



American Hospital
Association

Special Briefing for Low-volume Rural Hospitals

**Sunday, April 25, 4:00 p.m. – 4:30 p.m.
Lincoln Room East**

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

Payment Adjustment for Low-volume Hospitals.

The law improves the low-volume adjustment for FYs 2011 and 2012. For these years, a low-volume hospital will be defined as one that is more than 15 road miles from another comparable hospital and has up to 1,600 Medicare discharges. An add-on payment will be given to these hospitals in an amount to be determined by the HHS Secretary using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with Medicare discharges below 200, to no adjustment for hospitals with more than 1,600 Medicare discharges.

Hospital Outpatient Hold-harmless Payments.

The law extends the hospital outpatient hold-harmless payments for small rural hospitals with 100 or fewer beds for one additional year, through December 31, 2010. It also would make all SCHs eligible to receive these hold-harmless payments, regardless of their bed size in 2010 only. Hospitals will receive 85 percent of the difference between outpatient PPS payments and those that would have been made under the prior reimbursement system. This provision is retroactive to January 1, 2010.

Reasonable Cost Reimbursement for Lab Services in Small Rural Hospitals.

The law reinstates reasonable cost payment for clinical diagnostic laboratory services for qualifying rural hospitals with fewer than 50 beds in certain states with low density rural areas for cost reporting periods *beginning* from July 1, 2010 through June 30, 2011. This could affect services performed as late as June 30, 2012 if a hospital's cost reporting period began on June 30, 2011.

Rural Community Hospital Demonstration Program.

The law extends the Rural Community Hospital Demonstration Program for five additional years through December 31, 2014, increases the maximum number of participating hospitals from 15 to 30 and expands the eligible sites to rural areas in 20 states with low population densities. For hospitals currently in the demonstration, the inpatient payment amount is re-based. *The Medicare Prescription Drug, Improvement and Modernization Act of 2003* created this five-year demonstration program to test the feasibility and advisability of reasonable cost reimbursement for rural hospitals with fewer than 51 beds.

Adequacy of Medicare Payments for Health Care Providers Serving Rural Areas.

The law requires MedPAC to report to Congress on Medicare payment adequacy for rural health care providers by January 1, 2011. MedPAC will analyze rural payment adjustments, beneficiaries' access to care in rural communities, adequacy of Medicare payments to rural providers and quality of care, and make recommendations on appropriate changes to rural payment adjustments.

Increased Payments for Ambulance Services under Medicare.

The law extends the existing add-on payment for ground ambulance services – a 3 percent add-on for rural areas and a 2 percent add-on for urban areas – through December 31, 2010. It also extends through December 31, 2010 the air ambulance and “super rural” ambulance add-ons. This provision is retroactive to January 1, 2010.

MDH Program.

The law extends the MDH program for one year through September 30, 2012.

Section 508 Reclassifications.

The law extends Section 508 wage index reclassifications for the inpatient PPS for one year through September 30, 2010. This provision is retroactive to October 1, 2009.

Extension of Treatment of Certain Medicare Physician Pathology Services.

The law extends through December 31, 2010 the grandfathering provision that allows certain independent laboratories to receive direct payments for the technical component for physician pathology services that are furnished to certain hospital inpatients and outpatients. This provision is retroactive to January 1, 2010.

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.

Payments to Qualifying Hospitals in Medicare “Low-cost” Counties.

For FYs 2011 and 2012, the law provides \$200 million in each year to hospitals located in counties that rank in the lowest quartile of Medicare per-beneficiary spending, adjusted by age, sex and race. Each hospital will receive funding in an amount that is proportional to the Medicare inpatient hospital payments made to the individual hospital as a percentage of the Medicare inpatient hospital payments made to all hospitals receiving the funding.

Physician Supervision of Hospital Outpatient Therapeutic Services.

In the calendar years (CY) 2009 and 2010 outpatient PPS rules, CMS mandated requirements for “direct supervision” of outpatient therapeutic services. In 2010, CMS' 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 portrayed these changes as a “clarification and restatement” of requirements in place since 2001. The AHA will work to ensure CMS makes a more fundamental change to the physician supervision policy.

