CAH UPDATE

Harlan County Hospital
Alma, NE

Madelia Community Hospital & Clinic
Madelia, MN

Summer 2017

The American Hospital Association (AHA) is a tireless advocate working to ensure that the unique needs of our 1,000 critical access hospital (CAH) members are a national priority. This issue of the CAH Update reviews Hill action on efforts to repeal and replace the Affordable Care Act (ACA), reviews the federal budget, identifies AHA's advocacy agenda and outlines recent rulemaking and regulatory policy concerns effecting CAHs.

AHA Rural Hospital Leadership Award

American Hospital Association
Section for Small or Rural Hospitals
Rural Hospital Leadership Award

The AHA Rural Hospital Leadership Award is sponsored by the Section for Small or Rural Hospitals. The award recognizes small or rural hospital chief executives and administrators who have achieved improvements in local health delivery and health status through their leadership and direction. The award offers professional development and educational opportunities to outstanding small or rural hospital chief executives and includes a **$1,500 stipend** to offset the cost of attending an AHA educational program. The Rural Hospital Leadership Award applications are due on Aug. 18.

HILL ACTION ON THE AFFORDABLE CARE ACT

From the onset of the debate to repeal and replace the ACA, America's hospitals and health systems have been guided by a set of key principles that would protect coverage for

Americans. Unfortunately, legislation put forward by Congress so far moves in the opposite direction, particularly for our most vulnerable patients.

Rural communities would be especially hard hit by this legislation because rural regions tend to have sicker patients and more costly care, the need for access to coverage – both Medicaid and availability through the marketplace – is especially important. Many rural hospitals have a higher-than-normal percentage of Medicaid patients and lower-than-normal percentage of employer-based health covered patients and expected cuts to the program could adversely affect facilities – perhaps to the point of closure for some.

Senators July 28 voted 49-51 against the Health Care Freedom Act, a "skinny" bill to repeal parts of the ACA. Senators earlier rejected two amendments – the Better Care Reconciliation Act, which would have repealed and replaced parts of the ACA, and the Obamacare Repeal Reconciliation Act, which would have repealed parts of the ACA without replacement. Senate Majority Leader Mitch McConnell (R-KY) has pulled repeal legislation from consideration after the vote.

Our commitment to fighting for those critical objectives remains unchanged. The Senate's vote provides not a victory for one side or a loss for the other, but rather a new opportunity to reset and regroup. Working together, both parties in both chambers, should utilize this opportunity to fix the very real problems facing our health care system. The Senate vote shouldn't mark the conclusion of the debate but should serve as a catalyst to restart it in a bipartisan manner. Ultimately, any changes to the ACA must ensure the continuity of access and coverage for all who currently have it.

Please visit AHA's special advocacy resource page for a summary of legislative action, analysis and other advocacy tools and resources. To support our grassroots efforts and lobbying on Capitol Hill, the Coalition to Protect America's Health Care, of which the AHA is a founding member, ran TV, radio, and digital advertising reinforcing the need to protect coverage.

THE FEDERAL BUDGET

Federal Debt Ceiling

Recently, the Office of Management and Budget Director Mick Mulvaney told the House Budget Committee that tax receipts are coming in more slowly than expected and Treasury Secretary Steven Mnuchin is urging Congress to increase the debt ceiling. The debt limit was reinstated in March, but the Treasury Department is currently using "extraordinary measures" to avoid a devastating government default.

FY 2018 Budget

President's Request

President Trump recently submitted to Congress his budget request for FY 2018. The budget request, which is not binding, proposes savings of $627 billion over 10 years, of

which $610 billion is attributable to the request's Medicaid reform proposal. The budget also assumes $250 billion in savings from the repeal of the Affordable Care Act (ACA). The budget request would not make any direct reductions to Medicare funding. The budget request would extend the Children's Health Insurance Program funding through FY 2019, while calling for $5.8 billion in additional savings from program funding over the two-year window.

The AHA is deeply disappointed that the president's budget for FY18 eliminates funding for the National Health Service Corps and the graduate medical education (GME) payments to Teaching Health Centers. Failing to fund these important programs will further exacerbate the challenge of addressing workforce and physician shortages in rural communities. Additionally, we are disappointed to see reductions in funding for other rural health programs, including reduced funding for telehealth ($17M in FY17 to $10M in FY18) and the elimination of funding for Rural Hospital Flexibility Grants, which provides support for a range of activities focusing on critical access hospitals. Find more information on the White House's budget request in AHA Special Bulletin.

House Budget Resolution

The House Budget Committee approved House Concurrent Resolution 71, draft legislation that would provide $156 billion in discretionary funding for the departments of Labor, Health and Human Services, and Education in fiscal year 2018, $5 billion less than in FY 2017. According to a committee summary, the draft bill would provide $77.6 billion for HHS, $542 million less than last year but $14.5 billion more than the president's budget request. The proposal would increase funding for the National Institutes of Health by $1.1 billion and reduce funding by $398 million for the Health Resources and Services Administration, $306 million for the Substance Abuse and Mental Health Services Administration, $219 million for the Centers for Medicare & Medicaid Services, $198 million for the Centers for Disease Control and Prevention, and $24 million for the Agency for Healthcare Research and Quality. The House will be voting on its long-delayed budget resolution at the start of September.

Majority Leader Kevin McCarthy announced that the House will vote on a measure that includes just four of the 12 bills needed to fund the federal government – House Resolution 473 – providing for consideration of the bill (H.R. 3219) making appropriations for the Department of Defense for the fiscal year ending September 30, 2018, and for other purposes. That decision comes after GOP leaders failed to get enough Republican support to pass the full dozen without the help of their minority-party counterparts. The so-called "minibus" or "security-bus" will include measures that would fund the Pentagon and Department of Veterans Affairs, as well as the Legislative Branch, the Energy Department and water projects.

AHA REPRESENTATION AND ADVOCACY

Hospitals are transforming the way health care is delivered in their communities, working with other providers and community leaders to build a continuum of care to make sure every

individual gets the right care at the right time in the right setting. In order to continue this transformation, and to provide patients with the access to care they need and expect, hospitals need a supportive and modernized public policy environment. Below are some of the key areas of focus for AHA's 2017 advocacy agenda.

2017 Advocacy Agenda

In 2017, AHA is working with Congress urging them to:

- Extend funding for the Children's Health Insurance Program (CHIP), which covered roughly 5.6 million children as of February. Without an extension, states will start running out of federal funds in October, with the majority of states exhausting their money between January and March, according to the Medicaid and CHIP Payment and Access Commission.
- Reject reductions in Medicare funding for indirect medical education and direct Graduate Medical Education (GME) and pass the Resident Physician Shortage Reduction Act (S. 1301/H.R. 2267), which would increase the number of Medicare-funded residency positions.

Rural Hospital Advocacy Agenda

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. AHA's advocacy agenda for rural hospitals targets several priorities. Key areas of focus for rural hospitals and CAHs are included in the AHA's 2017 rural advocacy agenda.

- Pass S. 1130, the Rural Emergency Acute Care Hospital (REACH) Act, which would allow CAHs and small rural hospitals with 50 or fewer beds to convert to rural emergency hospitals and continue providing necessary emergency and observation services (at enhanced reimbursement rates); but stop inpatient services. The legislation also provides enhanced reimbursement rates for the transportation of patients to acute care hospitals in neighboring communities.
- Pass the Rural Hospital Regulatory Relief Act of 2017 (S. 243/H.R. 741), to make permanent the enforcement moratorium on CMS's "direct supervision" policy for outpatient therapeutic services provided in CAHs and small, rural hospitals.
- Pass the Rural Hospital Access Act of 2017 (S. 872/H.R. 1955), to permanently extend the Medicare-dependent hospitals and enhanced low-volume adjustment programs.
- Pass the Medicare Ambulance Access, Fraud Prevention, and Reform Act of 2017 (S. 967), to permanently extend the ambulance add-on payment adjustment.
- Pass the Medicare Access to Rehabilitation Services Act of 2017 (S. 253/H.R. 807), to repeal the outpatient rehabilitation therapy caps.

- Pass the Telehealth Innovation and Improvement Act (S. 787), to allow eligible hospitals to test offering telehealth services to Medicare patients and evaluate these services for cost, effectiveness and quality of care.
- Pass the Conrad State 30 and Physician Access Reauthorization Act (S. 898/H.R. 2141), which extends and expands the Conrad State 30 J-1 visa waiver program, which allows physicians holding J-1 visas to stay in the U.S. without having to return home if they agree to practice in a federally-designated underserved area for three years.

RULEMAKING AND REGULATORY POLICY

Medicare policy changes and payment adjustments often have significant and problematic consequences for rural providers. AHA is sensitive to the administrative burden and cost created by rules that fail to consider the unique circumstances of small or rural community hospitals. Recent policy changes are reviewed for their impact on the delivery of care in rural communities.

Rulemaking

Inpatient PPS Payment Update

CMS on August 2 issued its hospital IPPS final rule for FY 2018.The final rule would increase IPPS rates by 1.2 percent in FY 2018, after accounting for inflation and other adjustments required by law. The final rule effectively terminates the programs buoyed by the Medicare extenders as well as outlines some promising proposals intended to reduce regulatory barriers for hospitals, health systems and the patients they serve, such as on the CAH 96-hour rule, electronic clinical quality measures (eCQMs) and the electronic health record (EHR) incentive program.

Highlights of the final rule include:

- In this rule, CMS states that it reviewed the CAH 96-hour certification requirement to determine if there are ways to reduce its burden on providers. As a result, the agency states that it will direct Quality Improvement Organizations (QIOs), MACs, the Supplemental Medical Review Contractor (SMRC) and Recovery Audit Contractors (RACs) to make the requirement a low priority for medical record reviews conducted on or after Oct. 1, 2017. This means that, absent concerns of probable fraud, waste or abuse of the coverage requirement, these contractors will not conduct medical record reviews to determine compliance with the CAH 96-hour certification requirement. The AHA will continue to advocate for a legislative solution that permanently removes the 96-hour physician certification requirement as a condition of payment for CAHs. The AHA will continue to advocate for a legislative solution that permanently removes the 96-hour physician certification requirement as a condition of payment for CAHs.
- Terminates Medicare-dependent hospital (MDH) program as of October 1 (per MACRA and subject to any further Congressional extension)
    - CMS estimate: 96 of 158 current MDHs lose $119 million

    - The AHA will continue to advocate for a legislation extension of this program and supports the **Pass the Rural Hospital Access Act of 2017** (S. 872/H.R. 1955), to permanently extend the Medicare-dependent hospital program.
- Terminates temporary expansion of low-volume hospital (LVH) adjustment (per MACRA and subject to any further Congressional extension)
    - Reinstates pre-ACA 25% LVH adjustment for hospitals >25 miles from like hospital and <200 discharges
    - Decreases LVH payments by $311 million from FY 2017 to 2018
    - The AHA will continue to advocate for a legislation extension of this program and supports the **Pass the Rural Hospital Access Act of 2017** (S. 872/H.R. 1955), to permanently extend the enhanced low-volume adjustment program.
- CMS finalizes its proposal to, in FY 2018, begin a three-year phase in of incorporating hospitals' Worksheet S-10 data into the methodology for determining uncompensated care payments. CMS will continue to use data from a rolling three-year period to estimate uncompensated care costs. CMS indicated that it will continue to work with stakeholders to address issues related to the accuracy and consistency of the S-10 data through provider education and refinement of the instructions for the Worksheet S-10. We are disappointed CMS chose to implement the Worksheet S-10 data in FY 2018.
- The 21st Century Cures Act extended the Rural Community Hospital Demonstration for an additional five years and expanded the program to rural areas in all states. CMS has not yet finalized the selection of additional participants to participate in the demonstration. The performance period for previously participating hospitals will begin immediately after the date the period of performance under the first five-year extension period ended.

AHA submitted detailed comments to CMS on its response to the request for information on CMS flexibilities and efficiencies. A Special Bulletin is available for reference.

Outpatient PPS Payment Update

CMS has published its proposed rule to update Medicare Hospital Outpatient Prospective Payment System (OPPS) rates and policies for calendar year (CY) 2018. In addition to proposing rate updates, CMS solicits comments on a wide range of topics including deep OPPS reimbursement cuts for drugs obtained through the 340B drug discount program. CMS includes a "Request for Information on CMS Flexibilities and Efficiencies," as it has in other proposed Medicare payment rules this year. Specifically, CMS is seeking suggestions for ways the Administration can made improvements to the health care delivery system that reduce unnecessary burdens, increase quality of care, and lower costs. CMS will accept comments on the proposed rule until September 11, 2017.

Highlights of the proposed rule include:

- Increases aggregate OPPS payments for CY 2018 by 1.9 percent, or $897 million, compared to CY 2017, including the outpatient department (OPD) fee schedule increase (1.75 percent) and $26.2 million in pass-through spending on drugs, biologicals and devices

- Maintains the 7.1 percent payment adjustment for OPPS services and procedures performed at sole community hospitals (SCHs) located in rural areas
- Reinstates non-enforcement of direct supervision requirement for outpatient therapeutic services for CAHs and small rural hospitals with 100 or fewer beds for CYs 2018 and 2019:
    - Reduces regulatory burden and allows more time for rural providers to comply with supervision requirements and/or submit specific services to the Advisory Panel on Hospital Outpatient Payment for recommended changes in supervision level
- Continues implementation of the frontier floor policy for hospital outpatient departments and community mental health clinics (CMHC), which requires a frontier state wage index of at least 1.00
- Ends the 3-year transition in wage index for rural hospitals and CMHCs formerly designated as urban
- Reduces Medicare Part B reimbursement for separately payable drugs from average sales price plus 6 percent (ASP+6%) to ASP-22.5% (budget neutral), likely reducing drug payments by as much as $900 million for hospitals participating in the 340B program and increasing payments to other non-drug OPPS items and services by 1.4 percent
    - Does not affect CAHs as they are not paid under OPPS
    - Effective January 1, 2018, CMS proposes required use of a new claims modifier for drugs not purchased under 340B to gather more information on the true costs of drug acquisition
    - 22.5 percent is the MedPAC estimate of the average minimum discount received by 340B-participating hospitals
    - CMS solicits comment on: (1) whether Medicare should require 340B-participating hospitals to report their drug acquisition costs in addition to charges for each drug on the claim, (2) whether exceptions should be granted to certain groups of hospitals (e.g., SCHs, PPS-exempt cancer hospitals) due to access to care issues, (3) whether other types of drugs should also be excluded from reduced payment (e.g., blood clotting factors, orphan drugs, etc.) and (4) whether hospital-owned or –affiliated ASCs have access to 340B-discounted drugs
    - Please view the AHA Member Advisory. AHA will host a members-only webinar Aug. 15 at 2 p.m. ET to discuss the proposed rule, including provisions related to the 340B Drug Pricing Program.
- Announces a new searchable website comparing estimated payment and copayment amounts for items and services paid under the OPPS and ASC payment system, per the 21st Century Cures Act
- For 2018, CMS finalized modifications to the EHR Incentive Program. Hospitals and critical access hospitals will have the option to report modified stage 2 for the 2018 reporting period. CMS also finalized a reduction in the 2018 EHR reporting period from the full year to a minimum of any continuous 90-day period during the calendar year.
- Solicits ideas from the public for regulatory, sub-regulatory, policy, practice and procedural changes to reduce unnecessary burdens for clinicians, other providers, and patients and their families while also increasing quality of care, lowering costs,

improving program integrity and making the health care system more effective, simple and accessible, particularly as related to incentivizing screening, assessment, and evidence-based treatment for individuals with opioid use disorder and other substance use disorders
- Proposes regulatory language to conform to a policy adopted last year to implement a reduction in reimbursement for film X-rays. CMS also proposes to implement a statutory requirement that CMS reduce the OPPS payment for the technical component of an X-ray taken using computed radiography technology. The reduction equals 7% during 2018 through 2022, with a 10% reduction applicable beginning in 2023. These provisions apply to only OPPS and PFS not CAHs.

Physician Fee Schedule Update

The CMS notice of proposed rulemaking for the physician fee schedule (PFS) was released July 13 and proposes to make significant additional site-neutral cuts in payment for services furnished in off-campus provider-based departments (PBDs) of a hospital that began billing under the OPPS on or after November 2, 2015. Comments are due by Sept. 11. See the AHA Regulatory Advisory for details.

Highlights of the proposed rule include:
- Further reduces payments to off-campus PBDs for items and services now excluded from the OPPS in alignment with Section 603 "site-neutral payment" requirements. This most recent change would further reduce the PFS Relativity Adjuster to 25 percent (from 50 percent) of the amount that would have been paid under the OPPS.
- Creates a general care management bundled code for RHCs/FQHCs with one payment amount for CCM and behavioral health integration services and another for the psychiatric Collaborative Care Model.
- Proposes payment and policy updates for Medicare Diabetes Prevention Program including use of virtual MDPP services in the limited case of make-up sessions.
- Expand payment for telehealth services to include psychotherapy for crisis, health risk assessments, care planning for chronic care management, and counseling visit to determine low-dose computed tomography eligibility;

FCC Rural Health Care Program

The Federal Communication Commission should update its Rural Health Care Program to meet the growing demand for broadband telehealth services, the AHA said in comments submitted recently. Specifically, AHA recommends the program increase the Healthcare Connect Fund and HCF discount percentage; reduce administrative burden; support consortium administrative expenses and remote patient monitoring; and reconsider how it defines an eligible rural area. The comments were submitted in response to a public request for comments on how to accelerate access to broadband-enabled health care solutions in rural and other underserved areas.

AHA also is working with the FCC through its listening sessions on broadband. The Connect2Health Task Force is soliciting input from stakeholders regarding regulatory policy,

technical and infrastructure issues the emerging “broadband-enabled health care ecosystem.”

Visit AHA’s telehealth web site and fact sheet for additional information. For more resources on telehealth, including case studies and research reports, visit *www.aha.org/telehealth*.

MACRA Proposed Rule

On June 30 CMS issued a proposed rule updating the requirements of the quality payment program (QPP) for physicians and other eligible clinicians mandated by the Medicare Access and CHIP Reauthorization Act of 2015. The QPP includes two tracks – the default Merit-based Incentive Payment System and advanced alternative payment models. The rule proposes what eligible clinicians must report for the QPP's 2018 performance period, which will affect eligible clinicians' payment under the Medicare physician fee schedule in calendar year 2020.

Highlights of the proposed rule include:

- Increases the low volume threshold to exclude individual MIPS eligible clinicians or groups with ≤$90,000 in Part B allowed charges or ≤200 Part B beneficiaries. These changes likely would exclude a significant number of clinicians in Health Professional Shortage Areas (HPSA), rural and small practices. The proposed rule solicits comment on allowing MIPS excluded clinicians to opt-in in future years so they can be eligible for payment adjustments.
- Allows FQHCs and RHCs that voluntarily report to opt-out of sharing their data on Physician Compare. FQHCs and RHCs are exempt from participating if they choose. Method II CAHs are required to participate in the MIPS if above the low volume threshold.
- Adds Virtual Groups as participation option for year 2 -- solo practitioners and groups of 10 or fewer eligible clinicians can band together to participate in the MIPS if they meet certain administrative requirements by Dec. 1, 2017.
- Awards 5 bonus points to the final score of individual clinicians and small group practices (15 or fewer clinicians) that participate in at least one category of the MIPS.
- Proposes to allow facility-based eligible clinicians, including those practicing in rural hospitals, to convert their hospital’s Total Performance Score under the Hospital Value Based Purchasing Program into a MIPS Quality performance category and Cost performance category score.
- Makes change to the performance period and weight to final MIPS score:
    - Quality and Cost: 12-month calendar year performance period, and proposed continuation of 60% weight for quality and 0% weight for cost in final score in 2020, and
    - Advancing Care Information and Improvement Activities: 90 days minimum performance period.
- CMS proposes to continue most of the CY 2017 policies for the advanced APM track into CY 2018. The agency also proposes to implement an “Other Payer Advanced APM Determination Process” allowing clinicians, APM entities and

payers to obtain approval for Medicaid, Medicare Advantage and multi-payer models to qualify as advanced APMs.

CMS is accepting applications for 2017 hardship exceptions to the QPP's Advancing Care Information performance category. Clinicians eligible to participate in the QPP's MIPS may apply for hardship exceptions due to insufficient internet connectivity, "extreme and uncontrollable" circumstances, or lack of control over the availability of certified electronic health record technology. MIPS-eligible hospital-based clinicians are considered special status and do not need to apply for a 2017 hardship exception. For more information or to apply for a hardship exception, visit https://qpp.cms.gov/about/hardship-exception.

AHA is encouraged by CMS's proposal for a facility-based clinician reporting option, and applauds the agency's proposal to extend the use of modified stage 2 meaningful use requirements through 2018. AHA will encourage CMS to provide the same relief to hospitals. See the AHA Special Bulletin, Regulatory Advisory, and MACRA website. For more information. CMS's Quality Payment Program website has additional resources.

Health Care Policy and Regulatory Guidance

Guidance on Shared Space

CMS is working to finalize updated guidance related to co-location, which should clarify policies governing how hospitals can share space with other providers, the agency told the AHA recently. AHA has been urging CMS to provide more transparency about the agency's expectations for shared space and to allow for flexibility where needed and appropriate, especially for rural areas where hospitals may have visiting specialists. We continue to appreciate CMS's openness to hearing our concerns. We have asked CMS to make this guidance a priority and to align its policies as much as possible with the agency's broader mission to promote coordinated, patient-centered care across the continuum.

Bundled Payment Programs

The rules for the new Episode Payment Models (EPMs) for cardiac care and expanded Comprehensive Care for Joint Replacement (CJR) model are January 1, 2018. Hospitals in selected metropolitan areas will begin the new EPM bundles for heart attack and coronary bypass, including incentive payments for cardiac rehabilitation, and CJR will be expanded to include hip fracture surgeries. Although most rural hospitals will not participate in the bundles as the site of cardiac care or orthopedic surgery, rural hospitals may collaborate with EPM or CJR participants as providers of post-acute care.

Clinical Decision Support (CDS) Mandate under the Physician Fee Schedule

In the Protecting Access to Medicare Act of 2014, Congress included a mandate ordering providers to consult appropriate use criteria via electronic CDS when ordering outpatient advanced imaging exams for Medicare patients. Jan. 1, 2018 is the deadline for referring providers to begin consulting CDS when placing advanced outpatient imaging orders, and for furnishing providers to submit documentation of CDS use on Medicare claims for reimbursement.

EHR Incentive Program

CMS recently finalized rules making some needed changes to the program to increase flexibility in the short term. Unfortunately at the same time, it also finalized rules raising the bar on meaningful use requirements yet again with Stage 3 requirements that are required in 2018. These rules contain provisions that are challenging, if not impossible, to meet and require use of immature technology standards. AHA urges CMS to cancel Stage 3 of meaningful use by removing the 2018 start date from the regulation, and gather input from stakeholders on ways to further reduce the burden of the meaningful use program requirements.

Reducing Rx Drug Prices

The high cost of prescription drugs is putting a strain on Medicare, Medicaid and the entire health care system including patients. The AHA has been working with a number of stakeholders including the Campaign for Sustainable Rx Pricing, to raise awareness of and develop policy solutions to combat the problems caused by drug price increases.

Access to Care in Vulnerable Communities

In 2016, an AHA task force released its report on Ensuring Access to Care in Vulnerable Communities, which offers hospital and health system leaders nine innovative ways to preserve access to essential health services in vulnerable communities. These nine strategies are:

1. Addressing the social determinants of health
2. Global budgets
3. Inpatient/outpatient transformation strategy
4. Emergency medical centers
5. Urgent care centers
6. Virtual care strategy
7. Frontier health system
8. Rural hospital-health clinic strategy
9. Indian health service strategy

Successful implementation of these emerging strategies by vulnerable communities is dependent on numerous public policy changes. As such, AHA is developing the specific legislative and regulatory changes that are necessary to enable their implementation. We are advocating that policy makers make such changes a priority so that hospitals and health systems can better ensure access to care in vulnerable urban and rural communities.

Relationship building and open communication will be vital as you consider the strategies included in the task force report. AHA has developed a "Community Conversations Toolkit," designed to help you begin to engage in discussions related to the health care services offered in your community. This toolkit provides ways in which you can broadly engage your community through community conversations events, social media and use of the community health assessment. It also provides ways in which to focus your engagement on specific stakeholders – including patients, your board and clinicians.

The AHA will continue to release new tools and resources that will facilitate these community conversations as well as help you evaluate whether the task force's nine strategies are the right answer for ensuring access to essential health care services in your community. These resources will be available at *www.aha.org/EnsuringAccess*.

Visit the Section for Small or Rural Hospitals web site at http://www.aha.org/smallrural

For more information, contact John Supplitt, senior director, AHA Section for Small or Rural Hospitals, at (312) 422-3306 or jsupplitt@aha.org.