American Hospital Association™

Advancing Health in America

AHA Rural Health Services

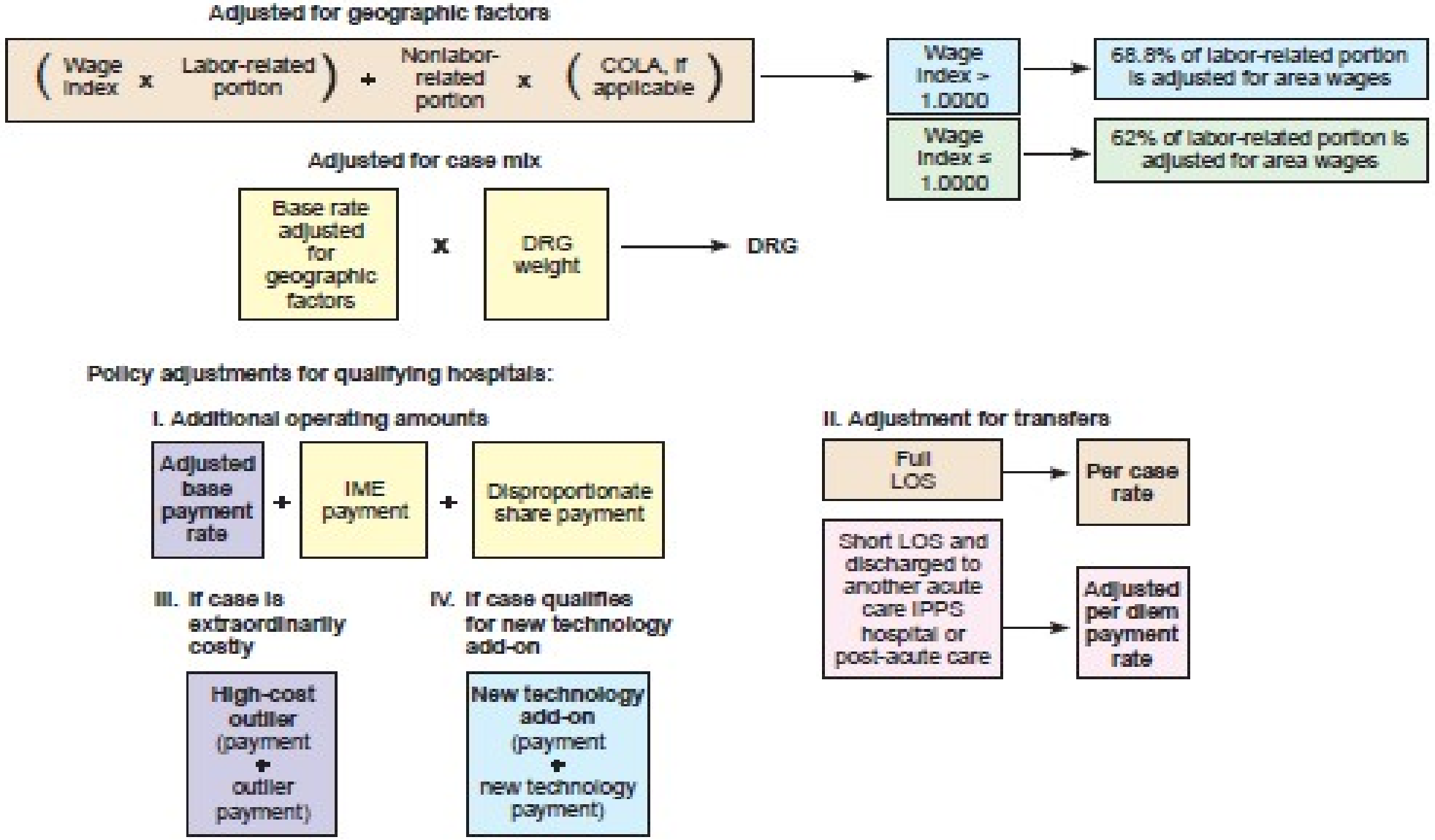
NEW MODELS OF PAYMENT AND DELIVERY

February 2020

Old Models of Payment and Delivery

Acute Care Hospital Inpatient Prospective Payment System

Operating Base Payment Rate



Critical Access Hospital (CAH)

Rural or acquires rural status (42 CFR 412.103 for detail)
More than 35 miles from nearest hospital or CAH or more than 15 miles in areas with hazardous terrain or only secondary roads or designated by state as "necessary provider" before 2006
25 beds or fewer (including swing beds)
24-hour emergency services
Annual average length of stay of 96 hours or less per patient for acute care

101 percent of "reasonable costs" for both inpatient and outpatient care. CAHs are not subject to inpatient prospective payment system (PPS) or outpatient (PPS) and are not "subsection (d)" hospital
101 percent of reasonable costs for swing bed services

Sole Community Hospital (SCH)

More than 35 miles from other "like" hospitals (excludes CAHs) or rural and one of the following:
Between 25 and 35 miles from other like hospitals and serves as main hospital in the vicinity (42 CFR 412.92 for detail) or
Between 15 and 25 miles, but other hospitals often inaccessible (e.g., due to severe weather)
Nearest like hospital is at least 45 minutes away

Inpatient: Higher of standard inpatient PPS or hospital-specific rate (HSR)
HSR derived from cost per discharge in a base year (1982, 1987, 1996, 2006), adjusted for inflation and case mix
Outpatient: Outpatient PPS + 7.1 percent (except drugs and biologics)

Medicare Dependent Hospital (MDH)

Rural or acquires rural status (42 CFR 412.103 for detail). Expired in 2017 but extended through 2022
Not a SCH
100 beds or fewer
At least 60 percent of inpatient days or discharges are Medicare Part A beneficiaries (42 CFR 412.108 for detail)

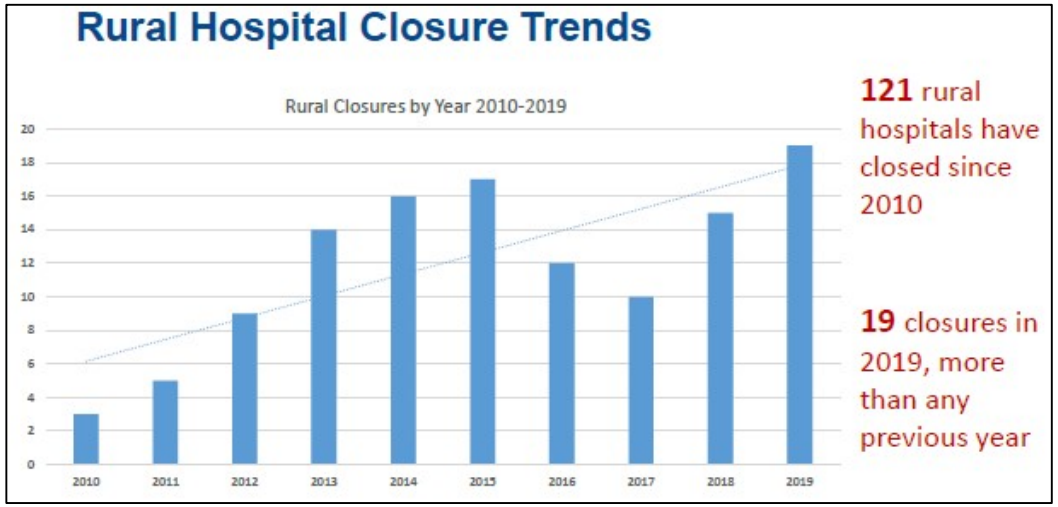
Inpatient: Standard IPPS + 75 percent of amount by which highest HSR exceeds PPS
HSR derived from cost per discharge in base year (1982, 1987, 2002), adjusted for inflation and case mix
Outpatient: Standard outpatient PPS

Rural Referral Center (RRC)

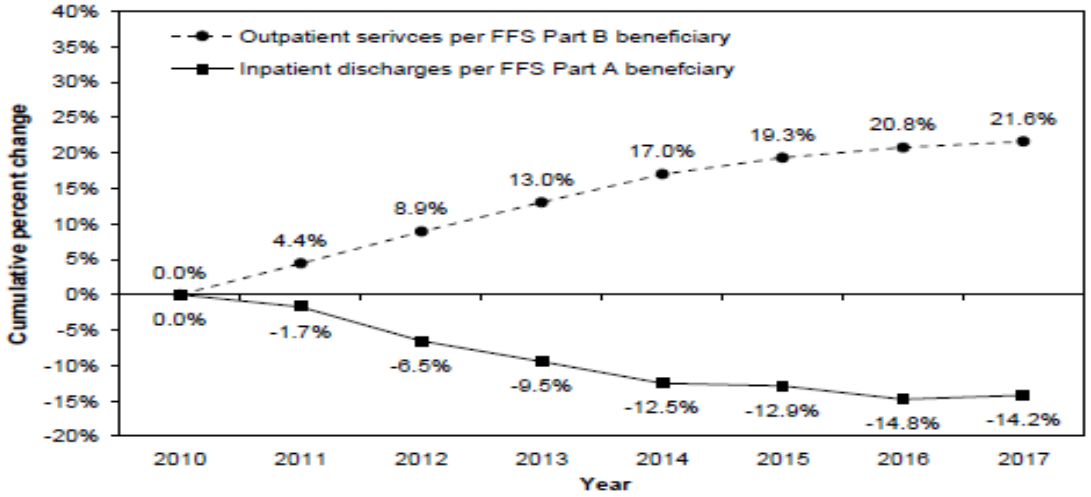
Rural plus one of the following (42 CFR 412.96):
275 beds or more, or
Most Medicare patients referred by outside providers AND most (services provided to) Medicare patients live 25+ miles away, or
High case-mix + high discharge volume + one of the following: mostly specialty practitioners, most inpatients live 25 miles away, many patients referred by outside providers

Inpatient: Standard inpatient PPS; special treatment for Medicare DSH and geographic reclassification
Outpatient: Standard outpatient PPS; receive inpatient reclassified wage index

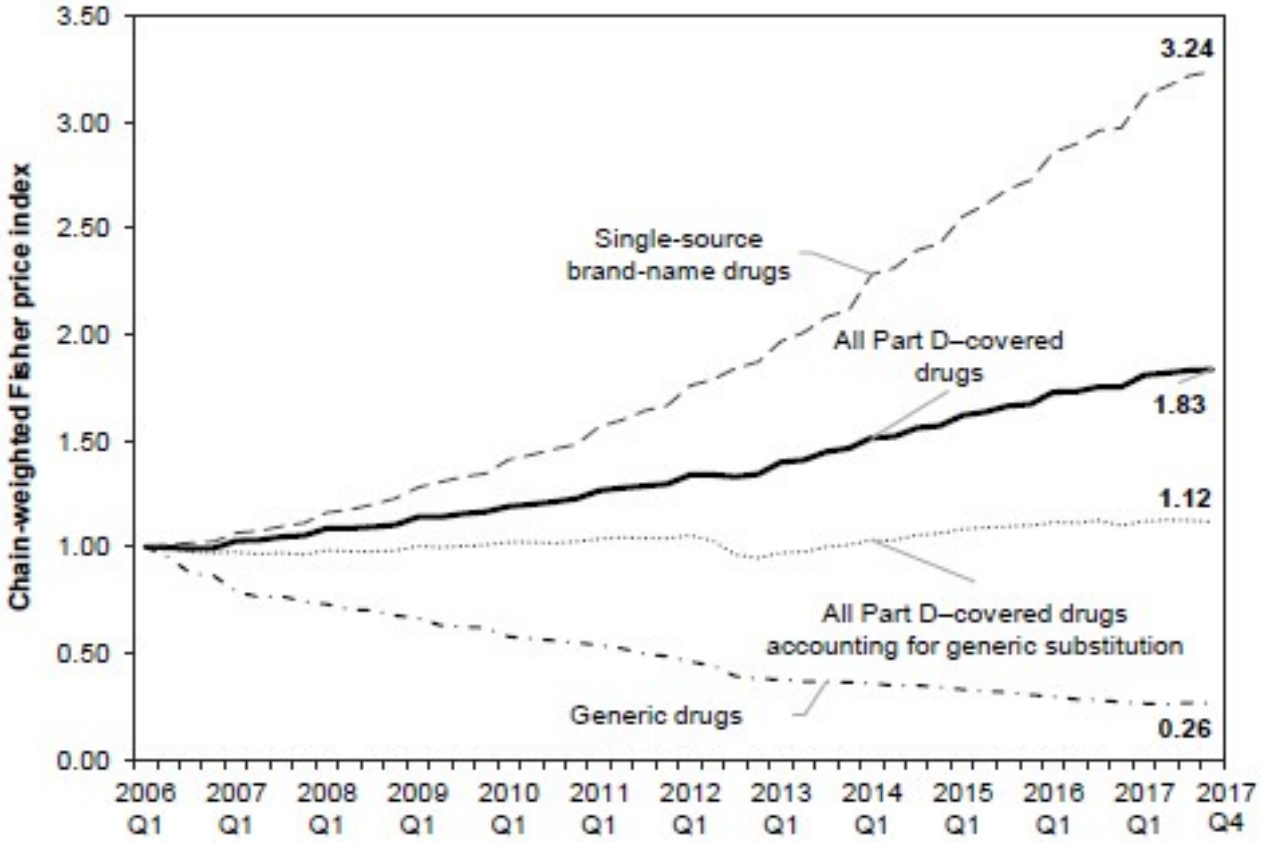
What we already know.



Percent Change Medicare Discharges 2010-17



Price growth for Part D–covered drugs, 2006–2017



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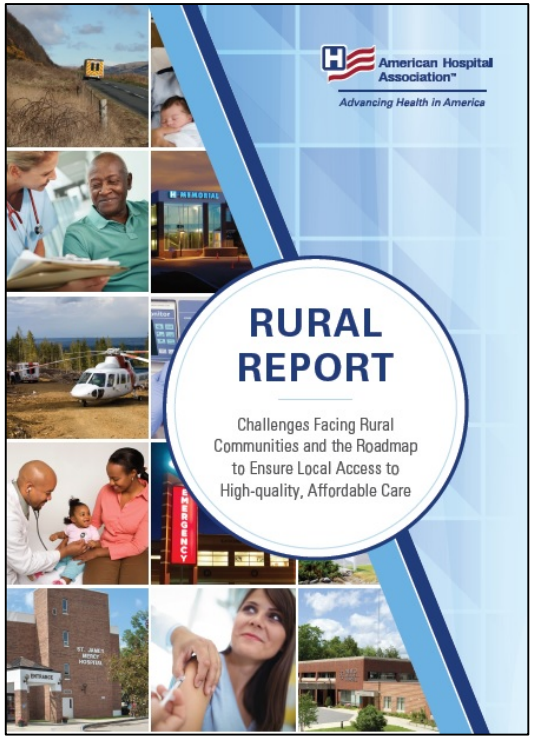
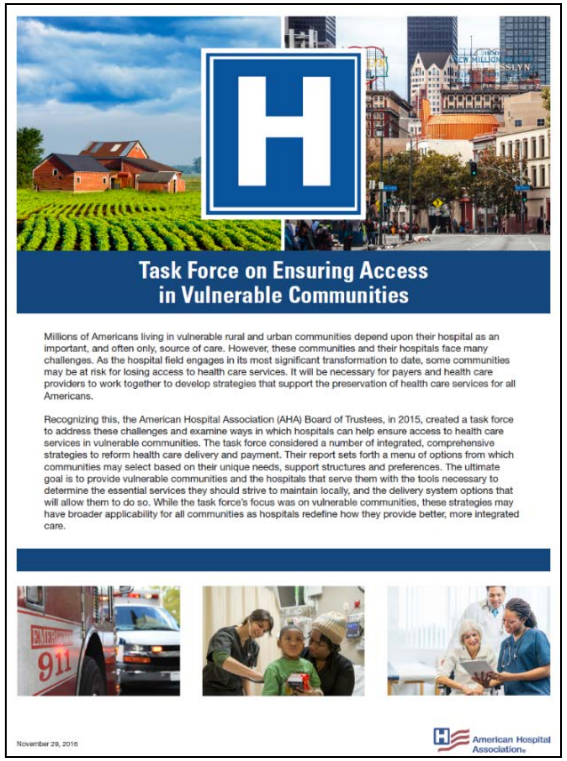
AHA Interventions





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2020
Rural Advocacy Agenda

America's rural hospitals are committed to serving their communities and ensuring local access to high-quality, affordable health care. The AHA is working to ensure federal policies and regulations are updated for 21st century innovation and care delivery, and new resources are invested in rural communities to protect access.

1. Support New Payment and Delivery Models
2. Ensure Fair and Adequate Reimbursement
3. Remove Red Tape
4. Support Telehealth and Health Information Technology
5. Bolster the Workforce
6. Rein in Prescription Drug Pricing

AHA Task Force on the ***Future of Rural Health Care***

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Congressional and Administration Efforts

CMS RURAL HEALTH STRATEGY

1. Apply a rural lens
2. Improve access
3. Advance telehealth and telemedicine
4. Empower patients
5. Leverage partnerships

HRSA
Health Resources & Services Administration

Rural Access to Health Care Services Request for Information

HOUSE COMMITTEE ON WAYS & MEANS
CHAIRMAN RICHARD E. NEAL

FOR IMMEDIATE RELEASE
July 16, 2019

CONTACT
Erin Hatch, 202-225-2856

Ways and Means Committee Launches Rural and Underserved Communities Health Task Force

explore holistic bipartisan policy options that could improve outcomes and care in these communities.

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CMS Innovation Center

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

- **Goals:**
  - Lower costs
  - Improve quality
- **Common mechanisms:**
  - Care coordination
  - Payment incentives

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CMS Innovation Center Rural Demonstrations

	Description	Examples
Accountable Care	▪ Coordinated care across clinicians and health care organizations with opportunities for shared savings ▪ May include pre-payments	▪ *Advanced Payment ACO Model* ▪ *ACO Investment Model*
Bundled Payments	▪ Combined payment to health care providers for all services provided during full episode of care	▪ *Bundled Payments for Care Improvement*
Enhanced Flexibility in Payment and Care Delivery	▪ Tests of more flexible approaches to payment or service design	▪ *Rural Community Hospital* ▪ *Frontier Community Health Innovation Project* ▪ *PA Rural Health Model*
Primary Care Transformation	▪ Payment models to support coordinated, patient-centered, high-quality primary care	▪ *Frontier Extended Stay Clinic*

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