

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.

Support New Payment and Delivery Models

As the health care field continues to change at a rapid pace, traditional approaches to paying for and delivering care may no longer be suitable 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.

New, voluntary models for rural providers should be developed and tested, and Congress and the Centers for Medicare & Medicaid Services (CMS) should expand opportunities to financially support rural health care access.

Rural Emergency Hospital (REH). Establishment of a REH designation under the Medicare program would allow existing facilities to meet a community's need for emergency and outpatient services without having to provide inpatient care. Emergency services would be provided 24 hours a day, 365 days a year, and communities would have the flexibility to align additional outpatient and post-acute services with community needs and receive enhanced reimbursement. **AHA supports legislation that would establish a new designation under the Medicare program to allow rural hospitals to continue providing necessary emergency and observation services (at enhanced reimbursement rates), but cease inpatient services.**

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 re-open the necessary provider CAH program to further support local access to care in rural areas.**

Infrastructure Financing for Rural Hospitals. As the hospital field engages in significant transformation, rural hospitals are seeking ways to adapt while continuing to meet patient needs. **The AHA urges Congress to help ensure that vulnerable communities are able to preserve access to essential health care services by providing infrastructure funding for hospitals that restructure their facilities and services offered to match community needs.**

Rural Community Hospital (RCH) Demonstration Program. Congress has twice extended the RCH program to allow hospitals with 25-50 beds to test the feasibility of cost-based Medicare reimbursement for inpatient services. A 2018 evaluation of this program found that RCHs maintained access to quality care and largely benefitted from the demonstration reimbursement structure. **The RCH Demonstration Program should be expanded and made permanent.**

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.**

Surprise Billing. AHA supports action to protect patients from unanticipated medical bills that they may incur because of unexpected gaps in their insurance coverage or as a result of emergencies. **We urge Congress to protect patients while allowing providers and insurers to negotiate payment rates for services provided without the use of a benchmark rate.** We also oppose proposals that would restrict certain contracting terms between providers and health plans, including policies that would allow insurers to steer patients to particular providers, as well as “cherry-pick” within a hospital system.

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.**

Prior Authorization & 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’ benefit 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 while increasing costs in the health care system. **We support legislation to streamline and improve prior authorization processes, which would help providers spend more time on patients, instead of paperwork (H.R. 3107).**

Maternal and Obstetric Care. Maternal health is a high 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 (H.R. 4995), 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 (H.R. 4996).**

Behavioral Health. Eliminating statutory barriers to treatment and reforming information-sharing laws related to a patient’s substance use disorder treatment history (H.R. 2062/S. 1012) 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 (S. 1576/H.R. 2874); and increase access to care in underserved communities.**

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

Remove Red Tape

Hospitals and health systems must comply with 341 mandatory regulatory requirements and an additional 288 requirements for post-acute care. 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.**

96-hour Rule. We urge Congress to pass legislation to permanently remove the 96-hour physician certification requirement for CAHs (S. 586/H.R. 1041).

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.

Co-location. CMS should clarify and formalize its guidance related to shared space or “co-location” agreements between hospitals and/or health care professionals to allow rural hospitals to partner with other providers to offer a broader range of services. For example, a rural provider may wish to lease space to visiting specialists, such as cardiologists and behavioral health professionals, to support local availability of specialty care. **CMS should provide**

language in its guidance expressly allowing such co-location arrangements that are deemed acceptable.

Care Coordination. We continue to urge the Administration to adopt final regulations for the Stark and Anti-kickback laws to protect clinical integration arrangements so that hospitals and physicians can work together to achieve a value-based system of coordinated care and improved patient outcomes.

These improvements could also help address sensitivities for rural hospitals to comply with these laws in light of their unique conditions. AHA will also continue to urge Congress to eliminate compensation from the Stark Law, to return its focus to governing ownership arrangements, and allow Anti-kickback law to govern all compensation arrangements.

Support Telehealth and Health Information Technology

Rural hospitals are committed to the improved care made possible through health information technology (HIT). However, they continue to face barriers that can impede their efforts, including burdens associated with regulatory requirements, technology acquisition and maintenance, and staffing needs. Updates to federal telehealth coverage policies are needed along with additional resources for providers to continue to adopt and use HIT.

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. **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 originat-**

ing sites, and expand the types of technology that may be used. Payers also should provide payment parity with services delivered in-person, and 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 expand telehealth for mental health services and emergency medical care; waive restrictions on the use of telehealth during national and public health emergencies; and expand the ability of rural health clinics and federally qualified health centers to provide telehealth (S.2741).

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 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.

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 of time if physicians holding J-1 visas agree to stay in the U.S. for three years to practice in a federally designated underserved area (S. 948/H.R. 2895).

Opioid Workforce. The shortage of SUD treatment providers has led to lengthy waiting periods for treatment and increased mortality from opioid misuse and addiction. **We urge Congress to pass the Opioid Workforce Act (H.R. 2439/S. 2892) to address existing shortages by adding 1,000 Medicare-funded training positions in approved residency programs in addiction medicine, addiction psychiatry or pain management.**

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 (S. 348/H.R. 1763).

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. In 2015, 340B hospitals provided \$50 billion in total benefits to their communities. Hospitals were able to provide these benefits despite significant fiscal pressures: in 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 effort to scale back or limit the effectiveness of

the 340B program as part of a plan to lower drug prices is misplaced. Reducing the program would have devastating consequences for the patients and communities served; 340B is vital to rural communities and must be protected.

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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