

Critical Access Hospitals



Critical Access Hospitals (CAHs) are vital for maintaining access to high-quality health care services in rural communities.

Presently, CAHs represent a quarter of all U.S. community hospitals and more than two-thirds of all U.S. rural community

hospitals. Since creation of the CAH program as part of the 1997 *Balanced Budget Act*, the American Hospital Association (AHA) has been advocating on behalf of CAHs for program improvements and enhancements. The AHA remains deeply committed to ensuring the needs of these safety-net hospitals are a national priority.

Related Resources

[AHA Advocacy Alliance for Rural Hospitals](#)

[AHA Section for Small or Rural Hospitals](#)

[Factsheet: Rural or Small Hospitals](#)

[Rural Health Care Homepage](#)

[CAH Infographic](#)

Below are just some of the ways AHA works for CAHs.

Working for Critical Access Hospitals

Engaging Critical Access Hospital Leaders

Providing Key Resources

Working for Critical Access Hospitals

Outdated regulations, duplicative or conflicting rules, and unworkable timelines increase the burden on CAHs and draw much-needed resources away from quality patient care. The AHA works on your behalf to repeatedly demonstrate the need for streamlined regulations, common sense rules and manageable timelines, as outlined below.

- **Ensured Passage of Medicare SGR Legislation.** AHA worked with Congress to pass bipartisan legislation to replace the flawed Medicare physician sustainable growth rate (SGR) formula. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) contained extensions of several programs critical to small and rural hospitals, a two-year extension to the Children's Health Insurance Program, and modifications to the Civil

Penalties law to enable hospitals and physicians to better work together to improve care for patients. Included among these changes are extensions of the:

- Work Geographic Practice Cost Index for physicians until Jan. 1, 2018
- Therapy cap exceptions process until Jan. 1, 2018
- Ambulance add-ons for ground ambulance services and super-rural areas until Jan. 1, 2018
- Increased hospital payment adjustment for certain low-volume hospitals until Oct. 1, 2017
- Medicare-Dependent Hospital program until Oct. 1, 2017
- Medicare home health rural add-on until Jan. 1, 2018
- Partial enforcement delay of “two-midnight” policy until Oct. 1, 2015.

AHA is disappointed that payments for hospital care were used, in part, as an offset given that Medicare already pays less than the cost of delivering services to beneficiaries. Notably, the legislation also rejected a number of flawed policy options, such as reductions to outpatient hospital services (so-called “site-neutral” cuts); reductions to Medicare bad debt payments; changes to the CAH program; and further delays to the ICD-10 program.

- **Supported Critical Access Hospital Relief.** AHA shared its [support](#) for the *Critical Access Hospital Relief Act* (S. 258/H.R. 169), which would remove the 96-hour physician certification requirement as a condition of payment for CAHs.
- **Fostered Access to Outpatient Therapeutic Services.** The Centers for Medicare and Medicaid Services (CMS) removed its moratorium on Medicare contractors enforcing the agency’s policies related to its “direct supervision” requirement of outpatient therapeutic services furnished in CAHs and rural hospitals with 100 or fewer beds. AHA has worked with Congress to resolve this ongoing problem and supports the Protecting Access to Rural Therapy Services Act (S. 257/H.R. 1611), which would protect access to outpatient therapeutic services by adopting a default standard of “general supervision” among other provisions. Newly introduced, [S.1461](#) and [H.R. 2878](#) would extend through CY 2015 the enforcement delay on direct supervision requirements for outpatient therapeutic services provided in CAHs and rural PPS hospitals with 100 or fewer beds.
- **Encouraged Support for the 340B Drug Pricing Program.** AHA urged the House Energy and Commerce Health Subcommittee to preserve the 340B Drug Pricing Program. AHA continues to support the Health Resources and Services Administration’s (HRSA) efforts to improve the 340B program for eligible hospitals and clinics, including discounts for orphan drugs. In response to its detractors, AHA’s “Setting the Record Straight on 340B” fact sheet (<http://www.aha.org/content/14/340BFactvsFiction.pdf>) separates fact from fiction on the 340B program. AHA is preparing its rebuttal on the recent HRSA omnibus guidance on the 340B program that proposed revising the definition of patient eligibility and eliminating infusion services among other issues.
- **Testified and Organized Congressional Member and Staff Briefings.**
 - May 7: Senate Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies - [Rural Health](#)



- June 9: Coordinated a Congressional Staff Briefing on Rural Hospitals
- June 16: Senate Rural Health Caucus Briefing on Capitol Hill Panel
- June 24: Senate Finance Committee Markup on Rural Bills Panel
- July 22: U.S. House of Representatives Subcommittee on Health of the Committee on Ways and Means - [MedPAC Report](#)
- July 28: U.S. House of Representatives Subcommittee on Health of the Committee on Ways and Means - [Rural Health](#)
- **Tracked CMS Guidance on Distance, Location and Regulatory Changes.** CMS has sent a series of letters and transmittals to state survey agencies with revised guidance on recent regulation changes as well as clarifications and updates to existing guidance. AHA is tracking these closely and appraising their impact on CAH eligibility as well as sub-regulatory changes to conditions of participation.
- **Rebuked HHS OIG Work Plan and Reports.** A series of reports originating in the Department of Health and Human Services' Office of Inspector General (OIG) demonstrate an unfortunate lack of understanding of how health care is delivered in rural communities. The OIG consistently and inappropriately focuses on potential savings Medicare could realize through changes in CAH eligibility or payment, rather than the needs of individuals living in rural America. [AHA continues to strongly advocate](#) for maintaining the CAH program as it is currently structured in order to help ensure that all patients in rural communities have access to health care.
- **Promoted Flexibility in Health IT Reporting.** AHA worked with CMS to propose a shortened meaningful use reporting period for 2015 to a 90-day period aligned with the calendar year and to provide additional flexibilities, including reducing the share of patients that must use the patient portal from 5 percent to at least one patient.
- **Guided the Work of the Coalition to Protect America's Health Care.** The [Coalition](#) is a recognized leader in digital advocacy, forming through social media and online ads a grassroots army of more than 1 million individuals who communicate directly to Congress about the harm cuts in hospital payments could have on patient care.
- **Provided Resources via the [Rural 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.



A comprehensive list of AHA's work can be found at www.aha.org/value.

Engaging Critical Access Hospital Leaders

Critical access hospital leaders have a strong and valued voice in AHA. They help shape key advocacy activities, policy positions and member services of particular interest to CAHs through their active involvement in many forums.

- **Task Force and Meetings on Ensuring Access to Care in Vulnerable Communities.** The AHA Board has created a 30-member task force to focus on ensuring access to care

in at-risk communities. The Task Force on Ensuring Access in Vulnerable Communities consists of two subcommittees that will examine the issue from the rural and urban perspectives. The task force convened members in September 2015 to begin the work and plans to send a report to the AHA Board of Trustees in mid-2016. During that time frame field hearings will be held for broader member input.

- **Governance and Policy-Making Roles.** AHA offers CAH leaders many opportunities to take an active role in shaping AHA policies and setting direction for the association. CAH leaders 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 Constituency Section for Small or Rural Hospitals.](#)** This section has more than 1,600 members, including about 975 CAHs from across the country. It 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 CAHs 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 also are provided for CAH 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 [Advocacy Alliance for Rural Hospitals](#) focuses on extending Medicare provisions critical to CAHs and rural hospitals. In addition, the alliance continues to work to protect CAHs and other rural hospital designations. The [Advocacy Alliance for the 340B Drug Pricing Program](#) focuses primarily on preventing attempts to scale back this vital program and supports expansion of 340B discounts.
- **[AHA Health Forum 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 CAH 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 Critical Access Hospitals

AHA membership means more than representation on critical regulatory and legislative issues. AHA offers CAHs 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.

- **Enrollment Toolkit.** AHA's enrollment toolkit supports hospitals' efforts to help consumers enroll in the Health Insurance Marketplace. The toolkit contains links to key resources from AHA and other national and local organizations, as well as case examples from hospitals on their enrollment efforts. AHA's "Get Enrolled!" webpage, www.aha.org/GetEnrolled, is continually updated with resources to help hospitals connect their community to coverage.
- **Equity of Care.** Addressing disparities is essential for performance excellence and improved community health. AHA issued [goals and milestones](#) from the National Call to Action, launched in 2011 to end health care disparities and promote diversity, and encourages hospitals to take the [#123forEquity Pledge](#) to eliminate health care disparities.
- **Veterans Hiring Resource.** [Hospital Careers: An Opportunity to Hire Veterans](#) is a toolkit for hospitals with guidance on recruiting veterans into hospital careers. The resource aims to assist hospitals hire veterans with clinical experience, as well as talent and leadership skills beyond their medical credentials.
- **Cybersecurity Resource.** The AHA invites members to listen to a new cybersecurity audio-cast series, *Cyber 911: Responding to a Cybersecurity Breach*. By listening to four short dialogues, health care leaders can gain a better understanding of what preparations their organizations need to take to respond effectively when a cybersecurity breach occurs. Each part can be downloaded at www.aha.org/advocacy-issues/cyber911.shtml.
- **Policy Reports and Research.** AHA's Committee on Research develops the AHA research agenda, studies topics in depth, and reports findings to the AHA Board and the field. The committee 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.** AHA's [Hospitals in Pursuit of Excellence](#) 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.
- **RACTrac.** The AHA RACTrac website provides information on the recovery audit contractor (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 RACTrac 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.

