

The Economic Impact of the Critical Access Hospital Program on Illinois Communities

EXECUTIVE SUMMARY

Illinois Critical Access Hospital Network



By Northern Illinois University

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THE ECONOMIC IMPACT OF THE CRITICAL ACCESS HOSPITAL PROGRAM ON RURAL ILLINOIS COMMUNITIES

Illinois has 51 small hospitals located throughout the state that are designated as Critical Access Hospitals (CAHs). The CAH Program was created by Congress in 1997 as a safety net to assure Medicare beneficiaries access to health care services in rural areas. It was designed to allow more flexible staffing options to respond to community needs, simplify billing methods, and create incentives to develop local integrated health delivery systems, including acute, primary, emergency, and long-term care. The Illinois Critical Access Hospital Network has contracted with Northern Illinois University to analyze the economic impact of the CAHs on their communities. This report presents the study findings.

The market areas served by CAHs are more than three times as rural as the state as a whole. The vast majority of these areas experienced net population loss between 2000 and 2005 and have more elderly, fewer young residents, and lower median incomes than the statewide averages. In two-thirds of the 33 rural CAH counties, hospitals are among the three largest employers in the county.

Two survey instruments were developed to capture information on the effect of CAH status on operating revenue, expenses, employment, patient loads, payor mix, capital expenditures, services, and relationships with other regional healthcare providers. Using input/output modeling and comparative analysis, 20 key findings were generated regarding current hospital operations and net changes in operation and services since CAH designation.

Key Findings

1. CAH status resulted in immediate and sustained improvements in revenues for almost every hospital that participated in the study, and in improved profitability for the majority of hospitals. However, despite these financial improvements, a number of hospitals reported an ongoing struggle with financial solvency.
2. Increases in Medicare reimbursement and in charges were the two main sources of revenue growth identified by respondents. Increased admissions were the third largest reason for improved revenue streams.
3. Changes in payor mix differed for CAH inpatients and outpatients. Following designation, inpatient changes included decreased reliance on Medicare and increased payments from the self-insured (self-payors). Outpatient changes included increases in both Medicare and Medicaid payments and a decrease in third party payments.
4. The patient revenues generated by this payor mix enabled a majority of CAHs to cover operating costs in 2005. However, only third party payors reimbursed at a rate for patient services that consistently exceeded expenses.

Executive Summary

Key Findings (continued)

5. Overall, the greatest shortfall in reimbursement is by Medicaid, followed by Medicare and the self-insured. In most cases, the hospitals receive net revenue from third party payors, suggesting a fair amount of cross-subsidy among payor categories.
6. CAHs represent a significant employer in rural Illinois communities. CAH designation enabled the majority of hospitals to increase their staffing levels, primarily in direct care positions. Significant quality improvements were attributed to these additional positions.
7. A number of hospitals were able to add clinics and needed patient and community services, expansions that account for much of the increase in direct patient care personnel.
8. The most significant change in service levels in hospitals that had been designated as CAH for at least two years was in outpatient admissions, which grew by an average of 50.9%. Increased admissions were explained, in part, as resulting from facility improvements and expansions and the hiring and retention of quality medical personnel that resulted from CAH designation.
9. Designation as a Critical Access Hospital allowed for the maintenance of patient and community services that were in financial jeopardy and the addition of specialty clinics and services that focused on the emerging healthcare needs of their community.
10. Many CAHs attributed improved services to the increased collaboration and communication with other regional providers that occurred since designation. These enhanced relationships allowed them to provide more services with existing resources.
11. CAH designation enabled many hospitals to address deferred capital improvements, including a number of life/safety projects and routine repairs. These increased capital investments in facility renovation and expansion, replacement of obsolete medical equipment, and the purchase of modern diagnostic and imaging equipment were credited with improving the ability of CAHs to deliver quality services to their communities.
12. COMPdata provided by five CAHs illustrate the breadth and versatility of the medical services these hospitals provide to their communities. In 2005, they treated an average of 108 different diagnoses for inpatients 65 and older and 91 diagnoses for those under 65. Moreover, there were only one or two cases reported for almost two-thirds of these diagnostic categories for both age groups.
13. The rural elderly are primary users of the CAHs. Individuals 65 and older represent 14.1% of the residents of the CAH counties, but made up 65.2% of all 2005 inpatient admissions for the five case study hospitals.
14. CAH designation has enabled small, rural Illinois hospitals to stabilize financially and maintain or expand quality healthcare services to their communities. The continued existence of these medical facilities has a significant local economic impact in revenues generated through hospital expenditures and through employee salaries.
15. The mature CAHs that provided financial data for this report experienced an annual increase of 9% in net revenue between 2000 and 2005, a robust growth rate when considering comparable rates of hospital output of 1.1% for the U.S. as a whole, -0.25% for the Great Lakes region and -0.6% for Illinois.

Executive Summary

Key Findings (continued)

16. In two-thirds of the rural counties in which CAHs are located, the hospital is among the three largest employers in the county and is a major economic driver for the regional economy. In 2005, the combined net operating revenue for the 33 CAHs that reported FY05 financial data was \$528 million.
17. In addition to these direct economic impacts, another \$235 million was generated by the CAHs in business-to-business transactions and the expenditures by CAH employees on local goods and services (i.e. indirect and induced impacts). The total estimated economic impact of all Critical Access Hospitals on their host counties in 2005 was \$763,794,674.
18. Construction projects undertaken by the participating hospitals, many of which were deferred until obtaining CAH status, generated additional economic benefit to their communities. In 2005, CAH facility renovations and expansions resulted in an estimated additional \$11.2 million in revenues to their counties and short-term employment for approximately 571 construction workers.
19. Future capital improvements planned for 2007 through 2011 will produce an estimated additional \$21.7 million in revenues and approximately 1,103 construction jobs.
20. Beyond financial stabilization and quality improvements, survey respondents identified benefits associated with CAH status as the ability to attract and retain qualified physicians and other healthcare personnel to these rural facilities and the opportunity to refocus their operations to improve efficiency.

Critical Access Hospitals throughout rural Illinois serve vital medical and economic purposes. In addition to providing a broad range of primary and emergency care and community services to medically vulnerable populations, particularly the elderly, CAHs are major contributors to the local economic base. Designation as a Critical Access Hospital and access to the financial benefits associated with that program have enabled many of these institutions not only to keep their doors open, but to update obsolete facilities and equipment and respond to the changing healthcare needs of their communities. The continued presence of the hospitals that participated in this study represents annual contributions of more than \$775 million to their local economies through expenditures and payroll.

