

Rural hospitals and health systems have been on the front lines of the COVID-19 pandemic, working to provide quality care for patients, families and communities. Despite unprecedented financial and health care challenges, rural hospitals remain committed to ensuring local access to high-quality, affordable health care during the pandemic and beyond.

The AHA is working to ensure federal policies and regulations are updated to reflect the urgent needs of hospitals and health systems during these challenging times. We continue to prioritize advancing innovation, making strides in care delivery and investing new resources to protect access to care for Americans living in rural communities.

The 2021 Rural Advocacy Agenda focuses on broader, forward-looking legislative and regulatory priorities for rural hospitals that are not necessarily connected to the COVID-19 crisis. AHA has a separate list of actions needed to respond to the COVID-19 pandemic to ensure that hospitals are able to continue to provide treatments, front-line health care personnel are able to provide care, and patients are able access health care services during the public health emergency (PHE).

Support Flexible Payment Options

As the health care field continues to change at a rapid pace, flexible approaches to paying for and delivering care are more critical than ever to sustain access to services in rural areas. Moreover, given the variability across rural communities, multiple models should be available to these providers so that they can test or select an approach that best suits their needs and circumstances. **Existing models for rural providers should be strengthened to ensure access to care for rural communities.**

Necessary Provider Designation for Critical Access Hospitals (CAHs). The CAH designation allows small rural hospitals to receive cost-based Medicare reimbursement, which can help sustain services in the community. Hospitals must meet several criteria, including a mileage requirement, in order to be eligible. A hospital can be exempt from the mileage requirement if the state certifies the hospital as a necessary provider; however, the necessary provider designation expired on Jan. 1, 2006. **AHA urges Congress to reopen the necessary provider CAH program to further support local access to care in rural areas.**

Medicare-dependent Hospital (MDH) & Low-volume Adjustment (LVA). MDHs are small, rural hospitals where at least 60% of their admissions or patient days are from Medicare patients. MDHs receive the inpatient prospective payment system (IPPS) rate plus 75% of the difference between the IPPS rate and their inflation-adjusted costs from one of three base years. **AHA supports making the MDH program permanent and adding an additional base year that hospitals may choose for calculating payments.** The LVA provides increased payments to isolated, rural hospitals with a low number of discharges. **AHA supports making the LVA permanent.** The MDH designation and LVA protect the financial viability of these hospitals to ensure they can continue providing access to care.

Rebasing for Sole Community Hospitals (SCHs). SCHs must show they are the the sole source of inpatient hospital services reasonably available in a certain geographic area to be eligible for the program. They receive increased payments based on their cost per discharge in a base year. **AHA supports adding an additional base year that SCHs may choose for calculating their payments.**

Ensure Fair and Adequate Reimbursement

Medicare and Medicaid each pay less than 90 cents for every dollar spent caring for patients, according to the latest AHA data. **Given the persistent and emergent challenges of providing care in rural areas, reimbursement rates across payers need to be updated to cover the cost of providing care.**

Additional COVID-19 Provider Relief Fund (PRF) Money with Rural Funding Set Aside. AHA urges Congress to provide significant additional money to the COVID-19 PRF to help ensure hospitals have resources to better prevent, prepare for, and treat COVID-19. **We support setting aside 20% of any new PRF money for rural providers so they have the financial support to continue serving communities.**

Reverse Rural Health Clinic (RHC) Payment Cuts. RHCs provide access to primary care and other important services in rural, underserved areas. **AHA urges Congress to repeal new payment caps on provider-based RHCs included in the 2020 end-of-year spending and COVID-19 relief package.**

Fix Drafting Error that Cuts Payments for Provider-based RHCs Opened in 2020. A legislative drafting error set payment rates for provider-based RHCs opened in 2020 lower than Congress intended. **AHA supports fixing that error so those provider-based RHCs, and others under development, receive the grandfather protections given to other established provider-based RHCs.**

Ambulance Add-on Payment. Rural ambulance service providers ensure timely access to emergency medical care but face higher costs than other areas due to lower patient volume. **We support permanently extending the existing rural and “super rural” ambulance add-on payments to protect access to these essential services.**

Prior Authorization and Payment Denials. Prior authorization is a tool that, when used appropriately, can be effective at helping providers adhere to evidence-based guidelines and their patients’ benefits structure. However, systematic and inappropriate delays of prior authorization decisions and payment denials for medically necessary care are putting patient access to care at risk. **We support legislation to streamline and improve prior authorization processes, which would help providers spend more time on patients instead of paperwork.**

96-hour Rule. We urge Congress to pass legislation to permanently remove the 96-hour physician certification requirement for CAHs. These hospitals still would be required to satisfy the condition of participation requiring a 96-hour annual average length of stay, but removing the physician certification requirement would allow CAHs to serve patients needing critical medical services that have standard lengths of stay greater than 96 hours.

Sequestration. Medicare sequestration bluntly cuts all payments to hospitals and CAHs by 2%. **AHA supports eliminating Medicare sequester cuts through the end of the COVID-19 PHE (H.R. 315).**

Site-neutral Policies. Site-neutral policies seek to reduce reimbursement for 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 or Medicaid, have medically complex conditions and live in high-poverty areas. **AHA opposes any expansion of site-neutral policies.**

Maternal and Obstetric Care. Maternal health is a top priority for AHA and its rural members. **We urge Congress to pass legislation that authorizes grants to improve maternal and obstetric care in rural areas and funding to promote best practices and educate health care professionals, as well as legislation that would give states the option to extend Medicaid and Children’s Health Insurance Program coverage for postpartum women from 60 days to one year after birth.**

Behavioral Health. Eliminating statutory barriers to treatment and reforming information-sharing laws related to a patient’s substance use disorder treatment history will improve care in rural communities. **We urge Congress to: fully fund authorized programs to treat substance use disorders, including expanding access to medication-assisted treatment; implement policies to better integrate and coordinate behavioral health services with physical health services; enact measures to ensure vigorous enforcement of mental health and substance use disorder parity laws; permanently extend flexibilities under scope of practice and telehealth services granted during the COVID-19 PHE; and increase access to care in underserved communities.**

Support Telehealth and Broadband Access

The COVID-19 PHE has illustrated how effective and critical telehealth services are to ensuring access to care in rural communities. Rural hospitals remain committed to the improved care made possible through health information technology (HIT). However, they continue to face barriers that can impede their efforts.

Telehealth. Telehealth expands access to services that may not otherwise be sustained locally. By increasing access to physicians and specialists, telehealth helps ensure patients receive the right care, at the right place, at the right time. However, even in cases where originating sites are eligible to bill Medicare for a telehealth facility fee, the reimbursement rates are marginal compared to the overall costs. **Congress should make permanent expanded telehealth coverage offered during the PHE. Medicare policies should be updated to cover telehealth delivery for all services that are safe to provide, eliminate geographic and setting requirements, ensure adequate reimbursement for originating sites, and expand the types of technology that may be used. It also is critical that hospitals**

and health systems are adequately reimbursed for the high upfront, and ongoing, maintenance costs of telehealth infrastructure. Congress should pass legislation to facilitate virtual care across state lines and allow eligible hospitals to test and evaluate telehealth services for Medicare patients. AHA supports legislation that will waive restrictions on the use of telehealth during national and public health emergencies; expand telehealth for mental health services and emergency medical care; and expand the ability of rural health clinics and federally qualified health centers to provide telehealth.

Broadband. Lack of affordable, adequate broadband infrastructure impedes routine health care operations (such as widespread use of electronic health records and imaging tools) and limits their availability. **Federal investment in broadband connectivity, including through a substantial increase in funding for the Federal Communications Commission's Rural Health Care Program, should continue to be a priority.**

Bolster the Workforce

Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals.

More than 60% of the health professional shortage areas (HPSAs) are located in rural or partially rural areas.

Targeted programs that help address workforce shortages in rural communities should be supported and expanded, including increased funding for loan repayment for physicians practicing in rural HPSAs.

Workforce policies and programs also should encourage nurses and other allied professionals to practice at the top of their license.

Graduate Medical Education. We urge Congress to pass legislation to increase the number of Medicare-funded residency slots, which would expand training opportunities in rural settings and help address health professional shortages.

Conrad State 30 Program. We urge Congress to pass legislation to extend and expand the Conrad State 30 J-1 visa waiver program, which waives the requirement to return home for a period if physicians holding J-1 visas agree to stay in the U.S. for three years to practice in a federally designated underserved area.

Reauthorize Nursing Workforce Development Programs. AHA supports reauthorizing these critical programs to support recruitment, retention and advanced education for nurses and other allied health professionals.

Licensure Reciprocity. Promote medical and nurse licensure reciprocity to allow practitioners to work across state lines.

Rein in 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.

340B Program. 340B hospitals provided \$64.3 billion in total community benefits in the most recent year for which data is available. Hospitals are able to provide these benefits despite significant fiscal pressures: in 2019, approximately 34% of 340B hospitals had a negative operating margin, and 40% of 340B critical access hospitals had a negative operating margin. The AHA strongly opposes ongoing drug company attempts to disregard the law and limit the distribution of certain

340B drugs to eligible hospitals. **We urge the Health Resources and Services Administration to take action to stop drug manufacturers from undermining the 340B program. Any effort to scale back or limit the effectiveness of the 340B program as part of a plan to lower drug prices is also misplaced. Reducing the program would have devastating consequences for the patients and communities 340B hospitals serve.**

High Price of Prescription Drugs. Policymakers need to take action to make prescription drugs more affordable. **Possible actions include taking steps to increase competition among drug manufacturers, improve transparency in drug pricing, advance value-based payment models for drugs, and increase access to drug therapies and supplies.**

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