

The Financial Performance of Rural Hospitals and Implications for Elimination of the Critical Access Hospital Program

George M. Holmes, George H. Pink,
and Sarah A. Friedman

University of North Carolina at
Chapel Hill

NRHA, May 8 2013



A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

Flex | University of Minnesota
Monitoring | University of North Carolina at Chapel Hill
Team | University of Southern Maine



A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

**Flex
Monitoring
Team**

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Study Purpose

- To compare the financial performance of rural hospitals with Medicare payment provisions to those paid under prospective payment
- To estimate the financial consequences of elimination of the Critical Access Hospital (CAH) program.

Method

- Financial data for 2004-2010 were collected from the Healthcare Cost Reporting Information System (HCRIS). HCRIS data were used to calculate measures of the profitability, liquidity, capital structure, and financial strength of rural hospitals.
- Linear mixed models accounted for the method of Medicare reimbursement, time trends, hospital, and market characteristics. Simulations were used to estimate profitability of CAHs if they reverted to prospective payment.

Study Motivation

- Original: March 10 2011 CBO study entitled “Reducing the Deficit: Spending and Revenue Options.”
- Recent: President’s 2013-14 Budget that proposes CAH reimbursement at 100 percent of cost AND prohibit CAH designation for facilities that are less than 10 Miles from the nearest hospital: Beginning in 2014, this proposal would prevent hospitals that are within 10 miles of another hospital from maintaining designation as a CAH and receiving the enhanced rate. [\$690 million in savings over 10 years]



A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

Flex
Monitoring
Team

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Results

- Rural hospitals that are more profitable:
 - Lower proportion of Medicare and Medicaid
 - Non-government owned and for-profit
 - Lower patient deductions
 - Higher outpatient and inpatient volume
- Rural hospitals that are more liquid:
 - Higher inpatient volume
 - Lower patient deductions
 - Non-government owned



A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

Flex
Monitoring
Team

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Results

- Rural hospitals that have more debt:
 - Higher inpatient volume
 - Non-government owned and for-profit
- Rural hospitals and their market:
 - Hospitals with more population in their market area and higher market share have better financial performance.

Finding 1: CAHs are different

- CAHs had lower unadjusted performance than every other rural hospital type, particularly pre-MMA converters
- After adjusting for factors known to affect financial performance, CAHs do better than rural hospitals paid under PPS, which means the program has a generally positive effect on financial performance.
- Thus the financial performance of CAHs would be worse if they were paid under prospective payment.



A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

Flex
Monitoring
Team

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Finding 2: Time trends have varying effects across hospital types

- For profitability, the time trend for most hospitals has been negative
- However, the time trend for CAHs is approximately zero
- Cost-based reimbursement has helped insulate CAHs from the effects of the recession



A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

Flex
Monitoring
Team

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Finding 3: Hospital characteristics are more important than state-specific factors in explaining financial performance

- For example, the characteristics of a community served by a hospital may be more important than the level of Medicaid reimbursement in a state.
- Changes in financial performance may be attributable more to changes at the local level than at the state level



A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

**Flex
Monitoring
Team**

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Finding 4: Elimination of the CAH program would lead to marked deterioration in financial performance

- The percentage of current CAHs with negative total margin would increase from 28.2% to 44.0%.
- Consistent with other estimates, such as MedPAC's 2004 report estimating \$1 million in increased Medicare revenue in 2006 resulting from being a CAH



A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

**Flex
Monitoring
Team**

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Conclusion: On the one hand...

- CBO states that eliminating the CAH, MDH, and SCH programs would save money and move Medicare toward a payment structure that compensates all hospitals in a consistent manner because smaller rural hospitals would no longer be able to participate in programs that compensated them at relatively higher rate.



A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

**Flex
Monitoring
Team** | University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

On the other hand

- If hospitals are unable to reduce their costs under IPPS, increased financial pressure from elimination of special payments to CAHs, MDHs, and SCHs might force some hospitals to convert to outpatient facilities or to close.
- Patients who reside in those areas might have difficulty getting access to care. Fleming et al found that communities experiencing a hospital closure experienced an average increase in travel time of 30 minutes.



A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

Flex
Monitoring
Team

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

The bottom line

- Eliminating the CAH payment classification would have considerable adverse financial consequences on the hospitals: nearly half would have a negative total margin, challenging their ability to remain financially viable in the long run.
- Such a substantial reduction in financial support could lead to a renewal of the high closure rates of the 1990s with concomitant deleterious effects on the health and economic well being of these communities

GM Holmes, GH Pink, and SA Friedman

The Financial Performance of Rural Hospitals and
Implications for Elimination of the Critical Access
Hospital Program

Journal of Rural Health 29(2): Spring 2013, 140-49.