

# 2024 Rural Advocacy Agenda



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 continued workforce shortages, emerging challenges posed by commercial and Medicare Advantage plans, soaring costs of providing care, 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.

## 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. Insurers must also be held accountable for applying prior authorization requirements in ways that contribute to clinician burnout so that clinicians can focus on what matters most: patients. **We support building on recent regulations and legislation that further streamline and improve prior authorization processes.**

## 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.

**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 (**S. 1110 / H.R. 6430**).

**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 (S. 1110).**

**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 (H.R. 1128).**

**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.**

## Ensure Fair and Adequate Reimbursement

Medicare pays 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.** The pandemic demonstrated 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 (**S. 2016 / H.R. 4189**).

**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 to match 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.**

**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 (H.R. 1666).**

**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 (**H.R. 1565**).

**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 (**S. 803**).

**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.**

**Behavioral Health.** Implementing policies to better integrate and coordinate behavioral health services will improve care in rural communities. **We urge Congress to enact a number of policies that authorize, expand and better integrate behavioral health programs.**

## 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 (**S. 1302 / H.R. 2389**).

**Conrad State 30 Program.** We urge Congress to pass the Conrad State 30 and Physician Access Reauthorization Act (**S. 665 / H.R. 4942**) 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 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 (**S. 862 / S. 940 / H.R. 1711**).

**Visa Recapture.** We urge Congress to pass the Healthcare Workforce Resilience Act (**S.3211 / H.R. 6205**), bipartisan legislation that would 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 rural disproportionate share 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, especially as it relates to community pharmacy arrangements.**

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