



Protect Rural Patients and Providers

Fighting for Rural Together

The National Rural Health Association and policy partners ask Congress to protect the fragile rural health care delivery system by protecting and extending critical rural health provisions. Congress itself created various rural health programs to meet the diverse needs of different types of rural communities. Allowing major modifications or failing to extend various rural health programs will jeopardize the rural health care safety net and access to primary, emergency, and inpatient care for millions of rural Americans throughout the nation. These programs include:

- **Medicare Dependant Hospital (MDH) Classification:** A rural hospital under 100 beds must have at least 60 percent of its days or discharges covered by Medicare Part A. The designation's payment methodology, established in the early 1990's, protects hospitals with high "Medicare share" from losses incurred under the PPS system. MDH classification payments are scheduled to expire for discharges occurring on or after October 1, 2013. Congress should make this classification permanent.
- **The Critical Access Hospital Program:** Critical Access Hospitals (CAHs) are geographically isolated, small rural hospitals that provide vital 24 emergency services, inpatient acute care, and primary outpatient care. The program was created in a bipartisan fashion in the Balanced Budget Act of 2013 to ebb the flow of rural hospital closures. And it has worked. Although CAHs continue to have extreme funding challenges and worse overall margins than any other hospital type, the massive number of closures has stopped. Congress must resist all efforts to decrease eligibility for this incredibly successful program.
- **Low-Volume Hospital Adjustment:** A number of low-volume hospitals currently receive a percentage add-on payment for each of their Medicare discharges. To qualify for the adjustment a hospital must be 15 road miles from another hospital and have less than 1,600 discharges during the fiscal year. This adjustment applies to facilities operating in the PPS system. This provision is set to expire on September 31, 2013. Congress should make these qualifications permanent.
- **Rural Physician Payments:** Currently a payment floor exists on the amount of geographic reductions to the work portion of the fee schedule that CMS is allowed to make. This provision guarantees that rural practitioners paid under the physician fee schedule are treated fairly. Congress should make this provision permanent.

National Rural Health Association and Policy Partners: AgriSafe Network, National Association of Rural Health Clinics, National Cooperative of Health Networks, National Organization of State Offices of Rural Health, National Rural Recruitment and Retention Network, National Association for Rural Mental Health

- **Outpatient Hold-Harmless Provision:** Reinstate outpatient “hold harmless” payments to small rural and Sole Community Hospitals. This provision protects vulnerable facilities from the urban-centric PPS payment system by allowing facilities to be paid based on their historical costs. The hold harmless provision expired December 31, 2012. Congress must reinstate this vital safety-net provision.
- **Rural Ambulance Providers:** Medicare currently provides increased payments to rural ambulance trips due to providers low volumes, high fixed costs, and lengthy trip distances. Congress must extend payment for ground and air ambulance services in rural super-rural areas.
- **Protect Rural Patients Access to Therapy:** Congress enacted financial limitations on outpatient PT, OT, and SLP services in 1997. As part of various “extender packages” Congress has established exceptions to these limitations at various points. Congress should extend these exceptions for all therapy services and exempt rural facilities, including CAHs from the cap calculation.