ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

CRITICAL ACCESS HOSPITALS IN ALASKA
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What is a Critical Access Hospital?

Medicare participating hospitals must meet the following criteria to be designated as a Critical Access Hospital (CAH)[1]:

- Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a CAH;
- Demonstrate compliance with the Conditions of Participation (COP's) found at 42 CFR Part 485 subpart F at the time of application for CAH status;
- Furnish 24-hour emergency care services 7 days a week, using either on-site or on-call staff;
- Provide no more than 25 inpatient beds that can be used for inpatient or swing bed services;
- May also operate a distinct part rehabilitation or psychiatric unit, each with up to 10 beds;
- Have an average annual length of stay of 96 hours or less per patient for acute care (excluding swing bed services and beds that are within distinct part units); and
- Be located either more than a 35-mile drive from the nearest hospital or CAH or a 15-mile drive in areas with mountainous terrain or only secondary roads or certified as a CAH prior to January 1, 2006, based on State designation as a "necessary provider" of health care services.

Characteristics of Alaskan Critical Access Hospitals

CAHs provide a broad range of services in rural Alaska, including preventative services, long-term services and supports, diagnostic imaging, laboratory, critical care, and 24/7 emergency services. When a CAH has Medicare approval to furnish swing bed services, it may use any of its inpatient beds for either acute care or skilled nursing facility (SNF)-level care[2]. Alaskan CAHs are located in the following communities:

Community	Hospital Name	Acute Beds	Long-Term Beds	Swing Beds	Tribally Operated
Barrow	Samuel Simmonds Memorial Hospital	14	0	0	Yes
Cordova	Cordova Community Medical Center	13	10	4	No
Dillingham	Kanakanak Hospital	16	0	4	Yes
Homer	South Peninsula Hospital	22	25	4	No
Ketchikan	PeaceHealth Ketchikan Medical Center	25	29	0	No
Kodiak	Providence Kodiak Island Medical Center	25	19	25	No
Kotzebue	Maniilaq Health Center	15	18	0	Yes
Nome	Norton Sound Regional Hospital	18	20	0	Yes
Petersburg	Petersburg Medical Center	12	15	5	No
Seward	Providence Seward Medical Center	6	43	6	No
Sitka	Sitka Community Hospital	12	15	12	No
Valdez	Providence Valdez Medical Center	11	10	0	No
Wrangell	Wrangell Medical Center	8	14	4	No

[1] CMS Medicare Learning Network, "Critical Access Hospitals Fact Sheet" www.cms.gov/Outreach-and-Education/Medicare-LearningNetwork/MLN/MLNProducts/downloads/ CritAccessHospfctsht.pdf

[2] CMS Medicare Learning Network, "Swing Bed Services" www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SwingBedFactsheet.pdf

Payment Methodology

CAHs receive cost-based reimbursement from Medicare, instead of standard fixed reimbursement rates. Cost-based reimbursement enhances the financial performance of small rural hospitals. Medicare pays CAHs nationwide for most inpatient and outpatient services to Medicare patients at 101% of reasonable costs, based on submission of a cost report.

Alaska Medicaid reimburses most inpatient and outpatient services to Medicaid patients in a CAH at 100% of cost. Many Alaska CAHs have co-located nursing home (long-term) beds, which are primarily paid for by Medicaid. Facility-specific Medicaid rates are based on an annual cost report submitted by the CAH.

Four of the Alaska CAHs are operated by tribal health organizations and have slightly different payment methodology. They are reimbursed by Medicare under the reasonable cost method of reimbursement as are other CAHs, however the cost report used by tribally operated facilities is different. These rates are facility specific rates[3]. For Medicaid payments, tribally operated CAHs receive an all-inclusive rate determined by the federal OMB (Office of Management and Budget) for all IHS/tribally operated Alaskan health care facilities. The professional component of inpatient care may be billed separately.

CAHs are an Important Part of the Rural Economy

- CAHs are often the largest or second largest employer in a rural community.
- If a rural hospital closes, severe economic decline in the rural community is the result. Physicians, nurses, pharmacists and other health care seek employment elsewhere. Patients travel farther for care or delay receiving care, resulting in poorer health outcomes.
- Businesses, families and retirees may not relocate to a rural area if hospital care is not available.

Nationwide CAHs represent over 22% of all community hospitals, however, Medicare expenditures to CAHs are less than 5% of the Medicare hospital budget.

The limited size and short stay length encourage CAHs to focus on providing care for common conditions and outpatient care, while referring other conditions to larger hospitals. This saves the Medicare program approximately $2.2 billion each year.

Challenges for Alaskan CAHs

According to a report by Cleverley and Associates[4], based on ten Alaska CAH 2010 cost reports:

- Costs are 31% higher in Alaska CAHs than the U.S. average CAH;
- Labor productivity differences appear to be a factor for higher cost at rural Alaska hospitals, this could be the result of lower patient volume and required minimum staffing levels;
- Cost of living is a major component of higher labor costs, as are workforce shortages;
- Ancillary costs, for example, lab, drugs, supplies, radiology, average 29% higher in Alaskan CAHs;
- Alaska CAHs serve large areas with low population density, which contributes to higher costs;
- Higher depreciation and leasing costs in Alaska CAHs are also a significant cost driver.

In addition to the daily operating challenges of small rural hospitals, the federal government is considering changes to the CAH Program that could force the closure of one or more Alaskan hospitals[5].

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[3] Medicare Claims Processing Manual, Chapter 19 Indian Health Services, section 110.3 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c19.pdf

[4] ASHNHA Report on Hospital Margin and Cost Position, Cleverley and Associates, 2012.

[5] National Rural Health Association Talking Points for HHS CAH Report.