

NRHA's Government Affairs Team spent countless hours educating policymakers on the issues important to rural America. Despite the challenging political atmosphere in DC, NRHA won significant legislative and regulatory reforms.

APPROPRIATIONS

The L-HHS funding bill included record funding for the rural health safety net and created opportunities for innovation and development.

FARM BILL

For the first time in the Farm Bill's history, the legislation included an entire section on rural health. Included in the bill were provisions to create a new Rural Health Liaison at the USDA, address the opioid epidemic, and enable rural hospitals to better access and utilize USDA loans.

OPIOID LEGISLATION

Congress passed the SUPPORT for Patients and Communities Act, which included most of NRHA's requests, making hundreds of millions of dollars available to rural communities.

MATERNITY CARE

Congress passed the Improving Access to Maternity Care Act, which identifies geographic maldistribution of maternity care providers. The bill was signed into law.

STATE OFFICES OF RURAL HEALTH

Congress passed legislation funding the offices through 2022 with bipartisan support, and the bill was signed into law.

NRHA TESTIMONY

NRHA testified before the Ways and Means and Finance Committees, providing a rural perspective to key policy conversations. NRHA also attended the White House's Opioids and Telehealth Summits to educate the Administration on rural health priorities.

FCC RURAL PROGRAM

The FCC approved a new \$100-million "Connected Care Pilot Program" to support telehealth for rural Americans.

CAH 35-MILE RULE

When CMS considered changing the 35-mile distance requirement for Critical Access Hospitals to consider provider-based clinics "like hospitals" within the mileage range, NRHA stopped the agency from moving forward with this very harmful change.

LOW-VOLUME HOSPITAL-INDIAN HEALTH SERVICE FACILITY PROXIMITY FIX

NRHA fought for a correction to allow rural hospitals to be eligible for the Medicare inpatient LVH adjustment regardless of their proximity to an IHS facility because they provide care to limited service groups.

340B EXEMPTION FOR SOLE COMMUNITY HOSPITALS

SCHs were exempt from a 28% cut to the reimbursement for Part B drugs. The final regulations included sections directly from NRHA's comment letter.

DEPRIORITIZATION OF 96-HOUR RULE AND THERAPY SUPERVISION REQUIREMENTS

NRHA worked to ensure that enforcement of the 96-Hour Rule was deprioritized and fought for a two-year moratorium on therapy supervision requirements. We are continuing to ask for a permanent fix to these two issues.

HOSPITAL STAR RATINGS

The majority of facilities that do not meet star rating requirements are CAHs, because CMS has not created rural metrics. Consumers often interpreted greyed-out stars to be low quality, rather than un-rated, but due to NRHA's advocacy, CMS eliminated grey stars.

A split Congress can create challenges, but NRHA's Government Affairs Team will fight to ensure that rural health issues are bridge issues where Democrats and Republicans can find common ground and make change happen.

LEGISLATIVE PRIORITIES

- Stop the flood of rural provider closures
- Development of programs that support the growth of the rural health workforce
- Support of rural telehealth programs, including funding and regulatory changes that will increase accessibility and affordability
- Reform of rural health care programs included in the Affordable Care Act that have had unintentional negative effects on rural America
- Secure and robust funding for rural health programs with long-term reauthorizations in the Labor-Health and Human Services Appropriations Package
- Inclusion of health care programs in a larger infrastructure package, reinforcing the role of rural providers in the rural economy
- Further improvements to policies to expand access to maternity care, oral health, and veterans care

REGULATORY PRIORITIES

- Common-sense fixes for the "exclusive-use" standard
- Keep the 340B Program for vulnerable populations
- Permanent fix for the CAH 96-hour rule
- Create and implement rural specific measures and compare rural providers to a like cohort in the MIPS program
- Continued development of policies regarding Medicaid waivers
- Change supervision requirements for outpatient therapy services to general supervision to protect access to care while maintaining patient safety
- Stopping of the implementation of the Section 603 Site Neutral payment for new off-campus provider-based department
- Improved USDA grants that can be used by rural providers to ease the application process and improve use
- Modify the ACO program to recognize the unique challenges and constraints faced by rural providers

RURAL HEALTH PRIORITIES

- **Increase awareness of the challenges facing rural patients and providers, and the incredible work they do with fewer resources**
- **Move regulatory reform forward to reduce undue burden and regulations for rural providers while preserving patient safety**
- **Continue moving forward to develop a new rural model with Congress and CMS in order to enable innovation and prevent hospital closures in rural areas**