

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.

Ensure Fair and Adequate Reimbursement

Medicare and Medicaid each pay approximately 87 cents for every dollar spent caring for patients, according to the latest AHA data. 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.**

Site-neutral Policies. 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. **AHA opposes any expansion of site-neutral policies.**

Behavioral Health. Eliminating statutory barriers to treatment and reforming information-sharing laws related to a patient's substance use disorder 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; 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%.

Support New Models of Care

As the health care field moves toward value-based care and population health, 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. However, many new models either exclude rural providers or overlook the unique challenges of providing care in rural communities.

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 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.**

Bundled Payments and the Physician Quality Payment Program (QPP) Alternative. Bundled payment arrangements generally provide a single, comprehensive payment that involves all of the services involved in a patient's episode of care. Yet most of the existing bundled payment models are not available to 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. In addition, CMS should continue to provide flexibilities for rural providers in its QPP. This includes the continuation of gradual increases to reporting requirements under the Merit-based Incentive Payment System (MIPS), and expanded opportunities for small and rural providers to participate in advanced alternative payment models (APMs).**

Remove Red Tape

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 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.**

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 for inpatient services. A 2018 evaluation of this program found that beneficiaries were assured access to quality care and participants largely benefitted from the demonstration reimbursement structure. **The RCH Demonstration Program should be expanded and made permanent. In addition, a case-mix adjustment should be applied to the target amount, as it has been applied in previous rounds of the demonstration, in order to account for fluctuations in patient acuity.**

Frontier Community Health Integration Project (FCHIP) Demonstration. This three-year demonstration, which started in 2016, tests several care delivery innovations, including cost-based reimbursement for telehealth services. Given the small number of participants (10 hospitals), an extension of the demonstration would increase data availability and allow for a more comprehensive evaluation of performance. The program expired as of July 2019. **The FCHIP demonstration should be extended and new models of care that address the varying circumstances of rural hospitals should continue to be tested and evaluated for effectiveness and cost.**

Direct Supervision. The "direct supervision" of a physician for low-risk procedures provided in CAHs and small, rural hospitals strains the already limited workforce in many rural communities, and increases costs, ultimately threatening access. **We urge policymakers to implement an effective, lasting solution to this antiquated requirement, such as finalizing CMS's recent proposal to change the minimum standard to general supervision or passing legislation to extend the enforcement moratorium on the CMS's "direct supervision"**

policy for outpatient therapeutic services provided in CAHs and small, rural hospitals (S. 895/H.R. 3416).

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 its rules related to shared space or “co-location” arrangements between hospitals and/or health care professionals to allow rural hospitals to partner with other providers to offer a broader range of services. These arrangements may

include leasing space once a month to specialists, such as cardiologists and behavioral health professionals, as well as implementing structural changes in order to facilitate patient experience.

Care Coordination. We urge Congress to 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 Anti-kickback Statute.

Support Health Information Technology

Rural hospitals are committed to the improved care made possible through health information technology (HIT), including electronic health records (EHRs) and telehealth. However, they continue to face barriers that can impede their efforts. Updates to federal telehealth coverage policies are needed along with additional resources for providers to continue to adopt and utilize HIT.

Broadband. Lack of affordable, adequate broadband infrastructure impedes routine health care operations (such as widespread use of EHRs and imaging tools) and limits their availability. **Federal investment in broadband connectivity should continue to be a priority.**

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 originating 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 allow eligible hospitals to test and evaluate telehealth services for Medicare patients.**

Promoting Interoperability Program (PIP). The use of EHRs to meet increased requirements for information exchange through programs like the PIP (formerly known as the EHR Incentive Programs, or meaningful use), 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. Rural hospitals must meet the same regulatory requirements for the PIP as other hospitals, yet often do not need the additional technology functionality contained in required,

expensive system upgrades. **While CMS recently provided needed flexibility in the PIP, concerns remain that the requirements and technology costs are beyond the reach of some rural hospitals.**

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.** 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. to practice in a federally designated underserved area for three years (S. 948/H.R. 2895).

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 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.

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