American Hospital Association

RURAL HOSPITAL ALERT

Friday June 8, 2012

The Rural Hospital Access Act

Reauthorizing MDH and extending low-volume adjustment

Following is information on recent activity concerning legislation that impacts your hospital – *The Rural Hospital Access Act of 2012*, (H.R. 5943) which was introduced in the House by Reps. Tom Reed (R-NY) and Peter Welch (D-VT). The legislation would reauthorize the Medicare-Dependent Hospital (MDH) program and extend the enhanced low-volume Medicare adjustment for prospective payment system hospitals for one year through September 2013. The legislation also calls for a GAO study on the impact of the add-on payments. After successfully working with the Senate sponsors to introduce, S.2620, AHA was able to secure commitments from two key House members to introduce a similar House version of this important legislation.

MEDICARE-DEPENDENT HOSPITAL 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 211 MDHs are eligible to be paid for inpatient services the sum of their prospective payment system (PPS) 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.

LOW-VOLUME ADJUSTMENT

The Patient Protection and Affordable Care Act (ACA) improved the low-volume adjustment for fiscal years 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 is 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 like larger hospitals. Although a low-volume adjustment had existed in the inpatient PPS prior to FY 2011, CMS had defined the eligibility criteria so narrowly that *only two to three hospitals qualified each year*. The improved low-volume adjustment better accounts for the relationship between cost and volume and helps level the playing field for low-volume providers and also sustains and improves access to care in rural areas. If it were to expire, these providers would once again be put at a disadvantage and have severe challenges serving their communities.

We encourage you to reach out to your members in the U.S. House of Representatives and ask them to co-sponsor this important legislation.