AHA Small or Rural Hospitals
Advocacy Agenda – 2009

Low-volume PPS hospitals

National payment policies, specifically prospective payment systems (PPS), often fail to recognize the special characteristics and unique circumstances of small rural hospitals. Many rural hospitals are too large to qualify for CAH status, but too small to absorb the financial risk associated with PPS programs. AHA has and will continue to advocate for relief on behalf of low-volume small or rural PPS hospitals.

Craig Thomas Rural Hospital and Provider Equity Act (R-HoPE), S. 1157
- Provides a low-volume adjustment for rural PPS hospitals with fewer than 2000 Medicare inpatient discharges
- Extends the outpatient hold-harmless provision for SCHs and rural hospitals with < 100 beds
- Provides a 5% add-on for 2 years for Medicare rural home health payment
- Extends Section 508 wage index re-classification
- Allows direct payments to independent labs for the tech component of path services
- Removes the DSH cap for rural hospitals
- Improves payments for ambulance services in rural areas

The Rural Hospital Assistance Act, H.R. 362, Reps. Boswell (D-IA) and Emerson (R-MO)
- Provides a PPS inpatient payment adjustment for low-volume rural hospitals having less than 1,500 Medicare inpatient discharges
- Provides for the use of the non-wage adjusted PPS rate under the MDH program
- Eliminates the Medicare hospital exception for physician-owned hospitals, but provides a limited exception for existing facilities

The Medicare Rural Health Access Improvement Act, S. 318, Sen. Grassley (R-IA)
- Provides a PPS inpatient payment adjustment for low-volume rural hospitals having less than 2,000 Medicare inpatient discharges
- Extends Medicare FLEX Grants
- Improves MDH Program payments to the hospital without regard to any adjustment for different area wage levels
- Extends and expands the Medicare hold-harmless for outpatient PPS and SCH adjustment
- Allows direct Medicare payments to independent labs for the tech component of path services
- Extends the rural ground ambulance bonus
- Improves payment to RHCs at $92 per visit
- Exempts DME suppliers in small MSAs and rural areas

The 340B Program Improvement and Integrity Act, H.R. 444, Reps. Rush (D-IL), Stupak (D-MI), and Emerson (R-MO)
- Extends the 340B drug discount pricing program to include inpatient drugs
- Expands eligibility to include rural CAH, MDH, SCH and RRC

The Rural Community Hospital Demonstration Extension Act, S. 1279, Sens. B. Nelson (D-NE), Begich (D-AK), Dorgan (D-ND), R. Bennett (R-UT), Hatch (R-UT), Johanns (R-NE), T. Johnson (D-SD), Murkowski (R-AK), Tester (D-MT) and Thune (R-SD). H.R. 3256, A. Smith (R-NE) and D. Young (R-AK)
- Extends the current demonstration an additional 5-years
- Expands the demonstration to include eligible hospitals located in rural areas in any State
- Increases the number of demonstrations to not more than 30 eligible hospitals

The Conrad State 30 Improvement Act, S. 628, Sen. Kent Conrad (D-ND)
- Permanently reauthorizes the Conrad State 30 Program
- Offers flexibility to the distribution of the annual per-state cap of 30
- Extends eligibility to H1-B physicians practicing in MUAs/HPSAs

Other Advocacy Priorities
- Reinstate CAH necessary provider status