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.

The Impact of the Cost Report

In 2019, Jefferson Healthcare partnered with an auditor's firm to understand the financial disincentive for providing non cost-based eligible services, and what is potentially lost revenue for the organizations who provide services such as these. 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 factors. Because the overall formula is reliant on cost, the ability to predict what staff would stay and contribute to the cost of other services, or if a space would be repurposed, it is all variable depending on the location, size, and strategic priority of the CAH. However, estimating that a certain number of allocated expenses would remain part of the overall book of business and others would not, 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 what are necessary services to a community but through a failing economic model. The only situation in which a CAH had no financial disincentive or lost revenue was in cases where the hospital did not provide any non-cost based service; in many communities, without the CAH providing these services, there would be 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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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