American Hospital Association

The Value of AHA Membership for Critical Access Hospitals

Critical Access Hospitals (CAHs) are vital for maintaining access to high-quality health care services in rural communities. Presently, CAHs represent a quarter of all U.S. community hospitals and more than two-thirds of all U.S. rural community hospitals. Since creation of the CAH program as part of the 1997 *Balanced Budget Act*, the American Hospital Association (AHA) has been a champion of CAHs, advocating for program improvements and enhancements. The AHA remains deeply committed to ensuring that these needs of these remote safety-net hospitals are a national priority.

Below are just some of the ways the AHA works for CAHs.

Working for Critical Access Hospitals

Outdated regulations, duplicative or conflicting rules, unworkable timelines – all of these – increase the burden on CAHs and draw much-needed resources away from patient care. The AHA repeatedly demonstrates the need for streamlined regulations, common sense rules and manageable timelines, as outlined below.

- **Medicare Conditions of Participation (CoPs):** Successfully urged CMS to revise many outdated CoPs for CAHs. The improvements included permitting CAHs to provide certain services (e.g., diagnostic, therapeutic, laboratory, radiology and emergency services) under service arrangements instead of directly themselves.
- **Outpatient Supervision:** Convinced CMS to extend for an additional year the delay in enforcement of direct supervision requirements for CAHs and small, rural hospitals. CMS also added four new voting members to the Advisory Panel on Hospital Outpatient Payment to represent CAHs and rural hospitals. At the panel's recommendation, CMS reduced the level of supervision for 49 services from direct to general.
- **Medicare Outpatient Therapy Cap:** Urged CMS to re-examine how to apply the 2012 *American Taxpayer Relief Act's* temporary therapy cap to outpatient therapy services provided in CAHs. CMS clarified that in CY 2013 CAHs will not be subject to the cap and may continue to provide therapy services above the $1,900 cap and will not need to request an exception or use a modifier on the claim.
- **Broadband Access:** Worked with the federal government to expand the reach and use of broadband connectivity for rural health care providers.
- **Electronic Health Records (EHR) and Method II Billing:** Convinced CMS to take steps to ensure that certain physicians who provide services in the outpatient departments of CAHs are eligible to participate in the Medicare EHR Incentive Program, beginning 2013. However, due to CMS system changes that will be implemented over the coming year, these Method II physicians will not be able to submit attestations until January 2014.
- **Stage 2 Meaningful Use:** Secured a delay in the start of the Stage 2 meaningful use requirements under the Medicare and Medicaid EHR Incentive Programs until fiscal year 2014. The AHA also convinced CMS to allow CAHs to include capital lease costs as allowable costs when calculating incentive payments.
- **Conrad State 30 J-1 Visa Waiver Program:** Worked with Congress as it approved legislation extending the J-1 visa waiver program, which allows foreign-born physicians to remain in the U.S. for three years after medical school to serve in medically underserved areas.
- **ICD-10 Delay:** Successfully urged CMS to delay the deadline for implementing ICD-10 diagnosis and procedure codes to Oct. 1, 2014.
- **Emergency Medical Treatment and Labor Act (EMTALA):** Convinced CMS not to expand the current EMTALA regulations. The agency said that a hospital has satisfied its EMTALA obligation when it admits an individual "in good faith in order to stabilize the [emergency medical condition]."
- **Certified Registered Nurse Anesthetists (CRNA):** Successfully urged CMS to allow CRNAs to bill directly and be reimbursed by Medicare for services determined by the state to be within their scope of practice, including chronic pain management.

- **Medicare Physician Payment:** Worked with Congress to prevent a 27% cut to Medicare physician payments in calendar year (CY) 2013.

- **Drug Shortages:** After strong advocacy by the AHA and a coalition of health care stakeholders, Congress passed the Food and Drug Administration Safety and Innovation Act, which included provisions to help alleviate critical drug shortages. The law:
  - strengthens requirements for manufacturers to notify FDA in advance of discontinuance or interruptions in drug production;
  - requires FDA to consider the impact on supply of drugs prior to taking enforcement actions against manufacturers;
  - permits expedited drug application reviews and site inspections to mitigate or prevent shortages;
  - requires coordination between the FDA and the Drug Enforcement Administration for shortages involving controlled substances;
  - relaxes FDA requirements for hospitals that repackage shortage drugs for use within their own health system; and
  - requires FDA to establish a task force to implement a strategic plan for responding to drug shortages and to submit an annual report to Congress.

Engaging Critical Access Hospital Leaders

Critical access hospital leaders have a strong voice in the AHA. They help shape key advocacy activities, policy positions and member services of particular interest to CAHs through their active involvement in many forums.

- **A Role in Governance and Policy-Making:** The AHA offers CAH leaders with many opportunities to take an active role in shaping AHA policies and setting direction for the association. They can play a formal role in association governance and policy formation by serving on the AHA's Board of Trustees, Regional Policy Boards, Governing Councils and committees. In addition, the association creates short-term advisory and work groups where members weigh in on more focused, time-sensitive policy issues.

- **AHA Section for Small or Rural Hospitals:** The AHA Section for Small or Rural Hospitals currently has more than 1,600 members from across the country and is comprised of CEOs from critical access, small or rural hospitals. The Section provides forums linking members with shared interests and missions to advise AHA on policy and advocacy activities and to discuss issues of great importance to CAHs and the field as a whole. These efforts are led by the Small or Rural Governing Council which meets at least three times a year. Valuable opportunities also are provided for CAH leaders to interact and network with one another through special member conference calls and meetings.

- **Advocacy Alliances:** The AHA's Advocacy Alliances provide members with another way to engage legislators on the specific issue or issues that have a direct impact on their ability to continue providing quality health care services in their communities. The **Advocacy Alliance for Rural Hospitals** focuses on extending Medicare provisions that expired in 2012 and those that will expire in 2013. In addition, this Alliance continues to work to protect CAHs and other rural hospital designations. The **Advocacy Alliance for the 340B Drug Discount Program** focuses primarily on preventing attempts to scale back this vital drug discount program and supports expansion of 340B discounts.

- **Rural Health Care Leadership Conference:** This annual conference brings together top thinkers in the field, and offers members strategies for accelerating performance excellence and improving the sustainability of rural hospitals.

- **Member Outreach:** Several times throughout the year CAH member CEOs are individually contacted by AHA staff and/or are invited to participate in small group CEO conference calls to discuss key AHA initiatives. During the calls, members contribute their perspectives and often receive additional tools and resources to address key challenges shared during the discussions.

Providing Key Resources for Critical Access Hospitals

Your membership in the AHA means more than representation on critical regulatory and legislative issues. We provide CAHs with the tools and resources to navigate today's changing landscape of health care delivery and to support your efforts to improve quality and increase value for the communities you serve. Also, through our Committee on Research, the AHA proactively works to ensure our members are prepared for the health care transformation that is expected in the long term.

- **Hospitals in Pursuit of Excellence (HPOE):** Looking to identify and share best practices? Through HPOE, an initiative from the AHA's Health Research & Educational Trust, we share action guides and reports that will accelerate performance improvement and support health reform implementation.

- **AHA Resource Center:** Highly trained information specialists assist members in accessing timely and relevant health services articles and data.

- **Reports and Research:** The AHA routinely analyzes the most pressing issues affecting the field. Recent reports examined the economic contributions of hospitals and changes required for creating a primary care workforce for the future. A previous report, "The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform," highlighted the unique circumstances facing our rural and CAH members.

- **RAC Audit Education Series:** Hospitals face a barrage of payment audits. The AHA Audit Education Series helps members be proactive in managing program integrity initiatives, such as the Recovery Audit Contractor (RAC) program.

- **Advocacy Action Center:** This web-based kit provides a set of resources and materials tailored to help you effectively communicate key messages. They'll help you explain your concerns to legislators, your hospital family and your community at large. These resources can also be accessed through our mobile app, available for both Apple and Android-based devices.