American Hospital Association

AHA Section for Small or Rural Hospitals
CAH Annual Report - 2004

CRITICAL ACCESS HOSPITALS
January – December 2004

*In 2004, we saw the number of critical access hospitals (CAHs) grow to 1,032, as identified by the Centers for Medicare & Medicaid Services (CMS). That's an increase of 185 from the end of 2003. CAHs represent 21 percent of all U.S. community hospitals and 47.6 percent of all rural community hospitals. During the year, the American Hospital Association (AHA) worked on legislative and regulatory fronts to support program improvements and enhancements for CAHs. This **2004 CAH Annual Report** describes the AHA's advocacy activities and member services on behalf of CAHs.*

LEGISLATIVE ADVOCACY

The AHA supported legislation to help CAHs to serve communities by: ensuring adequate payment on a reasonable cost basis for clinical laboratory outpatient services; funding through the Medicare Rural Hospital Flexibility and Small Hospital Improvement Program grants; and reauthorizing a program that supplies physicians to underserved areas.

Critical Access to Clinical Lab Services Act of 2004 - CMS requires a patient to be "physically present in a critical access hospital" when a laboratory specimen is collected in order for the CAH to receive cost-based reimbursement. Despite our objections, CMS has refused to change its position on this issue. In 2004, the Senate and House introduced legislation (S. 2426/H.R. 4257) to reinstate cost-based reimbursement to CAHs for reference lab services provided to patients who are not physically present in the hospital. The AHA will continue to work with key congressional staff to pass legislation to fix CMS' misguided policy.

State 30/J-1 Visa Waiver Program Reauthorization – The AHA supported H.R. 4453/S. 2302 to renew the State 30/J-1 Visa Waiver program, which brings primary care or specialty foreign physicians to medically underserved communities, such as those served by CAHs. Due to the strong advocacy efforts of the field, President Bush signed into law PL 108-447 that reauthorizes the State 30/J-1 Visa Waiver program for two years, retroactive to June 1, 2004.

Payment Under Medicare Advantage - Under the Medicare Modernization Act of 2003 (MMA), CAHs must be paid 101 percent of costs for inpatient and outpatient care. H.R. 4687 would have ensured that CAHs are paid at least these rates by Medicare Advantage plans. The AHA will continue its advocacy on this issue before the 109th Congress.

Appropriations - The President's FY 2005 budget proposal eliminated funding for the Medicare Rural Hospital Flexibility Grant Program. However, the AHA, along with its members, urged Congress to make funding for FLEX grants a priority in the FY 2005 budget resolution. The result: The FY 2005 omnibus funding measure included $39.5 million for the Medicare Rural Hospital Flexibility Program, which also funds the Small Hospital Improvement Program.

REGULATORY ADVOCACY

CMS issued several regulations in 2004 implementing several provisions of the MMA, as discussed below. As part of the AHA's advocacy efforts, we filed comment letters and pushed for regulations that are responsive to patients and hospitals.

Revised Metropolitan Statistical Areas (MSAs) - In our July 12 comment letter to CMS, the AHA expressed concern that CAHs designated as "urban" under the new geographic boundaries of the Core Based Statistical Areas adopted by CMS would lose their CAH status. Following the AHA's recommendation, CMS will allow those CAHs to retain their CAH status through **October 1, 2006**, allowing time for the affected facilities to be reclassified as "rural." This grandfathering clause was changed from January 1, 2006 to October 1 in a CMS technical correction to the final rule.

Payment Amounts for Inpatient CAH Services - A provision of the MMA provides payment to CAHs equal to 101 percent of reasonable cost for Medicare inpatient, outpatient and skilled nursing services, beginning for cost reporting periods on or after January 2, 2004. The AHA expressed concern about the implementation of this provision, and encouraged CMS to investigate whether there has been a delay in the increased payment rate and require fiscal intermediaries to make immediate, retroactive correction to CAH payment, if necessary.

Special Professional Service Payment Adjustment - For outpatient services, CAHs may elect to be paid under an optional method, "Method II," that allows hospitals to receive payment equal to 101 percent of costs for facility services plus 115 percent of the physician fee schedule for professional services rendered. In addition, a 5 percent bonus on professional services for either primary care or specialty care in physician scarcity areas will be provided, and a 10 percent bonus for physicians who serve in Health Professions Shortage Areas. The AHA urged CMS to ensure that its systems and that of its intermediaries and carriers will be ready to process these enhanced payments beginning July 1, 2005.

Periodic Interim Payment - A provision of the MMA provides for periodic interim payments (PIP) to CAHs. Some fiscal intermediaries indicated that existing CAH facilities would not be able to receive PIPs until the start of their cost reporting period beginning on or after July 1, 2004. The AHA urged CMS to clarify that all CAHs were eligible for these payments effective July 1, 2004.

Waiver Authority for Designation as a Necessary Provider - Beginning January 1, 2006, states will no longer be able to designate a facility as a "necessary provider" of health care, and thus as a CAH, if the hospital is located within 35 miles of another hospital (or within 15 miles in areas of mountainous terrain). The law includes a grandfathering provision for CAHs that are certified as "necessary providers" prior to January 1, 2006. The AHA expressed concern that some hospitals would receive the "necessary provider" designation from the state prior to January 1, 2006, but would not have had enough time to complete state survey and certification in order to be fully converted. The AHA recommended that CMS grandfather a hospital that is certified as a "necessary provider" by January 1, 2006, but may not be fully converted, as long as that hospital is continuing the process toward conversion to a CAH.

Medicare Advantage Proposed Rule - On August 3, CMS published a proposed rule implementing the MMA provision for Medicare Advantage (MA). This program replaces Medicare+Choice, an alternative to traditional fee-for-service for the elderly and disabled. Under the rule, MA regional plans would be able to meet access standards by designating "essential hospitals" with which the plans have failed to contract, but which are necessary to provide adequate medical access in large geographic areas, particularly rural. The AHA urged CMS to stipulate that CAHs are eligible for designation as "essential hospitals" and for supplemental CMS network payments in addition to MA plan payments. A final rule was published in January 2005 and did not include any changes to this provision.

CMS Interpretative Guidelines - The MMA increased the bed limit for CAHs from 15 to 25 acute care beds, beginning January 1, 2004. However, in May CMS revised the State Operations Manual that included changes to the interpretive guidelines for CAHs. Particularly troublesome, the guidelines referenced counting observation beds in the total CAH bed count. The AHA opposes CMS' policy change to include observation beds and patients in the inpatient count. The AHA will continue to monitor this issue closely.

MEMBER COMMUNICATIONS AND MANAGEMENT ASSISTANCE

Through its publications, Web site, work with state hospital associations, and personal contacts with members, the AHA Section for Small or Rural Hospitals serves as a valuable management resource to CAHs. For additional information about resources, please visit our Web site at http://www.hospitalconnect.com/aha/member_relations/cah/index.html.