American Hospital Association

Ensuring Adequate Resources for Patients and Communities

Medicare Small or Rural Hospitals

Issue

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.

AHA View

National payment policies, whether for prospective payment or cost-based systems, often fail to recognize the special characteristics and unique circumstances of small rural hospitals. Many rural hospitals are too large to qualify for CAH status but too small to absorb the financial risk associated with PPS programs. CAHs struggle to provide essential services to their rural communities because of low volumes. **As a result, the AHA advocates for the following legislation, which was introduced in Congress earlier this year:**

- ***The Craig Thomas Rural Hospital and Provider Equity Act*** (R-HoPE) (S.1605) and ***The Health Care Access and Rural Equity Act*** (H-CARE) (H.R.2860) – Would extend the outpatient hold-harmless provision for rural hospitals under 100 beds and sole community hospitals, 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, the bill would provide cost-based reimbursement for critical access hospitals' outpatient lab services regardless of where the patient is physically located, remove the cap on disproportionate share adjustment percentages for all hospitals and improve payments for ambulance services in rural areas. Introduced by Sens. Kent Conrad (D-ND) and Pat Roberts (R-KS) and Reps. Earl Pomeroy (D-ND) and Greg Walden (R-OR).

- ***The Critical Access Hospital Flexibility Act*** (S.1595) – The bill allow CAHs to meet either the current census limit of 25 beds per day, or a limit of 20 beds per day averaged over a cost reporting period. The bill was introduced by Sens. Gordon Smith (R-OR) and Ron Wyden (D-OR).

- ***The Sole Community Hospital Preservation Act*** (H.R. 1177) – Introduced by Reps. Tanner (D-TN) and Graves (R-MO), this bill would extend permanently the outpatient PPS hold harmless and permit the use of a more current year to re-establish the hospital target amount.

- ***The 340B Program Improvement and Integrity Act*** – (H.R.2606) Introduced by Reps. Bobby Rush (D-IL), Bart Stupak (D-MI) and Jo Ann Emerson (R-MO) would allow critical access hospitals, sole community hospitals, rural referral centers, Medicare-dependent hospitals to access 340B discounts for inpatient and outpatient drugs. The bill would also extend the discount to inpatient drugs for current eligible 340B hospitals.

- ***Payment of CRNA services in CAHs*** – (H.R. 3066) Introduced by Reps. Hare (D-IL) and Johnson (R-IL) the bill would permit pass-through payment for reasonable costs of certified registered nurse anesthetist services in critical access hospitals notwithstanding the reclassification of such hospitals as urban hospitals, including hospitals located in `Lugar counties', and for on-call and standby costs for such services.

- ***The Nursing Education and Quality of Health Care*** **Act** (S.1604) The bill would provide grants and programs to help train, recruit and retain nurses in rural areas. It also would create demonstration projects that integrate patient safety practices into nursing education programs. The bill was introduced by Sens. Rodham Clinton (D-NY) and Smith (R-OR)

- ***The Physician Pathology Services Continuity Act*** (S.458/H.R.1105) – This bill, introduced by Sens. Lincoln (D-AR) and Thomas (R-WY) and Reps. Tanner (D-TN) and Hulshof (R-MO), would permanently extend the grandfather clause to allow Medicare to continue to make direct payments to independent laboratories for the technical component of pathology services.

- ***Rural Health Services Preservation Act*** (S.630/H.R.2159) – This bill has been introduced by Sens. Coleman (R-MN), Harkin (D-IA) and Durbin (D-IL) and Reps. Kind and McMorris-Rodgers. It would require MA plans to pay CAH and RHC services, at minimum, what they otherwise would have been paid under Medicare (101% of allowable costs) with cost reconciliation, or 103% of interim rates without reconciliation (in or out of network).

- ***Critical Access To Clinical Lab Services Act*** (S. 1277) – Introduced by Sens. Nelson (D-NE) and Collins (R-ME) this bill would work to restore cost-based reimbursement of referral lab services.

Other Legislative Priorities. The AHA also will work to extend expiring legislative provisions, including a home health 5 percent rural add-on, cost-based payment for rural laboratory services provided by hospitals with less than 50 beds and ambulance mileage bonuses for transport of rural patients in low-population density areas. In addition, the AHA will work to expand existing cost-based payment to home health and skilled nursing facility settings for

CAHs and to rural hospitals with 25-50 beds for inpatient and outpatient services; and to allow flexibility for CAH relocation.

Inpatient PPS. The Centers for Medicare & Medicaid Services' (CMS) proposed inpatient prospective payment system (PPS) rule for FY 2008 would impose drastic cuts on Medicare payments to hospitals. In particular, the agency proposes a 2.4 percent cut to all hospitals in 2008 and 2009 in anticipation of coding changes CMS says hospitals might make under a new severity diagnosis-related group (DRG) system. CMS would create 745 new Medicare-Severity DRGs to replace the current 538 DRGs, and would overhaul the complication or comorbidity list. The reclassification would create up to three tiers of payment for each diagnosis. The rule also proposes eliminating the capital update for urban hospitals and the large urban add-on to capital payments. CMS also is considering discontinuing the teaching and disproportionate share hospital adjustments to capital payments. The rule includes a market basket update of 3.3 percent for those hospitals that submit data on 27 quality measures; hospitals not submitting data would receive a 1.3 percent update.

The AHA is analyzing the rule to understand its full impact; however, we oppose the 2.4 percent "behavioral offset" and cuts to capital payments, which will cut payments to hospitals by over $25 billion over the next five years. The AHA will work with the hospital field to develop our position and best response to the regulation.

CMS' Interpretative Guidelines on CAHs. CMS State Operations Manual's Interpretive Guidelines have limited CAHs' ability to relocate and build a replacement facility and maintain its critical access status. Specifically, the guidelines alter the definitions of mountainous terrain and secondary roads, and require review after one year as to whether the relocated hospital continues to serve 75 percent of the same population, provide 75 percent of the same services and employ 75 percent of the same staff. Necessary providers that fail the 75 percent test would lose their CAH status and be forced to convert back to the inpatient PPS, hurting these facilities' ability to continue providing care in their communities. **The AHA will continue to urge CMS to restate the definitions and adopt a five-mile safe harbor for relocating CAHs before applying the 75 percent test.**

Medicare wage index. *The Tax Relief and Health Care Act of 2006* requires MedPAC to recommend possible alternatives to the Medicare area wage index by June 30. CMS must consider these recommendations in its FY 2009 hospital inpatient PPS proposed rule. To consider possible reform of the area wage index, the AHA has convened a workgroup of national, state, regional and metropolitan hospital association executives. We agree that the area wage index is not functioning well and requires change. In particular, the current system is volatile – neighboring counties can have very different indices, and a hospital's wage index can drop even when the hospital increases wages substantially.

The AHA and its workgroup will continue to work with MedPAC and CMS throughout the next two years to develop potential changes that will address some of the existing area wage index's shortcomings.