

Approximately 72 million Americans live in rural areas and depend upon the hospital serving their community as an important, and often only, source of care. Remote geographic location, small size, and limited workforce along with physician shortages and financial resources pose a unique set of challenges for rural hospitals. In 2010, the AHA's Section for Small or Rural Hospitals (Section) advocated for the unique needs of our 1,630 constituents, which includes more than 975 critical access hospitals (CAHs).

This annual report highlights some of the legislative issues the AHA championed on behalf of small or rural hospital members particularly with the implementation of the Patient Protection and Affordable Care Act (ACA) of 2010 and the Medicare and Medicaid Extenders (Extenders) Act of 2010. It also reviews achievements in areas of regulatory policy, governance, organizational relationships, and member services.

REPRESENTATION AND ADVOCACY

Legislative Advocacy

Health Care Reform

In March, President Obama signed into law P.L. 111-148, or the ACA, and P.L. 111-152, the Health Care and Education Affordability Reconciliation Act of 2010. This legislation is estimated by the Congressional Budget Office to expand coverage to 32 million people at a cost of \$940 billion over fiscal years 2010-2019. The AHA applauds the historic steps that the health care reform legislation will take toward expanding health coverage and acknowledges the hospital field's significant contribution toward financing the coverage expansion as part of all stakeholders' shared responsibility.

Medicare Extenders Act

On December 15, the President signed into law P.L. 111-309, the Extenders Act. The law extends several provisions of the Medicare Modernization Act of 2003 and the ACA, including an extension of the physician payment update through calendar year 2011. AHA lobbied successfully for extension of several Medicare payment and rural protections including:

- ★ Exceptions process for Medicare therapy caps
- ★ Direct billing for the technical component of physician pathology services
- ★ Ambulance add-ons for services to patients in rural communities
- ★ Outpatient hold harmless for sole community hospitals (SCHs) and other rural hospitals
- ★ Reasonable cost payments for clinical lab tests to patients in rural areas
- ★ Section 508 reclassification
- ★ Medicare work geographic adjustment floor for physicians

Appropriations

In its continuing efforts to support fair and equitable payments for rural hospitals, the AHA urged lawmakers to approve a fiscal year (FY) 2010 Labor, HHS, and Education appropriations bill that would provide funding for rural health care programs. Ultimately special programs supporting rural health priorities were funded in a continuing resolution at current levels.

Other Legislative Advocacy

During 2010, the AHA wrote letters to members of Congress in support of legislation to:

- ★ repeal the Independent Payment Advisory Board
- ★ ensure that the full cost of certain provider taxes are considered allowable costs for purposes of Medicare reimbursements to CAHs
- ★ provide relief from Centers for Medicare & Medicaid Services (CMS) regulations with respect to direct supervision of outpatient therapeutic services
- ★ repeal the antitrust exemption available to health insurers for anticompetitive conduct including price fixing, bid rigging, and market allocation

In addition, AHA coordinated efforts with members of Congress to express their concerns in letters to CMS regarding:

- ★ restatement and clarification of existing policy on direct supervision of outpatient therapeutic services
- ★ the proposed definition of meaningful use of electronic health records

These will be among the several policy priorities and works in progress that shape AHA's advocacy agenda for small or rural PPS hospitals and CAHs in 2011.

Regulatory Policy

In 2010, the AHA represented small or rural hospital interests on several major rules, including final rules for the Medicare inpatient prospective payment system (PPS), the outpatient PPS, and meaningful use of electronic health records (EHR). We realized both gains and losses throughout the rulemaking process and many of the regulatory outcomes were a result of the implementation of rural provider protections and payment extenders mandated by the ACA.

Inpatient Prospective Payment System Final Rule

AHA advocated for a full IPPS market basket update and against documentation and coding offsets for FY 2011. However, in its final rule, CMS included a 2.9% cut for Medicare Severity Diagnosis Related Groups (MS-DRGs) to a full market basket update of only 2.35%, the lowest in many years. The AHA asserts that **CMS is overstating the effect of the documentation and coding change**. AHA will work with the Administration and Congress to ensure that CMS does not exceed its charge of ensuring budget-neutral implementation of MS-DRGs.

The rule improves the low-volume adjustment for FYs 2011 and 2012. CMS must provide eligible rural hospitals with an add-on payment in an amount determined using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with Medicare discharges below 200, to no adjustment for hospitals with 1,600 or more Medicare discharges.

AHA effectively advocated ensuring CAHs will be paid 101% of reasonable costs for all outpatient services they provide, regardless of the billing method elected. In the IPPS final rule CMS made the rule retroactive, meaning CAHs will continuously receive the 101% reimbursement, despite CMS' previous policy.

Despite opposition from the AHA, CMS finalized in the IPPS rule "clarification" of its policy regarding when provider taxes are considered allowable costs for CAHs under Medicare. Medicare contractors will determine the permissibility of provider taxes on a case-by-case basis, based on reasonable cost principles, and will determine if a reduction of the allowable tax expenses is necessary to account for payments CAHs receive that are associated with the assessed tax.

The IPPS rule extends the Rural Community Hospital demonstration for five additional years, through December 31, 2014. It also increases the number of participating hospitals from 15 to 30 and expands the eligible sites from 10 to 20 rural states with the lowest population density.

Outpatient Prospective Payment System Final Rule

In response to concerns raised by the AHA, CMS agreed to changes in its policy on direct supervision of outpatient therapeutic services, including no enforcement in CY 2011 for services provided in CAHs and in small rural PPS hospitals with 100 or fewer beds. In addition CMS agreed to a revised definition of “direct supervision” that allows more flexibility in the physical location of the supervising professional and a reduced level of supervision for certain outpatient therapeutic services, including observation and certain infusions and injections.

CMS agreed to continue increasing payments to SCHs by 7.1% for all services paid under the OPPI, with the exception of drugs, biologicals, services paid under the pass-through policy, and items paid at charges reduced to costs.

CMS implemented a 10% primary care incentive payment for certain services delivered by a primary care practitioner for five years, beginning January 1, 2011. CMS also implemented a 10% surgical incentive payment for certain major procedure codes delivered by general surgeons in a health professional shortage area for five years, beginning January 1, 2011.

Meaningful Use of Electronic Health Records

CMS published a final rule defining “meaningful use” of electronic health records (EHRs). The final rule establishes a single set of meaningful use criteria for hospitals large and small, rural and urban. It does not address concerns raised by the AHA that this approach could lead to a “digital divide” in the adoption and use of EHRs between large, urban hospitals and smaller, rural facilities. CMS has included CAHs as eligible for Medicaid EHR incentive payments if they meet a threshold of 10% or more Medicaid patient volume and other Medicaid requirements.

Other Proposed and Final Rules

The HRSA Office of Pharmacy Affairs implemented enrollment of newly covered entities eligible for the 340B drug pricing program as a result of the ACA, which include CAHs, rural referral centers, and SCHs. The program applies to outpatient services only.

John Supplitt, senior director, AHA Section for Small or Rural Hospitals, was appointed by HHS to the negotiated rule-making committee for the designation of Medically Underserved Populations (MUPs) and Health Professional Shortage Areas (HPSAs). The committee’s objective is to make recommendations for a revised, coordinated designation process that would define the indicators used for both designation types; clarify the distinctions between MUPs and HPSAs; and update both designations on a regular, simultaneous basis.

AHA supports a proposal by CMS revising the credentialing and privileging requirements for the provision of telemedicine services to include “privileging by proxy.” The change would allow a hospital receiving telemedicine services to rely upon the credentialing and privileging information from the hospital providing the telemedicine services.

AHA supported the Federal Communications Commission’s effort to reform its existing universal service rural health care support mechanism in order to expand the reach and use of broadband connectivity including a program to support the construction of new networks and another to subsidize costs for access to broadband services for eligible health care providers.

AHA is proud of the many regulatory wins we negotiated with support of Congress and through our comments to regulatory agencies. AHA will remain vigilant on other areas where rule making is burdensome or where the agency rule exceeds legislative intent.

AHA GOVERNANCE

Small or rural hospitals have a direct role in shaping AHA strategy and policy through representation on the [AHA Board of Trustees, Governing Council, and Regional Policy Boards](#) (RPBs). In 2011, nine rural hospital CEOs are members of the AHA Board of Trustees, eighteen are members of the Section governing council, and 28 serve as Section delegates and alternates across the nine RPBs. Other opportunities for involvement exist through task forces and ad hoc committees. The Section's nominating committee worked diligently to recruit members and broaden representation on AHA governance and policymaking bodies.

ORGANIZATIONAL RELATIONSHIPS

The AHA works closely with several partners, including the Health Resources and Services Administration (HRSA) Office of Rural Health Policy, National Rural Health Association (NRHA), The Joint Commission, and American Academy of Family Physicians, to affect positive change in federal policies and improve the status of small or rural hospitals across the country.

MEMBER SERVICES

Growing and sustaining the rural health care workforce, improving quality while controlling costs and maintaining access to essential services are priorities for small or rural hospitals. To help our members, the AHA offers a variety of resources such as best practices case examples ([Hospitals In Pursuit of Excellence](#)), and puts members in touch with others who have led the way on these issues.

Education and Technical Assistance

The AHA offers educational and technical assistance through Webinars, teleconferences, and workshops. The AHA sponsors the [Health Forum Rural Health Care Leadership Conference](#) and cosponsored other national and regional educational programs targeting rural hospitals. During 2010, the Section produced several [Webinars](#) on health reform, hospital/FQHC relations, direct supervision of outpatient services, meaningful use of EHRs, and federal legislative and regulatory policy updates. In addition, the AHA provided faculty for national and state association rural hospital conferences and helped to develop educational sessions for related organizations including the NRHA.

Communications

The AHA is the field's primary resource for timely communication on the issues affecting small or rural hospitals. Through its [Update](#) newsletters, [AHA News and News Now](#) publications, member calls, Web site, and site visits, the AHA reaches out and connects with members and solicits their opinions on a variety of strategic issues.

Recognition

Each year the AHA 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, with the [Shirley Ann Munroe Rural Hospital Leadership Award](#). Casey Meza, CEO, Clearwater Valley and St. Mary's Hospital & Clinics, Orofino, Idaho, was the 2010 recipient.

MOVING FORWARD

The AHA will continue to work hard on behalf of small or rural hospitals as they develop and implement reform strategies and tackle emerging issues. This report is only a summary of the many ways in which AHA adds value to small or rural hospitals. [Visit our Web site](#) for additional information.

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