American Hospital Association™
Advancing Health in America

2022 Rural Advocacy Agenda

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 2022 Rural Advocacy Agenda focuses on broader, forward-looking legislative and regulatory priorities 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.

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 **(H.R. 1887).**

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 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 (H.R. 1887).**

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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.**

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.**

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 (S. 2037/H.R. 2454).**

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 (H.R. 3173/S. 3018).**

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 or through 2022, whichever is later.**

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 to increase funding to promote best practices and educate health care professionals, as well as legislation that would require states 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 by investing in supports for virtual care and specialized workforce.**

Surprise Billing. AHA supports price transparency efforts by ensuring patients have access to the information they seek when preparing for care, including cost estimates when appropriate, and creating alignment of federal price transparency requirements to avoid patient confusion and overly burdensome duplication of efforts. **We support regulations to implement surprise medical billing protections for patients that do not inadvertently restrict patient access to care.**

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.**

Support Connected Care

The COVID-19 pandemic has demonstrated telehealth services can be a crucial access point for many patients. However, the reliance on virtual care during this time has also exposed the depths of the "digital divide": significant proportions of the population are unable to access care via telehealth modalities due to a lack of equipment, broadband internet, or knowhow. Hospitals and health systems also have experienced an increase in the frequency, severity and sophistication of cyberattacks on their networks.

Telehealth. Telehealth expands access to services that might 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 originating site requirements, and expand the types of technology that may be used for, and the types of practitioners that may provide, telehealth services. 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 coverage and reimbursement for audio-only services to ensure patients that may not have access to broadband internet or video-conferencing technology can still access care. AHA also supports legislation expanding telehealth for mental health services and emergency medical care and improving the ability of rural health clinics and federally qualified health centers to provide telehealth. The CONNECT Act (S. 1512/H.R. 2903) and the Telehealth Modernization Act (S. 368/H.R. 1332) are key bills to address these priorities.**

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.**

Cybersecurity. The pandemic has exacerbated threats from cyber criminals for hospitals and health systems. AHA supports efforts to increase government cybersecurity assistance including funding to support recruiting and training additional cybersecurity workforce, improving medical device security, and streamlining information sharing regarding threats to the field. AHA continues to encourage regulatory relief for hospitals and health systems that suffer a cyber breach and have certain recognized cybersecurity practices in place.

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, 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 (S. 834/H.R. 2256). AHA also supports passing the Pathway to Practice program, which would promote physician diversity and improve access to physicians in communities dealing with sustained hardship.

Bolster the Workforce (Continued)

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 (S. 1810/H.R. 3541).

Loan Repayment Programs. We urge Congress to establish a Rural America Health Corps to provide incentives for clinicians to practice in rural health professional shortage areas **(S. 924/H.R. 2130).**

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 **(S. 246/ H.R. 851).**

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 accounted for roughly 68% of the nearly $42 billion in uncompensated care provided by all hospitals in 2019. In addition, 340B hospitals provided nearly $68 billion in total community benefits. 340B hospitals provide these high levels of uncompensated care and community benefits to their community despite operating on razor thin margins, with approximately one out of every four 340B hospitals having a negative operating margin. **One of AHA's top priority is to protect the 340B program to ensure vulnerable communities have financial help to expand access to comprehensive health care services and life-saving prescription drugs by reversing harmful policies and holding drug manufacturers accountable to the rules of the program, especially as it relates to community pharmacy arrangements.** This is especially important for hospitals that are located in and/or serve rural communities. More than 80% of rural 340B hospitals use contract pharmacies to ensure their patients have access to needed outpatient drugs, as well as other essential services. We urge Congress and the Administration to ensure that 340B hospitals that were participating in the program at the start of the COVID-19 PHE and may have experienced changes to their DSH adjustment percentage due to the COVID-19 pandemic retain their 340B eligibility. **AHA supports legislation to provide 340B hospitals with certainty by allowing these hospitals to continue to access the 340B program during the public health emergency (S. 773/H.R. 3203).**

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.**

To learn more and view AHA's full 2022 Advocacy Agenda, visit www.aha.org.

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