American Hospital Association

CAH Update

Summer 2008

Small or Rural Hospitals

CAH Update provides critical access hospitals (CAHs) with information on legislative and regulatory proposals and activities that affect access to care, payment and quality. This issue includes reports on key CAH legislative proposals, the fiscal year (FY) 2009 inpatient proposed rule, CAH interpretive guidelines, TRICARE payments and quality reporting.

Legislative Advocacy

FY 2009 RURAL HEALTH APPROPRIATIONS

On June 26, the Senate Appropriations Committee passed its FY 2009 appropriations bill. Their proposal would provide $39.2 million for the Rural Hospital FLEX grant program. Funding for the program in FY 2008 was $37.9 million. The Administration's FY 2009 budget request did not include funds for this program.

Under the FLEX grant program, the Health Resources and Services Administration (HRSA) works with the states to provide support and technical assistance to help CAHs focus on quality and performance improvement and integrate emergency medical services. $15 million of the amount provided is earmarked to continue the Small Rural Hospital Improvement Grant Program, which supports small rural hospitals focus on quality improvement and adoption of health information technology.

A House appropriations bill is pending.

MEDICARE IMPROVEMENTS BILL PASSED

On July 15 the House and Senate overrode a veto of President Bush to the *Medicare Improvements to the Patients and Providers Act of 2008* (H.R. 6331), legislation that blocks a physician payment cut and provides $1.1 billion in funding for rural hospitals. The bill freezes physician payments for 2008 and provides a 1.1% increase for physicians in 2009. The legislation also extends the Medicare Rural Hospital Flexibility grant program; provides rebasing for sole community hospitals (SCHs); extends and expands the outpatient hold-harmless provision for small rural and SCHs; and extends Section 508 reclassification.

Among other things the bill:

- Extends the FLEX program through September 30, 2010 and expands the program to provide grants to increase access to mental health services for veterans in crisis and residents of rural areas. Also, provides assistance for small rural hospitals transitioning to nursing home status.
- Allows CAHs serving rural areas to receive 101% of reasonable costs for clinical lab services provided to Medicare beneficiaries regardless of whether the lab specimen was taken in the hospital or off-site at another facility operated by the CAH.
- Adds hospital/CAH-based renal dialysis facilities, skilled nursing facilities, and community mental health centers to the list of sites where Medicare beneficiaries can receive telehealth services.

- Revokes the unique authority of the Joint Commission (JC) to deem hospitals in compliance with the Medicare Conditions of Participation. This shall not affect the accreditation of a hospital by the JC, or under accreditation or comparable approval standards found to be essentially equivalent to accreditation or approval standards of the Joint Commission, for the period of time applicable under accreditation.

KEY LEGISLATIVE PROPOSALS

The AHA's rural health advocacy agenda also includes legislation aimed at supporting CAHs including:

- *The Craig Thomas Rural Hospital and Provider Equity Act* (S. 1605) and *The Health Care Access and Rural Equity Act* (H.R. 2860) were introduced early in the 110th Congress and serve as a baseline for rural hospital advocacy priorities. Of particular interest to CAHs is a provision that would provide cost-based reimbursement for CAHs' outpatient lab services regardless of where the patient is physically located.
- *The 340B Program Improvement and Integrity Act* (H.R. 2606) would allow CAHs, SCHs, rural referral centers and Medicare dependent hospitals to access 340B discounts for inpatient and outpatient drugs. The bill would also extend the discount to inpatient drugs for currently eligible 340B hospitals.
- *The Rural Health Services Preservation Act* (S. 630/H.R. 2159) would ensure CAHs receive at least 101% of costs for inpatient, swing-bed and outpatient hospital services and that rural health clinics receive the applicable all-inclusive rate for services provided to Medicare Advantage patients.
- *The Veterans Critical Access Act* (H.R. 6557) would allow CAHs to exempt from their daily inpatient bed limit care to veterans who have been referred by the Department of Veterans Affairs or veterans who are coordinating care with the VA.
- *The Critical Access Hospital Flexibility Act* (S. 1595) would 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.

REGULATORY PRIORITIES

INPATIENT FY 2009 PROPOSED RULE

In the FY 2008 inpatient final rule, the Centers for Medicare & Medicaid Services (CMS) imposed two requirements for disclosures to patients by certain hospitals and CAHs. The first one requires a hospital to disclose to all patients whether it is physician-owned and, if so, the names of its physician owners. The second one requires that those hospitals and CAHs that do not have a physician present in the hospital 24/7 provide a written notice to all inpatients and outpatients stating as much. The notice also must describe how the hospital or CAH would meet the medical needs of any patient who develops an emergency medical condition at a time when no physician is present in the hospital. The FY 2009 proposed rule sets forth penalties for failure to comply with these requirements. Specifically, CMS proposes to terminate the provider agreement of any hospital or CAH that fails to comply with the requirements. CMS also is soliciting public comments on whether hospitals and CAHs should educate patients about the availability of information regarding physician ownership under the proposed disclosure requirements and, if so, by what means.

In AHA's June 9 comment letter, we urged CMS to revisit issues that the AHA and others have raised regarding the overly burdensome approach of the second disclosure regarding on-premises physician availability. While the requirement may sound reasonable, it misses the mark on the real issue to be addressed: safety concerns in physician-owned specialty hospitals.

The burden associated with this requirement should be further reduced by not applying the requirement to all outpatient visits. The AHA urged CMS to limit its requirement to inpatient admissions and only those outpatient visits that include surgery, other invasive procedures, the use of general anesthesia or other high-risk treatment. Emergency department services should specifically be excluded.

CAH INTERPRETIVE GUIDELINES

Transmittal 34: On April 4, CMS issued revisions to survey protocol, regulations and interpretive guidelines for CAHs. The revision provides for CAHs to utilize beds for observation services while commingling patients that will not count against the statutory CAH maximum of 25 inpatient beds. Distinct part unit beds for acute psychiatric and rehabilitation services are excluded. The transmittal specifically lists the types of beds used for observation that do not count toward the 25 inpatient bed limit. The transmittal also addresses hospice. A CAH can dedicate beds to a hospice under arrangement, but the beds must count as part of the maximum bed count.

CMS will require that a CAH provide appropriate documentation to show that an observation bed is not an inpatient bed. The CAH must be able to document that it has specific clinical criteria for admission to, and discharge from, the observation service, and that these criteria are clearly distinguishable from those used for inpatient admission and discharge.

Transmittal 32: On January 18, CMS published revisions to Appendix W of the State Operations Manual, which implements the interpretive guidelines for CAHs released September 2007. It instructs surveyors on:

- Whether or not a CAH applicant satisfies the regulatory requirement to be located more than 35 miles from another CAH or hospital, and how to determine whether the CAH is eligible for application of the shorter, 15-mile standard due to mountainous terrain or lack of primary roads.
- Whether a CAH with a necessary provider designation remains essentially the same provider, serving the same service area and meeting the 75% rule after relocation.

Renovation or Expansion: Renovation or expansion of a CAH's existing building or addition of building(s) on the existing main campus of the CAH is not considered a relocation. That is, there is no change to its CAH designation and therefore no need for the Regional Office to make any determination on its continued CAH designation.

New CAH Facilities: All newly-constructed necessary provider CAHs are considered relocated facilities. This includes construction of a new facility that replaces the existing CAH main campus, even when on the same site as the original building. While of help for renovations and additions and clarifying the 75% rule, the transmittal offers little assistance regarding rebuilding or replacement on the campus foot print.

TRICARE PAYMENT FOR CAHS

In a June 4 comment letter, the AHA urged the Department of Defense's (DoD) TRICARE program to adopt Medicare's exact payment methodology for CAHs. Medicare reimburses CAHs 101% of their allowable and reasonable costs for inpatient and outpatient care. While TRICARE is required to use Medicare's payment methodology, DoD proposes to reimburse CAHs the billed charge or 101% of reasonable costs, whichever is less. For certain CAHs the proposal would have a devastating effect on their ability to provide critical patient care. The AHA also urged DoD to include interim payments and cost settlement mechanisms in the rule to guarantee that CAHs are reimbursed appropriately.

CAH OUTPATIENT QUALITY REPORTING

CMS granted the AHA's request to allow CAHs to submit and publicly report outpatient quality data along with other hospitals. Hospitals participating in Medicare's outpatient prospective payment system (PPS) are required to submit data on seven outpatient quality measures to receive a full payment update in FY 2009. Previously, CMS announced that CAHs would not be allowed to submit the outpatient measures because they are cost-based reimbursed rather than being paid under the PPS system. The AHA urged CMS to let CAHs participate in the quality reporting because of their commitment to public transparency and quality improvement. While CMS agreed to allow CAHs to participate, the agency has yet to provide CAHs instructions for measuring and reporting outpatient quality measures.

DESIGNATION OF MUPS/HPSAS

In its rule of Feb. 29, HRSA proposes to change how it designates Medically Underserved Populations (MUPs) and Health Professional Shortage Areas (HPSAs). HRSA recommends a revised methodology for a single "Index of Primary Care Underservice" to determine the level of underservice. The method includes three levels of designation for geographic HPSAs, population MUPs and safety-net facility HPSAs.

In a May 25 comment letter, the AHA urged HRSA to withdraw its proposed rule and called for further field testing and analysis to determine the impact of the proposed changes. HRSA received many substantive comments in addition to AHA's.

In a notice in the Federal Register of July 23, HRSA said that they will consider these comments carefully and based on a preliminary review it appears that they will need to make a number of changes. Instead of issuing a final regulation as the next step, HHS will issue a new Notice of Proposed Rulemaking for further review and public comment prior to issuing a final rule.

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

FLEXIBILITY FOR FLOOD-STRICKEN AREAS

On June 16, HHS Secretary Mike Leavitt declared a public health emergency in the flood-stricken states of Iowa and Indiana. As a result, CMS is waiving the normal burden of documentation for hospitals and nursing homes receiving flood victims. These facilities can act under a presumption of eligibility. CMS also will waive certain requirements for CAHs, skilled nursing facilities, long-term care hospitals and inpatient rehabilitation facilities, and expand the definition of "home" to allow Medicare beneficiaries to receive home health services in alternative sites. Specifically, CAHs will be allowed to take more than 25 patients and not count the expected longer lengths of stay for evacuated patients against the 96-hour average.

The JC Deeming Authority

The May 23 *Federal Register* included a proposed notice on The JC's application to continue its deeming authority for CAHs. In order to enter into a provider agreement with the Medicare program, a CAH must first be either certified by a state survey agency as complying with the conditions or requirements set forth in Part 482 and Part 485 Subpart F of CMS' regulations or demonstrate through accreditation by an approved national organization that all applicable Medicare conditions are met or exceeded. Accreditation is voluntary and not required of Medicare participation. The JC submitted all the necessary materials to renew its status.

Visit the Web site of the Section for Small or Rural Hospitals at http://www.aha.org/aha/key_issues/rural/index.html