

## 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, limited workforce,

physician shortages and constrained financial resources with limited access to capital.

*The AHA is a tireless advocate working to ensure that the unique needs of our rural 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.*

### 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](#)

Working for Rural Hospitals

Engaging Rural Hospital Leaders

Providing Key Resources

## Working for Rural Hospitals

*Burdensome and often outdated regulations, duplicative or conflicting rules, and unworkable timelines are especially challenging for rural hospitals and draw much-needed resources away from quality patient care. Below are just some of the ways AHA continues to advocate for rural hospitals.*

- **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:

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

While AHA is disappointed that hospital cuts were used as a partial offset to MACRA, the legislation rejected a number of flawed policy options that would be harmful to hospitals, such as reduction to outpatient hospital services (so-called “site-neutral” cuts); reductions to Medicare bad debt payments; changes to the critical access hospital (CAH) program; and further delays to the ICD-10 program.

- **Backed Critical Access Hospital Preservation.** AHA continues to strongly [support](#) the Critical Access Hospital Relief Act (S. 258/H.R. 169). The bill would remove the 96-hour physician certification requirement as a condition of payment for critical access hospitals (CAHs). AHA also has vocally opposed federal budget proposals that would change the mileage criteria and would reduce Medicare reimbursements from 101 percent to 100 percent of costs for CAHs. A series of reports originating in the Department of Health and Human Services’ (HHS) Office of Inspector General (OIG) demonstrate an unfortunate lack of understanding of how health care is delivered in rural communities. AHA refuted the OIG reports and strongly advocated for maintaining the CAH program as it is currently structured. 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 or payment.
- **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.
- **Supported Innovation in Rural Hospital Payments.** AHA supports bipartisan legislation introduced in the House and Senate (H.R. 672/S. 607) to extend for five years the Rural Community Hospital Demonstration Program, which enables small rural hospitals with fewer than 51 acute care beds in 20 rural states to test the feasibility of cost-based reimbursement.

- Advocated for Significant Changes to the Recovery Audit Contractor Program.** H.R. 2156, the Medicare Audit Improvement Act of 2015 would make significant, fundamental changes to the Recovery Audit Contractor (RAC) program. The legislation would:
  - Eliminate the contingency fee structure
  - Reduce payments to RACs that are inaccurate in their audit determinations and have high appeals overturn rates
  - Fix the CMS' unfair rebilling rules
  - Require RACs to make their inpatient claims decisions using the same information the physician had when treating the patient
- Promoted Equity in Hospital Readmissions.** The Hospital Readmission Reduction Program (HRRP) requires CMS to penalize hospitals for “excess” readmissions when compared to “expected” levels of readmissions. America’s hospitals are strongly committed to reducing unnecessary readmissions. However, three years of experience with the HRRP shows that hospitals caring for the poorest patients are disproportionately more likely to incur a penalty. AHA supports the Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2015 (S. 688/H.R. 1343) to ensure that hospitals caring for our nation’s most vulnerable patients are not unfairly penalized under the HRRP.
- 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](#)
- Opposed Site-Neutral Payment Policies.** Misguided site-neutral policies for hospital outpatient departments fail to recognize the unique and critical role hospitals play in their communities, such as providing 24/7 access to care, disaster and readiness response, and acting as the safety net for their communities.



- **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 five percent to at least one percent.
- **Facilitated Improved Health Care Access for Veterans.** The Veterans Choice Program (VCP) allows qualifying veterans to elect to receive hospital care and medical services from non-Veterans Affairs (VA) entities and providers when a veteran lives more than 40 miles away from or cannot be seen within 30 days at a VA facility. In written comments to the U.S. Department of Veterans Affairs, AHA expressed concern that the VA's interpretation of the 40-mile criterion unreasonably restricts many veterans' ability to access health care and offered suggestions for improving the program with respect to the mileage requirement, timely payment of claims and contracting to provide care. The VCP will now use driving distance to determine the distance between a veteran's residence and the nearest VA medical facility. Non-VA medical care providers may participate in the VCP by joining the Patient-Centered Community Care Network or by signing a provider agreement with Health Net Federal Services or TriWest Healthcare Alliance. For more information, the Veterans Choice website is: [www.va.gov/opa/choiceact](http://www.va.gov/opa/choiceact).
- **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.
- **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 one million individuals who communicate directly to Congress about the harm cuts in hospital payments could have on patient care.



A comprehensive list of AHA's work can be found at [www.aha.org/value](http://www.aha.org/value).

## 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.*

- **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.** The AHA offers rural hospital leaders many opportunities to take an active role in shaping AHA’s public policy positions and setting direction for the association. These opportunities include serving on 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 and comprises CEOs from critical access, small and rural hospitals. 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 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 also are provided for rural hospital leaders to interact and network with one another through special member conference calls and meetings.
- **[Advocacy Alliances](#).** 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 Discount Program](#) focuses primarily on preventing attempts to scale back this vital drug discount 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 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.*

- **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 “Get Enrolled!” webpage

([www.aha.org/GetEnrolled](http://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 in hiring veterans with clinical experience, as well as talent and leadership skills beyond their medical credentials.
- **Cybersecurity Resource.** 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](http://www.aha.org/advocacy-issues/cyber911.shtml).
- **Policy Reports and Research.** 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. Together with the Committee on Performance Improvement, COR released a report examining the changing health care landscape and the role trustees and community leaders can play to help guide hospitals during this time of change. The report includes a toolkit for initiating community conversations and engaging trustees in the redefinition of the "H." 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 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.

