



American Hospital
Association

Small or Rural Hospitals

Update

Summer 2007

This issue of **Small or Rural Update** provides information on key legislative proposals in Congress as well as regulatory priorities. A rural health appropriations chart shows funding levels for specific rural health programs in FY 2008. Updates are included on hospital discharge notices, hospital quality data, critical access hospital (CAH) interpretive guidelines and proposed changes to Internal Revenue Service (IRS) Form 990.

Rural Advocacy Agenda and Legislative Priorities

Several AHA-supported proposals have been introduced during the 110th Congress that would support small or rural PPS hospitals and CAHs. These bills are:

The Health Care Access and Rural Equity Act (H-CARE) (H.R. 2860) would extend through 2011 existing critical 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 reauthorizes for sole community hospitals, the 2% add-on for ambulance trips in rural areas and 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, and hospitals near a Section 508 hospital to participate in a group reclassification. CAHs would gain flexibility to respond to daily and seasonal fluctuations in patient load and cost-based reimbursement for outpatient lab services. The bill also would remove the cap on disproportionate-share 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)(S. 1605) 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 CAHs' 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. The bill was introduced by Sens. Kent Conrad (D-ND) and Pat Roberts (R-KS).

The Critical Access Hospital Flexibility Act (S. 1595) – Many hospitals have to respond to seasonal or daily demands that easily can drive their census above 25 beds. The bill would give CAHs needed flexibility and allow the hospitals 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. Sens. Gordon Smith (R-OR) and Ron Wyden (D-OR) introduced S. 1595.

The Nursing Education and Quality of Health Care Act (S. 1604) 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. Hillary Rodham Clinton (D-NY) and Gordon Smith (R-OR).

The Sole Community Hospital Preservation Act (H.R. 1177) would reauthorize permanently the outpatient PPS hold-harmless and permit the use of a more current year to re-establish the hospital target amount. Reps. John Tanner (D-TN) and Sam Graves (R-MO) introduced the bill.

The Physician Pathology Services Continuity Act (S.458/H.R. 1105) 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. The bill was introduced by Sens. Blanche Lincoln (D-AR) and Craig Thomas (R-WY) and Reps. John Tanner (D-TN) and Kenny Hulshof (R-MO).

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 rural health clinics receive the applicable all-inclusive rate for services provided to Medicare Advantage patients. The bill's sponsors are Sens. Norm Coleman (R-MN), Tom Harkin (D-IA) and Richard Durbin (D-IL) and Reps. Ron Kind (D-WI) and Cathy McMorris-Rodgers (R-WA).

Critical Access to Clinical Lab Services Act (S. 1277) – In 2003 CMS revised its lab payment policy specifying that CAHs could no longer be reimbursed at-cost for lab services, unless patients are physically present in the hospital lab when specimens are collected. Many CAHs continue to provide lab services at community health centers, skilled nursing facilities and in patients' homes. They are increasingly concerned about the costs of offering off-site lab testing. Introduced by Sen. Ben Nelson (D-NE), this bill would work to restore cost-based reimbursement of referral lab services.

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

REGULATORY PRIORITIES

Medicare Inpatient PPS Proposed Rule for FY 2008

The FY 2008 inpatient PPS proposed rule would cut \$25 billion over five years from hospitals. In our June 4 comment letter to CMS, the AHA expressed concern about several key provisions.

- Medicare-Severity DRGs (MS-DRGs): The MS-DRGs are a reasonable framework for patient classification, provided that they are used for several years, and that other severity systems are no longer considered by CMS. The AHA

recommends a four-year transition, with changes taking place incrementally from FY 2008-2011.

- Behavioral offset: The behavioral offset will cut payments to hospitals by \$24 billion over the next five years. The AHA believes that this unwarranted cut is a backdoor attempt at budget cuts. Hospitals have operated under the current inpatient DRG system for 23 years – the proposed MS-DRGs would be a refinement of the existing system; the underlying classification of patients and “rules of thumb” for coding would be the same.
- Capital PPS: The AHA opposes cuts to the capital inpatient PPS and the possibility of future capital IME and DSH payment cuts. These cuts are unprecedented, were not asked for by Congress, and will disrupt hospitals' ability to meet their existing long-term financing obligations for capital improvements. The cuts also could impede the adoption of IT, clinical research and upgrades to hospital infrastructure.

Medicare Outpatient PPS Proposed Rule and ASC Final Rule

CMS released the outpatient prospective payment system (OPPS) proposed rule for CY 2008 and an ambulatory surgical center (ASC) payment system final rule. AHA is currently reviewing the rules, but below are the highlights.

Outpatient PPS

- CMS proposes hospitals begin reporting 10 outpatient quality measures in 2008 in order to receive a full Medicare payment update in 2009. The quality measures, which have been adopted by the Hospital Quality Alliance, include five emergency department heart attack measures, two surgical care improvement measures and one measure each for treating heart failure, community-acquired pneumonia and diabetes. Hospitals that fail to report data for these measures in 2008 would receive a 2% reduction in their 2009 payment update.
- The proposed rule contains a 3.3% market basket update for outpatient PPS services.
- As required by law, CMS continues to phase out hold-harmless outpatient payments for certain rural hospitals with 100 or fewer beds that are not sole community hospitals by reducing from 90% to 85% the additional payment made to these

hospitals. The AHA is concerned about how the payment reduction will affect small rural hospitals and is pursuing legislation to make the full hold-harmless payments permanent.

- CMS proposes to package seven additional categories of supporting and ancillary services – guidance services, image processing services, intra-operative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast agents and observation services – to encourage hospitals to select the most clinically appropriate diagnostic and treatment approaches. The AHA is concerned that the packaging proposal could hurt rural hospitals that frequently use observation care to determine whether patients need to be transferred to other facilities for inpatient admission.

Ambulatory Surgical Centers

- As required by law, CMS will begin implementing a new ASC payment system in January 2008. The final rule allows ASCs to be paid for any surgical procedure that CMS determines does not pose a significant risk to Medicare beneficiaries when performed in an ASC and that is not expected to require an overnight stay. As a result, the ASC rule adds 790 procedures to the list for a total of 3,300 procedures.
- In the OPPS rule, CMS proposes to pay ASC services at 65% of the hospital outpatient department rate for corresponding services. Payments for ASC services that have been performed predominantly in physician offices will be capped at the physician office's rate. The agency will phase in the new ASC payment rates over four years, with full implementation in 2011.

The rules will be published in the Aug. 2 *Federal Register*. Comments on the OPPS proposed rule are due to CMS by Sept. 14 with a final rule expected this fall. Look for upcoming AHA *Regulatory Advisor*ies for more details.

Hospital Discharge Notices

The Centers for Medicare & Medicaid Services has posted to its [Web site](#) the final text for two forms hospitals must use effective July 2 to notify Medicare beneficiaries about their discharge appeal rights. In addition to the Important Message from Medicare (IM) and Detailed Notice of Discharge forms, the Web site includes sections from the claims processing

manual that contain detailed instructions for using the forms. Hospitals must issue the IM within two days of admission to all Medicare beneficiaries and obtain the beneficiary's signature. If the IM is delivered more than two days before discharge, beneficiaries must receive a signed copy prior to discharge. Beneficiaries who request an appeal will receive a more detailed notice from the hospital or health plan, if applicable. New forms were released May 25.

Hospital Quality Data

Beginning in June, the Hospital Compare Web site, www.HospitalCompare.hhs.gov, began displaying mortality data for hospital patients treated for heart attacks and heart failure. The data show consumers how heart attack and heart failure patients fared 30 days after admission to a hospital, and whether the post-admission mortality rate was the same, better or worse than the national mortality rate for the two conditions.

The mortality rates are calculated using a sophisticated risk-adjustment tool that takes into account one year of billing history for each patient. It adjusts for differences in each hospital's patient mix, so hospitals that care for older, sicker patients are on a level playing field with those patients who would be at less risk of dying within 30 days of admission. The new information will offer clinicians and hospitals new insights into opportunities to improve care.

Opportunity to Preview Data. Hospitals have until Aug. 14 to preview their latest quality data before it's posted to the Hospital Compare Web site Sept. 20. If any problems are detected, they should contact their Quality Improvement Organization. They also should review the demographic information displayed for their hospital on Hospital Compare and submit any changes to their state survey agency's coordinator by Aug. 17.

CAH Interpretive Guidelines

The AHA will continue to pursue regulatory fixes to CMS' prescriptive provisions on the relocation of CAHs that were included in the FY 2006 inpatient PPS final rule regarding the 75% test and revised definitions of mountainous terrain and secondary roads. The AHA has met with CMS staff on several occasions, and provided written comments on the guidelines. In addition, the AHA seeks to educate the field through updates, conference calls, news articles and other appropriate mediums. We continue to work with Congress for a permanent legislative fix to this issue.

IRS Form 990

All tax-exempt organizations must complete an IRS Form 990 annually. The IRS recently released for public comment a completely redesigned Form 990, which includes a 10-page "core" form and 15 specific schedules that tax-exempt organizations are required to complete as applicable. The schedules include a new Schedule H to be completed by all hospitals or other organizations that provide medical care. The proposed schedule H for tax-exempt hospitals asks about community benefit, billings and collection, management companies and joint ventures. In addition to Schedule H, other activity-specific schedules that request new information include compensation and tax-exempt bonds among others.

Through a series of member calls, the AHA is getting member input on the IRS' proposal. Comments on the new Form 990, including the schedules and instructions, will be accepted by the IRS until Sept.

14. The IRS expects a final version of the form to be implemented for tax year 2008. For additional information on the proposal, see the June 22 AHA *Regulatory Advisory* and the July 27 *Special Bulletin* includes a model comment letter; both are available at www.aha.org.

Medicare Gainsharing Demos

The Department of Health & Human Services published a notice in the July 5 *Federal Register* encouraging rural inpatient hospitals to apply to participate in the Medicare gainsharing demonstration program. Authorized under the DRA, the demonstration will test and evaluate methodologies to determine

whether gainsharing can successfully align incentives between hospitals and physicians to improve the quality and efficiency of care provided to beneficiaries and to promote improved operational and financial performance at hospitals. Two of the six short-term demonstration projects must involve rural hospitals. Because few rural hospitals applied when HHS initially issued a notice in September 2006, the agency is seeking additional applicants. Applications must be sent to the CMS by Sept. 4. For more information, contact CMS' Lisa Waters at (410) 786-6615 or GAINSHARING@cms.hhs.gov.

FY 2008 RURAL HEALTH APPROPRIATIONS

On June 21, the Senate Appropriations Committee passed its version of an FY 2008 appropriations bill. On July 19, the full House passed its version. The table below compares FY 2007 funding levels for key rural programs and services with the President's, Senate committee, and House's level.

LABOR-HEALTH AND HUMAN SERVICES-EDUCATION AND RELATED AGENCIES APPROPRIATIONS - FY 2008 (Amounts in millions)

Program	Final FY 2007	President's FY 08	Senate Committee	House's FY 08
Rural Health Research and Policy	\$8.7	\$8.7	\$9.5	\$9.5
Rural Outreach Grants	\$38.9	0	\$40.0	\$53.0
State Offices of Rural Health	\$8.1	\$8.1	\$9.0	\$9.0
Rural Hospital FLEX Grants	\$63.5*	0	\$38.5	\$63.5*
Delta Health Initiative	*	0	\$25	*
Rural AED	\$1.5	0	\$3.0	\$2.0
Denali Commission	\$39.3	\$0	\$39.2	0
Telehealth	\$6.8	\$6.8	\$7.0	\$7.0
NHSC	\$125.6	\$116.0	\$125.7	\$131.5
AHECs	\$28.7	0	\$28.7	\$31.2

*In FY 2006, the Delta Health initiative was funded through the Rural Hospital Flexibility Grant Program. This included Small Hospital Improvement Program grants.

Senator Craig Thomas – 1933-2007

Wyoming's U.S. Senator Craig Lyle Thomas succumbed to leukemia on June 4, 2007. He served as co-chair of the Senate Rural Health Caucus. During his distinguished career, he worked tirelessly to reform and strengthen the rural health care infrastructure and to improve health care for rural families. His leadership and advocacy for rural health care issues was renowned. This friend to rural hospitals will be missed.

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