



American Hospital
Association

Small or Rural Hospitals

This issue of *Update* provides information on AHA's advocacy agenda, the federal budget, rural legislative priorities, rural regulatory policy issues, the 2005 governing council chair of the Section for Small or Rural Hospitals, the Shirley Ann Munroe Leadership Award, and the proposed rule for the Medicare inpatient prospective payment system for fiscal year (FY) 2006.

AHA Advocacy Agenda

With input from hospital leaders from across the country, the American Hospital Association's (AHA) 2005 advocacy agenda focuses on protecting the health care safety net, increasing the affordability of care, improving the quality of health care, and expanding health care coverage to help more Americans get the care they need. In pursuing this broad-based advocacy agenda, the AHA will work to ensure hospitals have the resources necessary to serve their communities. We will continue to advocate for adequate Medicare and Medicaid funding, permanently banning physician self-referral to new limited-service hospitals, expanding coverage to the uninsured, improving the quality and safety of care, including the coordination of care for the chronically ill, and reforming medical liability.

Federal Budget

Congress in late April approved a FY 2006 budget resolution that calls for \$10 billion in Medicaid spending cuts over five years, beginning in FY 2007. The budget plan also leaves open the possibility of up to \$1 billion in Medicare spending cuts over five years. The budget resolution does not specifically target Medicaid for spending cuts. But the budget assumes that the House Energy and Commerce and Senate Finance committees – the panels with jurisdiction over Medicaid – will reduce funding for the program by \$10 billion.

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On Medicare, the budget instructs the House Ways & Means Committee, which has jurisdiction over Medicare, to cut \$1 billion over five years. While the instruction does not specifically require Medicare cuts, the fact the committee maintains legislative authority over the program leaves Medicare open to potential cuts.

Medicaid had been a major stumbling block to a House and Senate budget pact. The agreement on Medicaid followed several weeks of discussions between Sen. Gordon Smith, R-OR, Republican budget leaders, and administration officials. GOP budget writers accepted Smith's proposal for a Medicaid commission to study the program and his call for smaller cuts than originally proposed by House and Senate Republicans to secure support from him and other Republicans for Medicaid spending reductions.

Smith successfully pushed for an amendment to the Senate budget resolution in March that eliminated up to \$14 billion in Medicaid cuts. The House version of the budget called for five-year reductions of up to \$20 billion in Medicaid and up to \$18 billion in Medicare.

The Medicaid budget cuts would begin in 2007 to give the specially convened commission time to recommend cost-saving proposals. Smith is working with the White House to assemble the panel to recommend one round of changes by September 1, and issue a final report for restructuring Medicaid in December 2007.

To battle these cuts, the AHA launched a grassroots campaign during its Annual Membership Meeting in Washington, DC, held May 1 – 4. **The message to legislators: Hold hospitals harmless from cuts that affect our ability to get people the care they need!**

Rural Legislative Priorities

The AHA is working diligently on several legislative and regulatory fronts to support operational improvements and program enhancements for both small or rural PPS hospitals and Critical Access Hospitals (CAHs).

- **Rural Home Health Bonus.** The AHA supports the *Medicare Rural Home Health Payment Fairness Act*, (S. 300/H.R. 11), which would amend the Medicare Modernization Act (MMA) to provide for a two-year extension of the temporary 5 percent Medicare payment increase for home health services furnished in rural areas.
- **Sole Community Hospital Legislation.** The AHA supports permanently updating the cost year for determining the target amount, extending the hold-harmless provision for outpatient payment, and improving outpatient payment adequacy.
- **Rural Community Hospital (RCH) Assistance.** We support creating a new payment classification for rural hospitals with 50 or fewer acute care beds. This new payment system would provide Medicare inpatient and outpatient reimbursement at 101 percent of cost. It would also make enhancements to the CAH program to provide cost-based reimbursement for post-acute care services, including skilled nursing facility, home health, and ambulance services. S. 933, the Rural Community Hospital Assistance Act of 2005, which was introduced last year, was reintroduced by Sens. Ben Nelson, D-NE, and Sam Brownback, R-KS on April 28.
- **Critical Access Hospitals.** **The AHA supports the *Critical Access to Clinical Lab Services Act (S.236/H.R.1016)*, which would reinstate cost-based reimbursement to CAHs for lab services provided to patients who are not physically present in the hospital.** We also support H.R. 880, which would require Medicare Advantage plans pay CAHs at least 101 percent of costs for inpatient and outpatient services – the amount they are paid for Medicare fee-for-service patients. In addition, the AHA will work with lawmakers to introduce legislation that would allow CAHs to participate in the 340B drug discount program.

Rural Regulatory Policy

- **MedPAC Recommendations.** The Medicare Payment Advisory Commission (MedPAC) is

recommending a payment update of market basket *minus* 0.4 percentage points for hospital inpatient and outpatient services in 2006 and elimination of updates for home health and SNF payment rates for FY 2006. The payment update recommendation would apply to all hospitals under the inpatient prospective payment system, although the MMA authorized a full update for hospitals sharing data on 10 key quality indicators for FYs 2005 – 2007. **Our view: Recommendations to reduce payments to hospitals and for home health and SNF payments are misguided, and AHA will urge Congress to reject them.**

The AHA supports MedPAC's recommendation to extend the outpatient PPS hold-harmless provisions for SCHs and hospitals with less than 100 beds through calendar year 2006. In addition, MedPAC recommended extending until January 1, 2007, the moratorium on physician's self-referral to specialty hospitals in which they have an ownership interest. This recommendation to extend the moratorium sends an important message to Congress about conflict of interest concerns regarding physician ownership and self-referral.

- **MedPAC CAH Report.** At its April meeting, MedPAC discussed the CAH program's success in preserving rural hospitals and rural beneficiaries access to care, as part of its discussion in preparation for an interim report on the program due to Congress in June. The commission also reviewed data on CAH quality that showed that smaller CAHs have lower patient complication rates, while larger CAHs have lower mortality rates. MedPAC is critical of cost growth in CAHs and concerned about the growing number of CAHs. They agreed that their spring report to Congress would highlight two issues of concern about the CAH program – swing-bed payments and the number of CAHs located within close proximity of another hospitals – but would not include recommendations, saying it is too soon to

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recommend major changes to the relatively young program without fully understanding their impact.

Prior to MedPAC's April meeting, AHA expressed in a letter to Commissioners our concern about the direction of their report and will continue to remind policy makers of the importance of the program to Medicare beneficiaries and the communities served by CAHs.

- **Conditions of Participation (COP).** The Centers for Medicare & Medicaid Services (CMS) published a proposed rule to revise four of the current hospital COP in the February 25 *Federal Register*. The rule would expand the number of practitioners who may perform history-and-physical examinations and the time frame for the exam's completion; permit post-anesthesia evaluations for inpatients to be completed and documented by anyone qualified to administer anesthesia; allow verbal and other orders to be authenticated by any practitioner authorized to give such an order, but require the authentication be completed within 48 hours of the verbal order being issued, and this provision would sunset after five years; and provide more flexibility to hospitals in assuring the security of medications.
- **Medicare Advantage (MA) Program.** CMS' January 28 final rule for MA establishes a network adequacy fund of \$25 million to recruit essential hospitals. The purpose of the fund is to ensure the plan's network has adequate coverage in rural areas and to cover the marginal difference to the MA plan for reimbursing "essential hospitals" at the Medicare rate. (CAHs are not included in the definition of "essential hospitals" because they are not PPS hospitals.) The final rule also does not provide for reimbursement at 101 percent of costs by MA plans to CAHs for services to Medicare beneficiaries. The AHA will continue to monitor this issue and supports legislation to pay CAHs at 101 percent of costs.
- **CAH Interpretive Guidelines.** CMS' 2004 revisions to the State Operations Manual included changes to the CAH interpretive guidelines. These changes include counting observation beds that are commingled with inpatient beds in the total CAH bed count. Revisions, which have been promised but not yet finalized, are expected to include removal of the "commingling" language and non recognition of "observation units." The AHA continues to discuss these and many other fixes to the interpretive guidelines with CMS.

- **Hospital Compare.** The Hospital Quality Alliance launched *Hospital Compare*, a consumer-oriented display of hospital quality data available to the general public as of April 1. This new Web site, www.HospitalCompare.hhs.gov, marks a milestone in public accountability, and is the outcome of the Hospital Quality Alliance, a public-private partnership between hospitals, government, and other health care organizations. Consumers can research and compare 17 hospital quality measures for three common medical conditions – heart attack, heart failure, and pneumonia. AHA and other alliance partners will continue to enhance and expand the site.

Fitzgibbon Chair of 2005 Section Governing Council

Susan H. Fitzgibbon, president of Annie Penn



Hospital of Reidsville, N.C., and executive vice president of Moses Cone Health System, Greensboro, N.C., will lead the AHA Section for Small or Rural Hospitals for 2005, chairing the Section's 22-member governing council.

Governing council members are the elected representatives of the small or rural constituency section. The council advises AHA on numerous strategic policy, legislative, and regulatory issues, including the federal advocacy agenda, regulatory relief, and other priorities. The governing council is also an important channel of communication between the AHA and its small or rural constituents.

Founded in 1930, Annie Penn Hospital, which is located in north central North Carolina, has 110 acute care beds and a 92-bed nursing home. During her 20-year tenure, Susan Fitzgibbon has led the hospital through several important events, including a merger with Moses Cone that improved the ability of the hospital to serve its community by providing a greater array of services and resources.

2005 Shirley Ann Munroe Leadership Development Award

Applications are currently being accepted for the 2005 Shirley Ann Munroe Award. The Award recognizes small or rural hospital chief executives and administrators who have achieved

improvements in local health delivery and health status through their leadership and direction. The Award is designed to provide professional development and educational opportunities to outstanding small or rural hospital chief executives and includes a \$1,200 stipend to offset the cost of attending an AHA educational program. Applications for the 2005 Shirley Ann Munroe Award must be postmarked by Friday, June 3, 2005. For more information or to receive a brochure, please contact Hilda Fisher, Section for Small or Rural Hospitals, at (312) 422-3334 or visit the AHA web site at www.aha.org/aha/key_issues/rural/section/award

Proposed IPPS Rule for FY 2006.

CMS issued its proposed Medicare inpatient prospective payment system (IPPS) rule for FY 2006, which was published in the May 5 *Federal Register*. Following is a summary of some of the proposed rule's key provisions:

- **Payment Update.** The rule proposes a market basket update of 3.2 percent for those hospitals that submit data on 10 quality measures and 2.8 percent for those that do not. To qualify for the full update, CMS would require hospitals' continuous submission of quarterly data on the 10 measures, data for patients discharged through the fourth quarter of 2004 by May 15, 2005; and validation of hospitals' third quarter 2004 data.
- **Labor share.** The labor share of the standardized amount, which is the portion of Medicare payment adjusted for wages, would decrease from 71.1 percent to 69.7 percent.
- **Transfers.** The proposal calls for expanding the post acute-care transfer provision from 30 diagnosis related groups (DRGs) to 223. It proposes a new set of criteria for determining DRGs subject to this policy. The proposal would cost hospitals \$880 million in FY 2006 alone, the equivalent of a 1.1 percent cut in hospital payments. The AHA will fight this harmful change to the transfer provision.
- **Outliers.** The proposed rule would raise the outlier threshold from its current level of about \$25,800 to \$26,675.
- **Limited-Service Hospitals.** Specialty hospitals would not qualify under the Medicare statutory definition of a "hospital" if they are not primarily engaged in caring for hospital inpatients. Even if they meet the Medicare Modernization Act's test

for grandfathering under the 18-month moratorium on physician self referrals to specialty hospitals, those tests are applied only after meeting the basic statutory definition of a hospital. The proposed rule notes that many surgical and orthopedic specialty hospitals provide primarily outpatient services and look more like ambulatory surgical centers than hospitals. The proposal suggests the agency is considering closer scrutiny of these facilities. The AHA will urge CMS to do so.

- **Critical Access Hospitals.** CMS proposes restrictive guidelines for replacing or relocating Critical Access Hospitals (CAH). Beginning January, 1, 2006, states no longer will be able to certify hospitals as a "necessary provider," if they are within 35 miles of another hospital. The AHA believes the proposed rule would prevent a CAH with necessary provider status from relocating its facility, unless construction was under development before December 8, 2003, when the Medicare law was signed into law. AHA will work to ensure that appropriate and necessary CAH relocation is permitted.
- **Occupational Mix Adjustment.** The proposed rule would continue to adjust 10 percent of the wage index for the occupational mix of employees.
- **Provider-based Determinations.** CMS' proposed rule would add rural health clinics with at least 50 beds to the list of specific types of facilities and organizations for which determinations of provider-based status would not be made.

The AHA is analyzing the proposed PPS rule and said it soon will provide a detailed assessment for its members. The deadline for comments on the proposal is June 24. The final rule will be published by Aug. 1, according to CMS. The policies and payment rates will take effect on Oct. 1, 2005. The proposed rule is available at www.cms.hhs.gov/providers/hipps/frnotices.asp.

AHA Web Site:

www.hospitalconnect.com

Access AHA's web site for up-to-date information 24/7 on AHA advocacy issues, including *What's New*, *AHA's 2005 Advocacy Agenda*, *The Quality Initiative*, *Seven Steps to a Healthier America* and *Key Issues*.

The Section for Small or Rural Hospitals' web page, www.aha.org/aha/key_issues/rural/ provides information for the nation's small or rural hospitals, including critical access hospitals.