



American Hospital
Association

American Hospital Association SECTION FOR SMALL OR RURAL HOSPITALS 2004 Annual Report

PROTECTING THE PROMISE

Rural hospitals provide essential health care services to nearly 54 million people, including 9 million Medicare beneficiaries. Yet because of their small size, modest assets and financial reserves, and higher percentage of Medicare patients, they face great pressures as government payments decline. Given that rural populations are typically older, rural hospitals are even more dependent on Medicare. Yet Medicare margins are lowest for rural hospitals, with the smallest hospitals having the lowest margins. In 2004, the AHA continued advocating the needs of small and rural hospitals.

REPRESENTATION, ADVOCACY, AND POLICY DEVELOPMENT

Legislative Advocacy

The AHA, working with hospital leaders in a unified grassroots effort, achieved key legislative victories for small or rural constituents in several key areas. Together, we:

- Persuaded lawmakers to drop proposals to cut Medicaid funding by as much as \$11 billion over five years.
- Worked for passage of legislation that blocks OSHA from enforcing an onerous and unnecessary TB-fit protection standard.
- Pushed hard for legislation that secures \$151.9 million for the Nurse Reinvestment Act.
- Won renewal of the expired State 30/J-1 Visa Waiver program, which helps hospitals in medically underserved areas fill physician shortages in primary and specialty care.
- Gained \$652 million in additional FY 2005 spending for hospitals.

The AHA also worked with congressional leaders in both the House and Senate in support for funding for the National Health Service Corps, Medicare Rural Hospital Flexibility (FLEX) Grant Program, Small Hospital Improvement Grants, Rural Health Outreach and Network Development Grants, rural telehealth services, and nursing workforce and training programs.

Our working together also achieved a delay in the implementation of Centers for Medicare & Medicaid Services' (CMS) 75% inpatient rehab rule, and a delay in the Department of Homeland Security requirement for certain non-immigrant alien health care professionals to obtain a health care certificate prior to receiving an occupational visa. In addition, we convinced government to scuttle plans requiring hospitals to screen patients for citizenship status to qualify for uncompensated emergency care funding.

Regulatory Advocacy

A major part of AHA's advocacy agenda is to work for adoption of regulations that are responsive to the needs of both patients and hospitals. The AHA filed comment letters with the departments of Health and Human Services, Homeland Security and Labor, CMS, Health Resources and Services Administration (HRSA) and Federal Communications Commission on behalf of our constituents. The AHA commented on numerous proposed and final rules including:

- Criteria for establishing the Medicare Advantage program.
- Payment policies under the physician fee schedule for calendar year 2005, focusing on physician scarcity area and health professional shortage area incentive payments as applied to critical access hospitals (CAHs).
- Extension of the deadline for certain health care workers to obtain foreign health care worker certification.
- Physician recruitment arrangements in the interim final rule for physician self referral (Stark Law Phase II).
- Rural hospital and CAH provisions in the inpatient PPS proposed rule for FY 2005.
- Physicians' referrals to health care entities with which they have financial relationships.
- Rural health care universal services support mechanism for telecommunications.

Technical assistance with new rules is an important member service. The AHA developed advisories for our members on several new regulations, including:

- Medicare Inpatient and Outpatient PPS Rules
- Medicare Inpatient Psychiatric PPS Rule
- New OSHA Requirements for Public Hospitals
- 75% Rule for Inpatient Rehabilitation Facilities
- Phase II of "Stark II" Physician Self-Referral Rule
- Occupational Mix Data
- New Certification Requirement for Non-immigrant Alien Health Care Workers

Quality Measures

As the public, payers and others are demanding quality data, it's important to identify quality measurements that provide meaningful information about rural hospital care. That's why the AHA convened a workgroup of rural hospital leaders, academics, government representatives, and state hospital association leaders to develop rurally relevant quality measures. The AHA also had rural hospital leaders accepted to the National Quality Forum's rurally sensitive steering committee, a group that will add to the AHA workgroup's efforts and evaluate and potentially adopt quality measurements for rural hospitals.

SECTION GOVERNING COUNCIL

Shaping policy through member dialogue

The Small or Rural Governing Council advises the AHA on numerous legislative and regulatory issues that cover a wide array of topics including Medicare, Medicaid and private payer policies, quality reports, the uninsured, physician relations, and other strategic 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 Section's governing council members:

- Advocate directly before members of Congress on behalf of the AHA.
- Participated in the Section's leadership caucus with Regional Policy Board (RPB) delegates and alternates at the AHA Annual Membership Meeting in Washington, DC.
- Included state association representatives and their small or rural hospital members to participate in governing council meetings and share case examples of their hospitals and networks.
- Nominated rural hospital leaders who are appointed or elected to the AHA Board of Trustees, Section Governing Council, and RPBs.

Governing council members also serve on the review committee for the Shirley Ann Munroe Leadership Development Award, which in 2004 was presented to Lisa Schnedler, administrator, Van Buren County Hospital, Keosauqua, IA.

CRITICAL ACCESS HOSPITALS

Advocacy for CAHs

As of December 2004, CMS had identified 1,032 CAHs, an increase of 185 hospitals from the end of 2003. CAHs represent about 20 percent of all U.S. community hospitals and more than 45 percent of all U.S. rural community hospitals.

During 2004, CMS issued regulations to implement provisions that were included in the Medicare Modernization Act. The AHA commented to CMS on these and other rules effecting CAHs:

- Revising Metropolitan Statistical Areas and reclassification of CAHs from rural to urban.
- Payment amounts for inpatient, outpatient and skilled nursing services at 101 percent of costs.
- Special professional service payment adjustments.
- Periodic interim payments.
- Elimination of the state waiver authority for designation as a necessary provider.
- Payment for reference lab services.
- Revised Interpretive Guidelines for CAH survey and certification.
- Medicare Advantage designation and payment of CAHs as essential hospitals.

The AHA worked to secure funding for FLEX Grants and continues to work with CMS and members of Congress to address concerns affecting small or rural hospitals' ability to care for their communities.

**COMMUNICATION,
EDUCATION, AND
MANAGEMENT
STRATEGIES**

*Meeting members'
needs*

The AHA and the Section for Small or Rural Hospitals assists its hospital members through communication, education, and management strategy tools, resources, and services, such as:

- AHA News.
- The Section's *Update* newsletter.
- The Section's *CAH Update* newsletter.
- AHA Web site at www.aha.org.
- The Section's Web site at http://www.aha.org/aha/key_issues/rural/index.html.
- The Section's CAH Web site at http://www.aha.org/aha/key_issues/rural/focus/cah.html.
- AHA and Health Forum's Annual Rural Health Care Leadership Conference.
- Education on federal legislation, federal regulations, and quality and patient safety at NRHA's 27th annual national conference and the NRHA's CAH Conference.

In addition, the Section featured Rep. Earl Pomeroy (D-ND) as its speaker at the Section's breakfast at AHA's 2004 Annual Membership Meeting in Washington, DC.

**STATE ASSOCIATION
RELATIONS**

*Building consensus
through stronger
relationships*

The AHA and the Section for Small or Rural Hospitals work closely with its rural hospital liaisons at the state hospital associations in many ways, including:

- Bimonthly conference calls featuring federal legislative, regulatory and section updates.
- Casework and technical assistance for small or rural hospitals.
- State-sponsored member outreach calls on AHA advocacy strategies and policy developments.
- Programs for numerous state association conferences, meetings and workshops.

**INTER-ORGANIZATIONAL
RELATIONSHIPS**

*Expanding our sphere
of influence*

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

- American Academy of Family Physicians, Committee on Rural Health
- JCAHO Work Group on Accreditation Issues for Small and Rural Hospitals
- HRSA Office of Rural Health Policy (ORHP) Rural Health Issues Group, Flex Program Advisory Committee, Delta Rural Hospital Performance Improvement Project Advisory Committee, Flex Grant Review Committee, and SHIP Grant Review Committee
- NRHA's annual national conference and CAH conference planning committees