Chapter 5

State Medicaid Payment Policies for Critical Access Hospitals

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Introduction

In an increasing number of states, state offices of rural health and critical access hospitals (CAHs) report the growing importance of the Medicaid program to the financial health of CAHs. Although Medicaid revenue represents a comparatively small share of CAH's overall business (10.2% of gross revenues, on average[1]), Flex Program officials continue to report that Medicaid revenues are important to rural hospitals and that Medicaid reimbursement policies are a significant factor for hospitals in the decision of whether or not to convert to CAH status. In states with risk-based Medicaid managed care programs, there is an additional concern over the impact that capitated or discounted payments may be having on CAHs.

To gain a better understanding of the role and impact of state Medicaid programs and policies in the implementation of the Flex Program, the University of North Carolina (UNC) and the University of Southern Maine (USM) collaborated in a survey of the 47 states with Flex Programs to (1) document the methods states use to pay hospitals generally, and CAHs in particular, for inpatient, outpatient, home health and skilled nursing services, (2) assess the impact that cost-based and other enhanced payment approaches targeted to CAHs have had on state Medicaid programs, and (3) describe the role that Medicaid agency staff have played in the implementation of the Flex Program.[2] This chapter summarizes the survey methods and findings.

Approach

This study is based on a telephone interview survey of state Medicaid agencies. Using a semi-structured interview guide, we attempted to contact the official(s) within each state Medicaid agency who was most knowledgeable about the state's reimbursement policies for inpatient,

[1] Data obtained from the Year 3 survey of CAH administrators conducted by the Tracking Team.
[2] Three states were not contacted. New Jersey and Rhode Island are not eligible to participate in the Flex Program because they are completely urban (MSA) states. Delaware has chosen not to participate in the Flex Program because it has no hospitals interested in pursuing the CAH designation.

outpatient, home health, and skilled nursing facility services. Of the eligible 47 states, 5 are not included in the study results: Medicaid staff in 3 states (Massachusetts, Missouri, and New Mexico) declined to be interviewed, and in 2 states, Connecticut and Maryland, there are no certified CAHs and no expectation of conversions in the foreseeable future.

The interviews with Medicaid officials requested information about: (1) the state's reimbursement policies for inpatient, outpatient, psychiatric, skilled nursing, and home health services, (2) any special provisions for hospitals designated as CAHs or any other special types of providers, (3) the state's Disproportionate Share Hospital (DSH) program and any other Medicaid supplemental payment programs, (4) the impact of special payment policies on the Medicaid program, and (5) the Medicaid program's participation in the development and implementation of the Flex Program. A copy of the interview guide is appended.

Inpatient Care

Hospitals designated as CAHs are exempt from the Medicare Prospective Payment System (PPS) and are instead entitled to receive cost-based reimbursement for all inpatient Medicare claims. There is no such guarantee for Medicaid inpatient reimbursement, though in many states there have been efforts by Flex Program directors, state hospital associations and other hospital advocacy groups to establish an identical Medicaid inpatient reimbursement policy. It is important to note that whether cost-based reimbursement is the most advantageous payment methodology depends on the individual hospital's cost structure. However, although some hospitals may receive payments that are above costs under PPS, these institutions are less likely to choose to convert to CAH.

As shown in Table 1, 17 states (40% of the 42 states studied) 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 cost-based reimbursement through annual cost settlement. Throughout the year, hospitals are paid based on an interim rate that resembles the rate used for other hospitals. The interim rate may be based on Diagnostic Related Group (DRG) or Level of Care (LOC) grouping, a per diem allowance, a cost to charge ratio, or a standard percentage of charges method. It is important to note that an interim rate is not necessarily a lower payment; in fact, many hospitals are overpaid through the interim rate and must repay the excess during annual reconciliation under an agreement for strict cost-based reimbursement (which provides that a hospital shall receive no more than reasonable costs for services).

While cost-based reimbursement is the most common method for enhancing payments to CAHs, it is not the only approach states have taken, and in fact, other approaches create the opportunity for some CAHs to receive more than cost, depending on the individual institution's cost structure. For example, Oklahoma and Minnesota have a standard rate enhancement for all inpatient services delivered in CAHs. In Minnesota, the enhancement is in the form of a 20 percent add-on to the DRG calculation. In Oklahoma, CAHs receive a 38 percent enhancement

to the per diem payment. Kentucky provides CAHs with nearly a 100 percent enhancement to the per diem rate paid to other hospitals.

In North Carolina, the Medicaid program was reluctant to create a special payment methodology for CAHs, for fear of creating tension between facilities. Nevertheless, the agency felt a sense of responsibility to sustain local hospitals and recognized that the cost of the payment enhancement initiative was 'minimal' in the overall budget. The Medicaid program created a payment policy that is even better than cost-based reimbursement for many CAHs, and is perhaps the most generous payment methodology we learned of for CAHs. All hospitals are guaranteed DRG payments no lower than the 45th percentile for all North Carolina Medicaid participating hospitals. This 'payment floor' method is a clear advantage for small, low volume hospitals such as CAHs, whose costs are likely below the 45th percentile. At the end of the fiscal year, the North Carolina Medicaid program makes supplemental payments to all hospitals based on their cost reports in an attempt to reduce the hospitals' Medicaid deficits. If a CAH's Medicaid costs are above the 45th percentile, Medicaid promises 100 percent cost settlement through the supplemental payment; if their costs are below the 45th percentile, the facility keeps the difference, receiving more than costs for their inpatient Medicaid services.

Table 1. States with Differential Medicaid Inpatient Reimbursement Policies for Critical Access Hospitals

State	Interim Rate with 100% Cost Settlement	Method of Enhanced Payment	# CAHs[1]
Arkansas	✔		15
Hawaii*	✔		6
Iowa*	✔		35
Kentucky*		Enhanced per diem rate	13
Maine*	✔		6
Minnesota*		DRGs with 20% add on	33
Montana	✔		24
Nebraska	✔		55
Nevada	✔		5
New York*		110% of regional per diem average	7
North Carolina		Payment floor with 100% cost settlement	9
Ohio		Shortfall recovered through DSH payments	9
Oklahoma		Per diem rate with 34% add-on	16
Oregon*	✔		10
Washington	✔		17
West Virginia	✔		11
Wisconsin*	✔		21
Total			292

*Special payment does not apply to hospitals participating in Medicaid HMOs.
[1]Source: RHFP Tracking Team Website (www.rupri.org). Current as of May 1, 2002. The total number of CAHs=600.

New York and Ohio have slightly different approaches. In New York, all acute care hospitals are assigned to one of 8 geographic regions, and the hospitals within each region are used as peer groups to determine a hospital's per diem rates. CAHs in the region are guaranteed payment equal to 110 percent 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's approach is unique in that any CAH's Medicaid shortfall is recovered through DSH payments. Unlike other state DSH programs, there is a DSH pool protected for CAHs, with special criteria used to determine each CAH's share.

In addition to the states that have created differential policies for CAHs, there are other states where CAHs benefit from enhanced payment structures targeted to either all rural hospitals or all small hospitals. According to Medicaid officials, there is no need for a preferential CAH policy in these states because CAHs are eligible for enhanced reimbursement through these targeted reimbursement policies.

Table 2 identifies states with special payment policies for rural or small hospitals that apply to CAHs, but were not created specifically for CAHs (and many of which pre-dated the implementation of the Flex Program). In four of the six states, all rural hospitals are exempt from the standard inpatient reimbursement methodology applied to urban hospitals. In the other two states, small hospitals are exempted from the standard payment methodology. Except for the few CAHs located in urban counties, the 49 CAHs in these six states qualify for these alternative payment methodologies.

Two states' Medicaid inpatient policies reimburse CAHs at cost: In Idaho, CAHs are guaranteed 100 percent cost-based reimbursement through settlement and California's policy is essentially cost-based reimbursement. In the remaining four states, it is difficult to assess how beneficial the methodologies are for CAHs. For example, in Utah, Medicaid pays rural hospitals 94 percent of charges, a methodology that is more or less beneficial depending on the individual hospital's cost to charge ratio.

Table 2. States with Medicaid Inpatient Reimbursement Policies Specific to Rural or Small Hospitals

State	Description of Payment Methodology	# CAHs[1]
Alabama	All rural hospitals exempt from 80th percentile ceiling placed on prospective per diem rate. Hospitals are also eligible to receive low-occupancy adjustment if they meet criteria for supplemental payment.	0
Alaska	All small hospitals (≤ 4,000 acute days) may elect to contract for rate outside of normal PPS rate.	4
California	All rural hospitals paid lowest of customary charges or allowable costs.	9
Idaho*	All hospitals with fewer than 40 beds paid 100% of costs through annual settlement	18
Illinois	All rural hospitals paid using prospective DRG or cost-based per diem methodologies (hospitals select).	18
Utah*	All rural hospitals exempt from DRG system and are paid 94% of charges.	0
Total		49

*Special payment does not apply to hospitals participating in Medicaid HMOs.

[1]Source: RHFP Tracking Team Web site (www.rupri.org). Current as of May 1, 2002. The total number of CAH=600.

Table 3 identifies the inpatient Medicaid reimbursement payment methodologies in all other states. Again, it is important to point out that while these 17 states have not created preferential payments for CAHs, or any other group of hospitals that might include CAHs, the payment methodologies do not necessarily result in losses for the hospitals. In 9 states, hospitals are reimbursed prospectively using a DRG methodology, and 4 of these 9 rely on peer groupings to

set the DRG rates. The peer groupings serve to estimate costs based on hospital size or geographic location and recognize differences in patient volume in the rate setting process. Other

states pay hospitals a per diem for all inpatient Medicaid claims and some employ peer groupings to establish the rates for hospitals, again by size or geographic location.

Table 3. Inpatient Medicaid Reimbursement Methodology in States with No Special Payment Categories

State	Description of Payment Methodology	# CAHs[1]
Arizona	Prospective per diem rate	5
Florida	All inclusive per diem rate	7
Georgia	DRG payment system based on peer groups (all rural grouped together)	22
Indiana	Level of Care (LOC)/DRG method	12
Kansas	DRG payment system based on peer groups	45
Louisiana	Prospective per diem based on peer groups. DSH payments make up 100% of Medicaid shortfall for all rural hospitals	9
Michigan	Prospective DRG payment system	14
Mississippi	Per diem based on peer groups	7
North Dakota	DRG payment system based on peer groups	28
Pennsylvania	Prospective DRG payment system	5
South Carolina	Prospective DRG payment system. Some small hospitals eligible for quarterly supplemental payments.	1
South Dakota	DRG payment system. Some hospitals (including CAHs) may qualify for supplemental payments as 'At-Risk' or 'Access-Critical' Providers	27
Tennessee	Varies by health plan, but most commonly a per diem rate	6
Texas	Prospective DRG payment system based on peer groups	29
Virginia	DRG payment system	2
Vermont	All inclusive per diem rate based on peer groups	3
Wyoming	Prospective per discharge payment based on LOC categories	1
Total		223

[1]Source: RHFP Tracking Team Website (www.rupri.org). Current as of May 1, 2002. The total number of CAHs= 600.

In Tennessee, all Medicaid beneficiaries are enrolled in fully capitated managed care plans and hospitals negotiate their rates with the health plans. Thus, Medicaid does not have specific policies for hospital reimbursement for any category of hospitals. Although Tennessee (TennCare) currently does not have a special inpatient payment policy for CAHs, the state has attempted in the past to reconcile Medicaid losses for these hospitals and efforts are underway to establish a new reimbursement policy for the state’s six CAHs. In the past, a pool of money was allocated for a program called the Essential Access Hospital Program. Much like a DSH program, hospitals qualified for a share of the funds based on their TennCare (Medicaid) and uninsured volume. CAHs were guaranteed a minimum $50,000 payment regardless of the size of

their low-income population. Budget constraints have prevented the continuation of this program, but the Tennessee Hospital Association and TennCare are finalizing a proposal for cost-based reimbursement for CAHs and hope to present the plan for approval in the near future.

South Carolina and South Dakota also have supplemental payment programs for certain small or at risk hospitals. CAHs may qualify for these payments, but must meet the same eligibility criteria as any other hospital.

Many of the contacts from states without special payment policies 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. For example, Arizona secured a $1.7 million appropriation to supplement CAHs payments, only to have this fund reduced to $260,000 because of recent budget problems. Despite these obstacles, several state contacts explained that they will 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.

In a number of states, Medicaid officials explained that the reimbursement methodology used (for all hospitals) 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 the 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.

Outpatient Services

Reimbursement for Medicaid outpatient care is also an issue of great concern to CAHs. As for many small rural hospitals, outpatient Medicaid business is often more important financially than inpatient revenues. As seen in Table 4, 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, these 13 states have large concentrations of CAHs: only 31 percent of states have a special CAH outpatient payment policy, but 45 percent of all certified CAHs are located in these 13 states.

Table 4. Special Outpatient Medicaid Reimbursement for Critical Access Hospitals

State	Interim Rate with 100% Cost Settlement	Other Method	# CAHs[1]
Arkansas	✔		15
Georgia	✔		22
Idaho		CAHs are paid using cost to charge ratio but are not subject to the 5.8% reduction like other hospitals	18
Iowa*	✔		35
Minnesota*	✔		33
Montana	✔		24
Nebraska	✔		55
North Carolina		CAHs are paid 80% of their costs plus a supplemental payment.	9
Oregon	✔		10
Washington		Cost to charge ratio and fee schedule	17
West Virginia	✔		11
Wisconsin*	✔		21
Wyoming		70% of billed charges	1
Total			271

*Special payment does not apply to hospitals participating in Medicaid HMOs.
[1]Source: RHFP Tracking Team Website (www.rupri.org). Current as of May 1, 2002. Total number of CAHs= 600

Nine of these 13 states reimburse CAHs for 100 percent of the costs associated with treating Medicaid beneficiaries. The other four states provide an enhancement to CAH outpatient rates, but do not guarantee 100 percent cost settlement. North Carolina reported that while its goal is to bring the payments to CAHs as close to costs as possible, the lack of good and timely data from the hospitals makes it difficult to achieve 100 percent cost-based reimbursement.

Most Medicaid agencies have not implemented a preferential outpatient payment for CAHs and continue to pay them as all other hospitals are paid (Table 5). In two 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. In other states the method varies, but the most common methods for calculating payments are by using a fee schedule or a cost to charge ratio. Some states use different methods for different procedures; for example Vermont uses a fee schedule for labs and x-rays and a cost to charge ratio for other services. Peer groupings were not as commonly employed for outpatient payment calculations as for inpatient reimbursement. Only one state, California, reported that small rural hospitals have a different fee schedule than other hospital groups.

Table 5. Medicaid Reimbursement for Outpatient Services in States without Preferential CAH Policy

State	Interim Rate with 100% Cost Settlement	% of Charges	Fee Schedule	Cost to Charge Ratio	Other Method	# CAHs[1]
Alaska		✔				4
Alabama			✔			0
Arizona				✔		5
California			✔			9
Florida			✔			7
Hawaii			✔			6
Illinois					Lower of charges or fee schedule	18
Indiana					Flat rate or fee schedule	12
Kansas			✔			45
Kentucky	✔					13
Louisiana			✔		All rural hospitals recover Medicaid shortfall through DSH payments	9
Maine				✔		6
Michigan			✔			14
Mississippi					Lowest of: 75% of charges or a cost to charge ratio	7
North Dakota	✔					28
Nevada					Current Procedural Terminology (CPT) codes associated with fee schedule	5
New York					Per visit rate and DRG methodologies	7
Ohio			✔			9
Oklahoma			✔			16
Pennsylvania			✔			5
South Carolina			✔			1
South Dakota					Hospitals with more than 30 inpatient discharges are paid costs for outpatient services; facilities with less than 30 inpatient discharges receive 90% of charges	27
Tennessee					Method varies; hospitals negotiate rates with MCOs	6
Texas					TEFRA cost basis minus 20%	29
Utah		✔				0
Virginia					95% of allowable costs	2
Vermont					Cost to charge ratio and fee schedule	3
Total						293

[1]Source: RHFP Tracking Team Website (www.rupri.org). Current as of May 1, 2002. The total number of CAHs=600.

The Impact of Risk-Based Medicaid Managed Care on CAH Payments

An important caveat to our discussion of special, enhanced inpatient and outpatient Medicaid payment methodologies is that these policies usually do not apply to hospitals that participate in Medicaid managed care plan networks. In states with risk-based Medicaid health plans, state Medicaid agencies told us that they do not get involved in the rate-setting process between the health plans and the hospitals. We interviewed Medicaid officials in 22 states that have at least some risk-based Medicaid managed care in rural areas. Only two states, Oregon and Washington, have systems to ensure that all CAH receive cost reimbursement. Oregon achieves this by requiring managed care organizations (MCOs) to pay CAHs (and all hospitals with fewer than 50 beds) on a cost basis. Washington's approach is annual cost settlement: MCO payments to CAHs are raised to the reimbursement levels that non-MCO CAHs are receiving. In at least one state, Minnesota, state officials said that the impact of risk-based health plan payments to CAHs had become an issue for several CAHs.

Medicaid Payment for Other Services

Inpatient Psychiatric Care

None of the state Medicaid officials we spoke with mentioned that there are any special provisions for payment of CAHs for psychiatric services. Of the 33 state contacts who provided data on payment methods for inpatient psychiatric care, 17 described a payment methodology for inpatient psychiatric care that differs in some way from that used for reimbursing other inpatient care, but these differences apply generally across hospital types and are not specific to CAHs.

Hospital-Based Skilled Nursing Facilities

Among the 30 states where Medicaid officials offered information on payment of hospital-based skilled nursing facilities (SNFs), only Alabama and Hawaii have a payment methodologies for SNFs in CAHs that differs from the one used for other hospitals. In Alabama, CAH-based SNFs may receive an enhanced payment, not to exceed Medicare upper limit payments in the aggregate. Hawaii provides CAH-based SNFs with an exception process for costs in excess of routine cost limits, up to 200 percent of the routine limit. Three state contacts reported that none of their state's CAH's operate hospital-based SNFs.

Hospital-Based Home Health Services

There were no reported differences in payment for hospital-based home health services to CAHs versus other hospital types. Of the 30 state contacts that provided information on home health payment methodologies, at least 50 percent use a fee schedule. One state, New York, pays hospital-based home health agencies (HHAs) 110 percent of the rates paid to freestanding HHAs,

but this payment is offered to HHAs based in any type of hospital. In two states -- Montana and Vermont -- there are no hospital-based HHAs, and seven other state contacts were unable to answer the home health question.

Medicaid Disproportionate Share Hospital Payments

Overview of the Medicaid Disproportionate Share Hospital Program

Prior to 1981, states were required to pay hospitals the same rates for Medicaid patients as the federal government paid hospitals for Medicare patients. The Omnibus Budget Reconciliation Act of 1981 (OBRA '81) gave states the flexibility to develop Medicaid inpatient hospital reimbursement systems that differed from Medicare's. With this flexibility came the concern that states would use the provisions of OBRA '81 to cut Medicaid payment rates, thereby creating difficulties for hospitals serving large numbers of Medicaid and uninsured patients. To minimize the potential negative impact on these hospitals, OBRA '81 included a requirement that states make "additional" Medicaid payments to hospitals that serve a disproportionate number of low-income patients with special needs. The requirement to make additional payments to these hospitals became known as the Disproportionate Share Hospital or DSH program.

It is important to distinguish Medicaid DSH from Medicare DSH as they are two separate programs. Medicare DSH was established by the Tax Equity and Fiscal Responsibility Act of 1982 in order to protect "public or other hospitals that serve a significantly disproportionate number of patients who have low income or who are entitled to inpatient benefits under Part A."[3] The 1986 Comprehensive Omnibus Budget Reconciliation Act (COBRA) established the actual criteria for designating Medicare DSH hospitals and creating a DHS payment system. The Medicare DSH qualifying criteria establish disproportionate share patient percentage thresholds that hospitals must meet or exceed to qualify for DSH payments. These payments are made directly to the qualifying hospitals as add-ons to the Medicare DRG rates. CAHs, as a result of receiving Medicare cost based reimbursement, do not qualify for Medicare DSH payments.

How Does DSH Work?

States make DSH payments to qualifying hospitals (based on Medicaid or low-income utilization) to help finance the cost of providing care to uninsured people and Medicaid beneficiaries. The federal government reimburses the states for a portion of these payments, the exact portion of which depends on each state's Medicaid matching rate. Federal law mandates, at minimum, that states make DSH payments to hospitals that have a Medicaid inpatient use rate of at least one standard deviation above the mean of Medicaid inpatient utilization for the state, or a low-income use rate of 25 percent or more. As federal law also allows states broad flexibility in

[3] Public Law 97-248, Sec. 101.

the design of their DSH programs, states can go beyond the minimum federal requirements and make DSH payments to hospitals with Medicaid inpatient use rates as low as one percent. As a result, states exhibit a great deal of variability in their total spending on DSH programs as well as the methods used to determine which hospitals will receive DSH payments, how payments will be divided among eligible facilities, what the size of DSH payments will be, and whether conditions are imposed on hospitals that receive DSH payments.

In order to control the dramatic growth in federal Medicaid spending that occurred through the early 1990, Congress has imposed restrictions on how states finance their share of the DSH program and how they use federal DSH funds. The most recent of these restrictions has included the new Medicaid Upper Payment Limits (UPL), which limit the amount of extra federal Medicaid payments states can claim through intergovernmental payments from public hospitals and nursing homes. Essentially, the UPL restriction limits the extent to which states can group facilities together for purposes of calculating upper payment limits. This effectively reduces the amount of money that can be paid to state-owned public facilities and the level of potential intergovernmental transfers back to the state. As states use these intergovernmental transfers from public facilities as a major source of funding for their share of DSH payments, some states may be forced to reduce the size of their DSH programs.

DSH Payments for CAHs

Most states do not have special DSH payment provisions for CAHs and/or other small rural acute care hospitals. States without specific rural provisions tend to use the standards of Medicaid inpatient and low-income utilization standards established under the provisions of OBRA '81. Although no regulations preclude CAHs from receiving DSH payments if they meet the necessary criteria, most do not have the Medicaid or low-income volume to do so. Under the funding formulas established by the states, large urban public hospitals that tend to provide a large volume of Medicaid and indigent care receive the largest share of DSH payments. CAHs, in general, receive comparatively little DSH funding under these formulas. According to the Tracking Team's Year 3 survey of CAH administrators, only 22 percent of the responding hospitals receive DSH funds.

Based on our interviews, West Virginia and Ohio are the only states that specifically target CAHs under their DSH programs. In West Virginia, CAHs receive 100 percent of their uncompensated care costs (Medicaid discounts, indigent care, and charity care) under the DSH program. In the year following conversion, CAHs receive an initial cash infusion, as DSH payments include Medicaid uncompensated care costs for the year prior to conversion. In subsequent years, the total DSH payments to CAHs are reduced, as they no longer incur Medicaid contractual discounts due to the provision of cost-based reimbursement under the Medicaid program. The decision to provide CAH with 100 percent payment for uncompensated care was very controversial in that it required redistribution of the entire pool of DSH monies, thereby cutting the amount available to all other hospitals.

Ohio's DSH program, known as Hospital Care Assurance Program (HCAP), is run by the Ohio Department of Human Services in consultation with the Ohio Hospital Association. In 2001, HCAP established a separate DSH pool for CAHs. Although CAHs are small facilities that provide small amounts of indigent care relative to larger indigent care providers, the state recognizes through this pool that the existence of CAHs is crucial to the communities they serve, and that their uncompensated indigent care costs are often a large portion of their total facility costs.

Two additional states are considering or are in the process of making changes to their DSH programs for CAHs. Georgia has submitted plan amendments to expand DSH payments to state facilities and public CAHs to cover outpatient services, although the status of those amendments is unknown at this time. It is estimated that public CAHs, in the aggregate, will receive approximately $7.0 million in additional payments once the amendment goes into effect. In comparison, as a result of negotiations with the Iowa Hospital Association, Iowa is changing its DSH rules so that CAHs will no longer qualify for DSH payments. This change is based on the premise that CAHs already receive 100 percent of costs under the Medicaid program, thereby making DSH less important.

Rural-Specific DSH Payment Arrangements

In addition to the CAH-specific DSH payment arrangements described above, six states (Alaska, Georgia, Louisiana, South Carolina, Texas and Washington) have established special DSH payment arrangements that specifically target rural hospitals.

Georgia defines nine criteria for qualification for DSH funds, of which one targets small rural hospitals—public hospitals with less than 250 beds located in a non-MSA, with an inpatient utilization rate of at least one percent. Hospitals with less than 100 beds located in rural counties (including CAHs) receive a payment adjustment equal to 100 percent of the cost of covered services for patients without health insurance plus the cost of covered services provided to Medicaid patients, net of payments received and subject to maximum limitations described in the regulations. The standards established by the State of Georgia make it easier for rural hospitals (including CAHs) to qualify for DSH payments. Each year, approximately one-half of available DSH funds are disbursed to small rural hospitals.

Louisiana has established DSH criteria under which small rural hospitals are paid for uncompensated care costs based on their latest filed cost reports. The state has been able to pay 100 percent of uncompensated costs to rural hospitals for the last two years. Although it is difficult to predict what future appropriations will be, Louisiana will reevaluate the need to develop special reimbursement rates for the small rural hospitals if the pool of DSH hospitals grows, or if appropriations decrease to a point where the state can no longer pay cost-based reimbursement.

South Carolina's hospitals are classified by peer groups for purposes of the DSH program. Small rural hospitals (group 2) are cost settled under DSH for their Medicaid costs.

Texas allocates 5.5 percent of DSH payments to a separate pool for distribution to rural hospitals with less than 100 beds. DSH in Texas is a very political issue. Money for DSH comes from 9 hospital districts in the state. The hospital districts feel they are getting shortchanged, with DSH money going out to over 400 of the more than 500 hospitals in the state.

Washington has eight DSH payment categories including the Small Rural Hospital Assistance Program DSH (SRHAPDSH). Eligible hospitals are those with fewer than 75 licensed beds, and located in cities or towns with non-student populations of 13,000 or less. The apportionment formula is based on each SRHAPDSH hospital's Medicaid and other low-income reimbursement during the most current state fiscal year, less any low-income disproportionate share payments. To determine each hospital's percentage of Medicaid payments, the sum of individual hospital payments is divided by the total Medicaid payments made to all SRHAPDSH hospitals during the most currently available state fiscal year. The percentage is then applied to the total dollars in the pool to determine each hospital's payment within established limits.

Alaska has a complex DSH program with nine DSH payment categories including the Rural Hospital Clinic Assistance DSH. CAHs and other small rural hospitals may receive DSH payments under one or more of these categories if they meet the necessary criteria. Hospitals qualify for the Rural Hospital Clinic Assistance DSH if they enter into an agreement with the state to provide support services to a clinic that serves a population center that does not have road access to an acute care hospital within two hours or less. Available DSH funds are first used to fully fund four other DSH categories. After payments are calculated, 17 percent of the remaining DSH allocation, if any, is allotted to the Rural Hospital Clinic Assistance DSH category.

Importance of DSH Payments to Rural Hospitals

The majority of respondents did not offer an opinion on the importance of Medicaid DSH payments to rural hospitals. Of the 14 that did, 57 percent (8 respondents) did not think that DSH payments were very important for rural hospitals, primarily because these hospitals receive little, if any, DSH funding. In the remaining states, DSH was thought to be important to rural hospitals, particularly those with high Medicaid volumes.

Impact of Revisions to the Rules Governing the Calculation of Upper Payment Limits on DSH Payment Methods for CAHs

Given that few states have special DSH payment provisions for CAHs, most respondents did not expect the revisions to the rules governing the calculation of upper payment limits to have an impact on CAHs. Most were also unsure of the potential impact on their DSH programs. Respondents from Montana, Texas, and Utah were worried about the potential impact of these revisions on their DSH programs, with the individual from Texas estimating that the state would sustain a 20 percent reduction in DHS funds as a result of the federal changes. Montana's respondent estimated that the changes will eliminate payments to all CAHs, as Montana has a high percentage of CAHs and is a low DSH payment state.

The Impact of the Flex Program on State Medicaid Programs

Quantitative estimates of the financial impact on state Medicaid Programs of cost-based payments for CAHs are difficult to generate for two reasons. First, many of the states with cost-based hospital payment systems developed these systems prior to the implementation of the Flex Program. Second, most of the states that have developed such systems post-implementation of the Flex Program have not completed their hospital cost-settlements with the CAHs, and therefore do not have adequate data with which to assess the impact of the new payment methods.

Medicaid officials were nearly unanimous, however, in their opinion that the impact of cost-based payment for CAHs on Medicaid expenditures is likely to be minimal. This assessment was usually premised on the fact that 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 account for a very small portion of statewide Medicaid outpatient volume and expenditures.

While the financial impact of cost-based payment on the Medicaid Program is likely to be minimal, several state officials expressed the view that the impact on the financial health of individual CAHs was considerable. It will be very important in future evaluations to assess the impact of Medicaid payments on the financial health of hospitals that have converted to CAH status.

Medicaid Participation in Flex Program Development and Implementation

As this chapter has demonstrated, many state Medicaid programs employ a variety of hospital payment approaches that recognize, to some degree, the unique financial and operational characteristics of rural hospitals generally, and CAHs in particular. Given that so many states explicitly recognize CAHs as a separate category of provider, we were interested in knowing both the extent to which state Medicaid agencies had participated in the development of their state's Flex Program and the role(s) they played.

The Flex Program offered states the opportunity to engage Medicaid and other state agencies in policy development and program implementation. In nearly half of the states we surveyed, Medicaid program staff said that the agency was actively involved in some aspect of the development and implementation of the Flex Program. Medicaid participation has been both **formal** and **informal**. In some states, the involvement was very informal, often involving occasional meetings with office of rural health, hospital association representatives, and/or individual hospital administrators. In other states, Medicaid participation in the Flex Program

was more formal. Although it is hard to fully capture all of the forms that this more formal participation has taken, the following summarizes the roles that respondents described:

1. ***Participation in Flex Committees:*** In Minnesota, West Virginia, and Nevada among others, the Medicaid program has been represented on the formal Flex implementation committee.

2. ***Development of New Payment and Other Policies:*** As previously discussed in this chapter, the Flex Program prompted several state Medicaid programs to develop new payment and/or other policies for CAHs.

3. ***Consultation:*** Medicaid staff reported that they were often asked to consult with state office of rural health, hospital association representatives or others concerning conversion and/or payment issues. Most state Medicaid programs have had ongoing relationships with rural hospitals involving reimbursement, licensing or other issues. In some states, these consultation and technical assistance functions expanded with the development and implementation of the Flex Program.

4. ***Licensure and Certification Assistance:*** Hospital licensure, certification and survey functions are located within the Medicaid agency in many states. These units have been actively involved in a variety of roles in the development and implementation of policies and systems for conducting the necessary survey and licensure of CAHs.

We were also interested in whether the degree and type of Medicaid program participation in the Flex Program affected the likelihood that the Medicaid program adopted enhanced payment policies for CAHs and/or other rural hospitals. Our findings suggest that participation by the Medicaid program is, in most cases, unrelated to whether or not the state has adopted payment and other policies preferential to CAHs and/or rural hospitals. There are states where the Medicaid program has been a participant in the development and implementation of the Flex Program but has not changed its payment methods. There are also states, such as Michigan, with enhanced Medicaid hospital payment policies for inpatient and/or outpatient care for rural hospitals that pre-dated the Flex Program. In other states, the Medicaid agency was not represented in the Flex Committee but still participated in some aspect of the Flex Program. For example, in Arizona, Medicaid officials worked closely with state office of rural health staff and others to develop a methodology for allocating its $260,000 rural hospital fund.[4]

The interviews we conducted suggest that there are a few states, like California, Illinois, Tennessee, and Virginia, where the hospital association and/or the Medicaid Program are working hard to convince the legislature and governor to support Medicaid cost-based payment for CAHs. In Illinois, recent legislation supported by the state hospital association, passed by the

[4] This fund was originally appropriated at $1.7 million but budget cuts in the Medicaid Program have reduced the fund to this amount.

legislature, but not yet signed by the governor would grant cost-based reimbursement for the existing 19 CAHs. The legislation does not extend cost-based reimbursement to any new CAHs that might be designated in the future. In Ohio, the Medicaid Program has revised its Disproportionate Share Hospital payment methodology to assist CAHs. With nearly every state facing a serious budget crisis, however, it seems unlikely that states will be expanding payments for CAHs in the near term, even though the financial impact of doing so may be very small.

Summary of Key Findings

Medicaid represents a small but important source of revenue for CAHs. Flex Program officials continue to report that the adequacy of Medicaid payments to rural hospitals is a significant factor for hospitals in the decision of whether to convert to CAH status. In this study, we surveyed 42 of the 47 states with Flex Programs to document the methods states use to pay hospitals. The following is a summary of our key findings.

Inpatient Reimbursement

- Seventeen states (40% of the 42 states studied) have created special, enhanced 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 cost-based reimbursement through annual cost settlement.
- Some states employ other payment methodologies that create the opportunity for CAHs to receive more than cost, depending on the individual institution's cost structure.
- In six of the states we surveyed, while there are no special payment methodologies specifically targeted at CAHs, these facilities benefit from enhanced payment structures targeted to either all rural hospitals or all small hospitals. Forty-nine CAHs are located in these six states.
- Seventeen states have not created preferential payments for CAHs, or any other group of hospitals that might include CAHs.
- Many of the contacts from states without special payment policies 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.

Outpatient Reimbursement

- Most Medicaid agencies have not implemented a preferential outpatient payment for CAHs and continue to pay them as all other hospitals are paid.

- 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, these 13 states have large concentrations of CAHs: 45 percent of all certified CAHs are located in these 13 states. Nine of these 13 states reimburse CAHs for 100 percent of the costs associated with treating Medicaid beneficiaries. The other four states provide an enhancement to CAH outpatient rates, which may be above or below costs depending on the individual hospital's cost structure.

Impact of Medicaid Enhanced Payment on Medicaid Programs

- The impact of cost-based and other enhanced payment systems for CAHs on Medicaid expenditures is likely to be minimal. The total outpatient volume and expenditures in CAHs accounts for a very small portion of statewide Medicaid outpatient volume and expenditures.

- The impact of enhanced Medicaid payments on the financial health of individual CAHs can be considerable, however.

Medicaid Managed Care

- Enhanced inpatient and outpatient Medicaid payment methodologies do not typically apply to hospitals that participate in risk-based Medicaid managed care plans.

- In the 22 states that we surveyed that have at least some risk-based Medicaid managed care in rural areas, only two -- Oregon and Washington -- have policies that ensure that all CAH receive cost-based reimbursement like other CAHs in the state.

Disproportionate Share Hospital (DSH) Payments

- Most states do not have special DSH payments provisions for CAHs and/or other small rural acute care hospitals. The exceptions are Alaska, Georgia, Louisiana, Michigan, Ohio, South Carolina, Texas, Washington, and West Virginia. Medicaid DSH payments tend to be concentrated in large urban (often public) hospitals that provide the bulk of the indigent care in this country.

Medicaid Participation in the Flex Program

- Medicaid programs in most of the states we surveyed have been involved in developing and implementing the Flex Program in a variety of ways, participating in Flex implementation committees, developing new payment policies, and consulting with state office of rural health, hospital association and hospital representatives. Participation by the Medicaid program is, in most cases, unrelated to whether or not the state has adopted payment and other policies preferential to CAHs and/or rural hospitals.

Conclusion

While the reported impact of enhanced CAH reimbursement on state Medicaid budgets has been minimal, budgetary pressures created by rising Medicaid expenditures have hampered the efforts of some, but not all, states to implement enhanced CAH reimbursement. Cost based reimbursement is the most common, but not the only, form of enhanced CAH reimbursement developed by state Medicaid programs. States interested in supporting CAHs through enhanced reimbursement should evaluate the administrative and political choices inherent in cost based reimbursement against alternative methodologies. They should also investigate and learn from the experiences of those states that have been successful in implementing enhanced CAH reimbursement methodologies.

(appendix in separate file)