American Hospital Association

SUMMER 2009

CAH Update provides critical access hospitals (CAH) and other rural health care providers with the latest information on federal legislative and regulatory activity affecting payment, quality and access to care. Working with members of Congress and the administration, the AHA this year already has secured funding for CAHs to invest in health information technology (HIT), and continues to advocate for other legislative relief to ensure access to quality care for rural Americans. In addition, the AHA and its Section for Small or Rural Hospitals seek further regulatory improvements to the CAH program.

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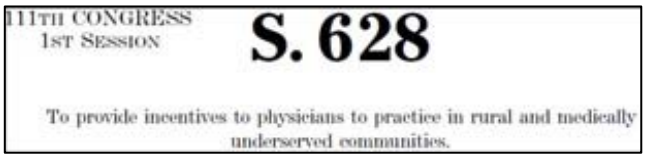
The American Recovery and Reinvestment Act (ARRA), signed into law February 17, establishes payment incentives for CAHs to adopt and use HIT that build off of the current cost-based payment system that pays CAHs 101 percent of their Medicare allowed costs. CAHs determined to be a "meaningful user" of certified electronic health record (EHR) technology can fully depreciate certified EHR costs beginning in fiscal year (FY) 2011. While the ARRA outlines some of the conditions hospitals must meet in order to be deemed meaningful users, CMS must further clarify the definition through the rulemaking process. A proposed rule is expected later

this year.

The ARRA also called for the creation of an HIT standards committee for the purposes of recommending standards and certification criteria for electronic health information exchange. Members include several hospital and health system representatives, including administrators from two systems with several rural hospitals: Judy Murphy, RN, vice president of information systems at Aurora Health Care in Milwaukee, WI; and James Walker, MD, chief medical information officer at Geisinger Health System in Danville, PA.

Visit the Section for Small or Rural Hospitals Web site at http://www.aha.org/aha/member-center/constituency-sections/Small-or-Rural/index.html

J1-Visa Waiver Program Improvements and Permanent Reauthorization


111TH CONGRESS
1ST SESSION

S. 628

To provide incentives to physicians to practice in rural and medically underserved communities.

Sen. Kent Conrad (D-ND) introduced on March 18 the Conrad State 30 Improvement Act (S. 628), AHA-supported legislation that would permanently reauthorize the Conrad State 30 visa waiver program. The program, set to expire at the end of September, allows physicians on J-1 visas to waive the requirement to return to their home country for two years if they agree to serve for three years in a health professional shortage area or medically underserved area. Each state is allowed 30 waivers. S. 628 also would allow physicians on H-1B visas to enter the program; exempt physicians who participate in the program from green card caps; and provide a mechanism by which the per-state caps can increase beyond 30 waivers. In addition, it would prohibit H-1B visa physicians from serving in "flex-slots," positions located outside underserved areas, and would reset H-1B visa physicians' visa expiration to six years from the time they enter the Conrad State 30 program. The bill is cosponsored by Sens. Sam Brownback (R-KS), Susan Collins (R-ME), Tim Johnson (D-SD) and Patty Murray (D-WA).

For more information, contact John Supplitt, senior director for the **Section for Small or Rural Hospitals**, at (312)422-3306 or at jsupplitt@aha.org.

Bed Count Flexibility for Determining CAH Status

Introduced by Sens. Ron Wyden (D-OR) and Mike Crapo (R-ID) and Reps. Ron Kind (D-WI) and Greg Walden (R-OR), the Critical Access Hospital Flexibility Act of 2009 (S. 307/HR. 668) would provide flexibility in the manner in which beds are counted for purposes of determining whether a hospital may be designated as a CAH under the Medicare program. The bill would allow either 25 beds on a daily basis or 20 beds, as determined on an annual, average basis. Only inpatient beds that are occupied shall be counted when determining the number of beds. It also excludes from the bed counts any that is used to provide care to a veteran

referred to the CAH by the Veterans Administration.

Extending Medicare FLEX Grants

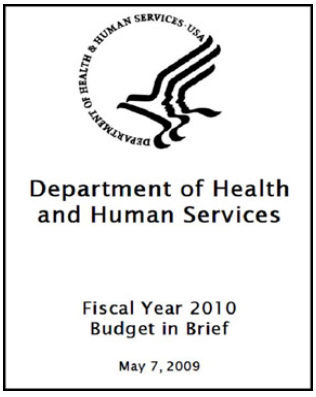
Sen. Charles Grassley (R-IA) in January introduced the Medicare Rural Health Access Improvement Act of 2009 (S. 318), which would extend Medicare FLEX Grants. In addition, the bill includes a low-volume payment adjustment for rural hospitals; extends treatment of physician pathology services under Medicare; extends the rural ground ambulance bonus; improves payment to rural health clinics at $92 per visit; and exempts durable medical equipment suppliers in small metropolitan and rural areas.

CAH Participation in the Medicare 340B Program

The 340B Program Improvement and Integrity Act of 2009 (H.R.444) would amend the Public Health Service Act to expand the 340B drug discount pricing program to include outpatient and inpatient drugs at CAHs, Medicare-dependent small rural hospitals, sole community hospitals and rural referral centers. Enrolled hospitals would be prohibited from obtaining covered outpatient drugs through a group purchasing arrangement; however, the Secretary of Health and Human Services (HHS) would be required to establish reasonable exceptions to such requirements, including for drugs unavailable through the program and to facilitate generic substitution when a covered drug is available at a lower price. Hospitals enrolled in the 340B drug discount program will be required to provide to each state a credit on the estimated annual costs for drugs provided to Medicaid recipients for inpatient use. The bill was introduced by Reps. Bobby Rush (D-IL), Bart Stupak (D-MI), and Jo Ann Emerson (R- MO).

Appropriations

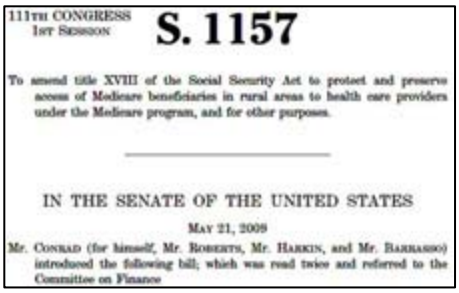
The president's FY 2010 budget proposal, released in May, calls for increased funding for select rural health programs. It includes more than $55 million in grant funding for rural health care services outreach, network and quality improvement; more than $9 million for services provided by state offices of rural health; and $8 million in telehealth grants for use in telecommunications technologies.



The AHA is urging lawmakers to approve an FY 2010 Labor, HHS and Education appropriations bill that provides adequate funding for rural health care programs. The table below compares FY 2008 and 2009 funding levels for key rural programs and services with the president's proposal and the Senate committee's levels.

FY 2010 APPROPRIATIONS SELECT RURAL PROGRAMS (in millions)	FY 2008 FUNDING LEVEL	FY 2009 OMNIBUS BILL	FY 2010 PRESIDENT'S BUDGET
Telehealth	$7.0	$7.55	$8.0
Rural Health Outreach Grants	$48.0	$53.90	$55.45
Rural Health Policy Dev.	$9.0	$9.7	$9.7
Rural Hospital FLEX grants	$38.0	$39.2	$39.2
State Offices of Rural Health	$8.0	$9.2	$9.45
Delta Health Initiative	$25.0	$26.0	$0
Denali Commission	$39.0	$19.6	$0
National Health Service Corps	$123.0	$134.97	$169.0
Nurse Loan Repayment & Scholarship	$31.0	$37.13	$125.0

Craig Thomas Rural Hospital and Provider Equity Act (S.1157) or R-HoPE



111TH CONGRESS
1ST SESSION

S. 1157

To amend title XVIII of the Social Security Act to protect and preserve access of Medicare beneficiaries in rural areas to health care providers under the Medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

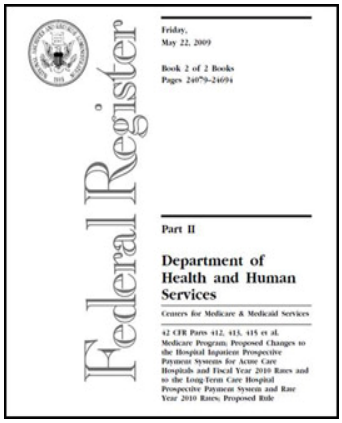
MAY 21, 2009

Mr. CONRAD (for himself, Mr. ROBERTS, Mr. HARKIN, and Mr. BARRASSO) introduced the following bill; which was read twice and referred to the Committee on Finance

Sens. Kent Conrad (D-ND), Pat Roberts (R-KA), Tom Harkin (D-IA) and John Barasso (R-WY) have introduced AHA-supported legislation that would improve Medicare reimbursements to rural hospitals. The Craig Thomas Rural Hospital and Provider Equity Act (S.1157) or R-HoPE would eliminate the isolation test for cost-based ambulance reimbursement for CAHs. Also, it would provide a temporary payment increase for hospitals with low-volume inpatient discharges. The bill also would continue allowing direct payments to independent laboratories for the technical component of pathology services, and the 5% rural add-on payment for home health services. In addition, the bill would extend the outpatient hold-harmless provision for sole community hospitals and rural hospitals with fewer than 100 beds, remove the cap on disproportionate share adjustment percentages for all hospitals and improve payments for ambulance services in rural areas.

Regulatory Advocacy

FY 2010 Inpatient PPS Proposed Rule



CMS' FY 2010 Medicare inpatient prospective payment system (PPS) proposed rule, issued May 1, implements provisions of the

Medicare Improvements for Patients and Providers Act regarding CAH payment of referral lab and ambulance services. A detailed analysis of the proposed rule is available in the May 13 AHA Regulatory Advisory. The AHA will send an official comment letter on the proposed rule ahead of CMS' June 30 comment deadline, which members may use as a model for their own comment letter to CMS. The agency will issue a final rule no later than Aug. 1; changes will take effect Oct. 1.

Payment for Clinical Diagnostic Laboratory Tests

CMS proposes that a CAH may receive 101 percent of reasonable cost-based payments for outpatient clinical diagnostic laboratory tests furnished to an individual who is an outpatient of the CAH even if the individual is not physically present in the CAH at the time the specimen is collected. The agency proposes that the individual must either have received outpatient services in the CAH on the same day the specimen is collected or the specimen must be collected by an employee of the CAH. A CAH also would receive 101 percent reasonable cost-based payments for individuals who are physically present in the CAH or at a facility that is a CAH-based provider when the specimen is collected, but in this case, the specimen would not need to be collected by an employee of the CAH.

CAH-based Clinical Diagnostic Laboratory Facilities

CMS proposes that these facilities, which are currently exempt from provider-based determinations, must meet the applicable provider-based status requirements when they are part of a CAH in order for the CAH to receive payment for their clinical diagnostic laboratory services based on reasonable cost. As part of meeting the provider-based status requirements, these facilities would have to meet CAH distance requirements. The regulations also provide that an off-campus provider-based department, remote location, or distinct part psychiatric or rehabilitation unit of a CAH that was created or acquired on or after Jan. 1, 2008, cannot be within 35 miles of a hospital or another CAH if the CAH is to continue meeting the location requirements.

Method II Payment

CMS proposes requiring CAHs that select the optional method (Method II) of reimbursement for outpatient facility services to receive 100 percent of reasonable cost instead of 101 percent of reasonable cost for those facility services. The proposed change would not affect payment for the professional component paid to physicians.

CAH-based Ambulance Services

Existing regulations provide that ambulance services are paid at reasonable cost if the services are furnished by a CAH or by an entity owned and operated by a CAH, but only if the CAH or entity is the only supplier or provider of ambulance service within a 35-mile drive of the CAH or entity. CMS is soliciting public comments regarding whether an ambulance service that is owned and operated by a CAH, and is eligible to receive reasonable cost-based payment should be required to meet the provider-based status rules. According to CMS, it can be argued that CAH-

owned and -operated ambulance suppliers or providers also should be required to meet the provider-based status requirements to demonstrate that the ambulance services are integrated with the CAH because the CAH ambulance services are paid at a higher Medicare payment level when they are owned and operated by a CAH compared to when they are freestanding.

Other Regulations

Certified Registered Nurse Anesthetists

There are two issues related to payment of certified registered nurse anesthetists (CRNA) – standby costs and pass-through payments – that remain unresolved.

Standby Costs

In February, and for the second time in 12 months, a ruling came before the Provider Reimbursement Review Board (PRRB) contesting nonpayment of CRNA standby costs at a CAH. The board ruled in favor of the hospital and the AHA wrote a letter to CMS urging the agency to affirm the PRRB decision. However, in a May 1 decision, CMS stated that Medicare will not reimburse CAH costs for on-call CRNAs. The AHA remains concerned that disallowing CRNA's standby costs threatens patients' access to care by forcing hospitals to inappropriately absorb these costs.

Pass-through Payments

CMS declared that CAHs in "Lugar Counties" or rural CAHs in whole counties deemed as a metropolitan statistical area no longer qualify for Medicare Part B billing exemption for CRNA services because they operate in an area considered metropolitan under CMS classification. CAHs are by definition limited-service facilities located in rural areas and CMS considers CAHs to be "hospitals" for purposes of extending eligibility for CRNA pass-through payments. Congressional intent was that urban hospitals that are redesignated and treated as rural hospitals would receive "all categories and designations available to rural hospitals," which would include pass-through payments for CRNA services. Nevertheless, CMS has denied pass-through payments to CAHs. This decision is being challenged at the administrative level.

Physician Supervision for Outpatient Therapeutic Services

In its 2009 outpatient PPS final rule, CMS "clarified" a longstanding policy requiring that a physician be onsite and immediately available whenever outpatient therapeutic services are provided in a hospital outpatient department, whether the department is within the hospital's main facility or located on or off the hospital campus. The AHA, along with a coalition of 11 other organizations, urged CMS to rescind the clarification because of its potential impact on patients' access to services, especially in communities serviced by CAHs where serious physician shortages continue.

TRICARE Reimbursement

In May 2008, the Department of Defense announced it would expand to CAHs nationwide the TRICARE demonstration in which CAHs in Alaska are reimbursed the lesser of the billed charge or 101 percent of reasonable costs for inpatient and outpatient care. The proposal awaits approval from the Office of Management and Budget before it can be implemented. While TRICARE under law must pay similarly to Medicare, the AHA urged TRICARE to pay CAHs using Medicare's exact methodology.