American Hospital Association

Update

Fall 2005

Small or Rural Hospitals

This issue of *Update* provides information on the federal budget, AHA's advocacy agenda; rural legislative priorities; the fiscal year (FY) 2006 appropriations process; rural regulatory policy issues including the final rule for the Medicare inpatient prospective payment system (PPS) for FY 2006, the proposed rule for the Medicare outpatient PPS for calendar year (CY) 2006, payment for emergency services provided to undocumented immigrants, improving safety of surgical care, Hospital Compare, and Medicare Advantage.

Budget Bills Advance AHA Agenda

As of late October, the Senate Budget Committee submitted to the full Senate 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 facilities to qualify as such for Medicare payments; **a one-year extension of the outpatient "hold harmless" provision for Sole Community Hospitals and rural hospitals with fewer than 100 beds, and rebasing and extension of the Medicare Dependent Hospital program through 2011,** among other hospital-specific measures.

In the House, authorizing committees are wrapping up their budget-reconciliation legislation. The Ways and Means Committee has proposed no Medicare cuts. But the House Energy and Commerce Committee would cut about $11 billion from Medicaid, partly by letting states impose beneficiary co-payments, including an emergency department co-payment for non-emergent care. The AHA has expressed concerns about the co-pay provision and its implications for hospitals and patients' access to care. Next steps: Proposed legislation will move to floor debates.

AHA's Advocacy Agenda

Key elements of the fall advocacy agenda are banning physician self referral to new limited-service hospitals, protecting access to rehabilitation services, and stopping the expansion of the post-acute care transfer policy.

Banning Physician Self-referral. When physicians own, even in part, the facilities to which they refer patients, their decisions are subject to competing interests. Because of concerns about patient selection – selectively referring or avoiding to treat certain patients, service selection, and quality oversight, the Medicare Modernization Act of 2003 (MMA) imposed a temporary moratorium on physician self-referrals under Medicare to new limited-service hospitals. While the moratorium expired June 8, 2005, the Centers for Medicare & Medicaid Services (CMS) put in place a "defacto" moratorium – barring new limited-service facilities from coming into the Medicare program for up to six months (until December 2005) to allow the agency time to carefully review its policies related to these entities. The AHA is urging Congress to permanently ban physician self-referral to new limited-service hospitals.

Protect Access to Inpatient Rehabilitation Services. CMS continues to phase-in the 75% Rule – a May 2004 regulation that is making it difficult for many patients to receive inpatient rehabilitation facility (IRF) services. Under this rule, facilities must treat 75 percent of their patients for one of 13 conditions to qualify as an IRF under Medicare. The AHA is advocating Congress to maintain a 50 percent threshold for two years, and establish an advisory council to recommend to Congress and the Department of Health and Human Services how to update the so-called "75% rule" to ensure it is clinically appropriate.

Medicare Inpatient Transfer Policy Expansion. In the final inpatient PPS rule, CMS expanded the post-acute care transfer provision from 30 DRGs to 182 DRGs. While the agency states that this policy will cost providers $780 million in FY 2006, the AHA's estimate suggests that the policy will decrease payments to providers by more than $1 billion. **The AHA opposes this expansion of the transfer policy.** It undermines the basic principles of prospective payment and clinical decision-making, and will hinder a hospital's ability to provide the full range of services that patients need. The AHA is urging Congress to address this misguided rule.

Medicaid – the Health Care Safety Net. For 40 years, Medicaid has served as the nation's health care safety net, providing access to health services for our nation's most vulnerable populations – the poor, the disabled and the elderly. Congress has proposed cutting $10 billion from the Medicaid program over five years. The AHA encourages Congress to consider thoughtful reform, not deep spending cuts, and hold hospitals harmless from cuts that could hurt a hospital's ability to provide patient care.

FY 2006 Rural Health Appropriations

A number of important rural programs are included in this funding measure. The House passed its version of a FY 2006 Labor-HHS-Education appropriations bill in late June, and the Senate Appropriations Subcommittee approved its version July 12, which is waiting action by the full Senate. The table below compares Fiscal year 2005 funding levels for key rural programs and services with the House and Senate committee-approved levels.

Comparison of Recommended Funding Levels for Selected Appropriations Programs FY 2006
October 27, 2005 (in millions of dollars)

Program	Fiscal Year 2005	House Passed Level	Senate Committee Level
NHSC	$131.448	$126.769	$126.796
Q. Burdick Training	$6.076	$0	$6.076
Nurse Loan Repay & Scholarship	$31.482	$31.369	$31.482
Rural Health Outreach Grants	$39.278	$10.767	$39.278
Rural Health Research	$8.825	0	$8.825
Rural AEDs	$8.927	$1.960	$8.927
Rural EMS	$0.5	$0	$0.5
Rural Hospital FLEX Grants	$39.180	$39.180	$39.180
Rural Telehealth	$3.916	$3.888	$3.888
Healthy Community Access Program	$82.9	$0	$60.0

Rural Legislative Priorities

The AHA is working diligently on several legislative fronts to support operational improvements and program enhancements for small or rural PPS hospitals and Critical Access Hospitals (CAHs).

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

Sole Community Hospitals. The AHA supports H.R. 2961, which would make permanent the hold harmless provision for outpatient payments to sole community hospitals. Reps. Greg Walden (R-OR) and John Tanner (D-TN) introduced the bill.

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, which was introduced by Sens. Ben Nelson (D-NE) and Susan Collins (R-ME), and Reps. Butch Otter (R-ID) and James Oberstar (D-MN).

Payment under Medicare Advantage. Under the 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.

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).

Expand 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) and Jeff Bingaman (D-NM), and Rep. JoAnn Emerson (R-MO), which would expand 340b program to include inpatient services and allow CAHs to participate.

Medicare Coverage for Pulmonary and Cardiac Rehabilitation. AHA supports S. 1440, which would establish a statutory benefit category under Medicare for pulmonary and cardiac rehabilitation services. Sens. Mike Crapo (R-ID) and Blanche Lincoln (D-AR) cosponsored the bill.

Medicare Inpatient PPS Final Rule for FY 2006

CMS published the final rule implementing FY 2006 changes to the Medicare hospital inpatient PPS in the August 12 *Federal Register*. The August 26 AHA *Regulatory Advisory* contains an in-depth analysis of the rule; however, a summary of selected provisions that affect small or rural hospitals follows.

PPS Rate Update. For FY 2006, the MMA provides an update to inpatient PPS rates equal to the full hospital market basket rate for those hospitals that submit data on 10 specific clinical measure of quality care. The most current forecast of the market basket rate increase for 2006 is 3.7 percent, up from 3.2 percent in the proposed rule. **As requested by the AHA, CMS changed the market basket estimation methodology, leading to the 0.5 percent increase in the market basket rate.** Hospitals that do not submit quality data will receive a payment update of market basket minus 0.4 percentage points, or 3.3 percent.

Labor Share. The MMA also permanently raised the standardized amount for other urban and rural hospitals to the large urban rate. By law, CMS must adjust the proportion of the standardized amount attributable to wages and wage-related costs (known as the labor-related share) by a factor that reflects the relative difference in labor costs among geographic areas (known as the wage index). Beginning in 2005, the MMA authorizes CMS to use 62 percent as the labor-related share for hospitals with a wage index less than 1.0. For hospitals with a wage index greater than 1.0, CMS will reduce the labor-related share from 71.1 percent to 69.7 percent.

The final operating standardized amounts for FY 2006 are as follows:

Area Wage Index Greater than 1.0

	Full Update (3.7%)	Reduced Update (3.3%)
Labor-related	**$3,297.84**	**$3,285.12**
Nonlabor-related	**$1,433.63**	**$1,428.10**

Area Wage Index Less Than 1.0

	Full Update (3.7%)	Reduced Update (3.3%)
Labor-related	**$2,933.52**	**$2,922.20**
Nonlabor-related	**$1,797.95**	**$1,791.02**

Expansion of Post-Acute Care Transfer Policy. For FY 2006, CMS expanded the post-acute care transfer policy from 30 DRGs to 182 DRGS by establishing a new set of criteria. DRGs will be subject to the transfer policy based on the following criteria:

- The DRG must have a geometric mean length of stay of at least three days;
- The DRG must have at least 2,050 post-acute care transfer cases;
- At least 5.5 percent of the cases in the DRG must be discharged to post-acute care prior to reaching the geometric mean length of stay for that DRG; and,
- If the DRG is one of a paired set of DRGs based on the presence or absence of a comorbidity or complication, both paired DRGs will be included if either one meets the three criteria above.

CMS chose the threshold of 2,050 post-acute care transfer cases and 5.5 percent of discharge before reaching the geometric mean length of stay because both are in the 55th percentile. CMS states that this policy will cost providers $780 million in FY 2006. However, the AHA's estimate suggests that the policy will decrease payments to providers by more than $1 billion.

The AHA is extremely disappointed in the final rule's expansion of the post-acute transfer provision to cover more DRGs. The AHA believes that the 55th percentile is in the range of average and hardly "disproportionate," as specified in the statute. CMS' policy is not in the

best interest of patients or caregivers and undermines clinical decision-making. Moreover, it penalizes hospitals for providing efficient care, at the most appropriate time and in the most appropriate manner. The AHA will continue to work with Congress to address this misguided policy.

Outlier Threshold. The final rule sets the outlier threshold at $23,600, similar to the AHA's recommendation. This marks a decline from the FY 2005 level of $25,800 and is lower than the proposed threshold of $26,675. **While the final rule is an improvement, the AHA remains concerned that CMS may not spend the full 5.1 percent set aside given that CMS' methodology only considers charge inflation and not actual cost growth.**

Wage Index Changes. FY 2006 wage index will be based on data for hospitals' FY 2002 cost reports. CMS data indicates that the national average hourly wage increased 6.2 percent compared to 2005. As a result, some hospitals may see their wage index decline relative to last year because even though their wages rose, they did not rise as quickly as those at other hospitals.

Urban Hospitals Redesignated as Rural. In 2005, CMS adopted new definitions for Metropolitan Statistical Areas (MSA). As a result, a small number of hospitals that were classified as urban in FY 2004 became classified as rural in FY 2005. Moving from an MSA with an urban rate to the rural statewide rate would have resulted in a significant decline in these hospitals' wage indices. In FY 2005, CMS implemented a three-year transition period (FYs 2005 – 2007) during which these hospitals will continue to be paid based on their previous MSA assignments, however, they will be considered rural for all other purposes. Beginning in 2008, these hospitals will receive their statewide rural wage index. In addition, the hospitals are eligible to apply for reclassification during the transition period and in subsequent years. **The AHA supports the continued transition for these hospitals to give them the opportunity and time to reclassify.**

Occupational Mix Adjustment. CMS is required to collect occupational mix data from all inpatient PPS hospitals every three years in order to construct an occupational mix adjustment to the wage index. The adjustment is to control for the effects of hospitals' employment choices, such as the use of registered nurses versus licensed practical nurses, rather than geographic differences in the costs of labor.

In the final rule, CMS states that it will continue to use the same methodology it has used previously, which consists of determining an adjustment for each of the seven general occupational categories. CMS will again limit the use of the occupational mix adjustment to 10 percent. This means that only 10 percent of the wage index will be based on an average hourly wage adjusted for occupational mix, and 90 percent will be based on an unadjusted average hourly wage. In the final rule, CMS indicates that 27.7 percent of rural areas and 52.1 percent of urban areas will see a decrease in their wage index as a result of the adjustment.

[NOTE: On October 14, CMS proposed changes to the occupational mix survey for the first half of 2006. Data from the survey will be used to adjust the wage index for the FY 2008 inpatient PPS. The AHA will issue a Regulatory Advisory soon with more details.]

Out-Migration Adjustment. Section 505 of the MMA provides hospitals in lower wage areas with a wage index adjustment if a significant number of hospital employees commute from the lower wage area to a higher wage area nearby. Hospitals that receive this adjustment are not eligible for geographic reclassification. The wage index adjustment is effective for three years.

Low Volume Hospitals. Section 406 of the MMA created a payment adjustment under inpatient PPS of not more than 25 percent to account for higher costs per case of low-volume hospitals. Eligible hospitals were defined as those located more than 25 miles from another facility with fewer than 800 discharges during the year – including Medicare and Medicaid patients. The final rule maintains a 25 percent increase in payments to hospitals with fewer than 200 discharges. For hospitals that have between 200 and 800 discharges, CMS will not provide an adjustment. **In its comments, the AHA expressed concern that CMS was ignoring congressional intent and denying hospitals with over 200 but less than 800 discharges access to this necessary payment increase.**

New Rural Referral Centers (RRCs). If a hospital wants to become a RRC, but does not meet the bed size criterion of 275 or more beds, it must meet two mandatory alternative criteria and one of three additional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume). The final rule updates the alternative criteria for RRC designation in FY 2006.

Provider-based Determinations. CMS will add rural health clinics with 50 or more beds that are affiliated with hospitals to the list of specific types of facilities and organizations for which determinations of provider-based status will not be made. **The AHA supports this change.**

Rural Community Hospital Demonstration Program. Section 410 of the MMA requires CMS to conduct a demonstration program in rural areas where qualifying hospitals with fewer than 51 beds will receive cost-based reimbursement, rather than PPS payment, for inpatient acute care and swing bed services for a five-year period. CAHs are not eligible for this program. Currently, 13 hospitals located in one of the following states with the lowest population density – Alaska, Montana, Nebraska, Nevada, New Mexico, South Dakota and Utah – are participating in the program. In the final rule, CMS states that it will implement the demonstration in a budget neutral manner by offsetting inpatient PPS payments to other hospitals by $12.7 million. **In its comments, AHA agreed that the MMA intended for the program to be budget neutral across the inpatient PPS.**

CAH Necessary Provider Status Relocations. If a hospital is unable to meet the distance requirement of being more than 35 miles from a PPS hospital or another CAH, current law allows a governor to certify a hospital as a "necessary provider." This designation allows the hospital to become a CAH. While the MMA terminates a state's authority to grant necessary provider status as of January 1, 2006, it included a grandfathering provision that allows any CAH that is designated as a necessary provider in the state's health plan prior to January 1, 2006 to maintain such designation. An issue then arose about the status of CAHs who are rebuilding or relocating their facilities.

In the May 5 proposed rule, CMS proposed very restrictive guidelines for rebuilding or relocating CAHs that have necessary provider status. The proposed rule would have allowed CAHs to rebuild on the existing site within 250 yards, or relocate on a contiguous piece of property if it was purchased by December 8, 2003. CAHs that moved any further distance would be relocating and would have to have shown that it submitted an application for relocation before January 1, 2006; met the same criteria for necessary provider status; served the same community with 75 percent of the same services, population and staff; complied with the CAH conditions of participation; and was under development as of December 8, 2003.

As a result of advocacy efforts by CAH member hospitals and the AHA, CMS relaxed these restrictions in the final rule. The arbitrary date restrictions and the difference between rebuilding and relocating were removed. As of January 1, 2006, necessary providers that wish to rebuild must:

- Serve 75 percent of the same population;
- Retain 75 percent of the same staff, and
- Provide 75 percent of the same services.

The AHA is very pleased that CMS has relaxed the restrictive guidelines for replacement/ relocation of necessary provider CAHs. The AHA will work with CMS to ensure that the 75 percent test is clearly laid out and applied fairly.

If after relocation, however, the CAH does not serve the same community, meaning that it cannot meet the 75 percent test, CMS will consider the relocation as a cessation of business at one location and establishment of a new business at another location. This means that such CAHs with necessary provider status, which cannot reapply for such status as of January 1, 2006, will lose their CAH status and have to convert back to the inpatient PPS.

CAHs in "Lugar Counties." The MMA provided that hospitals located in rural counties adjacent to one or more urban counties are considered to be located in the urban MSA to which the greatest number of workers in the county commutes. Such rural counties are referred to as "Lugar counties" (after Sen. Richard Lugar (R-IN) who authored this provision).

As a result of the most recent labor market definitions, certain counties that were previously not Lugar counties were redesignated as such effective October 1, 2004. This action has caused some CAHs located in these counties to be unable to meet the rural location requirement for designation as a CAH, even though the facility met the requirement when designated initially as a CAH.

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, therefore, not need to submit an application for reclassification to remain in compliance with the conditions of participation.

Medicare Hospital Outpatient PPS Final Rule for CY 2006

CMS issued in July a proposed rule for calendar year (CY) 2006 changes to the Medicare hospital outpatient PPS. AHA submitted comments on the rule in September highlighting concerns with some of CMS' proposals.

The AHA's analysis of the proposed rule indicates that many ambulatory payment classification (APC) rates continue to fluctuate dramatically, with payments much lower or higher in 2006 than in 2005. These changes make it extremely difficult for hospitals to plan and budget from year to year. In addition to this instability, the entire outpatient PPS is underfunded, paying only 87 cents for every dollar of hospital outpatient care provided to Medicare beneficiaries. **The AHA will continue to work with Congress to address inadequate payment rates and updates in order to ensure access to hospital-based outpatient services for Medicare beneficiaries.**

On November 2, CMS released its final rule, which goes into effect for services beginning on or after January 1, 2006. The rule implements a full market basket update, several policy changes, and requirements of the Medicare Modernization Act of 2003 (MMA).

Highlights:

- The rule includes a 3.7% market basket update; however, when combined with other MMA policy changes and changes to outlier policy, outpatient payments will increase by only 2.2%. Rural hospitals are projected to receive an average payment increase of 3.9%.
- Also, as required by the MMA, the rule ends "hold harmless" payments for small rural hospitals and for rural sole community hospitals (SCHs). However, based on an MMA-required study, CMS will increase payments to rural SCHs by 7.1% in 2006 instead of the 6.6% recommended in the proposed rule.
- CMS will pay for most separately payable drugs, including pharmacy overhead costs, at the rate of average sales price (ASP) plus 6.0%. Consistent with AHA recommendations, the final rule does not include a c-coding requirement for drug overhead charges. The proposed rule had added an additional 2% of ASP to account for pharmacy overhead costs.
- Consistent with AHA recommendations, the final rule does not apply a payment reduction for multiple imaging procedures. The proposed rule had included a 50% payment reduction when multiple imaging procedures within the same imaging category are performed during the same session.
- CMS will reduce the target for outlier payments from 2.0% to 1.0% of total outpatient spending. To meet the target, the agency will increase to $1,250 the fixed-dollar threshold that will have to be met for a service to qualify for an outlier payment.
- The final rule requires a doctor of medicine or osteopathy practicing in a CAH to periodically review and sign the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants. The physician must periodically, but not less than every 2 weeks, review and sign a sample of outpatient records according to the policies of the CAH and standards of practice where State law requires record reviews or co-signatures, or both, by a collaborating physician.

AHA staff are still examining the 766-page rule and will send an AHA Regulatory Advisory with further details. The final rule will be published in the November 10 Federal Register and goes into effect on or after January 1, 2006. Meanwhile, the proposed rule is available at: www.cms.hhs.gov/providers/hopps/.

Emergency Health Services 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 illegal 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.

Payments for hospitals will be made for medically necessary emergency services from 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, 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, hospital on-call payment and provider payment determination forms, is available at www.cms.hhs.gov/providers/section1011. Hospitals must submit both electronic and paper versions of the enrollment application form. Further, hospitals may begin billing CMS as of October 13 for services rendered between May 10 and June 30.

Hospital Compare Web Site Updated

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 payment, submitted data, an 11 percent increase in reporting. The next update of the Hospital Compare Web site will be mid-December.

The HQA is a public-private collaboration of government agencies, hospitals, quality experts, purchasers, consumer groups and other health care organizations that are 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.

Patient Safety Act

On July 29, President Bush signed the Patient Safety and Quality Improvement Act of 2005, P.L. 109-41, into law. The new law will allow hospitals, physicians, and other health care providers to create voluntary reporting systems involving medical errors in a manner that is legally privileged and confidential when reported to patient safety organizations (PSOs). The reported information will allow experts to analyze problems, recommend solutions, and advance patient safety. **The AHA ;supported this legislation and called the new law a major step toward improving the safety and quality of care Americans receive.** The AHA will continue to work with the hospital field and DHHS, specifically the Agency for Healthcare Research and Quality, to develop specifications and clear guidance for data collection and common formats.

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, 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.

Medicare Advantage Payment

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 "essential hospitals" 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 CAH's interim rates for inpatient, outpatient and swing beds. The AHA has urged CMS to reconsider this policy, as a CAH's interim rate may be significantly different than the full cost settled rate of year-end.

Survey Finds Hospitals Embracing IT

While nine out of 10 hospitals are using or considering using health information technology for clinical uses, most cite cost as a major impediment to broader adoption, especially for small or rural hospitals, according to a new AHA survey. The survey results suggest that the use of health IT in caring for patients is evolving as hospitals adopt specific technologies based on their needs and priorities, size and financial resources. While most are still in the beginning stages, the survey shows hospitals are making investments in IT, in large part, to make gains in the safety and quality of care.

Hospitals currently bear almost all the cost of IT investment, with no increase in payments. However, many of the financial benefits of IT, such as decreased need for repeat tests, accrue to those who pay for care. In looking at financing, the AHA urges policymakers to give special attention to less financially stable hospitals, smaller hospitals and those in rural locations. "Forward Momentum: Hospital Use of IT" summarizes the survey's findings and is at www.aha.org under "AHA Policy Forum."

Barbara Oestmann Receives Munroe Award

Barbara Oestmann, chief executive officer, Share Medical Center in Alva, OK is the 2005 recipient of the AHA's Shirley Ann Munroe Leadership Development Award. The award recognizes small or rural hospital leaders who have improved health care delivery in their communities through innovative and progressive efforts. Oestmann's leadership in developing a Telemedicine Consortium for Northwest Oklahoma, which includes 12 rural hospitals networked to share the costs and benefits, shows her commitment to rural health care in Alva and the surrounding communities. She also has partnered with local organizations to bring educational opportunities to medical center staff and to generate excitement health care careers in schools.

Share Medical Center, which has 37 acute care beds and 80 long-term care beds, is a member of Quorum Health Resources. As administrator, Ms. Oestmann has been instrumental in establishing new services at the hospital, such as ENT, orthopedics, radiology and mental health. She also has been successful in recruiting physicians to the community.

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

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