

Rural or Small Hospitals

BACKGROUND

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/or protected.

KEY PRIORITIES

Rural Legislation

Recently, Congress passed the *American Taxpayer Relief Act of 2012*, which contained many provisions important to rural hospitals and beneficiaries. The AHA is working to extend beyond 2013 the law's rural extender provisions, plus several others. Key rural hospital provisions are:

- MDH program (expires Sept. 30);
- Low-volume hospital payment adjustment (expires Sept. 30);
- Ambulance add-on payments (expires Dec. 31).
- 508 geographic reclassifications (expired March 31, 2012);
- Medicare reasonable cost payments for certain clinical diagnostic laboratory tests for patients in certain rural areas (expired June 30, 2012);

- Direct billing for the technical component of certain physician pathology services (expired June 30, 2012);
- Outpatient hold harmless payments (expired Dec. 31, 2012, although for SCHs with more than 100 beds, it expired March 1, 2012); and

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;

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- 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; and
- Extend 340B drug discount program to additional hospitals and for the purchases of drugs used during inpatient hospital stays, and oppose any attempts to scale back this vital program.

FY 2013 Federal Budget

In February 2012, President Obama released a budget outline for fiscal year (FY) 2013. The outline, which was similar to a proposal the White House released in September 2011, called 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, would put rural hospitals at risk of cuts in several areas. The proposed cuts include:

- **Rural hospitals.** The administration proposed 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 proposed a \$15 million cut to rural programs.

Regulatory Policy Priorities

Direct supervision. For the past four years, CMS has modified its policies related to the "direct supervision" of outpatient therapeutic services, threatening to magnify physician shortage problems. For 2013, at the AHA's urging, CMS adopted several positive changes to the regulations. Specifically, the agency:

- Allowed non-physician practitioners authorized to furnish direct supervision to also provide general or personal supervision for certain services;
- Modified the definition of direct supervision to remove all references to the physical boundaries within which the supervising practitioner must be located as long as he or she is "immediately available to furnish assistance and direction throughout the performance of the procedure;"
- Established a process for independent review of alternate supervision levels using the Advisory Panel on Hospital Outpatient Payments; and
- Delayed enforcement of the direct supervision policy through calendar year (CY) 2013 for CAHs and small and rural hospitals with fewer than 100 beds.

While we are pleased with this increased flexibility, the AHA remains concerned that hospitals and CAHs will have difficulty implementing these requirements. We continue to disagree with CMS's repeated

assertion that it has required direct supervision of outpatient therapeutic services since 2001. The AHA continues to work with CMS and Congress to make additional fundamental changes to the supervision policy. Specifically, we urge the agency to adopt a default standard of "general supervision" for outpatient therapeutic services, indicating that these procedures should be performed under the physician's overall direction and control, but the physician's presence should not be required during the performance of the procedure. In addition, we urge CMS to develop a reasonable exceptions process with provider input to identify those specific procedures that require direct supervision levels.

Conditions of Participation (CoP). In May of 2012, CMS updated a number of CoPs for hospitals and CAHs. AHA welcomed many of the changes, which will allow for more streamlined management and efficiency in the delivery of care. For example, under the revised

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CoPs, multi-hospital systems may operate with a single governing board. In addition, CAHs may provide certain services, such as diagnostic, therapeutic, laboratory, radiology and emergency services under service arrangements. However, AHA and other stakeholders objected to a provision in the final rule that would have required hospitals to include a member of the medical staff on their governing boards, since it would be difficult for some hospitals and systems (such as those with elected or appointed boards) to comply. As a result, CMS says it will not survey hospitals on that provision at this time. Additionally, AHA will continue to work with CMS on other issues of concern, such as ensuring that hospitals have flexibility in how medical staffs may be structured. Further changes to the CoPs are expected to be proposed this spring.

Electronic Health Records (EHRs) and Meaningful Use. CMS has established confusing meaningful use rules complicated by voluminous additional guidance, as well as a challenging operational structure. In addition, the final Stage 2 rules raise the bar even higher. For PPS hospitals, CMS will assess penalties beginning in FY 2015

based on whether a hospital met meaningful use in an earlier time period. For CAHs, the penalties will be based on same-year performance.

The AHA continues to work with CMS to clarify requirements and reduce the burden of registering and attesting to meaningful use. We are especially pleased that CMS has announced a reversal of its policy and will now allow CAHs to include capital leases as allowable costs in determining their meaningful use incentive payment. CMS also will allow providers additional time in 2014 to upgrade their EHRs and transition to Stage 2.

However, we continue to be concerned about the impact of the program on small and rural providers, and believe that the EHR incentives program should close, not widen, the existing digital divide. Only a small share of hospitals have met the meaningful use requirements for Stage 1 to date – about 30 percent of all hospitals, and only 15 percent of CAHs. Only CAHs that successfully attested to meaningful use in FY 2011 or FY 2012 will benefit fully from the incentives; the vast majority will come on board later and receive incentives for fewer years.

