

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-15

Subject: Economic Viability of Rural Sole Community Hospitals
(Resolution 133-A-14)

Presented by: Jack McIntyre, MD, Chair

Referred to: Reference Committee A
(John Ingram, III, MD, Chair)

At the 2014 Annual Meeting, the House of Delegates referred Resolution 133, “Economic Viability of Rural Sole Community Hospitals,” which was introduced by the New Mexico Delegation. Resolution 133-A-14 asked:

That our American Medical Association (AMA) study the complex economic factors that threaten the viability of sole community hospitals, and develop recommendations for advocacy and new policies addressing this urgent concern, with a report back by the 2015 Annual Meeting.

The AMA Board of Trustees assigned Resolution 133-A-14 to the Council on Medical Service. This report provides background on sole community hospitals and other federally designated rural hospitals; discusses factors affecting the economic viability of small rural hospitals; highlights organizations engaged in rural hospital advocacy; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

The sole community hospital (SCH) program was created by Congress in 1983 for the purpose of maintaining Medicare patient access to needed health services in geographically isolated communities. Section 1886(d)(5)(D)(iii) of the Social Security Act defines an SCH as a hospital that is more than 35 road miles from another hospital or that, by reason of factors such as isolated location, weather conditions, travel conditions or absence of “like” hospitals, is considered the sole source of inpatient care for Medicare patients in its area.¹

Medicare pays SCHs the higher aggregate payment of either the federal inpatient prospective payment system (IPPS) rate or a hospital-specific rate. Hospital-specific rates are based on historic costs from the hospital’s choice of either fiscal year 1982, 1987, 1996 or 2006, which is then updated for inflation.² Payments based on the IPPS may include add-ons such as outliers and disproportionate share hospital adjustments, which are not included in hospital-specific payments. SCHs also receive a seven percent adjustment in payments for outpatient procedures above hospital outpatient prospective payment rates.³

The SCH program is one of several rural payment programs implemented by the Centers for Medicare & Medicaid Services (CMS) to preserve patient access to health care and support provider sustainability in rural communities. Other programs include critical access hospitals (CAHs), which are limited service, rural hospitals that are state-certified as being necessary

1 providers and have 25 or fewer acute care beds, and the rural referral center program, which
2 supports high-volume rural hospitals that treat a large number of complex cases. Special
3 adjustments under these programs provide enhanced payments that rural hospital advocates claim
4 are necessary to prevent these facilities from closing.

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6 SCHs are by definition the sole source of care in a geographic area, and their numbers are small
7 (approximately 400) in comparison to CAHs, which numbered over 1,300 in 2013.⁴ Some hospitals
8 qualify for more than one rural payment program. For example, a hospital can be both an SCH and
9 a rural referral center and have its Medicare payments adjusted accordingly. Because states were
10 able to waive CAH distance requirements for “necessary provider” hospitals if other requirements
11 were met, some subsidized CAH-designated facilities are actually within miles of each other.
12 Medicare rural payment adjustments to these hospitals subsequently came under scrutiny, with the
13 bulk of the criticism aimed at state-designated CAHs. Criticism aside, it is generally accepted that
14 rural providers and patients face unique circumstances, and that economically viable providers are
15 critical to preserving access to high-quality care in rural communities.

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17 The reasons behind the financial constraints confronting SCHs in New Mexico are complex and
18 varied, and include modifications made by the state to the formula used to fund SCHs.⁵
19 Nevertheless, many of the dynamics threatening SCHs in that state are generalizable to facilities in
20 other parts of the country. For example, most SCHs are low-volume facilities. Many have
21 experienced decreased utilization. These factors alone impact facilities’ revenue and make small
22 rural facilities vulnerable to economic downturns, unexpected expenses or reductions in Medicare
23 and Medicaid payments. Certain shifts in patient coverage may also lead to payment reductions and
24 declines in hospital revenue. In New Mexico, concerns regarding higher numbers of Medicaid
25 patients seeking care at SCHs under the state’s Medicaid expansion program have been
26 documented by the local media.^{6, 7} Because Medicaid payment rates are on average 66 percent of
27 Medicare rates, an increase in Medicaid patients—especially when coupled with a decrease in
28 commercially insured patients—can threaten the financial health of small rural hospitals. These
29 facilities also need resources to invest in electronic health records, quality initiatives and to meet
30 other administrative requirements, although they may have less access to capital.

31 32 RURAL HOSPITAL ADVOCACY

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34 As part of its study of the economic viability of small rural hospitals, the Council identified two
35 organizations that lead federal advocacy efforts on behalf of these facilities: the American Hospital
36 Association (AHA) and the National Rural Health Association (NRHA). For more than 30 years,
37 the AHA and its Section for Small and Rural Hospitals have addressed the unique needs of this
38 constituency through advocacy in Congress and in regulatory arenas. The AHA Advocacy Alliance
39 for Rural Hospitals, with its focus on SCH, CAH, Medicare Dependent Hospital and Rural Referral
40 Hospital priorities, is an additional resource for AHA member hospitals to engage on rural hospital
41 issues.

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43 Active in rural health advocacy for 30 years, the NRHA is an association of individuals and
44 organizations whose mission is to improve the delivery of health services in rural areas. The
45 NRHA legislative and regulatory agenda includes SCH, CAH and other rural hospital designations
46 as priorities among a myriad of health policy issues that are routinely analyzed by NRHA for
47 relevance to rural health. Infographics depicting some of the threats posed to rural hospitals have
48 been developed by NRHA as part of its #SaveRural hospitals campaign.

RELEVANT AMA POLICY

Policy H-465.990 encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to care. Policy H-465.999 asks for a more realistic and humanitarian approach toward certification of small, rural hospitals. It is also AMA policy that implementation of legislation establishing SCHs be closely monitored to ensure that this program is implemented in a manner conducive to high-quality patient care and consistent with AMA policy, and that state medical associations be encouraged to monitor legislation or regulations governing the development and operation of limited service rural hospital facilities (Policy H-465.989[2,3]).

Policy H-465.984 directs the AMA to strongly encourage CMS and state departments of health to review rural health clinic program eligibility and certification requirements to ensure that only facilities in areas that truly do not have appropriate access to physician services are certified.

Policy D-465.999 directs the AMA to call on CMS to support individual states in their development of rural health networks, oppose the elimination of the state-designated CAH necessary provider designation, and pursue steps to require the federal government to fully fund its obligations under the Medicare rural hospital flexibility program.

Finally, the AMA has long-standing policy in support of reasonable and adequate Medicaid payments which is relevant to this discussion. Policy H-290.976[2] advocates that Medicaid payments to medical providers be at least 100 percent of Medicare payment rates. Policy H-290.997[4] promotes greater equity in the Medicaid program through adequate payment rates that assure broad access to care.

DISCUSSION

The Council recognizes that the survival and sustainability of rural health care providers including SCHs is vital, given that approximately one-quarter of the population resides in these areas and 10 percent of physicians practice there. The Council further recognizes the special health care needs of rural communities as well as the confluence of factors placing financial pressures on small rural hospitals. Accordingly, the Council recommends reaffirmation of AMA Policies H-465.989 and H-465.990.

The Council believes that inadequate payments under the Medicaid program are a significant contributor to the financial hardship facing SCHs in New Mexico and elsewhere. Therefore, the Council also recommends reaffirming AMA policy H-290.976, which advocates for reasonable Medicaid payments to medical providers, defined as at minimum 100 percent of Medicare rates.

Having studied the issues brought forth in Resolution 133-A-14, and heard specifically from the New Mexico Medical Society about rural hospital closures in that state as well as the dramatic changes in the financial landscape of one hospital struggling to stay afloat, the Council is sufficiently concerned about the status of some SCHs. Accordingly, the Council recommends that the AMA recognize that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities.

The Council believes that rural providers benefit from AMA legislative and regulatory advocacy on a plethora of issues. Nevertheless, the Council recognizes the leadership roles of AHA and NRHA in advocacy that is specific to small rural hospitals. The Council therefore recommends supporting the efforts of organizations advocating directly on behalf of small rural hospitals, provided that these efforts are consistent with AMA policy.

1 RECOMMENDATIONS

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3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 133-A-14, and that the remainder of the report be filed:

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6 1. That our American Medical Association (AMA) reaffirm Policy H-465.989, which directs
7 the AMA to closely monitor implementation of legislation establishing sole community
8 hospitals (SCHs) to ensure the program is conducive to high-quality care and consistent
9 with AMA policy. (Reaffirm HOD Policy)
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11 2. That our AMA reaffirm Policy H-465.990, which encourages legislation to reduce the
12 financial constraints on small rural hospitals in order to improve access to care. (Reaffirm
13 HOD Policy)
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15 3. That our AMA reaffirm Policy H-290.976, which advocates for Medicaid payments to
16 providers that are at minimum 100 percent of Medicare rates. (Reaffirm HOD Policy)
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18 4. That our AMA recognize that economically viable small rural hospitals are critical to
19 preserving patient access to high-quality care and provider sustainability in rural
20 communities. (New HOD Policy)
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22 5. That our AMA support the efforts of organizations advocating directly on behalf of small
23 rural hospitals provided that the efforts are consistent with AMA policy. (New HOD
24 Policy)

REFERENCES

- ¹ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Rural Health Fact Sheet Series: Sole Community Hospital. November 2014.
² Ibid.
³ Ibid.
⁴ U.S. Department of Health and Human Services, Office of Inspector General. Most Critical Access Hospitals Would Not Meet the Location Requirements if Required to Re-Enroll in Medicare. August 2013.
⁵ New Mexico Medical Society. Letter to the AMA Board of Trustees and Council on Medical Service. January 2, 2015.
⁶ Souler, D.A. Dona Ana County indigent hospital care faces overhaul. *Las Cruces Sun-News*. March 2, 2014. Available online at: http://www.lcsun-news.com/las_cruces-news/ci_25260625/do-ana-county-indigent-hospital-care-faces-overhaul
⁷ Quigley, W. NM's rural hospitals running on life support. *Albuquerque Journal*. February 11, 2014. Available online at: <http://www.abqjournal.com/351220/news/nms-rural-hospitals-running-on-life-support.html>