American Hospital Association

PROTECTING THE HEALTH CARE SAFETY NET

Ensuring Fair & Adequate Coverage **Medicare**

AHA Small or Rural Hospital Advocacy Agenda

Issue Americans depend on hospitals to be there when they need them – to respond swiftly to emergencies, to welcome new life into the world, to help patients cope with acute and chronic illness, and to care for those who have no place left to turn – 24 hours a day, 365 days a year. But increasing financial pressures are severely challenging hospitals' ability to fulfill this expectation. In 2003, 59 percent of hospitals had *negative* Medicare margins – that is, the majority of hospitals were paid less than the cost of caring for Medicare patients. Medicare margins have dropped every year since 1998, and the Medicare Payment Advisory Commission (MedPAC) predicts continued troubles with an estimated overall Medicare margin of *negative* 1.5 percent in 2005.

Contributing to Medicare payment challenges is a host of significant pressures – largely beyond hospitals' control. A sustained workforce shortage and rising health care liability premiums continue to drive costs higher. In addition, access to capital is poor as the average age of hospital facilities and the demand for expensive new information systems climb.

AHA View Small Rural Hospitals. Rural hospitals provide essential health care services to nearly 54 million people, including 9 million Medicare beneficiaries. Yet because of their small size, modest assets and financial reserves, and higher percentage of Medicare patients, they face great pressures as government payments decline. Given that rural populations are typically older, rural hospitals are even more dependent on Medicare. Yet Medicare margins are the lowest for rural hospitals, with the smallest hospitals having the lowest margins.

The AHA continues to advocate for legislation that will address the needs of small rural hospitals. **We support creating a new payment classification for rural hospitals with 50 or fewer acute care beds.** This new payment system would provide Medicare inpatient and outpatient reimbursement at 101 percent of cost reimbursement. **It would also make enhancements to the CAH program to provide 101 percent of cost reimbursement for post-acute care services**, including skilled nursing facility, home health and ambulance services. We expect this legislation, introduced last year, to be reintroduced in the 109th Congress shortly.

For sole community hospitals, the AHA supports permanently extending the hold-harmless provision for outpatient payment, updating the cost year for purposes of determining the target amount, and establishing a minimum payment-to-cost ratio for outpatient services paid under PPS.

Critical Access Hospitals. The Critical Access Hospital (CAH) program is essential for maintaining adequate access to health care services in rural communities. However, the survival of these isolated health care facilities could be threatened without needed improvements to the CAH program. The AHA supports the following legislative solutions:

- **Critical Access to Clinical Lab Services Act** (S.236/H.R.1016), which would reinstate cost-based reimbursement to CAHs for lab services provided to patients who are not physically present in the hospital. Cosponsored by Sens. Ben Nelson (D-NE) and Susan Collins (R-ME), and Reps. Butch Otter (R-ID) and James Oberstar (D-MN).

- **Payment Under Medicare Advantage** (H.R. 880), which would ensure that CAHs are paid at least what they are paid today – 101 percent of costs for inpatient and outpatient services – by Medicare Advantage plans. Introduced by Reps. Ron Kind (D-WI) and Tom Osborne (R-NE).

- **Medicare Rural Home Health Payment Fairness Act** (S.300/H.R.11), which would amend the MMA to provide for a two-year extension of the temporary 5 percent Medicare payment increase for home health services furnished in rural areas. Introduced by Sen. Susan Collins (R-ME) and Rep. Greg Walden (R-OR).

The AHA also will work with lawmakers to introduce legislation that would allow CAHs to participate in the 340B drug discount program, whereby they could purchase pharmaceuticals at significantly reduced rates. On the regulatory front, we will push for CMS to change the State Operations Manual's interpretive guidelines, so that observation beds are not counted toward the total CAH bed count.

Outpatient PPS. As hospital care continues to shift to the outpatient setting, we must address problems created by the outpatient PPS. While the numerous coding and data problems associated with the outpatient system have improved somewhat, the fundamental problem still exists: Medicare pays only 87 cents for every dollar of outpatient care costs. The outpatient reform provisions of the MMA, which alter the payment methodology for outpatient drugs, will mean that payment rates will continue to fluctuate between the various ambulatory payment classifications – the category of payment for outpatient services – with an ongoing lack of predictability or stability for providers. Further, while the MMA provides some relief for small rural hospitals and rural sole community hospitals by extending the rural hold-harmless provisions through 2005, relief is needed for all hospitals. **The AHA supports legislation to create a pool of new resources to address the under-funding of outpatient hospital services and enhances payments for clinic and emergency room visits. In addition, we support making rural hold-harmless payments permanent to ensure that rural hospitals are financially sheltered from outpatient PPS losses.**