MOAB
MEDICAL DEVELOPMENT

Regulatory Risk is Changing the Critical Access Hospital Business Model

According to the August 2013 report written by Daniel Levinson, Inspector General of Health and Human Services, **64% or 849 of currently certified Critical Access Hospitals would not meet Medicare's twenty (20) year old certification standard for being at least 15 or 35 miles from the nearest hospital.** In addition, in 2014 the Obama administration's budget recommended reducing CAH reimbursement from 101% to 100% of reasonable costs. The President's then proposed budget estimated the savings over 10 years to be $1.4 billion from reducing reimbursement to 100 percent of reasonable cost and $690 million from eliminating the critical access certifications of CAHs located fewer than 10 miles from another hospital. ***Savings to Medicare are direct reductions in revenue to the CAHs dollar for dollar.***

Levinson's report also estimated using 2011 dollars that if ½ of all CAHs not meeting the location standard were decertified, Medicare and Medicare recipients would save $860,000 and $485,000 per decertified CAH, respectively. **In today's dollar that equates to nearly $1.6 million in reduced net revenue per de-certified CAH.** Clearly, few if any of these CAH's would survive those reductions.

Long story short, especially with a fiscally conservative Trump administration in place and additional reductions to follow with changes to the ACA, CAHs need to change their business models and not rely long term on the Critical Access Hospital reimbursement and instead convert their infrastructure and clinical business model to micro hospitals. **Converting to micro hospitals will expand market share, increase cash flows, reduce operating costs, provide more physician coverage, and improve quality of and access to care at the local level.**

Micro Hospitals V. Critical Access Hospitals – Listed below is a summary table highlighting differences between CAH and Micro Hospitals. Keep in mind, CAH is a reimbursement designation while Micro Hospitals are brand new facilities located in new markets with modern design and infrastructure. Interestingly, an existing CAH can be relocated and replaced with a modern micro hospital and still be designated a CAH.

	Critical Access Hospital	Micro Hospital
Total Beds	25 maximum	+/- 25 beds
Physician Offices	Nearby	In building
Clinical Services	Excess IP capacity, older technology	OP design, high tech, non-invasive, minor surgery
Physician Specialties	Out of town	In building and via telemedicine
Modern Infrastructure	Most over 50 years old, antiquated, excess capacity, more expensive infrastructure	Out Patient, High Tech, Energy efficient, consumer friendly, Eco friendly, optimized capacity
Location	64% do not meet CAH criteria, population often shifted	Consumer traffic; new markets, growing population
Health System Relations	Affiliated or independent; transfer agreement	Integrated and financially supported, part of network
Replacement Cost	~$20 million	~$10 million
Medicare Reimbursement	101% of cost	Can be a CAH or prospective

Reimbursement: In general, CAH designation largely is tied to location of the hospital compared to the nearest hospital and operating less than 25 acute beds including swing bed designations. CAH's receive Medicare reimbursement 101% percent of their reasonable cost compared to prospective payment hospitals which receive fixed payment per discharge adjusted for acuity of diagnosis. CAH reimbursement pushes them to increase costs, while prospective payment hospitals are pushed to reduce costs per discharge. Finally, CAHs treat all patients for all payors, but they are only paid differently for Medicare patients. Commercial insurers and networks, however, normally do not give CAHs special consideration. Micro hospitals can be certified as CAHs and also traditional prospective payment.

Physician Offices: Micro hospitals have physician offices integrated into the building with the hospital services on the first floor. Health Systems usually will place their employed physicians in the building along with marquee outpatient services. CAHs are limited by their historical infrastructure and local physician economics, so physician offices are generally nearby but not in the hospital building. For specialty physicians, the health systems will place those specialties in the micro hospital often supported by telemedicine. This compares to traditional CAHs which infrequently provide full time specialists on campus or in town.

Infrastructure: CAH is a reimbursement designation; it is not a facility design. Most CAHs are older hospitals (+50 years old) that converted their reimbursement designation by reducing active licensed beds to 25 or less. Older acute care hospitals were designed specifically for lengthy inpatient stays and little outpatient services. As a result older CAHs have excess inefficient capacity

and older clinical technology. Comparably, micro hospitals are designed as outpatient heavy / inpatient light complemented by physician office space. As a result building designs are compact, energy efficient, often eco-friendly, and with lower operating costs. Finally, replacing an older CAH with a micro hospital design can be approximately ½ the investment cost compared to a traditional hospital design due primarily to “right sizing” the micro hospital facility.

Location: Micro hospitals can be placed anywhere within state licensure guidelines; they are typically located in growing demographics where other non-healthcare consumer business are being added. Conventional CAHs due to their age operate from a spectrum of locations where the surrounding neighborhoods are generally residential and not new retail spaces.

Health System Relations: Critical Access Hospitals are defined by special Medicare reimbursement for rural areas. Managed care networks are generally not required to include them in network or provide any special reimbursement. Micro hospitals owned by a health system, however, are included in the health systems managed care contracts. Also, micro hospitals are conduits for higher level patient care at the health systems more advanced hospitals. As a result, the ER physicians and the onsite physicians at micro hospitals are generally contracted or employed by the health system. The stronger connection allows the health system to lease the physician office space in the micro hospital for its employed and contracted physicians. Health systems benefit supporting CAH facilities through providing upstream support for more acute services for which the CAH is not capable of providing. Thus it becomes another access point for the larger health system.

Revenue Cycle Management: An independent CAH employs staff contracts with 3rd party companies for revenue cycle functions. The micro hospital leased by the health system will apply the health systems revenue cycle resources to solidify continuity of care and data management.

Recommendation: CAH should not give up their CAH designation, even though it could be eliminated by regulatory risk. Instead, CAHs should review the financing costs and return on investment of building a replacement CAH designed as a micro hospital. Between the medical retail demand, better location and design, ambulatory care focus, and network strength with an advanced partner, micro hospitals have a comparatively brighter future than most independent CAHs.