American Hospital Association

Strong Hospitals
RURAL HEALTH
Strong Communities

The AHA supports policies and legislation that enable rural hospitals to care for their communities. Below are some of the key areas of focus for our 2017 advocacy agenda.

PROMOTE REGULATORY RELIEF

- Direct supervision. Pass the *Rural Hospital Regulatory Relief Act of 2017* (S. 243/H.R. 741), to make permanent the enforcement moratorium on CMS' "direct supervision" policy for outpatient therapeutic services provided in critical access hospitals (CAHs) and small, rural hospitals.
- 96-hour physician certification. Remove the 96-hour physician certification requirement as a condition of payment for CAHs. These hospitals would still be required to satisfy the condition of participation requiring a 96-hour annual average length of stay.
- IT and meaningful use. Urge CMS to modify the meaningful use rules by allowing providers meeting 70 percent of the requirements to be designated as having met meaningful use. Advocate for HHS to cancel Stage 3.
- Medicare physician payment (MACRA). Urge CMS to implement the new payment system in a way that measures providers fairly, minimizes unnecessary data collection and reporting burden, focuses on important quality issues and promotes collaboration across the health care delivery system.
- Bed size. Provide bed size flexibility for CAHs.
- Care coordination. Update outdated regulations included in the "Stark" and Anti-Kickback laws to allow for clinical integration of patient care and better coordination between hospital and physician providers.
- Rulemaking. Ensure the unique circumstances of rural hospitals are accounted for in the rulemaking process.
- MedPAC. Ensure representation for rural health care on the Medicare Payment Advisory Commission.

SECURE THE FUTURE OF CRITICAL RURAL PROGRAMS AND POLICIES

- MDH and low-volume adjustment. Extend the Medicare-dependent hospitals (MDH) and enhanced low-volume adjustment programs.
- Ambulance add-on payment. Extend the ambulance add-on payment adjustment.
- Therapy cap. Exempt CAHs from the cap on outpatient therapy services. Extend the outpatient therapy exception process (and oppose the expansion of the cap to services provided in the outpatient departments of hospitals and CAHs).

PROTECT PATIENT ACCESS TO CARE

- Telehealth. Expand Medicare coverage and payment for telehealth and provide resources for additional study of the cost-benefit of telehealth.
- 340B Program. Preserve the 340B Drug Pricing Program and oppose attempts to scale back this vital program.
- Behavioral Health. Improve access to services, address workforce issues; and reduce the stigma associated with mental health and substance abuse.
- CAH designation. Maintain CAH designation, as currently defined.
- Medicare DSH. Relieve hospitals from cuts to Medicare disproportionate share hospitals.
- CAH payments. Ensure CAHs are paid at least 101 percent of costs by Medicare and are paid at least the same by Medicare Advantage plans.
- IPAB. Exempt CAHs from the Independent Payment Advisory Board.
- Provider taxes. Allow hospitals to claim the full cost of provider taxes as allowable costs.