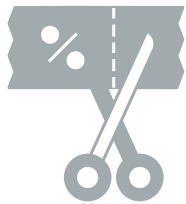




Protecting the Value of Federal Critical Access Hospital Designation

ISSUE

Growing enrollment in private Medicare Advantage plans in rural communities is destabilizing Critical Access Hospitals (CAH) and undermining the value of the federal CAH designation.



With increasing market penetration by private Medicare Advantage plans in rural areas, the benefit of being a federally designated Critical Access Hospital is cut in half.

Medicare Advantage plans do not follow the same rules or policies as traditional Medicare and are depriving CAHs of financial benefit and rural seniors of access to local health care – both Congressionally intended benefits of the CAH designation.

What is a Critical Access Hospital?

Texas has 86 federally designated Critical Access Hospitals.

Congress created the designation in 1997 in response to a wave of rural hospital closures. The intent of the designation is to reduce rural hospitals' financial vulnerability and maintain accessibility to health care in rural communities.

As a CAH, a hospital qualifies for traditional Medicare reimbursement at 101 percent of allowable costs for inpatient and "swing bed" services (rehabilitation care provided in the inpatient setting for patients who no longer need an acute inpatient stay but are not ready to be discharged).

To qualify as a CAH, a hospital must:

- Have 25 or fewer inpatient beds.
- Be more than 35 miles away from another hospital.
- Provide 24/7 emergency care services.
- Maintain an annual average length of stay of 96 or less for acute care patients.



There are solutions.

To restore the full Congressionally intended value of Critical Access Hospital designation and make Medicare Advantage a more reliable payer partner for Critical Access Hospitals, TORCH recommends the following CAH-specific legislative and regulatory solutions:

- 1 Require Medicare Advantage plans to follow traditional Medicare's cost-based reimbursement policy for CAHs.**

! Why This Matters:

Unlike traditional Medicare, Medicare Advantage plans are not required to reimburse CAHs at 101 percent of allowable costs. The negotiated payment amount may be comparable to or less than traditional Medicare rates but depends on the strength of the small local hospital's negotiating power with often much larger, national health plans.

In addition, Medicare Advantage plans are not required to cost settle with CAHs at the end of the hospital's fiscal year. In traditional Medicare, CAHs submit annual reports to account for Medicare costs and interim payments made throughout the year, and costs and payments are then reconciled annually so a CAH's allowable Medicare costs are fully reimbursed.

2 Allow CAHs to count Medicare Advantage patients as Medicare (not commercial) patients on required Medicare cost reports.

! Why This Matters:

Medicare cost reports count inpatient hospital days covered by Medicare Advantage plans as “commercial days,” not Medicare days. This means that if a hospital has 100 inpatient days for Medicare enrollees, 50 of which are paid for by a Medicare Advantage plan and 50 of which are paid for by traditional Medicare, only 50 days are counted on a hospital’s Medicare cost report. Not including Medicare Advantage days undercounts overall Medicare costs and reduces the value of cost-based reimbursement for traditional Medicare enrollees.

The Centers for Medicare & Medicaid Services also uses the data on Medicare cost reports to set future Medicare payment rates and to determine a hospital’s uncompensated care and DSH payments. CMS also uses the data to derive the wage index. Medicare payments are adjusted upward for areas with higher wage index values, and downward for areas with lower wage index values. When total Medicare costs do not reflect Medicare Advantage patient costs, overall costs are artificially deflated, with significant downstream effects.



3 Require Medicare Advantage plans to cover “swing bed” services.

! Why This Matters:

For Critical Access Hospitals, being able to provide post-acute inpatient hospitalization, rehabilitation care (i.e. physical therapy and speech therapy or skilled nursing) is how they keep patients close to home. When swing bed is not covered, Medicare Advantage enrollees who are hospitalized in an urban hospital can't return home to their rural community for post-hospitalization rehabilitation. This is a lose-lose for patients and for the rural hospital.

Contact us to learn more about leveling the playing field for rural seniors and hospitals >>

John Henderson

✉ jhenderson@torchnet.org

☎ (512) 873-0045