Statement of the Rural Hospital Coalition

House Committee on Energy and Commerce
Subcommittee on Health

"The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?"

January 9, 2014

Submitted by Nancy Taylor
On Behalf of the Rural Hospital Coalition
202.331.3133

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The Rural Hospital Coalition would like to thank Chairman Joe Pitts (R-PA), Ranking Member Frank Pallone (D-NJ), and other Members of the Health Subcommittee for holding a hearing on the Medicare extenders policies and for the opportunity to submit testimony on this important topic. The impact of these Medicare provider payment policies on rural beneficiaries, health care and communities cannot be understated. We strongly support the permanent extension of the Low Volume Hospital Adjustment and the Medicare Dependent Hospital Program at their current levels, as contained in the Senate Finance Committee bill passed out of Committee on December 12, 2013 (S. 1871). These two provisions go a long way to provide stability to health care services in rural communities around the country.

The Rural Hospital Coalition represents nearly one-fifth of all rural hospitals, with almost 200 facilities located across more than thirty 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 overall[1]. Rural hospitals are therefore vital to the communities they serve.

Because rural hospitals serve residents who are less likely to have private health insurance or prescription drug coverage, these hospitals provide higher rates of uncompensated care than metropolitan facilities[2]. At the same time, rural hospitals generally see a greater share of patients on Medicaid than urban facilities[3] – a program that has historically paid less for hospital services than the actual costs associated with providing care[4]. And while Medicare payments to rural

[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 December 26, 2013.
[2] Id.
[3] Rural Assistance Center, What are some challenges that rural hospitals face?, http://www.raconline.org/topics/hospitals/faqs, Accessed January 3, 2014.
[4] American Hospital Association, *Underpayment by Medicare and Medicaid: Fact Sheet*, December 2010, http://www.aha.org/content/00-10/10medunderpayment.pdf.

hospitals are also proportionally less than those paid to urban hospitals for the same services, the payment policies under consideration today help offset these and other challenges faced by rural hospitals – such as recruitment and retention of physicians and other providers[5]. In short, rural hospitals must manage the same overhead and operating costs as larger urban facilities, but have less opportunity to spread and recover these costs, often forcing rural hospitals to scale back services. Allowing the current rural Medicare payment policies to expire would not only threaten to deprive rural Americans of their only point of access to local health care services, it would also potentially weaken the economic backbone of these and surrounding communities.

Of the Medicare payment policies expiring on March 31, 2014, the two policies that are of greatest importance to rural hospitals and their communities were recently estimated by the Congressional Budget Office ("CBO") to **cost just over $4.2 billion over ten years for a permanent, but modified, extension** (see enclosed for the full list of Medicare extenders vital to rural hospitals). This ten-year cost estimate amounts to **less than 1% of the projected total Medicare spending next year alone**. Furthermore, while these provisions have only a miniscule 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. Below we provide some background and additional detail on the two most critical Medicare extenders, which are scheduled to expire on March 31, 2014.

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 hospital[6], and has less than 1,600 Medicare 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 incremental 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. The CBO estimates that a permanent extension of the low-volume adjustment – though modified – would cost roughly $2.8 billion over ten years.

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."[7] Congress applied this designation to rural hospitals with 100 beds of fewer, 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

[5] Id.

[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.

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

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. In a more recent estimate of a modified permanent extension of the MDH program, CBO projected that the overall cost would be roughly $1.4 billion over ten years.

In addition to these two payment policies, there are at least three additional payment policies that will expire on March 31, 2014. Another seven Medicare extenders have already expired, but had previously provided similar support to rural hospitals – a loss that these providers continue to feel. 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.

RURAL HOSPITAL COALITION

Medicare Extenders

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 that have been addressed by Congress in the past.

- **Extension of improved payments for low-volume hospitals** - Applies a percentage add-on for each Medicare discharge from a hospital more than 15 road miles from another like-kind hospital[8] that has fewer than 1,600 Medicare discharges during the fiscal year. The estimated cost is approximately $200 million over ten years for a one year extension.
    - *Expires: March 31, 2014.*
- **Extension of Medicare Dependent Hospital Program** - Extends 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. A one year extension was previously scored by CBO as a 0.
    - *Expires: March 31, 2014.*
- **Extension of outpatient hold harmless provision** - Extends the outpatient hold harmless provision for those rural hospitals and Sole Community Hospitals ("SCHs") with 100 or fewer beds. The estimated cost is approximately $200 million over ten years for a one year extension.
    - *Expired: December 31, 2012 for rural hospitals and SCHs with no more than 100 beds. It expired March 1, 2013 for SCHs with more than 100 beds.*
- **Hospital wage index improvement** - Extends reclassifications under Section 508 of the Medicare Modernization Act (P.L 108-173). The estimated cost is approximately $300 million over ten years for a one year extension.
    - *Expired: March 31, 2012.*
- **Extension of payment for the technical component of certain physician pathology services** -- Allows independent laboratories to bill Medicare directly for certain clinical laboratory services. The estimated cost is approximately $100 million over ten years for a one year extension.
    - *Expired: June 30, 2012.*

[8] 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 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 for a one year extension.

    - *Expires: March 31, 2014.*

- **Extension of the work geographic index floor under the Medicare physician fee schedule** - Applies 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 for a one year extension.

    - *Expires: March 31, 2014.*

- **Extension of ambulance add-ons** - Implements a bonus payment for ground and air ambulance services in rural and other areas. The estimated cost is approximately $100 million over ten years for a one year extension.

    - *Expires: March 31, 2014.*

- **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 for a one-year extension.

    - *Expired: June 30, 2012.*

- **Extension of physician fee schedule mental health add-on** - Increased the 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 for a one year extension.

    - *Expired: February 29, 2012.*

- **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 was previously scored by CBO as a 0 for a one year extension.

    - *Expired: June 30, 2012.*

- **Extension of Community Health Integration Models** - Removed the cap on the number of eligible counties in a State. This provision was previously scored by CBO as a 0.

    - *Expired: September 30, 2012.*