

The Landscape of Rural Health

Michigan Critical Access Hospital Conference

bslabach@ruralhealth.us X: @bslabach #ruralhealth November 9, 2023

Brock Slabach, MPH, FACHE Chief Operations Officer

Rural Health Policy Institute	Feb. 13-15, 2024	Washington, DC
Annual Conference	May 7-10, 2024	New Orleans, LA
Rural Hospital Innovation Summit	May 7-10, 2024	New Orleans, LA
Rural Health Clinic Conference	Sept. 24-25, 2024	Kansas City, MO
Critical Access Hospital Conference	Sept. 25-27, 2024	Kansas City, MO

Visit ruralhealth.us for details and discounts.

Destination NRHA Plan now to attend these 2024 events.





Why rural?



Rural areas make up 80% of the land mass in USA

Rural areas have roughly 17% of the US Population

Rural areas provide the food, fuel and fiber to power our nation

Access to high-quality health care is a requirement to keep these important resources available

An exchange between urban and rural that must not be overlooked

Historically, public policy has disadvantaged health care in rural communities



Our Future Depends on our <u>Advocacy</u>

- Investing in a Strong Rural Health Safety Net
- Reducing Rural Healthcare Workforce Shortages
- Addressing Rural Declining Life Expectancy and Inequality



Rural Social Drivers of Health



Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Pollution	Literacy	Food insecurity	Social isolation	Health
Income	Housing	Language	Access to healthy food	Community engagement	coverage Provider
Expenses	Transportation	Early childhood education	options	Discrimination	availability
Debt	Public Safety		SNAP		Provider
Medical Bills	Climate Change	Vocational training		Stress	linguistic and cultural competency
Support	Walkability	Higher education			Quality of care



Future: The Political Drivers of Health

The future of health equity begins and ends with the political determinants of health. --<u>Leslie Erdelack</u>

- Political drivers of health create the social drivers.
 Some examples:
 - Medicaid Expansion
 - GME Polices and specialties
 - Poor environmental conditions
 - Unsafe neighborhoods
 - Lack of healthy food options

 Defined: The Political determinants of health involve the systematic process of structuring relationships, distributing resources, and administering power, operating simultaneously in ways that mutually reinforce or influence one another to shape opportunities that either advance health equity or exacerbate health inequities.

--Daniel E. Dawes (2020)



Future: Commercial Drivers of Health

Defined as systems, practices, and pathways through which commercial actors drive health and equity. Source: The Lancet, March, 2023

Four industries (tobacco, unhealthy food, fossil fuel, and alcohol) are responsible for at least a third of global deaths per year. Source: The Lancet, March, 2023

- Commercial actors (CA) shape regulation and policies
- Favorable policies increase sales of possibly harmful products
- Policies enable CA to externalize the cost of harm
- Externalized costs met by states and individuals affected
- CAs enjoy large profits that propels
 a growing power imbalance



Capitol Hill Listens to You

Federal/State Officials value and want to hear YOUR input

- Capitol Hill values rural health advocate input.
- The Hill wants **YOUR** story.
- You and your legislators are neighbors.
- **YOUR** voice is important to help get meaningful legislation passed. As a provider and employer in a district, you understand how legislation will most impact a Member's constituency.



The real problem of humanity is the following, we have:

- paleolithic emotions
- medieval institutions
- godlike technology

Edward O. Wilson https://www.nytimes.com/2019/12/05/opinion/digital-technology-brain.html

The Stories We Tell





Population Health Disparity

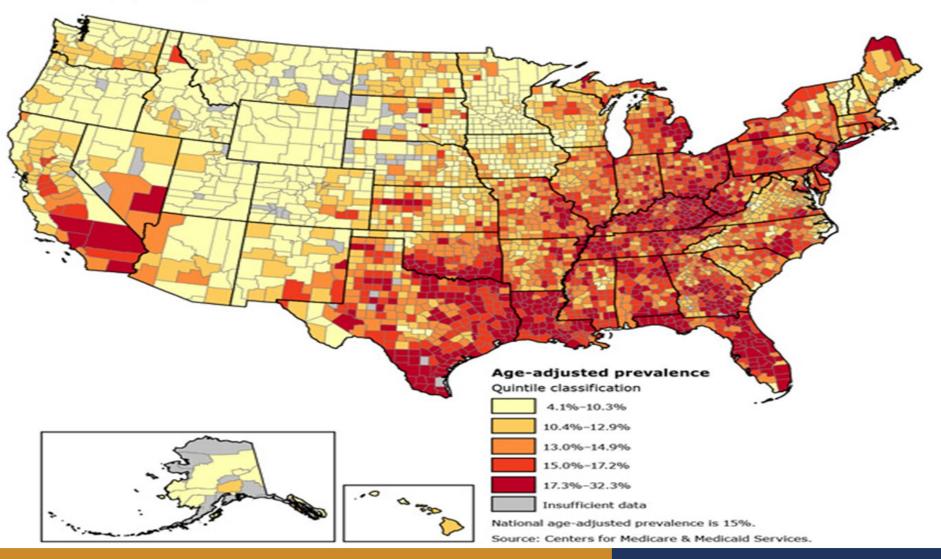
Rural v. Urban





Prevalence of Medicare Patients with 6 or more Chronic Conditions

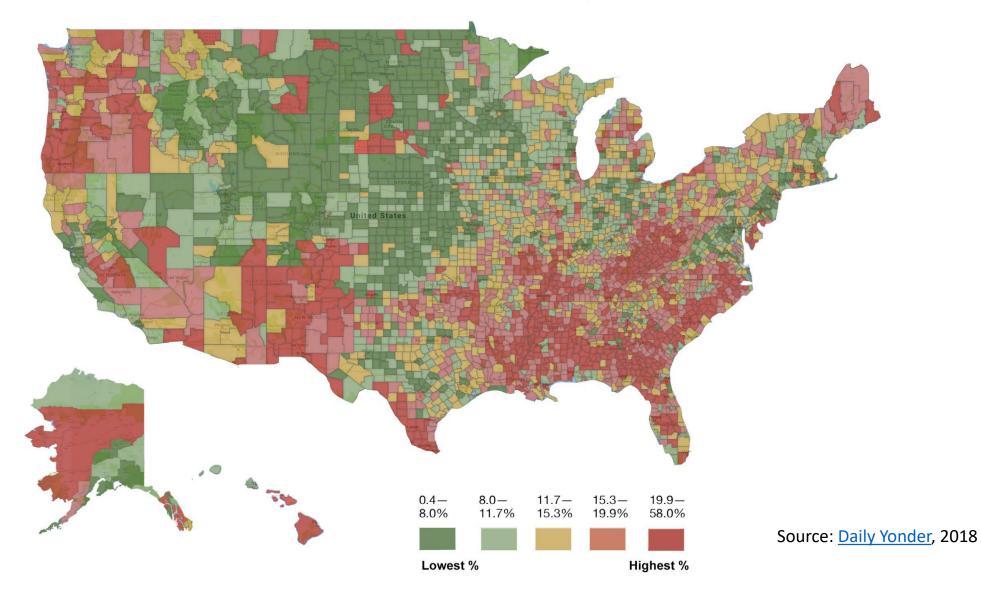
The Prevalence of Medicare Fee-for-Service Beneficiaries 65 Years or Older With 6 or More Chronic Conditions, by County, 2012



The Geography of Food Stamps



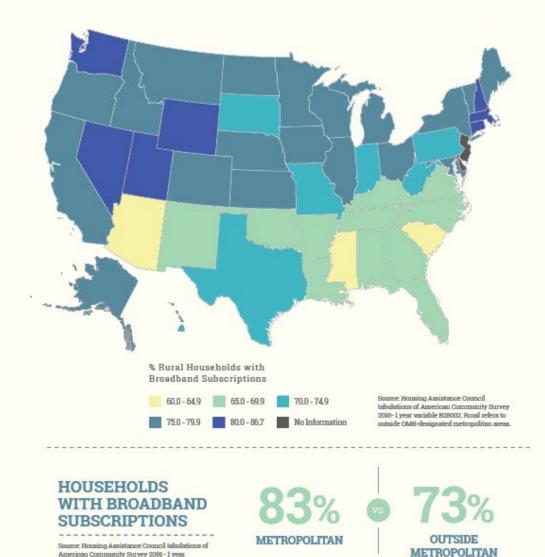
SNAP Enrollment as Percent of County Population



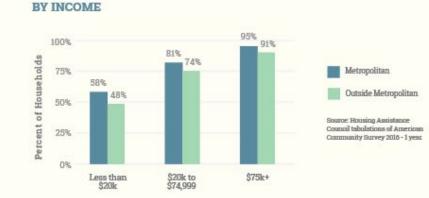
The Digital Divide in Rural America



RURAL HOUSEHOLDS WITH BROADBAND SUBSCRIPTIONS



BROADBAND SUBSCRIPTIONS



BY AGE



BY RACE / ETHNICITY

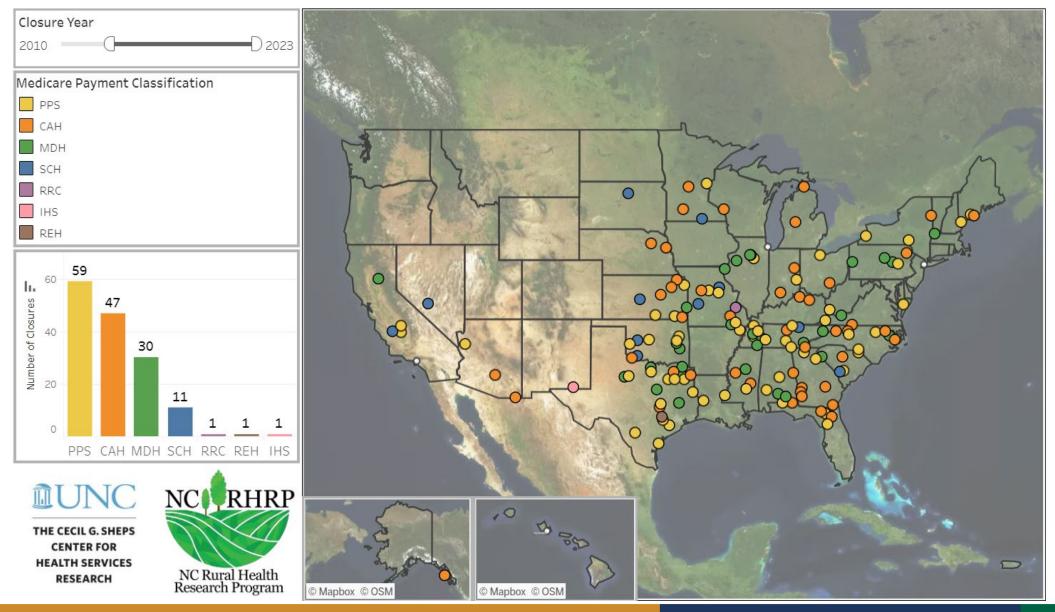


Source: <u>UNC Sheps</u> <u>Center for Rural Health</u>

Rural Hospital Closures



150 Closures since 2010





REH Conversion Map 17 Conversions Since Program Started



1 in Michigan: Sturgis

Potential Legislative Fixes and/or Areas for Clarification

- Expanded eligibility for closed facilities prior to 2020
- Inclusion of swing beds
- Participation in the 340B program
- AFP hospital market-basket update—inflation?
- Clarification of CAHs Necessary Provider (NP) and flip back to CAH
- Did not reclassify to rural prior to Dec. 27, 2020, ineligible for REH



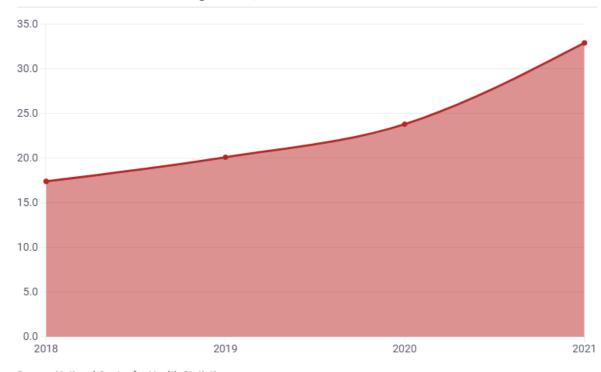
USDA/NRHA Rural Hospital TA Program

- Rural Hospitals that are current borrowers from USDA are eligible for full-range of services:
 - Strategic, Financial and Operational Assessment (SFOA)
 - Target services, for example:
 - Revenue Cycle
 - 340B assessment
 - Cost Report Review
 - Debt capacity/Market Analysis
 - Maternity Care Assessment
 - Long-term evaluation
 - Quality Measurement Assessment
- TA is free-of-charge to hospital
- Contact <u>Brock Slabach or Tommy Barnhart at NRHA</u>

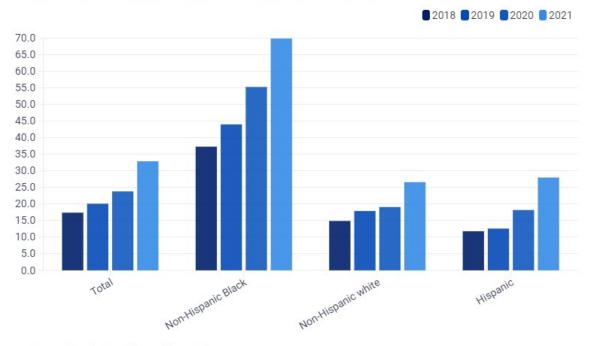


Maternal Mortality Crisis

U.S. Maternal Mortality Rate, 2018-2021



Maternal Mortality Rates by Race and Hispanic Origin



Source: National Center for Health Statistics

Chart: News Data Team at U.S. News

Maternal mortality rates are deaths per 100,000 live births. Total includes deaths for race and Hispanicorigin groups not shown separately, including women of multiple races and origin not stated.

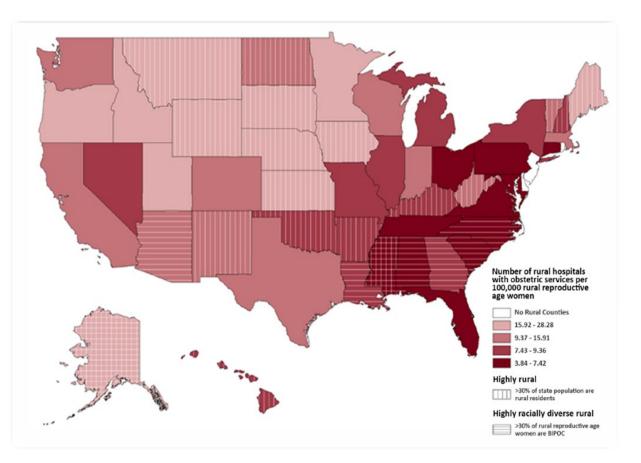


Source: <u>National Center for Health Statistics</u> Chart: News Data Team at U.S. News Maternal mortality rates are deaths per 100,000 live births.





Maternity Deserts Nationwide

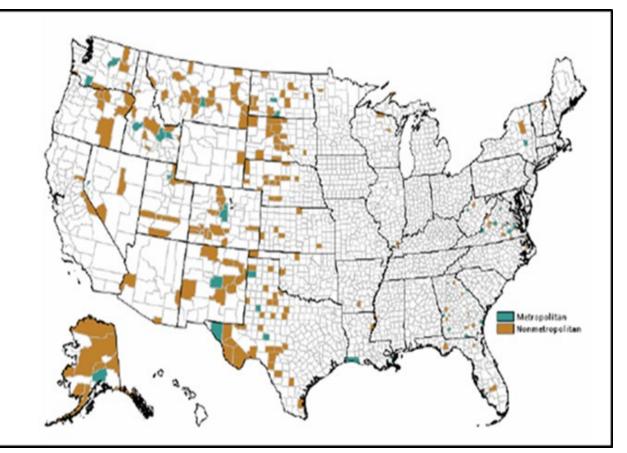


- 56% of rural counties lack hospitalbased OB services
- Substantial state and regional variability
- Loss of hospital-based OB services is most prominent in rural communities:
 - With a high proportion of Black residents
 - Where a majority of residents are Black or Indigenous have elevated rates of premature death

https://rupri.public-health.uiowa.edu/publications/policybriefs/2023/Hospital%20System%20Participation%20and%20Services.pdf



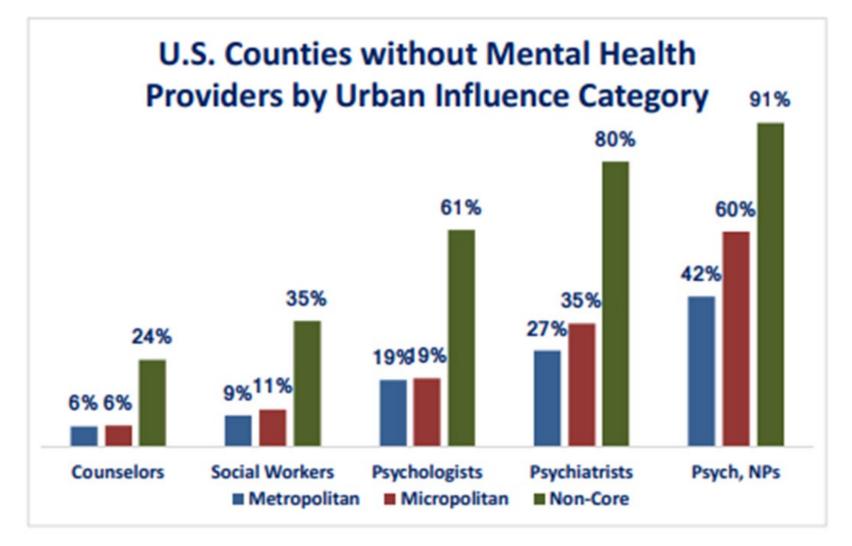
Rural Nursing Home Closures



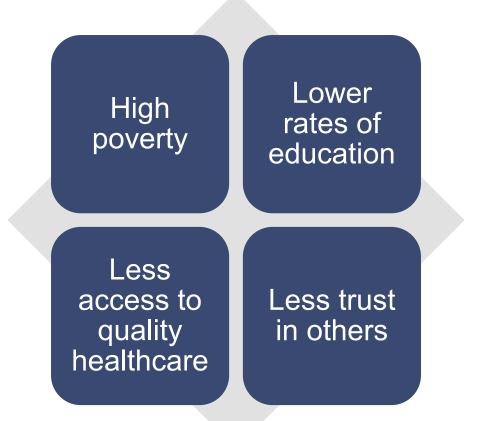
- 10% of rural counties are nursing home deserts
- From 2008-2018, *400* rural counties experienced at least 1 nursing home closure



Behavioral/Mental Health Workforce



Common Denominators where Covid Deaths Rates were High



What is clear is that COVID-19 exploited and compounded existing local racial inequities, health disparities, and partisan politics to create a syndemic a combination of local factors that interact, increasing the burden of disease from this pandemic and the likelihood of poor outcomes.

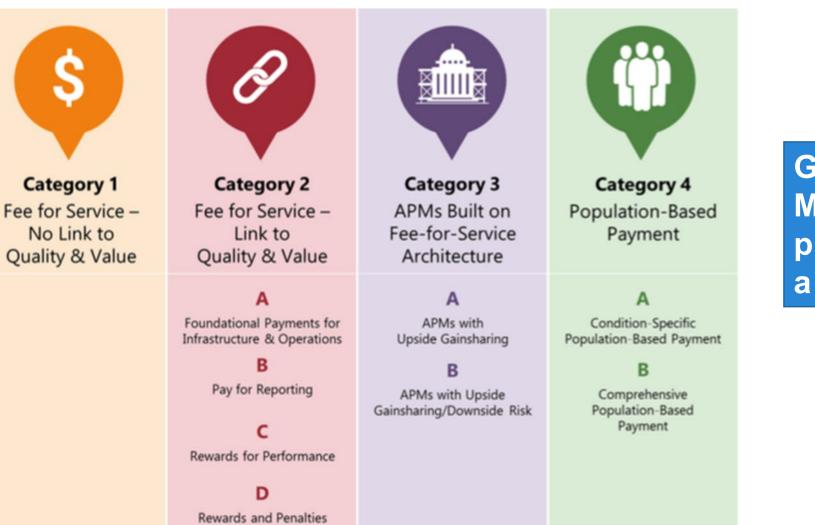
--<u>Thomas Bollyky</u>, Lancet, 2023

Looking Ahead: Innovation



Payment Transition Plan: CMS & CMMI





for Performance

Goal: 100% of Medicare payments to providers are through a VBP approach



Million Hearts Campaign Focus on Health Equity

Pregnant and Postpartum Women With Hypertension

Strategies

- Champion widespread SMBP use
- Expand / extend Medicaid coverage
- Close gaps in transition of care
- Promote aspirin use to prevent preeclampsia

People from Racial/ Ethnic Minority Groups

Strategies

- SMBP, HMM in trusted spaces
- Expand Medicaid coverage
- Tailored protocols to increase med intensification / med adherence
- Enhance sodium reduction
- Policies prohibiting sale of flavored tobacco products

People with Behavioral Health Issues Who Use Tobacco

Strategies

- Support integration of tobacco cessation treatment into mental health,
- substance use care
- Encourage smokefree behavioral health facilities
- Expand Medicaid coverage

People with Lower Incomes

Strategies

- Expand Medicaid coverage
- Support SMBP device loaner programs
- Support inclusion of evidence-based strategies in valuebased care delivery

People who Live in Rural Areas and Other 'Access Deserts'

Strategies

- Support availability of robust virtual and remote models of cardiac rehabilitation
- Support the use of SMBP and related telehealth
- Support expanded scopes of practice for NPs, PAs, PharmDs, and CHWs

SMBP = self-measured blood pressure monitoring; HMM = hypertension medication management; NP = nurse practitioner; PA = physician assistant; CHW = community health worker



CMMI: AHEAD Model

CMMI has announced a new innovation model for up to 8 states starting in 2025 that will include the following:

- Global Budget for hospitals (similar to PaRHM)
- Include a TCOC target/approach
- All-payer participation
- Include a primary care/provider incentive
- Directed toward safety-net providers (including rural)
- Address Mental health, SUD and SDOH
- Address Health Equity



CMMI: AHEAD Model

Tentative timeline for model release/implementation:

- December, 2023 release NOFO
- 2024 Select Model Participants
- 2025 Implement Model
- 10-year horizon for demonstration
- \$12M grant for lead agency—5 years

Like the Pennsylvania model, AHEAD model requires State to organize and implement the features of this program.

ACO Advanced Investment Payment

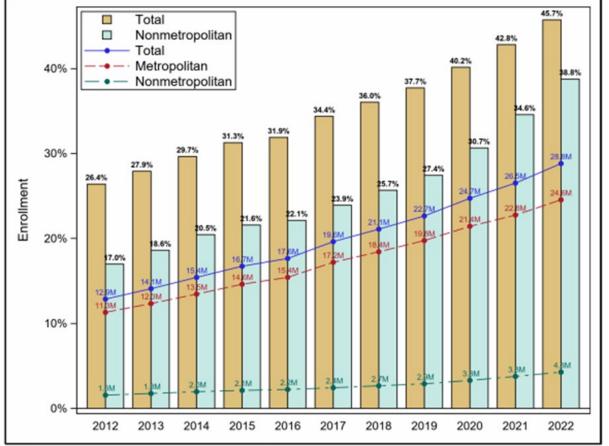
CMS finalized new policies for Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP) to support providers treating rural and underserved populations, including changes to:

- Provide Advance Investment Payments (AIPs) to Certain ACOs
 - A one-time payment of \$250,000
 - Eight quarterly payments, based on the number of assigned beneficiaries capped at 10,000
- Smooth the Transition to Performance-Based Risk
- Support Longer Term Participation in ACOs
- Promote Health Equity
- Update the Financial Methodology
 - Reduce the effect of ACO performance on historical benchmarks
 - Address market penetration
 - Strengthen incentives for ACOs serving medically complex and high-cost populations
- Next application period in 2024 for a Jan. 1, 2025 start date. More information.



Medicare Advantage Data—2022

Figure 1. Medicare Advantage Enrollment, March 2012-March 2022



Source: RUPRI Center for Rural Health Policy Analysis, analysis of Centers for Medicare & Medicaid Services' Medicare Advantage enrollment data.

- Overall MA enrollment grew by 8.7 percent (2.3 million) from 2021 to 2022.
 - The rate of growth was higher in *nonmetropolitan counties* (13.4 percent) than in *metropolitan counties* (7.9 percent).
- Overall, more than half of MA enrollees (57.9 percent) were in Health Maintenance Organization (HMO) plans.
 - The largest proportion of *nonmetropolitan enrollees* (51.5 percent) were in Local Preferred Provider Organization (PPO) plans
 - The largest proportion of *metropolitan enrollees* (61.4 percent) were in HMO plans

"Offering a rural payment add-on for MA plans that operate in rural areas may incentivize the delivery of high-quality care in rural areas" <u>Health Payer Intelligence</u>



Funding Opportunity

- Rural Health Network Development Planning Program
 - Planning and development of integrated health care networks
 - Expand access and improve quality of care in rural areas
 - 30 grants available in this opportunity
 - Applications due January 26, 2024
 - Link here for more information

News from Washington: Preparing for the Future





Recent Activities

- Recent comments on proposed rules:
 - <u>Comment</u> on Requirements Related to Mental Health Parity and Addiction Equity Act proposed rule.
 - <u>Response</u> to Physician-Focused Payment Model Technical Advisory Committee on Rural Participation in APMs RFI



Recent Activities

Drug Enforcement Administration Second Temporary Extension of COVID-19 Telemedicine Flexibilities.

- Amends rule from May.
- NRHA <u>summary</u>.
- Extends all telemedicine flexibilities for prescribing medications for OUD and other controlled substances through December 31, 2024.
 - Prior rule extended through November 11, 2023.
- DEA plans to issue final policy by fall 2024.



Current Activities

Minimum Staffing Standards for LTC Facilities <u>proposed</u> <u>rule</u>.

- 2 main provisions for nursing homes/SNFs:
 - Must have RN on site 24/7.
 - Must meet 0.55 hours per resident day (HPRD) for RNs and 2.45 for nurse aides.
 - Rural facilities must comply with RN requirement within 3 years.
 - Rural facilities must comply with HPRD within 5 years.
 - One-year hardship exemption (may be renewed) for certain facilities.
 - More in-depth info from listening session presentation.



Current Activities

Minimum Staffing Standards for LTC Facilities **proposed rule**.

- Member <u>comment template</u> now available!
- NRHA draft comment available for review.
- NRHA <u>summary</u>.
- Comments are due November 6 via <u>regulations.gov</u>.
- Please fill out nursing home <u>membership survey</u>!



MPFS NPRM

CY 2024 Medicare Physician Fee schedule (MPFS) proposed rule.

- NRHA <u>summary</u>.
- Comments were due September 11 via regulations.gov.
- Physicians facing -3.3% payment cut in 2024 due to statutory requirements and budget neutrality.
- Proposing new G codes to cover community health integration (incl. CHW services), SDOH risk assessments, and principal illness navigation.



MPFS NPRM

CY 2024 MPFS cont.

- Marriage & family therapists, mental health counselors can bill Medicare directly for services Jan. 1, 2024.
 - Addiction counselors that meet <u>Mental Health Counselors (MHC)</u> requirements can enroll in Medicare as MHC.
- HCPCS code for psychotherapy services furnished outside of a facility.
- Implementing telehealth flexibility extensions from Consolidated Appropriations Act of 2023.



MPFS NPRM

CY 2024 MPFS cont.

- RHCs/FQHCs:
 - Can bill for community health integration & principal illness navigation.
 - Remote physiologic monitoring and remote therapeutic monitoring in the general care management code.
 - General supervision for behavioral health services furnished incident to physician/NPP's services.
- Minor changes to Medicare Shared Savings Program.



- Prior authorization
 - Can only be used to confirm diagnosis, determine medical necessity
 - MA plans must comply with coverage and benefit conditions in traditional Medicare, national & local coverage determinations
 - When Medicare coverage criteria are not established, MA plans:
 - Must make publicly accessible coverage policies based upon widely used treatment guidelines or clinical literature
 - MA plans cannot revise its medical necessity determinations
 - 90-day transition period for ongoing course of treatment



- Network adequacy
 - MA plans must arrange for out-of-network medically necessary items and services that are not available in-network
- Behavioral health
 - Clinical psychologists and social workers now subject to time, distance, and minimum number requirements – can receive 10% credit
 - Did not finalize MOUD-waivered providers for network adequacy requirements
 - Primary care appointment wait times apply to behavioral health care
 - Emergency services: immediately
 - Not emergency but requires medical attention: within 7 business days
 - Routine/preventive: within 30 business days
 - Emergency medical services include mental health services. MA plans must cover emergency services without regard for prior authorization



- Targeting misleading marketing and advertising
 - MA ads must include specific plan name
 - Superlatives prohibited without supporting documentation
 - Prohibited from advertising benefits not available in a service area
 - Must provide annual notice that beneficiaries may opt out of business calls
 - Pre-enrollment checklist must include "effect on current coverage" item
 - Scope of appointments, business reply cards, and other contact mechanisms are valid for 12 months
 - Prohibited from using Medicare name, CMS/HHS logo in misleading way



- Health equity
 - Health Equity Index is added to the Star Ratings program to encourage MA plans to focus on improving care for enrollees with social risk factors.
 - MA plans must develop procedures to identify and offer digital health education to help enrollees access medically necessary telehealth benefits



CAH Issues

96-hour average length of stay

- Longer waits for tertiary transfer
- PAC placement more difficult due to staffing shortages
- Increased Obs. Status by commercial insurance/Medicaid MCOs
- Solutions:
 - Remove requirement altogether
 - Raise the average to 120 hours, for example
 - Other ideas?
- 72-hour qualifying length of stay for Swing Bed placement
 - Solution: Remove requirement altogether or lower the threshold to 36 hours, for example. Other?

Updates from Congress





Responses to Congressional RFIs

- NRHA Submitted responses to several Congressional
 Requests for Information
- 1. House Ways and Means Committee RFI: Improving Access to Health Care in Rural and Underserved Areas.
- 2. House Budget Committee RFI: Reducing Costs & Improving Outcomes
- 3. Senator Bill Cassidy RFI: Reforming the Centers for Disease Control and Prevention
- Access the Responses at: <u>https://www.ruralhealth.us/advocate/legislative-branch</u>



Congressional Bipartisan Rural Health Caucus

- Relaunched by Reps. Jill Tokuda (D-HI) and Diana Harshbarger (R-TN).
- Caucus Kickoff on September 20th.
- 45 Representatives have joined the CBRHC.
- The Caucus will be an opportunity to host briefings and events to educate and inform Members of Congress and the public.
- Will allow Members to interact with patients, providers, and health advocates.
- Another great legislative vehicle to help move NRHA's rural health priorities.





Rural Health Care Facilities Revitalization Act

- H.R. 5989 Introduced on 10/19/23 by Rural Health Caucus Members: Reps. Caraveo (CO-08), Moylan (GU), and Salinas (OR-06).
- The bipartisan Act authorizes rural health facilities to use federal agricultural funds to ensure their long-term financial stability. Access to additional funding through USDA can help rural hospitals to maintain sustainable operating margins.
- The Act would allow rural health care facilities, including hospitals, mobile health care clinics, home health agencies, and long-term care facilities, to use Community Facility Loans or loan guarantees under the U.S. Department of Agriculture to :
 - Refinance debt, update telehealth, and medical equipment, among other needs.
 - A waiver of credit requirements is available for facilities in financial distress.



CDC Office of Rural Health Authorization

- H.R. 5481/ S. 2977 Introduced by Rep. Michael Guest (MS-03) and Sens. Merkley (OR) and Hyde-Smith (MS).
- Congress for appropriated 5 million dollars to stand up an Office of Rural Health (ORH) within the CDC in the Consolidated Appropriations Act of 2023.
- NRHA strongly encourages the HELP committee to fully authorize the CDC Office of Rural Health to ensure this important work continues beyond a single year appropriation



FY 2024 Appropriations Update

- Speaker Mike Johnson has stated his intentions to put forth another stopgap measure, a Continuing Resolution (CR), to extend funding past Nov 17.
- The next CR may extend funding until Jan. 15 or April 15, 2024, giving the House more time to advance all 12 appropriations bills.
- A vote on the Labor/ Health and Human Services, and Agriculture appropriations bills are proposed to be held on the Week of Nov 13.
- Senate leaders struck a deal on the Minibus, which includes funding for Agriculture, Mil-Con-VA, and THUD.
- Collision course potential between House and Senate.



NRHA FY24 Appropriations Requests

- CDC Office of Rural Health \$10m
- Increase funding for Rural Maternal and Obstetric Management Strategies – \$24.6m
- Rural Hospital infrastructure and sustainability- \$35 m
- Rural Residency Planning and Development Program- \$14.5m
- Medicare Rural Hospital Flexibility Grant Program \$73m
- •Behavioral Health and SUD treatments \$175m

ADVOCATE WITH US!

https://www.ruralhealth.us/advocate/rural-health-advocacy-campaigns



Legislation We Support

• <u>S. 2477, Equitable Community Access to Pharmacist Services Act</u>

- Introduced by Sens. Thune (R-SD) and Warner (D-VA).
- House Companion by Reps. Smith (R-NE) and Matsui (D-CA).
- Allows for Medicare reimbursement for certain services provided by pharmacists including tests, treatments, and vaccines for influenza, RSV, COVID-19, and Strep.

• H.R. 4829, Physical Therapist Workforce and Patient Access Act

- Introduced by Reps. DeGette (D-CO) and Armstrong (R-ND).
- Allows physical therapists to be eligible for National Health Service Corps.
- H.R. 4605, Healthy Moms and Babies Act:
 - Introduced in House by Reps. Carter (R-GA) and Bishop (D-GA).
 - Senate Companion by Sens. Grassley (R-IA) and Hassan (D-NH).
 - Improves maternal health coverage, supports care coordination, focuses on quality measures under Medicaid and CHIP.



Legislation We Support

- H.R. 4713, Rural Hospital Technical Assistance Program Act:
 - Introduced in the House by Reps. Derek Kilmer (D-WA), Ronny Jackson (R-TX), and Jodey Arrington (R-TX).
 - Makes an existing U.S. Department of Agriculture (USDA) program which provides technical assistance for rural hospitals permanent.
- H.R. 4603, Rural Wellness Act:
 - Introduced by Reps. Caraveo (D-CO) and Finstad (R-MN).
 - Prioritizes programs designed to increase access to behavioral and mental health treatment in rural communities in certain Rural Development grant programs.

Support the Rural Health Infrastructure



- NEW: <u>S. 1571: Rural Hospital Closure Relief Act of 2023</u>
 - Restore Necessary Provider status for CAH conversion
- Support the rural safety net hospitals
 - H.R. 833 Save America's Rural Hospitals Act
 - H.R. 1565 Critical Access Hospital Relief Act
 - repeals the 96-hour physician-certification requirement for inpatient CAH services
 - S. 803: Save Rural Hospitals Act of 2023
 - Establish a national minimum rate of 0.85 for the AWI reimbursement rate
 - <u>S. 1110: Rural Hospital Support Act of 2023</u>
 - make permanent the MDH program and enhanced LVA and MDHs and SCHs to choose an additional base year
 - S1673/HR1666: Ambulance Add-on



Support the Rural Health Infrastructure

- Modernize the RHC program
 - <u>S. 198/H.R. 3730</u>, Rural Health Clinic Burden Reduction Act
 - Developing RHC Quality Reporting Program with enhanced payment
- Ensure the 340B Drug Pricing Program remains a viable lifeline
 - H.R. 2534: PROTECT 340B Act of 2023
 - Evaluating other 340b reform proposals
- Extending authorization for CHC and NHSC.
 - H.R. 2559: Strengthening Community Care Act of 2023



Strengthen the Rural Health Workforce

- Expand the Medicare Graduate Medical Education (GME) program
 - <u>S. 230/H.R. 83 Rural Physician Workforce Production Act</u>
 - S. 665 Conrad State 30 and Physician Access Reauthorization Act
 - H.R. 751 Fair Access in Residency Act
- Support development and capacity of health care providers
 - H.R. 2761 Reintroduce Improving Care and Access to Nurses Act
- Support loan repayment programs
 - <u>S. 940 Rural America Health Corps Act</u>



in

Address Rural Health Equity

- Expand Access to Maternal Health Services
 - S. 948 Healthy Moms and Babies Act
 - H.R. 3305 Black Maternal Health Momnibus Act
- Permanently Expand Telehealth Provisions
 - S. 1636 Protecting Rural Telehealth Access Act
 - S. <u>1642</u> Reconnecting Rural America Act
 - Reintroduction of CONNECT for Health Act Coming Soon!
 - Including in person payment parity for RHC and FQHC services
- Expand Access to Emergency Medical Services (EMS)
 - <u>S. 1673/ H.R. 1666 Protecting Access to Ground Ambulance Medical Services Act</u>

3 percent increase in the rate for ground ambulance services that originate in rural areas. Super Rural Bonus 22.6 percent increase in the base rate for ground ambulance transports that originate an area in the lowest 25th percentile of all rural areas

- Support Rural Public Health Capacity
 - Reauthorize and increase funding for new CDC Office of Rural Health

The Congressional Bipartisan Rural Health Caucus Advocacy Campaign

National Rural

- This is an opportunity to provide a space for Members of Congress to highlight challenges and advocate for policy solutions related to the delivery of health care and mental health services in rural and remote communities
- There are currently 45 Members within the Caucus and counting! We encourage you to contact your district Member of Congress to consider joining the caucus to help increase access to quality, affordable health care and mental health services for all rural Americans.
- The Caucus will host member meetings, briefings, and events designed to inform and educate Members of Congress of some of the most pressing rural health care issues and highlight potential policy solutions to enhance the quality and efficiency of health care services in rural areas

Encourage your Member of Congress to join the Rural Health Caucus!



New advocacy materials!

Hospital bills 1-pager

 Summaries of our main hospital bills to share with elected officials.



S. 1110

H.R. 833

Save America's Rural Hospitals Act

Reps. Graves (R-MO) and Huffman (D-CA)

This legislation works to ensure critical rural providers are equipped to support their patients through a number of provisions including permanently eliminates Medicare sequestration for rural hospitals, makes permanent Low-Volume Hospitals and Medicare-Dependent Hospitals designations, reverses cuts to reimbursement of bad debt, permanently increases Medicare payments for ground ambulance services, and reauthorizes the Flex program, among other provisions.

Critical Access Hospital Relief Act of 2023

Reps. Smith (R-NE) and Sewell (D-AL) This bill repeals the 96-hour physician-certification requirement for inpatient critical access hospital services under Medicare.

Rural Hospital Support Act of 2023

Sens. Casey (D-PA) and Grassley (R-IA)

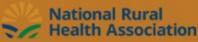
This bill makes permanent low-volume hospital and Medicaredependent hospital (MDH) designations, and allows sole community hospitals and MDH base year adjustments.



New advocacy materials!

<u>340B Priorities 1-Pager</u>

- Protect contract pharmacy arrangements
- Pass PROTECT 340B Act
- DSH waiver extension



NRHA 340B PRIORITIES

The 340B Drug Pricing Program is a lifeline that allows rural safety net providers to stretch scarce federal resources and keep their doors open to provide vital services to their communities. Significant 340B program restrictions by manufacturers and pharmaceutical benefit managers (PBMs) are hurting already struggling hospitals and clinics.

PROTECT 340B Act

H.R. 2534

Reps. Spanberger (D-VA) and Johnson (R-SD) Recently health insurers and PBMs have undermined the integrity of 340B for rural providers. This legislation would protect the lifeline program by prohibiting insurers and PBMs from discriminating against 340B covered entities or their contract pharmacies. Payers and PBMs would be held accountable for treating covered entities differently with regards to reimbursement of fees, patient's choice of pharmacies, and participating in standard or preferred networks.

Preserve contract pharmacy access.

Contract Pharmacy

Congress must curb manufacturers' restrictions on the number of contract pharmacies that a covered entity may use, which disproportionately constrains access for rural patients. Many rural covered entities are too small to support an in-house pharmacy and must rely upon outside pharmacies. The reality of rural geography is that rural providers have a patient base spread among a large geographic area. This makes maintaining access to unlimited contract pharmacies critical to ensuring rural patients can receive their 340B drugs at a convenient, local location.

DSH

Extend DSH waiver for 2 years.

DSH Extension Safety net hospitals were protected from losing 340B status due to changes in their disproportionate share (DSH) thresholds through cost reporting periods in 2022. Now that this protection has ended, more than 400 mostly small, rural hospitals are at-risk of losing eligibility in 2024 because of pandemic-era effects continuing to lower their DSH percentages. Congress must pass legislation to enact a 2-year extension for 340B eligibility protections.



New advocacy materials!



BUILD RURAL BROADBAND CAPACITY

Broadband access is critical for utilizing telehealth services. Increase support for **Community Connect, ReConnect, Rural Broadband, and Distance Learning & Telemedicine programs** to ensure rural America is connected.

SUPPORT RURAL DEVELOPMENT PROGRAMS

The RD title supports the backbone of rural communities, from hospitals to child care facilities. Congress must leverage key programs such as the **Community Facilities Loan & Grant Programs** to provide rural hospitals necessary capital and the strengthen economic health of rural areas.

ELEVATE RURAL HEALTH

Reauthorize the **Rural EMS & Equipment Assistance Program** and continue support for USDA's **Rural Health Liaison**. Congress must also address farmer behavioral health by supporting the Farm & Ranch Stress Assistance Network and authorizing a designated agricultural crisis hotline.

Farm Bill Priorities 1-Pager

- Supporting Rural Development, broadband programs
- Rural Hospital TA Program Act
- Hospital capital
- List of marker bills



Thank you.

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