American Hospital Association

The Value of AHA Membership for Rural Hospitals

Approximately 51 million Americans live in rural areas and depend on the hospital serving their community as an important source of care. These hospitals face a unique set of challenges because of their remote geographic location, small size, scarce workforce, physician shortages and constrained financial resources with limited access to capital.

The AHA works to ensure that the unique needs of this part of our membership are a national priority. Outlined below are just some of our most recent successes, including those of particular interest to rural health care providers.

Working for Rural Hospitals

Outdated regulations, duplicative or conflicting rules, unworkable timelines – all of these - increase the burden on rural providers and draw much-needed resources away from patient care. In 2012, AHA demonstrated the need for streamlined regulations, common sense rules and manageable timelines as outlined below.

- **Medicare Extenders:** As part of the Medicare physician payment fix bill, AHA worked with Congress to extend several provisions of importance to rural hospitals, including: ambulance add-on payments, the low-volume adjustment add-on, and the Medicare-dependent hospital program.
- **Sole Community Hospitals (SCHs):** AHA convinced the Centers for Medicare & Medicaid Services (CMS) to substantially modify its SCH policy to be consistent with existing regulations. CMS had proposed to clarify that it can revoke SCH classification retroactive to when it was first granted if it determines a hospital was incorrectly classified as an SCH.
- **Medicare Conditions of Participation (CoPs):** AHA successfully urged CMS to revise many outdated CoPs for hospitals and critical access hospitals (CAHs).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.
- **Outpatient Prospective Payment System (OPPS) Adjustment:** Successfully urged CMS to continue the adjustment of 7.1 percent to OPPS payments to certain rural SCHs, including essential access community hospitals (EACHs).
- **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. AHA also convinced CMS to allow CAHs to include capital lease costs as allowable costs when calculating incentive payments.
- **ICD-10 Delay:** Successfully urged CMS to delay the deadline for implementing ICD-10 diagnosis and procedure codes to Oct. 1, 2014. CMS also delayed enforcement of the new Version 5010 and D.0 transaction standards for electronic health care claims.
- **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]."
- **Conrad State 30 J-1 Visa Waiver Program:** AHA 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.
- **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.

Engaging Rural Hospital Leaders

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

- **AHA Formal Governance:** The voice of rural hospitals is well represented in the AHA's formal governance process including the Board of Trustees, regional policy boards, governing councils and various task forces and committees.
- **Section for Small or Rural Hospitals:** Tracks key issues of interest to rural hospitals and provides educational and technical assistance through webinars and workshops; past webinars focused on navigating the drug shortage and hospital/federally qualified health centers relations. In addition, members receive rural updates, alerts and information about community health centers and rural health clinics, the rural community hospital demonstration program, rural health grants and the Federal Communications Commission rural health care program. The section is led by a governing council comprised of small or rural hospital leaders from around the country.
- **AHA Advocacy Alliance for Rural Hospitals:** A special coalition created to provide members an additional avenue for targeted advocacy efforts. Activities include special briefing calls and e-mails to keep members up-to-date on key developments, special breakout sessions at AHA Advocacy Days and direct member outreach.
- **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 Relations:** AHA staff routinely contacts members directly to hear firsthand about the issues and challenges facing their hospitals and communities.

Providing Key Resources for Rural Hospitals

Your membership in the AHA means more than representation on critical regulatory and legislative issues. We provide rural hospitals 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 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.