

Leveraging the strength of Adventist Health – including its leaders, geographic footprint, and delivery system innovations – our advocacy program effectively influences public policies to protect and build the safety-net and rural health system.

Protect and Strengthen the Safety Net and Supplemental Funding

- Protect Medicare and the Medicaid supplemental safety net.
- Preserve the Affordable Care Act exchanges.
- Explore policies that aim to create sustainable funding for the health care safety-net.
- Protect 340B Drug Pricing Program.

Ensure Access and Sustainability

- Promote policies to protect individuals from being underinsured and uninsured.
- Advocate for payment innovation and delivery reform to improve healthcare efficiency, promote value-based care, and ensure better access to high-quality services while reducing overall costs.
- Promote discussions on commercial payor fairness to ensure equitable reimbursement rates, reduce disparities in payment practices, and support the financial sustainability of healthcare providers serving diverse patient populations.
- Remove barriers to integration and clinical networks of care.
- Advocate against site-neutral policies.
- Improve access to mental health resources.
- Encourage growth and pipeline programs to develop a diverse and skilled workforce to meet future healthcare demands.

Preserve Rural Health

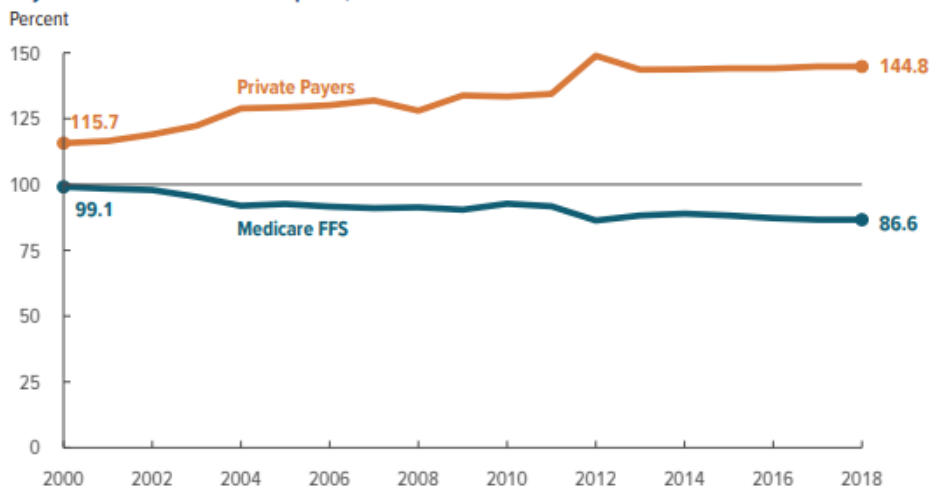
- Preserve Critical Access Hospitals and rural hospitals.
- Secure stability and expansion of rural health clinics.
- Promote new rural health models.
- Support new and established physician residency programs in rural health.
- Bolster rural pipeline programs.

Adventist Health continues to advocate for fair and adequate Medicaid and Medicare payments and coverage to protect and provide care for our most vulnerable populations.

Medicare and Medicaid are lifelines for the communities we serve. These programs ensure that elderly, medically frail, low-income, minority and other vulnerable populations can access the health services they need. Medicare and Medicaid account for about 75 percent of all care provided by Adventist Health hospitals. A strong Medicare and Medicaid program is key to much of the work we do for our patients and communities.

Recently, Medicare payment levels hit record lows. In 2022, Medicare paid just 82 cents for every dollar spent by hospitals caring for Medicare patients, resulting in \$99.2 billion in Medicare underpayments.

Payment-to-Cost Ratios for Hospitals, 2000 to 2018



Source: American Hospital Association; hospitalmedicaldirector.com

Policy Recommendations:

- Stop site-neural cuts to safety-net hospitals.
- Create a new safety-net definition take into account Medicaid care provided by hospitals.
- Increase Medi-Cal rate in California to align with inflation.

Preserving the ACA exchanges is a critical component of a sustainable and equitable healthcare system.

Preserving the Affordable Care Act (ACA) exchanges is essential for maintaining access to affordable healthcare for millions of Americans and ensuring the financial stability of hospitals. The ACA exchanges provide a marketplace for individuals and families to purchase health insurance, often with subsidies that make coverage more affordable. These exchanges are particularly vital for people who do not have employer-sponsored insurance and/or do not qualify for Medicaid, bridging a critical gap in the healthcare system.

For hospitals, the ACA exchanges play a significant role in reducing the burden of uncompensated care. Before the ACA, uninsured patients often relied on emergency rooms for medical care, leading to substantial financial losses for hospitals. With more individuals insured through the exchanges, hospitals are better equipped to manage their resources, focus on preventive and comprehensive care, and reduce costs associated with treating uninsured patients. This financial stability allows hospitals to invest in infrastructure, staff, and advanced medical technologies, ultimately improving the quality of care for all patients.

Patients benefit from the exchanges by gaining access to a wide range of insurance plans, enabling them to choose coverage that meets their specific needs. Subsidies offered through the ACA make insurance affordable for low- and middle-income families, reducing the financial barriers to seeking necessary medical care. This improved access leads to earlier diagnosis and treatment of illnesses, better management of chronic conditions, and overall improved health outcomes.

Policy Recommendations:

- Incentivize states that have not yet expanded Medicaid to do so, reducing the coverage gap for low-income individuals and ensuring broader access to affordable care.
- Invest in targeted outreach campaigns, navigator programs and enrollment assistance to create awareness and participation, particularly among younger healthier populations.
- Streamline enrollment process and reduce administrative hurdles to make signing up for coverage more accessible.

ACA Exchanges contributed to a dramatic decline in the uninsured rate. By 2016, the uninsured rate in the U.S. had dropped from 16% in 2010 to 8.6%, with more than 11 million Americans enrolled in ACA marketplace plans.

Source: Center on Budget and Policy Priorities

The Department of Health and Human Services reported that in 2021 alone, approximately 150 million Americans benefitted from free preventative care provisions, leading to earlier detection of health issues and lower long-term health costs.

Adventist Health is working to ensure the health care safety-net is available to patients that need it.

Protecting and strengthening the health care safety-net is essential to ensure that vulnerable populations, such as low income families, uninsured individuals, and those living in underserved communities, have access to critical medical services. Supplemental funding plays a vital role in stabilizing hospitals that serves as lifelines for these community members. to make the system sustainable, funding mechanisms that are resilient to economic fluctuations and designed to support long term growth are needed. By investing in sustainable financing strategies, the health care safety net can remain strong and adaptable to the evolving needs of our communities.

Safety-net funding is essential!

An estimated 1.1 million **Oregonians** have coverage through Medicaid or the Children's Health Insurance Program (CHIP).

Source: Center on Budget and Policy Priorities

More than one-third of **California's** population relies on Medi-Cal.

Source: California Department of Health Care Services

Over 400,000 of the population in **Hawai'i** has coverage through Medicaid

Source: Centers for Medicare & Medicaid Services

Policy Recommendations:

- Establish dedicated trust funds specifically for safety-net providers that are financed through stable revenue sources.
- Use Section 1115 waivers to pilot innovative funding models that strengthen safety-net services.
- Ensure diversified and sustainable revenue streams like public-private partnerships.
- Implement policies that trigger supplemental funding during public health emergencies or economic downturns to prevent gaps in funding that could lead to gaps in care.
- Transition to outcome-based reimbursement, rewarding safety-net providers for improving population health and reducing disparities.

Adventist Health understands that protecting 340B is necessary to provide care for uninsured patients and to support community health programs.

340B is a drug pricing program that came out of the Medicaid drug rebate program and 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. 340B is facing heightened scrutiny as policymakers, courts, and regulators question its oversight, transparency, and financial structure. The proposed rebate-based payment model has alarmed hospitals and would create overwhelming financial challenges on 340B participants already operating on thin margins. As a safety-net provider, Adventist Health continues to work to ensure the 340B program is protected so the most disadvantaged populations, which include low-income and severely isolated individuals, can still receive the care they need.



Source: American Hospital Association

Policy Recommendations:

- Work in partnership with coalitions to reverse the 340B Rebate program established by HRSA.
- Ensure statutory language prohibits manufacturers from restricting access to 340B discounts, closing loopholes that allow drug makers to limit distribution to impose contract pharmacy restrictions.
- Expand contract pharmacy access to ensure the ability of safety-net providers to partner with multiple contract pharmacies in rural or underserved areas where patients lack direct access to hospital pharmacies.

Adventist Health supports policies that make care more affordable and accessible, including those that protect individuals from being uninsured and underinsured.

People who lack health insurance are less likely to seek preventative and primary care services, and may delay treatment for major health conditions or chronic diseases. Those who have a regular source of primary care are more likely to comply with prescribed treatments and have lower rates of illness and premature death than those who are uninsured or underinsured. Underinsured and uninsured people often utilize hospital emergency departments as a primary care setting, which is costly in terms of staffing, resource allocation, and patient wait times. Overall, having health insurance increases the timely use of health services and improves health outcomes.

In 2023, California had an uninsured rate of 7.5%.

6.8% of Oregon's population was uninsured in 2023.

3.9% of Hawaii's population was uninsured in 2023.

Source: U.S. Census Bureau Small Area Health Insurance Estimates

Policy Recommendations:

- Establish a framework for the integration of Medicare and Medicaid Services for dual eligible individuals.
- Urge the consideration of health benefit designs that encourage patients to access and use cost-effective primary care, especially health services shown to delay or prevent the onset of chronic conditions.
- Support policies that achieve universal coverage with a lens of equitable access to care, especially for populations that have gone far too long without care.

Adventist Health promotes integrated, comprehensive strategies to reform care delivery and payment to improve healthcare efficiency, promote value-based care, and ensure better access to high-quality services while reducing overall costs.

Our current national health investment focuses heavily on medical interventions rather than strategies that address disease prevention or social and environmental conditions that affect population health. The traditional “fee-for-service” reimbursement system pays physicians and hospitals for each service provided to a patient, financially rewarding quantity over quality of the care provided. Healthcare providers understand the benefits of preventing chronic diseases, but financial incentives are designed to treat rather than prevent disease. As risk-bearing entities that provide payment models and incentives, healthcare payers (commercial health plans, Medicaid, and particularly Medicare) have influence that can affect preventative care services.

It is imperative that we change provider reimbursement from a volume focused model to value-based model that focuses on accountability for overall cost and quality. Services such as patient education and coordinated post-hospital care are often under-resourced because providers and hospitals don't have the adequate financial resources. A reformed system should support providers who provide primary care and reward value, quality, and organized delivery of care.

Healthcare costs continue to grow at an unsustainable pace of at least 2-3 times the rate of inflation.

Policy Recommendations:

- Modernize provider reimbursement by moving away from volume and intensity and toward quality and value of services.
- Promote integrated, comprehensive strategies to reform care delivery and payment to bring down the cost to health systems and improve community well-being.

Adventist Health supports policies that ensure equitable reimbursement rates, reduce disparities in payment practices, and support the financial sustainability of healthcare providers serving diverse patient populations.

Health plans are increasingly shifting administrative burdens to providers, requiring them to spend more and more time on the phone with insurers resubmitting claims, seeking prior authorization, and more. The more time providers spend writing appeals and gaining prior authorization takes time away from much-needed patient care, further contributing to provider burnout and driving up healthcare costs. Requiring providers to file multiple appeals to get reimbursed is not an infrequent process, with the annual value of challenged claims ranging from \$11 billion to \$54 billion annually. Insurance companies often drag out the prior authorization process required to transfer patients to skilled nursing facilities and rehabilitation facilities, leaving patients in limbo and delaying their transfer to a facility that is best suited to handle their needs. At the same time, patients are often left in the middle to wait and wonder, “Is my insurance company going to pay for this?” In addition to generating stress for patients, administrative burdens also increase costs. More than one-third of all health care costs in the U.S. are due to insurance company overhead and resources to deal with billing.

Physicians and their staff spend an average of almost two business days (14 hours) each week completing prior authorizations.

24% of physicians report that prior authorizations have led to a patient’s hospitalization.

Physicians report that on average, almost 1 in 5 prescriptions require prior authorization.

Source: American Medical Association

Policy Recommendations:

- Standardize prior authorization requirements and processes.
- Standardize communication services and process requirements.
- Increase oversight of health plans to stop unnecessary denials or payment delays.

By removing barriers to integration and clinical networks of care, we can create a better patient experience and effectively utilize resources.

Clinically integrated networks, such as Adventist Health, encompass hospitals, clinics, and other provider facilities that work together across different settings of care. Together, clinically integrated networks enhance patient care, improve care coordination, and significantly reduce healthcare costs for healthcare providers and patients. Across the continuum of care, networks are able to participate in value-based payment models such as Accountable Care Organizations (ACO's) that reward providers for achieving quality targets, improving patient outcomes, delivering care in a cost-effective manner.

Health systems with clinically integrated models are able to establish more consistent practices in utilization review, quality assurance, protocols and guidelines, and access to medical records. It also ensures that struggling hospitals can remain open, access resources necessary to comply with costly regulations, pay for new technology that improves patient safety and the quality of care, and support outreach programs that keep people healthy.

Policy Recommendations:

- Remove barriers to integration and clinical networks of care.
- Create policy solutions that help rural providers affiliate with other health systems to ensure care stays local.

Adventist Health continues to advocate against site-neutral payments that would place even greater financial pressure on hospitals who provide access to emergency care.

People rely on hospitals to provide round-the-clock access to critical care for all types of patients, to serve as a safety net provider for vulnerable populations, and to maintain emergency care on a standby capacity. Hospitals and their outpatient departments provide essential access to services that are otherwise not available in the community, treat patients with more complex and chronic conditions, and are subject to more expensive licensing, accreditation, and regulatory requirements. Site-neutral policies seek to reduce hospital payments by paying the same reimbursement rates whether performed in a hospital outpatient department (HOPD), physician's office, or ambulatory surgery center (ASC).

These site-neutral payments ignore the overall cost of care to hospitals, who provide care 24/7 to all, regardless of ability to pay. The cost of care delivered in hospitals must be taken into account, including the already low reimbursement rates that threaten rural, low-volume, and safety-net hospitals risk of closing. Cutting reimbursement to vulnerable care providers risks creating hospital deserts, depriving rural residents of much-needed access to care. Site-neutral payment reforms threaten patients' access to essential hospital services, especially for rural and low-income populations.

Site-neutral payments threaten a critical lifeline for hospitals, communities, and patients who are already at risk.

Policy Recommendations:

- Oppose any additional site-neutral payment cuts, which would reduce access to critical health care services, especially in rural and underserved communities.
- Address the true drivers of physician acquisitions, which include significant underpayments to providers and persistent delays and denials of care by commercial insurers.

Unless addressed, mental and behavioral health challenges will become more prominent across our communities. Adventist Health values a whole-person approach to health care and continues to advocate for improving mental health access.

Individuals seeking mental health care often discuss the large number of barriers that must be overcome in order to receive care for their concerns. Improving access to mental health services can be done in many ways.

1. Integrate mental health into medical care while improving access in community-based settings by addressing barriers, workforce shortages, and mental parity. Mental health stigmas often prevent people from seeking treatment or receiving care, so integrating mental health into primary care settings can increase the number of individuals reached. Cultural ideations also impact who may seek treatment for behavioral health concerns. Studies show individuals with serious mental illness have higher rates of morbidity and mortality due to chronic health conditions, highlighting the importance of addressing mental health concerns as soon as possible (CHCF Behavioral Health Integration Blueprint). Ensuring individuals have access to mental health services throughout the community can reduce the number of patients in mental distress at emergency departments.
2. Additional funding for long-term care to help institutionalize patients who enter the emergency room (ER) in mental distress, only to be stabilized and released without a long-term treatment plan. Patients who utilize the ER as behavioral, psychiatric, or primary care creates overcrowded conditions and strain in the emergency department.
3. Increase the amount of behavioral health providers covered by insurance plans. Patients often go without treatment because out-of-pocket costs are too high, providers don't accept their insurance, or the wait times are too long.
4. Community-based resources and education that can provide immediate relief and access regardless of insurance.

Policy Recommendations:

- Invest in more community-based resources for those with serious mental illness.
- Encourage primary care practices to identify community-based resources to help patients address toxic stress.
- Keep telehealth waivers in place that allow providers to deliver mental health services.
- Integrate mental health services into primary care settings and support decreasing stigma.
- Repeal the Medicaid Institutions for Mental Disease exclusion, which prohibits the use of federal Medicaid funds to cover inpatient mental health services for patients aged 21 to 64 in certain freestanding psychiatric facilities.

Adventist Health encourages growth and pipeline programs to develop a diverse and skilled workforce to meet healthcare demands.

Before the pandemic, our communities were facing healthcare provider shortages caused by an uneven distribution of workers. Rural and underserved communities tend to have fewer physicians, nurses, specialists, and other healthcare workers, while also facing higher rates of chronic disease, mental illness, and obesity. Of the 35 counties we operate in, 17 are designated as Medically Underserved Areas (MUA) or as a Health Professional Shortage Area (HPSA). According to the "Supply and Demand Projections of the Nursing Workforce: 2014-2030", a report produced by the Health Resources and Services Administration, California is facing a deficit of 40,567 Registered Nurses (RNs), which is nearly three times the deficit in several states such as Texas, New Jersey, and South Carolina.

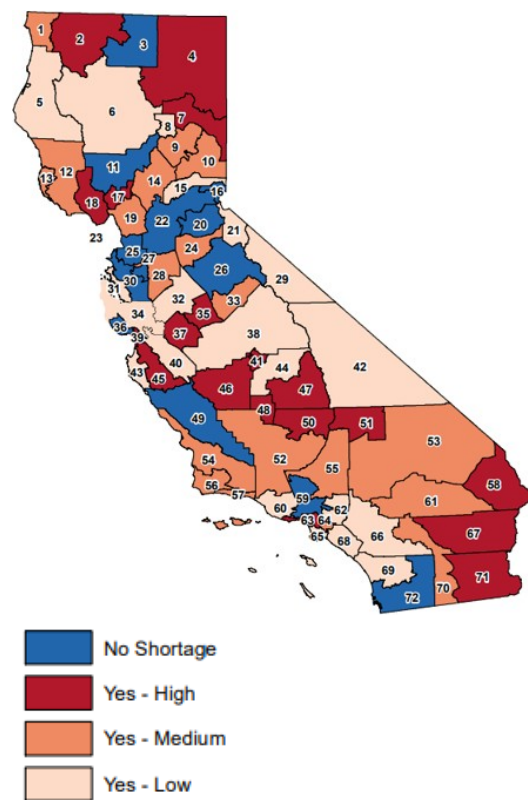
What We Are Doing:

Adventist Health has created a comprehensive workforce strategy including pipeline, development, and training programs to address the workforce shortage. The goal of these programs is to reduce turnover and turnover costs, increase workforce to accommodate growth, improve workforce diversity to reflect local communities, and form partnerships with community-based organizations and state and local agencies to support value-based care.

Policy Recommendations:

- Assist nursing workforce development programs to support recruitment, retention and advanced education for nurses and other allied health professionals.
- Direct funding to colleges to increase faculty in nursing and other clinical programs. Early identification and mentoring of highly prospective candidates to serve in rural and HPSAs.
- Reserve enrollment seats in nursing programs and allied health programs for local students in HPSAs.

According to a 2018 Nursing Workforce Study by the U.S. Department of Health and Human Services' Health Resources and Services Administration, by 2030 California will be facing an estimated deficit of 44,500 RNs.



CAH designation protects and ensures access to healthcare services so Adventist Health can continue providing care in rural communities.

On average, rural residents are older, poorer and generally have worse health conditions than urban residents. Requiring more medical attention and care, they also have more limited access to health services.

Adventist Health has multiple designated critical access hospitals (CAHs) in California and Oregon including Mendocino Coast, Howard Memorial, Tehachapi, Clear Lake and Tillamook. CAH designation status comes from the Centers for Medicare & Medicaid Services (CMS). In order to be eligible for the CAH designation, the hospital must be a currently participating Medicare hospital, ceased operations on or after November 29, 1989, or health clinic or center that previously operated as a hospital before being downsized to a clinic or center.

The CAH program helps rural hospitals serve their communities by providing increased revenues through the cost-based reimbursement Medicare Program. Designated CAHs have a different set of eligibility rules called Medicare Conditions of Participation. These eligibility rules protect and ensure the health and safety standards of the organizations.

Policy Recommendations:

- Re-define “reasonable” or “allowable” costs for CAHS to include additional patient centered costs.
- Remove the 96 hour Condition of payment for CAHs.



Adventist Health has 5
Critical Access Hospitals.

Rural Health Clinics are often the main source of primary care in rural communities and are vital to increasing access to care.

Signed into law by President Jimmy Carter in 1977, the rural health clinics (RHC) program was designed to improve access to health care in rural, underserved areas. Over forty-five years later, there are over 5,300 RHCs providing quality care to rural and underserved patients. However, as healthcare evolves, several program policies are in need of modernization to reflect the changing world. The Rural Health Clinic Burden Reduction Act of 2023 would accomplish this through the following provisions:

- Modernizes RHC physician supervision requirements by aligning them to state scope of practice laws governing PA and NP practice.
- Removes the requirement that RHCs must “directly provide” certain lab services on site and allows RHCs to instead offer “prompt access” to these services.
- Allows RHCs the flexibility to contract with or employ PAs and NPs.
- Maintains status quo location eligibility, allowing RHCs to be located in an area that is not in an urban area of 50,000 or more, given that the Census Bureau no longer utilizes the term “urbanized area.”
- Removes a regulatory barrier that limits RHCs provision of behavioral health services in areas experiencing a shortage of such services.



Adventist Health has over 65 Rural Health Care Clinics throughout California, Oregon, and Hawaii.

More than 20% of the Rural Health Clinics in California are part of the Adventist Health System.

As health care evolves, implementing new models for rural health will ensure financial sustainability.

Rural hospitals often struggle to keep their doors open due to declining financial performance, geographic isolation or low patient volume. Since 2010, over 180, mostly rural, hospitals have closed their doors, with many more decreasing service lines, leading to a lack of access for people in rural communities. Because of this, rural residents have higher rates of mortality, chronic diseases and disabilities as compared to urban residents. The hospital closures emphasize the importance of these hospitals in their communities, as well as the need for financially viable rural health models. Participation in innovative payment models that provide additional investment and flexibilities can be a helpful resource.

Policy Recommendations:

- Test new payment models of care in rural areas and sustainable system design.
- Identify models of care to better support the safety net needs of frontier and isolated rural communities.

Rural Hospitals make up about 35% of all hospitals

Approximately 43% of rural hospitals operate at a financial deficit.

Source: American Hospital Association



Adventist Health encourages investments in safety-net residency programs to ensure our healthcare professionals are trained and prepared to serve underserved and vulnerable communities.

Investing in safety-net residency programs is a crucial step in addressing the growing challenges of equitable healthcare delivery in underserved communities. Safety-net hospitals, which primarily serve low-income, uninsured, and underinsured populations, face significant staffing shortages that can hinder their ability to provide comprehensive care. Residency programs based in these institutions not only enhance the quality of care for vulnerable populations but also help cultivate a workforce committed to serving in areas with limited healthcare resources.

Physicians trained in safety-net settings are more likely to continue practicing in similar environments. A study found that 28.1% of physicians who train in a Rural Health Clinic and 31.2% who training in a Federally Qualified Health Center between 2001 and 2005 were practicing in these settings by 2009.ⁱ

One of the key benefits of safety-net residency programs is their ability to attract and retain physicians who are passionate about working in underserved settings. Studies have shown that residents who train in safety-net hospitals are more likely to continue practicing in similar environments after completing their programs. This continuity strengthens the healthcare infrastructure in medically underserved areas, reducing disparities in access to care and improving health outcomes for marginalized groups.

Encouraging investment in these programs also bolsters the overall healthcare system. Expanding the capacity of safety-net residency programs can alleviate workforce shortages in primary care and other high-demand specialties. Furthermore, financial support for these programs demonstrates a commitment to health equity and ensures that the benefits of medical education are distributed across all communities.

Policy Recommendations:

- Develop residency tracks tailored to the needs of rural and underserved communities, ensuring training addresses specific local challenges.
- Expand funding to support residency training in safety-net facilities.
- Allocate additional Medicare-supported GME slots specifically for safety-net hospitals.
- Invest in residency programs that integrate telemedicine, community-based care and interdisciplinary approaches to meet the needs of vulnerable populations.

Pipeline programs are a proven solution to address critical health professions shortages.

Workforce shortages and increasing labor expenses have pushed hospitals to utilize expensive contract labor firms to bolster staffing. For rural hospitals, soaring labor costs are especially challenging when nearly half of rural hospitals have negative operating margins. To avoid expensive contract labor and the underlying workforce shortages, pipeline programs that incentivize clinicians to work in rural areas can alleviate the workforce strain.

Policy Recommendations:

- Implement the National Healthcare Workforce Commission, which was authorized in the Affordable Care Act but never funded.
- Address the shortages rural providers face in maintaining an adequate workforce through programs like the National Health Service Corps (NHSC), Nurse Corps Loan Repayment Program (NCLRP), and Title VII and VIII workforce training programs.
- Test new models of team-based care to maximize the capacity of the rural workforce to serve people living in rural areas.
- Allow policies that allow trained professionals to work at the top of their licensure.

ADVENTIST HEALTH

DEPLOYED WORKFORCE DEVELOPMENT PROGRAMS

 Intro to Nursing

 ASN Program

 LAUNCH

 COPE Health Scholars

