Fact Sheet: Rural Hospital Support Act (S. 335) and the Assistance for Rural Community Hospitals Act

Medicare Payment for Rural or Geographically Isolated Hospitals

Background

Medicare pays most acute care hospitals under the inpatient prospective payment system (IPPS). Some of these hospitals receive additional support from Medicare to help address potential financial challenges associated with being rural, geographically isolated and low volume. These programs are Medicare-dependent Hospitals (MDHs), Low-volume Adjustment (LVA) and Sole Community Hospitals (SCHs).

Without action from Congress, the MDH and enhanced LVA programs will expire March 31, 2025.

Why are these programs important? The network of providers that serves rural Americans is financially fragile and more dependent on Medicare revenue due to the high percentage of Medicare beneficiaries who live in rural areas. Rural residents also on average tend to be older, have lower incomes and higher rates of chronic illness than urban counterparts. This greater dependence on Medicare may make certain hospitals more financially vulnerable. Indeed, Medicare only pays 82% of hospital costs on average according to our latest analysis. Additionally, over 150 rural hospitals have closed or converted to other provider types since 2010. These designations protect the financial viability of small, rural hospitals to ensure they can continue providing patients access to care.

Medicare-dependent Hospitals. Congress established the MDH program in 1987 to help support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. MDHs are small, rural hospitals where at least 60% of their admissions or patient days are from Medicare patients. MDHs receive the IPPS rate plus 75% of the difference between the IPPS rate and their inflation-adjusted costs from one of three base years.

Low-volume Adjustment. Certain factors beyond providers' control can affect the costs of furnishing services, including patient volume. This is particularly relevant in small and isolated communities where providers frequently cannot achieve economies of scale like larger hospitals. Congress established the LVA program in 2005 to help isolated, rural hospitals with a low number of discharges. Currently under the enhanced program, they must be more than 15 miles from another IPPS hospital and have fewer than 3,800 annual total discharges. These LVA hospitals receive a payment adjustment based on a sliding scale formula to ensure the patients and communities these hospitals serve continue to have access to care.

Sole Community Hospitals. The SCH program was created to maintain access to needed health services for Medicare beneficiaries in isolated communities. In order to be eligible for the program, SCHs must show that because of distance or geographic boundaries between hospitals, they are the sole source of inpatient hospital services reasonably available in a certain geographic area. They receive increased payments based on their cost per discharge in a base year.

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AHA Position — Cosponsor the Rural Hospital Support Act (S. 335) and the Assistance for Rural Community Hospitals (ARCH) Act

The Rural Hospital Support Act (S. 335) includes the following important AHA-supported policies to ensure access to care:

- Permanently extends the MDH program and adds an additional base year that hospitals may choose for calculating payments.
- Permanently extends the enhanced LVA program, which would continue to allow hospitals more than 15 miles from another IPPS hospital and have fewer than 3,800 annual total discharges to be eligible.
- Adds a base year that SCHs may select for calculating their payments.

The ARCH Act helps rural hospitals continue to serve their patients and communities by extending the current MDH and LVA programs by five years and will soon be reintroduced in the House.