2025 Rural Advocacy Agenda

American Hospital Association™
Advancing Health in America

Rural hospitals and health systems are committed to ensuring local access to high-quality, affordable health care. However, these hospitals continue to experience ongoing challenges that jeopardize their ability to provide local access to care and essential services. These include severe underpayments by Medicare and Medicaid, which threaten the financial stability of the health care system; challenges imposed by commercial and Medicare Advantage plans; and a heavy regulatory burden.

SUPPORT FLEXIBLE PAYMENT MODELS

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.

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 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.

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 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.**

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 REIMBURSEMENT, ACCESS TO CAPITAL & REGULATORY RELIEF

Medicare and Medicaid pay only 82 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.**

Telehealth. Telehealth services are a crucial access point for many patients. AHA supports legislation to make permanent coverage of certain telehealth services made possible during the pandemic, including lifting geographic and originating site restrictions, allowing Rural Health Clinics and Federally Qualified Health Centers to serve as distant sites, expanding practitioners who can provide telehealth and allowing hospital outpatient billing for virtual services, among others.

Infrastructure Financing for Rural Hospitals. Many rural hospitals were constructed following the passage of the Hill-Burton Act of 1947, which provided grants and loans for the construction and modernization of hospitals. Currently, many rural hospitals need to update their facilities and services to continue meeting the needs of their community. Yet, narrow financial margins limit rural hospitals' ability to retain earnings and secure access to capital or qualify for U.S. Department of Agriculture or U.S. Department of Housing and Urban Development mortgage guarantees. Without those resources, rural hospitals are sometimes unable to update facilities. **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 to meet community needs.**

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.

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 or maintain access to maternal and obstetric care in rural areas, including supporting the maternal workforce, promoting best practices and educating health care professionals.

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.

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.

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.**

Regulatory Burden. Reduce regulatory burden by identifying and advocating for the repeal of unnecessary and duplicative Conditions of Participation that increase hospital inefficiency and reduce the time providers can spend caring for their patients.

COMMERCIAL INSURER ACCOUNTABILITY

Underpayment by commercial insurance plans and systematic and inappropriate payment delays for medically necessary care are putting patient access to care at risk.

Cost-based Reimbursement for Critical Access Hospitals (CAHs) from Medicare Advantage (MA) Plans. Congress created a special statutory payment designation for CAHs in recognition of the unique role they play in preserving access to health care services in rural areas. As certain MA plans in rural communities rapidly grow, there is an erosion of this important financial protection. A greater portion of a CAH's revenue will be subject to negotiations with MA plans that often result in below-cost payment terms and involve onerous plan requirements that contribute to administrative burden, unnecessary delays and denials in approving and paying for patient care, and additional strains on the health care workforce. **We support legislation to ensure CAHs receive cost-based reimbursement for MA patients.**

Prompt Pay. Ensure prompt payment from insurers for medically necessary, covered health care services delivered to patients. **We support policies to increase oversight and accountability of health plans including establishing more stringent standards for timely payment** to address certain insurer tactics to delay and deny payment to health care providers.

Prior Authorization. Hold commercial health insurers accountable for ensuring patients have timely access to care, including by reducing the excessive use of prior authorization, ensuring expeditious prior authorization decisions and eliminating inappropriate denials for services that should be covered. **We support building on recent regulations and legislation that further streamline and improve prior authorization processes.**

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 enact legislation that would lift existing caps on the number of Medicare-funded residency slots, which would help alleviate physician shortages in rural and other underserved areas and improve patients' access to care. We also support robust funding for rural residency track programs, which provide medical residents additional training opportunities in rural areas.

Conrad State 30 Program. We urge Congress to make permanent and expand the Conrad State 30 J-1 visa waiver program, which waives the requirement for physicians holding J-1 visas to return home for a period if they agree to stay in the U.S. for three years and practice in 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.

Visa Recapture. We urge Congress to pass legislation to recapture up to 40,000 unused employment visas for foreign-trained workers (25,000 for nurses and 15,000 for physicians).

PROTECT THE 340B PROGRAM

The 340B Drug Pricing Program helps CAHs, Sole Community Hospitals, Rural Referral Centers and other disproportionate share hospitals serving vulnerable populations stretch scarce resources. Section 340B of the Public Health Service Act requires pharmaceutical companies participating in Medicaid to sell outpatient drugs at discounted prices to organizations that care for many uninsured and low-income patients.

Hospitals use 340B savings, for example, 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, including drug company efforts to diminish the program by limiting contract pharmacy arrangements and attempting to change access to 340B pricing from an upfront discount to a back-end rebate.**

To learn more and view AHA's full 2025 Advocacy Agenda, visit www.aha.org.