

CAH/FLEX

National
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Project

FINDINGS FROM THE FIELD

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State Medicaid Payment Policies for Critical Access Hospitals

Although Medicaid revenue represents a comparatively small share of Critical Access Hospitals' (CAHs) overall business (7.2% of all days, on average), Medicare Rural Hospital Flexibility Grant Program (Flex Program) officials continue to report that these revenues are important to rural hospitals and that Medicaid reimbursement policies are a significant factor in deciding whether to convert to CAH status. To gain a better understanding of the role and impact of state Medicaid programs and policies in the implementation of the Flex Program, the Flex Program Tracking Team documented the methods states use to pay hospitals generally and CAHs in particular.

Data Source

- Telephone interview survey of the official(s) within each state Medicaid agency who was most knowledgeable about the state's reimbursement policies for inpatient, outpatient, home health, and skilled nursing facility services.
- Of the 47 states participating in the Flex Program, five are not included in the study results: Medicaid staff in three states (Massachusetts, Missouri, and New Mexico) declined to be interviewed, and in two states, Connecticut and Maryland, there are no certified CAHs and no expectation of conversions in the foreseeable future.

How Do Medicaid Programs Pay CAHs For Inpatient Care?

CAHs are entitled to receive cost-based reimbursement for all inpatient Medicare claims. While there is no such guarantee for Medicaid inpatient reimbursement, many states have created or had pre-existing, alternative Medicaid inpatient payment methodologies targeted to CAHs and/or rural hospitals.

Of the 42 states studied, 17 (40%) have created differential Medicaid inpatient reimbursement policies for CAHs. Forty-eight percent of all CAHs are located in these 17 states. In 11 of the 17 states, the special payment policy is a cost-based methodology achieved through annual cost settlement. Other approaches, described below, create the opportunity for some CAHs to receive more than cost, depending on the individual institution's cost structure:

- **Minnesota:** CAHs receive a 20% add-on to the diagnosis-related group (DRG) calculation.
- **Oklahoma:** CAHs receive a 38% enhancement to the per diem payment.

- **Kentucky:** CAHs are given nearly a 100% enhancement to the per diem rate paid to other hospitals.
- **North Carolina:** All Medicaid-participating hospitals are guaranteed DRG payments no lower than the 45th percentile. At the end of the fiscal year, if a CAH's Medicaid costs are above the 45th percentile, Medicaid promises 100% cost settlement. If their costs are below the 45th percentile, the facility keeps the difference, receiving more than costs for their inpatient Medicaid services.
- **New York:** All acute care hospitals within each of eight geographic regions are used as peer groups to determine a hospital's per diem rate. CAHs are guaranteed payment equal to 110% of the average payment for their region. This payment methodology likely benefits CAHs, because larger and higher volume hospitals are used in the calculation of average payments.
- **Ohio:** Any CAH Medicaid shortfall is recovered through payments from a disproportionate share hospital (DSH) pool protected for CAHs, with special criteria used to determine each CAH's share.

In six other states, CAHs benefit from enhanced payment structures that were developed for either all rural hospitals (4 states) or all small hospitals (2 states), so Medicaid officials feel there is no need for a preferential CAH policy. Except for the few CAHs located in urban counties, the 49 CAHs in these six states qualify for these alternative payment methodologies. Two of the six states have alternate payment methods that are cost-based. In the remaining four states, it is difficult to assess how beneficial the methodologies are for CAHs. For example, the Utah Medicaid program pays rural hospitals 94% of charges, a methodology that is more or less beneficial depending on the individual hospital's cost to charge ratio.

The remaining 19 states have not created preferential payments for CAHs or any other group of hospitals that might include CAHs. However, Medicaid officials in a number of states explained that the general reimbursement methodology used is not necessarily harmful to CAHs. For example, hospitals in Arizona are paid using a statewide per diem rate that benefits small rural hospitals, like CAHs, because the costs in these smaller hospitals are very likely to fall below the statewide average. In Louisiana, the per diem method is much like an interim rate, as DSH funds are used to offset all Medicaid shortfalls for rural hospitals. Finally, in some states, peer groupings have been designed to support small facilities with low patient volume. Thus, the pursuit of cost-based or other alternative inpatient Medicaid reimbursement policies is not necessarily a goal in all states.

In some states where creating special payment policies for CAHs has been an unrealized goal, contacts described past efforts to create a differential policy for inpatient Medicaid reimbursement for CAHs. Budget constraints have been the most common obstacle to implementing such changes. In at least five states, Medicaid officials reported that their state's financial condition prevented progress towards establishing an enhanced rate for inpatient Medicaid care in CAHs. Despite these obstacles, several state contacts explained that they plan to continue to push for the establishment of a differential inpatient reimbursement policy for their state's CAHs in the interest of strengthening the financial viability of these facilities.

How Do Medicaid Programs Pay CAHs For Outpatient Services?

Outpatient Medicaid business is often of greater financial importance than inpatient revenues for small rural hospitals. Officials in 13 of the 42 states studied reported that they have a special outpatient payment policy for CAHs. Although this represents fewer states than have adopted alternative Medicaid reimbursement policies for inpatient services, 45% of all certified CAHs are located in these 13 states. Nine of these 13 states reimburse CAHs for 100% of the costs associated with treating

Medicaid beneficiaries. The other four states provide an enhanced rate to CAHs, but do not guarantee 100% cost settlement. In two other states, Kentucky and North Dakota, it was not necessary to create a special policy for CAHs, as all hospitals are paid costs for outpatient care. Only one state contact (from California) reported that small rural hospitals have a different fee schedule than other hospital groups.

Has Risk-Based Medicaid Managed Care Had An Impact On CAH Payments?

In states with risk-based Medicaid health plans, most state Medicaid agencies told us that they do not get involved in the rate-setting process between the health plans and the hospitals. Only two states among the 27 that have risk-based Medicaid managed care in rural areas have systems to ensure that all CAHs receive cost reimbursement. Officials in one state said that the impact of risk-based health plan payments to CAHs had become an issue for several CAHs.

How Does Medicaid Reimburse CAHs For Other Hospital Services?

None of the state Medicaid officials we spoke with mentioned that there are any special provisions for payment of CAHs for psychiatric services. Among the 30 states where Medicaid officials offered information on payment of hospital-based skilled nursing facilities (SNFs), only Alabama and Hawaii have payment methodologies for SNFs in CAHs that differ from the ones used for other hospitals. There were no reported differences in payment for hospital-based home health services to CAHs versus other hospital types.

Do CAHs Receive Medicaid DSH Payments?

Although no regulations preclude CAHs from receiving DSH payments if they meet the necessary criteria, most do not have sufficient Medicaid or low-income volume to do so. Based on our interviews, West Virginia and Ohio are the only states that specifically target CAHs under their DSH programs. In both states, the objective is to compensate CAHs for some or all of their Medicaid shortfall. Georgia Medicaid officials described an effort to modify DSH policies to create an additional benefit for CAHs. Six other states have DSH provisions that benefit rural hospitals (including CAHs), though the policies were not designed to target CAHs.

What Is The Impact Of The Flex Program On State Medicaid Programs?

State contacts could not provide quantitative estimates of the financial impact of special payment provisions for CAHs on state Medicaid Programs. They were nearly unanimous, however, in their opinion that the impact of cost-based payment for CAHs on Medicaid expenditures is likely to be minimal, as most CAHs have very small Medicaid inpatient volume. Although outpatient Medicaid use is much higher among CAHs than inpatient use, the total outpatient volume and expenditures in CAHs accounts for a very small portion of statewide Medicaid outpatient volume and expenditures.

Where Can I Get More Information?

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About this Project: Check out our website <http://www.rupri.org/rhfp-track/>

Background

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. The Program:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
3. Encourages the development of rural-centric health networks.
4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

Previous Findings From The Field and Tracking Project Reports

Report:	Rural Hospital Flexibility Program Tracking Project Year Three
Vol. 2, No. 7:	State Flex Programs--Perspectives of the Flex Coordinators
Vol. 2, No. 6:	A Critical Access Hospital Update, September 2002
Vol. 2, No. 5:	Reauthorizing the Medicare Rural Hospital Flexibility Grant Program: Lessons from the Field
Vol. 2, No. 4:	Critical Access Hospitals and Community Development
Vol. 2, No. 3:	Administration in Critical Access Hospitals
Vol. 2, No. 2:	Regionalization of Emergency Medical Services: The Experience of Michigan's Upper Peninsula
Vol. 2, No. 1:	Impact of the Rural Hospital Flexibility Program on Rural Emergency Medical Services: Evidence From the First Two Years

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