# 2012 Small/Rural Advocacy Agenda

**Because of their small size, modest assets and financial reserves, and higher percentages of Medicare patients, rural hospitals disproportionately rely on government payments.** Medicare payment systems often 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 system (PPS) programs. With deficit reduction as a key goal in Washington, rural health care providers continue to be in jeopardy.

## AHA POSITION

### The AHA is focused on ensuring all hospitals have the resources they need to provide high-quality care and meet the needs of their communities. That means:

- Advocating for appropriate Medicare payments;
- Working to extend expiring 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 reauthorized, updated and protected.

## KEY PRIORITIES

### 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 (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);
- MDH 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).

### The AHA will work with Congress to:

- Extend expiring provisions;

- Allow hospitals to claim the full cost of provider taxes as allowable costs;
- Ensure CAHs are paid at least 101 percent of costs by Medicare Advantage plans;
- Ensure that the Centers for Medicare & Medicaid Services (CMS) appropriately addresses 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 and stand-by services;
- Exempt CAHs from the Independent Payment Advisory Board;
- Provide small, rural hospitals with cost-based reimbursement for outpatient laboratory services and ambulance services;
- Provide CAHs bed size flexibility;
- Reinstate CAH necessary provider status;
- Remove unreasonable restrictions on CAHs' ability to rebuild;
- Extend hospital mortgage insurance FHA HUD 242 program for CAHs (expired July 2011);
- Make the Conrad 30 J1 Visa Waiver program permanent and expand the number of waivers available (expires June 1); and
- Extend 340B drug discount program for the purchases of drugs used during inpatient hospital stays and oppose any attempts to scale back this vital program.

## FY 2013 FEDERAL BUDGET

**Budget cuts.** In February, President Obama released a budget outline for fiscal year (FY) 2013. The outline, which is similar to a proposal the White House released last September, calls for cutting Medicare by about $268 billion and Medicaid by $52 billion over 10 years. This budget proposal, as well as other deficit and spending reduction bills, will put rural hospitals at risk of cuts in several areas. The proposed cuts include:

- **Rural hospitals.** The administration proposes changes to payments for rural providers. Starting in FY 2013, it would reduce CAH payments 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.
- **Rural health programs.** Rural health programs such as the Medicare Rural Hospital Flexibility Grant Program, Rural Health Outreach and Network Development, State Offices of Rural Health, Rural Telehealth, Rural Policy Development and other health care programs are vital to ensuring that needed services remain available in America's rural communities. The president's FY 2013 budget proposes a $15 million cut to rural programs.