REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

CRITICAL ACCESS HOSPITAL PROGRAM STUDY

(COPN Follow-Up)

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Preface

This report is a follow-up to the Joint Commission on Health Care's (JCHC) recent activities related to Virginia's Certificate of Public Need (COPN) Program. In December 2000, the JCHC issued a report entitled A Plan to Eliminate the Certificate of Public Need Program Pursuant to Senate Bill 337. Following the publication of that report, the JCHC introduced legislation during the 2001 Session (SB 1084 and HB 2155) which would have substantially eliminated the state's COPN program in three separate phases. Among the provisions of that legislation was language directing the JCHC, during Phase 1 of deregulation, to "study a possible state component to correspond with the federal critical access hospital program as set forth in the Balanced Budget Act of 1997, P.L. 105-33 and Title XVIII of the Social Security Act, as amended." While this legislation was not passed by the 2001 General Assembly, at its May 1, 2001 meeting, the JCHC directed the JCHC staff to complete this study.

Based on our research and analysis during this review, we concluded the following concerning critical access hospitals and the areas that they serve:

- The federal critical access hospital program is intended to assist small, rural hospitals, by providing reimbursement for 100 percent of reasonable costs from Medicare.

- Federal requirements for critical access hospital certification are based on distance from the nearest hospital, bed size, and average length of stay.

- Critical access hospitals are not required to provide the same full range of services required by Medicare of general acute care hospitals.

- The Virginia Department of Health submitted the Virginia Rural Health Care Plan to the federal government as a prerequisite for certifying certain Virginia hospitals as critical access hospitals.

- Rural localities in Virginia are confronted by numerous health care-related challenges.

- Two Virginia hospitals have already been certified as critical access hospitals, and three others are considered to be likely candidates for certification.

- The Virginia Department of Health does not believe that any other Virginia hospitals will convert to critical access hospital status.

- The federal critical access hospital program is not a panacea for all of the problems confronting rural hospitals. For example, it does little to support services such as obstetrics, pediatrics and emergency room care which are provided primarily to a non-Medicare population.

- Sixteen states, including North Carolina, Kentucky and West Virginia, provide critical access hospitals with reimbursement for 100 percent of their Medicaid-allowable costs.

- The fiscal impact of providing Virginia's critical access hospitals with reimbursement for 100 percent of their Medicaid-allowable costs would be relatively small (approximately $277,000, general funds).

- Expansion of the Medicaid Medallion II managed care program into additional localities will have potentially negative implications for the state's ability to provide Medicaid cost-based reimbursement to critical access hospitals.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on page 37.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments to us regarding the report. The public comments (attached at Appendix A) provide additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Virginia Department of Health, and the Virginia Hospital and Healthcare Association for their cooperation and assistance during this study.

Patrick W. Finnerty
Executive Director

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Authority for the Study

Background

This issue brief is a follow-up to the Joint Commission on Health Care's (JCHC) recent activities related to Virginia's Certificate of Public Need (COPN) Program. In December 2000, the JCHC issued a report entitled A Plan to Eliminate the Certificate of Public Need Program Pursuant to Senate Bill 337. Following the publication of that report, the JCHC introduced legislation during the 2001 Session (SB 1084 and HB 2155) which would have substantially eliminated the state's COPN program in three separate phases. Among the provisions of that legislation was language directing the JCHC, during Phase 1 of deregulation, to "study a possible state component to correspond with the federal critical access hospital program as set forth in the Balanced Budget Act of 1997, P.L. 105-33 and Title XVIII of the Social Security Act, as amended" While this legislation was not passed by the 2001 General Assembly, at its May 1, 2001 meeting, the JCHC directed the JCHC staff to complete this study.

The COPN deregulation plan and subsequent legislation included several provisions to help cushion hospitals from the impact of being less able, in a deregulated environment, to "cost-shift" reimbursement received from paying patients to help offset the cost of providing care to persons who have no financial means, and to subsidize the cost of certain services which generate relatively little revenue. One of these provisions called for the appropriation of $24 million (GF) in additional Medicaid reimbursement to hospitals by eliminating the 21 percent negative adjustment factor used by the Department of Medical Assistance Services. As a result of this, on average statewide, inpatient hospital reimbursement would equal Medicaid allowable costs.

Even with such a provision, however, reimbursement to individual hospitals would vary under the Medicaid inpatient reimbursement system. The federal critical access hospital program, described in this report, guarantees certain small rural hospitals 100 percent reimbursement of their allowable costs under the Medicare program. The central issue examined in this report is the establishment of a state component to the federal critical access hospital program. A primary aspect of such a state program could include a guarantee of 100 percent reimbursement of Medicaid allowable costs to critical access hospitals in Virginia.

Organization of Report

This report is presented in six major sections. Following this section, the second section provides a general overview of the federal critical access hospital program. The third section reviews the implementation of the federal program in Virginia, including development of the Virginia Rural Health Care Plan. The fourth section examines the extent to which critical access hospitals have been certified in Virginia, and discusses the potential for additional hospitals to be certified as critical access hospitals. The fifth section examines some approaches taken by other states to develop their critical access hospital programs, with a focus on the use of cost-based reimbursement through their Medicaid programs. The sixth and final section presents policy options.

II.
Overview of the Federal Critical Access Hospital Program

Rural Hospitals Across the Country Are Faced With Many Challenges

A recent analysis by the National Conference of State Legislatures identified several difficult issues confronting rural hospitals. While reduced Medicare reimbursement as a result of the federal Balanced Budget Act of 1997 (BBA97) is a key issue affecting both rural and urban hospitals, other factors are somewhat more unique to rural hospitals. These include:

- significant dependency on public payers, particularly Medicare;
- increasing percentage of patients over the age of 65,
- lack of access to capital, and
- rural hospital labor costs that are set at 71 percent of urban hospital costs for purposes of Medicare reimbursement, (i.e., they are paid less for providing the same service).

According to a recent report by the National Rural Health Association, "Rural health care providers are in a different position from their urban counterparts in regard to serving the uninsured. Patients cannot be so easily turned away in the rural setting where the selection of providers is much more limited."

The Critical Access Hospital Program is Part of the Medicare Rural Hospital Flexibility Program, and Is Intended to Assist Small, Financially Vulnerable Rural Hospitals

The Critical Access Hospital (CAH) program is part of the broader Medicare Rural Hospital Flexibility Program (MRHFP), which was authorized by the BBA97. The CAH program enables small rural hospitals to deliver acute care services with cost-based reimbursement from Medicare, as opposed to being reimbursed under the customary Diagnosis-Related Group (DRG) system. In order to qualify for the program, a hospital must meet certain requirements, including distance from the nearest hospital, maximum bed size and a maximum average length of stay. The MRHFP is a major national initiative to strengthen rural health care. In addition to the CAH component, the MRHFP encourages the development of rural health networks and also offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

The U.S. Health Care Financing Administration (HCFA) had certified 366 hospitals as CAHs as of April 30, 2001

Midwest and Western states tend to have more CAHs than Eastern states. The states with the most critical access hospitals are:

- Nebraska - 45,
- Kansas - 33,
- Iowa - 20,
- South Dakota - 19,
- Texas - 17,
- Montana - 16,
- Oklahoma - 16, and
- Idaho - 15.

Virginia, by comparison, currently has two CAHs. These are Bath County Community Hospital, in Warm Springs, and RJR-Patrick Community Hospital, in Stuart. A third hospital, Carilion Giles Memorial Hospital, in Pearisburg, is in the process of applying for CAH certification. Among Virginia's neighboring states, the number of CAHs varies substantially:

- West Virginia - 11,
- Kentucky - 10,
- North Carolina - 8,
- Tennessee - 4, and
- Maryland - 0.

There is no single profile of the "typical" CAH. However, there are several characteristics that are common to many CAHs across the country. According to a recent analysis of CAHs conducted at the University of North Carolina:

- 92 percent are in Health Professional Shortage Areas (HPSAs),
- 90 percent have a higher Medicare population than the state average,
- 89 percent have swing beds,
- the average distance to the closest hospital is 20.5 miles,
- the average daily patient census is 5.9 patients, and the average length of stay is 3.3 days,
- 50 percent have hospital-based home care,
- 37 percent provide obstetrical services, and
- 20 percent have hospital-based ambulances.

This same analysis estimates that there are an additional 1,127 hospitals in the United States, including 12 in Virginia that potentially may be eligible for CAH certification.

Federal Requirements for the CAH Program Focus on Hospital Eligibility and Reimbursement Mechanisms

The primary requirements for the CAH program, as contained in federal statutes and regulations, focus on the type of hospital that is eligible for CAH certification and on the manner in which such hospitals are reimbursed by Medicare. Furthermore, before any hospital in a state can obtain CAH status, the state must submit an application to HCFA, in the form of a state rural health care plan, for participation in the MRFHP.

Program Eligibility. A CAH must be located more than 35 miles from another hospital or 15 miles if it is located in "mountainous terrain". This federal criterion, known as the "distance" criterion, is the only one that is flexible. Specifically, a state may waive this criterion if the state has certified the hospital as a "necessary provider". This criterion, be it in the form of distance or necessary provider, is the threshold criterion for the CAH program. The necessary provider criteria are to be specified in the state's rural health care plan.

A CAH may be either a public, non-profit or for-profit entity. Furthermore, hospitals that closed within 10 years prior to November 29, 1999, or hospitals that downsized to either a health clinic or health center, may be designated a CAH if they meet the program eligibility criteria. There is no specific requirement that a hospital actually be in any kind of financial difficulty such as, for example, having a negative operating margin or total margin.

CAH eligibility is limited to very small hospitals whose patients, on average, have minimal lengths of stay:

- the hospital can have no more than 15 beds for acute inpatient care;
- a maximum of 25 beds are allowed if 10 of them are swing beds (i.e., no more than 15 beds may be used for acute care); and
- the average length of stay cannot exceed 96 hours.

Service Requirements. CAHs are generally not required to provide the same array of services as are general acute care hospitals under Medicare conditions of participation. For example, the CAH need not meet hospital standards relating to the number of hours during a day, or days during a week,

in which the facility must be open and fully staffed. However, the following requirements are applicable to CAHs:

- 24-hour emergency services and nursing services must be available, but the CAH need not otherwise staff the facility except when an inpatient is present;

- there must be a physician, a physician assistant or nurse practitioner with training or experience in emergency care on call and immediately available by telephone or radio contact, and available on site within 30 minutes;

- inpatient services may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who does not have to be present in the facility;

- a physician must be present for sufficient periods of time, at least once in every two week period, to provide medical direction, medical care services, consultation and supervision, and must be available through direct telephone or radio contact at all other times; and

- a partnership must be formed with another hospital for referrals and administrative requirements, such as credentialing and quality assurance and improvement.

Medicare Reimbursement. As previously mentioned, CAHs are reimbursed for their reasonable costs of providing inpatient services to Medicare patients, as opposed to receiving payment under the DRG system. Under the DRG system, reimbursement is not based on a hospital's actual costs but rather on the service intensity, according to the patient's particular diagnosis, of the care provided. For outpatient services, CAHs are reimbursed based on reasonable costs or, at the election of the CAH, a facility fee based on reasonable costs plus an amount based on 115 percent of Medicare's fee schedule for professional services.

Other CAH reimbursement provisions include the following:

- payment amounts are to be determined without regard to the amount of the customary or other charge;

- ambulance services provided by a CAH or by an entity owned or operated by a CAH are paid on a reasonable cost basis if the CAH or entity is the only provider or supplier of ambulance services within a 35 mile radius;

- reimbursement for reasonable compensation and related costs of all "on-call" emergency room physicians who are not present on premises, provided they

are not otherwise furnishing services, or on call at any other provider or facility;

- exemption of swing beds from the Medicare Skilled Nursing Facility Prospective Payment System, however HCFA's Minimum Data Set does have to be completed for each swing bed; and

- a prohibition on beneficiary cost sharing for clinical diagnosis laboratory tests.

III.
The Virginia Rural Health Care Plan

The Virginia Department of Health Developed the Virginia Rural Health Care Plan In Response to Legislation Enacted During the 2000 Session

According to federal law, a state rural health care plan must: 1) provide for the creation of one or more rural health networks (defined as an organization consisting of at least one CAH and at least one hospital that furnishes acute care services), 2) promote regionalization of rural health services, and 3) improve access to hospital and other health services for rural residents. Senate Bill 665 of the 2000 Session directed the Virginia Department of Health (VDH) to develop a state rural health care plan ("the plan") for submission to HCFA. The VDH Center for Primary Care and Rural Health, which serves as the state's office of rural health, played the lead role in coordinating the development of the plan.

According to the plan, which was submitted to HCFA in April 2000, the CAH program "will enable a number of rural hospitals experiencing financial difficulties to remain as providers of quality care in their communities." The plan states further that CAH designations "are intended to help small rural hospitals remain financially viable in communities that are unable or may be unable to support their existing hospital under current market conditions."

The plan establishes six goals:

- ensure access to hospitals and other health services for residents in rural Virginia,
- increase the number and quality of rural health networks on a local and regional basis,
- create an efficient administrative infrastructure to guide and oversee the state's CAH program,
- educate and assist hospitals desiring to convert to CAH status to ensure their sustainability and to promote quality of care,
- ensure a regulatory framework supportive of the creation of CAHs, and
- educate the Virginia General Assembly and members of the Virginia Hospital and Healthcare Association (VHHA) about the MRHFP and CAH designation in order to help them make informed policy choices.

Pursuant to the *Code of Virginia*, any CAH is authorized to lease the unused portion of its facilities to other health care organizations. A CAH is also permitted to reorganize its corporate structure to facilitate the continuation of the nursing home beds that were licensed to the hospital prior to its CAH

designation. In either instance, the health care services delivered by such other health care organizations shall not be construed as part of the CAH services or license. Any licensed hospital that has been designated a CAH and has been required to reduce its licensed bed capacity due to CAH conversion will, upon termination of CAH certification, be licensed to operate at the licensed bed capacity in existence prior to the CAH certification without the need for a COPN.

A CAH taskforce, consisting of representatives from VDH, VHHA, the Virginia Rural Health Association and rural hospitals, has assumed responsibility for reviewing progress in promoting access to care, particularly in CAHs. The CAH taskforce will review information called for in the plan and make recommendations to the Commissioner on rural health network developments, rural access issues, and progress towards fulfilling the plan.

The Virginia Rural Health Care Plan Described Numerous Challenges Confronting Rural Localities

In developing the plan, VDH prepared an extensive profile of Virginia's rural areas. The plan noted that a majority (54 percent) of Virginia's 135 counties and cities are still non-metropolitan in nature. A key component of the plan document was a comparative analysis of demographic, health status, and health access indicators in metropolitan and non-metropolitan localities.

Descriptive Information and Comparative Analysis. According to the plan document, "demographic, social, and economic indicators for Virginia's rural counties paint a familiar cycle of poverty and decline." For example, the plan document presented data indicating that residents of non-metropolitan localities in Virginia tend to be, on average, older and less affluent than residents of metropolitan localities (Figure 1). The plan also noted that nearly 40 percent of

Figure 1
Selected Social Attributes of Metropolitan vs. Non-Metropolitan Localities in Virginia

	Percent of Population Age 65 and Over	Percent of Population Below Poverty Level
Metropolitan	12.5%	10.9%
Non-Metropolitan	15.9%	15.6%

Source: JCHC staff review of the Virginia Rural Health Care Plan, (April 2000).

individuals 25 years of age and older in non-metropolitan localities lacked a high school degree, compared to 27 percent in metropolitan localities.

According to the plan, the health status of residents in Virginia's rural localities, as measured by certain indicators, is generally below that of Virginians who live in metropolitan areas (Figure 2). In terms of comparative health status indicators, the plan also noted that:

- The percentage of low birthweight infants was slightly higher (7.96 percent) in non-metropolitan localities than in metropolitan localities (7.38 percent).

- However, the number of lung cancer deaths per 100,000 population was slightly lower (41.8) in non-metropolitan localities than in metropolitan localities (42.6).

The plan states that, from a financial perspective, "access to health services is generally lower in nonmetropolitan than in metropolitan counties, although the differences are not as great as one might anticipate given current economic conditions." While the percentage of uninsured individuals was similar in metropolitan (13.5 percent) and nonmetropolitan areas (14 percent), Medicaid enrollment was significantly higher in rural localities. According to the plan, the percent of individuals enrolled in Medicaid was 11.1 percent in nonmetropolitan areas, compared to seven percent in metropolitan areas. Finally, the plan noted 73 percent of the state's nonmetropolitan counties have been designated as medically underserved areas by VDH. Thirty-four percent of non-metropolitan counties have been designated as HPSAs.

Figure 2
Selected Health Status Indicators of Metropolitan vs. Non-Metropolitan Localities in Virginia

	Infant Deaths Per 1,000 Births	Heart Disease Deaths per 100,000 Population
Metropolitan	6.9	135.5
Non-Metropolitan	8.2	152.2

Source: JCHC staff review of the Virginia Rural Health Care Plan, (April 2000).

Observations Concerning Status of Rural Health Systems. As previously stated, one of the important objectives of the MRHFP is the establishment and maintenance of integrated rural health systems. With that goal in mind, the plan contained a review of the current rural health infrastructure and provided a

number of observations. In 1999, Virginia had 36 hospitals located in nonmetropolitan localities. Thirty-eight counties do not have a hospital, but every nonmetropolitan county without one has a hospital in an adjacent county. Still, in nearly 20 percent of rural localities, residents are at least 20 miles from the nearest hospital.

Hospitals in nonmetropolitan Virginia exhibit many of the attributes found in rural hospitals in other states. Compared to Virginia hospitals located in metropolitan localities, rural hospitals tend to have:

- significantly fewer beds,
- a higher ratio of licensed to staffed beds ("licensed" refers to beds authorized by the hospital's COPN, while "staffed" refers to beds physically present and operational in the facility),
- lower average occupancy levels,
- shorter average lengths of stay, and
- smaller staffs.

According to the plan document, "The financial health of rural hospitals in Virginia has historically been good, although this has not always been the result of a given hospital's operating margin. Other sources of revenue have enabled some hospitals to remain solvent." Increased dependence on outpatient care as a source of revenue is another key attribute. In nonmetropolitan hospitals, inpatient services comprise 55 percent of gross patient revenues compared to 63 percent in metropolitan hospitals. In 25 percent of rural hospitals, inpatient services account for less than half of patient revenues. According to the plan, "The reduced reliance on inpatient care does give hospitals some flexibility to downsize even further their bed capacity. This could enable smaller hospitals to meet the bed requirement for a Critical Access Hospital without jeopardizing inpatient revenues."

The plan document noted that some health service integration has occurred through the efforts of individual hospital systems, "but services that are not good profit centers will not be well integrated into the system." Emergency Medical Services (EMS), for example, "has not always been a focus of system expansion efforts." According to the plan, significant gaps in EMS system development in rural counties are evident. The plan states that "The absence of a denser EMS network in association with some rural hospitals indicates an area where future efforts of the Medicare Rural Hospital Flexibility program must be directed."

According to the plan document, primary care services are well developed in some rural counties, "but in the majority of counties the primary care systems

are not fully developed." The plan described the primary care safety net infrastructure available to serve residents of rural Virginia:

- Community Health Centers (CHCs) - There are 51 CHCs in Virginia, 70 percent of which are located in rural areas. CHCs are private, nonprofit corporations located in a medically underserved area to provide comprehensive primary care to anyone, through use of a sliding-fee scale, regardless of ability to pay. CHCs provide core primary care services such as physician care, preventive and diagnostic services, and case management. Services are often provided to individuals who are insured but who are unable to receive care through more traditional means. The majority (70%) of CHCs have also been designated as Federally Qualified Health Centers by HCFA, entitling them to cost-based reimbursement from Medicare and Medicaid.

- Free Clinics - There are 32 free clinics in Virginia. Free clinics, which are staffed by volunteer medical professionals, provide medical services to low-income, uninsured individuals. Clinics rely heavily on local hospitals and other institutions for diagnostic services, and on volunteer medical specialists for referrals. However, this degree of reliance "limits the effectiveness of Free Clinics in those rural communities that do not have those resources to draw upon."

- HCFA-certified rural health clinics (RHCs). Virginia has 59 RHCs. Each RHC must have a midlevel provider (i.e., nurse practitioner, physician assistant) on staff. This has helped to improve access to these types of providers in rural communities.

The plan stated that while primary care services are networked with hospitals and emergency services in some rural counties, "in most rural counties primary care networks are fragmented and greater coordination is required." For example, "Physicians and clinics attempt to coordinate coverage, but it is not always done in a systematic fashion so gaps either in geographic coverage or for particular services occur."

The Virginia Rural Health Care Plan Establishes Criteria for Designation of "Necessary Provider" Hospitals

In order to be classified as a "necessary provider," a hospital must be the sole provider of hospital services in the county and meet two of the following five conditions:

- be located in a nonmetropolitan county that is a federally designated Medically Underserved Area (MUA) or a HPSA;

- be located in a county where the percentage of people living in poverty exceeds the state percentage;

- be located in a county where the percentage of population 65 years of age and older is greater than the state average;

- be located in a county where the most recent three-year unemployment rate exceeds the same three-year average rate for the state; or

- have a percentage of revenue from Medicare that exceeds the state average for Medicare reimbursement.

For purposes of the necessary provider criteria, hospitals located in cities are considered to be associated with the surrounding county. In other words, in order for a hospital located in a city to be designated a necessary provider, it must be the only hospital in its city and the surrounding county.

The Virginia Department of Health Receives Federal Grant Funding to Support Implementation of the Medicare Rural Hospital Flexibility Program in the State

VDH is now in the third year of the federal grant. VDH received $180,324 in funding during the first year, and $249,576 during the second year. For the third year, VDH is requesting $254,238 from HCFA. The funds are used for a variety of purposes, including financial feasibility studies and community needs assessments, legal consultation, newsletter and webpage development, educational conferences, and special studies. For example, VDH is in the process of developing a plan for improvement of EMS services in rural areas.

According to VDH's most recent report to HCFA, the focus of activity over the next year will be community development in the five localities with CAH- certified or CAH-eligible hospitals. Enhanced community development and needs assessment activities will be conducted to develop strategies for fostering rural health network development. The focus will be "to encourage cooperation among local physicians, local health departments, EMS providers, long term care and other health care providers to promote network development and integration." In addition, the two CAHs certified so far have requested technical assistance to better understand what changes in operations are needed to maximize their efficiency and quality as a CAH. For example, there are questions concerning admissions criteria and patient transfer.

IV.
Critical Access Hospitals In Virginia

This section of the report continues to discuss the federal critical access hospital program, but in specific relation to Virginia hospitals that either have been, or could potentially be, certified as critical access hospitals by HCFA. All references in this section to the CAH program relate directly to the federal program, as opposed to any state-specific component designed to provide additional assistance to critical access hospitals.

State Plan Identified "Possible" and "Likely" Hospitals for CAH Certification

The Virginia Rural Health Care Plan identified 16 hospitals that met either the federal distance criteria or the Virginia necessary provider criteria for CAH certification. They are as follows:

- Bath County Community,
- Carilion Franklin Memorial,
- Carilion Giles Memorial,
- Dickenson County Medical Center,
- Greensville Memorial,
- Page Memorial,
- Pulaski Community,
- R.J. Reynolds - Patrick County,
- Rappahanock General (Kilmarnock),
- Riverside Tappahanock,
- Russell County Medical Center,
- Shenandoah Memorial,
- Southampton Memorial,
- Southside Community (Farmville),
- Stonewall Jackson (Lexington),
- Tazewell Community, and
- Twin County Regional (Galax).

In developing the plan, the operations and staffed bed size of these 16 hospitals were further evaluated. Under appropriate conditions, according to the plan, hospitals with 40 or fewer staffed beds "would be able and willing to scale their bed size to the required conditions to meet CAH designation." Based on additional review, the plan identified a total of five hospitals that it considered to be likely candidates for CAH certification: Bath County Community Hospital, Carilion Giles Community Hospital, Dickenson County Medical Center, Page Memorial Hospital, and Patrick Community Hospital. According to the plan,

each of these hospitals meets the federal distance criteria, is located in a county that is considered mountainous, and has an average daily patient census that is lower than its number of staffed beds (Figure 3).

According to both VDH and VHHA staff, following submission of the plan to HCFA, Page Memorial Hospital was removed from the list of likely CAH candidates, and was replaced by Carilion Tazewell Memorial Hospital. According to VDH and VHHA, this was done due to reservations expressed by the management of Page Memorial about the need for CAH conversion coupled with the view that CAH conversion would be viewed as a more acceptable option by Tazewell Memorial.

Two Critical Access Hospitals Have Been Certified in Virginia and a Third Has Applied to the Virginia Department of Health for Certification

As previously mentioned, Bath County Community Hospital and R.J. Reynolds - Patrick County Hospital have been certified as critical access hospitals. A third facility, Carilion Giles Memorial Hospital, has submitted its application for CAH certification to VDH.

Figure 3

Likely Candidates for Critical Access Hospital Certification in Virginia

	Number of Staffed Beds	Average Daily Patient Census
Bath County Community	12	7.5
Carilion Giles Memorial	32	14.6
Dickenson County Medical Center	39	20.1
Page Memorial	20	16.3
RJR - Patrick County	34	11.7

Source: Virginia Rural Health Care Plan, (April 2000).

Pursuant to the Virginia Rural Health Care Plan, hospitals interested in obtaining CAH certification must submit a formal application that includes the following:

- a financial analysis of the implications of conversion to CAH status;
- documentation of public participation by all significant stakeholders in the decision;
- agreements with at least one network hospital addressing patient referral and transfer, development and use of communications systems, telemetry systems, electronic sharing of patient data, and the provision of emergency and non-emergency transportation among the facility and hospital;
- agreements concerning credentialing and quality assurance with one network hospital and with Virginia's Medicare Peer Review Organization or an equivalent entity; and
- a statement of assurance and a plan demonstrating that the hospital will meet the bed size, average length of stay, and emergency medical care requirements of CAH status.

Bath County Community Hospital. According to the hospital's management, CAH status was obtained as part of an overall strategy to minimize its financial losses. Given its relatively small number of beds and average daily patient census, the hospital did not have to eliminate any staffed beds, or make any other major changes to its operations, in order to convert to CAH status.

This hospital obtains 60 percent of its revenue from Medicare, 20 percent from commercial insurance, 16 percent from Trigon Blue Cross/Blue Shield and private pay patients, and only four percent from Medicaid. Only 38 percent of its revenue is derived from inpatient services. Outpatient services (19 percent), emergency services (19 percent) and home health services (15 percent) combine to form the majority of its revenue. An additional nine percent of revenue comes from skilled nursing services.

Bath County Community hospital does not provide obstetrical delivery services. The closest hospital which does so is Alleghaney Regional Hospital, about 40 minutes away. Prenatal care is provided locally by the VDH. According to the administrator, while some in the community would like to see the hospital provide obstetric delivery services, there would not be sufficient volume to provide the service at a satisfactory level of quality and patient safety.

According to management, key factors affecting the current and future financial viability of the hospital include its service volume and physician recruitment. The hospital's share of services provided to its local market is about 39 percent, while management would prefer its market share to be about 49

percent. In other words, the hospital would like for more people in its service area to receive needed medical care at its facility, as opposed to receiving care at other hospitals. For example, the hospital does not currently offer cardiology or gastronenterology services. The ability of the hospital to successfully recruit physicians affects its ability to capture a greater share of its own market.

According to the hospital management, transportation (other than EMS transport) is one of the major issues affecting access to health care in the hospital's service area. It is not clear whether or how the CAH program can help address this issue. According to the administrator, Bath County Community is not a "typical" rural hospital given its proximity to the Homestead Resort and its low Medicaid volume. Both of these factors are believed by the hospital administration to aid in the successful recruitment of physicians.

RJR - Patrick County Hospital. This hospital declared bankruptcy in 1999 and has since reorganized its operations under the management of a North Carolina-based health system. The hospital obtains 42 percent of its revenue from Medicare, 35 percent from commercial insurance, 16 percent from Medicaid and seven percent from other sources, which are primarily self-pay patients. In terms of service line revenue, 33 percent of revenue is derived from outpatient services, 32 percent from inpatient services, 21 percent from emergency room services, and 14 percent from skilled nursing facility services.

This hospital does not provide OB services. The closest hospital providing OB services is more than 30 miles away. The hospital administrator stated that, if possible, he would like to provide OB services to the community.

As is the case with many rural hospitals, physician recruitment is a major issue for Patrick County. According to the hospital's Chief Financial Officer, the facility is in desperate need of a full-time surgeon, but is having a difficult time recruiting one. Internal Medicine is another priority area for physician recruitment. Interestingly, the hospital is not yet experiencing significant problems with recruiting and retaining nurses. However, the availability of radiologic technicians is a major staffing problem for the hospital. The availability of funds for capital projects, including equipment replacement and building renovation, was cited as another key issue affecting the current and future viability of the hospital.

Carilion Giles Memorial Hospital. According to the hospital administrator, conversion to CAH status will enhance the facility's financial position. The CAH criteria match very closely to the hospital's current operations, so major changes are not envisioned as being necessary for CAH certification. In addition, according to the hospital administrator, the focus of CAH on rural health network development and strengthening of relationships

between the hospital and surrounding community is something that the hospital takes very seriously.

This hospital obtains 72 percent of its revenue from Medicare, 11 percent from commercial insurance and Trigon Blue Cross/Blue Shield, six percent from Medicaid, four percent from private pay patients and seven percent from other sources. Outpatient services account for 55 percent of its revenue, while inpatient services account for 45 percent.

Hospital management anticipates deriving several benefits from CAH status. These include increased reimbursement, an improved community-wide focus on health care planning, and an enhanced management focus on the hospital's core businesses. However, the hospital recognizes that it will have to give up seven staffed beds in order to receive CAH certification. While that reduction, according to the administrator, will not hurt operations on a day-to day basis, the facility's patient census does fluctuate unexpectedly from time to time. However, once the space occupied by those seven beds is converted to other purposes, it will become difficult to revamp that space to its prior use (i.e., back to inpatient beds.)

The hospital administrator cited transportation (aside from EMS transport) as the primary issue affecting access to health care in his service area. According to the administrator, access to quality primary care in the county is satisfactory. However, access to specialty care, particularly orthopedics, oncology, and pulmonology is much more problematic as these services are not provided at the hospital. The need for orthopedic care is the most frequent reason for transfer of patients out of the county.

Giles Memorial hospital does not provide obstetrical delivery services. The closest hospitals which do so are Montgomery Regional Hospital, about 35 minutes away and Carilion New River Valley hospital, about 45 minutes away. Pre-natal care is available through satellite offices. Giles County averages 185 births a year. According to the hospital administrator, that is sufficient for one OB/GYN but not two.

The primary factors affecting the current and future financial viability of the hospital, as identified by the hospital administrator, include reimbursement issues, including Medicare and Medicaid; personnel costs; physician recruitment, particularly specialists; and the extent of local economic development. The hospital administrator noted that the hospital is the second largest employer, in terms of payroll, in the county. The financial viability of the hospital is the key issue affecting the successful recruitment of physicians, and particularly specialists.

The hospital administrator said that, over the long run, if the hospital were not able to remain open, Giles County residents would have no place else to go in the county for health care. In addition, the existing cadre of local physicians would not be able to continue practicing in the county.

Other Likely Candidates for CAH Conversion. The VDH is working with management at both Dickenson County Medical Center and Carilion Tazewell Memorial Hospital in order to provide them with information about the CAH program. According to VDH staff, both hospitals have agreed to accept CAH program grants from VDH in order to conduct financial feasibility studies. It is not known at this time what the results of those studies will indicate concerning the feasibility of CAH conversion.

VDH Does Not Believe That There Are Any Other Hospitals for Which CAH Conversion Is Feasible at This Time

In its most recent report to HCFA, completed in May 2001, VDH stated that "it is not anticipated that any hospital in addition to the five [that the Center for Primary Care and Rural Health is currently working with] will be eligible for CAH assistance." VDH bases this conclusion on the lack of any other Virginia hospitals for which CAH conversion is feasible, given their bed size and average daily patient census.

Fourteen Virginia Hospitals, Located Primarily in Urban Areas, Have Closed Since 1996

Since 1996, 14 Virginia hospitals have closed. Only one of these, Wise Appalachian Regional Hospital, was located in a rural area. Other Virginia hospitals that have closed in recent years include:

- Bon Secours Stuart Circle (Richmond);
- Gill Memorial Eye, Ear, Nose and Throat Hospital (Roanoke);
- Loudon Hospital Center, Cornwall Campus;
- Newport News General;
- Norfolk Community;
- Pentagon City;
- Portsmouth General;
- Sentara Newport News;
- Richmond Memorial;
- Carilion Radford Community;
- Northern Virginia Doctors Hospital (Arlington);
- Sheltering Arms Hospital (Richmond); and
- Woodrow Wilson Rehabilitation Center - Hospital (Fishersville)

Following the closure of Richmond Memorial, Carilion Radford, Sheltering Arms, and Northern Virginia Doctors Hospital, these facilities were in effect all relocated to new facilities elsewhere in their regions. Woodrow Wilson Rehabilitation Center became a Comprehensive Outpatient Rehabilitation Facility.

Hospitals Identified by the Virginia Rural Health Care Plan as "Possible" Candidates for CAH Conversion Vary Substantially on a Number of Financial and Operational Indicators

Figure 4 presents some selected operational and financial indicators for eleven rural hospitals identified in the Virginia Rural Health Care Plan as "possible" candidates for CAH conversion. These data were obtained from Virginia Health Information (VHI), and are for 1999 which is the most recent year for which such data are currently available. The two hospitals (Bath and Patrick) that have already been certified as CAHs, the one (Giles) that has applied for CAH conversion, and the two others (Dickenson and Tazewell) with whom VDH plans to discuss CAH conversion are not included in Figure 4.

As shown in Figure 4, three of the hospitals (Franklin, Page, and Tappahanock) have less than 40 staffed beds. As previously mentioned, the plan states that, "under appropriate conditions" hospitals of this size would be able and willing to scale their bed size to the required conditions to meet CAH designation. Furthermore, the average daily patient census of each of these hospitals is less than its number of staffed beds. In addition, according to these data, their average lengths of stay were all under four days, or 96 hours.

There are, of course, numerous possible reasons why such hospitals may not benefit from CAH conversion, and thus would have little or no interest in pursuing it. Each of the three hospitals identified, for example, have positive operating margins and positive total margins. Furthermore, according to VDH staff, the conventional wisdom nationally is that CAH conversion is generally not feasible for hospitals with an average daily patient census of greater than 15.

Localities Served by Hospitals Identified by the Virginia Rural Health Care Plan as "Possible" Candidates for Critical Access Hospital Designation Vary in Terms of Demographic and Health Status Indicators

JCHC staff examined a variety of statistical data for those localities within which is located a hospital identified in the Virginia Rural Health Care plan as a possible candidate for CAH status. In the case of a hospital located in a central city, the surrounding county was also included. These data, which have previously been compiled from primary sources and published by the VHHA

Figure 4

Selected Characteristics of Hospitals Identified As Possible Candidates for Critical Access Hospital Designation (Data Reported to Virginia Health Information for 1999)

Hospital	Number of Staffed Beds	Average Daily In-Patient Census	Average Length of Stay (days)	Operating Margin (percent)	Total Margin (percent)
Franklin	35	20.91	3.8	8.63	13.27
Greensville *	*	*	*	10.09	10.09
Page	20	16.3	3.96	3.6	5.55
Pulaski	40	39.79	4.14	4.0	4.0
Rappahanock	64	35.54	4.69	5.11	6.2
Tappahanock	21	20.43	3.62	6.72	6.72
Russell	78	39.39	5.61	-7.23	-7.23
Shenandoah	64	26.59	3.87	-0.27	0.53
Southampton*	72	32.28	*	-6.26	-0.70
Southside Community	88	46.21	4.52	3.22	0.57
Stonewall Jackson	48	20.42	5.25	5.94	9.89
Twin County	77	55	4.43	-2.12	-2.20
Statewide Average	**167**	**117**	**5.73**	**2.37**	**4.44**

Note: * denotes that incomplete information for 1999 was submitted to Virginia Health Information. Average Daily Inpatient Census equals Number of Inpatient Days/365 calendar days.

Source: Virginia Health Information, 1999 data.

Figure 5
Selected Characteristics of Localities Served by Hospitals Identified As Possible Candidates for Critical Access Hospital Designation

Locality	Average Distance to Emergency Room (miles)	Women Receiving PreNatal Care in First Trimester (%)	Low Birth Weight Infants (%)	Ratio of Actual to Expected Sentinel Events	Residents Below Poverty Level (%)	Residents 65 years of age or older (%)
Carroll	22.7	84.6	10.6	0.24	13.8	16.5
Emporia	25.1	87.6	4.8	5.9	24.5	19.9
Essex	21.3	93	8.1	1.19	14.2	16.3
Franklin City	22	88.9	6.1	2.67	21.6	15
Franklin Co.	14.1	80.6	6.6	0.89	11.7	14
Galax	18.2	84.1	7.6	1.79	19.2	22.1
Grayson	22.1	66.2	7.7	0.49	15.9	17.7
Greensville	25.2	86.7	6.1	0.33	19.7	10.1
Lancaster	21.1	79.3	5.8	0.58	15.1	28
Lexington	21.1	83.3	6.8	1.79	16.9	16
Page	17.9	77.1	5.3	1.27	12.2	15.9
Prince Edward	31.6	81.3	5	1.5	21.4	13.8
Pulaski	8.5	85.2	8.5	0.29	13.6	15.9
Rockbridge	22.1	87.6	5.9	0.41	11.8	15.1
Russell	14.3	71.8	8.5	1.02	20.5	11.7
Shenandoah	15.7	78	7.4	0.82	10.7	17.1
Southampton	26.4	84.1	13.9	1.31	16.6	14.8
VIRGINIA	**18.4**	**84.8**	**7.8**	**1**	**11.3**	**11.2**

Source: Indicators of Healthy Communities 2000 (Virginia Hospital and Healthcare Association), and Health and Resource Data Guide 2000 (Virginia Department of Health).

and VDH, describe a wide range of local demographic, economic, and health-related conditions. Figure 5 summarizes data for the following variables:

- average distance to an emergency room for residents of the locality;
- percent of mothers who received prenatal care during their first trimester of pregnancy (1999);
- percent of low birth weight infants (1999);
- ratio of expected to actual hospitalizations for certain ambulatory-sensitive conditions (asthma, uncontrolled hypertension, uncontrolled diabetes, low birth weight, acute poliomyelitis, and rheumatic fever) that may have been prevented and managed successfully with outpatient care (1998);
- percent of residents with incomes below the federal poverty level in 1998; and
- percent of residents who were 65 years of age or older in 1999.

These data indicate that for 9 of the 17 localities, the ratio of actual to expected sentinel events was greater than the state average. According to the VDH Health and Resource Data Guide, a high ratio suggests that there may be problems with the primary care delivery system in a particular locality. Emporia had the highest ratio in the state at 5.9. Furthermore, in 11 of the 17 localities, residents were on average further away from the nearest emergency room than Virginians as a whole.

According to the data, in 10 of the 17 localities, the percentage of women receiving pre-natal care in the first trimester was below the state average of 84.8 percent. Grayson County, with only 66.2 percent of women receiving pre-natal care in the first trimester, was the second lowest locality in the state in terms of this measure. However, the percent of newborns in Grayson County that were actually low birthweight was 7.7 percent, which was nearly identical to the state average of 7.8 percent. In fact, only five of the 17 localities had low-birthweight percentages that exceeded the state average. Southampton was the highest, at 13.9 percent.

In terms of economic and demographic indicators, all 17 localities had poverty rates that exceeded the state average. Emporia had the highest percentage of residents with incomes below the federal poverty level, at 24.5 percent. In addition, all but one of these localities had a percentage of elderly residents that exceeded the state average. Lancaster, with 28 percent of its residents 65 years of age or older, had the highest percentage of elderly residents in Virginia.

The Virginia Rural Health Care Plan Discusses Remote Supervision of Certain Health Care Practitioners, But Remote Supervision is Not a Defined Term in the *Code of Virginia*

As previously mentioned, pursuant to the federal CAH statute, inpatient services may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who does not have to be present in the facility. There is a provision in the Virginia Rural Health Care Plan which is based on this federal statute. According to the plan, "a mid-level practitioner (i.e., Nurse Practitioner, Physician Assistant or Clinical Nurse Specialist) may provide care under the remote supervision of a physician if allowed by the Virginia Board of Medicine and the Virginia Board of Nursing."

The term "remote supervision" is not defined either in *Code of Virginia* or any of the state's administrative regulations. According to staff at the Department of Health Professions, while remote supervision is not clearly prohibited it is constrained by provisions concerning medical direction and supervision that are part of state law. Such provisions vary depending on the type of practitioner.

Physician Assistants. Board of Medicine regulations governing physician assistants (P.A.) are highly specific in terms of physician supervision requirements. The regulations define "direct", "general", and "personal" supervision:

- direct supervision - supervising physician is in the room in which a procedure is being performed by the P.A.,
- personal supervision - supervising physician is within the facility in which the P.A. is functioning, and
- general supervision - supervising physician is easily available and can be physically present within one hour.

According to the regulations, prior to the initiation of practice, a P.A. and the supervising physician must submit a written protocol to the Board of Medicine which identifies and describes the roles and functions of the P.A. The Board of Medicine may require information regarding the level of supervision (i.e., direct, personal, or general) with which the supervising physician plans to supervise the P.A. for selected tasks.

The regulations specify that a P.A. may perform the following procedures under general supervision:

- insert a nasogastric tube;
- insert a bladder, needle or peripheral intravenous catheter;
- minor suturing;
- venipuncture; and
- subcutaneous intramuscular or intraveneous injection.
-

All other procedures must be performed under direct supervision unless, after directly supervising the performance of a specific invasive procedure at least three times, the supervising physician attests to the competency of the PA. Such certification must be approved by the Board of Medicine. In addition, §54.1-2652 of the *Code of Virginia* states that a PA practicing in an emergency department shall be under the supervision of a physician "present within the facility."

Nurses. State regulations governing nurses, including nurse practitioners and clinical nurse specialists, are less specific in defining what is required in terms of physician supervision and oversight. According to DHP staff, that is primarily due to nurse practitioners and clinical nurse specialists being generally viewed as "collaborative partners" with physicians. Board of Nursing regulations define supervision as a physician "being readily available for medical consultation by the licensed nurse practitioner or the patient, with the physician maintaining ultimate responsibility for the agreed upon course of treatment and medications prescribed." There is no statutory or regulatory definition of supervision pertaining specifically to clinical nurse specialists.

It is not clear at this time whether any current or potential CAHs in Virginia would actually staff their facilities or utilize their personnel in such a way as to be out of compliance with Virginia's statutes and regulations governing the scope of practice. However, given the apparent inconsistencies between the federal CAH statute and Virginia's statutes and regulations, particularly with regard to physician assistants, this topic warrants further review and consideration as Virginia's CAH program continues to develop.

V.
State Approaches to Assisting Critical Access Hospitals

As previously mentioned, JCHC staff were directed to study the possibility of establishing a state component to the federal critical access hospital program. To the extent that this has been done by other states, the state component has typically taken the form of cost-based reimbursement provided by the state's Medicaid program to critical access hospitals. This section examines this type of approach in other states, and how it could be structured in Virginia.

Limitations of Medicare Cost-Based Reimbursement to Critical Access Hospitals

The CAH program is not a complete solution for all of the problems that confront rural hospitals, and that are associated with supporting essential health services in rural areas. Part of the inherent limitation of CAH is that it is based in the Medicare program. While Medicare is a major revenue source to hospitals, enhanced Medicare reimbursement under the CAH program does little to support services such as obstetrics, pediatrics, and emergency room care which are provided primarily to a non-Medicare patient population. These essential services, which according to VHHA staff are among the least profitable services in rural hospitals, instead rely on internal cross-subsidies from more profitable health services like ambulatory surgery and diagnostic imaging. Furthermore, cost-based reimbursement, even from a major revenue source such as Medicare, does not, by definition, provide a positive rate of return to any hospital.

Sixteen States Provide Critical Access Hospitals With Cost-Based Reimbursement Through Their Medicaid Programs

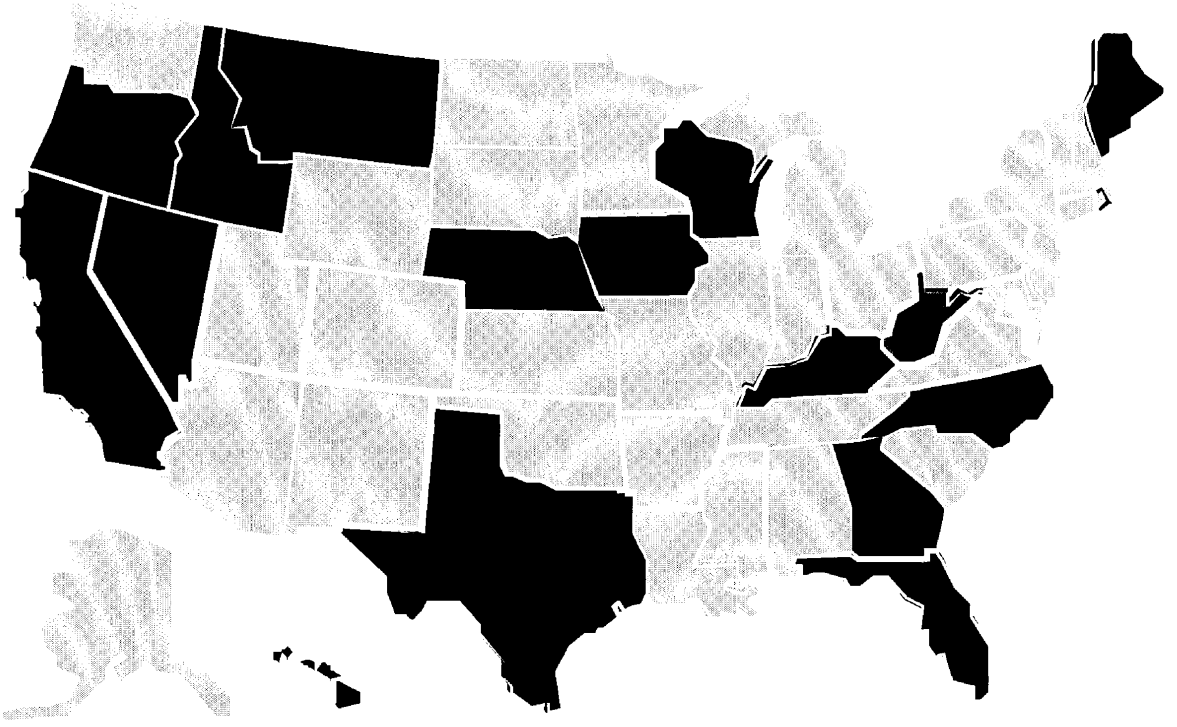
In an effort to provide increased financial resources to small rural hospitals and promote other rural health policy objectives, 16 states including Kentucky, North Carolina, and West Virginia have structured their Medicaid hospital payment systems so as to reimburse critical access hospitals on a cost basis (Figure 6). According to VDH and VHHA, the issue of cost-based reimbursement for CAH was raised with the Department of Medical Assistance Services (DMAS) during development of the state rural health care plan. However, according to both VDH and VHHA, DMAS expressed opposition to cost-based reimbursement at that time.

JCHC staff conducted telephone interviews with individuals in 10 of the states which currently provide Medicaid cost-based reimbursement to their critical access hospitals. Individuals from the state health department, Medicaid agency, and hospital association were interviewed in order to obtain information concerning the structure of critical access hospital programs in those states. Information obtained from five southeastern states is summarized below.

North Carolina. The objectives of CAH in North Carolina include 1) financial stabilization of small rural hospitals so that they can stay in existence and provide basic primary care to their areas, 2) physician recruitment and local economic development, and 3) promotion of primary care and community health. North Carolina has emphasized network development within the CAH program.

Figure 6

States Which Provide Cost-Based Medicaid Reimbursement to Critical Access Hospitals (States Shaded in Black)



Source: JCHC staff graphic based on data from the Rural Policy Research Institute.

The state's small rural hospitals tend to have Medicaid utilization of between 15 and 30 percent. Therefore, Medicaid cost-based reimbursement is seen as a strong incentive for obtaining CAH certification. Medicaid cost-based reimbursement is viewed as making these hospitals less reliant on fee-for-service volume to meet their fixed costs. North Carolina makes disproportionate share hospital (DSH) payments to CAHs in order to provide them with cost-based reimbursement. The fiscal impact to the state Medicaid program is minimal, estimated to be $250,000 for eight CAHs. North Carolina officials believe that there are opportunities for CAH service expansion in the outpatient arena, and that the CAHs will begin to realize this.

West Virginia. The objectives of CAH in West Virginia include 1) providing a model for small rural hospitals with very low service volume to be adequately compensated for services they provide, and 2) encouraging network development in rural areas. The state's CAHs tend to be located in very remote areas, with many requiring one or two hours travel time on the part of their patients. Medicaid uses DSH payments to provide the CAHs with 100 percent cost reimbursement. Despite the CAH program, West Virginia still has some rural hospitals that are continuing to struggle due, for example, to recruitment problems.

Kentucky. Key objectives of the CAH program include 1) providing small rural hospitals with additional financial assistance to help assure their continued survival; and 2) stabilizing the health care systems of rural communities, based on the theory that other elements of the system (i.e., physicians and health departments) are focused around a particular hospital. Since implementation of the CAH program in 1999, no hospitals have closed in Kentucky.

Currently, the Medicaid hospital reimbursement system is a prospective per diem with a number of limitations (i.e., peer groups and rate of interest controls.) Due to these limitations, virtually none of the state's hospitals have been paid their full costs by Medicaid. For the CAHs, these reimbursement restrictions are removed, and a retrospective cost settlement is conducted. The estimated fiscal impact to the Medicaid program is about $3.5 million (total funds) based on the assumption that the state will eventually have 15 CAHs.

Georgia. The objective of the CAH program in Georgia is to encourage and incentivize small rural hospitals to restructure their operations, while at the same time seeking to avoid state-funded bailouts of hospitals. Although about 50 percent of the state's population lives in the Atlanta metropolitan area, Georgia has many small, rural hospitals. In fact, the state's threshold CAH criteria were met by 64 hospitals. Georgia's Medicaid agency sent each of these hospitals a memorandum of understanding (MOA) under which the hospital

agrees to pursue CAH certification (including performance of a feasibility study) within two years, with the state providing technical assistance. Hospitals that signed the MOA were deemed certified as a CAH and began receiving cost-based reimbursement from Medicaid. Under the program, when CAH certification is actually received, these hospitals begin to receive additional Medicaid reimbursement for laboratory services.

Thus far, 32 hospitals have signed the MOA and ten of these have actually obtained CAH certification. The remaining 22 hospitals have not yet obtained certification. If these other 22 hospitals do not pursue CAH certification within two years, they must notify the state, whereupon 100 percent cost based-reimbursement stops. However, according to staff in Georgia's Medicaid agency, the state will not attempt to recoup prior payments. The estimated fiscal impact to the Georgina Medicaid program is approximately $3 million in total funds.

Florida. The objective of the CAH program in Florida is to preserve and protect the viability of rural hospitals that are sole community providers. The Florida Medicaid program reimburses hospitals on a prospective, cost-based per diem system. However, CAHs are exempt from the various targets and limitations that are built into the reimbursement system, with the result that CAHs are reimbursed for 100 percent of their costs. The financial impact to the Medicaid program is minimal since small rural hospitals account for a relatively small number of Medicaid patient days. Florida also has a rural DSH program which distributes $9.8 million per year, and a rural financial assistance program which distributes $1.2 million per year. The rural financial assistance program focuses on those rural hospitals that do not receive DSH due to the fact that they do not provide obstetrical services. Under the rural financial assistance program, each rural hospital receives at least $200,000 in state funds annually.

DMAS Has Estimated A Relatively Small Fiscal Impact Associated With Providing Cost-Based Reimbursement to Five Critical Access Hospitals in Virginia

As previously mentioned, the COPN deregulation plan called for the appropriation of $24 million (GF) in additional Medicaid reimbursement to hospitals by eliminating the 21 percent negative adjustment factor used by DMAS. As a result of this, on average statewide, inpatient hospital reimbursement would equal Medicaid allowable costs. Even with such additional funding, however, reimbursement to individual hospitals would vary under the Medicaid inpatient reimbursement system. Some Virginia hospitals would continue to receive reimbursement that would be lower than their allowable costs for providing inpatient services to Medicaid patients.

At the request of JCHC staff, DMAS staff calculated the estimated fiscal impact of reimbursing critical access hospitals for 100 percent of their allowable costs for treating Medicaid recipients. This would constitute, in effect, a reimbursement guarantee to these hospitals above and beyond whatever additional funding they might receive as a result of the statewide inpatient reimbursement reform provisions contained in the COPN deregulation legislation. The components of the DMAS estimate, which was limited to the five previously discussed "likely" candidates for CAH certification, are presented in Figure 7. According to DMAS, the estimated fiscal impact is $575,097 (total funds), which represents $276,909 in state general funds.

Figure 7

Fiscal Impact Estimate for Providing Cost-Based Medicaid Reimbursement to Critical Access Hospitals

Hospital	Medicaid Utilization	1999 Inpatient Medicaid Losses	DRG Case Rate 2001	Estimated 2001 DRG Case Rate @ 100% Cost
Bath	1.5%	$12,217	$2,583.25	$4,288.20
Giles	3%	-	$2,583.25	n/a
Dickenson	14%	$333,237	$2,583.25	$4,184.86
Tazewell	6%	-	$2,583.25	n/a
RJR-Patrick	9.3%	$229,643	$2,583.25	$4,743.18
Estimated Fiscal Impact		$575,097 (total funds)		
		$276,909 (general funds)		

Note: Estimate based on DMAS FY 1999 hospital cost report data. DMAS estimates that Giles and Tazewell currently are reimbursed for at least 100 percent of their Medicaid allowable cost. Actual fiscal impact could be affected by system wide increases in Medicaid inpatient reimbursement, as recommended by COPN deregulation plan, and could be less than estimated here.

Source: Department of Medical Assistance Services and JCHC staff interviews with VHHA staff.

Estimation Methodology. DMAS computed the estimate within the parameters of the current All-Payer Diagnosis Related Group (APDRG) inpatient

hospital reimbursement system. Under this methodology, payments depend on the type and complexity of a patient's illness, with reimbursement rates set in advance of services being provided, based on an expected number of days required to treat each type of illness or medical condition. In computing the estimate, DMAS calculated the amount of hospital losses incurred in providing care for Medicaid patients during FY 1999 (the most recent year for which cost data are available). In the case of hospitals which incurred Medicaid inpatient losses in FY 1999, DMAS then adjusted the hospital's 2001 DRG case rate such that Medicaid inpatient reimbursement would be equal to the hospital's allowable Medicaid costs. Utilizing this methodology, DMAS estimated that two of the hospitals, Giles and Tazewell, are already receiving at least 100 percent reimbursement for their allowable costs under the APDRG system, thereby minimizing the overall fiscal impact of providing cost-based reimbursement to CAHs. According to DMAS staff, the relatively minimal fiscal impact is primarily due to the low number of hospitals included in the estimate, and the relatively small amount of Medicaid utilization at each hospital.

The DMAS fiscal impact estimate was reviewed by VHHA staff, who stated that the methodology used was reasonable. However, given the statewide inpatient reimbursement reform provisions contained in the COPN deregulation legislation, VHHA staff noted that the DMAS estimate could in fact prove to be lower, and should be viewed as a high end for the estimate. It should be noted that during an initial interview with JCHC staff, VHHA staff indicated that their preliminary rough estimate of the fiscal impact of cost-based reimbursement for CAHs was approximately $2 million to $5 million total funds, which is substantially higher than the current DMAS estimate. However, this preliminary estimate was based on an assumption that there would be approximately 10 to 12 CAHs in Virginia.

Prior Estimates of Medicaid Cost Coverage Rates. In its 2000 report titled Review of the Medicaid Inpatient Hospital Reimbursement System, the Joint Legislative Audit and Review Commission (JLARC) estimated the Medicaid cost coverage rate for each of Virginia's hospitals for FY 1998, and compared that to the cost coverage rate estimated by DMAS. The rates for the five likely CAH candidates were reported as follows:

- Bath - 64% (DMAS) and 64% (JLARC),
- Dickenson - 82% (DMAS) and 79%(JLARC),
- Giles - 61% (DMAS) and 54%(JLARC),
- Patrick - 76% (DMAS) and 76%(JLARC), and
- Tazewell - 99% (DMAS) and 95%(JLARC).

The reason for the difference in estimated cost coverage rates is that JLARC included, as part of each hospital's costs, a measure of charity care costs incurred by the facility.

These cost coverage rates appear, at least in part, somewhat contradictory to the data upon which the DMAS fiscal impact estimate is based. In particular, the estimated FY 1998 cost coverage rate for Giles Memorial Hospital is relatively low, but DMAS reports that the hospital is currently receiving 100 percent of its costs under the APDRG system. On the other hand, the FY 1998 cost coverage rate for Tazewell is much more consistent with the current DMAS estimate. VHHA staff estimated that such fluctuation is possible, particularly for relatively low-volume providers such as these. Nevertheless, the DMAS fiscal impact estimate may require some additional refinement. In addition, if CAH certification is eventually achieved by more than the five previously mentioned hospitals, the Medicaid fiscal impact estimate will have to be revised.

Potential Impact of Cost-Based Medicaid Reimbursement. There is some question of how significant of an impact Medicaid cost-based reimbursement would have for each of these hospitals. It is reasonable to assume that the impact will be greater in those hospitals with larger Medicaid utilization rates. At Bath County Hospital, for example, hospital management expressed doubt that enhanced Medicaid reimbursement would have a significant impact on its operations, given the hospital's small Medicaid utilization rate. Giles County hospital and Patrick County hospital, on the other hand, both believe that cost-based Medicaid reimbursement would add some value.

DSH Payments. VHHA staff did state that, in their opinion, there is some precedent for the Virginia Medicaid program to reimburse hospitals at a rate greater than their actual costs. The specific example, according to VHHA, is the DSH program. In order to be eligible for DSH payments in Virginia, a hospital must either have a Medicaid patient utilization rate greater than 15 percent, or a low-income patient utilization rate greater than 25 percent. Under this program, DSH payments to the two state teaching hospitals (MCV and UVA), are multiplied by a factor of 11. These are called "enhanced" DSH payments. None of the other Virginia hospitals that receive DSH payments are reimbursed using that multiplier. During 2000, 26 acute care hospitals in Virginia received DSH payments. In addition, a hospital must have at least two obstetricians with staff privileges who are willing to provide obstetric services to Medicaid patients. DSH payments do not apply to hospitals that do not offer non-emergency obstetric services.

DMAS Currently Reimburses Certain Types of Services on a Cost Basis

Pursuant to state regulations, the following services are reimbursed on a cost basis:

- outpatient hospital services excluding laboratory services,
- rural health clinic services provided by rural health clinics or other federally qualified health centers,
- inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals, and
- services provided by rehabilitation agencies.

Medicaid Managed Care Could Affect Cost-Based Reimbursement of Critical Access Hospitals

The Medallion II program administered by DMAS requires mandatory enrollment in a managed care organization by most clients living in participating localities. As of July 1, 1999, the program operated in 46 localities and almost 150,000 Medicaid beneficiaries were enrolled. Currently, the Medallion II program is limited to localities in Central and Tidewater Virginia. Localitites in Northern, Northwest, Southside, and Southwest Virginia do not participate. Up until now, rural hospitals in Virginia have experienced very little managed care penetration in their communities. However, effective October 1, 2001, the Medallion II program will expand into an additional 50 Virginia localities, including many rural localities. Two of those localities, Giles County and Patrick County, are home to critical access hospitals. Localities in far Southwest Virginia, and far Northwest Virginia, will not be included in Medallion II at this time.

The expansion of Medicaid managed care into many of the state's rural localities could well have implications for the ability of CAHs in those localities to receive cost-based reimbursement from Medicaid. Assuming the state had made the policy decision to provide Medicaid cost-based reimbursement, the CAHs would have to negotiate their reimbursement with the managed care organizations, rather than receiving it directly from DMAS.

Traditionally, the State has avoided mandating contract payment provisions to managed care organizations that contract with DMAS. Rather, the policy approach has been to provide managed care organizations with flexibility, while at the same time attempting to hold them accountable for providing access to quality health care. The question becomes whether any type of exception should be made for critical access hospitals.

Among the other states (i.e., North Carolina, West Virginia, Kentucky, Georgia, and Florida) interviewed by JCHC staff, managed care was not considered to be a significant factor in their Medicaid programs, and therefore has had no impact on those states' policy decisions to provide cost-based Medicaid reimbursement to critical access hospitals. To the extent that any of these states utilize Medicaid managed care, it tends to be limited to urban, as opposed to rural areas. Kentucky does have a statute which requires any managed care health insurance plan that contracts with Medicaid to pay any critical access hospital at least the same rate as the CAH would receive from Medicare (i.e., 100 percent of allowable costs). However, since Kentucky does not have any CAHs located in a managed care region, the statute has not yet been relied upon or tested.

Conclusion

While the CAH program is certainly not a panacea for all of the issues facing small rural hospitals, it does provide some hospitals with an additional option for strengthening their financial and operational viability. The underlying public policy question is: How important is it for all of Virginia's small rural hospitals to remain in operation? The CAH program appears to be premised on the assumption that it is important for all these hospitals to remain open. Certainly, such a premise is entirely consistent with other state initiatives and activities designed to recruit and retain health care practitioners in rural areas, as well as to expand access to care to residents of rural localities. The CAH program also appears to be complimentary to many of the goals of Healthy Virginians 2010 established by the VDH, as well as with rural economic development interests. However, there are some potential scope of practice issues involving CAH personnel that may warrant additional review and consideration.

It is important to realize that not all rural hospitals are so small, nor experiencing financial difficulty to such a degree, that CAH conversion would likely be seen as a palatable option. In all likelihood, there will probably not be more than five CAHs in the near term in Virginia, unless Congress further expands the program's eligibility requirements (i.e., by allowing for a greater number of beds and a longer average length of stay). Proposals to expand the federal program are being developed and advocated by national organizations such as the National Rural Health Association. However, even in the absence of any further expansion of the federal program, Virginia could, if it chose, provide for more expansive criteria to define those small rural hospitals that could receive additional Medicaid reimbursement.

JCHC staff were directed to study the possibility of establishing a state component of the federal critical access hospital program. Medicaid cost-based

reimbursement to CAHs in Virginia would be a relatively small step that could be taken to provide some additional resources to these providers, and could serve as a key element for a Virginia-specific component to the federal program. The fiscal impact associated with cost-based reimbursement appears to be relatively minor as compared to the overall cost of Virginia's Medicaid program. However, the degree of actual impact on CAH operations from cost-based reimbursement will vary depending on the extent of Medicaid utilization at the facility. Moreover, expansion of Medicaid managed care into rural regions of the state could affect the ability of CAHs to receive cost-based reimbursement for services provided to Medicaid beneficiaries.

VI.
Policy Options

The following policy options are offered for consideration by the Joint Commission on Health Care regarding the establishment of a Virginia state component of the federal critical access hospital program. Since this report was conducted as a follow-up to the Joint Commission on Health Care's activities concerning COPN deregulation, these policy options could be considered as part of broader legislation concerning COPN, or they could be considered independently. Moreover, these policy options do not represent the full range of actions that the Joint Commission on Health Care may wish to pursue with specific regard to critical access hospitals, or within the broader context of rural health care policy. Furthermore, these policy options are not mutually exclusive. The Joint Commission on Health Care may choose to pursue two or more of Options II - V.

Option I: **Take No Action**

Option II: **Introduce legislation to establish a state component to the federal critical access hospital program by requiring the Department of Medical Assistance Services to reimburse critical access hospitals such that they receive 100 percent of their Medicaid-allowable costs.** ***This option could be structured to require DMAS to adjust the DRG case rate for critical access hospitals as part of the reimbursement rate rebasing process conducted every three years.***

Option III: **Introduce legislation requiring any insurer or managed care health insurance plan that contracts with the Department of Medical Assistance Services for the Medallion II program to reimburse critical access hospitals for services provided to Medicaid recipients such that they receive 100 percent of their Medicaid-allowable costs.**

Option IV: **Introduce legislation clarifying the authority of health care practitioners practicing in critical access hospitals to perform various types of health care procedures in situations during which the supervising physician is not physically present in the facility.**

Option V: **Include in the 2002 Workplan for the Joint Commission on Health Care further study and analysis of rural health care policy issues, including rural health status, access to primary and specialty care services, and provider recruitment and retention.**

APPENDIX A

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
Critical Access Hospital Study

Organizations/Individuals Submitting Comments

A total of six organizations and individuals submitted comments in response to the report on the critical access hospital study:

- Virginia Hospital & Healthcare Association (VHHA),
- R.J. Reynolds-Patrick County Memorial Hospital, Inc.,
- U.S. Congressman Virgil Goode, Jr.,
- The Medical Society of Virginia (MSV),
- Virginia Association of Health Plans (VAHP), and
- Trigon Blue Cross Blue Shield

Policy Options Included in the Critical Access Hospital Issue Brief

Option I: **Take No Action**

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Option V: **Include in the 2002 Workplan for the Joint Commission on Health Care further study and analysis of rural health care policy issues, including rural health status, access to primary and specialty care services, and provider recruitment and retention.**

Overall Summary of Comments

None of the commenters supported Option I, and VHHA expressed opposition to that option. Three of the six commenters (VHHA, R.J. Reynolds-Patrick County Memorial Hospital, Inc., and MSV) expressed support for Option II. Three commenters (VHHA, MSV, and VAHP) also expressed support for Option V. The VAHP expressed clear opposition to Option III, while VHHA and MSV expressed some concerns with that option. R.J. Reynolds-Patrick County Memorial Hospital expressed support for Option III. Option IV was clearly opposed by MSV, while the VHHA expressed some concerns with that option.

Summary of Individual Comments

Virginia Hospital and Health Care Association

William L. Murray, Vice President, commented that VHHA strongly supports Option II, and opposes Option I.

VHHA "strongly supports the spirit of Option III to the extent that it would help struggling rural hospitals in a Medicaid managed care environment but is concerned about unintended consequences." For example, legislation intended to set a floor on rates could in fact establish "a de facto ceiling." Mr. Murray stated that VHHA has long advocated that Medicaid managed care rates

should be a matter for negotiation between the health plan and the provider "without state intervention."

Regarding Option IV, VHHA feels that this type of scope of practice legislation "is fraught with potential for attracting unrelated scope of practice issues during a legislative session." VHHA strongly supports Option V. Mr. Murray suggested that the issue addressed by Option IV could be included in the study contemplated by Option V.

R.J. Reynolds-Patrick County Memorial Hospital, Inc.

Norman E. Walters, Administrator expressed support for Option II and Option III. Regarding Option III, Mr. Walters stated that the legislation should be structured so that "DMAS would have to review the reimbursement rate periodically to ascertain that the Critical Access Hospitals are indeed receiving 100% of the Medicaid Allowable Cost." Mr. Walters stated that 100 percent cost-based Medicaid reimbursement, had it previously been in effect, would have enabled the hospital to keep its Obstetrics Department open and enabled the hospital to provide a needed service to the county.

U.S. Congressman Virgil Goode, Jr.

Congressman Goode stated that the Critical Access Hospital Program could be of significant help and benefit to citizens in rural areas such as Patrick County. He expressed the hope that the JCHC will do all it can to assist and facilitate the Critical Access Hospital Program so that it will be available for hospitals and rural areas.

The Medical Society of Virginia

Michael Jurgensen, Director of Health Policy, expressed support for Option II. Mr. Jurgensen noted that "The nominal impact on the budget of DMAS should be more than offset by the advantages to be gained by maintaining these important community services."

Mr. Jurgensen stated that Option III deserves further examination. In particular, "consideration should be given to the impact this may have on managed care plans continued participation in the Medallion II program if the state elects to limit the flexibility in negotiating their own contractual relationships."

Mr. Jurgensen expressed opposition to Option IV. Without further evidence from existing CAH facilities that this is necessary to accomplish their

revised mission, and lacking information from other states, the MSV believes this option is premature.

Mr. Jurgensen expressed support for Option V, and suggested including the issues addressed by Options III and IV in the study contemplated by Option V.

Virginia Association of Health Plans

Lynn M. Warren, Director of Policy, expressed support for Option V.

Ms. Warren expressed opposition to Option III for two primary reasons:

- MCHIPs should have the flexibility to negotiate payment rates within the context of a free market and "in accordance with the value of services that the CAHs have to offer."

- Any additional mandates or administrative burdens placed on MCHIPs could result in the withdrawal of MCHIPs from the Medicaid market, "similar to what has occurred in the Medicare program."

In discussing VAHP's opposition to Option III, Ms. Warren noted that hospital payment methodologies currently vary among MCHIPs participating in the Medallion II program. Some of the MCHIPs reimburse hospitals according to Medicaid's DRG rates, some reimburse on a per diem basis, and others have a mixed approach. Ms. Warren also stated that if the JCHC concludes that CAHs need additional financial support, "a more suitable approach is to have the money flow directly from DMAS or the Commonwealth rather than from the MCHIPs."

Trigon Blue Cross Blue Shield

Leonard L. Hopkins, Jr., Vice President, Public Policy Officer, endorsed the comments submitted by VAHP.

JOINT COMMISSION ON HEALTH CARE

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