

Extending key Medicare provisions a priority for AHA and rural hospitals

Medicare's "hold harmless" outpatient payments help Alaska's Central Peninsula Hospital maintain access to necessary services for Medicare patients and deal with physician workforce challenges.

The 49-bed hospital is located in Soldotna (population 3,400) and serves about 35,000 residents in the Kenai Peninsula, about 150 miles south of Anchorage. The nearest hospital, a critical access facility, is located 75 miles away in Homer.

Medicare's hold harmless and other payment adjustments have helped Central Peninsula to recruit several physicians, including a neurologist, a pain management specialist and orthopedic spine surgeon in recent years. "The Medicare beneficiaries in our area have access to primary care providers and specialty services because of these types of programs," says hospital CEO Ryan Smith. "We've been fortunate to receive these payments, because they help us to continue providing access to care to all of our Medicare patients."

But the hold harmless outpatient payment policy and a number of other rural measures are set to expire at the end of this year. Smith says a lame-duck Congress should move quickly to extend them. "Otherwise, we would have to make tough choices about which services we could continue to provide," he says. "Rural hospitals, like ours, need these added payments."

The AHA will be pressing lawmakers to pass legislation extending the outpatient hold harmless payment and other important rural hospital provisions when a lame-duck Congress reconvenes Nov. 15. The AHA

and rural hospital leaders said the payment provisions recognize that rural providers serve a critical role in areas where the next nearest provider may be hours away.

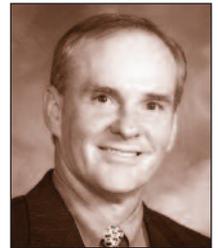
To help protect rural hospitals from steep Medicare payment reductions when the outpatient prospective payment system (PPS) took effect in 2000, Congress provided for transitional hold harmless payments to hospitals with no more than 100 beds. Under the legislation, modified in recent years, hospitals receive 85% of the difference between outpatient PPS payments and the payments they would have received under their previous cost-based system. These amounts are determined by using their 1996 Medicare cost reports, which hospitals file with their Medicare contractor after the end of each fiscal year.

The hold harmless provision includes payment protections for sole community hospitals – regardless of their size – and was extended through the end of this year by the 2010 "Patient Protection and Affordable Care Act" that was enacted last March. Sole community hospitals provide care in some of the nation's most rurally isolated areas.

Many rural hospitals face strong pressure related to their small size, modest assets and financial reserves, and higher percentage of Medicare and uninsured patients. In a still struggling economy, rural hospital administrators also point to other financial challenges – a shrinking workforce, demands for expensive new information systems and technology, and access to capital to fund needed infrastructure updates – and say the hold harmless outpatient and other Medicare

provisions are as important as they've even been to rural health care.

"These provisions allow us to recoup our costs and continue to fund vital services," said Robin Lake, president and CEO of North Arkansas Regional Medical Center, a 175-bed sole community hospital serving 13,000 residents in Harrison. Ending the payments "may affect our ability to continue to pay competitive wages, fund services which lose money, buy new or replacement capital equipment, fund physician recruitment and renovate our building." And that could lead to "many hospitals critically evaluating and possibly eliminating essential services which benefit the community," he said.



LAKE

Kansas Hospital Association President Tom Bell shares those concerns, noting that the outpatient hold harmless payment provision helps many Kansas hospitals provide important health care services for their communities. Like Smith and Lake, he worries that, "without it, rural providers would be forced to make the difficult decision of eliminating much needed services that are too costly to provide without the additional payment."



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In addition to the outpatient hold harmless provision, the AHA is pushing Congress to extend measures that allow independent laboratories to bill Medicare directly for the technical component of physician pathology tests for patients; provide an exceptions process for Medicare therapy caps; and renew the Section 508 reclassification program, which expired Sept. 30.

Medicare therapy caps limit Medicare Part B reimbursement for therapy services. Under the exceptions process, Medicare continues to pay for therapy services that exceed the cap if they are determined to be medically necessary. Under the lapsed Section 508 program, hospitals could apply to the Medicare Geographic Classification Review Board for reclassification to a neighboring urban or rural area for purposes of receiving a higher wage index.

Among other rural programs, the AHA

also urges lawmakers to extend: Medicare's bonus payments for ground and ambulance services; and to reinstate the "reasonable cost" reimbursement for laboratory services provided by certain small rural hospitals.

The AHA has said that, without congressional action in the lame-duck session, Medicare policy for rural hospitals will "revert back to detrimental provisions that limit access, beneficiary choice and provider reimbursement."