FACTSHEET

Rural and Small Hospitals

THE ISSUE

Approximately 57 million Americans live in rural areas and depend upon the hospital in their community. Remote geographic location, small size, limited workforce, physician shortages and often constrained financial resources pose a unique set of challenges for rural hospitals. Rural hospitals' patient mix also makes them more reliant on public programs and, thus, particularly vulnerable to Medicare and Medicaid payment cuts. With deficit reduction a continued threat in Washington, the continued viability of small and rural health care providers remains in jeopardy.

AHA POSITION

Medicare and other federal programs must account for the special circumstances of rural communities. The AHA works to ensure they do so by focusing on protecting vital funding, securing the future of existing special rural payment programs – including the critical access hospital (CAH), sole community hospital (SCH), Medicare-dependent hospital (MDH) and rural referral center (RRC) programs – and relieving regulatory burden.

KEY PRIORITIES

Protecting Vital Funding. The AHA continues to advocate that Congress maintain current policies that provide vital funding for rural and small hospitals. This includes:

- Ensuring CAHs continue to be paid at least 101 percent of costs by Medicare, and are paid at least the same by Medicare Advantage plans;
- Ensuring the current CAH mileage criteria do not change;
- Extending the Rural Community Hospital Demonstration program;
- Ensuring rural hospitals and CAHs have adequate reimbursement for certified registered nurse anesthetist services, including stand-by services;
- Providing CAHs with bed size flexibility;
- Reinstating CAH necessary provider status;
- Removing unreasonable restrictions on CAHs' ability to rebuild;
- Allowing hospitals to claim the full cost of provider taxes as allowable costs; and
- Extending the 340B Drug Pricing Program to additional hospitals and for the purchases of drugs used during inpatient hospital stays for all eligible hospitals.

Securing the Future of Existing Special Rural Payment Programs. The Medicare Access and CHIP Reauthorization Act of 2015 contained several provisions important to rural hospitals and their patients, including extensions for:

- The enhanced low-volume hospital payment adjustment, which provides additional payments to hospitals with low patient volumes (through Sept. 30, 2017);
- The MDH program, which provides certain small and rural hospitals with additional payments to ensure greater financial stability (through Sept. 30, 2017);
- Ambulance add-on payments that fairly reimburse rural ambulance providers for their higher per-trip costs due small patient volumes and long distances (through Dec. 31, 2017); and
- The outpatient therapy caps exception process (although we oppose the cap's current application to services provided in the outpatient departments of hospitals and CAHs (through Dec. 31, 2017)).

The AHA supports legislation to make these extensions permanent.

Relieving Regulatory Burden. Medicare policy changes and payment adjustments often have significant and problematic consequences for rural providers. **The Centers for Medicare & Medicaid Services (CMS) should better account for the unique circumstances of rural providers in the rulemaking process, especially regarding the policies below.**

Direct Supervision. CMS recently removed its moratorium on Medicare contractors enforcing its policies related to its "direct supervision" requirement of outpatient therapeutic services furnished in CAHs and

Continued on reverse

small rural hospitals with 100 or fewer beds. Therefore, for 2015 and beyond, the agency requires 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 did not heed the concerns voiced by CAHs and small rural hospitals that imposing this policy is not only unnecessary, but also will result in reduced access to care. Without adequate numbers of 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 direct supervision standard. **The AHA supports the Protecting Access to Rural Therapy Services Act (S. 257H.R. 1611), which takes steps to ensure this does not happen.**

96-hour Rule. CMS recently began 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 another hospital within 96 hours of admission. While CAHs must maintain an annual average length of stay of 96 hours, they offer some critical medical services that have standard lengths of stay greater than 96 hours. Enforcing the condition of payment will force CAHs to eliminate these "96-hour plus" services. The resulting financial pressure will severely affect their ability to operate and, therefore, threaten access to care for beneficiaries in rural communities. **The AHA supports the Critical Access Hospital Relief Act (S. 258/H.R. 169), which would remove the 96-hour condition of payment.** CAHs would still be required to satisfy the condition of participation requiring a 96-hour annual average length of stay.

Electronic Health Records (EHRs) and Meaningful Use. We continue to be concerned about the impact of the EHR incentive program on small and rural providers. Specifically, this program should close, not widen, the existing digital divide. Yet, AHA data indicate that small and rural hospitals, including CAHs, have found it more challenging to meet meaningful use requirements than their urban counterparts, due to limited vendor choice and capacity and financial challenges.

In 2015, CMS finalized a much-needed rule that offered providers more flexibility in meeting meaningful use requirements, as AHA advocated. The agency also finalized new, arduous requirements for Stage 3 of meaningful use that start in 2018, even though only 40 percent of hospitals and 10 percent of physicians had actually met Stage 2 in 2014. The AHA continues to advocate for more reasonable Stage 3 requirements and a later start to Stage 3 that builds on actual experience in Stage 2, including the experience of small and rural hospitals that may have fewer resources to meet the meaningful use mandates.