



Statement of the Rural Hospital Coalition

House Committee on Ways and Means
Subcommittee on Health

Hearing on Expiring Medicare Provider Payment Policies

September 21, 2011

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The Rural Hospital Coalition would like to thank Chairman Wally Herger (R-CA), Ranking Member Pete Stark (D-CA), and other Members of the Health Subcommittee for holding a hearing on the expiring Medicare provider payment policies and for the opportunity to submit testimony on this important topic. The impact of Medicare provider payment policies on rural beneficiaries, health care and communities cannot be understated.

The Rural Hospital Coalition represents nearly 20% of rural hospitals, with almost 200 facilities located across thirty-one states. Our hospitals are major drivers of many rural communities, providing jobs, revenue and the health care needed to keep rural Americans thriving. In many rural communities, rural hospitals serve as one of, if not *the*, largest employers. Rural hospitals can account for a full 20% of the revenue a rural community sees in a year. In addition, the existence of a high-quality hospital in a rural community is key to the economic development of that local community. A rural hospital is often a vital element in attracting investment and new employers to a rural community. Furthermore, a single hospital often serves as the sole provider of care for a community. Finally, rural Americans already earn significantly less than their urban counterparts, are more likely to live at or below the federal poverty level, and are more likely to experience worse health overall¹. Rural hospitals are therefore vital to the communities they serve.

However, rural hospitals consistently struggle financially, a situation exacerbated by historically inequitable Medicare reimbursement rates. Because rural hospitals serve residents who are less likely to have employer-provided health insurance, prescription drug coverage, and less likely to be covered by Medicaid, these hospitals provide higher rates of uncompensated care than metropolitan facilities². And while Medicare payments to rural hospitals are less than those paid to urban hospitals, the payment policies under consideration today help offset these and other factors faced by rural hospitals³. Allowing the current rural Medicare payment policies to expire could not only threaten to deprive rural Americans of their only point of access to local health care, it would also likely weaken the economic backbone of these and surrounding communities.

We certainly appreciate that, in light of the current necessity to focus on deficit reduction, it is important to ensure that these payment policies are serving their underlying purposes and that extending these policies is truly necessary. Of the Medicare payment policies expiring before December 31, 2012, the policies that are of greatest importance to rural hospitals and their

¹ National Rural Health Association, What's Different about Rural Health Care?, <http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care>, Accessed September 18, 2011

² Id.

³ Id.

communities were last estimated by the Congressional Budget Office ("CBO") to cost a total of \$2.3 billion over ten years (see enclosed for the full list of Medicare extenders vital to rural hospitals). This estimate amounts to less than one tenth of the total cost of extending all expiring payment policies under consideration today and it amounts to roughly 0.2% of the projected total Medicare spending over the next decade. Furthermore, while these provisions have a small impact on overall Medicare expenditures, they provide a much-needed lifeline to rural communities, the beneficiaries who live there, and to hospitals and communities across the country.

Section 508 - Area Wage Index Reclassification

The area wage index is used to adjust payment rates to account for estimated regional differences in the cost of paying hospitals and their employees. Hospitals in areas with a higher wage index receive higher Medicare payments for the same services than those hospitals in areas with a lower wage index. Section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") allowed hospitals meeting certain criteria to be reclassified into a higher wage-index area. This reclassification ensures that hospitals in so-called low wage index areas can afford to provide these same services to their patients, which do not necessarily cost less in low wage index areas. The reclassification also ensures that rural hospitals remain active employers and job creators, allowing them to offer competitive salaries to nurses, technicians and other employees who would otherwise travel to nearby higher wage index areas, diminishing the ability of these hospitals to offer the highest quality care to rural patients.

Outpatient Hold Harmless

The outpatient hold harmless provision was enacted by Congress to partially protect hospitals from substantial reductions in payments that occurred when the Centers for Medicare & Medicaid Services ("CMS") terminated cost-based reimbursement for outpatient services and began using the Outpatient Prospective Payment System ("OPPS"). The Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") extended this provision and allowed Sole Community Hospitals ("SCHs") with more than 100 beds to be eligible for this adjustment. As noted above, rural hospitals continue to struggle financially, and are not capable of absorbing the additional losses associated with removing the hold harmless provision. The CBO estimate for extending this provision for one year in 2010 was approximately \$200 million, a minor cost compared to the \$19 billion in total Medicare spending on outpatient services in 2007 alone.

Technical Component for Certain Pathology Services

The technical component for certain pathology services provision allows independent laboratories to bill Medicare directly for certain clinical laboratory services they provide for hospitals. Allowing this payment policy to expire would shift the costs of clinical laboratory services onto hospitals. This would significantly burden rural hospitals, which often rely heavily on independent laboratories for surgical pathology services.

In addition to the payment policies expiring on or before December 31, 2011, there are at least five additional payment policies that will expire on September 30, 2012 □ a mere nine months after the policies that today's hearing is focused on (see enclosed for a complete list of Medicare payment policies that affect rural hospitals). Of the policies expiring in 2012, the two discussed below are most critical to rural hospitals.

Improved Payment for Low-Volume Hospitals

The improved payment for low-volume hospitals applies a percentage add-on for each Medicare discharge from a hospital that is located 15 road miles or more from another hospital⁴, and has less than 1,600 discharges during a fiscal year. This provision affords qualifying hospitals an enhanced payment to account for the higher incremental costs associated with a low volume of discharges, as compared to the lower costs incurred per patient at higher volume hospitals. The enhanced payment is not provided after a one-time qualification, but requires that a hospital provide sufficient evidence to demonstrate that it continually meets the discharges and distance requirements, ensuring that hospitals which do not consistently qualify for the payment are not unjustly enriched by a one-time qualifying discharge rate or distance measurement.

Medicare Dependent Hospital Program

The Medicare Dependent Hospital ("MDH") program dates back to 1987, and was "intended to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges."⁵ Congress applied this designation to rural hospitals with fewer than 100 beds, not classified as an SCH, and having at least 60% of inpatient days or discharges covered by Medicare. As noted by the Medicare Payment Advisory Commission ("MedPAC"), a greater dependence on Medicare makes such hospitals more financially vulnerable to the prospective payment system ("PPS"). The MDH designation mitigates this financial risk, providing an enhanced payment to account for reduced payments under PPS. Additionally, the MDH designation provides small rural hospitals assurance that if its caseload falls by more than 5 percent due to circumstances beyond its control, the MDH will receive such payments as necessary to cover fixed operating costs. This designation allows many rural hospitals to keep their doors open. This provision was extended under the Patient Protection and Affordable Care Act, and was then scored by CBO as a 0.

We hope that this testimony provides insight into the impact that these Medicare payment policies have on sustaining health care delivery in rural America. Thank you, and we look forward to working with all Members on these important issues.

⁴ This applies only to "subsection (d) hospitals" □ Not including psychiatric hospitals, rehabilitation hospitals, children's hospitals, hospitals with average inpatient lengths of stay greater than 25 days, or cancer centers.

⁵ MedPAC, *Summary of Medicare's special payment provisions for rural providers and criteria for qualification*, June 2001, at 142.



Medicare Extenders

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As providers of health care in America's rural communities, we have a special understanding of the adverse impact failure to pass these extenders would have on beneficiaries and the providers on which they depend. Below is a list of provisions that have been addressed by Congress in the past. We request your attention and action to pass legislation that, at a minimum, will extend these policies beyond their current expiration.

- **Hospital wage index improvement** Extended reclassifications under section 508 of the Medicare Modernization Act (P.L. 108-173). The estimated cost is approximately \$300 million over ten years.
 - Medicare and Medicaid Extenders Act § 102 extends the reclassifications through FY 2011.*
- **Extension of improved payments for low-volume hospitals** Applied a percentage add-on for each Medicare discharge from a hospital 15 road miles from another hospital⁶ that has less than 1,600 discharges during the fiscal year. The estimated cost is approximately \$200 million over ten years.
 - Patient Protection and Affordable Care Act § 3125 made this policy effective through fiscal years 2011 and 2012.*
- **Extension of outpatient hold harmless provision** Extended outpatient hold harmless provision and allows Sole Community Hospitals with more than 100 beds to also be eligible for this adjustment. The estimated cost is approximately \$200 million over ten years.
 - Medicare and Medicaid Extenders Act § 108 extends the outpatient hold harmless provision through December 31, 2011.*
- **Extension of exceptions process for Medicare therapy caps** Extended the process allowing exceptions to limitations on medically necessary therapy. The estimated cost is approximately \$900 million over ten years.
 - Medicare and Medicaid Extenders Act § 104 extends the therapy caps exception process through December 31, 2011.*
- **Extension of payment for the technical component of certain physician pathology services --** Extended provision that allows independent laboratories to bill Medicare directly for certain clinical laboratory services. The estimated cost is approximately \$100 million over ten years.
 - Medicare and Medicaid Extenders Act § 105 extends the ability of independent laboratories to receive direct payments for the technical component of certain pathology services through December 31, 2011.*

⁶ This applies only to "subsection (d) hospitals" Not including psychiatric hospitals, rehabilitation hospitals, children's hospitals, hospitals with average inpatient lengths of stay greater than 25 days, or cancer centers.

- **Extension of the work geographic index floor under the Medicare physician fee schedule** □ Extended a floor on geographic adjustments to the work portion of the fee schedule, with the effect of increasing practitioner fees in rural areas. The estimated cost is approximately \$600 million over ten years.

 - *Medicare and Medicaid Extenders Act § 103 extends the existing 1.0 floor on the “physician work” index through December 31, 2011.*

- **Extension of ambulance add-ons** □ Extended bonus payments made by Medicare for ground and air ambulance services in rural and other areas. The estimated cost is approximately \$100 million over ten years.

 - *Medicare and Medicaid Extenders Act § 106 extended the increased Medicare rates for ambulance services, including in super rural areas, through December 31, 2011.*

- **Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities** □ Extended Sections 114(c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007. The estimated cost is approximately \$200 million over ten years.

 - *Patient Protection and Affordable Care Act § 3106 extended the payment rules to July 1, 2012.*

- **Extension of physician fee schedule mental health add-on** □ Increased payment rate for psychiatric services delivered by physicians, clinical psychologists and clinical social workers by 5 percent. The estimated cost is approximately \$100 million over ten years.

 - *Medicare and Medicaid Extenders Act § 107 extended the five percent increase in payments for certain Medicare mental health services through December 31, 2011.*

- **Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas** □ Reinstated the policy included in the Medicare Modernization Act of 2003 (P.L. 108-173) that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals. This provision in the Medicare and Medicaid Extenders Act was scored by CBO as a 0.

 - *Medicare and Medicaid Extenders Act § 109 extended this policy through July 1, 2012.*

- **Extension of Medicare Dependent Hospital Program** □ Extended the designation to rural hospitals with fewer than 100 beds, not classified as an SCH and having at least 60% of inpatient days or discharges covered by Medicare. This provision in the Patient Protection and Affordable Care Act was scored by CBO as a 0.

 - *Patient Protection and Affordable Care Act § 3124 extended this policy through September 30, 2012.*

- **Extension of Community Health Integration Models** □ PPACA § 3126 removed the cap on the number of eligible counties in a State. This provision in the Patient Protection and Affordable Care Act was scored by CBO as a 0.

 - *Expires September 30, 2012.*