FACTSHEET

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 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;

Continued on reverse

Continued

- 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.

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 2012, 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;
- 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) 2012 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.

Inpatient PPS rule. On April 24, CMS issued its FY 2013 inpatient PPS proposed rule. The rule proposes a cut of 1.9 percent to inpatient PPS payments to permanently eliminate what CMS claims is the effect of documentation and coding changes from FYs 2008 and 2009 that the agency says do not reflect real changes in case-mix. Additionally, it proposes a new 0.8 percent cut to permanently eliminate documentation and coding cuts from FY 2010. **This represents a total proposed coding cut of 2.7 percent, or $2.9 billion, for FY 2013.** CMS also proposes to restore the 2.9 percent cut that was made in FY 2012 to recoup past overpayments. Thus, as of the end of FY 2012, CMS's recoupment of past overpayments will be complete. We are deeply disappointed that CMS

Continued next page

has proposed additional coding cuts related to FY 2010. CMS believes that implementation of the Medicare Severity diagnosis-related groups (MS-DRGs) in FY 2008 led to documentation and coding changes that increased aggregate hospital payments compared to the previous DRG system, without corresponding increases in actual patient severity of illness. However, it is inappropriate for the agency to continue to compare hospital documentation and coding in FY 2010 to documentation and coding under the DRG system in FY 2007. **The AHA is conducting a detailed analysis of CMS's proposal and methodology for determining the coding offset and is committed to helping ensure that hospitals receive an appropriate update for FY 2013.**

In addition, CMS makes two proposals related to SCHs. First, the agency states that it has become aware of a number of MDHs that intend to apply for SCH classification upon the expiration of the MDH program. In order to facilitate a seamless transition for such hospitals, CMS proposes to add an exception to its SCH effective-date policy that would allow qualifying hospitals to obtain SCH status the day after the MDH program expires. In addition, CMS's other proposal relates to the duration of an SCH classification. Currently, a hospital's SCH classification remains in effect without the need for reapproval unless there is a change in the circumstances under which the classification was approved. However, the agency states that these regulations do not explicitly address a situation where a hospital never met the requirements to be classified as an SCH to begin with, but was nonetheless granted such classification. CMS is thus proposing to revise its regulations to state that if it determines a hospital was incorrectly classified as an SCH, the agency can revoke that classification retroactive to when it was first granted. **The AHA strongly disagrees with this proposed policy and believes it is patently unfair and inappropriately punitive.**

Finally, CMS proposed how it intends to manage payments under the hospital inpatient value-based purchasing (VBP) and the readmissions reductions programs, both beginning in FY 2013.

Conditions of Participation (CoP). Last fall, CMS proposed changes to the CoPs for the first time since 1985. These changes in large measure are intended to permit more effective governance and medical staff involvement in hospital care, reflect the evolving roles of non-physician providers, eliminate record keeping by hand, and otherwise modernize the CoPs. In issuing the proposed rule, CMS acknowledged that further changes will likely be necessary after these are put in place because so much of hospital practice has evolved since 1985. **The AHA saluted the changes CMS proposed, specifically the move to recognize a single governing body over multiple hospitals within a system, allowing CAHs to provide certain services, such as diagnostic, therapeutic, laboratory, radiology and emergency services under service arrangements and permitting advanced practice practitioners to serve in an expanded role.** The final rule is expected in the 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. **The AHA continues to work with CMS to clarify requirements and reduce the burden of registering and attesting to meaningful use.** We are concerned that the proposed Stage 2 rules ask for too much, and we will focus on ensuring that the rules represent a true incremental change from Stage 1, that the problems with the clinical quality measures are resolved, and that the penalty phase of the rule is implemented fairly.

We are especially 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. Data from the AHA's surveys indicate that, while hospitals as a whole saw tremendous increases in adoption of EHRs in 2011, the rate of increase was strongest among large and urban hospitals, and rural hospitals had the lowest level. In light of the mere 8 percent of hospitals that have met meaningful use requirements for Stage 1, the AHA believes that Stage 2 of meaningful use should not start until at least 75 percent of hospitals and physicians have successfully achieved Stage 1.