American Hospital Association®

Small or Rural Hospitals

Background

Approximately 46 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 small or rural hospitals. In addition, these hospitals' patient mix makes them more reliant on public programs and, thus, particularly vulnerable to Medicare and Medicaid payment cuts. Several proposals released by the Obama administration would put rural hospitals at risk of additional cuts in several areas. For example, the president's fiscal year (FY) 2015 budget outline proposes to reduce critical access hospital (CAH) payments from 101 percent to 100 percent of reasonable costs for savings of $1.7 billion over 10 years, and to eliminate the CAH designation for hospitals that are less than 10 miles from the nearest hospital for savings of $720 million 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, 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 – must be protected and updated.

Rural Legislation. The AHA was pleased that the Protecting Access to Medicare Act of 2014 (PAMA) contained several provisions important to rural hospitals and their patients, including one-year extensions through March 31, 2015, for the following:

- Low-volume hospital payment adjustment;
- MDH program;
- Ambulance add-on payments; and
- Outpatient therapy caps exception process (although we strongly oppose the continued expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.)

However, we are disappointed that the PAMA did not include provisions to suspend the direct supervision policy for outpatient therapeutic services or remove the 96-hour physician certification requirement for CAHs.

Direct Supervision. For the past several years, the Centers for Medicare & Medicaid Services (CMS) has modified its policies related to the agency's "direct supervision" requirement of outpatient therapeutic services. As of Jan. 1, CMS removed its prohibition on Medicare contractors enforcing the direct

supervision policy for outpatient therapeutic services furnished in CAHs and in small rural hospitals having 100 or fewer beds. Therefore, for 2014 and beyond, the agency will require a minimum of direct supervision for all outpatient therapeutic services furnished in hospitals and CAHs, unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic service.

The AHA is deeply disappointed that CMS has not heeded the concerns voiced by CAHs and small rural hospitals that imposing its direct supervision policy is not only unnecessary, but will result in reduced access to care. Without adequate numbers of physicians and other health professionals in rural communities to provide direct supervision, hospitals will have no choice but to limit their hours of operation or close certain programs due to their inability to meet the requirements of direct supervision.

Hospitals still have opportunities to present to the Advisory Panel on Hospital Outpatient Payment (HOP Panel) and urge it to evaluate and make recommendations to CMS on the appropriate level of supervision for outpatient therapeutic services. The HOP Panel is charged with assessing the appropriate supervision levels for individual hospital outpatient therapeutic services. As a result of the panel's past input, CMS has reduced the level of supervision for 49 outpatient therapeutic services. The next HOP Panel meeting is scheduled for the summer. Given the importance of this issue to the field, we strongly encourage hospitals to consult with their clinical staff and request an opportunity to testify before the HOP Panel's meeting regarding additional services that could safely be downgraded to general supervision.

For more information, see the AHA's "Medicare" issue paper.

96-hour Rule. 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, S. 2037/H.R. 3991, which would remove the 96-hour piece of the physician certification requirement as a condition of payment.** CAHs would still be required to satisfy the other physician certification requirements and the condition of participation requiring a 96-hour annual average length of stay. This bipartisan bill is cosponsored by Sens. Pat Roberts (R-KS) and Jon Tester (D-MT) and Reps. Adrian Smith (R-NE), Greg Walden (R-OR), Lynn Jenkins (R-KS) and David Loebsack (D-IA).

The AHA also continues to advocate before Congress for these critical programs and 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 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;
- Exempt CAHs from the cap on outpatient therapy 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. For more information, see the AHA's "340B Drug Discount Program" issue paper.

Electronic Health Records (EHRs) and Meaningful Use. Hospitals continue to struggle with the complex meaningful use rules, which include a requirement that all hospitals and physicians upgrade to the 2014 Edition Certified EHR this year, regardless of stage. Hospitals in both Stage 1 and Stage 2 also will face a higher bar to meet the performance metrics. For hospitals paid under the inpatient 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, so the FY 2015 penalties would be based on FY 2015 performance.

The AHA has advocated that the Department of Health and Human Services (HHS) extend the regulatory timelines for 2014 and allow all providers greater flexibility in Stage 2. Specifically, all hospitals and physicians should have the option to make the transition to the 2014 Edition Certified EHR and the Stage 2 requirements (or the revised Stage 1 requirements, as applicable) over the course of 2014 or 2015 and be given at least three years at each stage. Hospitals are reliant on their vendor partners to deliver certified EHR technology, and are facing challenges obtaining and installing certified EHRs that work as promised, making the current timelines unrealistic. For rural hospitals, one of the two major vendors had not yet certified a product as of April 1, 2014.

The AHA continues to be concerned about the impact of the EHR Incentive Program on small and rural providers; we believe that the program should close, not widen, the existing digital divide. Data from CMS suggest that CAHs, in particular, are less likely to have successfully attested to meaningful use than their urban counterparts. 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. For more information, see the AHA's "Health Information Technology" issue paper.