American Hospital Association™
Advancing Health in America

2023 Rural Advocacy Agenda

Rural hospitals and health systems are the lifeblood of their communities and are committed to ensuring local access to high-quality, affordable health care. At the same time, these hospitals are experiencing unprecedented challenges that jeopardize access and services. These include the after effects of a worldwide pandemic, crippling workforce shortages, soaring costs of providing care, broken supply chains, severe underpayment by Medicare and Medicaid, and an overwhelming regulatory burden.

The AHA continues to work with Congress and the Administration to enact policies to support rural hospitals. We also are working to support a public policy environment that will protect access to care, advance innovation, and invest new resources in rural communities.

Support Flexible Payment Options

As the health care field continues to change at a rapid pace, flexible approaches and multiple options for reimbursing and delivering care are more critical than ever to sustain access to services in rural areas.

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, to be eligible. A hospital can be exempt from the mileage requirement if the state certifies the hospital as a necessary provider, but only hospitals designated before Jan. 1, 2006 are eligible. **AHA urges Congress to reopen the necessary provider CAH program to further support local access to care in rural areas.**

Rural Emergency Hospital (REH) Model. REHs are a new Medicare provider type that small rural and critical access hospitals can convert to in order to provide emergency and outpatient services without needing to provide inpatient care. REHs are paid a monthly facility payment and the outpatient prospective payment system (OPPS) rate plus 5%. **AHA continues to support strengthening and refining the REH model to ensure sustainable care delivery and financing.**

Medicare-dependent Hospital (MDH) and Low-volume Adjustment (LVA). MDHs are small, rural hospitals where at least 60% of 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

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isolated, rural hospitals with a low number of discharges. **AHA also 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 sole source of inpatient hospital services reasonably available in a certain geographic area to be eligible. 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 challenges of providing care in rural areas, reimbursement rates across payers need to be updated to cover the cost of care.**

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 payment caps on provider-based RHCs** that limit access to care.

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.**

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.

Wage Index Floor. AHA supports legislation that would place a floor on the area wage index, effectively raising the area wage index for hospitals below that threshold with new money.

Commercial Insurer Accountability. 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 regulations that streamline and improve prior authorization processes, which would help providers spend more time on patients instead of paperwork. We also support a legislative solution to address these concerns.** In addition, we support policies that ensure patients can rely on their coverage by disallowing health plans from inappropriately delaying and denying care, including by making unilateral mid-year coverage changes.

Maternal and Obstetric Care. Maternal health is a top priority for AHA and its rural members. **We urge Congress to continue to fund programs that improve maternal and obstetric care**

in rural areas, including supporting the maternal workforce, promoting best practices and educating health care professionals. We continue to support the state option to provide 12 months of post-partum Medicaid coverage.

Behavioral Health. Implementing policies to better integrate and coordinate behavioral health services 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 by investing in supports for virtual care and specialized workforce**.

Bolster the Workforce

Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals. Nearly 70% of the primary care 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. 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 additional 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 make permanent 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 federally-designated underserved areas.

Loan Repayment Programs. We urge Congress to pass legislation to provide incentives for clinicians to practice in rural HPSAs. We support expanding the National Health Service Corps and the National Nurse Corps, which incentivize health care graduates to provide health care services in underserved areas.

Boost Nursing Education. We urge Congress to invest $1 billion to support nursing education and provide resources to boost student and faculty populations, modernize infrastructure and support partnerships and research at schools of nursing.

Health Care Workers Protection. We urge Congress to enact federal protections for health care

workers against violence and intimidation, and to provide hospital grant funding for violence prevention training programs and coordination with state and local law enforcement.

Support Telehealth Coverage

The pandemic has demonstrated telehealth services are a crucial access point for many patients. We urge Congress to build on the practices that have proven successful in recent years, including:

- Permanently eliminating originating and geographic site restrictions
- Permanently eliminating in-person visit requirement for behavioral telehealth
- Removing distant site restrictions on federally-qualified health centers and clinics
- Ensuring reimbursement parity based on place of service where the visit would have been performed in-person
- Continuing payment and coverage for audio-only telehealth services
- Permanently expanding the eligible provider types
- Removing unnecessary barriers to licensure
- Establishing DEA Special Registration Process for Telemedicine for administration of controlled substances
- Expanding cross-agency collaboration on digital infrastructure and literacy initiatives

Protect the 340B Program

The 340B Drug Pricing Program helps hospitals serving vulnerable populations stretch scarce resources. Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations that care for many uninsured and low-income patients.

Hospitals use 340B savings to provide free care for uninsured patients, offer free vaccines, provide services in mental health clinics, and implement medication management and community health programs. **The AHA opposes any efforts to undermine the 340B Program and harm the patients and communities it serves.**

To learn more and view AHA's full 2023 Advocacy Agenda, visit www.aha.org.

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