

Small and Rural Hospitals



Geographically, Minnesota is the 12th largest state. Given the great size of our state, small and rural hospitals are essential for ensuring that our residents have meaningful access to health care.

Minnesota's small and rural hospitals are the backbone of the physical and economic health of their communities. In addition to providing quality health care services, they are often the largest employer in the community, attract and employ a highly educated work force, and serve as a vital community resource for other employers' recruitment and relocation efforts.

Critical access hospitals

Congress enacted the critical access hospital (CAH) program as part of the 1997 Balanced Budget Act to ensure continuing access to health care services in rural and isolated areas. Recognizing that ordinary market forces of supply and demand combined with the increasing sophistication of modern medicine jeopardized the survival of these hospitals, Congress required Medicare to pay these CAHs their costs. In exchange, CAHs face certain growth limitations, most notably the 25-bed limitation. The Medicare Modernization Act of 2003 furthered this goal by requiring the Medicare program to reimburse CAHs 101

percent of their costs for providing inpatient and outpatient care to Medicare patients.

Today, all eligible Minnesota hospitals have converted to CAH status. With 79 CAHs Minnesota has the third largest numbers of CAHs in the

FEDERAL ACTION REQUESTED:

- Permanently rescind new physician supervision requirements contained in the 2010 OPSS rule.
 - Support H.R. 668/S. 307, the Critical Access Hospital Flexibility Act.
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nation (Iowa has 82 and Kansas has 84 CAHs). Emergency rooms and life-saving hospital services remain available to our residents, and collaborations between CAHs and larger hospitals throughout the state provide access to even the most complex medical procedures that no small community could otherwise support.

“Tweeners”

Minnesota also has approximately 21 regional hospitals that face additional challenges of managing patient volumes that are too small to thrive under the traditional below-cost payment system used by Medicare and, at the same time, providing levels of inpatient care that are too high to qualify for CAH status. These hospitals — unofficially referred to as “tweener” hospitals — provide critical services to entire regions of the state.

Some key priorities for Minnesota's small and rural hospitals include:

Rescind new CMS interpretations for physician supervision requirements

In the most recent Outpatient Prospective Payment System (OPPS) rule, which went into effect January 1, the Centers for Medicare and Medicaid Services (CMS) attempted to clarify previous policies regarding physician supervision requirements for outpatient services. However, this rule significantly changed longstanding Medicare policies and practices in ways that would unnecessarily drive up health care costs while reducing access to needed services in Minnesota.

The new policy essentially requires a physician to be immediately available at all times for numerous outpatient services, including observation services. This policy was imposed without any identified clinical need and without any discernment between medically complex services that naturally involve more physician-level participation and

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routine, low-risk procedures that have been performed safely for decades by trained health care professionals working under a physician's orders and general supervision.

Thankfully, after unanimous pressure from Minnesota's congressional delegation, CMS temporarily agreed not to enforce this new policy in CAHs. The agency noted, however, that it will revisit the policy in its annual rule making process for 2011.

Minnesota's CAHs greatly appreciate the leadership and unanimous support from our delegation that led to this positive development with CMS. And, we urge Congress to continue to pursue permanently rescinding this policy for all hospitals if CMS fails to adequately address its interpretation of the policy.

The CAH Flexibility Act

Many CAHs maintain an average daily census of 25 beds or less without complication. But some of Minnesota's CAHs need the flexibility to respond to seasonal variations in their communities or unexpected daily demands that can temporarily drive their inpatient census above 25. The CAH Flexibility Act will give hospitals the flexibility to choose between the currently required

25-patients-per-day count, or an alternative that would allow an annual average of 20-patients-per-day. This legislation will provide the flexibility needed by some CAHs to continue to meet the health care needs of their community.

