

Rural and Small Hospitals

THE ISSUE

Because of their size, modest assets and financial reserves, and higher percentages of Medicare patients, small and rural hospitals disproportionately rely on government payments. Medicare payment systems often fail to recognize the unique circumstances of small or 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, small and 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 that help them maintain financial viability;
- 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

The Protecting Access to Medicare Act of 2014 contained several provisions important to rural hospitals. The AHA continues to work to extend the law's rural extender provisions, plus several others. Key rural hospital provisions are:

- MDH program (expires March 31, 2015);
- Low-volume hospital payment adjustment (expires March 31, 2015);
- Ambulance add-on payments (expires March 31, 2015); and
- Outpatient therapy caps exception process (expires March 31, 2015). (While the AHA supports extending the outpatient therapy exception process, we oppose the expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.)

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;
- Exempt CAHs from the cap on outpatient therapy services;
- Provide CAHs 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, and oppose any attempts to scale back this vital program.

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Regulatory Policy Priorities

Critical Access Hospitals. Recent recommendations, if implemented through legislation, will challenge the continued viability of many CAHs and threaten beneficiaries' access to care in rural America.

- In April, President Obama released a budget outline for fiscal year (FY) 2015. The budget proposal called for substantial Medicare and Medicaid cuts over the next 10 years. In addition, the administration proposed changes to payments for CAHs. Starting in FY 2015, it would reduce CAH payments from 101 percent to 100 percent of reasonable costs and eliminate the CAH designation for hospitals that are less than 10 miles away from the nearest hospital.
- The HHS Office of Inspector General (OIG) issued a 34-page report on Aug. 15 recommending, among other things, that CMS seek legislative authority to remove necessary provider CAHs' permanent exemption from the distance requirement. This recommendation would negatively impact approximately 75 percent of currently existing CAHs, which provide necessary health care services to Medicare beneficiaries who would otherwise be unable to access hospital services.

CMS has recently indicated that it will begin enforcing a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. If enforced, CAHs would be forced to eliminate these "96-hour plus" services, and the resulting financial pressure on CAHs would severely affect their ability to operate and care for beneficiaries in rural communities. The AHA supports The Critical Access Hospital Relief Act of 2014 (H.R. 3991, S. 2037), which would remove this 96-hour physician certification requirement as a condition of payment for CAHs. If passed, a physician would not be required to state that the patient will be discharged or transferred in less than 96 hours in order for the CAH to be paid on that particular claim. CAHs would continue to need to meet the other certification requirements that apply to all hospitals as well as the condition of participation requiring a 96-hour annual average length of stay.

The AHA continues to strongly advocate to maintain the current CAH program, and also for fixes to payment and administration limitations that constrain the efficiency and effectiveness of these essential health care providers.

Conditions of Participation (CoPs). In February, CMS issued a proposed rule to revise certain existing Medicare requirements for hospitals, CAHs and other providers. The AHA welcomed a number of the changes, which were partially aimed at reducing burden and eliminating obsolete regulations. We were pleased that CMS proposed to rescind the CoP requirement that hospital governing bodies must include a member of the

medical staff, and replace it with a requirement for direct consultation between hospital governing bodies and medical staffs. While many hospital governing boards already include a medical staff member, the original requirement would have been difficult to meet in some circumstances, such as where boards are elected or appointed.

However, the AHA opposes a separate CMS proposal to require each hospital to have its own distinct medical staff. This would preclude hospitals in some multi-hospital systems from sharing an integrated, unified medical staff. The AHA believes that hospital leaders and medical staffs, working together, should be able to weigh the benefits of a variety of medical staff structures and determine what framework will best enable them to provide high-quality care to patients. We will continue to urge CMS to allow hospitals to have flexibility in how medical staffs may be structured. The final rule could be released in early 2014.

The AHA also supported proposed changes for CAHs that would: (1) remove a requirement for the participation of a non-CAH staff member in the development of patient care policies, and (2) modify the requirements for the on-site presence of a doctor of medicine or osteopathy, but maintain other requirements for doctors.

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 – fewer than half of all hospitals, and only one-third of CAHs. In addition, a recent study published in *Health Affairs* indicated that only 5 percent of hospitals have the ability to meet Stage 2 criteria. 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.

