



HOSPITALS THAT HAVE NOT YET CONVERTED: IS CAH STILL AN OPTION?

Questions and Issues for Small Rural Hospitals

This monograph was developed by Rural Health Consultants (RHC) of Lawrence, KS for the Technical Assistance and Services Center (TASC) for the Rural Hospital Flexibility Program



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Executive Summary

Since the enactment of the Medicare Rural Hospital Flexibility (Flex) Program as part of the Balanced Budget Act of 1997, conversion to a Critical Access Hospital (CAH) has been among the most widely used vehicles for enhancing the financial stability of small rural hospitals. Through October 1, 2002, 688 hospitals in 45 States have been certified as CAHs and there are close to 1,000 additional rural hospitals that are considered by their States to be eligible, but have not yet converted.

Conversion to a CAH does not necessarily result in financial improvement and is not, therefore, an economically viable option for every rural hospital. Requirements that a CAH maintain an acute care census of 15 inpatients or less and an annual average length of stay (ALOS) of 96 hours or less also make it difficult or undesirable for some hospitals to make the changes necessary to convert to CAH status. Other obstacles to conversion include incomplete or inadequate knowledge of the program, antipathy to government programs and regulation, and the presence of successful services (e.g., distinct-part Geriatric Psychiatric or Rehabilitation Units) that cannot be provided in CAHs.

This monograph presents a series of questions that State Flex Program managers and others should ask to better understand the reasons that hospitals have not converted to CAH status and assess the need for additional CAH conversion activities. These questions and several other issues that may present obstacles to CAH conversion are fully discussed in the report.

In summary, these questions and issues are:

' What Is the Reason That the Hospital Has Not Converted to a CAH?

Reason for Not Converting: Unfavorable Financial Feasibility Study

- Why was the study unfavorable?
- Has anything changed since the study was done?
- How long ago was the study conducted?

Reason for Not Converting: Acute Care Census Exceeds 15 Patients

- Is ALOS too high?
- On how many days during the year does the census exceed 15 patients?
- How high does the census get?
- Do high census days occur throughout the year or seasonally?
- Has high census been consistent for several years or is it a one-year or occasional

phenomenon?

- Does the hospital have a swing bed program? Are swing beds being used appropriately?
- Does the hospital provide outpatient observation services? Are observation services being used appropriately?
- Is the hospital part of a system or network?
- What is the admissions profile of each of the physicians on staff ?
- Are admissions appropriate to the hospital's capabilities and its role in the community and its health system/network?
- What are the financial implications of reducing census to comply with the CAH requirements?
- What are the community/social implications of reducing census to comply with the CAH requirements?

Reason for Not Converting: Average Length of Stay Exceeds 96 Hours

- What is the trend in ALOS over the last several years?
- How does ALOS compare to ALOS at similar hospitals?
- Is ALOS justified by the hospital's case mix?
- What are the hospital's most prevalent DRGs? How does ALOS for the most prevalent DRGs compare to ALOS for these DRGs at similar hospitals?
- How does ALOS for the most prevalent DRGs compare to the Medicare arithmetic mean length of stay for these DRGs?
- What is the ALOS by DRG for each physician that admits to the hospital? Is ALOS high for all physicians or just a few physicians? Does it vary depending on DRG?
- Does the hospital have a swing bed program? Are swing beds being used appropriately? Does the hospital provide observation services? Are observation services being used appropriately?

Reason for Not Converting: Little Interest in the Program

- Who isn't interested? Why aren't they interested?
- Has adequate education been provided?
- Have board members, administrators, and/or physicians from hospitals that have converted to CAHs been consulted?
- Has community input been sought?

Reason for Not Converting: Presence of a Geriatric Psychiatric Unit (or other Distinct-Part Unit)

' Does the Hospital Plan to Make Capital Investments?

' Does the State Medicaid Program Reimburse CAHs on a Cost-Basis?

How does the Medicaid program pay for services in CAHs? Does Medicaid use the Medicare

reimbursement methodology for CAHs?

- # What is the impact on the State Medicaid Program of paying CAHs on a cost-basis (using the Medicare methodology)?

It is likely that most of the hospitals that are legitimate candidates for CAH conversion and will benefit from the program have already converted. Nevertheless, it is also likely that a number of hospitals that could benefit have not converted, for a variety of reasons. A systematic assessment of small rural hospitals that have not converted, using the questions and issues raised in this monograph, will help State Flex Program managers ensure that the program is reaching all of the hospitals and rural communities that can benefit from it. Even if this process does not lead to CAH conversion, it will benefit the affected facilities by spotlighting issues that, if addressed, could improve the access, efficiency, and quality of the health care services available to the community.

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I. Introduction

Since the enactment of the Medicare Rural Hospital Flexibility (Flex) Program as part of the Balanced Budget Act of 1997, conversion to a Critical Access Hospital (CAH) has been among the most widely used vehicles for enhancing the financial stability of small rural hospitals. Through cost-based reimbursement from Medicare (and Medicaid in some States), many rural hospitals have enhanced revenues and improved their bottom lines. Meaningful networking with other providers has also allowed some CAHs to expand the scope of services available to local residents, take advantage of network-based revenue enhancement or cost-saving strategies, and engage in other projects and programs that had not previously been possible. In addition, in States that permit them to take full advantage of less burdensome Medicare Conditions of Participation, CAHs can realize some cost savings, as well.

Through October 1, 2002, 688 hospitals in 45 States have been certified as CAHs and certification or designation are pending for another 104. There are close to 1,000 additional rural hospitals that are considered by their States to be eligible, but have not yet converted to CAH status. Close to than 600 of these are further classified by their States as “likely” to consider conversion.¹

There are many reasons why a hospital may not convert to a CAH. Conversion does not necessarily result in financial improvement and is not, therefore, an economically viable option for every rural hospital. Because the Medicare Prospective Payment System (PPS) reimburses many hospitals more than their costs, particularly for inpatients, cost-based CAH payment can result in a decline in revenues. It is estimated that at least half of all rural hospitals that accurately assess the financial impact of CAH conversion find that it does not help. This proportion may shrink if Medicare continues to restrict the growth in hospital PPS payment and more rural hospitals experience Medicare operating losses. In these cases, CAH conversion may grow more attractive to these facilities over time.

Other possible deterrents to conversion are the program’s limits on average length of stay (ALOS) and census. A CAH must maintain a yearly acute care ALOS of 96 hours or less and may not provide care to more than 15 acute care inpatients at any one time. Hospitals that regularly exceed these utilization limitations, particularly the census limit, often find it difficult or undesirable to make the changes necessary to conform to the regulations. Other obstacles to CAH conversion include incomplete or inadequate

¹Rural Hospital Flexibility Program Tracking Project website, Updated MRHF Grid (as of October 1, 2002), <http://www.rupri.org/rhfp-track/mrhfgrid.html>.

knowledge of the program, antipathy to government programs and regulation, and the presence of successful services (e.g., distinct-part Psychiatric or Rehabilitation Units) that cannot be provided in CAHs.

This monograph is designed as a technical resource to help State Flex Program managers better understand the reasons that hospitals have not converted to CAH status and to assess the need for additional CAH conversion activities in the State (e.g., updated financial feasibility studies, program education, etc.). An understanding of the likelihood of conversion among a State's remaining small rural hospitals will allow Flex Program managers to appropriately allocate resources between CAH conversion and other activities.

II. What Is the Reason That the Hospital Has Not Converted to a CAH?

A. Reason for Not Converting: Unfavorable Financial Feasibility Study

' Why was the study unfavorable?

The primary reason that a hospital chooses not to convert to a CAH is a financial feasibility study that shows that conversion will not provide a financial benefit to the hospital. In the majority of these cases, CAH conversion and cost-based Medicare reimbursement result in increased revenue for outpatient (including lab) and swingbed services, but a decline in revenue for inpatient services. The balance between these changes determines whether CAH conversion has a positive or negative financial impact on the facility. For most hospitals in which CAH conversion is not financially favorable, declines in inpatient revenues outweigh the increases in outpatient and swingbed payment.

A factor that must always be considered is the quality of the financial feasibility study (i.e., Is the study accurate? Does it take into account the changes if any, that will take place as a result of CAH conversion?). A wide range of individuals and organizations conduct CAH financial feasibility studies, including hospital management, health system staff, consultants, and accounting firms. Most of these individuals and organizations are competent to conduct these studies and have an adequate understanding of the effects of CAH conversion. Occasionally, however, inexperienced or inadequately trained consultants or others conduct studies that use faulty assumptions or fail to accurately consider these factors. This issue is particularly important for those hospitals that exceed the CAH utilization limits and must make operational changes to bring their ALOS and/or census into conformance with program requirements. In selecting an individual or organization to conduct a financial feasibility study, State Flex Program managers and hospital administrators must consider these issues to ensure that the resulting analysis accurately predicts the impact of CAH conversion.

Hospitals that are eligible for CAH conversion but have not conducted a financial feasibility study should, of course, consider the reasons that the study has not been performed. Hospitals that do not consider themselves to be eligible for conversion or good candidates to become a CAH often change these perceptions if adequate program education is provided or other issues and concerns are addressed. There may also be hospitals that were not previously eligible, but changes in utilization or hospital operations have subsequently made CAH conversion a more promising option. Because the majority of financial feasibility and other analyses are paid for with Flex Program grant funds, there is usually little or no cost to the hospital in having one done (issues surrounding hospitals that have not yet conducted a financial feasibility study or are uninterested in the program are further discussed in other sections of the monograph).

If eligible hospitals have not conducted financial feasibility studies or there is some question about the accuracy of such analyses, the State should consider funding new feasibility studies for these hospitals.

' Has anything changed since the study was done?

Changes in utilization, operations, and other factors can have a profound effect on the viability of a small rural hospital and the feasibility of CAH conversion. This is particularly important in hospitals that have not converted because of high ALOS and/or census. Substantial declines in utilization, particularly on the inpatient side, can quickly change a hospital's financial picture and make CAH conversion comparatively more favorable. It is important that utilization trends be considered and that years in which utilization was atypical not be used as the basis of a financial feasibility study (unless appropriate data-based adjustments are made).

The trend in inpatient utilization in the majority of small rural hospitals is downward. Analyses based on a single year or years of unusually high utilization or on assumptions that utilization will increase following conversion should be viewed with caution. There are, of course, some facilities that buck these trends and are experiencing increased utilization. This must also be considered and taken into account when assessing the viability of CAH conversion.

Just as utilization changes can have a significant impact on financial viability, changes in payor mix also affect a hospital's financial status and the impact of CAH conversion. Because payor mix is relative (i.e., changes in utilization for one payor affect the proportion of utilization of other payors), the consequences of changes can be complex. Furthermore, there is no simple formula that predicts the results of a change in payor mix. For example, an increase in the proportion of Medicare patients does not automatically result in an increase in CAH viability relative to continued operation as a hospital. Conversely, a decrease in Medicare payor mix does not necessarily result in a decrease in CAH viability. As with all of these variables, changes in payor mix must be considered in context with other hospital operations and accounted for appropriately.

Additional factors to consider include changes in services, physician staff, and other aspects of the cost and revenue structure of the hospital since the time that the feasibility study was conducted. Changing the mix of services provided in the hospital can result in changes in costs and revenues and lead to changes in utilization, length of stay, and payor mix. The addition of new physicians (or mid-level practitioners, if they admit to the hospital) or the loss of such professionals, can impact utilization, length of stay, and other hospital operations. In small hospitals, in particular, a physician who is a major admitter, or one who rarely admits, can have a significant effect on the facility's financial status. Changes in the medical staff or their admitting practices, therefore, can lead to changes in the results of a financial feasibility analysis.

Other medical staff issues are paramount in the CAH conversion decision process. Physician support is important to the success of the program, while physician resistance to the change usually halts progress. These and other medical staff issues are discussed further, below.

Hospitals also must consider whether changes in services, practice patterns, or other factors can be made that would make CAH conversion more financially advantageous. Compared to a hospital that can become

a CAH and continue business as usual, CAH conversion is significantly more difficult and less likely in situations where operational changes must be made to comply with program requirements or to make the program work financially. Nevertheless, hospital boards and management should consider such changes, particularly in poorly performing hospitals in which CAH conversion will significantly enhance the bottom line. The types of changes required, and their impact, can vary and are discussed in the following sections of the report.

Hospitals that have experienced significant changes in utilization, payor mix, services, medical staff, or other operations since a financial feasibility study was conducted should consider a new analysis using more recent data that reflects these changes. Studies based on atypical hospital experience or that used questionable assumptions should also be redone using the most recent available data.

' How long ago was the study conducted?

Even if significant changes in hospital utilization or operations have not taken place, factors such as the costs of maintaining the physical plant may have changed enough to alter the financial viability of CAH conversion. In general, if a financial feasibility study is based on data that is three or more years old, it is probably a good idea to consider an update to the analysis using more recent information.

For example, the implementation of Medicare Outpatient PPS subsequent to the completion of a feasibility study may have changed hospital operations in a way that makes CAH conversion more viable. Even though small rural hospitals are supposedly "held harmless" from the effects of this payment system until the end of 2003, they must still adhere to many of its rules and are reimbursed under this system until the time of cost report settlement (which may be years later). As a result, even though they ultimately may not be reimbursed under the system, PPS may have a significant enough effect on outpatient services in small rural hospitals to change facility revenues, cost structure, and other operational details. The fact that almost all small rural hospitals are losing money on the treatment of Medicare outpatients, even under the payment system in effect prior to PPS, may amplify these effects.

B. Reason for Not Converting: Acute Care Census Exceeds 15 Patients

As noted above, CAHs are subject to two utilization requirements – the annual ALOS may not exceed 96 hours and no more than 15 acute care inpatients may be treated at any one time. Although there are some small rural hospitals that do not meet the ALOS requirement, far more are affected by the census limit (ALOS issues are addressed in the next section of the monograph). In these cases, it is important to understand the reasons for the high census days to determine whether this issue can be appropriately addressed or whether the facility is too busy to be a viable candidate for CAH conversion.

' Is ALOS too high?

The number of inpatients in a hospital is determined by two factors – admissions and length of stay. As

these figures increase, hospital census increases. High ALOS, therefore, results directly in an increase in census. ALOS issues are discussed below; this section of the report addresses other issues that affect facility census. Many of the questions that must be asked in assessing census issues are similar or related to the questions must be asked in addressing ALOS.

' On how many days during the year does the census exceed 15 patients?

Hospitals in which the census is higher than 15 on, for example, 10 days of the year, face a much different situation relative to CAH conversion than hospitals in which the census exceeds 15 on 100 days of the year. The fewer the number of days in which the census exceeds 15, the easier it is to manage this issue. There is no "magic number" that denotes the number of days beyond which CAH conversion is unlikely. In general, hospitals in which census exceeds 15 on no more than 5-10% of days during the year can often meet the CAH requirements with few changes in operations. For hospitals with more high census days, the issue may still be manageable, but the hospital is less likely to be able to comply with the CAH requirements without changes in services or the way that services are delivered. How difficult it is to address this issue is related, as well, to the other factors discussed in the monograph. The more "indicators" for high census and high ALOS that are present, the more difficult it is likely to be to address these issues.

' How high does the census get?

Following the same logical pattern discussed above, the higher the census figure, the more difficult it is to manage this issue. Even for hospitals that experience relatively few high census days, the total number of patients over 15 can pose difficulties in managing utilization. For example, a hospital that has 10 days during the year in which the census is as high as 17 patients will have a far easier time managing this issue than a hospital that experiences 10 days in which the census hits 25. Again, however, there is no established number over which CAH conversion cannot take place. Each hospital must consider each of these issues individually by considering the questions raised below.

' Do high census days occur throughout the year or seasonally?

Most hospitals experience times during the year in which utilization is highest. Typically, this occurs during the winter months, when influenza, pneumonia, and other illnesses are more prevalent, particularly among the elderly. Some hospitals experience seasonal increases in utilization because of tourism or location in a vacation or retirement area. These hospitals may face different issues in addressing high census periods than hospitals that consistently exceed the 15 patient limit throughout the year.

Congress has recognized these differences and has requested that the General Accounting Office (GAO) conduct an analysis to provide guidance on whether seasonal variations that result in high census should be allowed in CAHs. This report has not yet been released. Other proposals in Congress have required that

the 15 patient census limit be changed to an average daily census (ADC) of 15 (similar to the change in the length of stay provision from a 96 hour cap to a 96 hour average) or that CAHs be allowed to treat as many as 25 acute care patients at one time. Until legislation to enact these changes is passed, however, CAHs are subject to the 15 patient limit as set out in current law.

Again, there is no formula by which the census issue can be easily addressed. Strategies to address this issue will vary depending on the magnitude of the problem, the services available at the hospital, and by other factors discussed below. As a first step in understanding the issue, however, it is important to determine when high census days take place. The answers to the questions below will provide further understanding and guidance on how the issue can be addressed.

' Has high census been consistent for several years or is it a one-year or occasional phenomenon?

As with high ALOS, if high census is a one-year phenomenon, it can generally be assumed that more "typical" utilization trends will be reestablished over time. In some cases, however, hospital utilization may be trending upward, in which case days in which the census exceeds 15 may become more frequent in the future (as discussed above, utilization in most hospitals has been decreasing; it would be unusual, therefore, but not unprecedented, for a small rural hospital to experience a trend of increasing inpatient utilization). These hospitals will likely have a more difficult time adhering to the census limit as time goes on.

' Does the hospital have a swing bed program? Are swing beds being used appropriately?

Many small rural hospitals participate in the swingbed program, which allows them to use the same beds to treat both acute care and skilled nursing level patients. Many of these hospitals do not make optimal use of swingbeds, however, because payment often does not cover costs, physicians may not be knowledgeable about the program, or for other reasons. In addition, few payors other than Medicare reimburse for these services.

CAHs may participate in the swingbed program and maintain up to 25 beds to furnish both acute and skilled nursing level care, provided that no more than 15 of these beds are used for acute care at any one time. Skilled nursing stays in swingbeds are not acute care stays and are not counted toward the CAH census limit. In addition, unlike hospitals, which are paid a set per diem rate for swingbed services, swingbeds in CAHs are reimbursed by Medicare on a reasonable cost basis, eliminating any financial disincentive for using these services. As a result, the use of swingbeds for clinically appropriate patients can assist a CAH in managing census to ensure compliance with program requirements, without causing a financial hardship.

' Does the hospital provide outpatient observation services? Are observation services being used appropriately?

Observation services are furnished by a hospital to evaluate the condition of an outpatient and determine the need for admission to an inpatient unit. A patient in an observation bed is periodically monitored by the physician or nursing staff until the patient's status is clarified. Observation services must be ordered by a physician, and although a patient may stay overnight in an observation bed, the total stay is typically less than 24 hours. Facilities with observation units maintain policies and procedures to ensure that the patient can be quickly admitted or transferred to a hospital for more intensive inpatient care or discharged from the observation bed and continue to be treated on an outpatient basis. While in observation, the patient is considered an outpatient and any time spent in observation status does not count toward the CAH census limit.

Until recently, observation services were provided in many hospitals. However, with the implementation of the Medicare hospital outpatient PPS, observation services are no longer directly reimbursed and payment for observation is bundled into payment for the various Ambulatory Payment Classifications (APCs). As a result, many hospitals have discontinued the provision of observation services. CAHs, however, are not subject to the hospital outpatient PPS and observation, like other outpatient services, is reimbursed on a cost basis. As a result, the use of observation prior to admission can assist a CAH in managing census without causing a financial hardship. Observation should not be used with every patient; however, if there is some question regarding the need or desirability of admitting a patient, it may be clinically appropriate to place that patient in an observation bed for monitoring for up to 24 hours. In rare cases, Medicare may approve observation for as long as 48 hours.

' Is the hospital part of a system or network?

Small rural hospitals that are part of a larger health system or a well organized network can use these linkages to help manage census and maintain compliance with the CAH rules. Network partners can be transfer/referral destinations for patients with conditions that warrant a facility with higher capabilities and as a "safety valve" in the event of high utilization. If positive physician relationships are maintained between the facilities, therefore, patients can be routinely transferred or referred to an upstream facility if a bed is not available at the CAH. For hospitals that are interested in CAH conversion but often experience days in which the census exceeds 15, this is a compelling reason to develop and maintain close network linkages with other hospitals.

' What is the admissions profile of each of the physicians on staff ?

It is important for high census hospitals to understand the admissions patterns of the physicians on its medical staff. Identifying factors such as the number of patients admitted by each physician, the diagnoses of these patients, and how long they stay in the hospital will allow management to identify inappropriate or non-normative admissions practices and take suitable corrective actions. If it is discovered, for example, that a particular physician admits a disproportionate number of patients with a particular illness, does not appropriately refer patients to other facilities, or keeps patients in the hospital longer than other physicians

on the staff, hospital management can work with the medical staff to determine the reasons for these aberrations and decide on proper responses. Intra-staff comparisons of physicians are useful for utilization review and quality assurance purposes, so that “outlier” physicians can be identified and appropriate actions taken to normalize their practice. Addressing such issues can reduce both census and ALOS and improve the quality of care in the hospital.

‘ Are admissions appropriate to the hospital’s capabilities and its role in the community and its health system/network?

Most rural communities cannot support a full range of specialty and high tech services. As a result, rural hospitals must maintain agreements with other facilities to treat patients that cannot be adequately treated locally. Some physicians, however, continue to admit patients to small hospitals who may be more appropriately treated at another facility. This practice boosts census, which is normally a desirable goal. However, if compliance with the CAH census limit is an issue, hospitals should review admissions patterns to ensure that both admissions and transfers/referrals are appropriate. Some hospitals that are interested in CAH conversion actively work with their medical staffs to change the types of patients that are treated at the facility as a way to control census and ALOS. As noted above, hospitals that are members of a larger health system or otherwise maintain strong network linkages may be in a better position to implement such policies than those that do not have such natural referral partners.

‘ What are the financial implications of reducing census to comply with the CAH requirements?

A hospital that chooses to modify admissions and/or discharge policies and procedures in order to comply with the CAH utilization limits must carefully assess the financial implications of these efforts. As discussed above, if future utilization patterns are expected to change as a result of CAH conversion, these changes must be taken into account in the financial feasibility study.

This analysis is particularly important because most rural hospitals still make money on the treatment of Medicare inpatients. Reducing the volume of Medicare inpatients, therefore, may dramatically affect the relative financial merits of CAH conversion versus continuing operations as a hospital. Because Medicare patients tend to have more serious illnesses and stay in the hospital longer than other patients, reducing inpatient utilization will have a disproportionate impact on Medicare utilization, which will further affect the financial implications of CAH conversion. Reductions in acute care utilization may also lead to increases in the use of swingbeds and other services and these changes must be carefully assessed, as well.

‘ What are the community/social implications of reducing census to comply with the CAH requirements?

Many hospitals find that CAH conversion will provide financial benefits even if utilization must be reduced to comply with the CAH census limit. However, it may still be difficult in these cases to modify

admissions/discharge policies if physicians or community members object to these changes. There are three ways to cut census – reduce ALOS, reduce admissions, or a combination of both (appropriate use of swingbeds and observation services can affect both of these variables). A reduction in admissions, by definition, means that patients with conditions that had previously warranted admission to the hospital will not be admitted and may be referred to another facility for care. Community residents who prefer to be hospitalized locally and their families may object to these changes, along with physicians who may be reluctant to refer their patients to another doctor for care. As a result, hospitals that consider implementing reductions in inpatient utilization to comply with the CAH limits must include physicians and the community in the decision making process and carefully assess the community implications of such changes.

C. Reason for Not Converting: Average Length of Stay Exceeds 96 Hours

In addition to the 15 patient census limit, CAHs must maintain an annual ALOS of 96 hours or less. Most small rural hospitals are currently operating with ALOS at or below the 96 hour standard and do not need to decrease ALOS to comply with CAH requirements. In some hospitals, however, ALOS exceeds the CAH limit and must therefore be reduced if the facility converts to CAH status. In these cases, as with the high census hospitals discussed above, it is important to understand the reasons for the high ALOS to determine whether it can appropriately be reduced to less than 96 hours.

' What is the trend in ALOS over the last several years?

Hospital ALOS has been trending downward in the U.S. for the past two decades, although the rate of decrease has slowed over the years. Most small rural hospitals have operated for several years with ALOS below the CAH standard. There is no reason to believe that converting to CAH status will change ALOS experience or trends in these facilities.

In hospitals that have an annual ALOS of greater than 96 hours, however, it is important to understand utilization experience and trends. If the high ALOS is a one-year phenomenon, it can generally be assumed that it will not be repeated and that more “typical” utilization trends will be reestablished over time. An example is a small hospital that treated a much larger than usual number of high length of stay outlier cases during the previous year, thus skewing the ALOS measurement.

In some hospitals, however, depending on the reasons for the high ALOS and the ability of hospital administration and physicians to manage this factor, it is not safe to assume that ALOS will decrease in future years. Included in this group are both hospitals in which ALOS is consistently over 96 hours and those in which ALOS fluctuates greatly from year to year. These hospitals should carefully consider the issues presented below to determine whether it will be feasible and appropriate to bring ALOS below 96 hours.

' How does ALOS compare to ALOS at similar hospitals?

Peer hospitals, those facilities with similar characteristics, such as size, location, and patient population, are appropriate points of comparison to assess whether ALOS is reasonable. It is well established that the practice of medicine varies substantially across regions, so it is possible that a hospital with seemingly high ALOS is actually in line with similar hospitals in its area. Many State Health Departments and Hospital Associations maintain extensive databases of hospital information that can be used as sources for this comparison.

If such a database is not available in your State, it is strongly recommended that it be created. Development and maintenance of this information will incur costs and require that hospitals compile and submit data to the appropriate entity, something that many hospitals are reluctant or not easily able to do. Nevertheless, these data are invaluable in assessing hospital and health system performance and ideally would be readily available to hospitals and others for appropriate uses.

‘ Is ALOS justified by the hospital’s case mix?

Case mix is a measure of the types of patients that a hospital treats, based on diagnosis. The calculation of a facility’s case mix complexity considers factors such as severity of illness (the level of loss of function or mortality associated with a disease), prognosis (the probable outcome of the illness), treatment difficulty (patient management problems), the need for intervention (severity of illness that would result due to a lack of immediate or continuing care), and resource intensity (volume and types of services required for patient management).² Patients who are sicker and require a more comprehensive mix of services usually stay in the hospital longer than those who are less severely ill. As a result, case mix is generally a reliable indicator for length of stay and a hospital with a higher case mix will usually have a longer ALOS than one with a lower case mix.

An ALOS of greater than 96 hours, therefore, may be justified by a hospital’s relatively high case mix. On the other hand, a hospital with a long ALOS but a relatively low case mix should dig deeper to uncover the reasons for the high ALOS. Again, comparing case mix to that of peer hospitals is a useful tool to assess performance.

‘ What are the hospital’s most prevalent DRGs? How does ALOS for the most prevalent DRGs compare to ALOS for these DRGs at similar hospitals?

There are currently about 500 different Diagnosis Related Groups (DRGs) to identify the range of inpatient conditions treated in hospitals. Few hospitals, however, have the capability to treat all of these conditions,

²Hart, A.C. and Richards, B., Clinical Technical Editors. *DRG Guidebook, A Comprehensive Resource to the DRG Classification System, Seventeenth Edition*, Reston, Virginia: St. Anthony Publishing, Ingenix Publishing Group, 2000.

and in many small rural hospitals, a large proportion of inpatient utilization is attributable to patients with just a few common DRGs. It is not unusual for patients with only 10-20 different DRGs to comprise more than half of a hospital's inpatient utilization.

If a large proportion of a hospital's utilization is attributable to patients with a small number of diagnoses, it is these DRGs that have the most influence on the facility's ALOS. These effects are most pronounced in small hospitals, where a few long patient stays or long ALOS for one or more of these common DRGs can disproportionately influence the data and result in a long ALOS for the entire hospital. It is important, therefore, to determine whether a long ALOS for one or more DRGs is skewing the data for the entire facility, or if ALOS is high for many of the DRGs that the hospital treats. High ALOS for just a few DRGs may point to issues with the way that particular illnesses are treated or may be a result of a few outlier cases. High ALOS across the board, however, may point to issues with overall medical practice patterns, problems with the availability of placements for discharged patients, or other more systemic issues. As with the other data discussed here, comparison to peer hospitals is helpful in assessing these effects.

' How does ALOS for the most prevalent DRGs compare to the Medicare arithmetic mean length of stay for these DRGs?³

The Centers for Medicare and Medicaid Services (CMS) calculates the nationwide arithmetic mean length of stay for each DRG on a yearly basis. These figures are reported in publications such as the *DRG Guidebook*, cited above. Although these averages are used by CMS primarily for determining payment, they are also a useful measure for hospitals to compare their ALOS experience to the national averages for particular DRGs.

When utilizing these figures for comparison purposes, it is important to keep in mind that the arithmetic mean length of stay accounts for stays in all acute care hospitals, ranging from small rural hospitals to large tertiary care teaching facilities. Because small rural hospitals typically treat a less complex mix of patients than their larger counterparts, rural hospital ALOS will tend to be lower than that of urban facilities. For example, several common diagnoses, such as Heart Failure and Shock (DRG 127), Chronic Obstructive Pulmonary Disease (DRG 88), and Simple Pneumonia and Pleurisy (DRG 89), all have arithmetic mean length of stay greater than four days. If a small rural hospital treats a large proportion of patients with these diagnoses and ALOS is equivalent to the nationwide mean, the hospital would not be consistent with the CAH standard. As a result, although useful for comparison purposes, to develop meaningful conclusions,

³Two mean length of stay measurements, arithmetic mean length of stay and geometric mean length of stay, are commonly used. Arithmetic mean length of stay is the average number of days that patients within a given DRG stay in the hospital. It is equivalent to ALOS as used in this monograph. Geometric mean length of stay is a statistically adjusted value for all cases within a DRG, adjusted for outliers, transfer cases, etc. Arithmetic mean length of stay, which measures the actual length of hospital stays, is used here.

national figures are best used in conjunction with local data and data from peer hospitals. It is clear, though, that if a small rural hospital has an ALOS for a particular DRG that is higher than the Medicare arithmetic mean for that DRG, further analysis is warranted.

- ' What is the ALOS by DRG for each physician that admits to the hospital? Is ALOS high for all physicians or just a few physicians? Does it vary depending on DRG?

Another key data element for hospitals examining length of stay issues is the ALOS of patients treated by particular physicians. As with patient census, in a small rural hospital, the practice patterns of one or just a few physicians can have a profound effect on ALOS for the entire facility. If a key admitter keeps his/her patients in the hospital longer than other physicians on the staff, the ALOS for the entire facility will be higher. Discharge patterns can vary by physician or even by DRG (e.g., a physician may have appropriate ALOS for all patients except those with a particular diagnosis), so this type of analysis can be useful in pinpointing exactly where the problems lie. Again, comparison among physicians on the staff can be useful in determining whether practice patterns are appropriate.

- ' Does the hospital have a swing bed program? Are swing beds being used appropriately? Does the hospital provide observation services? Are observation services being used appropriately?

In addition to assisting in decreasing census, swingbeds and observation services can help in managing ALOS. Prudent and appropriate use of these services is one of the most direct ways to control ALOS to keep it under the CAH limits.

D. Reason for Not Converting: Little Interest in the Program

Many rural hospitals that are eligible and may benefit from CAH conversion never assess or even consider the option. As with the other reasons for not pursuing conversion, it is important to understand why hospital boards, administrators, and/or physicians are not interested in the program. The issues and questions presented below will help to determine the reasons for this lack of interest and approaches to addressing the issue.

- ' Who isn't interested? Why aren't they interested?

To fully analyze a lack of interest in CAH conversion, it is important to understand where the hospital's stakeholders stand. In situations such as this, it is most often members of the medical staff who object to conversion. Typically, this is due to perceptions by these physicians that the program will dictate the types of patients they can treat and how these patients are cared for. These perceptions are often shared by hospital boards and management. Boards and community members may be further concerned that a CAH is a downsized or "limited service" facility and will no longer be viewed as a full service hospital.

Many of these perceptions can be addressed by providing accurate information and analyzing hospital and physician data. In some cases, particularly in hospitals that must decrease utilization or make other operational changes to comply with the CAH requirements, these perceptions may accurately reflect the impacts of conversion. In other instances, however, these views are based on inaccurate information or simply a natural reluctance to change.

' Has adequate education been provided?

Although the situation has improved as more and more hospitals have converted to CAH status, there is still a substantial amount of misinformation about the program that is accepted in the hospital community. The perception of a CAH as simply a step in the process of closing or a “glorified band-aid station” is not unusual. As noted above, physicians are often under the impression that CAH conversion will somehow limit the types of patients they can see or dictate how they care for their patients. The belief that surgery and obstetrics are not permitted in CAHs is still fairly common. Other common misperceptions include confusion about the difference between the CAH program and Flex Program grants and a belief that CAH status is time-limited, a belief by hospital employees that CAH conversion threatens their jobs, and simple skepticism that the Medicare program will actually reimburse a provider on a cost basis.

Most of these issues can be addressed through a comprehensive education program that provides accurate information that is appropriate to each of the stakeholder groups. Boards, for example, may not need to know the details of the CAH claims process and cost report reconciliation, but should understand what cost-based reimbursement will mean for the financial status of the hospital. Physicians are generally interested in how CAH conversion will affect their practices and patients and may be less interested, for example, in the requirements of the State’s Rural Health Plan. All of these groups and individuals must receive accurate information in order to and understand how conversion affects the hospital and their interests and make a well informed decision about conversion.

It is important, as well, that data be used, to the extent possible, to fully inform the educational process. For example, assessments of physician admissions often demonstrate, to the surprise of physicians who object to the ALOS limit, that the ALOS of their patients over the last several years has been well below the 96 hour cap. In hospitals that must reduce utilization to comply with the CAH requirements, data analysis showing the likely impact on each physicians’ practice and patients can be conducted. Data on the effect of operating as a CAH on facilities that have already converted can be invaluable.

The bottom line is that stakeholders should understand that for most hospitals, CAH conversion is essentially transparent and results in no changes in operations or medical practice. On the other hand, for those hospitals in which change must occur to comply with program requirements, stakeholders must fully understand the scope of these changes and their implications.

Community and hospital education on the CAH program is frequently provided by State Flex Program staff

or other local individuals. While often appropriate, in some cases the message is better received if delivered by an “outsider” or a party that is perceived to have no direct connection to the outcome of the process. Outside educators and facilitators can be used in these cases to present information that may be seen as more informed and less biased than that provided by more familiar individuals. Outside experts can also be useful in “teaching the teachers,” and providing information and data to State Flex Program staff and others that may not be available otherwise. Like feasibility studies, funding for community and hospital education is often provided through Flex Program grants, making it easier for hospitals to utilize these resources if necessary.

‘ Have board members, administrators, and/or physicians from hospitals that have converted to CAHs been consulted?

One of the most effective ways to provide education about the CAH program is to obtain advice and guidance from stakeholders in hospitals that have converted and are operating as CAHs. With the widespread popularity of the program, it makes sense to utilize the vast pool of CAH experience that now exists across the nation. For example, physicians who are concerned about the impact of conversion on their practices and patients are often reassured after speaking to physicians who provide services in CAHs. Likewise, administrators often communicate best with other administrators and board members with other board members. In this way, the concerns of each of these groups can be addressed by those with similar backgrounds and interests. At the same time, those with CAH experience can provide first hand information on both the positives of the program and any potential downsides or obstacles to providing quality services that may have been encountered.

Many experienced CAH stakeholders are happy to make themselves available for such exchanges. Some go as far as to invite interested parties to visit their communities, tour their facilities, and meet with administrators, physicians, and others. Using this resource is similar to the value added of using an experienced outside facilitator, as discussed above. State Offices of Rural Health and hospital associations are aware of the hospitals that have converted in their States and can often provide assistance in matching interested stakeholders with appropriate individuals with CAH experience and coordinating these types of meetings.

‘ Has community input been sought?

One of the foundations of the Flex Program is the value in engaging communities in decisions regarding the future of the hospital and the local health system. Although the program may have little impact on hospital operations and it is possible to convert to CAH status without community input, hospital administrators that choose this route do so at their own peril. The effectiveness of the community “grapevine” is well understood by community organizers and others who work in small towns. A hospital that makes changes without informing and educating the community risks a backlash of community reaction fueled by rumor, misinformation, and fear of change. Even if CAH conversion will cause no changes in the way the hospital

operates, it is critical that hospital boards and administrators manage the information process in a way that effectively informs citizens about the program and its implications.

E. Reason for Not Converting: Presence of a Geriatric Psychiatric Unit (or Other Distinct-Part Unit)

A significant barrier to CAH conversion is that CAHs are not permitted to maintain distinct-part units other than a distinct-part skilled nursing facility (DP-SNF). As a result, services such as Geriatric Psychiatric (Geri-Psych) Units and Rehabilitation Units must be included when determining the CAH bed count, census, and ALOS. The long ALOS of most patients in such units will generally disqualify the facility from meeting the CAH ALOS limit. Congress has requested that GAO assess this issue as part of the study that will also address seasonal variations in utilization, but a report on the study has not yet been released. At this time, therefore, the presence of a distinct-part unit, most often a Geri-Psych Unit, is a common reason that hospitals that may otherwise benefit have not converted to CAHs.

Over the past decade, the operation of Geri-Psych Units has become a popular and effective way for rural hospitals to provide a needed community service that can also have a positive financial effect on the facility. These units, which are usually developed and managed by third party entities that specialize in these services, address the significant need for psychiatric treatment and services for the rural elderly population. They are reimbursed by Medicare on a cost-related basis and, if well utilized, can be a substantial profit center for the hospital. Like the CAH program, the ability of Geri-Psych Units to provide financial benefits to otherwise struggling rural hospitals has fueled their popularity. Hundreds of these units are located in small hospitals across the nation.

Hospitals with Geri-Psych Units that conduct an assessment and find that they can benefit from CAH conversion are faced with a dilemma. At this time, the two programs are mutually exclusive and a hospital may participate in one or the other, but not both. Hospitals in this situation must assess the relative financial impacts and effects on other hospital services, along with community needs, to decide on an appropriate course of action. In most cases, CAH conversion does not provide the level of financial benefit that is produced by a Geri-Psych Unit, so hospitals choose to continue to operate psychiatric services and forego participation in the CAH program.

There are several options for hospitals that are confronted with this issue and still wish to convert to CAHs. All of these options, which address ways of separating the distinct part unit from the hospital, have pros and cons and must be carefully evaluated. First, if CAH conversion is projected to provide a substantial financial benefit, the facility may choose to discontinue the provision of Geri-Psych services. In this case, the space occupied by the unit could remain empty or be reconfigured for other purposes. Unless provided by another local entity, inpatient psychiatric services for the elderly population would no longer be available in the community.

Second, a “hospital within a hospital” can be created and licensed, for example, as a psychiatric hospital.

As long as this new facility is separately licensed and certified and has its own provider number, it would not be considered part of the CAH even though it is located in the same physical plant or on the same campus. As a result, the CAH ALOS and census limitations would not apply; similarly, the new facility would not be cost reimbursed as part of the CAH. Space, services, and staff could be leased from the CAH, creating a source of revenue. The feasibility of this option, however, is usually marginal, given the limited number of beds and space available and the difficulty in meeting staffing and other conditions of participation for a “freestanding” psychiatric hospital. Reimbursement is not likely to be as favorable as reimbursement of the hospital-based unit and there may be State regulatory constraints to carrying out such a plan.

Third, the Geri-Psych Unit can be converted to a DP-SNF, currently the only type of distinct part unit that may be operated as part of a CAH. Clearly, the services provided in a DP-SNF are not the same as those provided in a Geri-Psych Unit and reimbursement is unlikely to be as favorable. Nevertheless, some of the same patients that are currently treated in the Geri-Psych Unit may be able to be treated in a DP-SNF. Again, given the limited number of beds and possible regulatory constraints, including limits in some States on new SNF beds, this option may not be feasible.

Fourth, the unit can be leased to another provider, ideally an affiliated network or system partner. This option is similar to the hospital in a hospital option discussed above, but instead of creating a new provider, the Geri-Psych Unit would become part of another hospital’s license and Medicare certification. Again, space, staff, and ancillary and support services could be leased, if necessary, from the CAH by the other provider. This may be a creative way for a network to utilize the space and continue to provide services that are needed by the community. Again, however, reimbursement for psychiatric services in this scenario may not be as favorable.

The presence of a Geri-Psych Unit is one of the primary reasons that some hospitals have not converted to CAHs, despite the benefits to them of participating in the program. Unless legislation is enacted to allow CAHs to retain these units, it is likely that this will continue to be a major obstacle.

III. Does the Hospital Plan to Make Capital Investments?

If a hospital has not invested in capital improvement in 10 years or longer, it is likely that substantial capital needs exist. In CAHs, capital costs, like other costs, are reimbursed by Medicare on a reasonable cost basis. As a result, for hospitals that need to invest in physical plant renovation or new construction, as many small rural hospitals do, CAH conversion may represent an effective method of financing these improvements. Most rural hospitals will recover far more of their capital investments through cost-based reimbursement than through the Medicare hospital inpatient PPS.

It is important to note, as well, that CAH conversion may improve the chances that a hospital will be able to secure financing for capital improvements. To approve a loan, lenders require that the borrower demonstrate that it will be able to cover debt service over the life of the loan. It is common, as well, that the borrower demonstrate that it has operated on sound financial footing for several years prior to receiving the loan. Some lenders and guarantors, most notably the Department of Housing and Urban Development (HUD), through the HUD 242 Program, will permit a CAH to demonstrate pre-conversion financial stability by calculating the financial status of the hospital as if it had been a CAH over the period in question. Because the hospital presumably converted to CAH status because the program provided a financial benefit, these pro forma calculations should show improved financial status relative to operations as a hospital. Future financial status should be improved as well, enhancing the likelihood that a loan will be approved. It must be noted, however, that a large proportion of CAHs still operate at a loss. These facilities may still experience great difficulty in securing loans or guarantees in the capital markets.

IV. Does the State Medicaid Program Reimburse CAHs on a Cost-Basis?

In most of rural America, Medicare is the dominant payor for health care services, often accounting for more than half of the revenue in rural hospitals. As a result, Medicare payment policy largely determines the financial viability of hospitals and the relative influence of other payors, such as Medicaid and commercial insurers, are comparatively modest. In some regions of the U.S., however, such as many parts of the Southeast, Medicaid is often the predominant payor for health care services. In these areas, while it may be helpful, cost-based Medicare payment to CAHs may not be sufficient to assure financial viability. Instead, payment for Medicaid services plays a larger role in determining the feasibility of CAH conversion. There is substantial data that demonstrates that cost-based Medicaid payment is necessary to make CAH a feasible option for some hospitals.

Medicaid coverage and payment varies widely from State to State. The Flex Program Tracking Project reports that 23 States provide enhanced Medicaid payments to CAHs for inpatient services and 13 provide enhanced payment for outpatient services. These enhanced payment policies generally do not apply to CAH payments from Medicaid managed care organizations and may not follow the cost-based Medicare payment methodology.⁴ Presented below are a series of questions that will help to determine whether Medicaid payment to CAHs is adequate or if the Medicaid program is an obstacle to CAH conversion.

- ' How does the Medicaid program pay for services in CAHs? Does Medicaid use the Medicare reimbursement methodology for CAHs?

The first step in determining the adequacy of Medicaid reimbursement to CAHs is understanding the methodology under which CAHs are paid. Most Medicaid programs do not change the way that services are reimbursed if a hospital converts to a CAH. Of the 23 States that report enhanced inpatient payment to CAHs, only 17 have created a special payment policy specifically for CAHs; the other six provide enhanced payments to all small and/or rural hospitals.⁵ Even among these States, however, payment is not necessarily “cost-based,” as recognized by Medicare. Many State Medicaid programs report that CAHs (and other rural hospitals) are reimbursed on a cost basis, but upon further evaluation, few of the payment methodologies used in these States mirror the cost-based methodology used for Medicare payment and are rarely as generous as this methodology. In some cases, Medicaid payment represents only a fraction of the actual costs of treating Medicaid patients.

⁴Rural Hospital Flexibility Program Tracking Team. *Rural Hospital Flexibility Program Tracking Project, Year 3 Report (covering fiscal year 2001-2002)*, September 6, 2002.

⁵*Ibid.*

‘ What is the impact on the State Medicaid Program of paying CAHs on a cost-basis (using the Medicare methodology)?

It is often assumed that paying CAHs (or other providers) on a cost-basis is financially irresponsible and will ultimately lead to an explosion in payments. There is a common belief among regulators and others that cost-based payments eliminate incentives to contain costs, resulting in inefficiency and excessive reimbursement. Despite its seeming logic, however, there is little evidence to support this view.

By definition, CAHs are small, low volume providers. Payments to these facilities represent a very small fraction of total Medicaid payments. Even if cost-based, therefore, reimbursement to CAHs is unlikely to lead to significantly higher program costs. Furthermore, if small rural hospitals close as a result of inadequate revenues, many of the patients that would have been treated in these facilities will instead receive care in high cost urban hospitals, where reimbursement may well exceed cost-based payment to CAHs. Some patients will be unable to travel outside the community for care, resulting in delays in treatment that can result in more serious illness higher costs later on. Medicaid must typically reimburse for the cost of travel, as well, which will be much higher if services are not available locally.

The Flex Program Tracking team reports that Medicaid officials who were interviewed were “nearly unanimous in their opinion that the impact of cost-based payment for CAHs on total state Medicaid expenditures is minimal.”⁶ In addition, studies conducted in Kansas found no evidence that costs in CAHs have increased at a greater rate than costs in hospitals that have not converted.^{7,8} Nevertheless, most States have not changed the way that CAHs are paid nor assessed the impact of cost-based payment on State Medicaid budgets.

In States in which Medicaid payment is an obstacle to CAH conversion, it is strongly recommended that State Flex Program managers and other interested parties, such as hospital associations, work to educate Medicaid officials about the CAH program and its importance to the health of rural residents and the economic well being of rural hospitals and communities. Data-based analyses showing the impact of cost-based reimbursement, using various assumptions for the future viability of hospitals, can be very useful in demonstrating the likely minimal effect of the CAH program on the State Medicaid budget (and may, in some cases, show that costs will decrease).

⁶*Ibid.*

⁷Rural Health Consultants and Wendling, Noe, Nelson & Johnson. *The Impact of the EACH/RPCH and CAH Programs on Participating Kansas Communities*. Kansas Rural Health Options Project, July 2000.

⁸Wendling, Noe, Nelson & Johnson. *Financial Success of the Critical Access Hospital Program in Kansas: A Comparative Study*. Kansas Rural Health Options Project, February 2002.

V. Conclusions

It is likely that most of the hospitals that are legitimate candidates for CAH conversion and will benefit from the program have already converted. Nevertheless, it is also likely that a number of hospitals that could benefit have not converted, for a variety of reasons. A systematic assessment of small rural hospitals that have not converted, using the questions and issues raised in this monograph, will help State Flex Program managers ensure that the program is reaching all of the hospitals and rural communities that can benefit from it. Even if this process does not lead to CAH conversion, it will benefit the affected facilities by spotlighting issues that, if addressed, could improve the access, efficiency, and quality of the health care services available to the community.