American Hospital Association
SECTION FOR SMALL OR RURAL HOSPITALS
Adding Value to AHA Membership

PROTECTING THE PROMISE

Over 55 million people, about one-fifth of America's population, live in rural areas served by about 2,000 rural community hospitals. Compared to the population in metro areas, the rural population is proportionately more elderly. There is also a greater proportion of uninsured individuals in rural areas, and more than a third of the rural elderly lack Medicare supplemental insurance. Excluding the elderly, rural areas also have comparatively more poor individuals than metro areas.

These demographics contribute to the mounting pressure on small or rural hospitals. These hospitals face challenges common to all hospitals, but their unique characteristics increase their vulnerability. Because of their humble assets, meager reserves, small size and large dependence on public financing, small or rural hospitals have experienced great difficulty absorbing the impact of federal policy and national market changes.

REPRESENTATION, ADVOCACY, AND POLICY DEVELOPMENT

Legislative Advocacy

Recently, the American Hospital Association (AHA) helped achieve major legislative wins in the *Deficit Reduction Act of 2005 (*DRA), as well as the 2006 Labor, HHS and Education appropriations bill.

The DRA extends the outpatient hold-harmless provision for rural hospitals with 100 or fewer beds for three years – at 95% of the hold-harmless payment the first year, moving to 90% in the second year, and then to 85% in the third year. The bill also rebases and extends the Medicare Dependent Hospital (MDH) program until 2011, while removing the Medicare disproportionate share hospital cap for MDHs. It extends the rural home health 5% add-on an additional year.

The 2006 Labor, HHS and Education appropriations bill includes $90 million for rural health programs above proposals made in earlier versions. The bill provides an additional $28.5 million for rural health outreach grants, $13 million for training and primary care dentistry, and $9 million for the Department of Health and Human Services (HHS) Office of Rural Health Research and Policy. While funding for FLEX grants remains level, the bill includes $25 million for a Delta workforce-training project.

Several other important bills were introduced in the first session of the 109th Congress. While some, such as fixes for outpatient hold-harmless, rural home health add-on and MDH payments, were adopted in the DRA, others remain in committee awaiting action. We remain hopeful that they will move in the second session. These bills include:

- ★ *Critical Access to Clinical Lab Services Act* (S. 236/H.R. 1016) – would reinstate cost-based reimbursement for critical access hospitals (CAHs) for reference lab services provided to patients not physically present in the hospital;
- ★ *Rural Community Hospital Assistance Act* (S. 933/H.R. 2350) –would expand cost-based reimbursement to rural hospitals with 25-50 beds for inpatient and outpatient services;
- ★ *Sole Community Hospital Preservation Act* (H.R. 2961) – would make permanent the hold-harmless provision for outpatient payments to sole community hospitals;

- ★ *The Rural Health Equity Act* (H.R. 880) – would require Medicare Advantage organizations to pay for CAH services and rural health clinic services at a rate that is at least 101% of the payment rate otherwise applicable under the Medicare program;
- ★ *Rural Access to Emergency Services Act* (S. 1108/H.R. 2525) – would amend title XVIII of the *Social Security Act* to make improvements to payments to ambulance providers in rural areas; and
- ★ *Safety Net Inpatient Drug Affordability Act* (S. 1840/H.R. 3547) – would establish a statutory benefit category under Medicare for pulmonary and cardiac rehabilitation services.

The AHA provided testimony opposing self-referral to physician-owned specialty hospitals and sent several letters to members of Congress on a diverse range of issues, including proposed Medicare and Medicaid budget cuts, funding for health care workforce development and nurse immigration, and funding for telehealth activities.

Partnering with our members and state associations proved vital to our successful advocacy. Grass roots efforts, at home and in Washington, were pivotal to restoring federal funds for discretionary rural and health care workforce programs, as well as the victories in the DRA.

Regulatory Advocacy

A major part of the AHA's advocacy agenda is to work for the adoption of guidelines and regulations that are responsive to the needs of both patients and hospitals. The AHA met or filed comment letters with the Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration (HRSA), and Federal Communications Commission, among others, on a range of issues affecting our constituents. The AHA commented on numerous rules including:

- ★ The Medicare inpatient prospective payment system (PPS);
- ★ The Medicare outpatient PPS;
- ★ The Medicare skilled nursing facility PPS;
- ★ Emergency services to undocumented immigrants; and
- ★ Rural health care support mechanism for telecommunications.

Federal Health Care Policy

AHA's representation of our small or rural hospital constituents also extends to emerging policy initiatives. Our efforts helped shape many initiatives, including:

- ★ Fair implementation of the occupational mix adjustment;
- ★ Closing the loophole on physician self-referral to limited-service hospitals;
- ★ The Surgical Care Improvement Project (SCIP) to reduce nationally the incidence of surgical complications;
- ★ Strategies for eliminating racial and ethnic health disparities;
- ★ Principles and guidelines on hospital billing and collections practices; and
- ★ The establishment of the Care Fund to help hospital workers and their families who were displaced by Hurricane Katrina.

CRITICAL ACCESS HOSPITALS

As of December 2005, CMS had identified over 1,200 CAHs, an increase of 168 hospitals over the prior year. CAHs represent 25% of all U.S. community hospitals and more than 60% of all U.S. rural community hospitals.

Advocacy for CAHs

During 2005, the AHA achieved increased flexibility for CAH "necessary provider" relocation and hospital replacement as part of the inpatient PPS final rule. The AHA worked to restore 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. In addition, the AHA was a leader in the effort to ensure that CAHs were fairly and objectively portrayed in the Medicare Payment Advisory Commission's June report to Congress. As a member of the Hospital Quality Alliance, the AHA helped update the Hospital Compare Web site to accurately record participation by low-volume rural hospitals and CAHs. The AHA will remain vigilant as we work toward more equitable treatment and fair administration of federal rules or guidelines governing small or rural hospitals. We'll fight CMS' regulatory overreach on its provisions guiding the relocation of CAHs.

SECTION GOVERNING COUNCIL

Shaping policy through member dialogue

The Section's Governing Council advises the AHA on numerous policy issues that cover a wide array of topics including Medicaid reform, *Emergency Medical Treatment and Active Labor Act regulations*, legislative and regulatory advocacy, public reporting of quality data, billings and collections, physician relations, unified health care policy, limited-service providers and other strategic issues. Council members are the elected representatives of the small or rural hospital constituency section and serve as an important channel of communication. The Governing Council meets three times annually and is active in many ways, including:

- ★ 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 Development Award, which provides developmental and educational opportunities to outstanding small or rural hospital CEOs. Barbara Oestmann, CEO of Share Medical Center, Alva, OK, was the 2005 winner.

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 programs at state association conferences and meetings; and
- ★ Routine communication on breaking issues and advocacy priorities.

COMMUNICATION, EDUCATION AND MANAGEMENT STRATEGIES

Meeting members' needs

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

- ★ AHA News;
- ★ The Section's Update newsletter;
- ★ The Section's CAH Update newsletter;
- ★ The Section's Web site at www.aha.org/aha/key_issues/rural/index.html;
- ★ The Section's CAH Web site at www.aha.org/aha/key_issues/rural/focus/cah.html;
- ★ The AHA and Health Forum's Annual Rural Health Care Leadership Conference;
- ★ Education on federal legislation, federal regulations and quality and patient safety at National Rural Health Association's (NRHA) annual national conference, NRHA's CAH Conference, and HRSA's Rural Health Performance Program;
- ★ Regular teleconferencing with CAHs, as well as at-large small or rural member hospitals; and
- ★ Focused teleconferences on Medicare Advantage, the *Rural Community Hospital Assistance Act* and SCIP.

INTER-ORGANIZATIONAL RELATIONSHIPS

In addition, the Section honored former U.S. Rep. Charlie Stenholm (D-TX) at its breakfast during the AHA's 2005 Annual Membership Meeting in Washington, DC.

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;
- ★ Joint Commission on Accreditation of Healthcare Organizations Work Group on Accreditation Issues for Small and Rural Hospitals;
- ★ HRSA Office of Rural Health Policy
  - ▪ Rural Health Issues Group
  - ▪ FLEX Program Advisory Committee
  - ▪ Delta Rural Hospital Performance Improvement Project Advisory Committee
  - ▪ FLEX Grant Review Committee
  - ▪ SHIP Grant Review Committee; and
- ★ NRHA's annual national conference and CAH conference planning committees.

This is a brief summary of how the AHA and the Section for Small or Rural Hospitals added value in 2005. Throughout the year, the AHA has worked collaboratively with its state association partners, and we will continue to work hard to earn your trust and support throughout 2006. For additional information, contact John Supplitt, senior director, AHA Section for Small or Rural Hospitals, at (312) 422-3306 or jsupplitt@aha.org.