American Hospital Association

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

The topic in front of all hospital leaders is the historic health care reform debate and how it could affect hospitals. As the advocate for over 1,600 rural hospital members including 950 critical access hospitals, the AHA has positioned itself as the field leader. This issue of ***CAH Update*** *reviews the health reform proposals being debated in Congress and identifies the issues of specific interest to CAHs. In addition to health reform, this issue reviews the status of legislation, regulation, and other federal policy affecting CAHs plus information on Hospitals in Pursuit of Excellence.*

Health Care Reform

Reforming the current health care delivery system means increasing coverage, creating a more equitable payment system and ensuring patient safety. At the heart of the health care effort should be one very simple maxim: getting people the care they need, when they need it. The American Hospital Association (AHA), Catholic Health Association (CHA) and the Federation of American Hospitals (FAH) were early participants in discussions with the Administration and members of Congress on reform proposals. For information on AHA's health reform strategy visit www.aha.org/aha/advocacy/health-reform.html (login required).

Three legislative measures have been drafted by committees of the U.S. House of Representatives and the U.S. Senate: *America's Affordable Health Choices Act of 2009, Affordable Health Choices Act* and *America's Healthy Future Act of 2009.* The House committees are still in negotiations but the Senate Finance Committee has passed a bipartisan bill that will be presented to the full Senate for a vote. A *Snapshot Comparison of Key Issues* that lists some of the major differences in the House and Senate health care reform packages is available at www.aha.org/aha/content/2009/pdf/090805-aa-attach-health-reform-snapshot.pdf (login required).

U.S. House of Representatives

America's Affordable Health Choices Act of 2009 (H.R. 3200) - The House Ways and Means Committee approved the "tri-committee" health care reform bill that is the product of the leaders of three key House committees: Ways & Means, Energy & Commerce and Education & Labor. This legislation focuses on three key policy areas: coverage, delivery system reform and Medicare and Medicaid payments.

Key proposals in the health care reform bill include:

- An expansive new public plan that – in addition to other insurance market reforms, Medicaid expansions and the creation of an insurance "exchange" – would expand coverage to an estimated 97 percent of Americans;
- Hospital payment cuts of $119 billion in market basket update reductions, $16 billion in payment reductions related to hospital readmissions and $20 billion in Medicare and Medicaid disproportionate share hospital (DSH) payments; and
- Elimination of the exception for physician-owned hospitals under the whole hospital and rural provider exceptions under the Stark law.

Of particular interest to CAHs is a provision to expand the 340B program to inpatient drugs for public and high-DSH non-profit hospitals. The bill also extends access to 340B inpatient and outpatient drugs for children's, critical access hospitals, Medicare-dependent hospitals, sole community hospitals, and rural referral centers.

U.S. Senate
In the Senate, health reform proposals were developed by the Health, Education, Labor and Pensions (HELP) Committee and the Finance Committee.

Affordable Health Choices Act (S.1679) - Introduced by Senator Tom Harkin (D-IA) for the HELP Committee. The bill creates a government-run public plan where the Secretary of HHS would negotiate provider payment rates, but leaves 34 million uninsured by 2019. Of interest to CAHs is the proposed expansion of the 340B drug discount program to CAHs and other entities.

America's Healthy Future Act of 2009 - On September 16, Senator Max Baucus (D-MT), chairman of the Senate Finance Committee, marked up the language proposed for this bill. The mark expands coverage, introduces new delivery system reforms, reduces Medicare and Medicaid payments and includes key provisions agreed to by the AHA, CHA, and FAH. The Senate bill includes a number of provisions that are relevant to rural PPS hospitals.

Of special interest to CAHs are provisions in the bill that would extend the Medicare Rural Hospital Flexibility Program through 2010, including SHIP grants; creating a national pilot program on payment bundling; and requiring rural consultation for reducing avoidable hospital readmissions. An amendment to the bill includes a technical correction which clarifies that CAHs are eligible to receive 101 percent of reasonable cost for providing outpatient services regardless of the billing method and for providing qualifying ambulance services. A final proposal will be presented to the full Senate for a vote. Provisions in all three proposals specific to small or rural hospitals may be found at http://www.aha.org/aha/member-center/constituency-sections/Small-or-Rural/ruralprovisions.html.

Whether included as part of health care reform legislation or through other legislative measures, the AHA will continue its advocacy efforts on behalf of CAHs that would allow an option to operate on average up to 20 inpatient beds per day, while having more than 25 at other times allowing for seasonal or other fluctuations, eliminate the distance requirements for cost-based reimbursement of CAH-based ambulance services, allow CRNA standby costs and pass-through payments, and extend the 340B drug discount pricing program to include inpatient drugs, as well as expand eligibility to include rural CAHs, Medicare dependent hospitals, sole community hospitals and rural referral centers.

As health care proposals advanced on Capitol Hill, the AHA is urging lawmakers to include medical liability reforms as part of any comprehensive health reform legislation that clears Congress. (See the one-page summary of the AHA's framework for liability reform www.aha.org/aha/content/2009/pdf/090922-framework-liability-reform.pdf).

Federal Budget

SELECT RURAL PROGRAMS (in millions)	Final FY 2009 Funding Level	President's Budget FY 2010	House FY 2010 approved	Senate Committee FY 2010 adopted
Telehealth	$7.55	$8.0	$15.0	Data unavailable
Rural Health Outreach Grants	$53.90	$55.0	$56.6	$55.45
Rural Health Policy Development	$9.7	$10.0	$10.2	$9.7
Rural Hospital FLEX grants	$39.2	$39.0	$41.2*	$41.2**
State Offices of Rural Health	$9.2	$9.0	$9.7	$10.45
Delta Health Initiative	$26.0	$0	$0	$40.0
Denali Commission	$19.6	$0	$0	$10.0

*Of that amount, $15.0 million is allocated to continue the Small Rural Hospital Improvement Program
**Of that amount, the Senate Committee includes $39.2 million to continue the Small Rural Hospital Improvement Program

On July 24, the House approved $73.7 billion in discretionary funding for Department of Health and Human Services programs in fiscal year (FY) 2010. Funding would increase by $92 million for nursing programs, $10 million for children's hospitals' graduate medical education programs, $43 million for bioterrorism hospital preparedness grants, and $23 million increase for rural health programs. The bill (H.R. 3293) provides FY 2010 funding for the Departments of Labor, Health and Human Services, and Education. On July 30, the Senate Appropriations Committee passed its version of a FY 2010 appropriations bill. However, movement on finalizing the FY 2010 appropriations bills has stalled. Congress adopted a Continuing Resolution to fund the government at FY 2009 levels through October 31. Veterans' health care is funded above 2009 levels.

The compares FY 2009 funding levels for key rural programs and services with the president's proposal, the House's approved and the Senate's committee's FY 2010 levels.

Legislative Advocacy

Several AHA-supported proposals have been introduced during the 111th Congress that would support critical access hospitals (CAH) and their communities.

Extending Medicare FLEX Grants
Introduced by Sen. Charles Grassley (R-IA) the *Medicare Rural Health Access Improvement Act of 2009* (S. 318) would extend Medicare FLEX Grants. The bill also improves Medicare dependent hospital (MDH) program payments to hospitals without regard to any adjustment for different area wage levels; redefines a low-volume PPS hospital as located more than 15 road miles from another PPS hospital and having less than 2,000 Medicare Part A beneficiary discharges; extends and expands the Medicare hold-harmless for outpatient PPS and sole community hospitals (SCH) adjustments; extends treatment of physician pathology services under Medicare; extends rural ground ambulance bonus; improves payment to rural health clinics at $92 per visit; and exempts durable medical equipment supplies in small metropolitan statistical areas and rural areas.

Medicare 340B Program Improvement
The 340B Program Improvement and Integrity Act of 2009 (H.R. 444) would amend the *Public Health Service Act* to expand the 340B drug discount pricing program to include outpatient and inpatient drugs at CAHs, small rural MDHs, SCHs and rural referral centers. Enrolled hospitals would be prohibited from obtaining covered outpatient drugs through a group purchasing arrangement; however, the HHS Secretary would be required to establish reasonable exceptions to such requirements, including for drugs unavailable

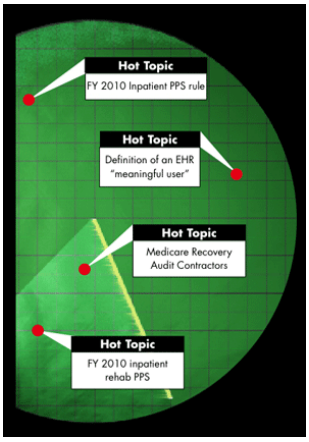
through the program, and to facilitate generic substitution when a covered drug is available at a lower price. Participating hospitals also would be required to provide to each state a credit on the estimated annual costs for drugs provided to Medicaid recipients for inpatient use. The bill was introduced by Reps. Bobby Rush (D-IL), Bart Stupak (D-MI) and Jo Ann Emerson (R- MO).

Bed Count Flexibility for Determining CAH Status
Introduced by Sens. Ron Wyden (D-OR) and Mike Crapo (R-ID) and Reps. Ron Kind (D-WI) and Greg Walden (R-OR), the *Critical Access Hospital Flexibility Act of 2009* (S. 307/HR. 668) would provide flexibility in the manner in which beds are counted for purposes of determining whether a hospital may be designated as a CAH under the Medicare program. The bill would allow either 25 beds on a daily basis or 20 beds, as determined on an annual, average basis. Only inpatient beds that are occupied shall be counted when determining the number of beds. It also excludes beds used to provide care to a veteran referred to the CAH by the Veterans Administration.

Pass-through and Standby Costs for CRNAs
Introduced by Sen. Richard Durbin (D-IL) and Rep. Phil Hare (D-17th IL), the *Rural Access to Nurse Anesthesia Services Act* (S. 1585/H.R. 3151) would permit pass-through payment for reasonable costs of certified registered nurse anesthetist (CRNA) services in CAHs notwithstanding the reclassification of such hospitals as urban hospitals, including hospitals located in "Lugar counties," and for on-call and standby costs for CRNA services.

The AHA's advocacy agenda for small or rural hospitals may be found at http://www.aha.org/aha/member-center/constituency-sections/Small-or-Rural/2009advocacyagenda.html.

Regulatory Update



2010 Inpatient PPS Final Rule
In the FY 2010 inpatient PPS final rule, the Centers for Medicare & Medicaid Services (CMS) addressed four policies related to CAHs. The agency:

- Implements Section 148 of the *Medicare Improvements for Patients and Providers Act of 2008*, which provided that clinical laboratory services furnished by a CAH be reimbursed 101 percent of costs, regardless of whether the patient is physically present in the CAH at the time the specimen is collected. Specifically, CAHs will receive 101 percent of costs for clinical laboratory services if the individual receives outpatient services in the CAH (or in a facility that is provider-based to the CAH) on the same day the specimen is collected or if the specimen is collected by an employee of the CAH (or of a provider-based department of the CAH). In either case, the individual does not need to be physically present in the CAH at the time the specimen is collected. If the individual is physically present in the CAH, or a department that is provider-based to the CAH when the specimen is collected, the CAH will continue to receive cost-based reimbursement. Under law, this policy is retroactively effective to July 1.
- Requires facilities furnishing only clinical diagnostic laboratory tests that operate as part of a CAH to meet provider-based criteria in order for the CAH to be paid for the services furnished at those facilities at 101 percent of reasonable costs. This policy is effective October 1, 2010.
- Changes the manner in which "Method 2" payments to CAHs are made. The statute that provides for Method 2 payments states that, under this method, CAHs will be reimbursed their reasonable costs for outpatient services; the statute does not specify that, under this method, CAHs will be reimbursed 101 percent of their reasonable costs for outpatient services. The rule adopts CMS' proposal to reimburse CAHs electing Method 2 at 100 percent of their reasonable costs for Method 2 outpatient services instead of at 101 percent of their reasonable costs for Method 2 outpatient services. Payments for CAHs that do not elect Method 2 and payments for professional services under Method 2 are not affected. This policy becomes effective for cost reporting periods beginning on or after October 1.

- Refrains from proposing or adopting any changes to rules regarding whether an ambulance service owned and operated by a CAH, and is eligible to receive reasonable cost-based payment, should be required to meet the provider-based status rules. In its final rule, CMS reiterates that it may be appropriate to require any part of a CAH to meet the provider-based rules in order to be paid at reasonable cost, but is not at this time proposing or adopting any changes to the regulations at §413.65 to require CAH-owned and operated ambulance services that are eligible to be paid at reasonable cost to meet the provider-based status rules.

CY 2010 Outpatient PPS Proposed Rule - Physician Supervision
In an August 26 comment letter regarding CMS' outpatient PPS proposed rule CY 2010, the AHA urged the agency to change its proposal for physician supervision of outpatient therapeutic and diagnostic services to make the policy a better fit with the way in which health care is delivered across the spectrum of hospital types.

Specifically, the AHA recommended that CMS further revise its definition of "direct supervision" to allow the supervising professional to be located anywhere on the hospital's campus or in a location in close proximity to the campus as long as he or she is able to respond in a timely manner, in accordance with the hospital's or CAH's policies, in order to furnish assistance and direction throughout the performance of the procedure. The AHA also called on CMS to allow non-physician practitioners to supervise cardiac and pulmonary rehabilitation services, and permit clinical social workers to supervise outpatient psychiatric services.

In addition to these improvements, the association urged CMS to consider a more thoughtful approach to the physician supervision of outpatient services. A final rule will be published by November 1 and takes effect January 1, 2010.

Other Regulatory Changes
Standby Costs: In February, and for the second time in 12 months, a ruling came before the Provider Reimbursement Review Board (PRRB) contesting nonpayment of CRNA standby costs at a CAH. The board ruled in favor of the hospital and the AHA wrote to CMS urging the agency to affirm the PRRB decision. In a May 1 decision, CMS stated that Medicare will not reimburse CAH costs for on-call CRNAs. The AHA remains concerned that disallowing CRNA's standby costs threatens patients' access to care by forcing hospitals to inappropriately absorb these costs.

Pass-through Payments: CMS declared that CAHs in "Lugar" counties or rural CAHs in whole counties deemed as a metropolitan statistical area no longer qualify for Medicare Part B billing exemption for CRNA services because they operate in an area considered metropolitan under CMS classification. CAHs are by definition limited-service facilities located in rural areas and CMS considers CAHs to be "hospitals" for purposes of extending eligibility for CRNA pass-through payments. Congressional intent was that urban hospitals that are redesignated and treated as rural hospitals would receive "all categories and designations available to rural hospitals," which would include pass-through payments for CRNA services. Nevertheless, CMS has denied pass-through payments to CAHs. This decision is being challenged at the administrative level.

Payment for Co-surgeons in a Method II CAH: When billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue codes (RC) 96X, 97X or 98X). Under some circumstances, the skills of two surgeons (each in a different specialty) are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. Medicare will pay for co-surgeon services only when the services are rendered by two surgeons, each with a different specialty, and the claim carries modifier 62 to show there were two surgeons for co-surgery.

Payment of Bilateral Procedures in a Method II CAH: Physicians and non-physician practitioners billing on type of bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning

their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue codes (RC) 96X, 97X or 98X). Bilateral procedures are procedures performed on both sides of the body during the same operative session. Medicare makes payment for bilateral procedures based on lesser of the actual charges or 150 percent of the Medicare Physician Fee Schedule (MPFS) amount when the procedure is authorized as a bilateral procedure. CR 6526 implements the 150 percent payment adjustment for bilateral procedures. Medicare contractors use payment policy indicators associated with certain procedures in the MPFS in processing claims and determining payment. Bilateral procedures rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedure is authorized as a bilateral procedure and is billed on TOB 85X with revenue code (RC) 96X, 97X or 98X and the 50 modifier (bilateral procedure).

Diabetes Self-Management Training (DSMT) Certified Diabetic Educator: Many CAHs provide diabetes self-management training and CMS allows for an exception for rural areas. That is, in a rural area, an individual who is qualified as a registered dietitian and as a certified diabetic educator that is currently certified by an organization approved by CMS may furnish training and is deemed to meet the multidisciplinary team requirement.

2010 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments: *The Medicare Prescription Drug Improvement and Modernization Act* Section 413(b) mandated that the automated HPSA bonus payment files be updated annually. CMS will create a new automated HPSA bonus payment file for claims with dates of service on or after January 1, 2010, through December 31, 2010 that will be posted in early December. Hospitals will find the annual HPSA bonus payment file and other HPSA information at www.cms.hhs.gov/hpsapsaphysicianbonuses. CAHs also should review the CMS Web site to determine whether a HPSA bonus will automatically be paid for services provided in your ZIP code area or whether a modifier must be submitted. You can determine if you are eligible for the automated payment by going to https://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/Downloads/instructions.pdf and following the instructions on the page.

Off-campus, Provider-based, and Co-location Requirements: The state operations manual used by surveyors for CAHs has been updated to reflect new standards and interpretive guidelines for co-location and off-campus services which could affect more broad-based CAH services. The guidelines stipulate that the distance to another hospital or CAH requirement does **not** apply to the following types of facilities/services, because such facilities or services are not eligible for provider-based status in accordance with §413.65(a)(1)(ii): Ambulatory surgical centers; comprehensive outpatient rehabilitation facilities; home health agencies; skilled nursing facilities; and hospices. CAHs need to be aware of the change and read this section carefully or risk losing their CAH status. The addition includes Section 485.610(e) Standard: Off-campus and Co-Location Requirements for CAHs. You can find the new Appendix W for CAHs at http://www.cms.hhs.gov/manuals/downloads/som107ap_w_cah.pdf.

Tricare Payments: A final rule implementing a Tricare payment method that pays CAHs the Medicare rate of 101 percent for inpatient, outpatient and swing-bed services was published in the August 31 *Federal Register.* The AHA had urged the Department of Defense to adopt Medicare's exact methodology for determining CAH reimbursement for inpatient and outpatient care. The AHA is pleased that the department has responded to the needs of beneficiaries and CAHs alike.

Hospitals in Pursuit of Excellence

The AHA's Hospitals in Pursuit of Excellence (HPOE) is a new resource for hospitals that provides field-tested practices, tools, education and other networking resources to accelerate performance improvement in the nation's hospitals. Visit the HPOE Web site at www.hpoe.org for additional information

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