SMALL AND RURAL HOSPITALS

The Missouri Hospital Association appreciates the Missouri congressional delegation’s support for legislative and other actions to address the challenges facing small and rural hospitals.

Those challenges include remote locations, small-scale operations, a limited workforce and physician shortages. They frequently are augmented by limited financial resources and a patient mix that makes them disproportionately reliant on Medicare and Medicaid and particularly vulnerable to payment reductions in those programs.

The recently-enacted 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 September 30, 2017)
- the Medicare Dependent Hospital program, which provides certain rural hospitals with additional payments to ensure greater financial stability (through September 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 December 31, 2017)
- the outpatient therapy caps exception process (through December 31, 2017)

Missouri’s small and rural hospitals appreciate the reauthorization of these payment extenders.

Missouri’s critical access hospitals also value the Missouri delegation’s continued support in disavowing efforts to curtail CAH payments and criteria for CAH designation.

CAHs also encourage the Missouri delegation to support the Critical Access Hospital Relief Act (H.R. 169/S. 258). These bills would reverse CMS’ initiative to require that a physician certify that a Medicare patient in a CAH may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. Currently, CAHs must maintain an annual average length of stay of 96 hours, but may offer some critical medical services that have standard lengths of stay greater than 96 hours. Enforcing the new standard will force CAHs to eliminate these “96-hour plus” services.

Missouri’s small and rural hospitals also ask for congressional attention to bills that would resolve concerns about CMS directives for physician supervision of certain outpatient therapy services. For 2015 and beyond, CMS requires a minimum of direct supervision for all outpatient therapeutic services furnished in rural 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.” This policy is difficult to implement, will reduce access and is clinically unnecessary. H.R. 1611 and S. 257 are starting points for legislative discussion.