

# CAH Update

## Summer 2006

As of June 27, the Centers for Medicare & Medicaid Services (CMS) reported that there are 1,283 Critical Access Hospitals (CAHs). This number represents more than 25 percent of all community hospitals and 64 percent of all rural community hospitals in the United States. This issue of **CAH Update** reviews the fiscal year (FY) 2007 federal budget as well as appropriations for rural programs, the AHA's advocacy agenda for CAHs (including legislative and regulatory priorities), CAH participation in *Hospital Compare* and AHA resources on Medicare Advantage.

### The Federal Budget

The President's FY 2007 budget request of \$36 billion in Medicare budget reductions includes \$15.9 billion in cuts to the inpatient, rehabilitation and outpatient hospital update factors. It also requests \$13.6 billion in Medicaid cuts over five years, including \$5.8 billion from hospitals. Medicaid spending would be reduced by the Department of Health and Human Services (HHS) through regulatory measures – without congressional consideration, and regardless of whether Congress were to pass a budget resolution with no Medicaid cuts. This spring, 82 House Republicans signed a letter – circulated by Rep. Peter King (R-NY), along with Reps. Cliff Stearns (R-FL), Dave Reichert (R-WA) and Rob Simmons (R-CT) – to HHS Secretary Michael Leavitt opposing the Administration's proposal.

The House 2007 budget resolution excludes specific cuts to Medicare and Medicaid. The House adopted the budget blueprint after including a measure allowing roughly \$7.1 billion in increased funding for health, labor and education programs. The Senate budget plan also spares hospitals from Medicare and Medicaid cuts.

### FY 07 Rural Health Appropriations

A number of important rural programs are included in this funding measure. The House Appropriation Subcommittee on Labor, HHS, and Education passed its version of an FY 2007 appropriations bill on June 13 and the Senate subcommittee passed its on July 19. Under the House proposal, there is no funding for rural EMS, the Denali Commission or health information technology, but core funding for FLEX and SHIP is maintained. The Senate funds the Delta Health Initiative as a separate line-item and at \$35 million. The table below compares funding levels between the President's proposal and the House and Senate committee-approved levels.

Comparison of Recommended Funding Levels for Selected Appropriations Programs FY 2007			
July 18, 2006 (in millions of dollars)			
Program	FY 2007 President Proposal	House Committee Level	Senate Committee Level
NHSC	125.5	131.5	125.5
Nurse Education & Retention	37.3	37.3	37.3
Nurse Loan Repay & Scholarship	31.1	31.1	31.1
Rural Health Outreach Grants	10.4	40.0	38.9
Rural Health Research	8.7	9.0	8.7
Rural Hospital FLEX Grants	0	40.0	38.5
State Offices of Rural Health	8.1	8.4	8.1
Rural AED	0	1.5	1.5
Rural Telehealth	6.8	10.0	6.8
Denali Commission	0	0	39.3

## 2006 AHA Advocacy Agenda

The AHA's comprehensive advocacy agenda for 2006 focuses on protecting care for patients and communities, strengthening the bond between hospitals and communities and helping people get the care they need. The AHA will work to ensure adequate funding for the Medicare and Medicaid programs; help identify solutions to the problems of the uninsured; fix the rehabilitation "75% rule;" implement a permanent ban on physician self-referral to new physician-owned, limited-service providers; address challenges in rural communities; continue its leadership role to improve the quality of care and patient safety; and provide hospitals with tools and resources they can use to strengthen their bonds with their communities. It also addresses the specific needs of CAHs.

### Legislative Advocacy

The AHA continues to advocate for key legislation to enhance and improve the CAH program. Throughout the 109<sup>th</sup> Congress, the AHA's efforts included support of several legislative proposals, including:

**The Rural Community Hospital Assistance Act** (S. 933/HR. 2350) – would extend cost-based reimbursement for rural hospitals with between 25 and 51 beds for inpatient and outpatient services, as well as for CAH nursing facilities, home health services, and ambulance services.

**The Critical Access to Clinical Lab Services Act** (S. 236/HR. 1016) – would remove CMS' requirement that a patient needs to be "physically present" at the CAH when a laboratory specimen is collected in order for the CAH to receive cost-based reimbursement.

**The Safety Net Inpatient Drug Affordability Act** (S. 1840/HR. 3547) – would expand the 340b drug discount program to include inpatient services and CAHs.

**The Rural Health Services Preservation Act of 2006** (S. 2819) – would ensure that CAHs and RHCs are paid no less by Medicare Advantage (MA) organizations than they would be by traditional Medicare. This payment floor would apply to both contracting and non-contracting providers and to CAH inpatient, outpatient and swing-bed services, as well as RHC services. MA

plans could negotiate rates with CAHs, but those rates would have to meet or exceed the payment floor. The legislation, introduced by Sens. Norm Coleman (R-MN) and Richard Durbin (D-IL), would allow two methods for determining minimum payment that meets this threshold: (1) through a payment rate of the hospital's interim rate and yearly cost reconciliation, or (2) a payment rate equal to 103 percent of the applicable interim payment rate without reconciliation.

**The Rural Health Equity Act** (H.R. 880) – introduced in the House in 2005; would ensure that plans pay CAHs at least 101 percent of costs for inpatient and outpatient services, regardless of whether services were provided on an in-network or out-of-network basis.

**The Rural Health Care Capital Access Act** (H.R. 4912) – would provide a five-year extension of the mortgage insurance program for CAHs under Section 242 of the National Housing Act, which insures loans for the construction and renovation of hospitals. Rep. Robert Ney (R-OH) introduced the bill. This extension would give the Federal Housing Administration and the Department of Housing and Urban Development time to review the program's impact before making a recommendation to Congress on whether the exemption should be made permanent.

**Rural Hospital and Provider Equity (HoPE) Act of 2006** (S. 3500) – would extend the MMA's outpatient hold-harmless provision for rural hospitals with fewer than 100 beds and SCHs, as well as the 5 percent rural add-on for home health services. Both provisions are set to expire. In addition, the legislation, introduced by Sens. Kent Conrad (D-ND) and Craig Thomas (R-WY), would provide cost-based reimbursement for CAH outpatient laboratory services (regardless of where the patient is physically located), remove the cap on disproportionate share adjustment percentages for all hospitals and improve payments for ambulance services in rural areas.

**The Medicare Rural Health Provider Payment Extension Act** (H.R. 5118) – would extend six rural provisions of the Medicare Modernization Act of 2003 (MMA) that have expired or will expire by 2008. The provision would extend the outpatient hold-harmless provision for sole community hospitals (SCHs) and rural hospitals with fewer than 100 beds; provide reasonable-

cost payment for outpatient laboratory services performed by rural hospitals; give a 5 percent add-on for rural home health services; and give a 2 percent payment increase for ground ambulance services originating in rural areas. Reps. Greg Walden (R-OR) and Earl Pomeroy (D-ND), who serve as co-chairs of the Rural Health Care Coalition, cosponsored the bill.

**The Physicians for Underserved Areas Act** (H.R. 4997, S. 2425) – would permanently reauthorize the J-1 visa waiver program. The program, which is vital to rural communities' ability to have access to needed services, was set to expire June 1. It allows international medical graduates who would otherwise be required to return to their home countries for two years to remain in the U.S. for an additional three years in exchange for serving in a rural area experiencing a physician shortage. Rep. Jerry Moran (R-KS) sponsored the House bill, while Sen. Kent Conrad (D-ND) introduced the companion bill in the Senate.

**Comprehensive Immigration Reform Act** (S. 2611) – would expand the number of visas that could be offered to physicians to practice in medically underserved areas of the country. The bill would extend permanently the State 30/J-1 visa waiver program, which was set to expire June 1; exempt nurses and physical therapists from the employment-based visa caps; and clarify that hospitals could continue to treat undocumented immigrants without risking criminal prosecution. **The prospect for passage of comprehensive immigration reform is uncertain. Therefore, the AHA advocates that Congress move separately to reauthorize the J-1 visa waiver program as soon as possible.**

## Regulatory Advocacy

**FY 2007 Inpatient PPS Rule: CAH Relocation and Replacement** – On April 12, CMS released the proposed rule implementing FY 2007 changes to the Medicare hospital inpatient prospective payment system (PPS). The AHA submitted its comments on June 12. While there are a number of major changes that may adversely affect PPS hospitals, the rule contained only one technical correction to the CAH program regarding CAH relocation. Nevertheless, the AHA took this opportunity to provide comments on the interpretive guidelines released in November 2005 regarding CAH relocation.

On November 14, 2005, CMS issued interpretive guidelines on the relocation of CAHs as a follow-up to the FY 2006 inpatient PPS final rule, which established the "75% test" – serving 75 percent of the same population, providing 75 percent of the same services and employing 75 percent of the same staff – for necessary-provider CAHs. The guidelines not only extended the 75% test to *all* CAHs, but also altered the definitions of "mountainous terrain" and "secondary road."

These guidelines go well beyond the regulations included in the FY 2006 rule that provoked widespread criticism from individual CAHs, hospital associations and federally elected officials. The "mountainous terrain" and "secondary road" definitions are overly prescriptive and the "75% test" does not provide reasonable flexibility based on natural variation in demographics, patient needs distribution patterns, normal employee and board attrition and necessary changes in services to meet community needs. **Rural hospitals that move a few miles are clearly the same providers serving the same communities.**

Many CAHs are planning to rebuild in the near future to improve site safety and quality of care by adding fire and smoke barriers, upgrading infrastructure to support utilities and air handling, modernizing telecommunications to support health information technology or making other essential upgrades.

CMS' guidelines not only will impose an unnecessary burden on CAHs, but also will preclude many of them from securing financing for needed capital improvements. The hospitals themselves, their hospital districts and their lenders cannot risk investing in a hospital that will be unsure of its status until a year after moving. **CMS should create a preliminary approval process to give assurances to those involved in the project that the CAH relocation will be approved if it meets the assertions made in the attestation submitted to CMS.**

This year, almost 60 House members signed a letter to CMS showing their support for their CAHs and urging changes to these guidelines. . Sens. Roberts (R-KS) and Harkin (D-IA) are circulating a letter to be signed by other Senators urging CMS Administrator McClellan to re-evaluate the interpretive guidelines used by CMS for approving CAH relocation and replacement construction. We agree with the members of

Congress and reiterate our suggestion from last year that a safe harbor be established for hospitals relocating within five miles of their existing locations. A safe harbor will reduce the administrative burden on not only the hospitals, but CMS and the state survey agencies as well.

**We urge CMS to create a safe harbor for CAHs moving a short distance and to make significant changes to these guidelines.**

**CAHs in Lugar Counties:** In its FY 2005 final rule, CMS interpreted a statutory provision modifying the status of rural counties with certain commuting patterns to metropolitan areas as applying to CAHs located in these counties (known as “Lugar counties” after the Senate sponsor of the provision) and allowed these facilities a grace period to seek reclassification as rural in order to retain their CAH status. While accommodating CAHs in this manner, the agency also took the position that any CAH being reclassified would no longer be eligible for pass-through payments for the services of certified registered nurse anesthetists (CRNAs).

This position is at odds with the agency’s view that *it is geographic reclassification that renders a CAH ineligible for such payments* – since, under CMS’ revised policy, a CAH located in such a county need not seek geographic reclassification to be a CAH. Apparently, it is CMS’ view that these CAHs can never qualify for CRNA pass-through payments, whether they have sought reclassification (under the old policy) or not (under the new policy). **We believe that all CAHs located in a newly designated Lugar county should receive pass-through payments, regardless of whether they sought reclassification, and urge CMS to revise its regulations accordingly.**

## Medicare Advantage Resources

Upon enactment of the Medicare Modernization Act in 2003, Congress revitalized the Medicare managed care program: substantial new funds were allocated and new program design options were added, as well as new payment methodologies. Implementation of the new

For more information on topics in *CAH Update* or the AHA Section for Small or Rural Hospitals, contact John T. Supplitt, senior director, or Dorothy Cobbs, associate director, American Hospital Association. TEL: 312-422-3334, [dcobbs@aha.org](mailto:dcobbs@aha.org).

Medicare Advantage (MA) program is well underway; marketing of plans began in October 2005, followed by the open enrollment period November 15, 2005 and launch of the new plans in January 2006.

The AHA has held several conference calls to update members on the status of MA, AHA advocacy efforts and information on contracting strategies with MA plans, especially private fee-for-service and regional PPOs. In May, the AHA conducted a teleconference series to address problems encountered by small or rural hospitals during implementation of the Medicare Advantage program, with a particular focus on contracting considerations. Discussion focused on contracted and deemed-contracted providers. For additional information on MA, including a rural-focused primer, visit the AHA Web site at [http://www.aha.org/aha/key\\_issues/medicare/ma\\_calls.html](http://www.aha.org/aha/key_issues/medicare/ma_calls.html).

## Quality

As of March, over 3,900 hospitals were reporting quality data to the Hospital Quality Alliance’s (HQA) *Hospital Compare* Web site. Over 600 CAHs are submitting data voluntarily and without Medicare payment incentives.

In a February 2006 report, *CAH Participation in Hospital Compare and Initial Results*, the Flex Monitoring Team – a consortium of the rural health research centers at the Universities of Minnesota, North Carolina and Southern Maine – found that “overall, the initial *Hospital Compare* results suggest that CAHs as a group are performing as well or better than non-CAH rural and urban hospitals on several measures for patients with pneumonia, including the initial antibiotic in four hours, pneumococcal vaccine, and blood culture prior to antibiotic measures. They are also performing as well or better than small non-CAHs on most AMI and pneumonia measures.”

The report is available at [www.flexmonitoring.org](http://www.flexmonitoring.org). AHA encourages CAHs to measure and report data to the HQA for Hospital Compare.

**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](http://www.hospitalconnect.com/aha/member_relations/cah/index.html)