, swing beds, and most outpatient services.

Critical access hospitals receive cost-based reimbursement from Medicare. This reimbursement mechanism allows cost-based reimbursement for 99 percent of the cost for the delivery of eligible services, including attributed indirect costs (overhead). Centers for Medicare and Medicaid Services (CMS) designed the Medicare cost report (MCR) to determine what payment is owed to CAHs. A financial document filed annually to Medicare, reported data includes the total costs of the institution, charges for care to all patients, the proportion of costs attributed to Medicare patients, and all Medicare payments received during that year. All services provided at a facility are included in the MCR; however, not all services receive cost-based reimbursement. If a CAH provides a service not identified as an eligible service, they do not receive cost-based reimbursement (CBR), and they also receive a Medicare cost report (MCR) financial penalty due to indirect costs being allocated to these non-CBR services.

III. PROPOSED SOLUTION

Critical access hospital infrastructure is a robust system that is designed to meet the needs of their rural communities. Minimizing the financial disincentives associated with providing non-CAH eligible services allows CAHs to provide services that are critical to improving the health of rural communities.

The ***Critical Access Hospital Modernization Act (CAHMA)*** seeks to allow CAHs to receive cost-based reimbursement for non-CAH eligible services and eliminate the MCR penalty.

IV. RECOMMENDATIONS

The CAHMA seeks to amend Title XVIII of the Social Security Act to clarify and expand reasonable cost for CAH payments under the Medicare program.

1. Describes expansion services as being considered ‘critical’ if not provided by other suppliers in the county, or if there is a distinct gap between the community’s need and capacity of other suppliers.
2. Expands CAH reasonable (and cost-based) indirect costs to cover the costs necessary to support a service delivery system to Medicare patients, without reducing reimbursement for necessary overhead when programs outside of the cost-based reimbursement model are added to a CAH’s set of services.

3. Expand allowable services under the critical access hospital cost-based reimbursement structure to include but not limited to:
    - Opioid use disorder treatment and other addiction services
    - Behavioral health services
    - Home health
    - Hospice
    - Palliative care
    - Ambulance services

V. CONCLUSION

The medical needs of rural communities have changed in the past 22 years, but the eligible services defined by Medicare for CAHs and the cost report payment methodology have not changed. Despite rural communities having disproportionate levels of opioid use, elderly individuals, and chronic illness, specialty behavioral health and substance use treatment, home health and hospice services, skilled nursing care, and EMS are considered non-cost report eligible services. If a CAH provides a non-cost report eligible service, they do not receive cost-based reimbursement and they also receive an MCR financial penalty associated with overhead; thus, disincentivizing CAHs to meet community healthcare needs. The Critical Access Hospital Modernization Act advocates for CAHs to receive cost-based reimbursement for non-cost report eligible services and eliminate the MCR penalty. By realigning the Medicare cost report to include critical community services that are not currently included on the Medicare cost report, rural communities can leverage CAH infrastructure to improve the health of their community.

Appendix 1: Washington State Non-Metro Counties with Behavioral Health and Skilled Nursing Facilities

Of the 18 non-metro counties as defined by the U.S. Department of Commerce in the state of Washington, all but one of these counties have a CAH present. Looking at behavioral health workforce deserts in these non-metro counties, all counties with no psychiatrists and/or psychiatric nurse practitioners have a CAH present, except for Wahkiakum (Exhibit 1). Furthermore, in the six non-metro counties with zero certified nursing homes per the Department of Social and Human Services, five of the six have CAHs present.

WA State Non-Metro Counties	CAH Present	Zero (0) Psychiatrists	Zero (0) Psychiatric Nurse Practitioners	Zero (0) Certified Nursing Homes (DSHS)
Adams	Yes	X	X	
Clallam	Yes			
Ferry	Yes	X	X	X
Garfield	Yes	X	X	X
Grant	Yes	X		
Grays Harbor	Yes	X	X	
Island	Yes			
Jefferson	Yes			
Kittitas	Yes	X		
Klickitat	Yes	X	X	X
Lewis	Yes			
Lincoln	Yes	X	X	X
Mason	Yes	X	X	
Okanogan	Yes	X	X	
Pacific	Yes			
San Juan	Yes	X	X	X
Wahkiakum		X	X	X
Whitman	Yes			

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[7] AHA advocacy Page https://www.aha.org/advocacy/critical-access-hospitals

[8] Public Law 105-33 – Aug. 5, 1997.