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	FOCUS ON CRITICAL ACCESS HOSPITAL DEVELOPMENT:	Vol. 2, No. 1
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Steve McDowell



Dear Friends,

For the past decade, Rural Health Consultants has had the privilege of working with health care providers, rural community leadership, government, and others to assure access to quality health care services. During the past two years, we have assisted rural community health systems in meeting the challenges imposed by the Balanced Budget Act of 1997 (BBA 97) and, more recently, the Balanced Budget Refinement Act of 1999 (BBRA). A key element of BBA 97 is the Medicare Rural Hospital Flexibility Program (MRHFP), which creates the Critical Access Hospital (CAH) as a new type of provider eligible for Medicare cost-based reimbursement. Much of the responsibility for developing and administering this program falls on states and providers, a flexibility which brings both challenges and opportunities to participants.

Mike Fadden



We would like to take this opportunity to provide you with practical information we have gathered through our experience in assessing the potential for hospitals to convert to CAHs. In this issue of *Hot Topics in Rural Health*, we discuss the process of conducting a CAH financial feasibility analysis and case examples of our findings from the studies we have completed in the last year. These cases underscore the need for careful analysis and a thorough understanding of all the implications involved in making the conversion to a CAH. In addition, we provide some thoughts regarding the policy issues confronting each state in the continuing development of this important rural safety net program.

Sheldon Weisgrau



We hope these thoughts will be of value to you and your organization as you continue the mission of assuring access to quality health care services in your State and local community.

Sincerely,
 Steve McDowell, Mike Fadden, and Sheldon Weisgrau

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 Rural Health
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CAH IMPLEMENTATION issues

Financial Feasibility

Conversion to a CAH does not necessarily result in financial improvement and is not, therefore, an economically viable option for every rural hospital. A financial feasibility study is essential for determining the impact of CAH conversion on each hospital that considers participating in the program. The process of conducting a financial feasibility study requires three discrete steps:

Step 1: Assessment of board, administration, and medical staff understanding of the MRHFP and the CAH.

If hospital leadership understand the details of the program, it is appropriate to move on to Step 2. If understanding is not adequate, a focused education plan that covers issues such as the differences between a CAH and a hospital, CAH payment, the role of a network, etc. should be developed.

Step 2: Assessment of board, administration, and medical staff vision for the hospital and the community health system.

Hospital leadership should have a comprehensive vision of the role of CAH conversion in assuring access to quality cost effective health care services. If this vision is not developed, the hospital should pursue a process for consensus building on the future of the local health system and the role of a CAH in the system. When an appropriate vision has been established, move to Step 3.

Step 3: Conduct a feasibility study to assess the impact of CAH conversion on the hospital, based on the shared vision.

The data elements necessary for the CAH feasibility study vary depending on the circumstances of the hospital and the desired outcome.

Type 1: For those facilities with stakeholders who understand CAH, have a strategic plan which calls for no change in operations, have an ALOS of 96 hours or less, and have no operating days with a census of greater than 15, the necessary data element is the latest Medicare cost report. This data set will allow for an assessment of whether or not cost based Medicare reim-

“Conversion to a CAH is not an economically viable option for every rural hospital.”

bursement will increase facility revenues over current Medicare reimbursement.

Type 2: For those facilities with an ALOS of more than 96 hours, operating days in which the census exceeds 15, and/or a strategic plan that includes rural system building, a different type of feasibility study is needed. The data needed to conduct such a study will usually include, at a minimum:

For a common cost reporting year:

- ▶ Audited financial statements and notes;
- ▶ Medicare Cost Report and working papers;
- ▶ Trial balance for the last month of the reporting period;
- ▶ List of inpatient and outpatient services available during the reporting year;
- ▶ Description of changes in services during and after the reporting period;
- ▶ Departmental utilization statistics (i.e., lab tests, meals served, x-rays, etc.);
- ▶ Gross and net outpatient revenue by payor;
- ▶ Dates when acute care census exceeded 15 with actual census for each date;
- ▶ ADC and ALOS for the two years prior to study year; and
- ▶ Utilization data for each discharge for the common cost reporting year:
 - ▶ Patient identifier
 - ▶ DRG number
 - ▶ Date of Admission
 - ▶ Date of Discharge
 - ▶ Length of stay
 - ▶ Payor
 - ▶ Billed charges
 - ▶ Reimbursement
 - ▶ Discharge disposition

A comprehensive analysis using these data will provide hospital leadership with a reliable pro forma estimate of the bottom line effects of operating the hospital as a CAH. □

CASE examples

Reimbursement Alert!

As this newsletter was being completed, RHC became aware of a possible change in Medicare payment policy that could have serious consequences on CAHs. An apparent error in the BBRA provision eliminating beneficiary coinsurance for lab services has been interpreted by HCFA to require a change in reimbursement for these services from cost-based payment to payment based on the fee schedule. A draft revision to the Medicare Hospital Manual also notes this change and there is some concern that it applies to radiology services, as well. The increase in revenue from cost-based payment for lab services is often the determining factor in making conversion to a CAH financially viable. Returning to payment based on the fee schedule could mean financial failure for CAHs that converted from hospital status based on anticipated increases in lab payment.

RHC urges you to contact your fiscal intermediary and HCFA Regional Office for more information on this issue and ask your Congressional representatives to quickly remedy this error.

Case Examples Selected From Our Practice

Conversion to a CAH is not an economically viable option for every rural hospital. Each hospital has a unique set of variables that collectively determine the financial impact of converting to a CAH. In the table, below, four key variables are illustrated for nine hospitals. These data show that hospitals can have

similar variables with very different results. These few cases, selected from dozens of studies we completed in the last year, underscore the importance of conducting a thorough financial feasibility analysis before making a decision to convert to a CAH.

Hospital	ALOS	ADC	% Medicare Acute Care Days	Provider-based Rural Health Clinic	Bottom Line Impact
A	3.5	7.3	70.2	No	\$(411,502)
B	4.0	7.5	66.2	Yes	\$535,658
C	6.0	18.7	65.7	No	\$(773,181)
D	3.5	2.1	82.1	Yes	\$196,609
E	2.4	2.1	74.6	No	\$279,540
F	4.3	18.5	51.1	Yes	\$574,901
G	3.9	8.8	85.8	Yes	\$(351,932)
H	3.0	6.9	31.6	No	\$(70,379)
I	3.8	6.5	68.8	No	\$170,220

ALOS = Average Length of Stay

ADC = Average Daily Census

POLICY issues

With these more flexible federal requirements, it is now up to States to maintain network building as a cornerstone of the program.

The BBRA makes several changes to the MRHFP which fundamentally alter the nature of the program and make many more hospitals candidates for CAH conversion. These changes include a modification of the LOS provision from a per patient limit of 96 hours to an annual ALOS of 96 hours and a provision to allow for-profit hospitals and hospitals that closed or downsized in the last 10 years to reopen as CAHs. The BBRA also permits hospitals that are located in MSAs to be reclassified as rural if they are considered rural by their States or meet other criteria. These hospitals may then convert to CAHs or take part in other rural specific programs.

Chief among the BBRA changes is the modification of the LOS provision. Because virtually all hospitals have patients that stay more than four days, the 96 hour limit meant that inpatient utilization would decrease and clinical practice changes would be needed in hospitals that converted to CAHs. As a result, strong network linkages were necessary to define appropriate locations of care and provide for placement and treatment of longer stay patients.

Many small rural hospitals, however, maintain an annual ALOS of less than 96 hours. In these cases, no clinical changes are necessary to meet the CAH LOS requirement and the importance of effective network relationships is diminished. Even hospitals with ALOS over four days will have a much easier and less disruptive adjustment to the new LOS provision. Perhaps without realizing it, Congress has now established policy that allows many, if not most, small rural hospitals to be reimbursed on a cost basis if they so choose. While such payment policy will undoubtedly improve the bottom line of a great many hospitals, it also undermines one of the original purposes of the MRHFP—to enhance access to care through the development and support of rural

health networks. With these more flexible federal requirements, it is now up to States to maintain network building as a cornerstone of the program, through avenues such as grant making, regulation, and Medicaid payment incentives.

A provision of the BBRA that could have been a powerful incentive for network development is unlikely, unfortunately, to have that effect. Integrated Part B, or All Inclusive Outpatient Payment, would bundle facility and professional fees into a single cost based payment, encouraging integration between CAHs and their physicians. The BBRA language addressing this issue, however, is unclear and will need to be changed to have the desired effect.

With LOS no longer a major barrier to CAH conversion, the program limit of 15 beds (or 15 acute care patients in swing bed facilities) becomes more significant. As an expanded number of hospitals consider CAH conversion, the size and inpatient volume of potential CAHs will increase. Since federal policy now favors making CAH an option for many more small rural hospitals, it may now also make sense to loosen the restriction on the number of patients that may be treated in a CAH and change the 15 bed limit to an annual average daily census of 15.

While all these changes expand the pool of potential CAHs, other BBRA provisions will lessen the financial pressures that often lead to CAH conversion. Most notably, the provision that allows small rural hospitals to be held harmless from payment reductions as a result of outpatient PPS reduces the incentive for some hospitals to convert to CAHs, which are exempt from PPS. The hold harmless provision, however, expires in 2004 and in the meantime, MedPAC will conduct a study of the appropriateness of covering rural hospitals under PPS. □

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