American Hospital Association

Small or Rural and Critical Access Hospitals

Small or Rural Hospitals

Rural hospitals provide essential health care services to nearly 54 million people, including 9 million Medicare beneficiaries. Because of their small size, modest assets and financial reserves, and higher percentage of Medicare patients, these hospitals 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 the lowest for rural hospitals.

The AHA continues to advocate for legislation that will address the needs of small rural hospitals, including:

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. Sens. Sam Brownback (R-KS) and Ben Nelson (D-NE) and Reps. Jerry Moran (R-KS) and Rubén Hinojosa (D-TX) introduced the bill.

The Sole Community Hospital Preservation Act (H.R.2961) would make permanent the hold harmless provision for outpatient payments to sole community hospitals and improve inpatient payments to sole community hospitals. Reps. Greg Walden (R-OR) and John Tanner (D-TN) introduced the bill.

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. Sen. Susan Collins (R-ME) and Rep. Greg Walden (R-OR) sponsor the legislation.

Pulmonary and Cardiac Rehabilitation Act (S.1440/ H.R. 4824) would establish a statutory benefit category under Medicare for pulmonary and cardiac rehabilitation services. Sens. Mike Crapo (R-ID) and Blanche Lincoln (D-AR) and Reps. Pickering (R-MS) and Lewis (D-GA) introduced the bills.

The Medicare Rural Health Provider Payment Extension Act (H.R. 5118) would amend the MMA of 2003 to extend certain Medicare payment methodologies provided for rural health care providers including:

- Extension of the outpatient hold harmless for rural hospitals under 100 beds and Sole Community Hospitals
- Reasonable cost payment for outpatient lab services performed by rural hospitals and,
- A 5% rural add-on for home health services.

Rural Hospital and Provider Equity Act (R-HoPE) (S. 3500) would create or increase Medicare payments to rural hospitals and make changes to guidelines for CAHs, sole community hospitals, clinics, ambulances, nursing homes, and home health care providers in rural areas. The bill would eliminate the twelve percent DSH cap, reinstate the outpatient hold harmless, create a low-volume adjustment, assist CAHs, extend the 2 percent rural ambulance adjustment, provide loans to finance rural facilities improve infrastructure, extend physician recruitment bonuses, and much more. Sens. Thomas (R-WY) and Conrad (D-ND) introduced the bill.

The Comprehensive Immigration Reform Act (S. 2611) includes several provisions to address caregiver shortages. The bill would extend permanently the State 30 J-1 visa program, which is set to expire June 1, 2006. In addition, the bill would allow more qualified internationally trained nurses to work in the U.S. The bill would exempt nurses and physical therapists from the caps - an exemption that would expire in 2017. This legislation is similar to companion bills introduced in the House as H.R. 4997 and Senate as S 2425, the “Physicians for Underserved Act.” It will be an uphill struggle for lawmakers to reconcile the differences between the House and Senate-passed immigration bills and adopt a final bill this year. Because of that uncertainty, the AHA is advocating for Congress to move separately to reauthorize the J-1 visa waiver program as soon as possible.

Critical Access Hospitals

The CAH program is essential for maintaining adequate access to health care services in rural communities. However, the survival of these remote health care facilities could be threatened without needed improvements to the CAH program. The AHA supports the following legislative solutions:

The Rural Health Equity Act (H.R.880) would ensure that Medicare Advantage (MA) plans pay CAHs and rural health clinics at least 101 percent of costs for inpatient and outpatient services, whether or not the CAH has a contract with the patient’s MA plan. Reps. Ron Kind (D-WI) and Tom Osborne (R-NE) introduced the bill.

The Rural Health Services Preservation Act (S. 2819) introduced by Sens. Norm Coleman, R-MN, Tom Harkin, D-IA, and Dick Durbin, D-IL, would ensure that CAHs are paid no less by MA organizations than they would by traditional Medicare. This payment floor would apply to both contracting and non-contracting providers and to inpatient, outpatient and swing-bed services. MA plans could negotiate rates with CAHs but those rates would have to meet or exceed payment floor. This bill would allow two methods for determining payment that equals this threshold: Through a payment rate made up of 101% of a hospital’s interim rate and a yearly cost reconciliation; or a payment rate equal to 103% of the applicable interim payment rate without reconciliation.

The Rural Health Care Capital Access Act (H.R. 4912) would provide a five-year extension of the Federal Housing Administration's (FHA) mortgage insurance program for CAHs under Section 242 of the National Housing Act. Insures the loans lenders make for the construction and renovation of hospitals. Rep. Robert Ney (R-OH), introduced the bill.
The Critical Access to Clinical Lab Services Act (S.236/H.R.1016) would reinstate cost-based reimbursement to CAHs for referral lab services provided to patients who are not physically present in the hospital. Sens. Ben Nelson (D-NE) and Susan Collins (R-ME), and Reps. Butch Otter (R-ID) and James Oberstar (D-MN) introduced the legislation.

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. Sens. John Thune (R-SD) and Jeff Bingaman (D-NM), and Reps. JoAnn Emerson (R-MO) and Bobby Rush (D-IL) introduced the legislation.

Regulatory Priorities

CMS' State Operations Manual's Interpretive Guidelines: CMS has restricted the use and location of observation beds in CAHs. In addition, CMS has limited a CAHs ability to relocate and build a replacement facility. Interpretive guidelines alter the definitions of mountainous terrain and secondary roads, and require review after one year to certify that 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. AHA advocates changing the interpretive guidelines so that observation beds are not counted toward the total CAH bed count. We also will urge CMS to restate definitions and adopt a five-mile safe harbor for relocating CAHs before applying the 75 percent test.

Occupational Mix: CMS announced that it would be making changes to its proposed inpatient PPS rule in response to a lawsuit requiring CMS to collect new data on the mix of hospital employees and to fully adjust by Oct. 1, 2006 the area wage index for occupational mix. CMS released on Feb. 10 a new occupational mix survey collecting information from Jan.1-June 30. CMS now will require hospitals to submit Jan. 1-March 31 data by June 1 and April 1-June 30 data by Aug. 31. The new information will be used to adjust the area wage index in the final rule.

Hospital Discharge Notices: CMS proposed a rule that would replace the current 2-step process followed by post-acute providers with a 3-step process for

hospitals. Comments are due June 5. Under the change the discharge notice would require hospitals to deliver to beneficiaries the following:

1. Important Message from Medicare (IMM) at admission.
2. Notice of planned discharge to every patient at least 1-day prior to discharge
3. Detailed explanation of a discharge notice in the event of a challenge to a planned discharge