American Hospital Association

Update

Winter 2006

Small or Rural Hospitals

This issue of *Update* reviews the recently passed health care bill and its rural provisions. It also reviews the changes in leadership for the 110th Congress. Rural appropriations are discussed and an extensive review and analysis of final rules for inpatient, outpatient, and other regulations is included. The issue also reviews changes in quality reporting, announces the recipient of the 2006 Shirley Ann Munroe Leadership Award, and provides information on the Health Forum's upcoming rural conference.

Tax Relief and Health Care Act

Before adjourning for the year Congress passed the *Tax Relief and Health Care Act of 2006* (H.R. 6408) that freezes physician payments for 2007 and implements a 1.5% bonus incentive for physicians who participate in a voluntary quality reporting system. The bill also establishes the maximum Medicaid provider tax rate at 5.5%. Medicaid regulations currently allow states to tax hospitals, nursing homes, and pharmacies up to 6% of their gross revenue. The administration had proposed reducing the maximum tax rate from 6% to 3%.

The package also extends for one year a provision that requires Medicare to continue paying labs directly for the technical component of physician pathology services furnished to hospital patients, and extends reasonable cost reimbursement for outpatient lab payments for rural hospitals under 50 beds. In addition, the bill extends Section 508 of the *Medicare Modernization Act* (MMA), which allows for geographic reclassification for six months for certain hospitals currently receiving 508 funding. It also reduces the annual update by 2 percentage points for outpatient services provided by hospitals and ambulatory service centers that fail to report certain quality measures, starting in 2009.

In other action, Congress passed a continuing resolution funding Health and Human Services programs at fiscal year (FY) 2006 levels through Feb. 15, 2007. Finally, lawmakers passed a two-year extension of the J-1 visa waiver program. The program, which expired June 1, allows foreign physicians who have completed medical residency programs in the U.S. to remain in the country on their J-1 visa provided they agree to practice medicine for three years in an underserved area.

The 110th Congress

November's election changed the balance of power in Congress. For the first time in 12 years, the Democrats control both the House and Senate. Following are the key health care leaders on Capitol Hill:

In the Senate
Majority Leader Harry Reid (NV)
Majority Whip Dick Durbin (IL)
Finance Comm. Chair Max Baucus (MT)
Budget Comm. Chair Kent Conrad (ND)
Health, Education, Labor & Pensions Comm. Chair Ted Kennedy (MA)
Appropriations Comm. Chair Robert Byrd (WV)

In the House
House Speaker Nancy Pelosi (CA)
Ways & Means Comm. Chair Chas. Rangel (NY)
Ways & Means Health Sub. Chair Pete Stark (CA)
Energy & Commerce Chair John Dingell (MI)
Energy & Commerce Health Sub. Chair Frank Pallone (NJ)
Budget Comm. Chair John Spratt (SC)
Appropriations Comm. Chair David Obey (WI)

FY 2007 Rural Health Appropriations

On June 13, the House Committee on Appropriations approved the Labor, Health and Human Services, and Education spending levels for FY 2007. On July 20, the Senate Appropriations Committee approved their version of the spending bill for FY 2007, which provides $142.8 billion for the Departments of Labor, Health and Human Services, and Education, an increase of $870 over the amount approved by the House. Neither bill received a floor vote.

House and Senate Appropriations Committee Funding of Select Items for Fiscal Year 2007 Dollars in Millions

Line-item	FY 2006 Level	FY 2007 House Approps Comm.	FY 2007 Senate Approps. Comm.
Rural Health Research/Policy	$8.7	$9.0	$8.7
Rural Outreach Grants	$38.9	$40.0	$38.9
State Offices of Rural Health	$8.1	$8.4	$8.1
Rural Hospital Flexibility Grants	$63.5*	$40.0	$38.5
Delta Health Initiative	NA	NA	$35.0*
Rural AED	$1.5	$1.5	$1.5
Denali Commission	$39.3	$0.0	$39.3
Telehealth	$6.8	$10.0	$6.8
Nurse Education/Retention	$37.7	$37.3	$37.3
Nurse Loan & Scholarship	$31.4	$31.1	$31.1
Area Health Education Centers (AHECs)	$28.7	$28.7	$28.7
Community Health Centers	$1,782.3	$1,988.0	$1.926.1
National Health Services Corp	$125.5	$131.5	$125.5

**FY06 enacted numbers for Rural Hospital Flexibility Grants include $25 million for the Delta Health Initiative. The House Appropriations Committee funds the Flex and SHIP programs, but does not fund the Delta Health Initiative. The Senate Appropriations Subcommittee funds the Delta Health Initiative as its own line item*

A number of important rural programs are included in this funding measure. Under a continuing resolution passed by Congress, funding for rural health programs will remain at their 2006 funding levels until Feb. 15, 2007.The following table shows the levels of funding under the continuing resolution.

Inpatient PPS Final Rule for FY 2007

CMS published the final rule implementing FY 2007 changes to the Medicare hospital inpatient prospective payment system (PPS) in the Aug. 18 *Federal Register.* However, the final wage indices and payment rates were not published until Oct. 11 due to a federal court decision requiring CMS to collect new data and fully implement the occupational mix adjustment in FY 2007. CMS estimates that the FY 2007 changes will provide, on average, a 3.5% payment increase to hospitals overall. However, rural hospitals will receive a 3.9% average increase. CMS also estimates that the total impact of these changes for FY 2007 operating payments will result in a $3.4 billion increase over FY 2006. The AHA's Aug. 11 and Oct. 6 *Regulatory Advisories* contain an in-depth analysis of the rule and the agency's notice; however, a summary of selected provisions that affect small or rural hospitals follows.

PPS Rate Update. Under federal law, hospitals that submit data on quality measures for heart attack, heart failure, pneumonia and surgical care are eligible for a full inflationary update of 3.4%, while those that do not submit data will receive just a 1.4% update.

By law, CMS must adjust the proportion of the standardized amount that is attributable to wages and wage-related costs (known as the labor-related share) by a factor that reflects the relative difference in labor costs across geographic areas (known as the wage index). For FY 2007, CMS maintained a labor-related share of 62% for those hospitals with wage indices less than 1.0, and 69.7% for those hospitals with wage indices greater than 1.0. The labor-related share for Puerto Rico will remain 58.7%.

The final standardized amounts are:

Area Wage Index Greater Than 1.0

Full Update (3.4%)		Reduced Update (1.4%)	
Labor-Related	Non-labor-Related	Labor-Related	Non-labor-Related
$3,397.52	$1,476.97	$3,331.80	$1,448.40

Area Wage Index Less Than 1.0

Full Update (3.4%)		Reduced Update (1.4%)	
Labor-Related	Non-labor-Related	Labor-Related	Non-labor-Related
$3,022.18	$1,852.31	$2,963.73	$1,816.48

DRG Changes. The FY 2007 DRG changes are noteworthy, but more modest than the sweeping changes CMS proposed. CMS will implement a cost-based weighting methodology – tabling the proposed consolidated severity-adjusted DRG system for consideration. During FY 2007, 33% of the DRG weight will be based on the new methodology while 67% of the weight will be based on the old methodology of weighted charges. For FY 2008, the split will be 67% cost-based weighting and 33% charge-based weighting, before moving to 100% cost-based weight in FY 2009. Please refer to the Aug. 11 *Regulatory Advisory* for a full analysis.

Outlier Threshold. Cases will qualify for outlier payments in FY 2007 if their costs exceed the PPS rate for the DRG – including indirect medical education, disproportionate share hospital (DSH) and new technology payments – in addition to the fixed-loss threshold of $24,485. This is $1,045 lower than the $25,530 proposed threshold and likely will result in Medicare outlier spending closer to the 5.1% of funds set aside. The AHA is pleased that CMS altered its methodology for calculating the fixed-loss threshold, which we have urged for years.

Occupational Mix Adjustment. The occupational mix adjustment neutralizes the effect a hospital's mix of employees has on the wage index. CMS initially planned to adjust only 10% of the wage index for occupational mix for FY 2007 because of questionable data. However, due to the court ruling, CMS is fully implementing the occupational mix adjustment using data collected from January 1 to March 31, 2006. For hospitals that did not report occupational mix data, CMS has used the average mix for that hospital's labor market area. The final wage index values for 70.2% of rural areas will increase as a result of this adjustment, while 29.8% of rural areas will experience a decrease in their wage index.

CMS has posted the occupational mix adjusted wage indices, out-migration adjustments and their decisions on hospital reclassifications on the CMS Web site at http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp.

New Hospital Labor Markets. In the FY 2005 rule, a small number of hospitals classified as urban in FY 2004 were reclassified as rural as a result of revised standards defining Metropolitan Statistical Areas (MSAs). Because reclassification would have resulted in a significant decline in these hospitals' wage indices, CMS implemented a three-year transition period (FYs 2005 – 2007). In the FY 2007 rule, CMS extended the hold-harmless period for these hospitals for one more year. However, these hospitals will be considered rural for all other purposes and no longer will be eligible for adjustments such as the large urban add-on to the capital rates.

Medicare Dependent Hospitals. The final rule implemented a provision in the *Deficit Reduction Act* (DRA) that not only reauthorized the Medicare Dependent Hospital (MDH) program, but also added FY 2002 as an allowable base year. MDHs will be paid 75% of the difference between the PPS payments and the hospital-specific rate, rather than 50%. MDHs also will no longer be subject to the 12% DSH cap.

Certification of MDHs and SCHs. The proposed rule included a provision that would have required an approved MDH or Sole Community Hospital (SCH) to notify CMS of any change affecting its classification status. Previously, fiscal intermediaries (FIs) were

responsible for evaluating a hospital's continuing qualification for MDH or SCH status.

Many commenters, including the AHA, argued that hospitals should not be held accountable for reporting occurrences of which they might not be aware or that lie outside their control. Regardless, CMS finalized this policy with some modifications. CMS agreed that hospitals should not have to report on circumstances that are difficult to track, such as competitors' market share. It also specified which types of changes should be tracked:

For SCHs:
- distance between it and another like-hospital;
- demographic classification status (urban/rural);
- number of beds; and
- travel time between itself and a like-hospital.

For MDHs:
- geographic classification status (urban/rural); and
- if the number of beds is greater than 100.

CMS expects hospitals to self-disclose such material changes in circumstances to their FIs, rather than the regional office as proposed, or face a retroactive cancellation of their designation back to the occurrence of the event once an FI discovers their ineligibility. In addition, CMS clarified that the retroactive cancellation also would apply to hospitals that were aware of changes in circumstances not listed above, but did not notify their FI. If the change is not on the list above, and the provider was unaware, then the hospital will be notified that its status will be revoked 30 days after the regional office discovers the change in circumstance. If the hospital becomes aware of a change that is not on the list and notifies the FI, then the cancellation would be effective as of the day the FI was notified.

Drop in Volume at MDHs and SCHs. An MDH or SCH may apply for special payments if it experiences a decrease of 5% or more in the total number of inpatient discharges that were out of its control from one cost-reporting period to another. The adjustment is intended to cover the fixed costs that the hospital is unable to reduce in the year following the volume decrease. Recognizing that the source for comparing the hospital's staffing to other similar hospitals in the area has not been updated since 1989, CMS gives hospitals a choice. For all open adjustment requests, hospitals may choose between the 1989 *Monitrend Data Book*, occupational mix data or *AHA Annual Survey* data. Beginning with adjustment requests for decreases experienced in 2007, hospitals may choose between the occupational mix data and *AHA Annual Survey* data.

CAHs. The final rule made only one immaterial technical correction related to Critical Access Hospitals (CAHs). CMS declined to address the AHA's concerns with the interpretative guidelines issued in November 2005 regarding relocation. However, CMS noted that it is actively considering the issue.

New Rural Referral Centers. If a hospital wants to become a Rural Referral Center (RRC), but does not have 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 updated the alternative criteria for RRC designation in FY 2007 to include:

- a case-mix index that is at least equal to either the median case-mix index for urban hospitals in its census region (excluding hospitals with approved teaching programs) or the national median case-mix index (1.3132), whichever is lower; or
- at least 5,000 discharges per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located (at least 3,000 for osteopathic hospitals).

No region has a discharge value of less than 5,000, thus 5,000 discharges is the minimum criterion for all hospitals. The median case-mix index values are listed in the chart below:

Region	Median Case-Mix Index Value
1. New England (CT, ME, MA, NH, RI, VT)	1.2313
2. Middle Atlantic (PA, NJ, NY)	1.2619
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3252
4. East North Central (IL, IN, MI, OH, WI)	1.3118
5. East South Central (AL, KY, MS, TN)	1.2926
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2344
7. West South Central (AR, LA, OK, TX)	1.3872
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3877
9. Pacific (AK, CA, HI, OR, WA)	1.3366

Outpatient PPS Final Rule for CY 2007

CMS published the hospital outpatient PPS final rule in the Nov. 24 *Federal Register*, which includes payment policy and rates for the outpatient PPS and ambulatory surgical centers (ASCs) for calendar year (CY) 2007. The AHA's Dec. 7 *Regulatory Advisory* contains an in-depth analysis of the rule; however, a summary of selected provisions that affect small or rural hospitals follows.

Payment Rate Update. While the rule provides a 3.4% market basket update in payment rates for hospital outpatient services, average outpatient payments to all hospitals will increase by 3.0% due to other changes in the rule. Payments to rural hospitals overall will increase by 2.7%, with payments to SCHs increasing by 2.6% and payments to other rural hospitals increasing by 2.8%.

In the final rule, CMS decided not to link the outpatient PPS payment update to hospital reporting of *inpatient* quality measures in effect under the inpatient PPS quality reporting program. This decision is consistent with recommendations from the AHA and others that any link between quality reporting and payment for *outpatient* services should be based on *outpatient* quality measures. CMS intends to develop appropriate quality measures for the outpatient PPS, and in 2009 implement a 2.0 percentage point reduction to the PPS conversion factor update for those hospitals that do not meet the requirements for its outpatient quality reporting program. (*The Tax Relief and Health Care Act also mandates an outpatient/ASC quality reporting program starting in 2009*.)

Wage Index. For the outpatient final rule, CMS applies the FY 2007 inpatient PPS wage index (fully adjusted for differences in occupational mix) as published in the Oct. 11 *Federal Register*. This includes the wage indices to be in effect through March 31, 2007, as well as those to be in effect on or after April 1, 2007, to accommodate the expiring reclassification provisions under Section 508 of the MMA.

Transitional Corridor Hold-harmless Payments. As required by the DRA, the final rule continues to phase-out the transitional corridor hold-harmless payments for rural hospitals with 100 or fewer beds that are not SCHs. For 2007, when the outpatient PPS payment is less than the payment that the provider would have received under the previous reasonable cost-based system, the payment amount is increased by 90% of the difference between those two payment systems. This represents 5% less in hold-harmless payments than these hospitals received in 2006. CMS also clarifies that Essential Access Community Hospitals (EACHs) are considered to be SCHs under the law and therefore are ineligible for hold-harmless payments.

Rural Adjustment for SCHs. Consistent with current policy, CMS will continue to increase payments to rural SCHs by 7.1% for all services paid under the outpatient PPS, with the exception of drugs, biologicals, brachytherapy seeds and services paid under the pass-through policy. The rule also clarifies that EACHs are treated as SCHs for purposes of receiving the 7.1% adjustment, assuming these entities otherwise meet the rural adjustment criteria. The adjustment is budget-neutral and is applied before calculating outliers and coinsurance.

Coding and Payment for Clinic and ED Visit Services. In the final rule, CMS makes significant changes to the evaluation and management (E/M/) codes and payment levels for hospital clinic, emergency department (ED) and critical care visits. The agency postpones finalizing the G codes for clinic visits and "type A" EDs – open 24/7 – until national visit coding guidelines have been established. Therefore for 2007, CMS instructs providers to continue to use the CPT codes to bill for hospital clinic visits and for "type A" ED visits. In addition, the agency adopts five new G codes to describe hospital emergency visits provided in "type B" EDs – open less than 24/7 – and creates five APC payment levels for clinic and ED visits. Also, a new G code and a related new APC are established for critical care services that involve activation of the hospital's trauma response team. CMS states that until national guidelines are established, hospitals should continue to use their own internal E/M visit coding guidelines. The agency hopes to receive additional input from the AHA and the American Health Information Management Association, among others, to address the areas of concern that are raised in the final rule. Please refer to the Dec. 7 *Regulatory Advisory* for a full analysis.

Outlier Policy. Outlier payments are added to the APC amount to mitigate hospital losses when treating high-cost cases. The rule continues to include both a fixed-dollar outlier threshold and a percentage threshold, but CMS raises the fixed-dollar threshold to $1,825 – $575 more than in 2006. Thus, to be eligible for an outlier payment in 2007, the cost of a service must exceed 1.75 times the APC payment amount (the percentage threshold) and be at least $1,825 more than the APC payment amount. When the cost of a hospital outpatient service exceeds these applicable thresholds, Medicare will make an outlier payment that is 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate.

Emergency Medical Screening in CAHs. CMS changes the CAH conditions of participation to allow a registered nurse with training and experience in emergency care and who is on-site at the CAH to serve as qualified medical personnel to screen individuals who present to the CAH emergency department, if the nature of the patient's request is within the registered nurse's scope of practice, consistent with applicable state laws and such screening is permitted by the CAH's bylaws or rules and regulations. CMS clarifies that if the registered nurse begins the emergency medical screening and determines that the nature of the individual's condition is outside his/her scope of practice under state law, the appropriate authorized personnel must be contacted to see the patient within 30 minutes (or 60 minutes if the CAH is located in a frontier or remote area or permissible under the state's health plan) to conduct the emergency medical screening and provide stabilizing treatment.

Medicare Contracting Reform. The MMA contracting reform provisions require the current FIs and carriers be replaced with new Medicare Administrative Contractors (MACs). The transition to the new contracting program must be completed by October 2011. In this rule, CMS adopts conforming changes to the regulations that will assign providers to the MAC that is contracted to administer the types of services billed by the provider within the geographic locale in which the provider is physically located.

Other Rules and Regulations

CMS relaxes four requirements for conditions of participation

In its Nov. 27 final rule, CMS relaxes four current requirements or conditions that hospitals must meet to participate in the Medicare and Medicaid programs. Effective Jan. 26, hospitals have up to 30 days before a patient's admission or 24 hours after admission to complete a medical history and physical examination and allows more health care professionals to perform the exam. The record of the exam must be entered into the patient's medical record within 24 hours after admission. In addition, CMS stipulates that all verbal orders given by a medical professional

must be recorded within 48 hours in the patient's medical record by the medical professional or another practitioner responsible for the patient's care. Previously, verbal orders could only be entered in the medical record by the physician who issued them. The agency also requires hospitals to secure all drugs and biologicals. Finally, CMS will permit any individual who is qualified to administer anesthesia, rather than the person who administered it, to conduct the post-anesthesia evaluation.

HUD withdraws proposal to raise health care mortgage insurance rates

The Department of Housing and Urban Development (HUD) has withdrawn a proposal to increase mortgage insurance premiums for the 242 health care insurance program and certain other Federal Housing Administration (FHA) programs after Congress and others, including the AHA, overwhelming opposed the increase. Therefore, the premiums will remain unchanged from fiscal year 2006. HUD's proposed premium increase would have increased hospitals' construction costs by millions of dollars and would have reduced access to capital for hospitals. On a related issue, Congress passed ***The Rural Health Care Capital Access Act*** (H.R. 4912) which will extend for five years the FHA's mortgage insurance program for CAHs under the 242 program.

CMS allows hand-sanitizer dispensers in hospital exit hallways

CMS will permit hospitals and other health care facilities to place alcohol-based hand-rub dispensers in exit hallways as long as certain safety precautions are met. The Sept. 22 final rule is similar to an interim final rule released last March. The AHA and its American Society for Healthcare Engineering worked for nearly four years to amend fire safety regulations to allow more widespread use of hand-rub dispensers, which can improve health care practitioners' hand hygiene and reduce infections.

Quality Reporting

CMS' Medicare outpatient PPS final rule included new quality measures that hospitals must submit in order to qualify for a full market basket update under the FY 2008 *inpatient* PPS. These additional measures were previously adopted for public reporting by the Hospital Quality Alliance, of which the AHA is a co-founder. In addition to 30-day mortality rates for heart attack and heart failure patients, and surgical care, the new measures include patients' experience of care as measured by the HCAHPS survey. HCAHPS will allow patients to provide hospitals with feedback on staff performance, pain control, facility environment and other measures. Hospitals that fail to report these quality measures face a penalty of 2 percentage points from their inpatient update for 2008.

HCAHPS is applicable to virtually all adult inpatients, thereby minimizing the concern of small sample size that is found with the clinical measures reported on Hospital Compare. The AHA supports HCAHPS and encourages hospitals to begin using the survey.

Implementation of HCAHPS began Oct. 2006 and the reporting period covers nine months through June 2007. Training sessions for hospitals and survey vendors will occur in early 2007. A brief "dry run" will be held for March 2007 discharges.

To be ready to submit HCAHPS data and qualify for a full FY 2008 inpatient PPS update, hospitals need to begin the following steps:

- Identify a vendor who is certified to collect the HCAHPS data as prescribed or have staff trained so that the hospital can administer its own surveys.
- Indicate to the Q-Net Exchange that you will submit data or authorize the Q-Net Exchange to accept your data from your survey vendor.
- Participate in a dry run that tests the entire process, from selection of patients to be surveyed through successful submission of data to the QIO Clinical Warehouse.

If your hospital has not begun to use the HCAHPS survey, contact your QIO or survey

vendor now or take advantage of the training opportunity in early 2007 if you wish to collect and submit your own data. If you have any concerns about your hospital's status to submit HCAHPS data, please check with the AHA at 1-800-424-4301. The AHA's Nov. 20 *Quality Advisory* provides details about CMS' new quality measures for FY 2008.

Brian Shockney Receives Munroe Award

Brian T. Shockney, president and CEO of Memorial Hospital in Logansport, Ind., is the 2006 winner of the American Hospital Association's Shirley Ann Munroe Leadership Award. The award recognizes small or rural hospital leaders who have improved health care delivery in their communities through innovative and progressive efforts. Shockney has developed and implemented model programs to promote health and extend services throughout the community. These programs include an Rx Assist Program to help locate free pharmaceuticals for uninsured patients, placing a pediatrician in a local elementary school with a high population of uninsured and underinsured students, and working with the University of Notre Dame to improve and expand care for the rapidly growing Latino population. Memorial Hospital lead in the development of a 1.3-mile fitness trail and has been very active in working to address healthy nutrition and lifestyles for its area youth. Memorial is an 83-bed inpatient acute care hospital with a 21-bed skilled nursing facility offering almost 75,000 outpatient visits annually. It is located in a predominantly agricultural community in central Indiana.

20th Annual Rural Health Care Leadership Conference

The Health Care Forum/AHA Rural Health Care Leadership Conference is scheduled for January 21-24, 2007 at the Point Hilton Tapatio Cliffs Resort, Phoenix. For 20 years, the Conference has convened rural leaders who seek inspiration and guidance on the changing rural health care environment to advance their professional development and hospital's standing in the community. The conference agenda draws from the experiences of skilled practitioners and national experts. Its programming strikes the balance between today's operational challenges and tomorrow's strategic decisions.

This year's program promises to be among the best. Visit the Conference web site at http://www.healthforum.com/healthforum/html /conferences/conf_ruralhealth.html for additional information on the agenda and registration.

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

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