Small and rural hospitals preserve access to care

**Key Points**

- **Mileage restrictions** - Congress recognized the importance of access to health care in rural communities and the vulnerabilities of small and rural hospitals by creating the CAH program. Yet, some budget-cutting proposals would eliminate the CAH designation for any hospital that is fewer than 10 to 15 miles from another hospital. In Minnesota, as many as 20 hospitals could lose their CAH designation under these proposals, jeopardizing access to care in rural Minnesota.

- **The 96-hour requirement** - CAHs maintain an annual average hospital stay of 96 hours or less per patient, but some individual patients need care that extends for more than 96 hours. For example, a Medicare beneficiary with pneumonia may wish to receive care from the local CAH and remain close to family and home rather than traveling to an urban or regional prospective payment system hospital. The CAH Relief Act would keep the requirement of having an annual average length of stay of 96 hours or less, but would provide needed relief from the overly burdensome 96 hours per individual patient requirement.

- **Outpatient therapeutic services supervision requirements** - Beginning in 2009, CMS interpreted physician supervision requirements for outpatient therapeutic services delivered in a hospital in a manner that significantly changed longstanding Medicare practices. CMS issued this new interpretation in the absence of clinical evidence. While several implementation delays were issued, the requirements are now in effect. These requirements will increase health care costs unnecessarily, potentially reduce access to services, and make no improvement to the quality of care. The Protecting Access to Rural Therapy Services Act will reverse these interpretations and create an exemption process to ensure higher levels of physician supervision for those services that are complex enough to require a higher level of supervision.

- **Across-the-board cuts to reimbursement** – Sixteen Minnesota CAHs have a negative operating margin and 37 have less than a 3 percent operating margin. Some policy makers have proposed reducing cost-based reimbursement to CAHs from 101% to 100% of allowable costs for inpatient, outpatient and swing bed services. In Minnesota, this would mean a loss of more than $56 million over 10 years to CAHs.

**Federal solutions**

- Co-sponsor H.R. 169/S.258, the Critical Access Hospital (CAH) Relief Act.


- MHA opposes proposed mileage restrictions and cuts to reimbursement for CAHs.
Background

In addition to providing life-saving access to quality health care services, Minnesota’s small and rural hospitals are often the largest employers in their communities, attract a highly educated workforce, and serve as vital community resources for other employers’ recruitment and relocation efforts. Because of their small size, modest assets and higher percentages of Medicare patients, rural hospitals disproportionately rely on government payments.

Congress enacted the CAH program in 1997 to ensure continuing access to health care services in rural areas. Recognizing that ordinary market forces of supply and demand combined with the costs associated with the increasing sophistication of medicine jeopardized the survival of these hospitals, Congress required Medicare to pay CAHs differently than larger hospitals. In exchange, CAHs agreed to certain growth limitations, most notably the 25-bed limitation. With 79 CAHs, Minnesota has the third largest number of CAHs in the nation.

Minnesota also benefits from 21 hospitals that are larger than CAHs but face the challenge of managing patient volumes that can be too low to thrive under the traditional below-cost payment system used by Medicare. Congress provides rural payment programs for some of these facilities designated as a sole community hospital, Medicare-dependent hospital, or rural referral center. These payments are essential to ensuring that Minnesota’s regional hospitals can remain the cornerstone of their communities.

The Minnesota Hospital Association and the Minnesota Department of Health’s Office of Rural Health and Primary Care convened a task force of CAHs to investigate alternatives to across-the-board cuts and mileage restrictions that will reduce Medicare spending while protecting vital access to care for Minnesota’s rural residents. As the task force continues its work, MHA asks that our delegation protect and maintain the current CAH program, and also work to fix the administrative limitations of the 96-hour and direct supervision requirements.