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

Overview

Critical access hospitals (CAH), a federal designation for hospitals that meet several conditions known as the Medicare Conditions of Participation, provide the majority of healthcare to rural communities, 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, and 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.

Need for Behavioral Health Services

The opioid crisis disproportionately impacts rural communities, with opioid overdose deaths in rural communities surpassing urban areas by 45%.[1] Despite having a similar need for services as urban areas, a fraction of all opioid treatment programs are situated in rural areas. 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.

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.

This example of hospitals losing revenue for adding a needed service is repeated across the country. Providing home health, hospice, skilled nursing, and opioid treatment services are all non-cost report eligible services, and so adding these to the hospital results in significant financial losses

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.

By realigning the Medicare cost report to include critical community services that are not currently included as cost-based eligible on the Medicare cost report, rural communities will be better able to leverage CAH infrastructure to improve the health of their community.

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1 Hancock, C., Mennenga, H., Andrilla, H. (2017, February). Treating the Rural Opioid Epidemic. *National Rural Health Policy Brief* , Retrieved September 22, 2018, from https://www.ruralhealthweb.org/advocate/policy-documents