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# **Protect Low-Volume Hospitals and Rural Patients**

#### What is the Low-Volume Hospital Program?

The Low-Volume Hospital Adjuster was created by Congress to help rural hospitals who have a low number of Medicare patients offset the higher incremental costs of providing care for seniors. First proposed by the Medicare Payment Advisory Commission (MedPAC) in 2001, the adjustment operates on a sliding scale. (MedPAC is an independent Congressional agency established to advise Congress on issues affecting the Medicare program.) The adjuster assists hospitals with certain fixed costs and other operating costs that low-volume hospitals struggle to meet because of a lack of economies of scale. The current low volume calculation methodology is set to expire on October 1, 2012.

#### **History of the program adjustment:**

Following the creation of the Critical Access Hospital (CAH) designation, rural Americans access to health care was significantly improved. However, the CAH program did not assist many rural communities and many struggling rural facilities. Many PPS hospitals that did not qualify for the CAH system were still left in a precarious financial situation that threatened their viability and access to care in their communities. Congress enacted a version of the low volume adjustment to begin in 2005. However, because of the limited interpretation of the program by CMS, only 3 or 4 hospitals received any payments at all. Congress rectified this in 2009 by modifying the payment adjustment for fiscal years 2011 and 2012. Action is again needed to make sure that these vulnerable facilities are protected and access to care is guaranteed for beneficiaries in these communities.

#### How has this payment adjustment helped?

- Increase health care access to rural Americans who are typically older, poorer and sicker than their urban counterparts.
- Allow small hospitals the flexibility to reconfigure their operations and provide more services. Beneficiaries are then able to
- Stabilize economically fragile health care facilities' total margin, cash flow margins, and liquidity
- Encourage the development of rural health networks.

## Is this program successful?

Yes, the LVH adjuster has helped a number of rural facilities with low volumes provide additional services on a local level. The adjuster means that rural Medicare beneficiaries can stay in their own communities for vital services.

## **Economic benefits of rural hospitals**

Rural hospitals are one of the two biggest employers in rural areas – around 14 percent of total employment in rural communities is attributed to the health sector. In the past, a closed hospital has meant as much as a 20 percent loss of revenue in the local rural economy, a drop in the per capita income and an increase in local unemployment.

### What happens if the adjustment is not reauthorized?

If the current LVH adjustment is not reauthorized, the calculation will revert to its pre-2009 calculation. Under this calculation only hospitals with under 200 total discharges will receive any additional payments from CMS. Historically, this calculation has only applied to 3-4 hospitals, making the intent of both MedPAC and Congress completely void. The hospitals that have been getting this adjustment will be thrust back into the urban-centric PPS system and patient services will be put at risk.