Protecting the Promise of Care

Medicare - Small or Rural Hospitals

Background

Because of their small size, modest assets and financial reserves, and higher percentages of Medicare patients, rural hospitals disproportionately rely on government payments. While their Medicare margins have improved in recent years, over 60 percent of rural hospitals still lose money treating Medicare patients. Medicare payment systems fail to recognize the unique circumstances of small, rural hospitals. Many rural hospitals are too large to qualify for CAH status, but too small to absorb the financial risk associated with PPS programs. Also, existing special rural payment programs – CAH, sole community hospital (SCH), Medicare-dependent hospital (MDH) and rural referral center (RRC) – need to be updated.

AHA View

The AHA's 2010 advocacy agenda focuses on ensuring hospitals have the resources they need to provide high-quality care and meet the needs of their communities, particularly under health care reform. That means:

- Advocating for adequate Medicare payments;
- Implementing health care reform in a manner that improves care coordination and promotes efficiency;
- Working to extend expiring Medicare provisions;
- Improving Medicare payments to rural hospitals;
- Encouraging Congress to shore up payments for hospitals that train the physicians of the future; and
- Reining in unfair Medicare claims denials by Recovery Audit Contractors (RACs) and similar activities of fiscal intermediaries and Medicare Administrative Contractors.

Small or Rural Hospitals

Annual Appropriations - Rural Health Programs. The AHA recommends increased funding for rural health care programs, such as the Medicare Rural Hospital Flexibility Grant Program, Rural Health Outreach and Network Development, State Offices of Rural Health, Rural Telehealth and Rural Policy Development. These programs are currently funded at $129 million. These and other HHS programs play a significant role in ensuring that needed services remain available to hospitals and residents in America's rural communities

Health Care Reform – The Patient Protection and Affordable Care Act (PPACA). The AHA is pleased that Congress included the following legislative relief as part of the PPACA:

- Extended the outpatient hold-harmless payments for certain hospitals in rural areas;
- Extends direct payments to independent labs for the technical component for physician pathology services for hospital inpatients and outpatients;
- Extended the Medicare Rural Hospital Flexibility Program;

- Created a payment adjustment for low-volume hospitals;
- Ensured that CAHs are paid 101 percent of costs for all outpatient services regardless of the billing methods elected;
- Extended and expanded the Rural Community Hospital Demonstration Program;
- Extended the Medicare Dependent Hospital program for 1- year;
- Extended reasonable cost reimbursement for laboratory services in small rural hospitals; and,
- Reinstated a 3 percent rural home health care add-on.

In addition, the AHA will work with Congress to:

- Provide small, rural hospitals with cost-based reimbursement for outpatient lab services and ambulance services;
- Ensure CAHs are paid at least 101 percent of costs by Medicare Advantage plans;
- Ensure CAHs receive cost-based reimbursement for certified nurse anesthetist services; and,
- Remove unreasonable restrictions on CAHs' ability to rebuild.

340B Drug Discount Program. Safety-net hospitals depend on the 340B drug discount program to provide outpatient pharmacy services to some of their most vulnerable patients. The AHA is pleased that, under health reform, Congress has expanded eligibility for the discount drug prices available under the program to CAHs and certain SCHs and RRCs, but disappointed the expansion doesn't go far enough. The AHA will continue to work to ensure that the program is expanded to inpatient drugs, for all hospitals, including MDHs, RRCs and all SCHs.

Geographic Variations. Data produced for many years by researchers in the *Dartmouth Atlas of Health Care* depicts substantial variation in the use of health care services and in health care spending across the country. The PPACA directs the HHS Secretary to pay hospitals in the lowest quartile of counties (determined by cost per Medicare beneficiary adjusted for age, sex and race) a bonus payment for the next two years. The payments will total $200 million for FY 2011 and $200 million for FY 2012.

Regulatory Policy

Physician Supervision of Hospital Outpatient Therapeutic Services. In both the 2009 and 2010 outpatient PPS final rules, CMS mandated new coverage requirements for "direct supervision" of outpatient therapeutic services. The new policy requires that a supervising physician or non-physician practitioner be physically present and immediately available at all times when Medicare beneficiaries receive outpatient therapeutic services. CMS has depicted significant changes as merely a "clarification and restatement" of rules established in 2001. Consequently, hospitals are at risk for unwarranted enforcement actions. **The AHA will work to ensure CMS makes a more fundamental change to the physician supervision policy.**