American Hospital Association

AHA Section for Small or Rural Hospitals
CAH Annual Report - 2005

CRITICAL ACCESS HOSPITALS
January – December 2005

*The number of critical access hospitals (CAHs) continued to increase during the year. As of December 2005, the Centers for Medicare & Medicaid Services (CMS) identified 1200 CAHs, an increase of 168 hospitals from the end of 2004. At that time, CAHs represented 24 percent of all U.S. community hospitals and 60 percent of all U.S. 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 **2005 CAH Annual Report** describes the AHA's advocacy activities and member services on behalf of CAHs.*

REPRESENTATION, ADVOCACY, AND POLICY DEVELOPMENT

Advocating for Program Improvement on the Legislative Front: The AHA has been a leading advocate for CAHs since the inception of the program in 1997. Our message has remained consistent, that CAHs are important to the delivery of essential health care services in rural areas. The AHA represents CAHs on Capitol Hill through strong relationships with congressional committees, congressional testimony and letters, and advocacy days. We work with Congress to achieve fair payment and more administrative flexibility for CAHs. **During 2005, the AHA supported the following legislative proposals:**

The Rural Community Hospital Assistance Act (S. 933/H.R.2350) would expand cost-based reimbursement to hospitals with between 25 and 51 beds eligible for Medicare inpatient and outpatient services, and provide cost-based reimbursement for CAH skilled nursing facilities, home health services and ambulance services. The bill was introduced by Sens. Sam Brownback (R-KS) and Ben Nelson (D-NE) and Reps. Jerry Moran (R-KS) and Rubén Hinojosa (D-TX).

The Critical Access to Clinical Lab Services Act (S.236/H.R.1016) would reinstate cost-based reimbursement to CAHs for lab services provided to patients who are not physically present in the hospital. The legislation was introduced by Sens. Ben Nelson (D-NE) and Susan Collins (R-ME), and Reps. Butch Otter (R-ID) and James Oberstar (D-MN).

The Rural Health Equity Act (H.R.880) would ensure that Medicare Advantage plans pay CAHs at least 101 percent of costs for inpatient and outpatient services, regardless of whether the CAH has a contract with the patient's Medicare Advantage plan. The bill was introduced by Reps. Ron Kind (D-WI) and Tom Osborne (R-NE).

The Medicare Rural Home Health Payment Fairness Act (S.300/H.R.11) would provide for a two-year extension of the temporary 5 percent Medicare payment increase for home health services furnished in rural areas. The legislation is sponsored by Sen. Susan Collins (R-ME) and Rep. Greg Walden (R-OR).

The Safety Net Inpatient Drug Affordability Act (S.1840/H.R.3547) would expand the 340b drug discount program to include inpatient services and allow CAHs to participate. The 340b drug discount program provides safety net hospitals with the ability to purchase pharmaceuticals at significantly reduced rates. Currently, CAHs are unable to participate because they do not receive Medicare disproportionate share payments. The legislation was introduced by Sens. John Thune (R-SD) and Jeff Bingaman (D-NM), and Reps. JoAnn Emerson (R-MO) and Bobby Rush (D-IL).

Pursuing Fairness in the Regulatory Arena: The AHA also represents the interests of CAHs to numerous federal agencies, but most notably CMS and the Office of Rural Health Policy. Through advocacy efforts and letters to the Secretary of the Department of Health and Human Services, the CMS administrator, and others, the AHA pushed for flexible and fair rules for payment and program participation. The AHA has commented on all proposed rules affecting CAHs, including more flexible guidelines for hospital building, replacement, and relocation.

CMS' CAH Relocation Criteria: On November 14, CMS issued interpretive guidelines on the relocation of any CAH. The CMS' State Operations Manual's Interpretive Guidelines related to a requirement in the FY'06 inpatient PPS rule that allows necessary provider CAHs to relocate. However, the interpretive guidelines are an example of regulatory overreach. CMS has restricted the use and location of observation beds in CAHs and the circumstances in which any CAH can relocate and maintain its critical access status. Specifically, the guidelines alter the definitions of mountainous terrain and secondary roads, and require review after one year as to whether the relocated hospital continues to serve 75 percent of the same population, provide 75 percent of the same services and employ 75 percent of the same staff. Necessary providers that fail the 75 percent test would lose their CAH status and be forced to convert back to the inpatient PPS, hurting these facilities' ability to continue providing care in their communities The AHA encouraged member hospitals to share their concerns about how the changes to the criteria would affect any plans to relocate. The AHA will use the comments to push CMS to change the interpretive guidelines.

Medicare Advantage: CMS has indicated that MA plans may pay a CAH's interim rate for inpatient, outpatient and swing beds. The AHA has urged CMS to review this policy, as a CAH's interim rate may be significantly different than costs settled at year-end.

MEDPAC: In its March and April meetings, MedPAC staff raised concerns about the growth in the CAH program and discussed possible changes aimed at curbing the program's Medicare cost. The AHA expressed its concerns to the commission in an April 1 letter. We were pleased that MedPAC's June report to Congress did not include recommendations that would have adversely affected CAHs.

REPORTING QUALITY DATA: As a member of the Hospital Quality Alliance, AHA was prominent in introducing and updating the *Hospital Compare* Web site to accurately record participation by low-volume rural hospitals and CAHs. More than 450 CAHs, a category that is not eligible for the incentive payments, submitted data, an 11 percent increase in reporting.

FLEX GRANT FUNDING: The FY'06 appropriations for the Rural Hospital Flexibility Program included $64.18 million. This included $39.18 million for the FLEX grant program and $25 million for a Rural Health, Education, and Workforce Infrastructure Demonstration Program. We continue to support adequate funding for FLEX grants.

MEMBER COMMUNICATIONS AND MANAGEMENT ASSISTANCE

Through its publications, Web site, conference calls, 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. The AHA sponsored a series of member calls to help prepare hospitals for the rollout of the expanded Medicare Advantage (MA) program, which began January 1, 2006. In addition, the AHA issued four program policy papers to help hospitals understand the MA program and its impact. One paper specifically addresses rural hospital issues. **For additional information about CAH resources, please visit our Web site at http://www.hospitalconnect.com/aha/member_relations/cah/index.html.**