



Change in Profitability and Financial Distress of CAHs from Loss of Cost-Based Reimbursement

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October 31, 2014

* Presenter
Gateway Webinar

Overview

- Policy Context
- Status quo
 - Profitability by hospital type
 - Geographic variation
- Effects of eliminating cost-based reimbursement
 - Overall
 - By region
 - On beneficiaries
- Closures
- Related studies



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Proposals to cut Medicare Reimbursement to CAHs

President's Budget, CBO and OIG have proposed:

- Reducing CAH payments by one percentage point of reasonable costs.
- Eliminating the CAH designation for hospitals that are less than 10 miles from the nearest hospital.
- Eliminating the CAH program altogether and converting all CAHs to PPS.
- Removing Necessary Provider CAHs' permanent exemption from the distance requirement.



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Profitability of Rural Hospitals

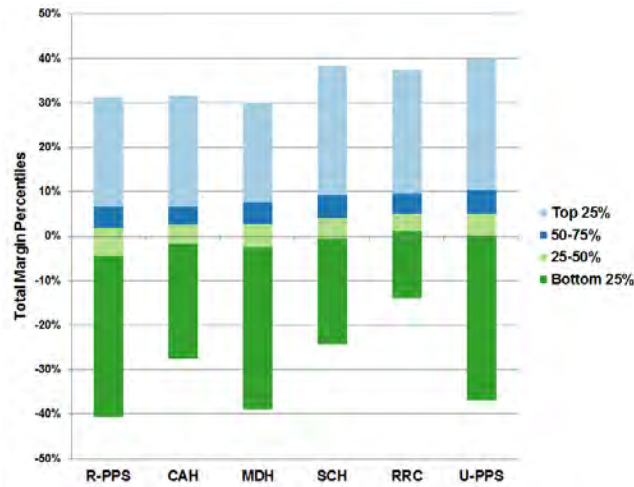
George H. Pink, PhD; Victoria Freeman, RN, DrPH;
Randy Randolph, MRP; and G. Mark Holmes, PhD

http://www.shepscenter.unc.edu/wp-content/uploads/2013/09/Profitability-Findings-Brief-Final_August-2013.pdf



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2012 Total Margin Distribution by Hospital Type

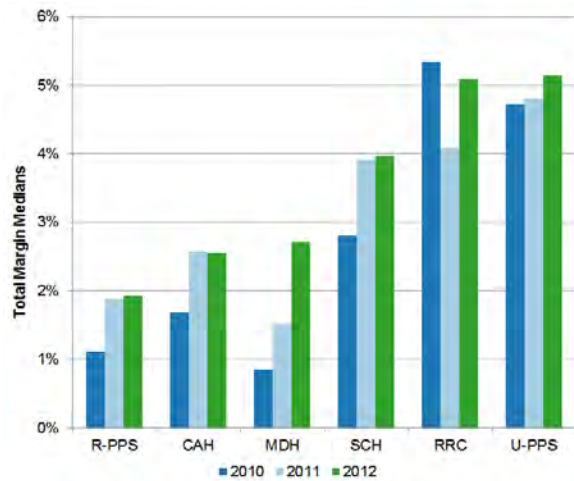


*Outlier hospitals ($\leq 1\%$ or $\geq 99\%$) were excluded.



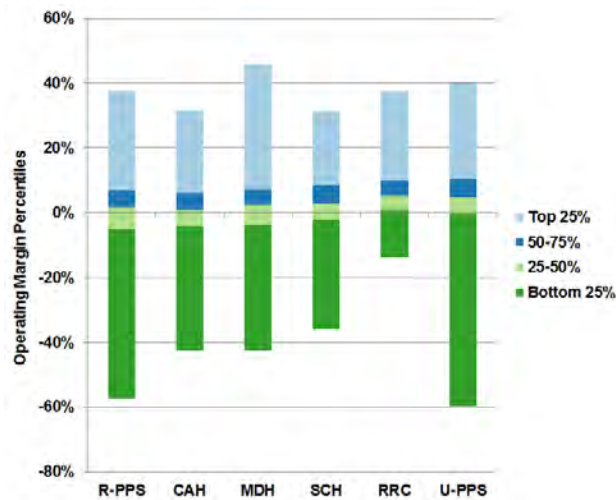
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2010-12 Total Margin Medians



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2012 Operating Margin Distribution by Hospital Type

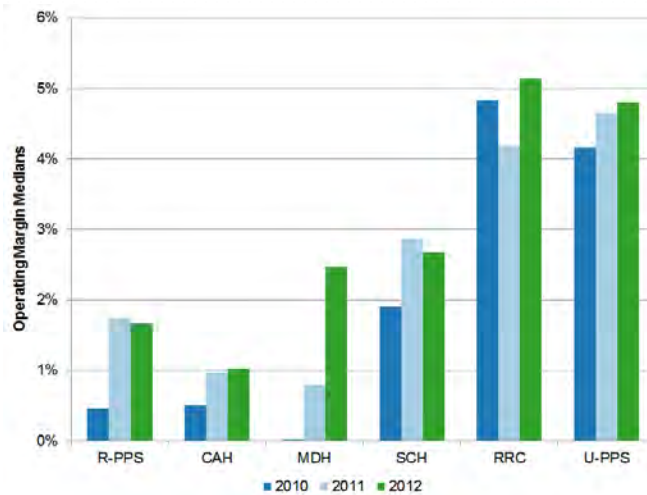


*Outlier hospitals ($\leq 1\%$ or $\geq 99\%$) were excluded.



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2010-12 Operating Margin Medians



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Key Findings

- Urban hospitals paid under PPS and Rural Referral Centers had consistently the highest profitability in comparison to hospitals with other payment classifications.
- Rural hospitals paid under PPS and Critical Access Hospitals generally had the lowest profitability in comparison to hospitals with other payment classifications.
- Across all hospital payment classifications, profitability improved between 2010 and 2012.



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Geographic Variation in the Profitability of Critical Access Hospitals

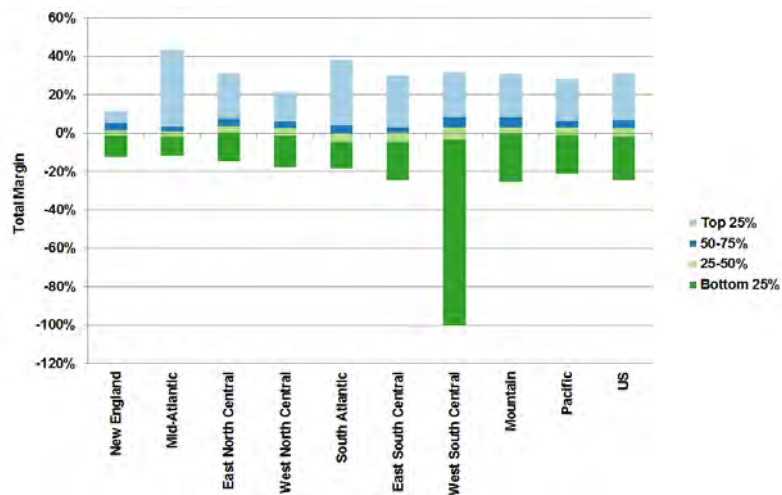
George H. Pink, PhD; Victoria Freeman, RN, DrPH;
Randy Randolph, MRP; and G. Mark Holmes, PhD

http://www.shepscenter.unc.edu/wp-content/uploads/2013/12/Geographic-Variation-in-the-Profitability-of-CAHs-Findings-Brief-Final_Sept-2013.pdf



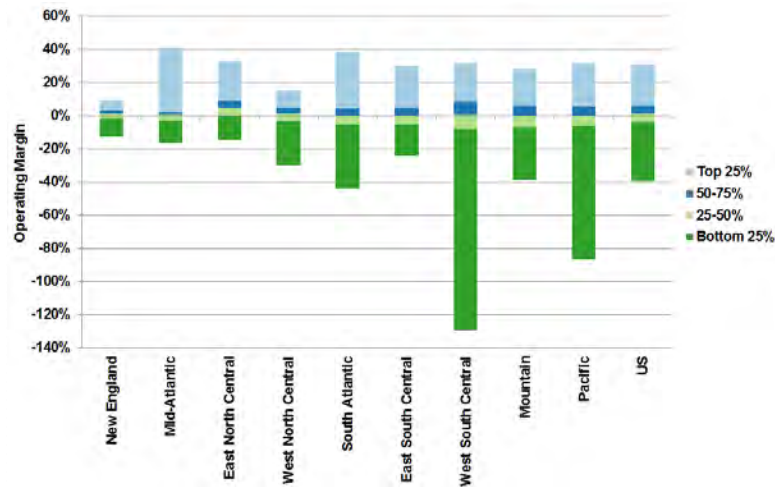
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2012 Total Margin Percentiles



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2012 Operating Margin Percentiles



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Key Findings

- Profitability of CAHs varies greatly across states and US Census divisions.
- CAHs in Hawaii, Georgia, and Kansas had both the lowest total margin and the lowest operating margin
- CAHs in South Atlantic and East South Central had both the lowest total margin and the lowest operating margin. CAHs in East North Central had both the highest total margin and the highest operating margin.
- The decertification of CAHs and the loss of cost-based reimbursement are likely to reduce hospital profitability, with some states and regions more adversely affected than others.



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Change in Profitability and Financial Distress of Critical Access Hospitals from Loss of Cost-Based Reimbursement

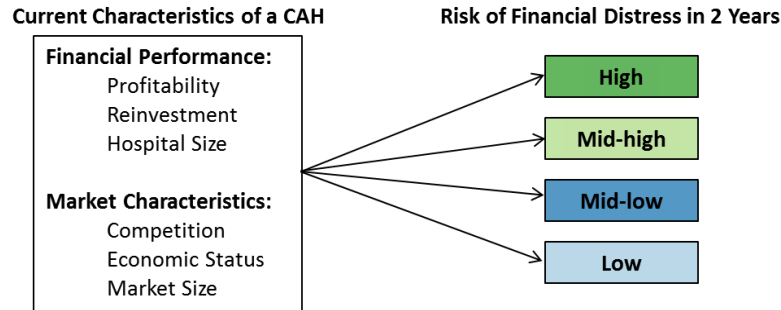
G. Mark Holmes, PhD and George H. Pink, PhD

<http://www.shepscenter.unc.edu/wp-content/uploads/2013/12/Change-in-Profitability-and-Financial-Distress-of-CAHs-November-2013.pdf>



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Model of CAH Financial Distress

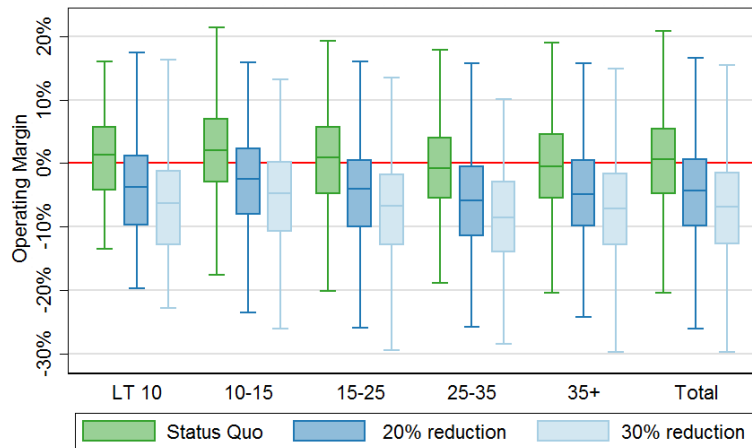


Potential Reductions in Medicare Reimbursement to CAHs

- **Medicare Payment Advisory Committee.** In 2005 study, MedPAC estimated that under PPS, CAHs would be paid approximately 30% less for inpatient, outpatient, laboratory, and post-acute (swing bed) services as compared to cost-based reimbursement.
- **Congressional Budget Office.** In 2011 study, CBO estimated that reversion to PPS would be a 20% decrease in Medicare revenue to CAHs, MDHs, and SCHs.
- **Office of the Inspector General.** In 2013 study, estimated that the net effect of conversion would be approximately a 17% decrease in Medicare revenue to a CAH.
- This study investigated change in risk of financial distress from 20% and 30 percent reduction in Medicare revenue.

(Anecdotally: may be larger than this?)

2011 Distribution of Operating Margin by Medicare Revenue Scenario and Distance to Nearest Hospital

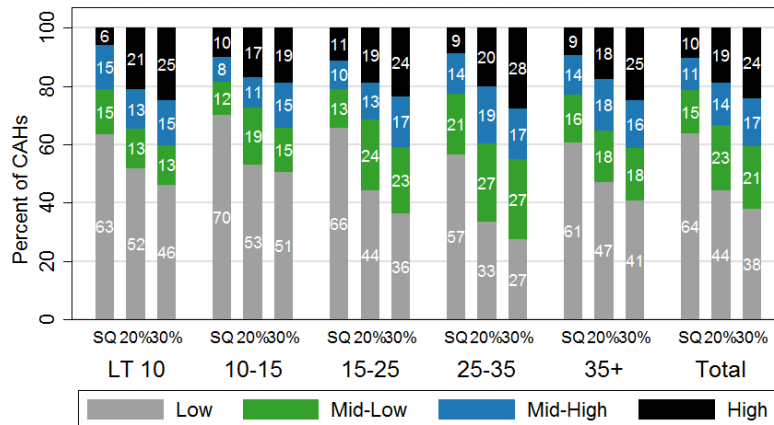


Outlier values not included in Figure.



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Risk of Financial Distress by Medicare Revenue Scenario and Distance to Nearest Hospital



Scenarios: SQ = Status Quo; 20% = 20% reduction in Medicare Revenue;
30% = 30% reduction in Medicare Revenue.
N = 1215 CAHs (5 w/ unknown distance), 2011 fiscal years.



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Key Findings

- **20% and 30% reductions to Medicare revenue**, the percentages of CAHs with negative operating margins are projected to be 72% and 80%, respectively. The distribution is largely independent of distance to nearest hospital.
- **20% reduction to Medicare revenue**, 39% of hospitals that are 25-35 miles from the nearest hospital and 36% of those that are greater than 35 miles from the nearest hospitals are projected to be at high or mid-high risk of financial distress.
- **30% reduction to Medicare revenue**, 45% of hospitals that are 25-35 miles from the nearest hospitals and 41% of those that are greater than 35 miles from the nearest hospitals are projected to be at high or mid-high risk of financial distress.



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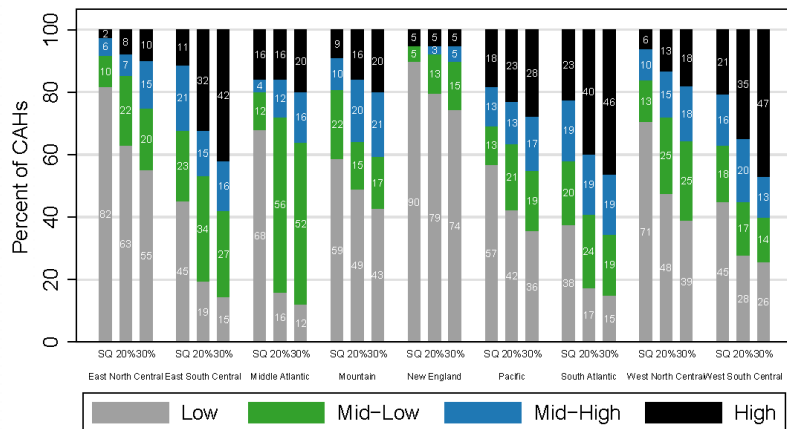
Financial Distress of Critical Access Hospitals by Geographic Location

G. Mark Holmes, PhD and George H. Pink, PhD



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Financial Distress by Scenario and Census Division

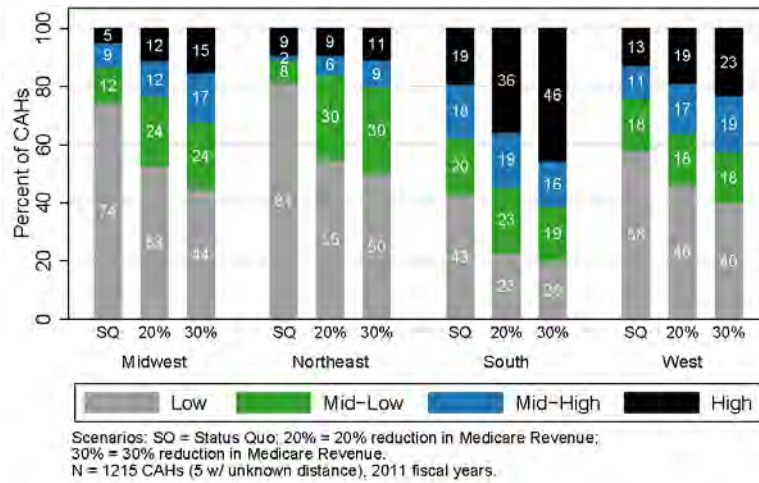


Scenarios: SQ = Status Quo; 20% = 20% reduction in Medicare Revenue;
30% = 30% reduction in Medicare Revenue.
N = 1215 CAHs (5 w/ unknown distance), 2011 fiscal years.



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Financial Distress by Scenario and Census Region



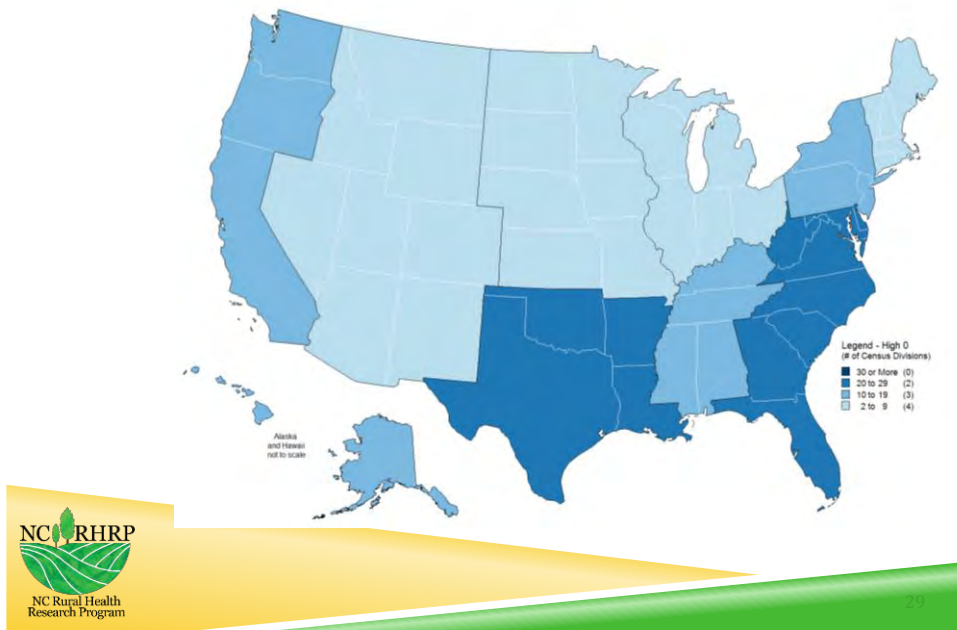
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Census Divisions

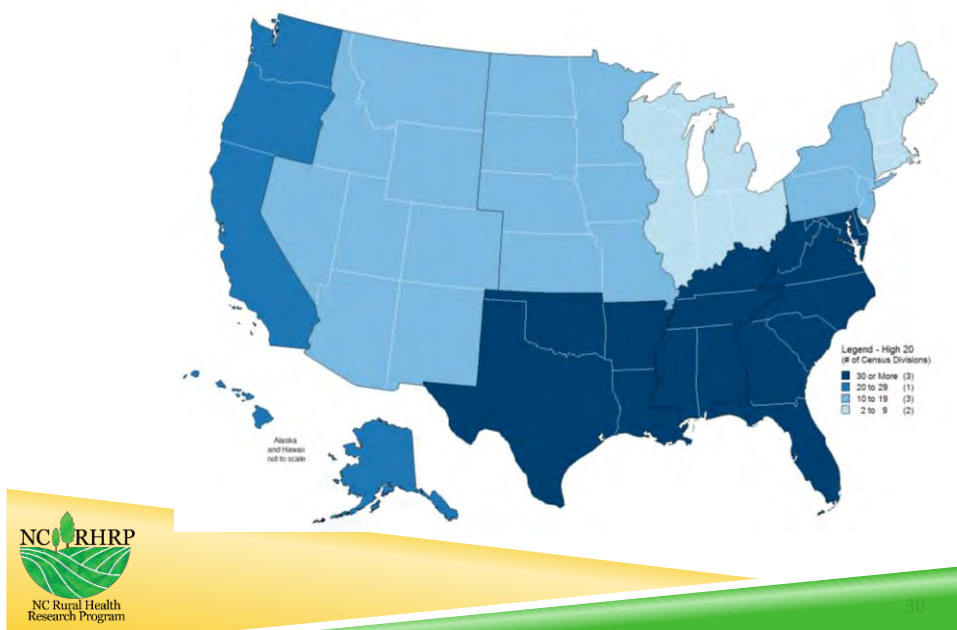


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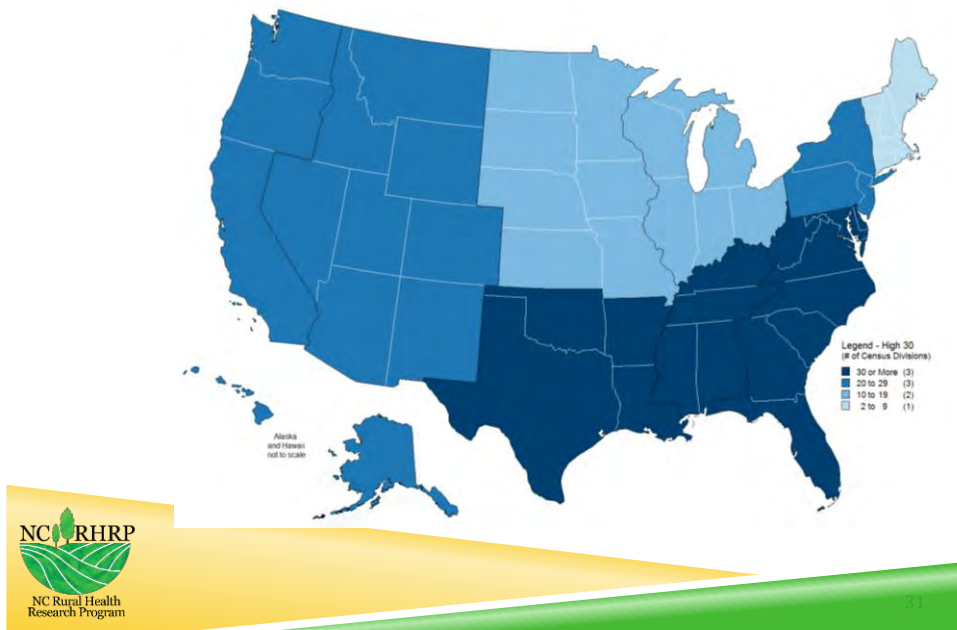
**Percent of CAHs at high risk of financial distress:
Status quo - No reduction in Medicare reimbursement**



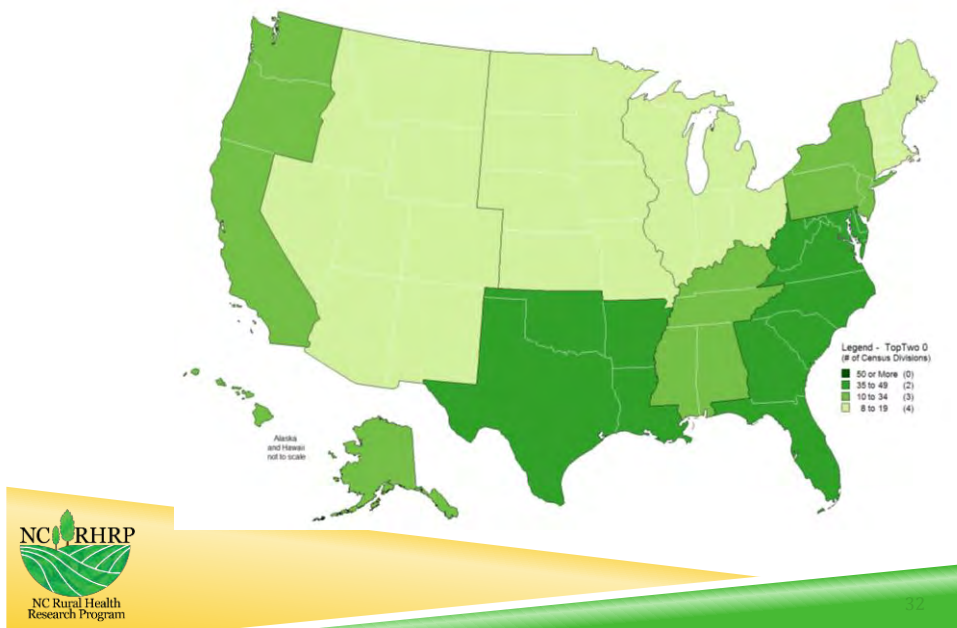
**Percent of CAHs at high risk of financial distress:
20% reduction in Medicare reimbursement**



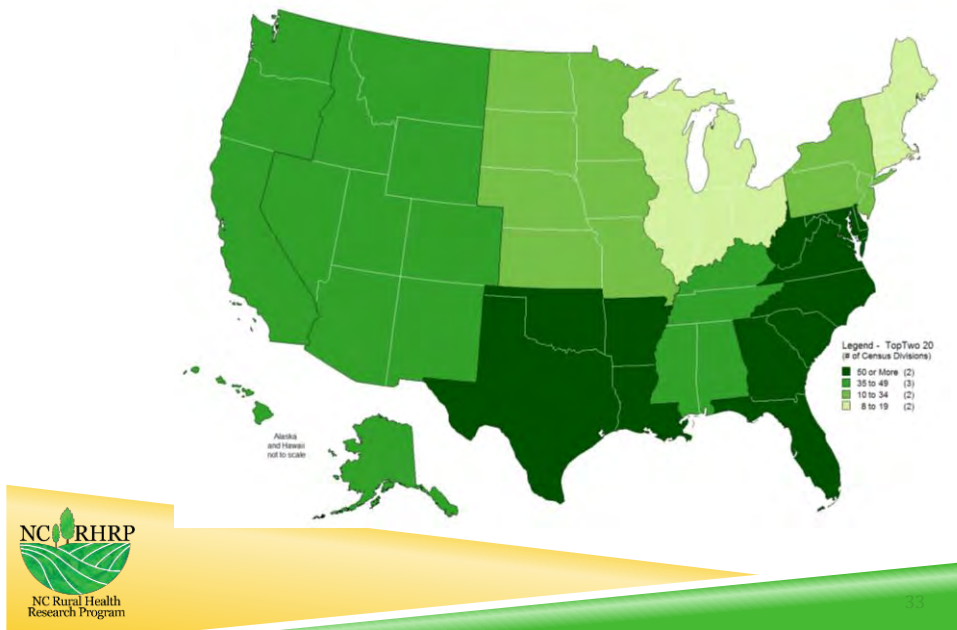
**Percent of CAHs at high risk of financial distress:
30% reduction in Medicare reimbursement**



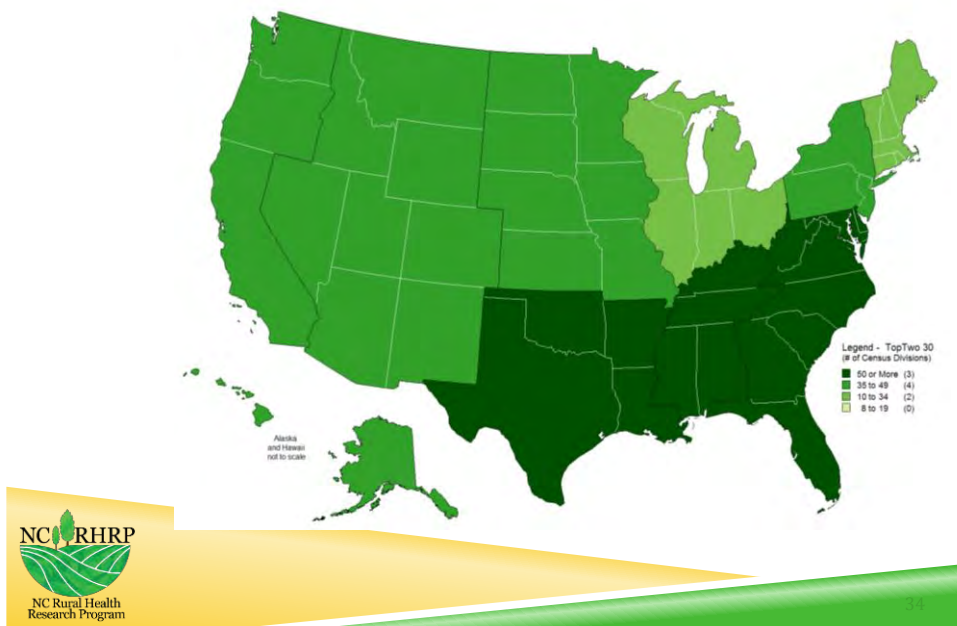
**Percent of CAHs at high and mid-high risk of financial distress:
Status quo - No reduction in Medicare reimbursement**



**Percent of CAHs at high and mid-high risk of financial distress:
20% reduction in Medicare reimbursement**



**Percent of CAHs at high and mid-high risk of financial distress:
30% reduction in Medicare reimbursement**



Key Findings

- CAHs in the South sees the sharpest increase in risk: if the 30% reduction were enacted, nearly half of CAHs in the South be at high risk of financial distress. All three divisions in the South would face acute financial pressure.
- New England and the East North Central - which have the highest total and operating margins - would see little change in the risk of financial distress.



Financial Implications

- There would be an increase in the number of CAHs experiencing **insolvency**, which occurs when an organization can no longer meet its financial obligations with its lenders as debts become due.
- Insolvency may lead to **reorganization bankruptcy** (Chapter 13), in which debtors restructure their repayment plans to make them more easily met, or
- **liquidation bankruptcy** (Chapter 7), in which debtors sell certain assets in order to make money they can use to pay off their creditors.



Organizational Implications

- **Merger** with another hospital
- **Acquisition** by another hospital, system, or holding company
- **Conversion** to long-term care, FQHC, clinic
- **Affiliation** with a system, network or alliance
- **Lease** of hospital to another hospital
- **Management contract** with another hospital or management company
- **Closure.**



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Implications for Beneficiary Travel Time if Financially-Vulnerable Critical Access Hospitals Close

Victoria A. Freeman, RN, DrPH; Randy K. Randolph, MRP;
George H. Pink, PhD and G. Mark Holmes, PhD

<http://www.shepscenter.unc.edu/wp-content/uploads/2013/12/Implications-for-Beneficiary-Travel-Time-if-Financially-Vulnerable-Critical-Access-Hospitals-Close.pdf>



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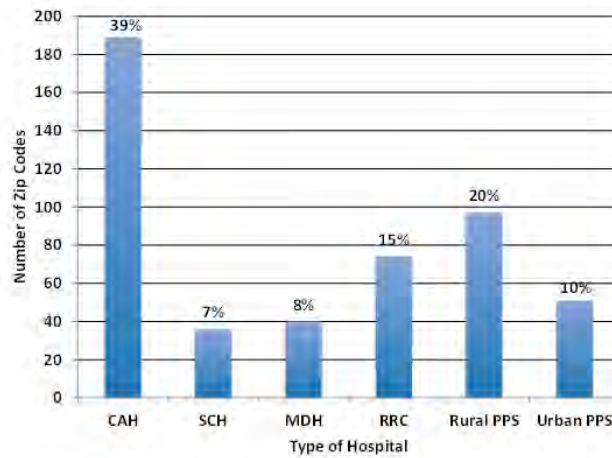
Distance to Nearest Hospital Before and After Closure of Vulnerable Hospitals in Affected ZIP Codes

	Status Quo	With Closures	Change in Miles
Mean miles	9.9	17.8	7.9
Median miles	9.4	16.6	6.6
Range	0.1 to 46.7	2.1 to 52.0	0 to 38.4

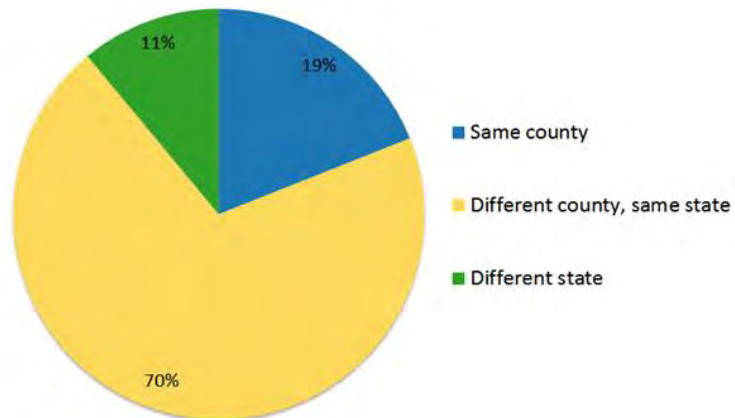


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Type of the New Nearest Hospital for Affected Zip Codes



Location of New Nearest Hospital Compared to Old Nearest Hospital



Key Findings

- **Residents would have to travel an average of 7.9 miles farther to access a hospital.**
 - Residents in 39% of affected ZIP code areas would experience a driving distance increase of less than 5 miles.
 - The distance would increase between 5 and 10 miles for 31% of ZIP codes.
 - For another 31% of ZIP code areas, the increased driving distance would be 10 miles or more.
- **The new nearest hospital would not be a CAH for the majority of affected ZIP code areas.**
- **The new nearest hospital for residents in 70% of affected ZIP codes areas would be located in a different county than the original nearest hospital.**
 - Eleven percent of ZIP code areas would now be nearest a hospital in another state.



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Implications

- **Eliminating the CAH payment classification would have considerable adverse financial consequences on the hospitals: between 36% and 45% would be at high or mid-high risk of financial distress, challenging their ability to remain financially viable in the long run.**
- **Such a substantial reduction in financial support could lead to a renewal of the high closure rates of the 1990s with concomitant deleterious effects on the health and economic well-being of these communities.**
- **Which leads us to our next project...**



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Rural Hospital Closures

- NC Rural Health Research Program is collecting data about rural hospital closures
- Go to <http://bit.ly/ruralclosures>

where you can get up-to-date data and information

- If you hear of an actual or probable closure, you can submit information

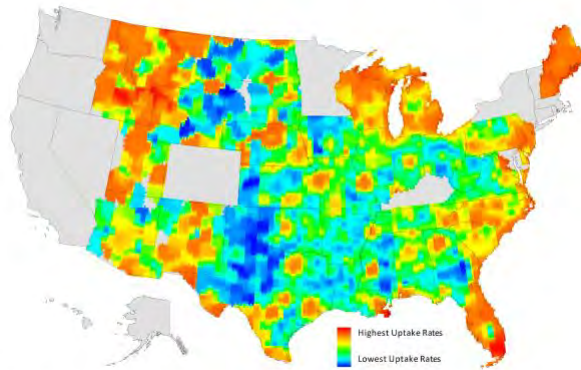


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Other recent products

- Enrollment in the FFM
- Mergers and acquisitions
- Medicaid expansion
- Now available: 2014 CAHFIR
- Coming soon: the 21st Century Hospital

Figure 1: Regional Variation in Locally Weighted Plan Selection Rates in the Federally Facilitated Marketplace



States shaded in grey have state health insurance marketplaces. Grey areas in Federally Funded Marketplace States are sparsely populated, and a reliable rate could not be calculated. See text for data sources and notes.



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North Carolina Rural Health Research Program

Location:

Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill
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Steve Rutledge



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Resources

North Carolina Rural Health Research Program

<http://www.shepscenter.unc.edu/programs-projects/rural-health/>

Rural Health Research Gateway

www.ruralhealthresearch.org

Rural Assistance Center (RAC)

www.raconline.org

National Rural Health Association

www.ruralhealthweb.org

National Organization of State Offices of Rural Health

www.nosorh.org

