

# 2018 Rural Advocacy Agenda

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America's rural hospitals are committed to serving their communities and ensuring local access to high-quality, affordable health care. The AHA is working to ensure federal policies and regulations are updated for 21st century innovation and care delivery, and new resources are invested in rural communities to protect access.

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## Fair & Adequate Reimbursement

Medicare pays 87 cents and Medicaid pays 88 cents for every dollar spent caring for patients, according to a 2017 AHA survey of community hospitals. Additionally, these programs do not cover the range of services needed in many communities, such as certain behavioral health and addiction treatment services. **Given the persistent, recent, and emergent challenges of providing care in rural areas, Medicare and Medicaid payment rates need to be updated to cover the cost of providing care.**

**Sequestration.** Congress should end Medicare sequestration, which bluntly cuts all payments to hospitals and critical access hospitals (CAHs) by 2 percent.

**Site-neutral.** Site-neutral policies seek to reduce reimbursement for non-emergency services delivered in provider-based departments (PBDs). These policies fail to recognize that patients treated in PBDs – relative to those seen in physician offices – are more likely to be on Medicare, Medicaid, have medically complex conditions, and live in high-poverty areas. PBDs also must comply with more comprehensive licensing and regulatory requirements. **Any expansion of site-neutral policies should be opposed.**

**Originating Site.** Rural hospitals often are the “originating site” for telehealth services, meaning that the hospital is the local site where patients physically go to receive a service

provided from a health professional located at a distant site. However, even in cases where the originating site is eligible to bill Medicare for a telehealth facility fee payment, the reimbursement rates are marginal compared to the overall costs. **Federal payers should provide payment parity with services delivered in-person and cover the cost of providing telehealth at the originating site.**

**Behavioral Health.** Barriers to treatment such as the Medicare 190-day lifetime limit on inpatient psychiatric treatment should be eliminated and information sharing laws related to a patient's substance use history should be updated. Congress also should fully fund authorized programs to increase access to treatment; enhance access to medication-assisted treatment; enforce mental health payment parity laws; and strengthen prescription drug monitoring programs and prescriber education.

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## New Models of Care

As the health field moves toward value-based care, hospitals are participating in alternative payment and care delivery models that have different incentives than the traditional fee-for-service system, and often connect patients to services beyond the walls of the hospital. **New rural models need to be developed and those currently being tested by the Centers for Medicare & Medicaid Services (CMS) need to be evaluated for success, and if appropriate, expanded and extended.**

**Rural Emergency Medical Center (REMC) Model.** Congress should pass the REMC Act (H.R. 5678) and the Rural Emergency Acute Care Hospital (REACH) Act (S. 1130). These bills would establish a new 24/7 rural emergency medical designation under the Medicare Program to allow existing small, rural hospitals to continue providing necessary emergency and observation services (at enhanced reimbursement rates), but cease inpatient services.

**Global Budgets.** Global budgets prospectively set an annual budget for a defined set of health care services, such as all hospital inpatient and outpatient services. They provide financial predictability for rural hospitals and is currently being tested in Pennsylvania; a similar model has been implemented in Maryland. **These models should be explored further.**

# 2018 Rural Advocacy Agenda

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**Bundled Payments.** Bundled payment arrangements generally provide a single, comprehensive payment that involves all of the services involved in a patient's episode of care. Most of the existing bundled payment models are beyond the reach of rural hospitals due to their low volume and other unique circumstances. **Voluntary bundled payment models for rural providers should be tested to determine their feasibility and success in improving quality and affordability.**

**Rural Community Hospital (RCH) Demonstration Program.** Congress has twice extended the RCH demonstration program to allow hospitals with 25-50 beds to test the feasibility of cost-based Medicare

reimbursement. These hospitals are too large to be CAHs, but too small to benefit from economies of scale. **The RCH Demonstration Program should be expanded and made permanent.**

**Frontier Community Health Integration Project Demonstration.** This three-year demonstration, which started in 2016, is testing several care delivery innovations, including cost-based reimbursement for telehealth services and certain CAH-owned ambulance services. Ten hospitals located in Montana, Nevada, and North Dakota are participating. **New models of care that address the varying circumstances of rural hospitals should continue to be tested and evaluated for effectiveness and cost.**

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## Regulatory Relief

Hospitals and health systems must comply with 341 mandatory regulatory requirements and an additional 288 requirements for post-acute care. They spend \$39 billion each year – \$76 million for an average-sized community hospital – on non-clinical regulatory requirements. While rural hospitals are subject to the same regulations as other hospitals, their lower patient volumes mean that, on a per-patient basis, the cost of compliance is often higher. **Policymakers should provide relief from outdated or unnecessary regulations that do not improve patient care.**

**Direct Supervision.** Congress should pass the Rural Hospital Regulatory Relief Act (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.

**96-hour Physician Certification.** Congress should pass the Critical Access Hospital Relief Act (H.R. 5507) to permanently 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.

**Co-location.** CMS should clarify its rules related to shared space or "co-location" arrangements between hospitals and/or health care professionals to continue to

allow rural hospitals to partner with other providers to offer a broader range of services, such as leasing space once a month to medical specialists such as behavioral health specialists and dermatologists.

**Care Coordination.** Congress should create a safe harbor under the Anti-Kickback Statute to protect clinical integration arrangements that work to improve care through collaboration; and eliminate compensation from the Stark Law to return its focus to government ownership. While not intended by the laws, the potential for violating these statutes may be higher for rural hospitals in light of their unique conditions. For example, low patient volume may necessitate the need to share specialists with non-affiliated hospitals, as a result, ongoing patient referrals to these facilities could implicate the AKS.

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## Health Information Technology (HIT)

Rural hospitals are committed to the improved care made possible through health information technology, including electronic health records (EHRs) and telehealth. However, they continue to face barriers, such as regulatory burden, lack of adequate broadband and skilled personnel, and the high costs of purchasing, maintaining and updating equipment and software systems to collect and transmit health information.

**Promoting Interoperability Program (PIP).** The use of EHRs and other health IT to meet increased requirements for information exchange through programs like the PIP result in significant investment to purchase, upgrade, and maintain equipment and software. Many of these costs are

ongoing, including expensive system upgrades required by regulation and the recruitment and retention of trained staff to use and service the technology. **Additional flexibility is needed in the PIP, including the elimination of the "all-or-nothing" approach to meeting program requirements**

# 2018 Rural Advocacy Agenda

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and the availability of a timeline that supports the safe and effective implementation and optimization of the 2015 edition certified EHR technology.

**Telehealth.** Medicare policies should be updated to cover telehealth delivery for all services that are safe to provide, eliminate geographic and setting requirements, and expand the types of technology which may be used (e.g., remote patient monitoring). Congress should 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.

**Broadband.** Federal investment should continue to be expanded to ensure access to adequate broadband infrastructure for telehealth services and to facilitate health care operations, such as widespread use of EHRs and imaging tools. **Funding should be maintained for the Federal Communications Commission Rural Health Care Program and Healthcare Connect Fund.**

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## Workforce

Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals. While almost 20 percent of the U.S. population live in rural areas, less than 10 percent of U.S. physicians practice in these communities.

**Targeted programs that help address workforce shortages should be supported and expanded.**

**Conrad State 30 Program.** Congress should pass the Conrad State 30 and Physician Access Act (S. 898/H.R. 2141) to extend and expand the Conrad State 30 J-1 visa waiver program, which waives the requirement to return home for a period of time if physicians holding J-1 visas agree to stay in the U.S. to practice in a federally designated underserved area for three years.

**Graduate Medical Education.** Congress should pass the Resident Physician Shortage Reduction Act (S. 1301/H.R. 2267) to increase the number of Medicare-funded residency slots, which would expand training opportunities in rural setting and help address health professional shortages.

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## Prescription Drug Prices

The increased cost of prescription drugs is straining providers' ability to access the drug therapies they need to care for their patients and the ability of patients to pay for their medicines. **Action is needed to reduce the cost of prescription drugs and to prevent erosion of the 340B drug pricing program, which helps hospitals serving vulnerable populations stretch scarce resources.**

**High Price of Prescription Drugs.** Policymakers need to make prescription drugs more affordable. Possible actions include fast-track generic medicines to market; prevent drug manufacturers from making small adjustments to older drugs in order to reap the financial benefits and protections reserved for new drugs; and prohibit payments to generic manufacturers to delay the release of a cheaper version of a prescription drug.

**340B Program.** In 2015, 340B hospitals provided \$50 billion in total benefits to their communities. Hospitals were able to provide these benefits despite significant fiscal pressures. That same year, one out of every four 340B hospitals had a negative operating margin, and one in three 340B CAHs had a negative operating margin. **Any focus on the 340B program as part of a plan to lower drug prices is misplaced. Efforts to scale back the program would have devastating consequences for the patients and communities served.**



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