

**Statement
of the
American Hospital Association
before the
Committee on Energy and Commerce,
Subcommittee on Health
of the
United States House of Representatives**

**“The Extenders Policies: What Are They and How Should They Continue Under a
Permanent SGR Repeal Landscape”**

January 9, 2014

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the AHA appreciates the opportunity to submit a statement regarding certain Medicare provider payment provisions that are due to expire soon. We applaud the Committee for holding this hearing.

LOW-VOLUME ADJUSTMENT

The Patient Protection and Affordable Care Act improved the then low-volume adjustment for fiscal years (FY) 2011 and 2012. For these years, a low-volume hospital was defined as one that was more than 15 road miles (rather than 35 miles) from another comparable hospital and had up to 1,600 Medicare discharges (rather than 800 total discharges). An add-on payment was 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.



This enhanced low-volume adjustment was extended by Congress in several subsequent years. Over 500 hospitals received the low-volume adjustment in FY 2013.

Medicare seeks to pay efficient providers their costs of furnishing services. However, certain factors beyond providers' control can affect these costs. 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 prospective payment system (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 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.

The low-volume adjustment expired on Oct. 31. However, the *Bipartisan Budget Act of 2013* extended the program through March 31, 2014.

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 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.

The MDH program expired on Oct. 31. However, the *Bipartisan Budget of 2013* extended the program through March 31, 2014.

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* increased payments by 2 percent for rural ground ambulance services and included a super rural payment for counties are in the lowest 25 percent in population density. Congress, in the *Medicare Improvements for Patients and Providers Act (MIPPA)*, raised this adjustment to 3 percent for rural ambulance providers. Most recently, Congress extended these adjustments until March 31, 2014.

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.

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* temporarily expanded the therapy cap to services provided in hospital outpatient departments (HOPDs) from Oct. 1 through Dec. 31, 2012. The ATRA continued the temporary expansion of the therapy cap to services provided in HOPDs through Dec. 31, 2013, and further extended the therapy cap exceptions process through Dec. 31, 2013. *The Bipartisan Budget Act of 2013* extended both provisions through March 31, 2014.

In addition, the ATRA required CMS to count therapy services furnished by a critical access hospital (CAH) toward the therapy cap through Dec. 31, 2013. As a result, in the Physician Fee Schedule final rule for calendar year 2014, CMS reassessed and reversed its longstanding interpretation of existing statute by subjecting CAHs to the therapy cap beginning Jan. 1.

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

CONCLUSION

Over the years, Congress has enacted several provisions to address the special challenges rural hospitals encounter in delivering health care services to the communities they are committed to serving. The AHA urges the Committee to recognize that the circumstances that necessitated these provisions continue to exist; therefore, it is appropriate that they be extended.