

CAH Update

Fall 2005

This issue of **CAH Update** reports on legislative priorities, regulatory activities, fiscal year (FY) 2006 appropriations, quality initiatives and national growth statistics. As of October 31, CMS reported that there were 1,168 CAHs, representing 54 percent of rural community hospitals and 24 percent of all U.S. community hospitals.

AHA's Key Advocacy Issues

The AHA's advocacy agenda continues to focus on four key issues: Medicaid protection, a ban on physician self-referral to new limited service hospitals, and legislation to protect access to rehabilitation services and stop the expansion of the post-acute care transfer policy.

Budget Bills Advance AHA Agenda

On November 3, the Senate passed a budget reconciliation package that contained several provisions advocated by the AHA and hospital leaders. The Senate package includes a permanent ban on physician self-referral to new limited-service hospitals; a two-year extension of the 50 percent threshold for inpatient rehabilitation hospitals; a one-year extension of the outpatient "hold harmless" provision for Sole Community Hospitals (SCHs) and rural hospitals with fewer than 100 beds, and rebasing and extension of the Medicare Dependent Hospital program until 2011, among other hospital-specific measures. The House of Representatives is expected to vote on its budget-reconciliation legislation in November. Their package currently includes no Medicare provisions and roughly \$11 billion in Medicaid cuts. Our critical concern with the House bill is a provision that would regulate the rate out-of-network hospitals and their emergency departments (EDs) are paid by Medicaid managed care plans. At a minimum, this provision would cut hospital ED care by at

least \$60 million over the next five years. Tens of millions of dollars more in cuts from hospitals could benefit managed care plans. The House is expected to vote soon, and House and Senate conferees will then be appointed to reconcile the bills. Congressional leaders have expressed a desire to have a conference bill finished before the Thanksgiving recess. However, action could be delayed until December.

Legislative Priorities

A summary of legislative priorities follows.

Critical Access to Clinical Lab Services

CMS requires a patient to be "physically present in a critical access hospital" when a laboratory specimen is collected in order for the CAH to receive cost-based reimbursement. Both the Senate and the House have introduced legislation (S. 236/H.R. 1016) to reinstate cost-based reimbursement to CAHs for reference lab services provided to patients who are not physically present in the hospital. The AHA will continue to urge lawmakers to pass this bill introduced by Sens. Ben Nelson (D-NE) and Susan Collins (R-ME), and Reps. Butch Otter (R-ID) and James Oberstar (D-MN).

Rural Community Hospital (RCH) Assistance Act

Under the Rural Community Hospital Assistance Act, hospitals with 25 to 50 beds would be eligible for cost-based reimbursement for inpatient and outpatient services. The bill (S. 933/H.R. 2350), introduced by Sens. Ben Nelson (D-NE) and Susan Collins (R-ME), and Reps. Jerry Moran (R-KS) and Rubén Hinojosa (D-TX), also would expand cost-based reimbursement for CAH skilled nursing facilities, home health services and ambulance services.

Payment under Medicare Advantage

Under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), non-contracting CAHs must be paid 101 percent of costs for inpatient and outpatient care. The Rural Health Equity Act (H.R. 880), introduced by Reps. Ron Kind (D-WI) and Tom Osborne (R-NE), would ensure that Medicare Advantage plans pay at least this amount to contracting CAHs and rural health clinics for those services.

Expanding 340b Program Eligibility to CAHs

The 340b drug discount program provides safety net hospitals with the ability to purchase pharmaceuticals at Medicaid prices for outpatient services. Currently, CAHs are unable to participate because they do not receive Medicare disproportionate share hospital (DSH) payments under the inpatient PPS. The AHA will continue to advocate for S. 1840/H.R. 3547, introduced by Sens. John Thune (R-SD), Jeff Bingaman (D-NM), Rep. JoAnn Emerson (R-MO), and Bobby Rush (D-IL), which would expand the 340b program to include inpatient services and allow CAHs to participate.

Rural Access to Emergency Services Act of 2005

The proposed legislation (S. 1108/H.R. 2525) would allow critical hospitals to receive cost-based reimbursement when providing ambulance services regardless of distance traveled, ensure rural EMS squads receive full reimbursement for emergency runs, establish an ambulance-specific definition of "rural" and "urban" for Medicare reimbursement, provide resources for the purchase of telecommunications equipment, and provide demonstration project funds to integrate EMS systems with the state and local health care systems. This legislation was introduced by Sens. Kent Conrad (D-ND) and Pat Roberts (R-KS) and Reps. Mark Kennedy (R-MN) and Earl Pomeroy (D-ND).

Medicare Rural Home Health Payment Fairness Act

The AHA supports S. 300/H.R. 11, which would amend the MMA to provide for a two-year extension of the temporary 5 percent Medicare payment increase for home health services furnished in rural areas. The legislation is sponsored by Sen. Susan Collins (R-ME) and Rep. Greg Walden (R-OR).

FY 2006 Appropriations

The House passed its version of the FY 2006 Labor-HHS-Education appropriations bill in June, while the Senate approved its version in late October. The bills are currently in conference committee.

The FY 2006 appropriations for the Rural Hospital Flexibility Program include \$64.180 million dollars. This includes \$39.180 million for the FLEX grant program and \$25 million for a Rural Health, Education, and Workforce Infrastructure Demonstration Program to solicit and fund proposals from local governments, hospitals, universities, and rural public health-related entities and organizations for research development, educational programs, job training, and construction of public health-related facilities. Funding levels for other rural programs include Quentin Burdick Nurse training at \$6.076 million, Rural Health Research at \$8.825 million; rural telehealth at \$3.888 million; Rural Access to Emergency Devices \$8.927 million; rural EMS at \$0.5 million; and \$8.321 million for State Offices of Rural Health.

Regulatory Update

CMS has issued its final rule on Inpatient PPS for FY 2006. This rule addresses the concerns that many CAHs, who are necessary providers, have about their ability to rebuild aging facilities in a location other than their current location. In addition, CMS has issued a number of change requests (CR) and transmittals related to payment issues for CRNAs, Method II billing for physicians, physician scarcity area (PSA) bonuses, health professional shortage area payments (HPSA), and low osmolar imaging. A transmittal was also issued on Section 1011 funding for ER care for undocumented immigrants.

Medicare Inpatient PPS Final Rule for FY 2006

The rule, published in the August 12 *Federal Register*, included important information about the CAH relocation requirements that were outlined in the proposed rule of May 5. In that rule, CMS had proposed to bar necessary provider CAHs from relocating more than 250 yards from their current location, unless they were under development by December 8, 2003.

The AHA opposed this rule and as a result, worked with CAH members to communicate

to CMS the detrimental effects that this rule would have.

As advocated by the AHA, CMS removed the arbitrary date restrictions and will allow a CAH, including existing necessary providers, to relocate if it meets the three criteria of a “75 percent test.” That is, 75 percent of the patients must come from the same service area as before the relocation, 75 percent of the services must be the same as at the prior facility, and 75 percent of the staff must be the same as at the prior facility. CMS did not adopt provisions in the proposed rule that would have set a date by which a CAH must notify CMS of its intent to relocate or required that construction plans were under way prior to the enactment of the MMA.

The proposed PPS inpatient rule also addressed CAHs in “Lugar counties.” These counties, named after Sen. Richard Lugar (R-IN) who authored the provision, are rural counties adjacent to one or more urban counties and considered to be in the Metropolitan Statistical Area to which the greatest number of workers in the county commute. CMS proposed changes that would permit CAHs located in a county that in FY 2004 was not part of a Lugar county, but as of FY 2005 was included in such a county as a result of the new labor market area definitions, to maintain their CAH status until September 30, 2006. After October 1, 2006, these facilities would have to meet at least one of the criteria in §412.103(a)(1) through (a)(3) to be eligible to reclassify from urban to rural status.

In the final rule, CMS eased the burden for these facilities. Beginning in FY 2006, facilities in Lugar counties will be considered for the purposes of CAH participation to be located in rural areas. CAHs will not need to submit an application for reclassification to remain in compliance with the Conditions of Participation.

Certified Registered Nurse Anesthetists (CRNA) Pass-through Payments

In its CR Transmittal 3833 dated July 22, CMS clarifies that payment for Method I and Method II CAHs keep their pass-through exemptions and includes billing instructions for Method II CAHs that gave up their pass-through exemption. Method I CAHs were not given instructions on CRNA pass-through billing. As a result, some CAHs have not been paid for their CRNA pass-through services since October 2002. CR 3833 directs fiscal intermediaries (FIs) to pay CRNA

pass-through whenever the CRNA indicator is present on the provider files. In addition, Method II CAHs that gave up their pass-through exemptions were not receiving proper reimbursement and the formula has been corrected. Regardless of which option a CAH chooses (Method I or Method II), CAHs that qualify for the CRNA exemption can receive payment for the CRNA professional fees from their FI.

Billing Requirements for Physicians under Method II Critical Access Hospitals

CR 3800 updates and replaces an earlier transmittal regarding type of bill 85x; payment at 115% of the applicable Medicare Physician Fee Schedule (not supplemental); procedures for bonus payments for services rendered at off-site outpatient departments; and clarification on exemption of CAHs from the one- and three-day window provisions.

Implementation of PSA Bonus and HPSA Payment to CAH

In CR 3790, with an effective date of January 1 and implementation date of July 15, CMS states that physician scarcity designations will be based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in every county. In addition, physician scarcity areas will be identified based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in each identified rural census tract. Based on the amount actually paid (not the Medicare approved payment amount for each service), Medicare will pay a 5 percent physician scarcity bonus on a quarterly basis. A single service may be eligible for both the new physician scarcity bonus as well as the current health professional shortage area bonus payment. Payment will be based on the zip code of where the service was performed, and the physician scarcity bonus designations will be updated every three years.

The MMA also extended the Health Professional Shortage Area (HPSA) provision to include a 10 percent bonus for mental health physician (psychiatrists) services rendered in a CAH that is located in a HPSA. Psychiatrist services rendered in a CAH located in a primary medical care HPSA are eligible to receive bonus payments. In addition, psychiatrists rendering service in a CAH located in a mental health HPSA are eligible to receive bonus payments.

Section 1011, Funding ER Care for Undocumented Immigrants

In the May 13 *Federal Register*, CMS published the final implementation guidance for Section 1011 of the MMA, which provides for federal reimbursement for emergency health services furnished to undocumented immigrants. The program provides \$250 million per year for FY 2005 through 2008 to reimburse hospitals, certain physicians and ambulance providers for emergency services furnished to undocumented immigrants, along with a few categories of legal immigrants. This is the first time that the federal government is acknowledging and directly reimbursing providers for the costs of caring for undocumented immigrants.

Eligible providers may include Indian Health Service facilities, whether operated by the Indian Health Service, an Indian tribe or a tribal organization. A critical access hospital is also a hospital under the statutory definition.

Payments for hospitals will be made for medically necessary emergency services from the time of the individual's arrival at the emergency department until the patient is stabilized. According to CMS, providers are not required to, and are not encouraged to, directly ask patients their immigration status. Providers, however, will have to answer the following questions:

- Is the patient eligible for, or enrolled in Medicaid?
- Is the patient a Mexican citizen with a border-crossing card or has the patient been paroled into the U.S. with a form I-94?
- If the patient is foreign born, can any forms of foreign identification be documented that would indicate eligibility, such as a foreign birth certificate, passport, voting card or driver's license?

Additional information, including the provider enrollment application and hospital on-call payment and provider payment determination forms, is available at www.cms.hhs.gov/providers/section1011.

Low Osmolar Imaging

CMS has eliminated the restrictive criteria for the payment of low osmolar contrast media (LOCM) for non-hospital patients, effective January 1, 2005. Payment for LOCM furnished as part of medically necessary imaging procedures for intrathecal procedures and in intraarterial and

intravenous injections will be made regardless of any of the following five medical conditions: history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting; history of asthma or allergy; significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmial unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension; generalized severe debilitation; and sickle cell disease. In addition, CMS established new codes and a new payment methodology for LOCM, which became effective April 4, 2005.

MedPAC Report to Congress

At March and April meetings, MedPAC staff raised questions about growth in the CAH program and discussed possible changes aimed at curbing the program's Medicare costs. 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. The commissioners 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 hospital—but would not include recommendations, saying it is too soon to recommend major changes to the relatively young program without fully understanding their impact.

In its June report to Congress, MedPAC discussed what it saw as CAH program accomplishments: it has helped low-volume hospitals remain financially viable and has prevented rural isolated hospitals from closing. The Commission also identified three drawbacks: cost-based Medicare payments may reduce hospitals' incentives to control costs; higher payment rates, especially for post acute care in swing beds; and some CAHs are close to other hospitals and may not be critical to beneficiaries' access to care. The AHA is pleased that MedPAC dropped proposed recommendations that could have led to the closure of many CAHs, and instead highlighted issues for further study and analysis. The CAH program is essential for maintaining adequate access to health care services in rural communities. There are now almost 1,200 CAHs, and this number reflects the inadequacies of the PPS systems in reimbursing low-volume, small or rural hospitals.

Quality and Patient Safety

Critical access hospitals, like PPS hospitals, want to ensure that they are providing quality care and that the community perceives that CAHs are places where quality care is delivered. CAHs are participating in quality reporting efforts such as Hospital Compare and the Surgical Care Improvement Project.

Hospital Compare

On September 1, the Hospital Quality Alliance (HQA) updated its Hospital Compare Web site (www.hospitalcompare.hhs.gov) with the latest data from participating hospitals. The site enables patients and families to compare the performance of virtually all the nation's acute care hospitals on 18 common quality measures for heart attack, heart failure and pneumonia care. Due to the efforts of the HQA, of which AHA is a member, the way in which outcomes are reported, especially for CAHs, has improved significantly from the time of the site's initial launch.

About three-fourths of the 4,000 reporting hospitals provided information on all 18 measures, up from 23 percent of hospitals when Hospital Compare began in April. In addition, more than 600 hospitals have begun reporting on surgical infection prevention, one of the newest additions to Hospital Compare. More than 450 CAHs, a category that is not eligible for the incentive payments, submitted data, an 11 percent increase in reporting. The next update of the Hospital Compare Web site will be made in mid-December.

The HQA is a public-private collaboration of government agencies, hospitals, quality experts, purchasers, consumer groups and other health care organizations working together to implement a national strategy for hospital quality measurement and advancing quality of care. As part of its strategic planning process, the HQA is examining what additional measures should be added over time. The HQA is committed to ensuring more rurally relevant measures are included. To help identify such measures, Stratis Health, the QIO in Minnesota, was charged with developing recommendations.

Surgical Care Improvement Project

The Surgical Care Improvement Project (SCIP) is a national quality partnership of organizations committed to improving the safety of surgical

care through the reduction of postoperative complications. Partners in the initiative include the AHA, the federal Agency for Healthcare Research and Quality, CMS, Centers for Disease Control and Prevention, American College of Surgeons, Joint Commission on Accreditation of Healthcare Organizations and other health care organizations. The ultimate goal of the partnership is to reduce nationally the incidence of surgical complications by 25 percent by the year 2010. SCIP will provide hospitals with strategies to reduce four common surgical complications: surgical wound infections, dangerous blood clots, perioperative heart attacks, and ventilator-associated pneumonia. **The AHA encourages all hospitals to join SCIP.** To learn more, visit www.aha.org and click on the SCIP icon. Also, register for AHA member conference calls on SCIP December 6 at 3 pm ET and December 15 at 4 pm ET.

Medicare Advantage Call Series

CMS' January 28 final rule on the Medicare Advantage (MA) program established a network adequacy fund of \$25 million to recruit essential hospitals. The fund's purpose 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 an "essential hospital" at the Medicare rate. CAHs are not included in the definition of "essential hospitals" because they are not PPS hospitals.

Inpatient PPS hospitals and CAHs that contract with MA plans will be paid by the plan at terms established in the MA plan contract. Inpatient PPS hospitals that do not contract with MA plans will be paid 100 percent of the Medicare PPS rates. CAHs that do not contract with MA plans should be paid 101 percent of costs. However, CMS has indicated that MA plans may pay the CAHs' interim rates for inpatient, outpatient and swing beds. The AHA has urged CMS to review this policy, as a CAH's interim rate may be significantly different than a year-end cost settled rate. The AHA sponsored a series of member calls to help prepare hospitals for the rollout of the expanded Medicare Advantage program, which begins January 1, 2006. In addition, the AHA issued four program policy papers to further help hospitals understand the MA program and its impact. One paper specifically addresses rural hospital issues. The series can be found at http://www.aha.org/aha/key_issues/medicare/ma_calls.html

CAH National Growth Statistics

The following table provides a detailed description of the 1,168 critical access hospitals identified as surveyed and certified by CMS and reported in the OSCAR data base as of October 31, 2005.

Centers for Medicare & Medicaid Services Critical Access Hospitals – OSCAR Data Base October 31, 2005		
Item	Number	Percent
Number of Beds	25,906	
Average Number of Beds	22	
Number with swing beds	1,086	93%
Number without swing beds	82	7%
Accredited (source JCAHO/AOA)	280	24%
IHS/Tribal Ownership	11	0.95%
Closures	17	1.5%
Metropolitan CAHs	180	16%
Necessary Provider (NP)	592	62%
Frontier County CAHs	241	21%
Psychiatric Distinct Parts	39	
Rehabilitation Distinct Parts	5	
Total DPUs	44	3.7%
%CAHs/Medicare Hospitals		119%
Total CAHs	1,168	

Rural Health Leadership Conference - January 2006

19TH ANNUAL
Rural Health Care
Leadership Conference



Health Forum and the American Hospital Association invite you to the Nineteenth Annual Rural Health Care Leadership Conference. The conference is scheduled for January 18-21, at The Westin La Paloma Resort & Spa, Tucson, AZ.

Hospital executives will benefit from case studies of operational best practices at leading rural hospitals, insightful analyses of industry-wide

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trends, demands for quality reporting and increased transparency, and calls for payment reform and action on Capitol Hill that will dramatically affect rural providers. Trustees will benefit from special sessions that candidly dissect the lessons of governance failures, while gaining specific techniques and strategies to help govern more effectively.

To see the conference agenda visit www.hospitalconnect.com. To register for the conference call 773-622-5648.

Call the hotel directly at 520-742-6000 and identify yourself as attending the Rural Health Care Leadership Conference to receive the special rates. To reserve your room at the special conference rate call the hotel as soon as possible and no later than December 23, 2005.

The Care Fund



Hurricane Katrina is among the worst natural disasters in our nation's history. Thousands of people have been harmed by this terrible storm, including hospital personnel in Louisiana, Mississippi and Alabama who suffered devastating losses, yet continued caring for their patients and neighbors. The hospital associations in the affected states have established The Care Fund to help affected hospital staff and their families rebuild their lives. As of October 28, hospitals and their employees, community organizations, businesses and individuals have pledged a total of more than \$1.7 million, which includes an AHA donation of \$100,000. But the need is great ... more than 5,800 hospital employees have been identified as needing financial aid to recover from Katrina. Individual donations are tax deductible and management costs are being donated so that 100 percent of the contributions go to those in need. Visit www.thecarefund.net for information on how to make a donation.

AHA's Web Site:
Access AHA's Web site for up-to-date information on critical access hospitals, click http://www.hospitalconnect.com/aha/member_relations/cah/index.html