

Small or Rural Hospitals

Background

Approximately 51 million Americans live in rural areas and depend upon the hospital as an important, and often the only, source of care in their community. 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 half of rural hospitals, Medicare does not cover the costs of caring for Medicare patients.

Equally troubling are several proposals released by the Obama administration that would put rural hospitals at risk of cuts in several areas. For example, the president's fiscal year (FY) 2013 budget outline sought to reduce critical access hospital (CAH) payments from 101 percent to 100 percent of reasonable costs. In addition, the administration proposed to eliminate in FY 2014 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 protected and updated.

Rural Legislation. *The American Taxpayer Relief Act of 2012* contained many provisions important to rural hospitals and beneficiaries, including extending the following provisions that had expired:

- Low-volume hospital payment adjustment (now expires Sept. 30);
- Medicare-dependent hospital program (now expires Sept. 30);
- Ambulance add-on payments (now expires Dec. 31); and
- Outpatient therapy caps exception process (now expires Dec. 31). (*While the AHA supports extending the outpatient therapy exceptions process, we oppose the temporary expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.*)

The AHA is working to extend beyond 2013 the law's aforementioned rural extender provisions, in addition to several others. We also will advocate before Congress for these critical programs and provisions:

- 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);
- 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 services, including 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 with bed size flexibility;
- Reinstate CAH necessary provider status;
- Remove unreasonable restrictions on CAHs' ability to rebuild; and
- Extend the 340B drug discount program to additional hospitals and for the purchases of drugs used during inpatient hospital stays for all eligible hospitals, and oppose any attempts to scale back this vital program.

OTHER CONCERNS

Direct Supervision. For the past several years, CMS has modified its policies related to the agency's "direct supervision" requirement of outpatient therapeutic services. For 2013, at the AHA's urging, CMS adopted several positive changes to the regulations, including a delayed enforcement of the direct supervision policy through 2013 for CAHs and small and rural hospitals with fewer than 100 beds. For more information, see the AHA's "Medicare" issue paper.

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 final Stage 2 rules raise the bar even higher. For hospitals paid under the Medicare prospective payment system, 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 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. We also are pleased that CMS has determined that physicians who provide services in the outpatient departments of CAHs and for whom bills are submitted via the optional, or “Method 2,” billing approach are now eligible to participate in the Medicare EHR Incentive Program. Finally, 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. To date, only a small share of hospitals have met the meaningful use requirements for Stage 1 – fewer than half of all hospitals, and less than one-third 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 qualify later and receive incentives for fewer years.