



SUMMER 2009

American Hospital
Association

*As Congress tackles health care reform legislation, the AHA continues to advocate on behalf of America's hospitals to ensure your issues are part of the reform debate. The association also continues to work with the Centers for Medicare & Medicaid Services (CMS) and other federal agencies for fair regulations affecting rural hospitals. This **Small or Rural Update** includes the latest information on health care reform, rural health appropriations in the federal budget and key rural health legislation and regulations.*

Health Care Reform

The AHA's health care reform principles call for coverage for all, paid for by all. On July 8 the AHA, Catholic Health Association and Federation of American Hospitals announced an agreement with the White House and Senate Finance Committee Chairman Max Baucus, D-MT, that calls for reductions in Medicare and Medicaid payments of \$155 billion over 10 years, with those reductions tied to expanding coverage to 95% of Americans.

By expanding coverage, the AHA estimates, conservatively, that hospitals' uncompensated care burden will be eased to at least \$171 billion. Some health care analysts believe the savings will be even more. Bank of America-Merrill Lynch estimates hospitals could gain between \$214 billion to \$236 billion over 10 years through expanded coverage. The emerging Senate Finance Committee package offers an important opportunity to develop a bipartisan product, and would avoid billions of dollars in provider cuts proposed in the House reform bill. That bill's troubling public plan option continues the underfunding of providers by paying Medicare rates, and has an overly aggressive readmissions policy. We also oppose two proposals now circulating in Congress that would create a new federal entity with broad authority to cut Medicare spending by targeting provider payments. A White House proposal would create an "Independent Medicare Advisory Council," also known as IMAC with members appointed by the president. A similar proposal by Sen. Jay Rockefeller (D-WV) and Rep. Jim Cooper (D-TN) would vastly expand the powers of the current MedPAC. Both proposals would give a new entity broad authority to set reimbursement rates for Medicare providers, and would make those decisions binding unless Congress acted specifically to stop them.

Health reform is unfolding rapidly in Washington. To help members navigate the course of this historic debate and how legislation could affect hospitals, the AHA every week, and additionally as events warrant, e-mails hospital leaders *Health Reform Update* with links to that week's latest news, resources and advocacy. Check www.aha.org and go to [Health Reform Update](#) for more information.

Federal Budget

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, which now moves to the full Senate for a vote.

The table 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.

SELECT RURAL PROGRAMS (in millions)	Final FY 2009 Funding Level	President's Budget FY 2010	House FY 2010 approved	Senate Comm. 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.	\$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
National Health Service Corps	\$134.97	\$169.0	\$141.8	\$142.0
Nurse Loan Repayment and Scholarships	\$37.13	\$125.0	\$125.0	\$64.1

* 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

Legislative Advocacy

Several AHA-supported proposals have been introduced during the 111th Congress that would support small or rural prospective payment system (PPS) hospitals and critical access hospitals (CAHs).

Improved Payments for Low-volume Hospitals

Introduced by Reps. Leonard Boswell (D-IA) and Jo Ann Emerson (R-MO), the *Rural Hospital Assistance Act of 2009* (H.R. 362) would increase the Medicare inpatient payment adjustment for low-volume hospitals located more than 15 road miles from another PPS hospital and having less than 1,500 Medicare Part A beneficiary discharges. H.R. 362 also would allow the use of non-wage adjusted PPS rates under the Medicare-dependent hospital (MDH) program and eliminate the Medicare hospital exception for physician-owned hospitals with a limited exception for existing facilities.

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 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.

Improved Medicare Reimbursement for Rural Providers

Sens. Kent Conrad (D-ND), Pat Roberts (R-KA), Tom Harkin (D-IA) and John Barrasso (R-WY) have introduced AHA-supported legislation that would improve Medicare reimbursements to rural hospitals. *The Craig Thomas Rural Hospital and Provider Equity Act of 2009* (S.1157) would temporarily increase payments for hospitals with low-volume inpatient discharges and continue allowing direct payments to independent laboratories for the technical component of pathology services and the 5% rural add-on payment for home health services. In addition, it would extend the outpatient hold-harmless provision for SCHs and rural hospitals with fewer than 100 beds, remove the cap on disproportionate share hospital (DSH) adjustment percentages for all hospitals and improve payments for ambulance services in rural areas.

Regulatory Advocacy

2010 Inpatient PPS Final Rule

CMS has issued a hospital inpatient and long-term care prospective payment system [final rule](#) for fiscal year 2010 that would increase average inpatient payments by 1.6%. The final rule includes a market-basket update of 2.1% for those hospitals that submit data on quality measures; hospitals not submitting data would receive a 0.1% update. While the proposed rule initially included a cut of 1.9% to eliminate what CMS claims is the effect of coding or classification changes which the agency says do not reflect real changes in case-mix, the final rule does not implement this cut. This represents an increase of \$2.2 billion in payments to hospitals in FY 2010. CMS stated that it will wait until it analyzes data from FY 2009 before it makes a documentation and coding-related cut. The AHA is pleased that CMS has taken the prudent approach and decided to wait until it has complete data from FY 2008 and FY 2009 before implementing a cut. CMS also reversed its prior cut of capital indirect medical education payments to teaching hospitals, resulting in about \$5 billion to teaching hospitals over the next 10 years. The AHA is reviewing the final rule and will provide additional details to members in an upcoming *Special Bulletin*.

CAH-specific Proposals

Payment for Clinical Diagnostic Laboratory Tests Furnished by CAHs. Under the proposed rule, CAHs would be able to receive reasonable cost-based payments for outpatient clinical diagnostic laboratory tests furnished to a beneficiary who is an outpatient of the CAH (and therefore receiving services directly from the CAH) even if the beneficiary is not physically present in the CAH at the time the specimen is collected.

The AHA urges CMS to explicitly state that if the patient for which the laboratory services are performed is in a facility that is *not* provider-based to the CAH, the CAH will still receive 101 percent of costs for these services, as long as the patient received outpatient services in the CAH on the same day the specimen was collected or an employee of the CAH collected the specimen. Secondly, the AHA requests that CMS explicitly state that employees of CAHs' provider-based facilities are considered employees for purposes of this policy. Clarification is needed that CAHs will still receive 101 percent of costs for clinical laboratory services if the specimen was collected by an employee of a CAH's provider-based facility.

CAH-Based Clinical Diagnostic Laboratory Facilities. CMS believes that clinical diagnostic laboratory facilities could generate an increase in Medicare payments when they are part of a CAH compared to when they are freestanding or when they are part of a hospital. CMS proposes that these facilities, which are currently exempt from provider-based determinations, must meet the applicable provider-based status requirements when they are part of a CAH in order for the CAH to receive payment for their clinical diagnostic laboratory services based on reasonable cost. In addition to meeting the provider-based status requirements, these provider-based facilities also would have to meet other requirements for provider-based facilities operated by CAHs, including distance requirements.

The AHA opposes requiring laboratory facilities that operate as part of a CAH to meet applicable provider-based criteria in order for the CAH to be paid for the services furnished at those facilities at 101 percent of reasonable costs and urges CMS to drop any further consideration of this requirement.

Method II Payment. CMS proposes requiring CAHs that select the optional method (Method II) of reimbursement for outpatient facility services to receive 100 percent of reasonable cost instead of 101 percent of reasonable cost for those facility services. The proposed change would not affect payment for the professional component paid to physicians.

The AHA believes that this proposed change to Method II payments goes directly against the intent of Congress, and is disappointed that CMS did not conduct a financial impact analysis of this proposed change. Given that the impact of this proposal is so large for these small hospitals, CMS should withdraw its proposed change to CAH Method II payments. If the agency wants to move forward with this proposal, it should both set forth its own detailed and thorough impact analysis and re-issue its proposed change in the inpatient PPS final rule to again solicit comments that will be informed by the results of CMS' impact analysis. Unless this occurs, the public will be lacking information that is critical for them to adequately comment on this proposal.

CAH-Based Ambulance Services. In the proposed rule, CMS solicits public comments 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. The AHA believes that such a requirement is not appropriate. The existing 35-mile ambulance-related distance requirement meets the requirements of the law and is more than adequate to ensure that only appropriate ambulance services receive cost-based reimbursement.

CY 2010 Outpatient PPS Proposed Rule

CMS released the calendar year (CY) 2010 outpatient PPS and ambulatory surgical center (ASC) proposed rule on July 1. The proposed rule includes a 2.1 percent market basket update for outpatient PPS services, with hospitals projected to receive a total of \$31.5 billion for outpatient services in 2010. Comments on the proposed rule are due to CMS by Aug. 31. A final rule is expected this fall and takes effect Jan. 1, 2010. A detailed summary of the proposed rule can be found in AHA's July 24 [Regulatory Advisory](#).

Quality Reporting. Hospitals in 2010 must continue to report on the 11 outpatient quality measures finalized in last year's final rule. Hospitals that fail to meet the outpatient reporting requirements would receive a 2 percent reduction in their payment update. CMS does not propose to add any new quality measures for the 2011 annual payment update.

The rule outlines a proposed data validation process for 2011; while hospitals would be required to participate in the validation process to receive their full annual payment update, the results of their data validation would not affect their payment. The rule also discusses a different data validation process that would begin in 2012 and is similar to the process outlined in last year's proposed rule.

Healthcare-associated Conditions. CMS discusses some of the comments received to date on whether and how it should expand its healthcare-associated conditions policy to the hospital outpatient setting, but the agency offers no new proposals.

Physician Supervision. In response to concerns raised by the AHA and other hospital and physician groups, CMS proposes to revise several policies for the physician supervision of outpatient services, beginning in 2010. However, CMS does not rescind its physician supervision policy "clarification" laid out in its 2009 outpatient PPS final rule, which the AHA asserts is a change in policy, not merely a clarification. The AHA will continue to press for rescission in its comment letter.

As the AHA prepares comments on the proposed rule, we seek feedback from members on whether changes CMS proposes to the physician supervision requirement for therapeutic outpatient services for 2010 and beyond fully meet the needs of hospitals and their patients. In the [proposed rule](#) the CMS says it has eliminated the requirement for therapeutic outpatient services furnished in a hospital, CAH or their on-campus outpatient departments that a supervising physician (or certain non-physician practitioners who would now be permitted to provide supervision as part of the proposed rule change) must be present in the department when the procedure is performed. Instead, as the proposed rule reads, "direct supervision" for such services requires that the supervising practitioner must be present "on the same campus, in the hospital or CAH or on-campus provider-based departments of the hospital or CAH" and "immediately available to furnish assistance and direction while the procedure is being performed." Thus, the proposed change may not offer hospitals any greater compliance flexibility than the current requirement because CMS' preamble discussion suggests that the "general definition of immediate" means "without interval of time." AHA members are encouraged to e-mail their feedback to docsupervisionrule@aha.org.

Emergency Department Services. In 2010, CMS proposes to pay for all five emergency department (ED) service levels provided in "Type B" EDs – those that offer emergency-level services but are not open 24/7 – using their median costs, similar to how "Type A" ED (EDs open 24/7) payments are calculated. In order to accomplish this, CMS would create a new ambulatory payment classification for a Level 5 Type B Emergency Visit.

Hold-harmless Payments and Adjustment for Rural SCHs. As required by law, CMS no longer would provide hold-harmless outpatient payments to rural hospitals and SCHs with 100 or fewer beds. However, CMS will continue to apply a 7.1 percent payment increase for most rural SCH services and procedures paid under the outpatient PPS.

CY 2010 Physician Fee Schedule Proposed Rule

In the CY 2010 physician fee schedule proposed rule, CMS proposes cutting physicians' Medicare payments by 21.5%. However, in anticipation of similar action by Congress, CMS proposes to remove physician-administered drugs from the annual payment update formula, which the agency projects will increase physician payments in future years. CMS also proposes reducing physician payments for advanced imaging services in order to promote reduced utilization, and requiring certain providers of the technical component of advanced imaging services, including physician offices, mobile units and independent diagnostic testing facilities, to be accredited by 2012, as

stipulated in the *Medicare Improvements for Patients and Providers Act*. Comments on the proposed rule are due to CMS by Aug. 31.

Other Regulations

Certified Registered Nurse Anesthetists

There are two issues related to payment of certified registered nurse anesthetists (CRNA) – standby costs and pass-through payments – that remain unresolved.

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 a letter to CMS urging them to affirm the PRRB decision. However, 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.

IN MEMORIAM

Shirley Ann Munroe Rural Health Care Advocate

Shirley Ann Munroe, a rural health care leader and former AHA vice president, died June 7 at age 85. She served as the first director of the AHA’s Section for Small or Rural Hospitals.

The AHA established the Shirley Ann Munroe Leadership Award in her honor in 1990, the year after she retired from the association. The award recognizes small or rural hospital executives and administrators who have achieved improvements in local health delivery and health status through their leadership. The award’s 20th winner will be named this year.

When it established the award, the AHA said that “Shirley Ann Munroe set a standard of dedication and leadership that continues to inspire her professional peers in small and rural hospital administration.”

Munroe was administrator of then 43-bed Hillside Hospital – now Adventist Health Ukiah (CA) Valley Medical Center – from 1956 to 1977, when she joined the AHA. She served as an AHA vice president in Chicago for 12 years.

Her legacy is a benchmark for professional hospital management, rural community health development, and health care representation and advocacy.



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

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