American Hospital Association

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 the only, source of care. Remote geographic location, small size, and limited workforce along with physician shortages and often constrained 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.

Equally troubling, President Obama's fiscal year (FY) 2013 budget proposal would reduce payments to critical access hospitals (CAHs) from 101 percent to 100 percent of reasonable costs. In addition, effective in FY 2014, it would eliminate the CAH designation for hospitals that are less than 10 miles from the nearest hospital. Together, the administration estimates these rural proposals would save approximately $2 billion over 10 years.

AHA View

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. 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.

Rural Legislation. In February, Congress passed the *Middle Class Tax Relief and Job Creation Act of 2012*, which contained many provisions important to rural hospitals and beneficiaries. **The AHA is working to extend beyond 2012 the law's rural extender provisions, plus several others. Key rural hospital provisions are:**

- 508 geographic reclassifications, which are opportunities for hospitals meeting certain criteria to appeal their wage index classifications (expired March 31);
- Medicare reasonable cost payments for certain clinical diagnostic laboratory tests for patients in certain rural areas (expires June 30);
- Direct billing for the technical component of certain physician pathology services (expires June 30);
- Low-volume hospital payment adjustment (expires Sept. 30);
- Medicare-dependent hospital program (expires Sept. 30);

- Outpatient hold harmless payments (expires Dec. 31, although for SCHs with more than 100 beds, it expired March 1); and
- Ambulance add-on payments (expires Dec. 31).

In addition, 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 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

Health Professional Shortage Areas (HPSAs) and Medically Underserved Populations (MUPs). As required by the *Patient Protection and Affordable Care Act*, the Health Resources and Services Administration (HRSA) plans to establish a comprehensive methodology for designating MUPs and Primary Care HPSAs using a negotiated rulemaking (NR) process. The AHA and representatives from a diverse group of providers and technical experts from both urban and rural areas participated in a 28-member NR committee. The committee's objective was 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 deliberated 14 months to draft its recommendations, which were delivered to the Health and Human Services secretary on October 31, 2011. We expect HRSA to issue an interim final rule sometime this year.