Hospital Issues Not Yet Resolved

The American Hospital Association (AHA) is making one last legislative push to address two important hospital items that are still not resolved as the end of the 110th Congressional session approaches and Congress adjourns for the upcoming November 4 election. The AHA is trying to generate support for the Preserving Access to Healthcare (PATH) Act of 2008 (S.3656), a bill introduced last week by Senator Charles Schumer (D-NY) and five other senators to delay for six months cuts to both Medicare capital indirect medical education (IME) payments and Medicaid outpatient payments. The Medicare capital IME payment reduction, which took effect October 1, was a part of the FY 2009 Medicare Inpatient Prospective Payment System (PPS) Final Rule. It eliminates $1.3 billion over five years from teaching hospitals.

The cuts to Medicaid outpatient services come by way of a Medicaid rule that was not included as part of an extension on the moratoria preventing the implementation of certain other Medicaid rules until April 1, 2009. A proposal to block implementation of the rule was stripped from the Iraqi war funding legislation that was enacted in June. Among other things, it would limit the definition and scope of Medicaid outpatient services provided in a hospital clinic, hospital facility, or rural health clinic to only those that Medicare would pay for under its outpatient PPS program or that are recognized by Medicare as an outpatient hospital service under an alternate payment methodology. It also tinkers with the way in which upper payment limits are applied to hospital outpatient services.

CMS has indicated that it cannot reliably determine the fiscal impact of this proposed rule due to a lack of available data, but believes the rule would not significantly alter current payment practices in most states. Congressional Budget Office estimates are that the outpatient rule would reduce federal Medicaid outlays by $0.3 billion over five years and $0.7 billion over 10 years. However, a March 2008 report prepared for the House Committee on Oversight and Government Reform puts the tab at a minimum $2.1 billion over the next five years. The rule could also negatively impact children covered by Medicaid programs and children’s hospitals. While Medicare serves as a benchmark for the Medicaid payment, Medicare covers very few children and does not cover preventive and screening services provided under Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT), a mandatory Medicaid benefit.

Arkansas’ Political Scene – Up Close

Dustin McDaniel, the Arkansas Attorney General, will be the featured speaker at the Arkansas Hospital Association’s Advocacy/Trustee Luncheon on Thursday, October 9. McDaniel will discuss what is expected to be a challenging 2009 session of the Arkansas General Assembly, how the outcome of the 2008 presidential election may affect Arkansans and other timely political issues. The advocacy lunch is part of the AHA’s Annual Meeting and Trade Show to be held October 8-10 at the Peabody Hotel in Little Rock. For a copy of the annual meeting program and registration brochure, click on http://arkhospitals.org/calendarannual.htm.
Legal Note: The ADA Amendments Act of 2008

On September 25, 2008, President Bush signed into law the ADA Amendments Act of 2008 (ADAA of 2008). The ADAA of 2008 expressly rejects the holdings in several U.S. Supreme Court decisions that had narrowed the definition of who is entitled to protection under the Americans With Disabilities Act of 1990 (ADA) as well as a portion of the current Equal Employment Opportunity Commission (EEOC) regulations.

According to the EEOC, the ADAA of 2008 retains the ADA’s basic definition of “disability” as an impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment. However, it changes the way that these statutory terms should be interpreted in several important ways.

The changes included in the ADAA of 2008, which will be effective January 1, 2009, include, but are not limited to, the following:

- The determination of whether an impairment “substantially limits a major life activity” is to be made without reference to the effects of mitigating measures or assistive devices other than ordinary eyeglasses or contact lenses. For example, even if a diabetic person can control her condition with medication, she still may be considered disabled.
- An impairment that is episodic or in remission is a disability under the ADA if it would substantially limit a major life activity when active. For example, a person with cancer that is in remission may be considered disabled.
- An individual who is discriminated against because he is “regarded as” having a disability is protected under the ADA regardless of whether or not an actual disability exists under most circumstances.

Under the ADAA of 2008, more people will qualify as disabled individuals under the ADA. Accordingly, hospitals will want to work with internal compliance staff and legal counsel, as appropriate, to ensure that they fully understand the new requirements and are ready for the changes to the ADA that will go into effect on January 1, 2009. Existing policies, processes and procedures should be evaluated and may need to be revised, and staff training on the new requirements is advisable.

Transmittal Affects Medicare Recoupment Policies

On September 12, CMS issued Transmittal 141 implementing Section 935 of the Medicare Appeals Process. The Transmittal changes the way that interest is to be paid to a provider or supplier whose overpayment is reversed at subsequent administrative law judge (ALJ) or judicial levels of appeal. It defines the overpayments to which the limitation applies, how the limitation works in concert with the appeals process and the change in our obligation to pay interest to a provider or supplier whose appeal is successful at levels above the qualified independent contractor (QIC). Previously, if a provider or supplier elected to appeal an overpayment determination, there was no effect on Medicare’s ability to recover the debt. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure. Click on [http://www.cms.hhs.gov/Transmittals/Downloads/R141FM.pdf](http://www.cms.hhs.gov/Transmittals/Downloads/R141FM.pdf) to access the Transmittal.
Final FY 2009 Wage Index Data

The Centers for Medicare & Medicaid Services (CMS) on October 1 released final wage index, standardized amount and other data for the Inpatient Prospective Payment System (PPS) for fiscal year (FY) 2009. On July 31, when CMS published the inpatient PPS final rule, the agency stated that it was still implementing Section 508 reclassification and other wage index extensions contained in the Medicare Improvements for Patients and Providers Act of 2008 that passed in July. Therefore, CMS was only able to provide tentative FY 2009 wage index values for hospitals, as well as tentative standardized amounts, relative weights and thresholds for outliers and new technology add-on payments.

For hospitals in labor markets affected by the Section 508 extension, CMS has assigned the highest FY 2009 wage index for which the agency believes the hospital is eligible. Hospitals have until October 18 to inform CMS whether they wish to revise the decision CMS has made on its behalf. If your hospital is in one of these markets, we recommend that you review the wage index that CMS has assigned you.

The final operating standardized amounts for FY 2009 are as follows:

Area Wage Index Greater Than 1.0

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<th>Full Update (3.6%)</th>
<th>Reduced Update (1.6%)</th>
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<tbody>
<tr>
<td>Labor-related</td>
<td>$3,574.50</td>
<td>$3,505.49</td>
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<tr>
<td>Non-labor-related</td>
<td>$1,553.91</td>
<td>$1,523.91</td>
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Area Wage Index Less Than 1.0

<table>
<thead>
<tr>
<th></th>
<th>Full Update (3.6%)</th>
<th>Reduced Update (1.6%)</th>
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<tbody>
<tr>
<td>Labor-related</td>
<td>$3,179.61</td>
<td>$3,118.23</td>
</tr>
<tr>
<td>Non-labor-related</td>
<td>$1,948.80</td>
<td>$1,911.17</td>
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Cases would qualify for outlier payments in FY 2009 if their costs exceed the inpatient PPS rate for the diagnosis-related group, including indirect medical education, disproportionate share hospital and new technology payments, plus a fixed-loss threshold of $20,045. This is down from the tentative FY 2009 amount of $20,185 and the final FY 2008 amount of $22,185. A display copy of this notice will be posted at the following link http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp#TopOfPage.

Medicare Publishing Medically Unlikely Edits

CMS announced October 1 that it will publish most of the edits utilized in its Medically Unlikely Edit (MUE) program to improve the accuracy of claims payments. The MUE (previously called Medically Unbelievable Edits) program was implemented in January 2007 with the intent to reduce payment errors for Medicare Part B claims. The edits check the number of times a service is reported by a provider or supplier. Claims processing contractors then utilize the edits to assure that providers and suppliers do not report excessive services. Providers and suppliers, who report
services on claims using HCPCS/CPT codes along with the number of times (i.e., units of service) that the service is provided, have complained in the past because the edits have not been made available to the public. Prior studies, including one by the U.S Department of Health and Human Services’ Office of the Inspector General in May 2006, identified significant Medicare overpayments because provider or supplier claims sometimes report services with too many units of service. These errors may be caused by numerous factors, including clerical errors and coding errors. To date, CMS has not determined if there have been any savings in the MUE program since it was implemented.

Outpatient Quality Data Warehouse Difficulties

Hospitals submitting outpatient quality reporting data may have received erroneous feedback reports or submission reports due to technical problems at the CMS quality data warehouse. The American Hospital Association has made CMS aware of the problem, which the agency is working to fix, and will keep hospitals updated on the status of the problem. Data submission for the inpatient quality reporting program is not affected.

Psych Hospitals’ Measures Ready

Effective with October 1 discharges, free-standing psychiatric hospitals will be able to meet their ORYX performance measurement requirements using The Joint Commission’s Hospital-Based Inpatient Psychiatric Services (HBIPS) measure set. ORYX is The Joint Commission’s performance measurement and improvement initiative to integrate outcomes and other performance measurement data into the accreditation process. General medical/surgical hospitals that provide acute inpatient psychiatric services also will be able to select the HBIPS measure set as one of four core measure sets needed to meet ORYX requirements for 2008. For more information, visit http://www.jointcommission.org/PerformanceMeasurement/PerformanceMeasurement/Hospital+Based+Inpatient+Psychiatric+Services.htm.

The AHA Calendar

October 2008
8 “Dancing with the Devil” – How to Negotiate with Managed Care Contracts for Hospitals – Webinar T2434 Rescheduled from October 2, 2008
8-10 Arkansas Hospital Association’s 78th Annual Meeting and Trade Show, Peabody Hotel Little Rock
8 High Stakes Communication Series – 7-Part Audioconference Series – Part 7: Critical Thinking/Listening
14 How to Have a Margin Discussion with Your Doctors – Webinar AZ101408 Time Has Been Changed

Editor's Note: The Notebook will not be published October 13 due to the Arkansas Hospital Association’s 78th Annual Meeting and Trade Show being held this week at The Peabody Little Rock and Statehouse Convention Center. The next issue of The Notebook will be published October 20.