American Hospital Association

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SECTION FOR SMALL OR RURAL HOSPITALS
2008 Year in Review

The Section for Small or Rural Hospitals adds value to AHA membership through its many functions and services and provides a home for more than 1,650 AHA hospital constituents including over 950 critical access hospitals (CAHs). The Section monitors the challenges confronting CAHs and communicates them across the Association. With input from its 18-member Governing Council, the Section identifies issues and concerns, develops strategies, designs solutions, provides education, and collaborates with key national partners to improve the environment for these essential providers.

Recognized as the national advocate for hospitals and the communities and patients they serve, the AHA works with member hospitals; state and regional hospital associations; and other related organizations to shape and influence federal legislation and regulation to improve the ability of our members to deliver high quality health care. The AHA ensures that the unique needs of its various constituents are heard and addressed in national health policy development, legislative and regulatory debates, and judicial matters.

REPRESENTATION AND ADVOCACY

The AHA represents small or rural hospitals on Capitol Hill through strong relationships with congressional committees, congressional testimony and letters. The AHA works with Congress to achieve fair payment and more administrative flexibility for small or rural hospitals. Working with our strategic partners and members, the AHA has accomplished some significant victories including:

- ⋆ **Medicare Improvements to Patients and Providers Act of 2008 (H.R. 6331)** – Among other things, MIPPA:
  - Extends and expands the FLEX program to provide grants to mental health services for veterans and residents of rural areas
  - Provides a new base year for SCHs for cost reporting periods on or after January 1, 2009 based on FY 2006 cost reports.
  - Reinstates the add-on payment for ground ambulance services and provides an 18-month hold harmless for air ambulance regions recently reclassified from rural to urban
  - Extends for 18 months the provision that allows independent labs to continue to bill Medicare directly for the physician pathology services they provide to hospitals.
  - Extends provisions that ensure small rural hospitals receive payments for outpatient services that are at least 85% of what they received before the hospital OPPS took effect. This provision would also extend to SCHs < 100 beds.
  - Allows CAHs serving rural areas to receive 101% of reasonable costs for clinical lab services provided to Medicare beneficiaries regardless of whether the lab specimen was taken in the hospital or off-site at another facility operated by the CAH.

- ⋆ **Conrad State 30 Improvement Act (H.R. 5571)** – Extends the J-1 visa waiver program through March 6, 2009, subject to the overall limit of 30 participants per state. Increases from five to 10 the number of alien physicians who may serve in state facilities.

- ⋆ **Continuing Resolution (H.R. 2638)** – Congress passed a continuing resolution to fund the federal government through March 6, 2009 for federal agencies including the Department of Health and Human Services (HHS). HHS programs include appropriations for select rural programs including CAH FLEX grants, outreach and network grants, and community health centers to name a few. These and other rural programs are funded at the equivalent FY 2008 levels. H. R. 2638 also authorizes the Secretary of Veterans Affairs to spend $250 million for establishment and implementation of a new rural health outreach and delivery initiative through September 30, 2010.

- ⋆ **Emergency Economic Stabilization Act** (H.R.1424); established Mental Health Parity bill while prohibiting discrimination on the basis of genetic information with respect to health insurance and employment.

- ⋆ **Testimony and Letters to Congress**
  - As the House Health Subcommittee of the Committee on Energy and Commerce examined the need for a second short-term economic stimulus legislative package, the AHA asked in a statement for the record that Congress place a moratorium on the Medicaid and Medicare rules that could adversely impact access to much-needed services. as they examine the need for a second short-term economic stimulus legislative package to stave off a deep economic recession.
  - AHA sent a letter to Sen. Wyden (D-OR) expressing support for S. 3367, legislation that proposed to align timeframe designations crucial to the certification of rural health clinics (RHCs).
  - In a letter to Rep. Greg Walden (R-OR) AHA expressed support of H.R. 6557, the *Veterans Critical Access Act* that will allow CAHs to exempt from their daily inpatient bed limit care provided to veterans who have been referred by the Department of Veterans Affairs, or veterans who are coordinating care with the department. This legislation offered CAHs the ability to continue to care for their current patients, while also being able to provide critical care to veterans who need immediate services in their own communities.
  - In a letter to House Commerce Committee leaders, AHA commended the bipartisan sponsors of H.R. 6357, the PRO(TECH)T Act of 2008, on their efforts to promote the adoption of information technology by our nation's health care providers.
  - In a letter to Senate Judiciary Committee leaders, AHA opposed H.R. 4854, the False Claims Correction Act of 2007, which as written will hurt patients and hospitals alike by forcing funds that are needed for patient care to be diverted to defend the hospital against frivolous lawsuits.

- In a letter to members of the House Judiciary Committee, AHA expressed support for H.R. 5924, the Emergency Nurse Supply Relief Act, which will help alleviate the current nursing shortage by providing an exemption from current employment-based visa caps for nurses. It also helps address domestic supply by establishing a program to help prepare more nurse educators.
- In a letter to the House Ways and Means and Senate Commerce Committee leadership, AHA lent support to H.R. 2091/S. 1963 to allow bonds with credit enhancement b the Federal Home Loan Banks to be treated as tax-exempt which would provide an alternative credit enhancement opportunity at a time when capital markets are under pressure.

REGULATORY POLICY

The AHA represents the interests of small or rural hospitals to numerous federal agencies, but most notably the Centers for Medicare & Medicaid Services (CMS) and the Health Resources and Services Administration. 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. The AHA has commented on all proposed rules affecting small or rural hospitals and has inspired regulatory agencies to either redraft or reconsider proposals for a single index of primary care underservice, conditions of participation and payment of rural health clinics (RHCs), participation in public reporting of quality measures for outpatient services, clarification on the use of standing orders, payment of therapy services on a contractual basis at CAHs and more. These rules and others would have created tremendous burdens for our members, but more importantly for the residents in our rural communities.

The AHA continues to track these and other issues such as conditions of participation for specialized services, and work toward fair implementation of the guidelines for CAH relocation and rebuilding and definitions of medically underserved and professional shortage areas.

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 2008, the AHA represented small or rural hospital interests on several major rules including:

★ **Hospital Inpatient Prospective Payment Final Rule**
- Under PPS, hospitals that submit data on 30 quality measures will receive a 3.6 percent market-basket update, while hospitals not submitting data will receive a 1.6 percent update. CMS added 13 new measures in FY 2010 for PPS hospitals to receive a full payment update.
- Beginning with discharges on January 1, 2009 hospitals that have fewer than five heart attack, heart failure, pneumonia or surgical care patients in a calendar quarter will not be required to submit data for those patients. Hospitals that have fewer than five HCAHPS-eligible patients in any month will not be required to submit HCAHPS surveys for that month.

- Beginning in FY 2009, CMS will apply a statewide (rather than a nationwide) rural floor budget neutrality adjustment to the wage index. The budget neutrality adjustment for the imputed floor also will be applied at the state level. In this rule, CMS extends the imputed rural floor through 2011.
- The final rule updates the alternative criteria for meeting the rural referral center designation criteria in FY 2009.
- CMS announced four additional hospitals have been added to the 9 current hospitals under the Rural Community Hospital Demonstration Program. The program concludes with the cost reporting year beginning with discharges on or after October 1, 2009.
- In the inpatient PPS rule, CMS refined and finalized its methodology and published the data sources that can be used to determine the core staffing factors used for calculating the volume adjustment for use when applying for special payments as a SCH or MDH.
- SCHs will be paid based on the rate that results in the greatest aggregate payment, using either the federal rate or their hospital specific rate based on their 1982, 1987, 1996 or 2006 costs per discharge.
- All hospitals including CAHs must furnish patients written notice if a physician is not present in the hospital 24 hours per day, seven days per week, and how the emergency medical needs of any patient will be handled when no physician is present. The final rule clarifies enforcement.
- To meet their on-call list obligation through participation in a "community-call plan," agreements must be formal among the participating hospitals. Pre-approval by CMS is not required before hospitals implement such plans.

★ **Hospital Outpatient Prospective Payment Final Rule**

- CMS will continue to provide hold-harmless outpatient payments to rural hospitals with 100 or fewer beds at a rate of 85% through Dec. 31, 2009. In addition, CMS expands the same hold-harmless payments to SCHs (urban and rural) with 100 or fewer beds in 2009.
- CMS will continue increasing payments to rural SCHs, including essential access community hospitals, by 7.1% for all services paid under the outpatient PPS, with the exception of drugs, biologicals, services paid under the pass-through policy and items paid at hospitals' individual charges adjusted to cost.

★ **Other Rules or Notices**

- In a letter to the CMS Administrator, AHA wrote to request that CAHs be given the opportunity to voluntarily submit quality data on outpatient services because of their commitment to public transparency and quality improvement. CAHs previously not able to submit quality of care data under the hospital outpatient quality data reporting program will now be allowed to do so beginning with patient encounters in first-quarter 2009. CAHs can register to participate in the program by completing and submitting a Notice of Participation before Jan. 31, 2009.
- In a letter to the HRSA Administrator, AHA opposed the proposal to revise and consolidate the criteria and process for designating medically underserved areas and populations (MUA/P) and health professional shortage areas (HPSA)

because of the unforeseen and significant adverse impact the change could have on the providers and programs that depend on these designations for federal funding and the communities they serve. HRSA proposed to change how it designates MUPs and HPSAs through a revised methodology for a single "Index of Primary Care Underservice" to determine the level of underservice. HRSA has withdrawn this rule pending further research on its impact.

- CMS released its proposed rule on Changes in Conditions of Participation Requirements and Payment Provisions for Rural Health Clinics (RHCs) and Federally Qualified Health Centers. Under the rule, CMS would review all shortage areas and mandate triennial state review for certification of HPSAs for clinics to be eligible. It proposes exception criteria for essential provides for those unable to meet eligibility requirements. It revises payment to RHCs at 80% of reasonable costs after application of beneficiary copayments and deductibles, and it requires RCHs to establish a QAPI program. This rule remains under review with no release date scheduled for the final rule.
- CMS announced the names of the new national Recovery Audit Contractors in October. The program must be implemented in all 50 states by January 1, 2010. However, CMS is required to impose an automatic stay in the contract work of the four new contractors. This action is the result of protests filed by two unsuccessful bidders for the RAC program with the Government Accountability Office (GAO). A decision would be due for these protests in early February. The four RAC contracts and any work under those contracts are on hold pending the outcomes of the protests.
- The Department of Defense proposed that TRICARE reimburse CAHs the lesser of either billed charges or 101 percent of reasonable costs for inpatient and outpatient care. This rule is still under review.
- The Internal Revenue Service released final instructions for Form 990 and Schedule H. Schedule H is optional for tax year 2008; however, the entire schedule is required for 2009. The new form is divided into 6 sections: 1) Charity care & certain other community benefits, 2) Community building, 3) Bad debt, Medicare, and billing and collection practices, 4) Management companies and joint ventures, 5) Facility information, and 6) Supplemental information. Except for the section on "Facility Information," Schedule H is not required to be filed until a hospital makes its 2009 IRS filings sometime in 2010.
- In a letter to the CMS Administrator, AHA addressed a CMS letter sent to state survey agency directors revising interpretive guidelines pertaining to regulatory changes to the Hospital Conditions of Participation (CoPs) that contradict accepted standards of care in hospitals and have the potential to place patient safety in jeopardy. CMS issued revised interpretive guidelines clarifying that standing orders and written protocols for drugs or biologicals may be used in hospitals. CMS said that standing orders should be written in the patient's chart and signed by the practitioner responsible for the care of the patient, but that the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances.
- In the final rule for the physician fee schedule, CMS clarifies that PT/OT/ST services furnished at a CAH distinct part unit are billable if provided by staff

(employed or under contract) qualified under State law and that meet Medicare conditions of participation.

- CAH-based renal dialysis centers, including satellites are eligible for Medicare payment when they serve as originating sites for telehealth services. When a CAH-based renal dialysis center serves as the originating site, the facility fee is covered in addition to any composite rate or monthly capitation payment amount.
- CMS published instructions for CAH survey and certification on definitions of mountainous terrain and 2 roads as well as on CAH relocation and rebuilding. The guidelines permit CAHs to remodel extensively on their current site, but they limit rebuilding of necessary providers to those that meet the 75% test (same services, market, staff) and ALL the conditions by which they were deemed under their State's rural health plan.
- CMS issued revisions to the guidelines used for observation beds at CAHs. CMS now allows commingling of patients and identified beds that may be used for observation and that do not count against the CAHs 25-bed maximum. However, CAHs must provide documentation on use of OBSV beds to the surveyor's satisfaction or risk losing CAH status.

★ **Organizational Relationships**

- The Department of Veterans Affairs (VA) has appointed a 13-member rural health advisory panel to evaluate current VA programs and identify barriers to health care. The committee is chaired by James Ahrens, former president and CEO of the Montana Hospital Association and past member of the governing council of the AHA Section for Small or Rural Hospitals.
- Three new members joined the Medicare Payment Advisory Commission (MedPAC) including George Miller Jr., who previously served on the AHA Board of Trustees and Governing Council for the AHA Section for Small or Rural Hospitals.

MEMBER REPRESENTATION, SERVICES AND TECHNICAL ASSISTANCE

Working to Address Workforce Shortages, Access and Quality

Along with payment, priority issues for CAHs are workforce, quality, and access to essential services. The AHA offers its members workforce resources such as case examples and peer contacts. The AHA's leadership in the area of information technology has helped expand the tools available to small or rural hospitals from distance learning to electronic medical records. As a member of the Hospital Quality Alliance, the AHA is a partner in developing a reliable means of measuring and reporting health outcomes to the public. The AHA has advocated for the development of rurally relevant measures of performance and recognition of quality outcomes for CAHs and has led in development of standards for patient safety. These efforts are featured in various AHA publications, studies, and reports including the AHA Web site, "Telling the Hospital Story," and *TrendWatch*.

AHA Governance
Small or rural hospitals are well represented across the breadth of AHA Governance. They have a direct role in shaping AHA strategy and policy through representation on the AHA Board of Trustees, Governing Council of the Section and Regional Policy Boards. Other opportunities for input by small or rural hospital leaders abound through participation in task forces, conference calls, meetings and committees.

At the core are the AHA's member governance are the Governing Councils and Regional Policy Boards (RPBs), which provide a unique blend of forum and network, linking members with shared interests and missions. Through the Section's Governing Council and RPBs, members put political, economic and market-driven issues on AHA's agenda where they help shape AHA services and policy.

Communications and Member Relations
The AHA is the field's primary resource for timely communication on the most critical information affecting CAHs. Member CAHs are solicited for their opinions through individual contacts or regular group calls and provide an important perspective on a variety of strategic issues including legislative, regulatory, quality, workforce or other public policy priorities. Through its *Update* newsletters, member calls, Web site, and site visits the AHA reaches out and connects with CAHs.

Education and Recognition
The AHA offers its members a variety of services ranging from education to technical assistance. The AHA is pre-eminent in educating its member CAHs. The AHA sponsors the Health Forum Rural Health Care Leadership Conference and cosponsors other national and regional educational programs targeting CAHs. In addition, the AHA provides faculty for national and state association meetings and helps develop educational sessions for related organizations, such as the National Rural Health Association (NRHA). The AHA also offers educational sessions through teleconferences, and each year a CEO from a member hospital is honored for his/her innovation and service with the Shirley Ann Munroe Rural Hospital Leadership Award.

Inter-organizational Relations
The AHA works closely with several partners including state hospital associations, American Academy of Family Physicians, Federal Office of Rural Health Policy, the Joint Commission, NRHA, and others to combine resources to influence change. By partnering with related organizations, the AHA has expanded its sphere of influence to improve the status of CAHs across the country.

This is an example of how the AHA and the Section for Small or Rural Hospitals added value in 2008. AHA will continue to work hard to earn your trust and support throughout 2009. For additional information, contact John Supplitt, senior director, AHA Section for Small or Rural Hospitals, at (312) 422-3306 or jsupplitt@aha.org.