

Critical Access Hospital Modernization Act: The Impact of the Cost Report

Overview

Critical access hospitals (CAH), a federal designation for hospitals that meet Medicare Conditions of Participation and receive cost-based reimbursement, including indirect costs (overhead), for the list of eligible services determined in 1997. Cost-based reimbursement covers many services a hospital provides, including emergency department services, inpatient unit, swing beds, and most outpatient services. Home health, hospice, and behavioral health services such as acute mental health and substance use disorder treatment, among others, are not CAH Medicare cost report eligible services; these services are attributed significant overhead that is not paid by Medicare. The financial cost for providing these services by a CAH can range in the hundreds of thousands of dollars, and strongly disincentivizes critical access hospitals from providing what are critical services to undeserved communities. Given that CAHs provide the majority of healthcare to rural communities, a financial disincentive can be catastrophic to a hospital's ability to stay open and the community's ability to receive needed services.

The Impact of the Cost Report

In 2019, Jefferson Healthcare partnered with an auditor's firm to understand the financial disincentive for organizations providing non cost-based eligible services and the potential lost revenue. Looking at a total of 36 CAHs, the majority from Washington State, many of these facilities offered some sort of non-Medicare cost report cost-based eligible service. These services ranged from home health to hospice, ambulance services to skilled nursing facilities, retail pharmacies to occupational health service lines. Thirteen (36%) of the CAHs included in this evaluation did not provide any non-cost based eligible services at all.

The lost reimbursement was estimated based on a number of cost factors including estimated staffing, space, location and the number of allocated expenses would remain part of the overall book of business. Based on this information an algorithm was developed that estimated between 33% and 55% of attributable costs would be reimbursed back to the CAH if the service line was shut down. For a CAH that runs a skilled nursing facility in Montana, there is a financial disincentive estimated between \$445,000 to \$675,000. With a net patient service revenue of less than sixty-eight million dollars, three-quarters of a million in lost revenue is a significant cost. Due to their square-footage, skilled nursing facilities and other service lines that had significant space requirements have the most attributable overhead cost. Services like ambulances were relatively minor, with a financial disincentive ranging between an estimated \$170,000 to \$260,000 for one CAH in Washington. Although this seems more minimal, in an environment where rural healthcare systems are closing, these are incredibly difficult financial decisions to keep these services open.

Estimating the financial impact from the Medicare cost report is not an easy task but is critical when trying to understand the disincentive associated with providing necessary services to a community through what could be considered a failing economic model. In many communities, without the CAH providing these necessary services, there is no other options other than traveling great distances or not receiving care. Changing the reimbursement model to one that does not penalize CAHs for providing critical services is the most sustainable step to increasing access in rural communities.

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