



Maintain Support for Small and/or Rural Hospitals

AHA View

Medicare and other federal programs must account for the special circumstances of rural communities. The AHA focuses 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. With congressional budget crises a continued threat in Washington, the continued viability of small and rural health care providers remains in jeopardy.

Background

Approximately 51 million Americans live in rural areas and depend upon the hospitals in their communities. 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.

Key Priorities **Protecting Vital Funding**

The AHA continues to advocate for 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;
- 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 allowing the purchase of 340B 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 multi-year 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 to small patient volumes and long distances (through Dec. 31, 2017); and
- The outpatient therapy caps exception process (through Dec. 31, 2017) – although we oppose the cap’s current application to services provided in the outpatient departments of hospitals and CAHs.

The AHA strongly advocated for extensions of these programs, and we will continue to urge Congress to renew these programs for the full fiscal year (FY) 2018 and beyond.

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 following policies:

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 small rural hospitals with 100 or fewer beds. 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 this policy will be difficult to implement, will reduce access and is clinically unnecessary. The AHA supports the Protecting Access to Rural Therapy Services Act (H.R. 1611/S. 257), which would:

- Adopt a default standard of “general supervision” for outpatient therapeutic services, supplemented with a reasonable exceptions process with provider input to identify those specific procedures that require direct supervision;
- Ensure that, for CAHs, the definition of “direct supervision” is consistent with the CAH conditions of participation that allow a physician or non-physician practitioner to present within 30 minutes of being called; and
- Prohibit enforcement of CMS’s retroactive reinterpretation that the “direct supervision” requirements applied to services furnished since Jan. 1, 2001.

96-hour Rule. CMS has published guidance, in relation to its two-midnight admissions policy, that implies that the agency 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 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 (H.R. 169/S. 258), 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. The AHA continues 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, CMS data indicate that CAHs, in particular, have found it more challenging to meet meaningful use requirements than their urban counterparts, partly due to limited vendor choice and capacity.

Maintaining Access to Capital Funding

Small and rural hospitals are often at a natural disadvantage for borrowing money. They generally have a limited service area, slower population growth, fewer assets, physician recruiting and retention challenges and lower real or potential credit ratings. Generally, smaller hospitals must have substantially stronger financial ratios to receive the same credit rating as a larger hospital.

The AHA supports the Municipal Bond Market Support Act of 2015 (H.R. 2229), which would permanently increase the bank qualified annual debt limit from \$10 million to \$30 million, index that amount for inflation and apply it to individual borrowers. The \$10 million limit was created in The Tax Reform Act of 1986 and is worth significantly less today due to inflation. Bank qualified debt allows hospital bond authorities to directly place hospital bonds with banks, particularly community banks, enabling them to deduct a percentage of the carrying costs for purchasing these bonds as with their other investments. As a result, hospitals pay up to 0.5 percentage points less in borrowing costs for their debt. These changes would ease rural hospital access to the capital markets and lower the cost of financing needed infrastructure.

Small and rural hospitals often cannot access the capital necessary to make critical renovations and upgrades because they do not meet the high benchmarks bond rating agencies require to earn investment-grade ratings. The AHA continues to work to ensure adequate funding and efficient operation of federal hospital

financing programs such as the Department of Agriculture's Community Facilities Direct Loan and Grant, and Community Facilities Loan Guarantee programs, and the HUD 242 Hospital Mortgage Insurance program. The Community Facilities programs primarily finance health care, public safety and educational facilities. The department anticipates servicing 8 million rural residents through the financing of these types of new and improved community facilities or 14 percent of the rural population in 2015. While the HUD 242 Mortgage Insurance Program has approved several refinancings recently, since 2012 it has been slow to approve new entrants into the program. With the rating agencies maintaining a negative outlook for nonprofit hospitals, HUD leadership is more fully supporting the mission of the Section 242 program so that HUD is beginning to re-emerge to play a role in hospital financing. The AHA continues to work with HUD 242 leadership to find ways to re-energize the 242 program so that it can increase its presence in hospital capital financing.