

Over [46 million Americans or about 15 percent of U.S. residents](#) live in rural areas and depend upon their local hospital as an important, and often only, source of care. America's nearly 2,000 rural community hospitals frequently serve as an anchor for their region's health-related services, providing the structural and financial backbone for physician practice groups, labs, health clinics and post-acute and long-term care services. In addition, these hospitals often provide essential, related services such as social work, school nursing, wellness and other types of community outreach.

The [economic contribution](#) of rural hospitals is often [underestimated and overlooked](#). These hospitals are often the [largest or second largest employer](#) in the community and offer highly-skilled jobs. A strong health care network also adds to the attractiveness of a community as a place to settle, locate a business or retire.

Rural hospitals provide their patients with the highest quality of care while simultaneously tackling challenges due to their often remote geographic location, small size, limited workforce, and constrained financial resources. Rural hospitals' low-patient volumes make it difficult for these organizations to manage the high-fixed costs associated with operating a hospital. This in turn makes them particularly vulnerable to policy and market changes, and to Medicare and Medicaid payment cuts. Compounding these challenges, rural Americans are more likely to be [uninsured](#) and to have [lower incomes](#), and they are, on average, [older](#) and [less healthy](#) than Americans living in metropolitan areas.

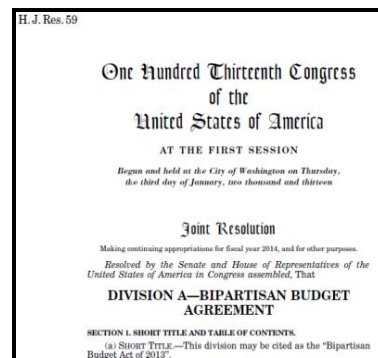
The AHA and its [Section for Small or Rural Hospitals](#) has addressed the unique needs of our 1,600 constituents, including 975 critical access hospitals (CAHs) for over 30 years. This report highlights some of the legislative issues the AHA championed on behalf of small or rural hospital members for the year ending 2013. It also reviews achievements in areas of regulatory policy, governance, and member services such as education, leadership, and communications.

### REPRESENTATION AND ADVOCACY

When signed into law, H.J. Res. 59 – *Continuing Appropriations Resolution, 2014* included the *Bipartisan Budget Act of 2013* and the *Pathway for SGR Reform Act of 2013*, which provided significant victories for rural hospitals. In addition to providing a temporary patch for payment to physicians under the Sustainable Growth Rate, (SGR) it funds annual appropriations for rural health programs at existing levels and includes an extension of Medicare payment provisions for rural hospitals and physicians.

#### *Medicare Extenders*

*The Pathway for SGR Reform Act of 2013* included extension of several key Medicare extenders including the:



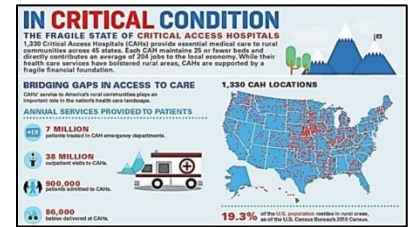
- Work Geographic Practice Cost Index floor
- Medicare inpatient hospital payment adjustment for low-volume, rural hospitals
- Therapy cap exceptions process
- Medicare-dependent hospital (MDH) program
- Ambulance rural and super rural add-ons

It also included a delay of reductions to Medicaid disproportionate share hospital (DSH) allotments, which is important to many rural safety-net hospitals.

### Advocacy in Action

The AHA is working to ensure that all hospitals have the resources they need to provide high-quality care to their communities. This is evident in our [Advocacy Agenda for Small or Rural Hospitals](#). Our legislative priorities at year-end included:

- *The Two-Midnight Rule Delay Act*, H.R. 3698, calls for Centers for Medicare & Medicaid Services (CMS) to implement a new payment methodology for inpatient stays in FY 2015.
- *The DSH Reduction Relief Act*, H.R. 1920/S. 1555, which eliminates the first two years of planned cuts to Medicare and Medicaid DSH payments.
- *The Medicare Audit Improvement Act*, H.R. 1250/S. 1012, which reins in overly aggressive Medicare auditors and contractors.
- *The Protecting Access to Rural Therapy Services Act*, H.R. 2801/S. 1143, which protects access to hospital outpatient therapeutic services by adopting a default standard of general supervision rather than direct supervision for these services.
- *The Rural Hospital Access Act*, H.R. 1787/S. 842, would reauthorize the MDH program and the enhanced low-volume Medicare adjustment for inpatient PPS hospitals.



The [AHA Advocacy Alliance for Rural Hospitals](#) is an additional avenue for AHA members to engage on issues in which they care deeply. The Alliance will reach out to rural hospital advocates with a focus on Critical Access Hospital, Sole Community Hospital, Medicare Dependent Hospital, and Rural Referral Hospital priorities; direct supervision, hospital/Federally Qualified Health Center/Rural Health Center relations, "Tweener" priorities, and the Rural Community Hospital Program demonstration.



### REGULATORY POLICY

Over the past year and working on your behalf the AHA represented the interests of small or rural hospitals to numerous federal agencies, but most notably CMS, the Health Resources and Services Administration (HRSA), and the Federal Communications Commission (FCC). AHA commented on several major rules including final rules for the Medicare inpatient prospective payment system (PPS), outpatient PPS, and the Medicare physician fee schedule. We achieved some major victories in regulatory policy and enforcement, including but not limited to:

- **Two-Midnight Policy:** AHA succeeded in delaying enforcement of the CMS requirements for admission and medical review criteria for hospital inpatient services.
- **Direct Supervision of Hospital Outpatient Therapeutic Services:** For calendar year (CY) 2013 CMS extended its policy not to enforce the direct supervision policy in CAHs and rural hospitals with 100 or fewer beds.

- **Medicare Electronic Health Record (EHR) Incentives:** Physicians who provide services in the outpatient departments of CAHs and for whom bills are submitted via the “Method 2” billing approach (CAH II) are now eligible to participate in the EHR Incentive Program. CAH II physicians began participating in calendar year 2013.
- **FCC’s Rural Health Care Program:** The FCC’s revised [Rural Health Care Program](#) (RHCP) and the new [Healthcare Connect Fund](#) (HCF) were effective in 2013. Approximately \$400 million in annual funding will be available to health care providers (HCPs) as part of the RHCP, of which \$150 million is for the HCF.
- **Medicare Conditions of Participation (CoP):** CMS issued a proposed rule on Medicare CoPs aimed at reducing burden and eliminating obsolete regulations. This rule clarifies several changes and permits CAHs to provide certain services (e.g., diagnostic, therapeutic, laboratory, radiology and emergency services) under arrangement.
- **Office of Inspector General (OIG) Report on CAH Eligibility:** AHA strongly rebuked a report from the Department of Health and Human Services (HHS) OIG recommending CMS disqualify existing CAHs that fail to meet the program’s federal mileage criteria.
- **Physician Certification of a 96-hour Stay in CAHs:** The AHA urged, but did not convince CMS to delay enforcement of the 96-hour physician certification requirement as a condition of payment for CAHs. A legislative fix has been introduced in Congress.
- **Outpatient Prospective Payment System (OPPS) Adjustment:** AHA convinced CMS to continue the adjustment of 7.1 percent to the OPPS payments to sole community hospitals including essential access community hospitals.
- **Stark Protections for Health Information Technology (HIT) Donations:** Consistent with AHA input, CMS and the HHS OIG extended through 2021 the regulatory protections under the Stark and anti-kickback laws for HIT donations from hospitals to physicians.

The AHA is proud of the many regulatory policy wins we achieved with support of Congress and through our comments to federal regulatory agencies. The AHA will remain vigilant on areas where rule making is burdensome or where an agency exceeds its authority, and pursue changes as needed to ensure equitable treatment of small or rural hospitals.

## AHA SECTION FOR SMALL OR RURAL HOSPITALS



The [AHA Section for Small or Rural Hospitals](#) ensures that the unique needs of this constituency are a national priority. The Section monitors the issues facing its members, develops policy, and identifies solutions to their most pressing problems. The Section provides a blend of forum and network to advise AHA on advocacy activities and deliberate on policies important to all small or rural hospitals. The Section Governing Council leads this effort while Section members also are represented on each of AHA’s nine Regional Policy Boards (RPBs) and the AHA Board of Trustees.

### 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 [RPBs](#). In 2013, five small or rural hospital CEOs were members of the AHA Board of Trustees, 18 are members of the Section Governing Council, and 28 serve as Section delegates and alternates across the nine RPBs. Still 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 Office of Rural Health Policy, Federal Communications Commission, National Rural Health Association, and state hospital associations 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 services such as education and technical assistance, communications, and leadership recognition.

### Education and Technical Assistance

The AHA offers education and technical assistance through Webinars, teleconferences, and workshops. The AHA sponsors the [Health Forum Rural Health Care Leadership Conference](#) and supports other national and regional rural hospital conferences as a sponsor or faculty. During 2013, the Section produced [webinars](#) on accessing the [Healthcare Connect Fund](#), direct supervision, and several federal advocacy and policy updates. Resources such as [The Role of Small and Rural Hospitals and Care Systems in Effective Population Health Partnerships](#), which describes how small and rural hospitals and care systems can develop effective population health partnerships are available from [Hospitals In Pursuit of Excellence](#).

### 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, consultations, [Web site](#), and site visits, the AHA reaches out and connects with members and solicits their opinions on a variety of strategic issues.

### Leadership Recognition



Each year the AHA recognizes with the [Shirley Ann Munroe Rural Hospital Leadership Award](#), a small or rural hospital chief executive who has achieved improvements in local health care delivery and health status through their leadership and direction. Susan Starling, RN, president and CEO, Marcum & Wallace Memorial Hospital, Irvine, KY, received the 2013 award.

## MOVING FORWARD

The AHA and the Section 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, or contact John Supplitt, senior director, AHA Section for Small or Rural Hospitals, at (312) 422-3306 or [jsupplitt@aha.org](mailto:jsupplitt@aha.org).

