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Top Threat to Rural Health Care

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To qualify for Critical Access Hospital status, CAHs must be at least 35 miles (or 15 miles in mountainous terrains or areas that only have rugged secondary roads) from another hospital or designated by their state as a "necessary provider", cannot have more than 25 acute-care beds, must offer 24-hour emergency services and cannot have an annual average length of stay greater than 96 hours. Since 1997, CAHs have been paid 101% of their allowable costs for outpatient, inpatient, lab and other services to ensure the CAH stays open for its community. By comparison, traditional hospitals paid through the Medicare inpatient and outpatient prospective payment systems typically cover about 93% of the costs of Medicare patients.

Now the viability of many CAHs has been threatened. In April, as part of his budget proposal, President Obama proposed cutting more than $2.1 billion from CAHs over the next decade. These cuts would come from a reduction from 101% of allowable costs to 100% and a prohibition of CAH designation for facilities that are less than 10 miles from the nearest hospital. On the heels of the President's budget proposal, in August, in a widely publicized report, the Department of Health and Human Services Office of Inspector General (OIG) found that 846 of the 1,332 CAHs across the country did not meet the 35 mile requirement. In the report, the OIG urged removal of the "necessary provider" exemption leading to decertification of CAHs that did not meet new location-related requirements. Decertification would move the impacted CAHs from the 101% cost based reimbursement to the Medicare inpatient and outpatient prospective payment systems. The OIG estimates that such a change would have saved the government $449 million in 2011 alone.

Which of these proposals gets implemented, if any, remains uncertain. But it is fair to conclude with these proposals, cuts to disproportionate share payments, and other pressures, CAHs will face even greater pressure on revenues in the years to come than ever before. This does not mean CAHs must shutter their doors or lose their independence and community control through a merger. CAHs can avoid this fate through a well-developed strategy involving looking beyond political boundaries for strategic affiliations and clinical integration with other providers, a shift from volume-based care to value-based care, and careful management. The time to develop and implement these steps is now, ahead of the looming cuts.