American Hospital Association

Update

Summer 2006

Small or Rural Hospitals

This issue of *Update* reviews the AHA's advocacy agenda for rural hospitals; the fiscal year (FY) 2007 federal budget and appropriations; rural regulatory policy issues including the proposed FY 2007 rule for the Medicare inpatient prospective payment system (PPS); a proposed Medicare discharge notice rule; and interpretive guidelines for Critical Access Hospital (CAH) relocation and replacement.

AHA Advocacy Agenda and Rural Legislative Priorities

The AHA is working on several legislative fronts to support program enhancements and operational improvements for small or rural PPS hospitals and CAHs.

The Rural Community Hospital Assistance Act (S. 933/H.R. 2350) would expand cost-based reimbursement to hospitals with between 25 and 51 beds eligible for Medicare inpatient and outpatient services, and provide cost-based reimbursement for CAH skilled nursing facilities, home health services and ambulance services. Sens. Sam Brownback (R-KS) and Ben Nelson (D-NE) and Reps. Jerry Moran (R-KS) and Rubén Hinojosa (D-TX) introduced the bill.

The Rural Hospital and Provider Equity Act (HoPE) (S. 3500) would create or increase Medicare payments to rural hospitals and make changes to guidelines for CAHs, sole community hospitals (SCHs), clinics, ambulances, nursing homes and home health care providers in rural areas. The bill would eliminate the 12 percent disproportionate share hospital (DSH) cap, reinstate the outpatient hold-harmless provision, create a low-volume adjustment, extend the 2 percent rural ambulance adjustment, provide loans to finance rural facilities' infrastructure improvements, extend physician recruitment bonuses, and much more. Sens. Craig Thomas (R-WY) and Kent Conrad (D-ND) introduced the bill.

The Medicare Rural Health Provider Payment Extension Act (H.R. 5118) is similar to HoPE and would amend the Medicare Modernization Act of 2003 (MMA) to extend certain Medicare payment methodologies for rural health care providers including:

- The outpatient hold-harmless provision for rural hospitals with fewer than100 beds and SCHs;
- Reasonable-cost payment for outpatient laboratory services performed by rural hospitals; and
- A 5 percent rural add-on for home health services.

The Rural Health Equity Act (H.R. 880) would ensure that Medicare Advantage (MA) plans pay CAHs at least 101 percent of costs for inpatient and outpatient services, regardless of whether the CAH has a contract with the patient's MA plan. Reps. Ron Kind (D-WI) and Tom Osborne (R-NE) introduced the bill.

The Rural Health Services Preservation Act (S. 2819) introduced by Sens. Norm Coleman (R-MN), Tom Harkin (D-IA) and Dick Durbin (D-IL), would ensure that CAHs and RCHs are paid no less by MA organizations than they would be by traditional Medicare. This payment floor would apply to both contracting and non-contracting providers and to CAH inpatient, outpatient and swing-bed services, as well as RHC services.

MA plans could negotiate rates with CAHs, but those rates would have to meet or exceed the payment floor.

This bill differs from the H.R. 880 in that it would allow two methods for determining minimum payment that equals this threshold:

1. Through a payment rate made up of 101 percent of a hospital's interim rate and a yearly cost reconciliation; or
2. A payment rate equal to 103 percent of the applicable, interim payment rate without reconciliation.

The AHA supports both the House and the Senate versions of this legislation and is pleased that the issue of adequate payment for CAHs continues to receive needed attention from members of Congress in both chambers.

The Sole Community Hospital Preservation Act (H.R. 2961) would make permanent the hold-harmless provision for outpatient payments to SCHs and improve inpatient payments to SCHs. Reps. Greg Walden (R-OR) and John Tanner (D-TN) introduced the bill.

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

The Pulmonary and Cardiac Rehabilitation Act (S. 1440/ H.R. 4824) would establish a statutory benefit category under Medicare for pulmonary and cardiac rehabilitation services. Sens. Mike Crapo (R-ID) and Blanche Lincoln (D-AR) and Reps. Charles Pickering (R-MS) and John Lewis (D-GA) introduced the bills.

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

The Rural Health Care Capital Access Act (H.R. 4912) would provide a five-year extension of the Federal Housing Administration's mortgage insurance program for CAHs under Section 242 of the National Housing Act, which insures the loans lenders make for the construction and renovation of hospitals. Rep. Robert Ney (R-OH) introduced the bill.

The Safety Net Inpatient Drug Affordability Act (S. 1840/H.R. 3547) would expand the 340b drug discount program, which provides safety net hospitals with the ability to purchase pharmaceuticals at significantly reduced rates, to include inpatient services and allow CAHs to participate. Currently, CAHs are unable to participate because they do not receive Medicare DSH payments. Sens. John Thune (R-SD) and Jeff Bingaman (D-NM) and Reps. JoAnn Emerson (R-MO) and Bobby Rush (D-IL) introduced the legislation.

The Comprehensive Immigration Reform Act (S. 2611) includes several provisions to address caregiver shortages. The bill would extend permanently the State 30/J-1 visa program, which was set to expire June 1. In addition, the bill would allow more qualified, internationally trained nurses to work in the United States. Under current law, 140,000 employment-based visas are available each year for skilled professionals, subject to per-country caps. The bill would exempt nurses and physical therapists from the caps through 2017.

This legislation is similar to the "Physicians for Underserved Act," companion bills that were introduced in the House (H.R. 4997) and Senate (S. 2425). It will be an uphill struggle for lawmakers to reconcile the differences between the House- and Senate-passed immigration bills and adopt a final bill this year. Because of that uncertainty, the AHA is advocating for Congress to move separately to reauthorize the J-1 visa waiver program as soon as possible.

The Health Information Technology Promotion Act (H.R. 4157) was approved by the House Ways and Means Subcommittee on Health. This legislation is intended to accelerate the use of health information technology and

would establish national standards on privacy and implementation of electronic health records. The bill also would clarify that current medical privacy laws apply to data stored or transmitted electronically, and would require the Secretary of Health and Human Services to recommend to Congress a privacy standard to reconcile differences in federal and state laws. It would offer anti-kick back and physician self-referral exemptions for hospitals that share hardware, software or information training and support services to physicians primarily to exchange health information electronically, and require HHS to modernize the coding system by adopting the ICD-10 system by October 1, 2009. The bill would codify the Office of the National Coordinator for Health Information Technology in law and delineate its roles and responsibilities. The AHA supports most of the provisions of the legislation, but believes additional funding is necessary to fully realize its benefits.

FY 2007 Rural Health Appropriations

A number of important rural programs are included in this funding measure. The House Appropriation Subcommittee on Labor, HHS, and Education passed its version of an FY 2007 appropriations bill on June 13 and the Senate subcommittee passed its on July 19. The table below compares funding levels between the President's proposal and the House and Senate committee-approved levels.

Comparison of Recommended Funding Levels for Selected Appropriations Programs FY 2007
July 18, 2006
(in millions of dollars)

Program	President Proposal	House Committee Level	Senate Committee Level
NHSC	125.5	131.5	125.5
Nurse Education/Retention	37.3	37.3	37.3
Nurse Loan Repay & Scholarship	31.1	31.1	31.1
Rural Health Outreach Grants	10.4	40.0	38.9
Rural Health Research	8.7	9.0	8.7
Rural Hospital FLEX Grants	0	40.0	38.5
State Offices of Rural Health	8.1	8.4	8.1
Rural AED	0	1.5	1.5
Rural Telehealth	6.8	10.0	6.8
Denali Commission	0	0	39.3

Medicare Inpatient PPS Proposed Rule for FY 2007

On April 12, CMS released the proposed rule implementing FY 2007 changes to the Medicare hospital inpatient prospective payment system (PPS). The proposed rule contains the most significant changes to the PPS since its inception, with hospitals standing to potentially gain or lose. However, questions remain about the concepts and methodology used to create the changes and whether the changes will create a better payment system. The AHA submitted its comments on June 12. Specifically, the AHA supports the following:

One-year Delay: The AHA supports a one-year delay in the proposed diagnosis-related group (DRG) changes given the serious concerns with the HSRVcc methodology and the lack of information on the CS-DRG methodology. The AHA and the hospital field are committed to working with CMS over the next year to address these concerns.

Valid Cost-based Weights: We support moving to a DRG-weighting methodology based on hospital costs rather than charges, but CMS' proposed HSRVcc method is flawed.

A New Classification System Only if the Need Can Be Demonstrated: The AHA does not support a new classification system at this time, as the need for a new system is still unclear. Much more work is still needed to understand the variation within DRGs, and the best classification system to address that variation, before CS-DRGs or any other system should be selected or advanced.

Simultaneous Adoption of Any Changes to Weights and Classifications: If the need for a new, more effective classification system is demonstrated, the system should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by the two, generally offsetting, changes.

Three-year Transition: Any changes should be implemented with a three-year transition period,

given the magnitude of payment redistribution across DRGs and hospitals.

Collaborative Approach to Moving Forward: The AHA commits to working with CMS to develop and evaluate alternatives for new weights and classifications. The AHA's comment letter is available at www.aha.org under "What's New."

Occupational Mix: CMS initially stated in the proposed rule that it would again limit the occupational mix adjustment to 10 percent because of concerns regarding the validity of the data and the potential financial impact on hospitals. However, as a result of the decision handed down by the U.S. Court of Appeals for the Second Circuit on April 3 in *Bellevue Hospital Center v. Leavitt*, CMS on May 12 released a proposed rule revising the occupational mix adjustment portion of the FY 2007 inpatient PPS proposed rule. As a result of the court ruling, CMS must collect new data on the occupational mix of hospital employees and fully adjust the area wage index for FY 2007. This means that the final wage index tables will not be ready in time for the August 1 final inpatient PPS rule and hospitals will not be able to fully asses the impact of the rule on their facilities. However, the AHA has posted estimates of the FY 2007 wage indexes on the AHA members' website at: http://www.aha.org/aha/key_issues/ipps/ipps_occmixresources.html.

CAHs in Lugar Counties: In its FY 2005 final rule, CMS interpreted a statutory provision modifying the status of rural counties with certain commuting patterns to metropolitan areas as applying to CAHs located in these counties and allowed these facilities a grace period to seek reclassification as rural in order to retain their CAH status. While accommodating CAHs in this manner, the agency also took the position that any CAH being reclassified would no longer be eligible for pass-through payments for the service of certified registered nurse anesthetists.

This position is at odds with the agency's view that *it is geographic reclassification that renders a CAH ineligible for such payments* – since, under CMS' revised policy, a CAH located in such a county need not seek geographic reclassification to be a CAH. Apparently, it is CMS' view that these CAHs can never qualify for CRNA pass-through payments, whether they have sought reclassification (under the old policy) or not (under the new policy). **We believe that all CAHs located in a newly designated Lugar county should receive pass-through payments, regardless of whether they sought reclassification, and we urged CMS to revise its regulations accordingly.**

SCH/MDH Changes in Qualification Status: The proposed rule would require an approved SCH or Medicare dependent hospital (MDH) to notify the appropriate CMS Regional Office of any change affecting its classification as such. **The AHA recommended that this function remain a responsibility of the FIs, who are in a better position to monitor these circumstances**

In addition, an MDH or SCH may apply for special payments if due to circumstances beyond its control, it experiences a decrease of five or more percent in its total number of inpatient discharges from one cost reporting period to another. If the hospital qualifies, it must demonstrate that it took measures to scale back its nursing force commensurately. The adjustment is intended to cover the fixed costs that the hospital is unable to reduce in the year following the volume decrease. CMS proposes using the occupational mix adjustment data currently being collected for wage index purposes to calculate nursing hours per inpatient day for a hospital in question and local peer hospitals.

The occupational mix adjustment was only partially implemented in its first three years, primarily due to the questionable data and results. The current collection, which is occurring again under rushed circumstances, may also result in questionable data. **We do not believe that it is wise to assume that the occupational mix adjustment data will be appropriate for this use. The AHA believes that the data within the AHA Annual Survey should be sufficient for CMS to determine the nursing levels per patient day.**

MDH Implementation: The rule would also implement a provision in the DRA championed by the AHA that not only reauthorized the MDH program, but also added FY 2002 as an allowable base year. In addition, MDHs will be paid 75 percent of the difference between the PPS payments and the hospital-specific rate, rather than 50 percent. Furthermore, MDH's will no longer be subject to the 12 percent DSH cap.

Changes in Quality Data Collection Dates: AHA urged a that quality data on all 21 quality measures identified in the regulation be required for patients discharged on or after July 1, 2006, not January 1 2006 as stated in the proposed rule. The measures at the same as those currently being requested as part of the voluntary Hospital Quality Alliance work, but AHA noted it was unfair to expect hospitals to be able to go back to January 1, abstract all of the needed data for any measures they are not currently collecting data on, and submit it by August 15th, as they would have to do to comply with the regulation as proposed. Hospitals that do not submit the required measures will experience a 2% reduction in Medicare payment.

CAH Relocation and Replacement

On November 14, 2005, CMS issued interpretive guidelines on the relocation of CAHs as a follow-up to the FY 2006 inpatient PPS final rule, which established the "75% test" – serving 75 percent of the same population, providing 75 percent of the same services and employing 75 percent of the same staff – for necessary-provider CAHs. The guidelines not only extended the 75% test to *all* CAHs, but also altered the definitions of "mountainous terrain" and "secondary road."

These guidelines go well beyond the regulations included in the FY 2006 rule that provoked numerous critical responses from individual CAHs, associations and federally elected officials. The "mountainous terrain" and "secondary road" definitions are overly prescriptive and the "75% test" does not provide reasonable flexibility based on natural variation in demographics, patient needs distribution patterns, normal employee and board attrition and necessary changes in services to meet community needs. **Rural hospitals that move a few miles are clearly the same providers serving the same communities.**

Many CAHs are planning to rebuild in the near future to improve site safety and quality of care by adding fire and smoke barriers, upgrading infrastructure to support utilities and air handling, modernizing telecommunications to support health information technology or making other essential upgrades.

CMS' guidelines not only will impose an unnecessary burden on CAHs, but also will preclude many of them from securing financing for needed capital improvements. The hospitals themselves, their hospital districts and their lenders cannot risk investing in a hospital that will be unsure of its status until a year after moving. **We recommended that CMS should create a preliminary approval process to give assurances to those involved in the project that the CAH relocation will be approved if it meets the assertions made in the attestation submitted to CMS.**

This year, almost 60 members of Congress signed a letter to CMS showing their support for their CAHs and urging changes to these guidelines. We agree and reiterate our suggestion from last year that a safe harbor be established for hospitals relocating within five miles of their existing locations. A safe harbor will reduce the administrative burden on not only the hospitals, but CMS and the state survey agencies as well. **We continue to urge CMS to create a safe harbor for CAHs moving a short distance and to make significant changes to these guidelines.**

For more information, contact John T. Supplitt, senior director, AHA Section for Small or Rural Hospitals, at (312) 422-3306 or jsupplitt@aha.org.

Hospital Discharge Notices

CMS has issued a proposed rule that, if finalized, would replace the current two-step process for Medicare discharge notices followed by post-acute providers with a three-step process. Under the change, hospitals would be required to deliver to beneficiaries the following:

- An Important Message from Medicare (IMM) at admission;
- A notice of planned discharge to every patient at least one day prior to discharge; and
- A detailed explanation of a discharge notice in the event of a challenge to a planned discharge.

The AHA submitted comments on the proposed rule on June 5. The AHA believes that this proposal is based on a basic misunderstanding of how patient care decisions are made in a hospital setting, how the discharge planning process works and the real impact – both financial and operational – that the proposal would have on hospitals. Also, no compelling case for the need for this change has been made. Therefore, the AHA does not believe CMS should proceed with these changes without a more thorough and realistic examination of the process. The AHA is specifically concerned about the following:

- The proposed discharge notice process is unnecessarily burdensome because it is out of sync with standard discharge planning and physician discharge order patterns;
- The alarmist language of the proposed generic discharge notice could cause beneficiaries to doubt whether the planned discharge is appropriate. Consequently, it likely will stimulate an increase in the number of unwarranted appeals and delayed discharges at the expense of the hospital and other patients awaiting admission; and
- The hardcopy signature and recordkeeping requirements are counter to hospitals' movement to electronic medical records and federal efforts that encourage an even faster conversion.

The AHA recommended that CMS withdraw the proposal and retain the current requirements.

Health Information Technology: A Rural Provider's Roadmap to Quality

On September 21-23, 2006 the Health Resources Services Administration's Office of Rural Health Policy will hold a national meeting in Missouri at the Kansas City Marriott Downtown focused on rural health information technology (HIT).

In an effort to explore the benefits of HIT adoption and its link to quality improvement, this conference will provide an opportunity for rural providers to:

- Learn about the basic components of HIT
- Focus on the initial steps of strategic planning for HIT investments
- Understand how to find appropriate technology to meet individual quality aims
- Share best practices and lessons learned about HIT implementation.

This conference is specifically designed for the rural provider who is considering making an HIT investment to meet quality aims, but is not sure where to start.

The meeting seeks to attract rural health care providers, including:

- Small and Solo Physician Practices
- CAHs and Small Rural Hospitals
- Rural Health Clinics and FQHCs

For registration information contact Caroline Cochran, ORHP, (301) 443-0835.

Visit the AHA Section for Small or Rural Hospital Web Site at http://www.aha.org /aha/key_issues/rural/index.html