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Outdated regulations, duplicative or conflicting rules, unworkable timelines – all of these - increase the burden on rural providers and draw much-needed resources away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- **Medicare Conditions of Participation (CoPs):** AHA successfully urged CMS to revise many outdated CoPs for hospitals and critical access hospitals (CAHs).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.

- **A Role in Governance and Policy-Making:** The AHA offers rural hospital leaders 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 comprises 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 rural hospitals 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 are also provided for rural hospital 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 **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 critical access 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 rural hospital 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 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.
- **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.