American Hospital Association

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SECTION FOR SMALL OR RURAL HOSPITALS

2008 Year in Review

In 2008, the AHA's Section for Small or Rural Hospitals worked hard to serve the unique needs of our 1,650 constituents, which includes more than 950 critical access hospitals (CAH). With input from its 18-member governing council, the Section helped focus AHA policy and advocacy efforts on behalf of small or rural hospitals, and supported the AHA's mission to protect hospitals' ability to care for their communities.

In addition, the AHA works closely with several partners, including the Federal Office of Rural Health Policy, National Rural Health Association (NRHA), The Joint Commission, and American Academy of Family Physicians, to effect positive change in federal policies and improve the status of small or rural hospitals across the country.

This report highlights some of the many legislative, regulatory and legal victories we achieved together in 2008 – proof that much can be accomplished when we work together.

REPRESENTATION AND ADVOCACY

Through strong relationships with congressional committees, expert testimony and timely correspondence, the AHA last year was instrumental in achieving fairer payment and more administrative flexibility for small or rural hospitals via several pieces of legislation.

Federal Relations

A major legislative victory came in the passage of the Medicare Improvements to Patients and Providers Act of 2008 (MIPPA). It blocked a scheduled 10.6 percent cut in Medicare payments to physicians and provided a 1.1 percent increase for the 2009 fee schedule. The legislation also contained several provisions that will significantly improve the health and health care in rural communities. Among other things, the MIPPA:

- Expands and extends the FLEX program and increases access to mental health services for veterans and residents of rural areas;
- Provides a new base year for sole community hospitals (SCH) for cost reporting periods on or after January 1, 2009, based on fiscal year (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 physician pathology services they provide to hospitals;
- Extends provisions that ensure small rural hospitals, as well as SCHs with fewer than 100 beds, receive payments for outpatient services that are at least 85 percent of what they received before the hospital outpatient prospective payment system took effect; and
- Allows CAHs 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 at another facility operated by the CAH.

Congress last year also passed legislation extending the Conrad State-30 J-1 visa waiver program through March 6, 2009, subject to the overall limit of 30 participants per state. The law also increases from five to 10 the number of foreign physicians who may serve in state facilities.

The AHA was instrumental in securing a moratorium through March 31, 2009, to prevent the Centers for Medicare & Medicaid Services (CMS) from implementing Medicaid rules related to: intergovernmental transfers and certified public expenditures; and graduate medical education. These rules would have cost the states, hospitals and other providers an estimated $36 billion over five years, a staggering price tag that would have had hospitals and state Medicaid programs reeling from the financial burden these regulations posed. If these regulations had been implemented in 2008, poor children and mothers, the elderly and the disabled that are served by the Medicaid program would have been severely impacted.

Also, as part of a continuing resolution to fund the federal government through March 6, 2009, Congress appropriated $250 million to the Department of Veterans Affairs to establish and implement a new rural health outreach and delivery initiative through September 30, 2010.

Testimony and Letters to Congress

The AHA often provides expert witness testimony. For example, as the House Energy and Commerce Subcommittee on Health last year was considering a second economic stimulus package, the AHA in a statement for the record urged the committee to place a moratorium on certain Medicare and Medicaid rules that could adversely impact access to much-needed services in rural areas.

The AHA last year also sent several letters to lawmakers urging action on behalf of America's hospitals. For example, the AHA sent a letter to Sen. Wyden (D-OR) expressing support for legislation (S. 3367) he introduced that would align timeframe designations crucial to the certification of rural health clinics (RHC). In another letter to Senate Judiciary Committee members, the AHA urged senators not to support legislation amending the False Claims Act, which as written would have hurt patients and hospitals alike by forcing needed funds for patient care to be diverted to defend hospitals against frivolous lawsuits.

REGULATORY POLICY

The AHA last year provided 41 comment letters to federal agencies, including the Department of Health and Human Services, on proposed rules, and was often successful in convincing them to redraft or reconsider proposals that would have created tremendous burdens for small or rural hospitals and their communities.

Federal Relations

In 2008, the AHA represented small or rural hospital interests on several major rules, including the final rules pertaining to the Medicare inpatient prospective payment system (PPS) and the outpatient PPS.

The AHA was successful in getting CMS to allow CAHs to voluntarily submit quality data on outpatient services beginning with patient encounters in the first-quarter of 2009. Deferring to the AHA and others, the Health Resources and Services Administration (HRSA) withdrew its proposal to revise and consolidate the criteria and process for designating medically underserved areas and populations and health professional shortage areas. The AHA warned that the change would have an adverse impact on communities and the providers and programs that depend on these designations for federal funding.

The AHA also convinced CMS to retract new language in the Medicare Conditions of Participation interpretive guidelines that would have significantly hampered patient care and put patients' safety at risk by essentially prohibiting hospitals from using standing orders or written protocols for patient care.

And the AHA urged CMS to "pause and fix" the recovery audit contractor (RAC) program before moving forward with implementation of the national rollout. In moving forward with the national program, CMS responded to AHA recommendations by requiring RACs to have a medical director, preventing the recoupment of funds and allowing hospitals to keep the payment if they chose to appeal, and limiting the number of medical records that can be requested by the RACs each month. AHA and its state affiliates also worked with congressional leaders to request a Government Accountability Office study on CMS oversight of RACs and the RAC program.

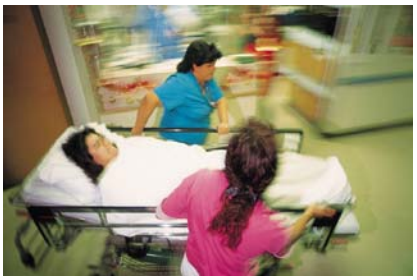
The AHA continues to track the following issues: a CMS proposed rule changing the Medicare conditions of participation requirements and payment provisions for rural health clinics and federally qualified health centers; a Department of Defense proposed rule to reimburse CAHs the lesser of either billed charges or 101 percent of reasonable costs for inpatient and outpatient care under TRICARE; and Medicare conditions of participation for specialized services. In addition, the AHA continues working toward fair implementation of the guidelines for CAH relocation and rebuilding and definitions of medically underserved and professional shortage areas, and is in the process of helping nonprofit hospitals become familiar with the Internal Revenue Service's new tax Form 990 and Schedule H for hospitals. Schedule H is optional for tax year 2008, but will be required when hospitals submit their 2009 IRS filings in 2010.

Organizational Relationships

The Department of Veterans Affairs (VA) last year 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 AHA's Section for Small or Rural Hospitals Governing Council.

Also in 2008, the Medicare Payment Advisory Commission appointed three new members, including George Miller Jr., who previously served on the AHA Board of Trustees and the AHA's Section for Small or Rural Hospitals Governing Council. AHA Section staff participates on committees for the HRSA, rural research centers, and The Joint Commission.

MEMBER REPRESENTATION, SERVICES, AND EDUCATION



Growing and sustaining the rural health care workforce, improving quality while controlling costs and maintaining access to essential services are priorities for small or rural hospitals. To help our members, the AHA offers a variety of resources such as best practice case examples, and puts members in touch with others who have led the way on these issues. The AHA offers educational and technical assistance, including Webinars, teleconferences and on-site tutorials.

Education and Technical Assistance

As a member of the Hospital Quality Alliance, the AHA has advocated for the development of relevant measures of performance and recognition of quality outcomes for rural hospitals and has led in the development of patient safety standards. AHA has provided instruction and examples on IRS requirements for Form 990 Schedule H. It sponsors the Health Forum Rural Health Care Leadership Conference and cosponsors other national and regional educational programs targeting rural hospitals. In addition, the AHA provides faculty for national and state association meetings and helps develop educational sessions for related organizations, such as the NRHA.

AHA Governance

Small or rural hospitals have a direct role in shaping AHA strategy and policy through representation on the AHA Board of Trustees, Small or Rural Governing Council and Regional Policy Boards (RPBs). The governing councils and RPBs provide a unique blend of forum and network, linking members with shared interests and missions. Other opportunities abound through task forces, conference calls and ad hoc committees.

Communications

The AHA is the field's primary resource for timely communication on the issues affecting small or rural hospitals. Through its *Update* newsletters, *AHA News* and *News Now* publications, member calls, Web site and site visits, the AHA reaches out and connects with members and solicits their opinions on a variety of strategic issues.

Recognition

Each year the AHA recognizes small or rural hospital chief executives and administrators who have achieved improvements in local health delivery and health status through their leadership and direction with the Shirley Ann Munroe Rural Hospital Leadership Award. Ronald Cork, president and CEO of Avera St. Anthony's Hospital in O'Neill, NE, was last year's recipient.

The AHA will continue its hard work on behalf of small or rural hospitals in 2009.
This is only a summary of the many ways in which AHA adds value to small or rural hospitals. For a full report, visit our web site at http://www.aha.org/aha/member-center/constituency-sections/Small-or-Rural/index.html.
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