American Hospital Association®

Fact Sheet: Expiring Medicare Provisions

The Issue

Over the years, Congress has enacted several provisions to address the special challenges rural and other hospitals encounter in delivering health care services to the communities they are committed to serving. Most recently, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which included, among other provisions, extensions through Sept. 30 or Dec. 31, 2017 of a number of programs important to hospitals.

AHA Position

These provisions are critical and must be further extended or made permanent.

Why?

These programs are of critical importance to hospitals and the patients and communities they serve. It is often difficult for hospitals to plan for community and patient needs when there is uncertainty over whether a program will continue. For these reasons, it is necessary that Congress extend these important provisions.

Background

- **Medicare-dependent Hospital (MDH) Program.** The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. Additionally, rural residents on average tend to be older, have lower incomes and suffer from higher rates of chronic illness than their urban counterparts. This greater dependence on Medicare may make certain rural hospitals more financially vulnerable to prospective payment. To reduce this risk and support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, Congress established the MDH program in 1987. The approximately 200 MDHs are paid for inpatient services using the sum of their prospective payment system (PPS) payment rate plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. These payments allow MDHs greater financial stability and leave them better able to serve their communities. This program expires Sept. 30, 2017. **The AHA supports the Rural Hospital Access Act of 2017 (S. 872/H.R. 1955), which would make the MDH program permanent.**
- **Low-volume Adjustment.** The Affordable Care Act (ACA) improved the low-volume adjustment for fiscal years (FYs) 2011 and 2012; this improvement was then extended several times. For these years, a low-volume hospital was defined as one that was more than 15 road miles (rather than 35 miles) from another comparable hospital and had up to 1,600 Medicare discharges (rather than 800 total discharges). An add-on payment was given to qualifying hospitals, ranging from 25 percent for hospitals with fewer than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges. Medicare seeks to pay efficient providers their costs of furnishing services. However, certain factors beyond providers' control can affect the costs of furnishing services. Patient volume is one such factor and is particularly relevant in small and isolated communities where providers frequently cannot achieve the economies of scale possible for their larger counterparts. Although a low-volume adjustment had existed in the inpatient PPS prior to FY 2011, the Centers for Medicare & Medicaid Services (CMS) had defined the eligibility criteria so narrowly that only two

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to three hospitals qualified each year. The enhanced low-volume adjustment in the ACA better accounts for the relationship between cost and volume, helps level the playing field for low-volume providers, and sustains and improves access to care in rural areas. This enhanced low-volume adjustment expires Sept. 30, 2017. **The AHA supports the Rural Hospital Access Act of 2017 (S. 872/H.R. 1955) which makes the enhanced low-volume adjustment permanent.**

- **Ambulance Add-on Payments.** Small patient volumes and long distances put tremendous financial strain on ambulance providers in rural areas. To help alleviate this situation and ensure access to ambulances for patients in rural areas, the Medicare Prescription Drug Improvement and Modernization Act increased payments by 2 percent for rural ground ambulance services and also included a super rural payment for counties in the lowest 25 percent in population density. Congress, in the Medicare Improvements for Patients and Providers Act, raised this adjustment to 3 percent for rural ambulance providers. Congress appropriately decided that these additional rural payments were necessary and important because rural ambulance providers incur higher per-trip costs because of longer travel distances and fewer transports of patients. These provisions ensure that ambulance services are more appropriately reimbursed and that beneficiaries in rural and super rural areas will have access to emergency transport services. **The AHA supports the Medicare Ambulance Access, Fraud Prevention, and Reform Act of 2017 (S. 967/H.R. 3236) that permanently extends these add-on payments for ambulance services, which will otherwise expire on Dec. 31, 2017.**

- **Outpatient Therapy Caps.** Medicare currently sets annual per beneficiary payment limits for outpatient therapy services (physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP)), provided by therapists and other eligible professionals in certain settings. The law allows for an exceptions process to the cap if the therapy is deemed medically necessary. This exceptions process has been extended numerous times in legislation. In 2012, the Middle Class Tax Relief and Job Creation Act temporarily expanded the therapy cap to services provided in hospital outpatient departments (HOPDs) from Oct. 1 through Dec. 31, 2012. The American Taxpayer Relief Act (ATRA) continued the temporary expansion of the therapy cap to services provided in HOPDs through Dec. 31, 2013, and further extended the therapy cap exceptions process through Dec. 31, 2013. The Protecting Access to Medicare Act of 2014 provided additional extensions of the therapy caps exceptions process, which expired on March 31, 2015. MACRA further extended the outpatient therapy caps exceptions process through Dec. 31, 2017. In addition, the ATRA required CMS to count therapy services furnished by a critical access hospital (CAH) toward the therapy cap through Dec. 31, 2013. As a result of the ATRA, in the physician fee schedule final rule for calendar year 2014, CMS reassessed and reversed its longstanding interpretation of existing statute by subjecting CAHs to the therapy cap beginning Jan. 1, 2014. **While the AHA supports further extending the outpatient therapy exceptions process, we oppose expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs. The AHA supports the Medicare Access to Rehabilitation Services Act of 2017 (S. 253/H.R. 807), to repeal outpatient rehabilitation therapy caps.**

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