American Hospital Association

Update

Summer 2008

Small or Rural Hospitals

The American Hospital Association works with members of Congress, regulatory bodies and other national associations to advocate on behalf of the nation's small or rural hospitals. This issue of ***Small or Rural Update*** provides a review of the latest news on key legislative and regulatory priorities.

Advocacy Agenda

FY 2009 RURAL HEALTH APPROPRIATIONS

On June 19, the House Appropriation Subcommittee on Labor, HHS and Education approved a bill specifying discretionary funding for federal health and human services programs for FY 2009. The Labor-HHS spending bill would restore $240 million in funding that had been cut to health professions and nursing education programs, increase funding for the National Institutes of Health by $1.2 billion and provide $75 million in grants to expand state health care initiatives for the uninsured. The bill also would provide $80 million more than last year for mental health and substance abuse programs and $31 million more for rural health programs. The bill is pending consideration by the full committee.

On June 26, the Senate Appropriations Committee passed its version of a fiscal year (FY) 2009 appropriations bill. The table below compares FY 2008 funding levels for key rural programs and services with the president's proposal and the Senate committee's levels.

Labor-HHS-Education and Related Agencies Appropriations – FY 2009
As of June 26, 2008 (amounts in millions)

Program	Final FY 08	President's FY 09	Senate's FY 09
Rural Health Research/Policy	$8.6	$8.7	$9.0
Rural Outreach Grants	$48.0	0	$51.4
State Offices of Rural Health	$8.0	8.1	8.0
Rural Hospital FLEX Grants	$37.9	0	$39.2
Delta Health Initiative	$24.6	0	$25.0
Rural AED	$1.5	0	$1.5
Telehealth	$6.7	$7.1	$8.0

MEDICARE BILL

Both chambers of Congress recently passed the *Improvements for Patients and Providers Act* (H.R. 6331) which includes a physician payment fix and several rural hospital provisions. The legislation would freeze physician payments for 2008 and provide a 1.1% increase for physicians in 2009. It also would extend the Medicare Rural Hospital FLEX grant program, and expand it to provide grants to increase access to mental health services for veterans in crisis and residents of rural areas. In addition, the Act would improve rural teleheath services and provide a new base-year for sole community hospitals (SCHs) based on their 2006 costs. Among other provisions, the bill would:

- Establish a demonstration project for community health integration models to allow states to test ways to better coordinate acute and post-acute services in rural areas.
- Extend for 18 months beginning July 1, 2008, the provision that allows independent labs to continue to bill Medicare directly for the technical component of physician pathology services furnished to hospital patients.
- Extend until Dec. 31, 2009, outpatient hold-harmless provisions that ensure small rural hospitals receive payments for outpatient services that are at least 85% of what they received before the outpatient prospective payment system took effect. This provision would also extend this protection to SCHs under 100 beds.
- Extend the add-on payment for ground ambulance services at 3% for rural services, provide an 18-month hold harmless for air ambulance regions recently classified from rural to urban, and clarify the medical review standard for air ambulance services.
- Extend Section 508 classification, which allows certain hospitals to reclassify to a higher wage index.
- Allow 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 within the county.

The bill will be sent to President Bush for his signature; however, he has threatened to veto the measure due to the provisions that would cut payments to Medicare Advantage plans.

MORATORIUM ON SIX MEDICAID RULES ENACTED

President Bush on June 30 signed into law (P. L. – 110-252) the Iraq war spending bill that includes a moratorium delaying six of seven impending Medicaid rules until April 2009. The legislation delays Medicaid rules covering certified public expenditures, intergovernmental transfers, and graduate medical education that would have a dramatic impact on hospitals, cutting hospital payments by more than $5 billion over five years. The new law also delays Medicaid rules affecting state provider tax laws, case management services, rehab services and school outreach.

The AHA is pleased that these six Medicaid regulations have been put on hold, preserving care for millions of patients. However, we are deeply disappointed that political pressures caused them to drop both the ban on physician self-referral to new hospitals and the outpatient Medicaid regulation from the bill. The AHA will continue to advocate on these two issues as Congress works into the fall.

OTHER KEY LEGISLATIVE PROPOSALS

The AHA will continue to work to gather support for the following rural legislative proposals introduced during the 110th Congress.

- *The Craig Thomas Rural Hospital and Provider Equity Act* (S. 1605) and *The Health Care Access and Rural Equity Act* (H.R. 2860)
- *The 340B Program Improvement and Integrity Act* (H.R. 2606)
- *The Rural Health Services Preservation Act* (S. 630/H.R. 2159)

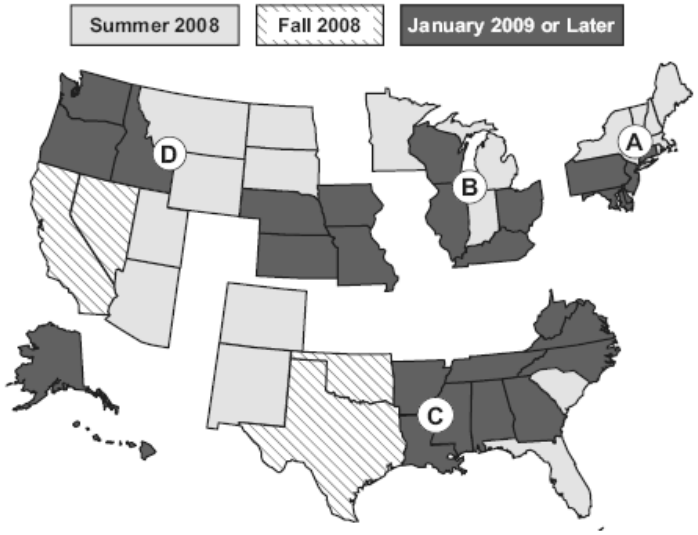
CONRAD STATE 30 PROGRAM

The AHA supports S. 2672/H.R. 5707, which would permanently extend the Conrad State 30 program and improve access to physicians in shortage areas. The Conrad program allows state health departments to request J-1 visa waivers for up to 30 foreign physicians per year to work in federally designated Health Professions Shortage Areas or Medically Underserved Areas. The bill also would give states more flexibility in placing physicians, and allow physicians who hold an H-1B visa to receive an exemption in exchange for service in an underserved area. The bill's sponsors are Sen. Kent Conrad (D-ND) and Rep. Earl Pomeroy (ND). The program expired June 1.

Physicians who are already in the program can remain until their commitment is met, but no new physicians will be able to enter the program until Congress enacts an extension. The AHA also supports H.R. 5571, which would extend the Conrad program for five years.

RAC PROGRAM

The Recovery Audit Contractor (RAC) program was authorized by Congress to identify improper Medicare payments – both overpayments and underpayments. The demonstration project began in California, Florida, and New York and was expanded to Massachusetts and South Carolina when Congress made the RAC program permanent in 2006. CMS is required to expand the program nationwide by 2010 (see schedule). During the three-year demonstration, RACs collected $980 million in overpayments from Medicare providers in the pilot states, with over 95% of these funds collected from hospitals.



RAC Expansion Schedule

The AHA has serious concerns with the RAC program and CMS' expansion plans. While CMS has made some positive changes – staggering the expansion schedule, with different states coming under review in 2008 and 2009; prohibiting RACs from reviewing claims with dates of service prior to October 1, 2007; and establishing medical record request limits – more changes are necessary. The AHA will urge Congress to pass the *Medicare Recovery Audit Contractor Program Moratorium Act* (H.R. 4105), which would place a one-year moratorium on the RAC program. Sponsored by Reps. Lois Capps (D-CA) and Devin Nunes (R-CA), this bill would provide Congress, CMS and hospitals with time to address the many serious problems with the RAC program, including the need to establish more appropriate payment incentives as well as greater management, oversight, and transparency of RACs.

To learn more about the RAC program, visit "Highlights" at www.aha.org. The site contains educational resources, links to external resources and listings of upcoming RAC-related events, as well as the latest news from the AHA and CMS.

REGULATORY PRIORITIES

The AHA has provided guidance to its members on a number of regulatory issues, including the 2009 inpatient and outpatient prospective payment system (PPS), and rural health clinic proposed rules. The Health Resources and Services Administration (HRSA) designations for Medically Underserved Populations/Areas and Health Professional Shortage Areas and guidance for Medicare denials are important issues that the AHA will continue to monitor.

INPATIENT PROPOSED RULE

On April 14, CMS released its FY 2009 proposed rule for the hospital inpatient PPS. A final rule will be released by Aug. 1, and changes will take effect Oct. 1. The proposed rule includes a market basket update of 3.0% for eligible hospitals that submit data for 30 quality measures. Eligible hospitals not submitting data would receive a 1.0% update. In addition, FY 2009 marks the end of the transition to the new Medicare-Severity DRG system. Beginning October 1, DRG weights will be fully adjusted for severity and calculated solely on cost-based relative weights. Among other areas are provisions in the rule including:

Hospital Quality Data. The proposed rule would add 43 new quality measures for payment determination in FY 2010 – more than double the number of measures on which hospitals must report. Adding such a large number of disparate measures is an unfocused approach to quality reporting that provides no direction to hospitals on quality improvement priorities. It is important that any measures added to the pay-for-reporting program first go through the rigorous, consensus-

based assessment processes of both the National Quality Forum and the Hospital Quality Alliance (HQA). Of the proposed measures, only 10 have been adopted by the HQA. We do not believe that the other 33 measures proposed by CMS are ready for reporting at this time.

Hospital-acquired Conditions. In the FY 2008 inpatient PPS final rule, CMS adopted eight conditions for which it would no longer pay a higher diagnosis-related group rate beginning in FY 2009 if the conditions were not present on admission. This year, CMS proposes to expand the list and include nine additional conditions when the payment policy takes effect on October 1. Of the 17 total conditions, only four are ready to include for FY 2009. The remaining conditions should not be implemented for FY 2009 because they are not reasonably preventable, it is difficult to determine whether they are present on admission, or the patient population included by CMS is too broad.

Other Proposals. We also strongly oppose the following direct payment cuts:

- Raising the threshold for wage index geographic reclassification, thereby making it more difficult for hospitals to qualify;
- Applying budget neutrality on a statewide basis for the rural floor, imputed rural floor and geographic reclassifications;
- Phasing out the indirect medical education adjustment to capital payments, which cuts payments to teaching hospitals by $1.3 billion over five years; and
- Expanding the post-acute care transfer policy to include patients receiving home health care services within seven days of discharge, which is estimated to reduce payments by $50 million in FY 2009 and $330 million over five years.

OUTPATIENT & ASC PROPOSED RULE

CMS released the outpatient PPS and the ambulatory surgical center (ASC) payment system proposed rule for calendar year 2009 on July 3, which was published in the July 18 *Federal Register*. Comments on the rule are due by Sept. 2 with a final rule expected this fall. The final rule will take effect Jan. 1, 2009. Highlights of the proposed rule include:

Update. The rule includes a 3.0 percent market basket update for outpatient PPS services, with hospitals projected to receive $28.7 billion for outpatient services in 2009. CMS estimates that rural hospitals will see an overall 3.6 percent increase in payment considering all the changes in the proposed rule.

Quality Reporting. For 2009, the rule proposes to link Medicare payment for outpatient services to the reporting of certain quality measures. That is, in order to receive the full outpatient payment update for 2009, hospitals must have reported data in 2008 on seven quality measures of emergency department and perioperative surgical care. Hospitals that fail to meet the outpatient reporting requirements would receive a 2% reduction in their payment update. For 2010, CMS also proposes to include an additional four quality measures of medical imaging efficiency in order for hospitals to receive the full payment update in 2010. Hospitals with five or fewer patients for a measure would not be required to submit data for that calendar quarter.

ED Services. CMS proposes four new APCs for services provided in “Type B” emergency departments (EDs) that offer emergency-level services but are not open 24 hours per day, seven days per week. Data collected over the last two years shows that most emergency visits to Type B EDs are more expensive than clinic visits, the current payment level assigned to these Type B emergency services, but less costly than emergency visits in “Type A” EDs that are open 24/7. The proposed payment rate for the new Type B APCs reflects these cost differences. However, as the costs for the most intensive emergency visits are approximately the same between Type A and B EDs, CMS would use a single APC for these visits.

Hold-harmless Payments. As required by law, the agency would no longer provide hold-harmless outpatient payments to rural hospitals

with 100 or fewer beds that are not SCHs. However, the rule proposes to continue to provide rural SCHs with a 7.1 percent increase in payment for most services under the outpatient PPS.

Partial Hospitalization Program Services. CMS is proposing to establish two separate partial hospitalization program (PHP) rates, one for days with three services ($140) and one for days with four or more services ($174). The rates CMS proposes to pay for these PHP services are significantly lower than the $203 per diem rate paid for PHP services in 2008. In addition, CMS would no longer pay for PHP services that had fewer than three services per day.

For ASCs. CMS continues the transition to the new outpatient PPS-based payment system for ASCs. In 2009, the second year of a four-year transition, CMS proposes to pay for ASC services at a rate that is based on a blend of 50 percent of the 2007 ASC payment amount and 50 percent of 2009 fully implemented ASC amount.

RURAL HEALTH CLINICS

CMS recently issued changes to the conditions of participation requirements and payment provisions for rural health clinics (RHCs) and federally qualified health centers. Under the June 27 proposed rule, new and existing RHCs would have to be located in shortage areas, whose designation must be renewed at least every three years. Existing RHCs that were no longer located in rural or shortage areas as defined by the proposed rule could keep their designation if they meet certain criteria. The rule also revises the payment methodology setting Medicare payment at no more than 80% of reasonable costs, *after* application of beneficiary co-payments and deductibles. Further, the rule revises the criteria that allow certain hospital-based RHCs to exceed the per visit payment limit. RHCs also would be required to establish a quality assessment and performance improvement program. CMS will accept comments on the proposed rule through Aug. 26.

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). A designation of underservice is used to prioritize the distribution of federal and state funds to provider shortage areas. In fact, more than 34 federal programs use these shortage designations for eligibility and funding criteria.

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 HPSA, population MUPs and safety-net facility HPSA.

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. The AHA's main concerns were:

- It is impossible to determine with any certainty what designation or funding level a health center, clinic, population or area will receive under the index of primary care underservice.
- The rule's analysis uses nearly 10-year-old data from 1999.
- The analytical model HRSA developed to assess the potential impact of these proposed changes has not been widely distributed – making it difficult for communities and facilities to adequately assess the impact of the proposed rule.

In the proposed rule, HRSA also encourages state and local government to increase their role in defining service areas, underserved populations groups and unique local conditions. However, HRSA has not adequately assessed

the added burden to states and local governments in meeting these new responsibilities.

NEW GUIDANCE PREVENTS RECOUPMENT DURING APPEALS PROCESS

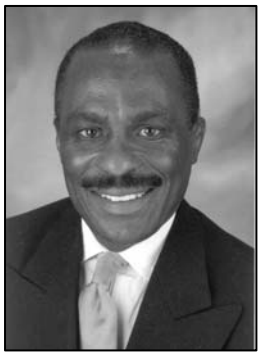
As required by law, CMS has issued new guidance for hospitals that are appealing payment denials by the agency and its contractors. This improvement to the appeals process was mandated by Congress five years ago in the *Medicare Modernization Act* (MMA). The new guidance, Transmittal 314, affects all Medicare appeals activity, including appeals of medical necessity review denials by fiscal intermediaries (FIs) and Medicare administrative contractors (MACs), along with appeals of payment denials by RACs. The AHA had urged Congress to include this regulatory relief in the MMA, and asked CMS to implement the provision as part of the AHA's RAC advocacy efforts. This long-awaited improvement helps hospitals that are engaged in CMS' lengthy and burdensome appeals process, which can take as long as 24 months.

Under the new guidance, when a Part A overpayment is found by a MAC, FI or RAC, funds shall not be recouped if the provider submits an appeal for re-determination within the first 40 days after denial. If the initial overpayment determination is upheld, funds will be recouped starting 60 days later, unless the provider appeals to a qualified independent contractor (QIC) – the second stage of the appeals process. The FI may then begin recoupment if the denial is upheld, even if the denial is appealed again. The transmittal notes that interest on the denied payment will continue to accrue, but will not be assessed if the denial is overturned in favor of the provider.

VA Rural Health Advisory Committee

Approximately 23% of America's veterans live in rural areas. These veterans are in poorer health than veterans in urban areas due to long travel distances to access care and lack of preventative care. To examine ways to enhance health care services for veterans in rural areas, the Department of Veterans Affairs (VA) has appointed a 13-member rural health advisory panel to evaluate current VA programs and identify barriers to health care. The committee is chaired by James Ahrens, former president and CEO of the Montana Hospital Association and past member of the governing council of the AHA Section for Small or Rural Hospitals.

MedPAC



George Miller

Three new members, including two hospital executives, will join the Medicare Payment Advisory Commission (MedPAC) when the commission reconvenes in September. They will serve three-year terms on a panel that advises Congress on Medicare payment policy. The new MedPAC members are Peter Butler, Rush University Medical Center's executive vice president and chief operating officer in Chicago; Michael Chernew, Harvard Medical School's professor of health care policy in Boston; and George Miller Jr., Catholic Health Partner's senior vice president and Community Health Partners' president and CEO in Springfield, OH. Miller previously served on the AHA Board of Trustees and Governing Council for Small or Rural Hospitals. He joins Thomas M. Dean, M.D., a family physician in Wessington Springs, SD, as one of two commissioners with direct experience in rural hospitals.

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

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