The Value of AHA Membership for Rural Hospitals

Approximately 46 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Outdated regulations, duplicative or conflicting rules, and unworkable timelines increase the burden on rural providers and draw much-needed resources away from quality patient care. In 2013 and early 2014, AHA demonstrated the need for streamlined regulations, common sense rules and manageable timelines as outlined below.

- **Extension of Medicare Provisions.** As part of the most recent Medicare physician payment fix bill, AHA worked with Congress to extend several provisions of importance to hospitals through April 1, 2015, including: ambulance add-on payments, the enhanced low-volume adjustment, the Medicare-dependent hospital program, and the outpatient therapy cap exceptions process.
- **Recovery Audit Contractors (RACs).** Continue to forcefully call for relief from overly aggressive Medicare auditors and their unmanageable medical record requests and inappropriate payment denials. The AHA is looking for solutions through the courts and the regulatory and legislative fronts. The AHA-supported Medicare Audit Improvement Act would level the playing field with RACs.
- **Medicare Conditions of Participation (CoPs).** AHA successfully urged CMS to revise many outdated CoPs for hospitals and critical access hospitals (CAHs).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.** The AHA supports the Protecting Access to Rural Therapy Services Act, which would allow general supervision by a physician or non-physician practitioner for many outpatient therapy services.
- **96-Hour Rule.** The AHA urged the Centers for Medicare & Medicaid Services (CMS) to delay enforcement of the 96-hour physician certification requirement as a CoP for CAHs and supports the Critical Access Hospital Relief Act of 2014, which would remove this requirement.
- **Outpatient Prospective Payment System (OPPS) Adjustment.** Successfully urged CMS to continue the adjustment of 7.1 percent to OPPS payments to certain rural sole community hospitals (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.
- **501c3 Tax Provisions for Health Care.** Urged the Senate Finance Committee to retain current tax code incentives that support access to hospital services.
- **EHR and Method II Billing.** Convinced CMS to take steps to ensure that certain physicians who provide services in outpatient departments of CAHs are eligible to participate in the Medicare EHR Incentive Program beginning in 2013. Secured extra time for physicians to complete their online attestations for meaningful use, and a one-time window for hospitals to attest to meeting meaningful use after the deadline for fiscal year (FY) 2013.
- **Protections for Health IT Donations.** Consistent with AHA input, CMS and the Department of Health and Human Services (HHS) Office of Inspector General extended through 2021 the regulatory protections under the Stark and antikickback laws for health IT donations from hospitals to physicians. The protections were set to expire in 2013. AHA continues to urge the agencies to make the protections permanent.
- **Medicaid Disproportionate Share Hospital (DSH) Payments.** Worked with Congress to delay scheduled cuts to Medicaid DSH payments for the next three years.
- **Medicare DSH.** Helped persuade CMS to reduce the size of the overall Medicare DSH cut in FY 2014 from a proposed $1 billion to $550 million. CMS also will distribute uncompensated care DSH payments on a per-discharge (rather than periodic interim) basis, avoiding a potential cut in Medicare Advantage payments to hospitals of about $3 billion annually. Worked with CMS to revise cost reporting procedures to align the uncompensated care DSH payments with each individual hospital's cost reporting period. We continue to urge Congress to delay the Medicare DSH cuts contained in the Affordable Care Act (ACA).
- **Medicare physician payment.** Worked with Congress to prevent a 24% cut to Medicare physician payments that was scheduled to take place Jan. 1 through April 1, 2015.

Engaging Rural Hospital Leaders

Rural hospital leaders have a strong and valued 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 critical to rural hospitals. In addition, this Alliance continues to work to protect critical access and other rural hospital designations. The **Advocacy Alliance for the 340B Drug Pricing 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

Membership in the AHA means more than representation on critical regulatory and legislative issues. The AHA offers rural hospitals the tools and resources to navigate today's changing health care delivery landscape and to support the efforts to improve the quality of care for the communities they serve.

- **Policy Reports and Research.** The AHA's Committee on Research (COR) develops the AHA research agenda, studies topics in depth and reports findings to the AHA Board and the field. The COR recently developed the report, *Your Hospital's Path to the Second Curve: Integration and Transformation*, which outlines potential paths to managing life in the gap and achieving the Triple Aim. Other AHA research reports have focused on patient engagement and advanced illness management.
- **HPOE Guides and Reports.** The AHA's Hospitals in Pursuit of Excellence (HPOE) shares action guides and reports to help accelerate performance improvement. For example, *The Role of Small and Rural Hospitals and Care Systems in Effective Population Health Partnerships* describes how hospitals can develop partnerships that balance the challenges and opportunities encountered in providing health management, and *The Second Curve of Population Health* builds upon prior AHA reports that outline a road map for hospitals to use as they transition to the second curve of population health.
- **RAC*Trac*.** The AHA RAC*Trac* website provides information on the RAC survey that collects data from hospitals on a quarterly basis to assess the impact of the Medicare RAC program on hospitals. The site also offers webinars and reports that highlight the survey findings and provides access to the RAC*Trac* analyzer tool that compares similar hospitals' RAC activity.
- **AHA Resource Center.** Highly trained information specialists assist members in accessing timely and relevant health services articles and data.
- **Advocacy Action Center.** This Web-based kit provides a set of resources and materials tailored to help hospital executives effectively communicate key messages and explain concerns to legislators, the hospital family and the community at large. These resources can also be accessed through AHA's mobile app, available for both Apple and Android-based devices.