American Hospital Association

CAH Update

May 2005

Small or Rural Hospitals

The number of critical access hospitals (CAHs) continues to grow. As of March 29, 2005, the Centers for Medicare & Medicaid Services identified 1,088 CAHs.

This issue of **CAH Update** provides information on AHA's advocacy agenda, the federal budget, legislative priorities, regulatory issues, and the proposed rule for the Medicare inpatient prospective payment system for fiscal year (FY) 2006.

AHA Advocacy Agenda

With input from hospital leaders from across the country, the American Hospital Association's (AHA) 2005 advocacy agenda focuses on protecting the health care safety net, increasing the affordability of care, improving the quality of health care, and expanding health care coverage to help more Americans get the care they need. In pursuing this broad-based advocacy agenda, the AHA will work to ensure hospitals have the resources necessary to serve their communities. We will continue to advocate for adequate Medicare and Medicaid funding, permanently banning physician self-referral to new limited-service hospitals, expanding coverage to the uninsured, improving the quality and safety of care, including the coordination of care for the chronically ill, and reforming medical liability.

Federal Budget

In late April, Congress approved a FY 2006 budget resolution that calls for $10 billion in Medicaid spending cuts over five years beginning in FY 2007. The budget plan also leaves open the possibility of up to $1 billion in Medicare spending cuts over five years. Although the budget resolution does not specifically reference Medicaid for spending cuts, the budget assumes that the House Energy and Commerce and Senate Finance committees – the panels with jurisdiction over Medicaid – will reduce funding for the program by $10 billion.

On Medicare, the budget instructs the House Ways & Means Committee, which has jurisdiction over Medicare, to cut $1 billion over five years. While the instruction does not specifically require Medicare cuts, the fact that the committee maintains legislative authority over the program leaves Medicare open to potential cuts. Medicaid had been a major stumbling block to a House and Senate budget pact, but the agreement reached calls for the creation of a Medicaid commission to study the program. Sen. Gordon Smith (R-OR) is working with the White House to assemble the commission to recommend one round of changes by Sept. 1, and issue a final report for restructuring Medicaid in December 2006.

The Medicaid budget cuts would begin in 2007 to give the specially convened commission time to recommend cost-saving proposals. To battle these Medicare and Medicaid cuts, the AHA launched a grassroots campaign during its Annual Membership Meeting in Washington, DC, held May 1 – 4. **The message to legislators: Hold hospitals harmless from cuts that affect our ability to get people the care they need!**

Legislative Priorities

The AHA is working diligently on several legislative and regulatory fronts to support program enhancements for critical access hospitals.

Critical Access to Clinical Lab Services Act. AHA supports the Critical Access to Clinical Lab Services Act (S.236/H.R.1016), which would reinstate cost-based

reimbursement to CAHs for lab services provided to patients who are not physically present in the hospital.

Rural Home Health Bonus. AHA supports the Medicare Rural Home Health Payment Fairness Act (S. 300/H.R. 11), which would amend the Medicare Modernization Act (MMA) to provide for a two-year extension of the temporary 5 percent Medicare payment increase for home health services furnished in rural areas.

Rural Community Hospital Assistance Act. AHA supports creating a new payment classification for rural hospitals with 50 or fewer acute care beds. This new payment system would provide Medicare inpatient and outpatient reimbursement at 101 percent of cost. It would also enhance the CAH program by providing cost-based reimbursement for post-acute care services, including skilled nursing facility, home health, and ambulance services. S. 933, the Rural Community Hospital Assistance Act was introduced by Sens. Ben Nelson (D-NE) and Sam Brownback (R-KS) on April 28. House companion legislation (H.R. 2350) was recently introduced by Reps. Jerry Moran (R-KS) and Rubén Hinojosa (D-TX).

Medicare Advantage. Reps. Ron Kind (D-WI) and Tom Osborne (R-NE) introduced legislation (H.R. 880) to ensure that CAHs are paid at least what they are paid today—101 percent of costs for inpatient and outpatient services—by Medicare Advantage plans. The AHA endorsed the legislation in an April 12 letter to Rep. Kind.

340B Drug Discount Plan. The 340B drug discount program allows safety net hospitals an ability to purchase pharmaceuticals at Medicaid rates. Currently, CAHs are unable to participate because they do not receive Medicare disproportionate share payments under the inpatient prospective payment system (PPS). The AHA will work with lawmakers to introduce legislation that would allow CAHs to participate in the 340B drug discount program, whereby they could purchase pharmaceuticals at significantly reduced rates.

Regulatory Issues

MedPAC CAH Report. At its April meeting, the Medicare Payment Advisory Commission (MedPAC) discussed the CAH program's success in preserving rural hospitals and rural beneficiaries access to care in preparation for its June interim report to Congress on CAHs. The commission also discussed the first broad analysis of quality data for CAHs. MedPAC is critical of cost growth in CAHs and concerned about the growing number of CAHs. In addition, they agreed that their spring report to Congress would highlight two issues of concern – swing-bed payments and the number of CAHs located within close proximity of another hospital – but would not make any recommendations, saying it is too soon to recommend major changes to the relatively young program. **Prior to MedPAC's April meeting, the AHA expressed concern in an April 1 letter to the commission about the direction of MedPAC's March discussion. The AHA will continue to remind policy makers of the importance of the program to Medicare beneficiaries and the communities served by CAHs.**

Medicare Advantage (MA) Program. CMS's Jan. 28 final rule on the MA program establishes a network adequacy fund of $25 million to recruit essential hospitals. The purpose of the fund is to ensure the plan's network has adequate coverage in rural areas and to cover the marginal difference to the MA plan for reimbursing "essential hospitals" at the Medicare rate. (CAHs are not included in the definition of "essential hospitals" because they are not PPS hospitals.) The final rule also does not provide for reimbursement at 101 percent of costs by MA plans to CAHs for services to Medicare beneficiaries. The AHA will continue to monitor MA plans' network adequacy in rural areas and supports legislation for planned payment to CAHs at 101 percent of costs.

CAH Interpretive Guidelines. CMS's 2004 revisions to the State Operations Manual included changes to the CAH interpretive guidelines, such as counting observation beds that are commingled with inpatient beds in the total CAH-bed count. Revisions, which have been promised but not yet finalized, are expected to include removal of the "commingling" language and non-recognition of "observation units." The AHA continues to discuss these and many other fixes to the interpretive guidelines with CMS.

Hospital Compare

On April 1, the Hospital Quality Alliance launched Hospital Compare, a consumer-oriented display of hospital quality data available to the general

public. This new Web site, www.HospitalCompare.hhs.gov, marks a milestone in public accountability and is the outcome of the Hospital Quality Alliance, a public-private partnership between hospitals, government, and other health care organizations. Consumers can research and compare 17 hospital quality measures for three common medical conditions – heart attack, heart failure, and pneumonia.

The fundamental goal of Hospital Compare is to effectively communicate with consumers. Turning clinical data into understandable information for consumers is a difficult task, and the Hospital Quality Alliance relied on consumers focus group testing to provide insights on how to best present the information. One issue of particular interest to CAHs is that consumer consistently viewed missing data as a defect. Many CAHs did not submit data on all 17 measures. When their data were displayed next to those of the other, larger hospitals, it raised concerns among consumer focus group participants.

In order to more clearly communicate that these were small hospitals that understandably would not have relevant data to report for many of these measures during a given period, a separate table for CAHs was created, along with an explanation of what a CAH is. Thus, consumers will better understand why there may be gaps in the data for these hospitals. **The AHA and other alliance partners are eager to identify other, more effective ways of displaying performance data, and will continue to refine and improve the display.**

Proposed IPPS Rule for FY 2006

CMS issued its proposed Medicare inpatient prospective payment system (IPPS) rule for FY 2006, which was published in the May 5 *Federal Register*. With regard to CAHs, CMS proposes restrictive guidelines for replacing or relocating CAHs. (Beginning Jan. 1, 2006, states no longer will be able to certify hospitals as a "necessary provider," if they are within 35 miles of another hospital.) The proposed rule provides a definition of rural; establishes criteria for determining if a new CAH facility is a replacement of an existing facility in essentially the same location, a relocation of the facility to a new location, or a cessation of business at one location and establishment of new business at another location. It also examines whether a CAH can retain its necessary provider designation after relocation.

CAH Replacement. CMS proposes to determine whether building a new CAH facility in a different location is a replacement of an existing facility at the same location, relocating the facility in a new location, or ceasing business at one location and establishing a new business at another location should be considered a CAH replacement.

To be considered a replacement, a CAH would have to meet the following proposed criteria:

- Construction was undertaken within 250 yards of the current building, or
- The replacement was constructed on land that is contiguous to the current CAH, and that land was owned by the CAH prior to Dec. 8, 2003; and
- The CAH is operating under a state-issued necessary provider waiver.

Relocation and Necessary Provider Designation.

CMS proposes that when a CAH is determined to have relocated, it may continue to operate under its necessary provider designation, which exempts the hospital from the 35-mile distance from other providers requirement, only if:

1. The relocated CAH has submitted an application to the state agency for relocation prior to Jan.1, 2006. The following items need to be included in the application:

    - A demonstration that the CAH will meet the same state criteria for the necessary provider designation that were established when the waiver was originally issued.
    - Assurance that, after the relocation, the CAH will be servicing the same community and will be providing essentially the same services with essentially the same staff (defined as serving at least 75 percent of the same service area with 75 percent of the same services offered, and staffed by 75 percent of the same staff, including medical staff, contracted staff, and employees).
    - Assurance that the CAH will remain in compliance with all of the Conditions of Participation in the new location.

- Proof that construction plans were "under development" prior to Dec. 8, 2003.

2. In the application, the CAH demonstrates that the replacement will facilitate access to care and improve the delivery of services to Medicare beneficiaries.

The AHA believes the proposed rule would prevent a CAH with necessary provider status from relocating its facility, unless construction was under development before Dec. 8, 2003, when the MMA was signed into law. The AHA will work to ensure that appropriate and necessary CAH relocation is permitted.

CAHs in Lugar Counties.
CMS is proposing changes that would permit CAHs located in an area that, in FY 2004, was not considered part of a Lugar county, but as of FY 2005 was included in such a county as a result of the new labor market area definitions, to maintain their CAH status until Sept. 30, 2006. After Oct. 1, 2006, these facilities must meet at least one of the criteria in §412.103(a)(1) through (a)(3) to be eligible to reclassify from urban to rural status.

The AHA is analyzing the proposed PPS rule and will develop a strategy to change CMS's proposed CAH relocation policy. The deadline for comments on the proposal is June 24. The final rule will be published by August 1, according to CMS. The proposed rule is available at http://www.cms.hhs.gov/providers/hipps//frnotices.asp

AHA's Web Site:
www/hospitalconnect.com
Access AHA's Web site for up-to-date information 24/7 on AHA advocacy issues, including What's New, AHA's 2005 Advocacy Agenda, the Hospital Quality Alliance, Seven Steps to a Healthier America, and Key Issues.
For information on critical access hospitals, click http://www.hospitalconnect.com/aha/member_relations/cah/index.html

Replacement Case Studies

Many CAH-designated hospitals were built 50 years ago with Hill-Burton funds. Renovations to these aging facilities may be too costly or simply impossible. Our state association partners have identified 32 CAHs that are in the process of building replacement facilities or have recently replaced the hospitals. Please visit our Web site to read three case studies on CAH replacement, including Shoshone Medical Center, Kellogg, ID, North Valley Hospital, Whitefish, MT, and Community Hospital of Bremen, IN. http://www.aha.org/aha/key_issues/rural/focus/cah.html

2005 Shirley Ann Munroe Leadership Development Award

Applications are currently being accepted for the 2005 Shirley Ann Munroe Award. The Award 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. The Award is designed to provide professional development and educational opportunities to outstanding small or rural hospital chief executives and includes a $1,200 stipend to offset the cost of attending an AHA educational program. Applications for the 2005 Shirley Ann Munroe Award must be postmarked by Friday, June 3, 2005. For more information or to receive a brochure, please contact Hilda Fisher, Section for Small or Rural Hospitals, at (312) 422-3334 or visit the AHA Web site at www.aha.org/aha/key_issues/rural/section/award .

For more information on topics in *CAH Update* or the AHA Section for Small or Rural Hospitals, contact John T. Supplitt, senior director, or Dorothy Cobbs, senior staff specialist, American Hospital Association. TEL: 312-422-3334, FAX: 312-422-4590, dcobbs@aha.org.