

## Small or Rural Hospitals

### Background

Approximately 72 million Americans live in rural areas and depend upon the hospital serving their community as an important, and often only, source of care. Remote geographic location, small size, and limited workforce along with physician shortages and financial resources pose a unique set of challenges for rural hospitals. Compounding these challenges, rural hospitals' patient mix makes them more reliant on public programs and, thus, particularly vulnerable to Medicare and Medicaid payment cuts. For more than 60 percent of small or rural hospitals, Medicare does not cover the costs of caring for Medicare patients.

### AHA View

Medicare payment systems fail to recognize the unique circumstances of small, rural hospitals. Many rural hospitals are too large to qualify for Critical Access Hospital (CAH) status, but too small to absorb the financial risk associated with prospective payment systems. *The Patient Protection and Affordable Care Act of 2010 (ACA)* made strides toward providing these hospitals with adequate reimbursement, but more is needed. In addition, existing special rural payment programs – the CAH, sole community hospital (SCH), Medicare-dependent hospital (MDH) and rural referral center (RRC) programs – need to be updated.

The AHA is working to ensure that all hospitals have the resources that they need to provide high-quality care and meet the needs of their communities. We are advocating for appropriate Medicare payments, extending expiring beneficial Medicare provisions, improving federal programs to account for special circumstances in rural communities, and seeking adequate funding for annually appropriated rural health programs.

**Rural Legislation.** In December 2010, Congress passed the *Medicare and Medicaid Extenders Act (MMEA)*, which contained many provisions important to rural hospitals and beneficiaries. The law extended:

- 508 geographic reclassifications, which are opportunities for hospitals meeting certain criteria to appeal their wage index classifications, through September 30, 2011;
- Medicare reasonable cost payments for certain clinical diagnostic laboratory tests for patients in certain rural areas through July 1, 2011;
- the floor on Medicare work geographic adjustment, known as the GPCI;
- the outpatient hold harmless provision;
- the exceptions process for Medicare therapy caps;
- direct billing for the technical component of certain physician pathology services; and
- ambulance add-on payments through December 31, 2011.

### **The AHA is working to extend these rural provisions beyond 2011.**

Further, as part of the ACA, Congress extended and expanded many important rural provisions. For example, lawmakers greatly expanded the payment adjustment for low-volume hospitals for fiscal years (FYs) 2011 and 2012; extended and expanded the rural community hospital demonstration; and ensured that CAHs are paid 101 percent of costs for all outpatient services, regardless of the billing method selected.

In 2011, the AHA continues to urge Congress to:

- allow hospitals, but especially CAHs, SCHs and MDHs, to claim the full cost of provider taxes as allowable costs;
- require Medicare Advantage plans to pay CAHs at least 101 percent of costs;
- instruct the Centers for Medicare & Medicaid Services (CMS) to appropriately address the issue of direct supervision for outpatient therapeutic services for rural hospitals and CAHs;
- ensure rural hospitals and CAHs have adequate reimbursement for certified registered nurse anesthetist services, including stand-by services;
- exempt CAHs from the Independent Payment Advisory Board;
- provide CAHs with bed size flexibility;
- reinstate CAH necessary provider status; and
- remove unreasonable restrictions on CAHs' ability to rebuild.

### **OTHER CONCERNS**

**Federally Qualified Health Centers (FQHCs).** FQHCs are community-based and patient-governed organizations that provide comprehensive primary care services to medically underserved communities and vulnerable populations, regardless of their ability to pay. *The American Recovery and Reinvestment Act* provided \$2 billion for investment in health centers to support health care services, capital renovations and repairs, and health information technology. In addition, the ACA mandated appropriations of \$11 billion over five years, including \$9.5 billion for service expansion and \$1.5 billion for construction.

The recent infusion of federal support for FQHCs has led to increased discussions among hospitals as to their effect on health care and health care delivery in their communities. Hospitals have widely divergent views on whether hospitals and FQHCs are competitors or partners. In 2010, the AHA established a member workgroup to discuss policy and advocacy around FQHCs. The group has focused on a variety of actions and strategies, including: gathering additional hospital input, monitoring issues to determine whether regulatory or legislative

change is needed, on-going tracking of federal funding of health centers and implementation of relevant provisions of the ACA, and providing educational tools and resources to enhance collaboration between hospitals and health centers. In addition, **the AHA is working with the Health Resources and Services Administration (HRSA) to improve collaboration between hospitals (both rural and urban) and FQHCs.**

**Health Professional Shortage Areas (HPSAs) and Medically Underserved Populations (MUPs).** As required by the ACA, HRSA plans to establish a comprehensive methodology for designating MUPs and Primary Care HPSAs using a negotiated rulemaking (NR) process. Last year, HRSA created a 28-member NR committee that includes the AHA and representatives from a diverse group of providers and technical experts from both urban and rural areas. The committee's objective is to make recommendations for a revised, coordinated MUP and HPSA designation process that would, at a minimum, consistently define the indicators used for both designation types; clarify the distinctions between MUPs and HPSAs; and update both types of designations on a regular, simultaneous basis. The committee hopes to release a report by July 1, 2011. However, if the NR Committee is unable to reach consensus on its recommendations, HRSA will develop a proposed rule on its own.