American Hospital Association

Update

Winter 2007

Small or Rural Hospitals

As 2007 comes to a close, this issue of ***Update*** reviews the progress made by the American Hospital Association (AHA), together with our members, on advocating for small or rural hospitals. In addition, it provides information on the status of fiscal year (FY) 2008 appropriations, the Shirley Ann Munroe Leadership Award, and funding for rural telehealth programs.

AHA's Advocacy Agenda for Small or Rural Hospitals

During the first session of the 110th Congress, the AHA supported a number of legislative proposals that would preserve rural access to care. These bills include:

The Health Care Access and Rural Equity Act (H-CARE) would extend through 2011 existing rural health provisions of the *Medicare Modernization* (MMA) and *Deficit Reduction Acts* (DRA). Introduced by Reps. Earl Pomeroy (D-ND) and Greg Walden (R-OR), H.R.2860 would extend the outpatient hold-harmless provision for rural hospitals with fewer than 100 beds and include sole community hospitals (SCHs), extend the 2% add-on for ambulance trips in rural areas, and extend the 5% add-on for rural home health services. It also would extend Section 508 of the MMA to allow certain Medicare wage index reclassifications to proceed in a non-budget neutral way. Critical access hospitals (CAHs) would gain flexibility to respond to daily and seasonal fluctuations in patient load and receive cost-based reimbursement for outpatient lab services. The bill also would remove the cap on disproportionate-share (DSH) adjustment percentages for all hospitals, rebase sole community hospital payments, provide grants for health information technology, and expand the 340B drug discount program.

The Craig Thomas Rural Hospital and Provider Equity Act (R-HoPE) would extend the outpatient hold-harmless provision for rural hospitals under 100 beds and SCHs, continue the grandfather clause allowing direct payments to independent laboratories for the technical component of pathology services, and extend the 5% rural add-on payment for home health services. In addition, S. 1605 would provide cost-based reimbursement for CAHs' outpatient lab services regardless of where the patient is physically located, remove the cap on DSH adjustment percentages for all hospitals and improve payments for ambulance services in rural areas. The bill was introduced by Sens. Kent Conrad (D-ND) and Pat Roberts (R-KS).

The Children's Health and Medicare Protection Act (CHAMP) includes almost $4 billion in rural provisions. Specifically, H.R. 3162 would provide two-year extensions for the following: a 5% home health add-on for services provided in rural areas; a 2% increase for rural ground ambulance services; current outpatient prospective payment hold-harmless provision for hospitals with fewer than 100 beds; section 508 wage index reclassifications; cost-based payments for outpatient lab services for rural hospitals under 50 beds in low population areas; a physician scarcity bonus, and a provision that allows independent laboratories to bill Medicare directly for the technical component of pathology services they provide to hospitals. The bill also includes a provision to increase the DSH cap to 16% for hospitals for two years.

In addition, other legislation introduced in Congress this year included provisions for permanent reauthorization of the outpatient hold harmless for SCHs and the use of a more current base year for the hospital specific rate. Also, there were provisions specific to CAHs addressing bed-size flexibility, cost-based reimbursement for

clinical lab and ambulance services, 340B discounts for inpatient and outpatient drugs, and payment at 101% of cost for inpatient, swing-bed and outpatient hospital services by Medicare Advantage plans.

Spurred by considerable national grassroots advocacy, Congress unanimously approved legislation preventing CMS from fully implementing more than $20 billion in prospective payment cuts to hospital inpatient Medicare services over the next five years. The cuts are part of the controversial "behavioral offset" contained in the inpatient prospective payment system (PPS) final rule for FY 2008, which took effect October 1. The legislation reduces CMS's recommended cuts in 2008 and 2009 by half, resulting in a restoration of $2.5 billion in payments over the next two years and $7 billion over the next five years. However, the 2010 rate cut of 1.8% remains. The bill also directs the Secretary of HHS to adjust for hospital underpayments or overpayments if prospective cuts do not accurately account for real changes in case mix once the new Medicare-severity DRG system is fully implemented by 2010. The bill was signed by President Bush on September 29 as Public Law 110-090.

Regulatory Priorities

There were strong wins on the regulatory front for CAHs and PPS hospitals. The AHA continued its dialogue with CMS on interpretive guidelines and relocation for CAHs. We also submitted comments on the Medicare proposed and final rules for inpatient and outpatient PPS, and ambulatory surgical centers (ASCs).

CAH Interpretive Guidelines

CMS' 2005 interpretive guidelines severely limited CAHs' ability to rebuild and relocate while maintaining their cost-based payment status. To change the guidelines, the AHA undertook an extensive advocacy campaign, including a survey of the field, congressional letters and meetings with CMS officials. On September 7, CMS released revised CAH interpretive guidelines that reflect many of the policy changes recommended by the AHA and CAH leaders. Effective immediately, the revised guidelines:

- No longer require CAHs without "necessary provider" designation to pass the "75% test" upon relocation
- Provide examples of acceptable documentation and allow alternative documentation to be used to demonstrate compliance with the 75% test
- Require CMS regional offices to review letters of attestation and issue preliminary determinations, but final approval will not be granted until six months to a year after rebuilding or relocating
- Require a lower threshold of evidence for hospitals rebuilding on their existing campuses
- Relax the definitions of "mountainous terrain" and "secondary roads" for the purposes of determining whether a facility is exempt from the mileage requirement

While "necessary provider" CAHs still must meet the 75% test, CMS' revised interpretive guidelines provide greater flexibility for these hospitals.

- For service area test, CAHs may present information on its service area based on a zip code analysis of the populations served in the old and new locations. CAHs may even lessen documentation where circumstances of relocation are simple (re-building onsite, in the parking lot, or next door) or even use a different methodology if agreed upon by CMS for reasonableness.
- For staff test, CMS has aggregated staff and made allowances for natural attrition and historical patterns.
- For services test, rather than be measured by the volume of services or billing codes, CMS requires a CAH to demonstrate that it provides 75% of the same lines of service and that these services are generally available under the same terms or at the same hours.

The new guidelines will significantly ease the process of rebuilding and relocating for CAHs. And, CMS' revisions to the definitions of mountainous terrain and secondary roads add flexibility for CAH "necessary providers." The AHA is pleased that CMS adopted many of our recommended changes; however, we remain concerned that CMS did not adopt them all.

Medicare Inpatient PPS for FY 2008

CMS' final rule for FY 2008 hospital inpatient PPS took effect October 1, and included the following major changes:

- A 3.3 percent market-basket update for eligible hospitals that submit data on 27 quality measures and 1.3 percent update for those hospitals that do not
- The creation of 745 new Medicare-severity diagnosis-related groups (MS-DRGs) to

replace the current 538 DRGs, implemented over two years
- A "behavioral" offset to eliminate what CMS claims will be changes in coding practices as a result of the MS-DRGs. CMS had called for a cut of 1.2% in FY 2008; 1.8% in 2009 and 1.8% in 2010. However, P.L. 110-090 reduces the cuts in 2008 and 2009 by half, from 1.2% to 0.6% and from 1.8% to 0.9% respectively, but leaves the 2010 cut of 1.8% intact. The behavioral offset is not applicable to hospital-specific rates for sole community hospitals and Medicare dependent hospitals.
- Changes for payment adjustments to low-volume rural hospitals, alternative criteria for rural referral center designation, and the rural community hospital demonstration program

Hospital-acquired conditions: The final rule adopts eight conditions for which CMS will not provide higher payments in FY 2009 if the selected event occurs while a patient is under the care of the hospital. The change will take effect with Medicare patients discharged on or after October 1, 2008.

Recognizing that some of these complications could have occurred prior to admission, the DRA requires hospitals to submit the secondary diagnoses that are present on admission (POA) when reporting payment information for discharges on or after October 1. If the complication is POA, it could be used to assign the patient to the higher-paying DRG. Due to complications implementing this change, CMS delayed the POA coding requirement until January 1, 2008.

Patient safety: The final rule also called for a written disclosure to patients of how emergencies are handled when the hospital does not have a physician available on the premises 24 hours a day, seven days a week. CMS does not plan to prescribe specific language for the notice, but the notice must specifically state that the hospital does not have physicians on the premises 24/7 and describe how the hospital will meet any emergency needs when a doctor is not on the premises.

Hospitals may take this opportunity to share their referral arrangements and, if transfer is required, describe how they are connected to a larger network of providers. CAHs and other small hospitals may use this as an opportunity to talk about how they maintain a local source of emergency care and act as a structured entry into the larger delivery system. It also is a chance to build support for and describe how the hospital works with local EMS and regional trauma networks.

Medicare Outpatient PPS for CY 2008

On November 1, CMS released the outpatient PPS/ASC final rule for calendar year (CY) 2008 that also included several changes to the inpatient PPS. The rule takes effect January 1, 2008. Highlights of the rule are:

- Provides a 3.3% market basket update for outpatient PPS services
- Requires hospitals to begin reporting on seven hospital outpatient quality measures in April 2008 in order to receive the full payment update in 2009
- Incorporates into the final rule CMS' proposal to package into the primary procedure the costs of seven additional categories of items and services that it considers to be ancillary and supportive, including the packaging of observation services

CMS finalized two changes to the Medicare requirements for CAHs that participate under a grandfathered "necessary provider" CAH designation. First, CMS will no longer permit a necessary provider CAH to enter into co-location arrangements with hospitals unless such arrangements were in effect on or before January 1, 2008 and the type and scope of services offered by the facility co-located with the necessary provider CAH do not change. Second, CMS clarified that if a CAH operates a provider-based facility that was created after January 1, 2008, it must comply with the CAH distance requirement of a 35-mile drive to the nearest hospital (or 15 miles in the case of mountainous terrain or secondary roads). Rural health clinics are excluded from this requirement.

In addition, CMS finalized its proposal to require hospitals to complete and document Medicare patients' medical histories and physicals conducted after admission and prior to a procedure requiring anesthesia services. Post-anesthesia evaluations of patients before release from the recovery area also are required.

ASC Changes

CMS set new Medicare coverage and payment policy for 2008 by linking ASCs to the outpatient PPS. In the ASC final rule, CMS broadly expanded the services that can be provided in an ASC for Medicare payment. The AHA's August 23 and November 28 *Regulatory Advisories*, available at www.aha.org, have additional details on ASC changes.

FY 2008 Rural Health Appropriations

The table below compares FY 2007 spending levels for select rural health programs with the president's proposal and the House and Senate Conference Committee's agreement. On November 13, President Bush vetoed legislation funding federal Labor, Health and Human Services and Education programs for fiscal year 2008. However, a continuing resolution funds federal programs at fiscal year 2007 levels through December 21.

RECOMMENDED FUNDING LEVELS FOR APPROPRIATIONS SELECTED RURAL PROGRAMS FY 2008 (in millions of dollars)

Program	FY 2007 Funding	Pres. Request FY 2008	Conference Committee FY 2008
Rural Outreach/Network Grants	38.9	0.0	52.96
Rural Health Research/Policy	8.7	8.7	9.5
State Offices of Rural Health	8.1	8.1	9.0
Rural Hospital Flexibility Grants	63.5	0.0	38.54
Rural & Community AED	1.4	0.0	2.5
Telehealth	6.8	6.8	7.0
Denali Commission	39.3	0	39.3
Community Health Centers	1,988	1,988	2,213
National Health Service Corps	125.5	116	131.5
Delta Health Initiative	0	0	25.0

Munroe Leadership Award

Russell W. Johnson, CEO, San Luis Valley Regional Medical Center in Alamosa, CO, is the 2007 winner of the AHA's Shirley Ann Munroe Leadership Award. The award, sponsored by the AHA's Section for Small or Rural Hospitals and HRET, recognizes the accomplishments of small or rural hospital leaders who have improved health care delivery in their communities through innovative efforts.

Johnson has served as CEO of San Luis Valley Regional Medical Center (SLVRMC) for six years and has 22 years of health care management experience. The medical center is the only full-service community hospital serving the 47,000 people living in 8,000 square miles of rural, southern Colorado.

This year the Shirley Ann Munroe Leadership Award also recognized three finalists for their significant achievements in service to their community:

- Kirk A. Dignum, Ph.D., president and CEO, Mercy Regional Medical Center, Durango, CO
- Louis D. Kraml, CEO, Bingham Memorial Hospital, Blackfoot, ID
- Mark J. Woodring, CEO, Myrtue Medical Center, Harlan, IA

FCC Announces $417 Million Rural Telehealth Program

To significantly increase access to acute, primary and preventive health care in rural America, the Federal Communications Commission recently dedicated more than $417 million for the construction of 69 statewide or regional broadband telehealth networks in 42 states and three U.S. territories under the Rural Health Care Pilot Program (RHCPP).

The pilot program will pay up to 85% of the costs incurred to deploy a state or regional dedicated broadband health care network, including:

- Initial network design studies;
- Transmission facilities;
- Recurring and non-recurring costs of advanced telecommunications and information services, such as connection to the public Internet; and
- If requested, costs of connecting the regional or state networks to Internet2 or National LambdaRail, which are both dedicated nationwide backbones.

The remaining costs of 15% or more are funded by the applicants based on the amount of the funding awarded to them under the pilot program. Medical services and technologies themselves are not covered by the program.

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