Medicare and other federal programs must account for the special circumstances of rural communities. The AHA works to ensure they do so by focusing on protecting vital funding, securing the future of existing special rural payment programs – including the critical access hospital (CAH), sole community hospital (SCH), Medicare-dependent hospital (MDH) and rural referral center (RRC) programs – and relieving regulatory burden.

Approximately 51 million Americans live in rural areas and depend upon the hospital in their community. Remote geographic location, small size, limited workforce, physician shortages and often constrained financial resources pose a unique set of challenges for rural hospitals. Rural hospitals’ patient mix also makes them more reliant on public programs and, thus, particularly vulnerable to Medicare and Medicaid payment cuts. With deficit reduction a continued threat in Washington, the continued viability of small and rural health care providers remains in jeopardy.

Protecting Vital Funding. The AHA continues to advocate that Congress maintain current policies that provide vital funding for rural and small hospitals. This includes:

- Ensuring CAHs continue to be paid at least 101 percent of costs by Medicare, and are paid at least the same by Medicare Advantage plans;
- Ensuring the current CAH mileage criteria do not change;
- Extending the Rural Community Hospital Demonstration program;
- Ensuring rural hospitals and CAHs have adequate reimbursement for certified registered nurse anesthetist services, including stand-by services;
- Providing CAHs with bed size flexibility;
- Reinstating CAH necessary provider status;
- Removing unreasonable restrictions on CAHs’ ability to rebuild; and
- Allowing hospitals to claim the full cost of provider taxes as allowable costs;
- Extending the 340B Drug Pricing Program to additional hospitals and for the purchases of drugs used during inpatient hospital stays for all eligible hospitals.

Securing the Future of Existing Special Rural Payment Programs. The Protecting Access to Medicare Act of 2014 contained several provisions important to rural hospitals and their patients, including one-year extensions through March 31, 2015 for:

- The enhanced low-volume hospital payment adjustment, which provides additional payments to hospitals with low patient volumes;
- The MDH program, which provides certain small and rural hospitals with additional payments to ensure greater financial stability;
- Ambulance add-on payments that fairly reimburse rural ambulance providers for their higher per-trip costs due small patient volumes and long distances; and
- The outpatient therapy caps exception process (although we oppose the cap’s current application to services provided in the outpatient departments of hospitals and CAHs).

These programs should be renewed for the full fiscal year (FY) 2015 and beyond.
**Relieving Regulatory Burden.** Medicare policy changes and payment adjustments often have significant and problematic consequences for rural providers. The Centers for Medicare & Medicaid Services (CMS) should better account for the unique circumstances of rural providers in the rulemaking process, especially regarding the policies below.

**Direct Supervision.** CMS recently removed its moratorium on Medicare contractors enforcing its policies related to its “direct supervision” requirement of outpatient therapeutic services furnished in CAHs and small rural hospitals with 100 or fewer beds. Therefore, for 2015 and beyond, the agency requires a minimum of direct supervision for all outpatient therapeutic services furnished in hospitals and CAHs, unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic service. The AHA is deeply disappointed that CMS did not heed the concerns voiced by CAHs and small rural hospitals that imposing this policy is not only unnecessary, but also will result in reduced access to care. Without adequate numbers of health professionals in rural communities to provide direct supervision, hospitals will have no choice but to limit their hours of operation or close certain programs due to their inability to meet the direct supervision standard. The AHA supports the Protecting Access to Rural Therapy Services Act (S. 257), which takes steps to ensure this does not happen.

**96-hour Rule.** CMS recently began enforcing a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. While CAHs must maintain an annual average length of stay of 96 hours, they offer some critical medical services that have standard lengths of stay greater than 96 hours. Enforcing the condition of payment will force CAHs to eliminate these “96-hour plus” services. The resulting financial pressure will severely affect their ability to operate and, therefore, threaten access to care for beneficiaries in rural communities. The AHA supports the Critical Access Hospital Relief Act (S. 258/H.R. 169), which would remove the 96-hour condition of payment. CAHs would still be required to satisfy the condition of participation requiring a 96-hour annual average length of stay.

**Electronic Health Records (EHRs) and Meaningful Use.** We continue to be concerned about the impact of the EHR incentive program on small and rural providers. Specifically, this program should close, not widen, the existing digital divide. Yet, CMS data indicate that CAHs, in particular, have found it more challenging to meet meaningful use requirements than their urban counterparts, partly due to limited vendor choice and capacity.

In late August, CMS finalized a rule providing limited flexibility for providers demonstrating meaningful use in 2014. Unfortunately, the rule offers little practical relief because the agency continues to require that the vast majority of hospitals meet all Stage 2 requirements for a full year – from Oct. 1, 2014 through Sept. 30, 2015. The AHA is very disappointed that hospitals will be required to report a full year of performance, rather than one fiscal quarter as we had recommended, especially because hospitals not meeting meaningful use requirements will begin to receive penalties in FY 2015. (Hospitals in their first year of participation will still have a reporting period of one quarter.) Therefore, the AHA supports the Flexibility in Health IT Reporting (Flex-IT) Act (H.R. 270), which would give hospitals and eligible professionals more flexibility in meeting meaningful use requirements in FY 2015. In addition, we continue to work with CMS to clarify requirements and reduce the burden of registering and attesting to meaningful use.
Tuesday, January 27, 2015

**NEED ACTION FROM** Critical access hospital leaders

**ACTION.** Contact your senators to co-sponsor S. 258

**WHEN.** Immediately

**WHY** Eliminates 96-hour physician certification requirement for CAHs

**Senate Introduces Bill to Remove 96-hour Physician Certification Requirement for CAHs**

*Companion to H.R. 169*

Today, Sens. Pat Roberts (R-KS) and Jon Tester (D-MT) introduced the Critical Access Hospital Relief Act, S. 258, which would remove the 96-hour physician certification requirement as a condition of payment for critical access hospitals (CAHs). Specifically, this AHA-supported bill amends the Social Security Act to remove the condition of payment but leaves the condition of participation intact. A physician would not be required to state that the patient will be discharged or transferred in less than 96 hours in order for the CAH to be paid on that particular claim.

CAHs would continue to need to meet the other certification requirements that apply to all hospitals as well as the condition of participation requiring a 96-hour annual average length of stay. Earlier this month, the House introduced a companion bill, H.R. 169.

While CAHs typically maintain an annual average of 96 hours per patient, they offer some medical services that have standard lengths of stay greater than 96 hours. If CAHs are forced to eliminate these “96-hour plus” services, the resulting financial pressure on CAHs would severely affect their ability to operate and care for beneficiaries in rural communities.

Original co-sponsors of S. 258 include Sens. Jon Tester (D-MT), Dan Coats (R-IN), Jim Inhofe (R-OK), Tammy Baldwin (D-WI), Jerry Moran (R-KS), Chuck Grassley (R-IA), John Barrasso (R-WY), Deb Fischer (R-NE), John Hoeven (R-ND), Thad Cochran (R-MS), John Thune (R-SD), Steve Daines (R-MT), Roger Wicker (R-MS), Lisa Murkowski (R-AK), Heidi Heitkamp (D-ND), Jeff Merkley (D-OR).

The AHA will work with CAHs to garner support for S. 258 and H.R. 169. Please contact your legislators and urge them to cosponsor the Critical Access Hospital Relief Act.
Thursday, January 8, 2015

NEED ACTION FROM
Rural hospital leaders

ACTION.
Contact your U.S. Representative to co-sponsor H.R. 169

WHEN.
Immediately

WHY
Eliminates burdensome 96-hour stay for CAHs

H.R. 169 Will Remove Physician Certification of 96-hour Stay as a Condition of Payment for CAHs

Urge your U.S. Representative to co-sponsor this bipartisan bill

Rep. Adrian Smith (R-NE) recently introduced the Critical Access Hospital Relief Act (H.R. 169), AHA-supported legislation that would remove the 96-hour physician certification requirement as a condition of payment for critical access hospitals (CAHS). Greg Walden (R-OR), David Loebsack (D-IA), Lynn Jenkins (R-KS), and Todd Young (R-IN) are original cosponsors of the legislation.

Specifically, H.R. 169 would amend the Social Security Act to remove the condition of payment, but leave the condition of participation intact. A physician would not be required to state that the patient will be discharged or transferred in less than 96 hours in order for the CAH to be paid on that particular claim. CAHS would continue to need to meet the other certification requirements that apply to all hospitals as well as the condition of participation requiring a 96-hour annual average length of stay.

Please urge your members of Congress to join as a co-sponsor of H.R. 169, the Critical Access Hospital Relief Act.
**Tuesday, January 27, 2015**

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<th>NEED ACTION FROM</th>
<th><em>Rural hospital leaders</em></th>
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<tr>
<td>ACTION.</td>
<td><em>Contact your senators to co-sponsor S. 257</em></td>
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<td>WHEN.</td>
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<td>WHY</td>
<td>Establishes a default standard of general supervision for outpatient therapeutic services among other priorities</td>
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**Senate Introduces Bill to Protect Access to Rural Therapy Services S. 257**

Sens. Jerry Moran (R-KS), Jon Tester (D-MT) and John Thune (R-SD) today introduced the Protecting Access to Rural Therapy Services (PARTS) Act (S.257) which would protect access to outpatient therapeutic services, such as application of a cast or splint to a finger, simple wound debridement, and cardiac and pulmonary rehabilitation services. Specifically, this AHA-supported bill, S.257, would:

- Adopt a default standard of “general supervision” (rather than “direct supervision”) by a physician or non-physician practitioner (NPP) for outpatient therapeutic services;
- Create an exemption process using a provider advisory panel to identify those outpatient services risky and complex enough to require direct supervision;
- Ensure that for critical access hospitals (CAHs), the definition of “direct supervision” is consistent with the CAH conditions of participation that allow a physician or NPP to present within 30 minutes of being called; and
- Holds hospitals and CAHs harmless from civil or criminal action regarding the Centers for Medicare & Medicaid Services’ retroactive reinterpretation of “direct supervision” requirements for the period 2001 through 2015.

**The AHA will work with rural hospitals to garner support for S. 257. Contact your senators and urge them to support S. 257, and educate your representative about the supervision policy using the AHA Factsheet.**
Tuesday, February 3, 2015

NEED ACTION FROM
Rural hospital leaders

ACTION.
Contact your lawmakers to co-sponsor the Rural Hospital Access Act

WHEN.
Immediately

WHY
Bill makes MDH and low-volume payment adjustment permanent

Bill makes the MDH and Low-volume adjustment permanent

Urge your legislators to cosponsor S. 332/H.R. 663

Sens. Charles Grassley (R-IA) and Chuck Schumer (D-NY) joined Reps. Tom Reed (R-NY) and Peter Welch (D-VT) late yesterday to introduce the Rural Hospital Access Act of 2015 (S. 332/H.R. 663), respectively, which makes permanent both the Medicare-dependent hospital (MDH) program and the enhanced low-volume Medicare adjustment (LVA) for small rural prospective payment system (PPS) hospitals.

The current short-term extension of these programs is scheduled to expire on March 31, if Congress does not act. These programs are vital to America’s rural hospitals and the patients and communities they serve.

The AHA is committed to advocating on behalf of rural hospitals and will work to garner support for S. 332 and H.R. 663. Please urge your lawmakers to cosponsor the Rural Hospital Access Act. (Please click here for a pdf version of AHA’s letters of support).

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AHA-supported bill would help hospitals meet FY 2015 EHR requirements

Urge your representative to co-sponsor

Rep. Renee Ellmers (R-NC) has introduced the Flexibility in Health IT Reporting (Flex-IT) Act (H.R. 270), AHA-supported legislation that would give hospitals and eligible professionals more flexibility in meeting meaningful use requirements for electronic health records (EHRs) in fiscal year 2015. Specifically, the legislation would shorten the 2015 reporting period to 90 days from the current 365 days for Medicare and Medicaid EHR Incentive Program participants using the 2014 Edition Certified EHR. Without this change, the vast majority of hospitals are required to meet all Stage 2 requirements starting on Oct 1, 2014, and maintain compliance through Sept. 30, 2015.

Hospitals continue to be challenged with the current regulatory timeline for EHR delivery, installation and implementation. Additionally, they are challenged to find other providers capable of receiving a summary of care document to meet the transitions of care objective in the EHR Incentive Program. Without relief from the full year of use and reporting requirement,
hospitals could face financial penalties despite their best efforts at compliance.

Original cosponsors of the legislation are Reps. Ron Kind (D-WI), David Scott (D-GA), Marsha Blackburn (R-TN) and Glen Thompson (R-PA).

Please contact your representative today and urge him or her to sign on as a cosponsor.
IN CRITICAL CONDITION
THE FRAGILE STATE OF CRITICAL ACCESS HOSPITALS
1,330 Critical Access Hospitals (CAHs) provide essential medical care to rural communities across 45 states. Each CAH maintains 25 or fewer beds and directly contributes an average of 204 jobs to the local economy. While their health care services have bolstered rural areas, CAHs are supported by a fragile financial foundation.

BRIDGING GAPS IN ACCESS TO CARE
CAHs’ service to America’s rural communities plays an important role in the nation’s health care landscape.

ANNUAL SERVICES PROVIDED TO PATIENTS
- **8 MILLION** patients treated in CAH emergency departments.
- **38 MILLION** outpatient visits to CAHs.
- **809,000** patients admitted to CAHs.
- **82,000** babies delivered at CAHs.

DELICATE LIFELINES
CAHs’ small size means that they can only focus on providing the most essential medical services, in contrast to higher-volume hospitals that have more resources and flexibility to offer a wider range of services. CAHs simply don’t have the same economies of scale as their larger counterparts. More than 60% of their revenue comes from government payers, such that any payment reductions to Medicare or Medicaid would have an immense impact on CAHs’ ability to provide access to beneficiaries in rural communities.

CAH PERCENTAGE OF GROSS REVENUE, BY PAYER:
- **40.4%** PRIVATE
- **44.4%** MEDICARE
- **14.0%** MEDICAID
- **1.2%** OTHER GOVERNMENT

A SPECIAL MEDICARE PAYMENT STRUCTURE
CAHs survive in large part due to a federal reimbursement structure that provides them funding of 1% above the cost of providing care.

MEDICARE MARGINS, BY SERVICE AND HOSPITAL TYPE:
- **NON-CAH**
  - INPATIENT: -13%
  - OUTPATIENT: 0%
- **CAH**
  - INPATIENT: 1%
  - OUTPATIENT: 1%

MANY CAHS STILL STRUGGLE
Although Medicare pays CAHs 1% above the cost of providing care, CAH revenues from other payers often don’t cover costs, illustrating why adequate Medicare payments must continue in order for CAHs to be able to provide care for rural populations.

PERCENTAGE OF CAHS WITH NEGATIVE ALL-PAYER MARGINS:
- **38.5%** NEGATIVE OPERATING REVENUE
- **30.3%** NEGATIVE TOTAL MARGIN

1,330 CAH LOCATIONS

19.3% of the U.S. population resides in rural areas, as of the U.S. Census Bureau’s 2010 Census.

SOURCES: AMERICAN HOSPITAL ASSOCIATION | UNITED STATES CENSUS BUREAU

Data on services and payment from 2013.
For more than 20 years, Congress has provided relief from high prescription drug costs through the 340B Drug Pricing Program. The program requires participating pharmaceutical companies to sell covered outpatient drugs at a discount to eligible health care organizations. To be eligible, hospitals must serve a disproportionate share of uninsured and low-income patients. This program gives patients better access to drugs they need and helps hospitals enhance care capabilities by stretching scarce federal resources.

**Small Program, Big Benefits**

2%  
Portion of the United States’ $325 billion in annual drug purchases made through the 340B program

$3.8 BILLION  
Total annual savings for 340B eligible providers

340B creates valuable savings on outpatient drug expenditures to reinvest in patient care and health activities to benefit the communities they serve. It also saves money for state and federal governments.

62%  
Percentage of all uncompensated care provided by 340B hospitals

340B increases access to care for our most vulnerable populations - participating hospitals provided $28.6 billion in uncompensated care in 2013.

**Who Are 340B Hospitals?**

- About half are urban; half are rural.
- 929 (43.4%) are critical access hospitals (CAHs).
- Located in 1,529 or 47% of all US counties.

**340B Hospitals Meet Rigorous Requirements**

**340B ELIGIBILITY**

Hospitals must:

- Be designated as a not-for-profit hospital.
- Be classified as a Children’s Hospital, Cancer Hospital, Sole Community Hospital, Rural Referral Center, Critical Access Hospital or a Medicare Disproportionate Share Hospital.
- Serve a large proportion of uninsured and low-income patients.
- Undergo random audits by the federal government and pharmaceutical manufacturers.
- Recertify annually as an eligible 340B provider.

**Preserve the 340B Program; Protect the Safety Net**

Sources: Health Resources and Services Administration; IMS Health; 2013 American Hospital Association Annual Survey Data; Apexus
Thursday, February 5, 2015

NEED ACTION FROM... Critical access and small, rural PPS hospitals
ACTION... Contact your legislators
WHEN... Your immediate attention is requested
WHY... Support bipartisan legislation to permanently extend add-on payments for ambulance services in rural areas

Support S. 377/H.R. 745

_Bipartisan legislation provides for permanent extension of add-on payments for ambulance services in rural areas_

A bipartisan group of legislators in the House and Senate late Wednesday introduced the “Medicare Ambulance Access, Fraud Prevention, and Reform Act of 2015,” legislation that permanent extends add-on payments for ambulance services in rural areas. The AHA-supported bill was introduced by Sens. Pat Roberts (R-Kan.) and Charles Schumer (D-N.Y.) and Reps. Greg Walden (R-Ore.) and Peter Welch (D-Vt.). Original cosponsors are Sens. Susan Collins (R-Maine) and Patrick Leahy (D-Vt.) and Reps. Devin Nunes (R-Calif.) and Richard Neal (D-Mass.).

Congress has routinely provided for additional rural payments for ambulance providers, because they incur higher per-trip costs due to longer travel distances and fewer transports of patients. The current extension of these payments will expire on March 31 without further action from Congress.

In addition to protecting access to ambulance services in rural areas through adequate payments. This legislation directs the Secretary of Health and Human Services to study how the additional payments should be modified (if at all) to account for the costs of providing ambulance services in urban, rural, and super-rural areas. This would ensure federal payments are aligned with appropriate data and utilization patterns. Finally, the bill directs the Secretary to establish a process for preauthorization of ambulance services for patients with end stage renal disease.

Please contact your legislators to urge them to cosponsor S.377/H.R.745, which permanently extends add-on payments for ambulance services in rural areas.

_The AHA is focused on ensuring small or rural hospitals have the resources they need to provide high-quality care and meet the needs of their communities._
Rural Health Digital Toolkit

Join your colleagues by sending Washington a strong message – “Protect rural health care.” Here are some sample posts and messages to get you started! Use these messages on your organization’s Facebook or Twitter page and tag your members of Congress, @AHAadvocacy, and use the tag #RuralHealth with the message. Another great idea is to take a photo of your congressional meeting and tweet that photo while adding the member of Congress to the tweet and thanking them for meeting.

General

- Critical Access Hospitals provide vital care to #Medicare patients who would otherwise be unable to access health care services
- We must advocate for the health of #rural America + protect rural hospital services
- CAHs face reduced payment proposals which threaten their essential, life-saving, role in our nation’s health care landscape
- Low-volume payment adjustment helps level the playing field for #Rural providers + improves #AccessToCare = Congress should renew!
- Medicare dependent hospital program provides financial stability to rural hospitals with aging patients – We must renew to protect #RuralHealth
- Congress needs to extend ambulance add-on payments – #Rural ambulance providers incur higher costs due to longer travel distances + fewer patients
- #Rural hospitals continue to make advancements in reducing preventable readmissions #RuralHealth

96-hour Condition of Payment

- If CAHs can no longer provide services longer than 96 hours, it would affect their ability to operate + threaten access to care for patients

Use the AHA Advocacy Action Center online to make your voice heard.

www.aha.org/ruraladvocacy
Meaningful Use

- Achieving meaningful use is much harder for rural hospitals, #EHR incentives should close, not widen the digital divide
- Please support the #FlexIT bill to get #rural hospital across the finish line

CAH Status

- Provide relief from the constant threat of cuts to hospitals already feeling the squeeze [http://ow.ly/t7KaQ](http://ow.ly/t7KaQ)
- Losing #CAH status is a real threat to many rural hospitals = which means loss of care in isolated communities [http://ow.ly/t7K6j](http://ow.ly/t7K6j)

Extender / Expiring Provisions

- #Congress has supported health in rural America in past years thru programs that are now in danger of expiring [http://ow.ly/t7K45](http://ow.ly/t7K45)

Messages for Facebook / Other

- Rural hospitals provide essential health care services to nearly 51 million people
- Rural hospitals face great pressures as government payments decline due to their small size, modest assets and financial reserves, and higher percentage of Medicare patients since rural populations are typically older than average urban populations

Don’t forget to include the hashtag #RuralHealth when you post your messages!

Share Graphics

Visit [www.aha.org/infographics](http://www.aha.org/infographics) for all of AHA’s infographics.

Please contact Carly Moore at cmoore@aha.org or Emily Gustafson at egustafson@aha.org with any questions.

Use the AHA Advocacy Action Center online to make your voice heard. [www.aha.org/ruraladvocacy](http://www.aha.org/ruraladvocacy)