FACTSHEET

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 *American Taxpayer Relief Act of 2012* (ATRA), which contained many provisions important to hospitals. Yet a number of programs critical to hospitals will expire this year or already have expired.

AHA POSITION

These provisions are critical and must be further extended and, in some cases, 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.

KEY PROVISIONS

PROVISIONS EXPIRING IN 2013

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 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.

Low-volume Adjustment

The Patient Protection and Affordable Care Act (ACA) improved the low-volume adjustment for fiscal years (FYs) 2011 and 2012. For these years, a low-volume hospital is defined as one that is more than 15 road miles (rather than 35 miles) from another comparable hospital and has up to 1,600 Medicare discharges (rather than 800 total discharges). An add-on payment will be 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. About 500 hospitals are currently receiving the low-volume adjustment.

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 to three hospitals qualified each year. The improved 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 program expires Sept. 30.

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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* (MMA) 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. These provisions expire Dec. 31. In addition, the law calls for the Secretary of Health and Human Services to undertake studies on ambulance costs.

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* (MCTRJCA) temporarily expanded the therapy cap to services provided in hospital outpatient departments (HOPDs) from Oct. 1 through Dec. 31, 2012.

The ATRA further extends the therapy cap exceptions process through Dec. 31, 2013, and continues the temporary expansion of the therapy cap to services provided in HOPDs through Dec. 31, 2013. In addition, the ATRA requires temporary application of the therapy cap to outpatient therapy services provided in critical access hospitals (CAHs) through Dec. 31, 2013. Also, the MCTRJCA-mandated additional manual medical review process for beneficiaries who reach a threshold of $3,700 in outpatient therapy services will continue, and will apply to therapy services provided in HOPDs and CAHs.

While the AHA supports extending the outpatient therapy exceptions process, we oppose the temporary expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.

PROVISIONS THAT ALREADY HAVE EXPIRED

Outpatient Hold-harmless Payments for Small Rural Hospitals and Sole Community Hospitals

When the outpatient PPS was implemented, Congress made certain rural hospitals with 100 or fewer beds eligible to receive an additional payment adjustment, referred to as "hold harmless" transitional outpatient payments (TOPs). "Hold harmless" TOPs were intended to ease their transition from the prior reasonable cost-based payment system to the outpatient PPS. That provision originally expired Jan. 1, 2004; however, because of concerns about the financial stability of these small rural hospitals, Congress has extended the provision every year since and has subsequently expanded it to apply to equally vulnerable sole community hospitals (SCHs). It is important to note that not every eligible hospital benefits from the hold harmless every year; instead, it is only those whose costs exceed their payments during that cost year.

Hospitals that receive TOPs already have Medicare payments that are well below their Medicare costs, with payments averaging about 82 percent of costs. With the expiration of this provision, TOPs-eligible hospitals are subject to a cut of about 16 percent to Medicare outpatient payments. With such a large gap between payments and costs, it will be difficult for these vulnerable hospitals to continue to provide access to critical outpatient services, such as emergency department services and chemotherapy. This program expired Dec. 31, 2012, for rural hospitals and SCHs with no more than 100 beds. It expired March 1, 2012, for SCHs with more than 100 beds.

Section 508

The area wage index is greatly flawed in many respects. It is highly volatile from year to year, and is based on unrealistic geographic boundaries. These fundamental problems warrant a full and comprehensive re-evaluation and redesign of a system that CMS itself acknowledges is burdensome.

In an attempt to introduce more equity into the system, certain exceptions to the wage index have been created. One example is Section 508 of the MMA, which allows certain qualifying hospitals to receive wage index reclassifications and assignments that they otherwise would not have been eligible to receive.

The Section 508 program provides critical help to hospitals with wages that are not representative of their area, but that slip through the cracks of the current reclassification criteria. Specifically, many hospitals apply each year to the Medicare

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Geographic Classification Review Board for reclassification to another area to receive a higher area wage index. The current criteria for reclassification require a hospital to be in close geographic proximity to the area to which it wants to reclassify and to have wages that are a certain amount higher than hospitals in its own area, but comparable to the hospitals in the area to which it seeks reclassification. The 508 criteria were designed to accommodate categories of hospitals that, based on CMS experience, fall just beyond the current regulatory reclassification criteria. The program provides them with the resources necessary to be able to attract and retain a sufficient workforce and best serve their beneficiaries. This program expired March 31, 2012.

Payment for the Technical Component of Physician Pathology Services Furnished to Hospital Patients

Medicare has long paid independent laboratories directly under the physician fee schedule for both the preparation (technical component (TC)) and interpretation (professional component) of patient specimens obtained from hospital inpatients and outpatients. It did so because many hospitals do not have the capacity to furnish these services within their in-house labs and, therefore, contract with independent labs for their pathology services.

The history of the development of the hospital PPS and CMS's guidance on physician pathology TC costs makes it clear that the independent laboratory TC costs have never been included in the Medicare-Severity Diagnosis-Related Groups (MS-DRGs).

Eliminating direct payment to independent labs will be especially burdensome for small and rural hospitals, which often lack the surgical volume necessary to support in-house services and instead rely heavily on independent labs for physician pathology services. These hospitals will have to establish costly and administratively complex new billing systems and procedures, stretching already scarce resources and potentially forcing them to reduce the variety of services they provide. Further, the hospitals also will have to pay the independent labs directly for their services, despite the fact that Medicare DRG payments do not include these costs. This provision expired June 30, 2012.

Reasonable Cost Based Payment for Outpatient Clinical Lab Tests in Small Hospitals Located in Qualified Rural Areas

The MMA also included a provision requiring reasonable cost reimbursement for outpatient clinical laboratory tests furnished by hospitals with fewer than 50 beds in certain "qualified rural areas" for cost-reporting periods beginning on July 1, 2004 through 2008. A "qualified rural area" is defined as an area with a population density in the lowest quartile of all rural county populations, a designation that CMS refers to as "super rural."

Congress initially enacted reasonable cost reimbursement for outpatient clinical lab tests in these small rural hospitals because they have fewer patients over which to spread fixed expenses and, therefore, costs per case tend to be higher. Extending this provision has critical implications for patients and hospitals located in sparsely populated rural areas. Despite their small size and their smaller base of patients, these hospitals still have to maintain a broad range of basic services, including laboratory services, to meet the health care needs of their communities. In fact, in these communities, the hospital may be the only source of clinical laboratory testing services for miles. This provision expired June 30, 2012.