American Hospital Association

CAH Update

Summer 2007

Small or Rural Hospitals

This issue of *CAH 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 quality data and critical access hospital (CAH) interpretive guidelines.

Rural Advocacy Agenda and Legislative Priorities

Several AHA-supported proposals have been introduced during the 110th Congress that would allow CAHs to better serve their communities. These bills are:

The Children's Health and Medicare Protection Act of 2007 (CHAMP) (H.R. 3162) would reauthorize and expand the State Children's Health Insurance Program, but it also includes several provisions in support of rural hospitals and health care including:

- Increasing the DSH adjustment cap
- 2-year extension of floor on Medicare physician work geographic adjustment
- 2-year extension of direct billing for technical component of physician pathology services
- 2-year extension of bonus for physician scarcity areas
- 2-year extention of the hold harmless for OPPS at 90%
- 2-year extension of 5% add-on for rural home health services

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) gives CAHs needed flexibility and allows 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. The bill was introduced by Sens. Gordon Smith (R-OR) and Ron Wyden (D-OR).

Critical Access to Clinical Lab Services Act (S. 1277) would work to restore cost-based

reimbursement of referral lab services. 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. The bill was introduced by Sen. Ben Nelson (D-NE).

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).

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).

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).

REGULATORY PRIORITIES

Medicare Outpatient PPS Proposed Rule

On August 2, CMS published in the *Federal Register* the outpatient prospective payment system (OPPS) proposed rule for CY 2008. The proposed rule contains payment policy and rate-setting proposals that apply to the outpatient PPS. The rule's major provisions include:

- A 3.3% market basket update for OPPS services;
- A requirement that hospitals begin to report data on a set of 10 outpatient quality measures in 2008 in order to receive a full outpatient market basket update in 2009. The rule also solicits comments on an additional 30 measures for possible future implementation;
- Increasing the size of the outpatient PPS payment bundles by packaging the costs of seven ancillary and supportive items and services into the primary procedure;
- Creating two "composite" ambulatory payment classifications (APCs) that would provide one bundled payment for several major services provided on the same date of service during a single encounter;
- Continuing to phase out the hold-harmless outpatient payment for certain rural hospitals with 100 or fewer beds by reducing from 90% to 85% the additional payment made to these hospitals;
- Paying for certain separately payable drugs and biologicals at the rate of average sales price plus 5 percent – a 1% reduction from 2007;
- Raising the fixed-dollar threshold for outliers to $2,000 from $1,825;
- Several changes to the hospital conditions of participation (CoP) related to initial medical history and physical examination and post-anesthesia evaluation requirements; and,
- Reducing the partial hospitalization program per diem rate to $178 from $233.37.

The OPPS rule will adopt the wage indices issued in the inpatient PPS final rule published in August. As in prior years, 60 percent of the APC payment is adjusted by the wage index. CMS proposes to continue its policy of paying for visits to emergency departments that are not open 24 hours a day, seven days a week at the hospital clinic rate.

Changes to CAH and Hospital CoPs

CMS proposes two changes to the Medicare participation requirements for CAHs that participate under a grandfathered "necessary provider" CAH designation. One change involves co-location of CAHs with other facilities and the other involves provider-based facilities of CAHs.

Co-location. CMS proposes that a necessary provider CAH no longer be permitted to enter into co-location arrangements with hospitals unless such arrangements were in effect on or before January 1, 2008 and the type and scope of services offered by the facility co-located with the necessary provider CAH do not change. CMS also clarifies that if a

change of ownership occurs, the CAH's grandfathered necessary provider status and co-location agreement(s) would transfer to the new owner only if the new owner assumes the provider agreement from the previous owner.

CMS notes that current co-location agreements generally involve co-location of a CAH with a specialty psychiatric or rehabilitation hospital. Without the proposed change, CMS is concerned that necessary provider CAHs may co-locate with PPS hospitals, including physician-owned specialty hospitals, or with other CAHs. In CMS' view such co-locations are not consistent with the statutory framework that requires CAHs to meet minimum distance requirements from other hospitals or CAHs. CMS notes that CAHs can operate as many as 45 beds, and that CAHs seeking to provide specialized services can create distinct part units in CAHs rather than making arrangements with other providers to share space at the CAH location.

Provider-based Facilities of CAHs. CMS also proposes to clarify that if a CAH operates a provider-based facility or a psychiatric or rehabilitation distinct part unit that was created after January 1, 2008, it must comply with the CAH distance requirement of a 35-mile drive to the nearest hospital (or 15 miles in the case of mountainous terrain or secondary roads). CMS believes that the necessary provider CAH designation cannot be considered to extend to any facilities not in existence when the CAH originally received its necessary provider designation from the state.

In the case of a necessary provider CAH that violates either of these proposed requirements relating to co-location arrangements or off-campus facilities, CMS would terminate its provider agreement. This could be avoided if the CAH corrected the violation or converted to a hospital paid under the PPS.

Revisions to the Hospital CoPs. CMS is proposing several changes to the hospital CoPs to clarify the timeframe requirements for the initial medical history and physical examination and its update and the post-anesthesia evaluation requirements for patients undergoing outpatient surgeries and procedures. CMS finalized some changes to these requirements in a November 2006 final rule but has received comments that those requirements were unclear in regards to patients receiving outpatient care.

In the existing CoPs, a medical history and physical examination is required to be completed and documented for each patient no more than 30 days before or 24 hours after admission. Additionally, an updated examination of the patient must be completed and documented within 24 hours after admission when the medical history and physical examination are completed within 30 days before admission.

In the proposed rule, CMS states that it will keep these requirements, but add that the medical history and physical examination, or updated examination, also must be completed prior to surgery or a procedure requiring anesthesia services. CMS does not intend to include minor procedures that require only the administration of local anesthetics, such as skin lesion biopsies, under this requirement.

CMS also is proposing slight changes to the CoPs regarding anesthesia services. Currently, a post-anesthesia evaluation must be performed for inpatients within 48 hours of surgery. For outpatients, the CoPs stipulate that a post-anesthesia evaluation must be performed in accordance with the policies and procedures approved by the medical staff. CMS is revising these requirements to develop one policy that is applicable to both inpatients and outpatients. The new requirement will state that a post-anesthesia evaluation must be completed after surgery or a procedure requiring anesthesia services, but before discharge or transfer from the post-anesthesia recovery area. CMS also is clarifying that a pre-anesthesia evaluation must be completed within 48 hours prior to surgery or a procedure requiring anesthesia services.

Comments on the outpatient PPS proposals are due to CMS by September 14. A final outpatient rule will be published this fall and takes effect January 1, 2008.

Reporting of Hospital Quality Data

The *Tax Relief and Health Care Act of 2006* mandated that CMS establish a program under which hospitals must report data on the quality of hospital outpatient care to receive the full annual update to the OPPS payment rate. Hospitals that fail to report outpatient quality data would incur a reduction in their annual payment update factor of 2.0 percentage points, beginning in 2009. CMS proposes to use 10 outpatient measures of care for heart attack, heart failure, surgical care improvement, pneumonia and diabetes mellitus. Hospitals must submit quality data effective with outpatient services provided on or after January 1, 2008. In addition, hospitals must meet administrative and data collection, submission and validation requirements. Data for the outpatient

measures will be collected from hospital records, and CMS is currently finalizing the specifications for these measures so that they explicitly assess care provided in hospital outpatient settings. See the AHA's July 27 *Quality Advisory* for more details.

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.

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 sum also includes Small Hospital Improvement Program grants.

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.

My Care Counts is a nationwide effort to keep quality health care in our communities. *My Care Counts* is asking anyone concerned with our ability to continue to provide access to high quality health services to sign a **Call to Action** urging members of Congress to reject cuts to hospital services under the Medicare and Medicaid programs. Sign on today! To learn more visit http://mycarecounts.org/.

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