American Hospital Association

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SECTION FOR SMALL OR RURAL HOSPITALS
2007 Annual Report

As the national advocate for small or rural hospitals, the American Hospital Association (AHA) works with Congress and regulatory agencies on health care policy that affects the ability of our members to deliver care and improve the health status of their community. Through its Section for Small or Rural Hospitals, the AHA serves more than 1,650 members. The rural constituency includes sole community providers, Medicare dependent hospitals, rural referral centers, prospective payment system (PPS) hospitals, and critical access hospitals (CAHs).

During 2007, the AHA supported a number of legislative proposals to improve rural health, and provided comments and recommendations to regulatory agencies, such as the Centers for Medicare & Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA). We are pleased to report our activities on behalf of our members.

REPRESENTATION AND ADVOCACY

Legislation

Through its grassroots advocacy activities, the AHA was successful in working with members of Congress on legislation preventing CMS from fully implementing more than $20 billion in cuts to payment for hospital inpatient Medicare services over the next five years.

The AHA supported several legislative proposals that would preserve rural access to care. There were two bills introduced during the first session of the 110th Congress that represented bipartisan efforts by the House Rural Health Care Coalition and the Senate Rural Health Caucus.

- ★ *The Health Care Access and Rural Equity Act (H-CARE)* would extend through 2011 existing rural health provisions of the *Medicare Modernization* (MMA) and *Deficit Reduction Acts* (DRA). H.R. 2860 also would extend the outpatient hold-harmless provision for rural hospitals with fewer than 100 beds; extend the 2% add-on for ambulance trips in rural areas, and extend the 5% add-on for rural home health services. CAHs would gain flexibility to respond to daily and seasonal fluctuations in patient load and receive cost-based reimbursement for outpatient lab services.

- ★ *The Craig Thomas Rural Hospital and Provider Equity Act (R-HoPE)* would extend the outpatient hold-harmless provision for rural hospitals under 100 beds and sole community hospitals, continue the grandfather clause allowing direct payments to independent laboratories for the technical component of pathology services, and extend the 5% rural add-on payment for home health services. In addition, S. 1605 would provide cost-based reimbursement for CAHs' outpatient lab 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.

Before adjourning the first session S. 2499, the *Medicare, Medicaid and SCHIP Extension Act of 2007* was passed. The legislation would extend the following provisions:

- Medicare payment incentives for physician scarcity areas for six months ending July 1, 2008.
- Floor on work geographic adjustment under the Medicare physician fee schedule for six months ending July 1, 2008.
- Medicare payment of independent labs for the technical component of certain physician pathology services provided to hospitals for six more months ending June 30, 2008.
- Payment of cost-based outpatient lab services for rural hospitals with fewer than 50 beds in certain low-population areas for six months ending June 30, 2008.
- Section 508 geographic reclassifications through September 30, 2008

The AHA also will work to advance other bills introduced to extend permanently the outpatient PPS hold harmless and permit the use of a more current year to re-establish the sole community hospital target amount; improve CAH bed-size flexibility; establish cost-based reimbursement for CAH clinical lab and ambulance services; expand 340B discounts for inpatient and outpatient drugs to critical access, Medicare dependent and sole community hospitals and rural referral centers; and payment at 101% of cost for inpatient, swing-bed and outpatient hospital services by Medicare Advantage plans.

The AHA continues to advocate for adequate funding for rural health appropriations. Fiscal year 2008 funding for Rural Hospital Flexibility Grants is $37.9 million; State Offices of Rural Health is $8.0 million; Rural Outreach Grants is $48.0 million; Rural Health Research is $8.6 million; Delta Health Initiative is $24.6 million; telehealth is $6.7 million, and Rural and Community AEDs is $1.5 million.

REGULATION

The AHA also represents the interests of small or rural hospitals to numerous federal agencies, most notably CMS. Through advocacy efforts and letters to the Secretary of HHS, CMS administrator and others, the AHA pushes for flexible and fair rules for payment and program participation. In 2007, the AHA had several regulatory accomplishments on rural issues.

★ As part of the effort to identify quality measures relevant to rural providers, AHA urged CMS to adopt five specific heart attack care measures in the outpatient PPS final rule as part of its new outpatient quality reporting program. When a CMS contractor announced in December that it would not allow CAHs to submit the outpatient measures, the AHA objected, citing the importance of allowing CAHs to demonstrate their commitment to transparency and quality improvement. We worked with CMS to allow CAHs to submit and publicly report outpatient quality data.

★ Our persistence on behalf of our members resulted in revisions to CMS' 2005 interpretive guidelines for CAHs and CAH rebuilding and relocation criteria. Generally, the revisions have been embraced as a significant improvement that will facilitate CAH rebuilding and replacement. The AHA is pleased that CMS adopted most of our recommended changes, but remains concerned that CMS did not adopt them all. We will continue to work with CMS to reduce obstacles to CAH rebuilding and replacement and permit CAHs to effectively serve Medicare beneficiaries and others.

★ *The Tax Relief and Health Care Act of 2006* requires MedPAC to recommend possible alternatives to the Medicare area wage index by June 30. CMS must consider these recommendations in its FY 2009 hospital inpatient PPS proposed rule. To consider possible reform of the area wage index, the AHA has convened a workgroup of national, state, regional and metropolitan hospital association executives. The AHA agrees that the area wage index is not functioning well and requires change. In particular, the current system is volatile – neighboring counties can have very different indices, and a hospital's wage index can drop even when the hospital increases wages substantially. The AHA and its workgroup will continue to work with MedPAC and CMS throughout the next two years to develop potential changes that will address some of the existing area wage index's shortcomings.

SMALL OR RURAL GOVERNING COUNCIL

The Section's Governing Council advises the AHA on numerous policy issues. Governing council members are the elected representatives of the small or rural hospital constituency section and serve as an important channel of communication. The council is active in many ways, including:

Shaping policy through member dialogue

- Meeting directly with members of Congress;
- Working with state association representatives and their small or rural hospital members to join in governing council meetings;
- Nominating rural hospital leaders who are appointed or elected to the AHA Board of Trustees, Section Governing Council, and Regional Policy Boards; and
- Selecting a recipient for the Shirley Ann Munroe Leadership Award. This award provides educational opportunities to outstanding small or rural hospital CEOs. Russell W. Johnson, CEO, San Luis Valley Regional Medical Center, Alamosa, CO was the 2007 recipient.

The governing council met three times in 2007. At each meeting, governing council members were updated on rural health federal legislative and regulatory issues, as well as other key policy issues. Policy priorities discussed include *Health for Life,* a national framework for health reform; no-charge for serious, adverse events; health disparities; behavioral health and working under Medicare Advantage.

INTER-ORGANIZATIONAL RELATIONSHIPS

Expanding our sphere of influence

The AHA and the Section collaborate with other national organizations and the federal government in support of rural hospitals. These relationships include:

- ★ American Academy of Family Physicians, Committee on Health of the Public
- ★ The Joint Commission, Work Group on Accreditation Issues for Small and Rural Hospitals;
- ★ HRSA Office of Rural Health Policy Rural Health Issues Group
- ★ HRSA FLEX Program Advisory Committee
- ★ HRSA Delta Rural Hospital Performance Improvement Project Advisory Committee, and
- ★ National Rural Health Association (NRHA)

STATE ASSOCIATION RELATIONS

Building consensus through stronger relationships

The Section works closely with its rural hospital liaisons at the state hospital associations in many ways, including:

- ★ Bimonthly calls featuring federal legislative and regulatory updates;
- ★ State-sponsored federal updates with local hospital executives;
- ★ Education at state association conferences and meetings; and
- ★ Routine communication on breaking issues and advocacy priorities

COMMUNICATION, EDUCATION AND MANAGEMENT STRATEGIES

Expanding our knowledge through tools and technical assistance

The AHA and the Section assist members through communication, education and management strategy tools and resources, and services such as:

- ★ AHA News and AHA News Now
- ★ The Section's Update and CAH newsletters
- ★ The Section's Web site at www.aha.org/aha/key_issues/rural
- ★ The Section's CAH Web site at www.aha.org/aha/key_issues/rural/focus/cah.html
- ★ The Health Forum's Annual Rural Health Care Leadership Conference
- ★ Education on federal legislation, federal regulations and rural health programs and policy at NRHA's Annual National and CAH Conferences and HRSA's Rural Health Performance Program; and
- ★ Regular teleconferencing with CAHs, as well as at-large small or rural member hospitals

This is a brief summary of how the AHA and the Section for Small or Rural Hospitals added value in 2007. Throughout the year, the AHA worked collaboratively with its state association partners, and AHA will continue to work hard to earn your trust and support throughout 2008.

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