



whether they should receive post-acute services are clinical decisions. Second, expanding the transfer provision undercuts the basic principles of inpatient PPS – a system based on averages and positive incentives to be efficient. The transfer provision unfairly penalizes hospitals for the efficient treatment of patients. It is especially unfair to rural hospitals, which have always had shorter patient lengths of stays. Finally, the provision reduces incentives to integrate care with other providers in the community, such as home health agencies, because the provision penalizes hospitals for doing so. **The AHA has worked to limit expansion of the transfer provision in the past and will continue to fight this misguided policy in the upcoming inpatient payment rule.**

Inpatient Rehabilitation 75% Rule. The 75% Rule is one of the criteria an inpatient rehabilitation facility must satisfy to be eligible for Medicare reimbursement. Under the rule, 75 percent of patients discharged during a cost report period must be treated for one of 13 conditions. The Centers for Medicare & Medicaid Services (CMS) changed the list of eligible conditions in July 2004 from 10 to 13 conditions, which fell far short of modernizing the 20-year old rule. Rather, the new “updated” rule restructured the qualifying conditions using arbitrary measures that are inconsistent with current medical practice and literature. The 75% Rule could significantly limit patient access to inpatient rehabilitative care, especially for patients with conditions that do not count toward the 75% Rule, such as cardiac and pulmonary conditions. Diminished access to inpatient rehabilitation care would also be particularly harmful for cancer and transplant patients.

Since the final rule was issued, the AHA identified implementation concerns and communicated problems to CMS, seeking resolution. We also continue to assess the impact of the new regulation on inpatient rehabilitation patients and providers on an ongoing basis, so we can quantify and describe to Congress and other policy makers the harm being caused by the 75% Rule. Next steps: awaiting the congressionally required report by the Government Accountability Office. The highly anticipated report will impact whether CMS issues a new rule. After analyzing the report, we will re-evaluate all strategies to improve the 75% Rule, so that it distinguishes inpatient rehabilitation units and hospitals from general acute care hospitals – the primary purpose of the 75% Rule – *and* allows access to comprehensive inpatient rehabilitation for clinically appropriate patients.

Psychiatric PPS. CMS began implementation of the new PPS for psychiatric hospitals and units on January 1. The PPS implements a per diem system with daily rates adjusted for DRG weights, co-morbidities, wage index, teaching status, rural location, patient age, outliers, emergency department, electroconvulsive therapy, and interrupted stays. As recommended by the AHA, CMS developed a stop-loss protection for hospitals that experience extreme losses. The stop loss applies to rural facilities with PPS payments that are less than 70 percent of their original cost-based payments.

While we are pleased that CMS made many of the changes the AHA called for, the new PPS still does not adequately account for differences in psychiatric facilities, patients or



treatments. **The fiscal impact on some psychiatric facilities will lead to diminished access to care or the elimination of psychiatric services in some communities. The AHA will continue to work with CMS to ensure the adequacy of payments to all psychiatric facilities.**

Teaching Hospitals. The Medicare Modernization Act of 2003 (MMA) acknowledges the special role of teaching hospitals by increasing reimbursement for these facilities. This support comes from raising the indirect medical education (IME) payment adjustment. This adjustment is vital to helping teaching hospitals fulfill their multiple missions of training future physicians, conducting valuable medical research and offering highly specialized services, such as burn and trauma care. The IME adjustment will decline steadily over FYs 2006 and 2007 and revert back to 5.5 percent in FY 2008. **Congress must strengthen Medicare’s commitment to teaching hospitals by ensuring that the IME adjustment is maintained at sufficient levels and is not reduced below 6.0 percent.**

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.



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-cost. **It would also make enhancements to the CAH program to provide cost-based 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 cost-based reimbursement for inpatient and outpatient services.

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.**