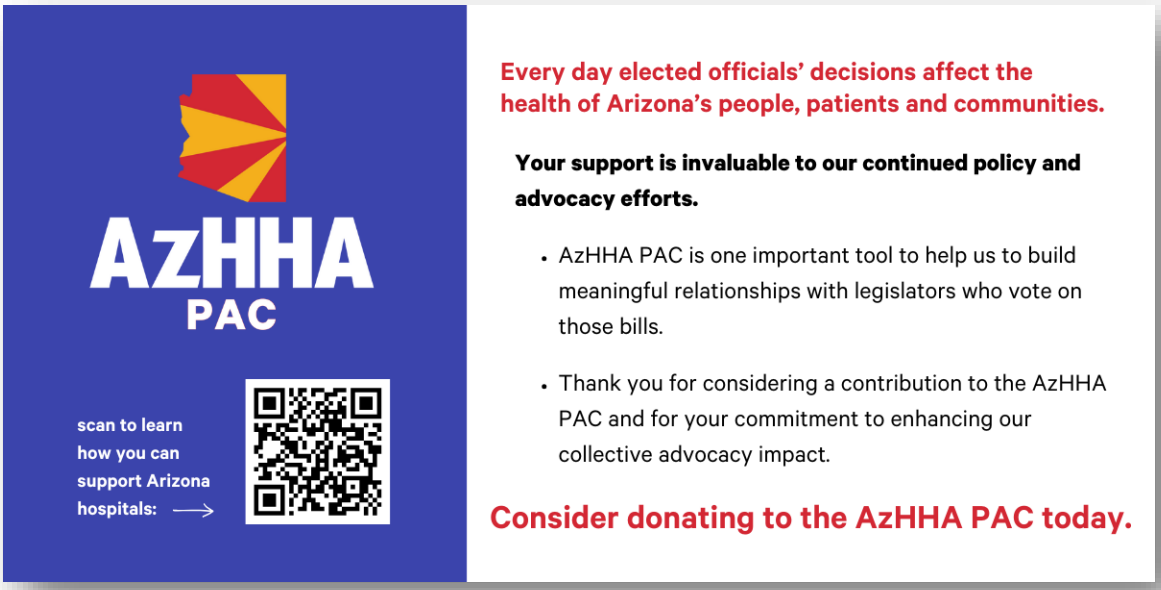
AzHHA
Arizona Hospital and Healthcare Association

POLICY AND ADVOCACY AGENDA

Providing clear positions and priorities to support hospital financial stability, healthcare workforce development, access to care and patient safety across Arizona.

AzHHA 2026 Policy and Advocacy Agenda

Contents



How to use this document

This is your quick reference guide to the policy areas we track each year. Each section provides a position statement and concise bullet points on what we support, oppose and monitor, along with an evaluation checklist you can use on any proposal. Use this as your first resource before drafting testimony, attending a meeting or weighing in on a bill.

Who this is for

- Public Policy Committee members and AzHHA staff
- Hospital leaders preparing for meetings or hearings
- Coalition partners who need a clear view of our stance

How it's organized

- **Evergreen priority areas.** Each page follows the same pattern: Position, we support, we oppose, always on watch and an evaluation checklist.
- **Not bill-by-bill.** It's a compendium of standing priorities we use to evaluate specific proposals as they come up.
- **Bill Screen Template.** Use the one-page template at the end to gather the essentials for any bill before we establish a position.

When to use it

- **Before meetings:** review the relevant section, jot down key points and verify talking points.
- **During the session:** Match these pages with the Bill Screen Template to determine Support, Oppose or Monitor.
- **Between sessions:** Update "Last reviewed" and add any new watch items or examples that came up.

Setting a position

- **Support:** Enhances access, quality, safety or sustainability and is practically feasible.
- **Oppose:** Likely to harm patients, destabilize hospitals or impose unworkable requirements.
- **Monitor:** Impact is unclear, needs revision or requires more data or stakeholder input.

AzHHA policy objectives and priorities

The Arizona Hospital and Healthcare Association (AzHHA) remains committed to advancing healthcare excellence across our state. Our purpose is to bring together diverse voices to advance health and healthcare in Arizona. Our policy objectives for the upcoming year support this purpose with a focus on enhancing patient care, promoting healthcare equity and driving innovation.

We aim to strengthen our healthcare workforce, improve access to quality care and advocate for policies that support the well-being of all Arizonans. By collaborating with healthcare providers, policymakers and communities, we strive to create a healthier future for everyone.

2026 AzHHA policy objectives

Financial security and access to care

Advance fiscal and budgetary policies that provide financial stability for the most vulnerable hospitals and healthcare systems.

Better care

Advance patient-centered policies that result in improved quality of care and patient satisfaction.

Better health

Advance policies that will effectively improve the health of populations.

Improved value

Advance sensible policies that reward value and create a more efficient healthcare system.

Innovation and transformative healthcare

Advance policies that will support AzHHA member hospitals and health systems to thrive in emerging healthcare markets and successfully respond to transformative and disruptive healthcare technologies.

Hospital financial stability

POSITION

AzHHA advocates stable coverage and funding, enabling hospitals to maintain bed availability, pay staff fair market wages and deliver high-quality care to patients. We support adequate and predictable base rates in Medicaid and Medicare, as well as transparent processes for calculating supplemental and state-directed payments. Additionally, we advocate for fair managed care rules that include prompt payment and transparent appeals processes.

We promote sensible eligibility and enrollment processes in Medicaid to reduce churn and use provider assessments to offset Medicaid underpayment and uncompensated care.

We oppose cuts to Medicaid and Medicare, the diversion of provider-generated funding into the state general fund and reductions in provider reimbursement without a plan to stabilize the delivery system. Our goal is to establish a healthcare financing system that is actuarially sound, CMS-compliant and workable for both rural and safety-net hospitals and large urban health systems.

WE SUPPORT

- **Adequate, predictable base rates**
  - Regular rebasing for inpatient and outpatient reimbursement, tied to credible cost indexes
  - Timely adoption of APR-DRG and outpatient updates so reimbursement rates keep pace with costs
  - Rural and critical access hospital reimbursement adjustments that reflect the cost of delivering care in rural and frontier communities
- **Transparent supplemental and state-directed payment programs**
  - Clear methodologies, payment schedules and public documentation
  - Programs that reward access, quality and essential standby services
  - Stable design across plan years so hospitals can budget
- **Coverage stability and sensible eligibility and enrollment processes**
  - Policies that prevent churn for adults and kids who remain eligible for Medicaid and Title XIX
  - Smooth transitions between Medicaid, Title XIX, the Marketplace and commercial coverage

- **Fair managed care rules and prompt payment**
  - Clean-claim standards, interest on late payments and simple resubmission pathways
  - Transparency in claims and prior authorization denials, substantive denial statements and points of contact for dispute resolution
  - Timely credentialing of providers, reduction of duplicative administrative activities and retroactive payments for credentialed providers
  - Practical and effective care coordination between physical health, behavioral health, post-acute care and long-term care
- **Responsible use of provider assessments**
  - Transparency and hospital input on reimbursement models
  - Use of assessment funds to bolster Medicaid base rates and quality incentive payments
- **Targeted investments in the workforce that improve access to care**
  - Investments in graduate medical education (GME) and indirect medical education (IME)
  - Investments in nursing, other allied health professions and administrative professionals
  - Developing rural residency programs, increasing rotations in rural and underserved communities and incentivizing programs that meet a demonstrated community need
  - Funding for specialty, high-acuity services like trauma, OB and NICU

WE OPPOSE

- **Cuts that reduce access to care**
  - Across-the-board base rate reductions or elimination of essential supplemental payments
  - Caps and limits on services that ignore medical necessity or acuity
- **Budget maneuvers that destabilize hospitals**
  - Sweeps of provider assessment to backfill general fund obligations
  - Wholesale reduction in funding for Medicaid and Title XIX
  - Reimbursement methodology changes without transparency and stakeholder engagement

- **Opaque payment practices**
  - Claw-backs for technical errors after claims were adjudicated in good faith
  - Denials that do not cite specific criteria or provide a workable appeal

- **Unfunded mandates and administrative burden**
  - New reporting or authorization requirements that increase administrative costs
  - Unclear policies for audits and inspections from regulators that place burdensome demands on clinical staff, which jeopardize patient care

ALWAYS ON WATCH

- **State budget and assessment policy**
  - Reauthorization timelines, rate-setting calendars and use of assessment proceeds
- **Federal waivers and rule changes**
  - 1115 waiver terms, state-directed payment approvals and managed care rules
- **Rate methodologies and updates**
  - APR-DRG changes, outpatient fee schedules and quality withholds
- **Safety-net funding**
  - DSH allotments, FMAP shifts and any federal caps that affect Arizona
- **Plan performance and data**
  - Encounter integrity, prompt-pay compliance and transparent denial and overturn rates

EVALUATION CHECKLIST

- ☐ **Does it preserve or expand timely access to essential hospital services?**
  - Trauma, OB, NICU, behavioral health, rural care, etc.
- ☐ **Is funding adequate, stable, and predictable for hospitals and patients?**
  - No cost shifts, clear schedules and practical transition plans
- ☐ **What is the impact on rural and safety-net providers?**
  - Adjustments that reflect volume, distance and standby costs
- ☐ **Are the administrative expectations workable?**
  - Simple rules, clear criteria and reasonable audits and reporting
- ☐ **Is it compliant with federal requirements and actuarially sound?**
  - CMS approval path is clear, with documented methodologies

- **Can hospitals implement it without disrupting care?**
    - Realistic timelines, testing and support for operational changes

Last reviewed:
August 2025

Healthcare workforce

POSITION

AzHHA advocates for policies that expand the clinician and allied health professional pipeline, expedite entry into practice and ensure team safety and support. We back funding for GME and training programs, streamlined licensing and team-based care with clear training and supervision. We promote workplace safety, mental health resources and practical incentives that help hospitals recruit and keep staff, especially in rural and high-acuity settings. We also support fair labor practices and transparent agency arrangements that stabilize staffing without increasing costs.

WE SUPPORT

- **State support for Graduate Medical Education (GME), Indirect Medical Education (IME) and clinical training**
  - New residency slots in high-need specialties and rural rotations
  - Paid preceptor models and malpractice coverage for trainees
  - Simple, uniform site agreements and background checks across systems
- **Recruitment and retention incentives in shortage areas**
  - Loan repayment and forgiveness, tax credits, relocation and housing stipends
  - Visa pathways and expedited licensing for internationally trained clinicians with competency verification
  - Targeted incentives for hard-to-fill roles such as ED and ICU nurses, behavioral health, respiratory therapy, imaging, lab and EMS
- **Licensing efficiency, portability, and compacts**
  - Participation in RN, APRN, physician, EMS, PT, OT, SLP, psychology and other compacts
  - Service-level timelines for initial licenses, renewals and background checks
  - Universal endorsement standards and temporary practice permits to begin sooner
- **Team-based care with patient safety guardrails**
  - Data-supported scope of practice updates combined with training, supervision, setting limits and staffing formularies where appropriate
  - Clear delegation protocols and adaptable staffing options for hospitals to match acuity

- **Workplace safety and well-being**
  - Violence prevention plans, reporting tools and trespass authority where necessary
  - Access to mental health services, fatigue management and flexible scheduling
  - Childcare solutions and innovation grants for safe staffing models
- **Pipeline development from high school to advanced practice**
  - Scholarships, dual-enrollment health programs (career and technical education/CTE) and career exploration
  - CNA-to-RN ladders, bridge programs and tuition reimbursement
  - Community college and university partnerships and rural grow-your-own models

WE OPPOSE

- **Unfunded staffing mandates and rigid ratios**
  - One-size-fits-all requirements that overlook acuity, layout and workforce supply
  - Penalties without funding, waivers or realistic timelines
- **Scope changes without training or safety**
  - Expansions that circumvent competency, supervision or quality metrics
  - Policies that divide teams or raise liability without advantages
- **Administrative hurdles that slow hiring**
  - Duplicative background checks, slow credentialing and redundant onboarding
  - Barriers to licensing for qualified out-of-state or international clinicians
- **Price practices that destabilize hospitals**
  - Non-transparent staffing agency markups and restrictive contracts
  - Clauses that prevent permanent hiring or impose excessive conversion fees

ALWAYS ON WATCH

- **Compact participation and licensure timelines**
  - Reciprocity, temporary permits and service-level standards
- **Clinical training capacity**
  - Preceptor availability, liability coverage and rotation funding
- **Workplace safety rules**
  - Violence prevention, OSHA changes and workers' compensation impacts

- **Agency staffing and labor policy**
    - Transparency, overtime rules and emergency contract terms
- **Rural workforce supports**
    - Housing, transportation and differential pay options

EVALUATION CHECKLIST

- ☐ Does it expand supply where patients need it, including rural and high-acuity areas?
- ☐ Is patient safety ensured through training, supervision and measured outcomes?
- ☐ Are costs transferred or shifted to hospitals without support?
- ☐ Does it lessen administrative friction in hiring, credentialing and licensing?
- ☐ Can hospitals implement within realistic timelines with minimal disruption to care?

Last reviewed:

August 2025

Access, flow and utilization management

POSITION

AzHHA advocates for policies that enable patients to receive the appropriate level of care at the right time, ensuring smooth transitions throughout the continuum of care. This includes prehospital entry, ED arrival, inpatient care, interfacility transfers, post-acute placement and safe discharge.

We support transparent, enforceable timelines for prior authorization and medical-necessity decisions, transparent utilization management standards and accountable networks with sufficient bed capacity, specialty coverage and transportation.

We endorse transfer pathways that prioritize clinical need, reduce ambulance offload delays and prevent unnecessary ED boarding. We oppose practices that block or slow transfers, misclassify status (such as observation versus inpatient) to avoid payment, or rely on opaque denials and retroactive audits. We call on payers to report on denial rates, overturns, delays and expedited authorizations for time-sensitive services.

Furthermore, we encourage coordinated solutions to address post-acute bottlenecks involving SNF, LTACH, rehab, behavioral health, home health, DME and hospice. This includes dependable acceptance of interhospital transfers for specialty services, equitable transport coverage and network adequacy that supports rural Arizona.

WE SUPPORT

- **Reasonable prior authorization timelines and transparency**
  - No prior auth for emergent stabilization, labor and delivery, NICU care or interfacility transfer to a higher level of care when time sensitive
  - Decision clocks that match clinical urgency: within one hour for time-sensitive transfers, 24 hours for urgent inpatient services, 72 hours for routine care and post-acute placement
  - Deemed approval if timelines are missed, with authorization numbers issued automatically
  - A single authorization that follows the patient across settings within an episode of care when clinically appropriate
  - Gold-carding or prior-auth exemptions for high-performing providers based on low denial and high overturn rates
  - Public, plain-language criteria with real-time status portals and a direct clinician-to-clinician review option

- **Transfer and placement standards that reduce avoidable delays**
  - A duty to accept transfers when capacity and needed specialty services are available, including out-of-network acceptance when services are not available locally
  - Clear time targets for acceptance decisions and transport authorization, plus an escalation path when delays occur
  - Coverage for medically necessary transport and bed-to-bed coordination, including ambulance offload support when hospitals are at surge
  - A real-time, statewide view of specialty coverage and bed availability to match patients to the right site of care
  - Standardized clinical handoffs and documentation so receiving teams have what they need upon patient arrival
- **Timely approvals for post-acute care to free up beds**
  - Decision timelines that prevent avoidable inpatient days for SNF, LTACH, IRF, inpatient psychiatric, rehab, home health, DME and hospice care
  - Weekend and holiday coverage so discharges are not paused for days
  - Acceptance of standardized functional assessments and clear, written denial rationales tied to published criteria
  - Bed-hold or per-diem payments when health plan delays keep a medically ready patient in an acute bed
  - Authorizations that carry through level-of-care transitions, so care is not re-authorized multiple times for the same episode
  - Health plan obligations to actively help secure placement when network capacity is constrained, with special attention to rural markets

WE OPPOSE

- **Utilization policies that cause ED boarding or extended length of stay**
  - Arbitrary length-of-stay caps, weekend or holiday authorization blackouts, or rules that block medically necessary transfers
  - Practices that delay psychiatric or pediatric placements or deny transport needed to complete a transfer
  - Concurrent review cycles that change targets mid-stay or ignore clinical documentation already provided
- **Opaque denial practices without clear appeal rights**
  - Denials without specific criteria cited, retroactive denials after discharge for technical issues, or refusal to provide clinician-to-clinician reviews conducted by experts in the relevant field
  - Appeal windows so short they are impractical, or appeal processes that do not pause discharge or payment timelines
  - Failure to honor independent external review or to publish overturn rates and reasons

- **Administrative rules that pull clinicians from the bedside**
    - Duplicative documentation, portal-only submissions that require manual re-entry and frequent form changes with little or no notice
    - Requiring physician-only calls for routine matters that qualified staff can handle
    - Audits or pre-bill reviews that demand large record pulls without a clear purpose or that are disruptive to patient care

ALWAYS ON WATCH

- **Appeal timelines, external review standards and data reporting**
    - Appeal clocks that pause adverse actions until a decision is made
    - Clinician-to-clinician reviews with same or similar specialty
    - Independent external review access with clear timelines
    - Public reporting on denial and overturn rates by line of business
    - Turnaround time reporting that matches clinical urgency
- **Care management requirements for high-need patients**
    - Care plans that add value without creating delays or duplicate assessments
    - Warm handoffs across settings with clear points of contact
    - Support for caregiver training, DME delivery, and home services
    - Reasonable documentation standards that reflect patient complexity
    - Flexible requirements for rural and low-resource settings
- **Post-acute capacity and placement barriers**
    - Real-time visibility into SNF, LTACH, IRF, psych and rehab availability
    - Network adequacy and out-of-network acceptance when capacity is lacking
    - Weekend and holiday authorization coverage
    - Coverage for medically necessary transport and bed-to-bed coordination
    - Special attention to behavioral health and pediatric placements

EVALUATION CHECKLIST

- ☐ **Does it improve access, quality, or safety for patients in Arizona?**
    - Shorter time to treatment or transfer
    - Reduced ED boarding and avoidable inpatient days
    - Clear patient protection and measurable outcomes

- **Is there stable funding, or does it shift costs to hospitals?**
    - Identified payer or state funding for new mandates
    - No retroactive takebacks for administrative issues
    - Payment for plan-caused delays and fair transport reimbursement
- **What is the impact on the workforce and rural communities?**
    - Less administrative time away from patients
    - Flexibility for small-volume and rural facilities
    - Supports telehealth, transport, and training pipelines
- **Are timelines and reporting reasonable and aligned with federal rules?**
    - Decision timeframes that match acuity, with deemed approvals if missed
    - Standard data definitions and simple submission pathways
    - Consistent with HIPAA and other federal privacy requirements

Last reviewed:

August 2025

Behavioral health and substance use

POSITION

AzHHA advocates for a system that provides timely, evidence-based behavioral health and substance use care across the continuum of care. This includes working crisis lines and mobile teams, quick placement into appropriate care levels and seamless transitions to outpatient and recovery services.

We support parity in integrated medical and behavioral healthcare, as well as sufficient capacity for psychiatric, detox, residential, Partial Hospitalization Programs (PHP), Intensive Outpatient Programs (IOP) and outpatient treatments. Our focus is on low-barrier access to medications for opioid and alcohol use disorders, same-day initiation in EDs and inpatient units, and consistent warm handoffs.

We oppose prior authorization rules and network gaps that lead to ED boarding, weekend or holiday authorization blackouts and payment policies that treat behavioral health differently from medical care. The goal is to reduce delays, ensure safer transitions and improve patient outcomes across all communities in Arizona, including rural areas.

WE SUPPORT

- **A full crisis care continuum**
  - 24/7 call, text and chat lines with warm transfers between 988 and 911
  - Mobile crisis teams, crisis stabilization and short-term observation with safe handoffs
  - Real-time bed and appointment visibility to speed placement
- **Inpatient, residential, and step-down capacity**
  - Adequate psychiatric, detox and withdrawal management beds
  - Residential treatment, PHP and IOP slots so patients can step down safely
  - Coverage for medically necessary transport and bed-to-bed coordination
- **Parity enforcement and integrated care**
  - Equal coverage and utilization rules for behavioral and physical healthcare
  - Same-day billing for primary care and behavioral health in the same clinic
  - Integrated models that co-locate or coordinate physical and behavioral healthcare

- **Timely access to evidence-based SUD treatment**
  - Low-barrier access to medications for opioid use disorder and alcohol use disorder
  - Rapid starts in EDs, inpatient units and maternity settings with warm handoffs
  - Coverage for harm reduction, recovery supports and peer services
- **Youth and perinatal behavioral health**
  - School-linked services, tele-psychiatry, and timely pediatric specialty care
  - Screening and treatment for perinatal and postnatal mood and anxiety disorders
- **Workforce and safety**
  - Recruitment and retention for psychiatrists, NPs, therapists, social workers, peers and techs
  - Safe staffing, de-escalation training and secure care environments

WE OPPOSE

- **Barriers that delay or deny medically necessary care**
  - Prior authorization hurdles, fail-first requirements or arbitrary visit caps
  - Policies that block timely transfers or transport approvals for behavioral health patients
- **Non-parity payment and cost sharing**
  - Lower reimbursement, higher copays or stricter utilization management practices than for comparable physical health services
- **Practices that increase ED boarding**
  - Network gaps, weekend authorization blackouts or placement processes that stall discharges
- **Restrictions on evidence-based SUD care**
  - Limits on MOUD starts, dose caps without a clinical basis or rules that disrupt continuity of care
- **Fragmented rules and duplicative reporting**
  - Licensing and documentation requirements that add burden without improving safety or outcomes

ALWAYS ON WATCH

- **988 and crisis system performance**
  - Call answer times, mobile team coverage and smooth handoffs with 911 and EMS

- **Network adequacy and placement**
    - Availability of psych, detox, residential, PHP and IOP across regions, including pediatric access
- **Parity compliance and UM**
    - Transparent criteria, timely reviews and public reporting on denials and overturns
- **Transitions of care**
    - Follow-up within seven days after ED or inpatient discharge and access to medications at discharge
- **Tele-psychiatry and virtual care**
    - Coverage and payment policies that keep rural and after-hours access viable
- **Forensic and competency interfaces**
    - Forensic psychiatric capacity and competency restoration timelines that affect ED boarding, transfers and inpatient flow.

EVALUATION CHECKLIST

- ☐ Does it improve timely access across crisis, outpatient, inpatient and recovery services?
- ☐ Does it reduce ED boarding and unnecessary inpatient days through faster reviews and placements?
- ☐ Is funding stable and adequate, including rates that support beds, teams and transport?
- ☐ Does it uphold parity and cut administrative barriers that delay care?
- ☐ Will it strengthen transitions of care, including medication starts and follow-up within seven days?
- ☐ Does it work for rural Arizona through tele-psychiatry, mobile crisis and realistic network standards?

Last reviewed:

August 2025

Rural health and EMS

POSITION

AzHHA advocates for policies that ensure rural Arizonans have access to local and dependable care. This includes securing sustainable funding and fair reimbursement rates for small hospitals and clinics, maintaining responsive EMS systems for response, treatment and transportation, and providing practical support for telehealth services and specialist consultations. We endorse coverage for air and ground ambulance services, clear transfer protocols to higher levels of care and real-time tracking of bed and specialty availability across regions. Additionally, we support workforce strategies that help recruit and retain clinicians in rural areas, such as housing, training and streamlined licensing processes. We oppose generic mandates, payment reductions and administrative rules that overlook factors like distance, patient volume and standby costs. We aim to build a stable rural healthcare network where patients receive safe, timely care close to home, with seamless transfers when more advanced treatment is necessary.

WE SUPPORT

- **Stabilization funding and fair reimbursement for rural providers**
  - Cost-based or low-volume adjustments that reflect standby capacity and distance
  - Protection for essential services like ED, OB, trauma, dialysis and imaging
  - Predictable supplemental payments tied to access and quality
- **EMS system readiness and sustainability**
  - Adequate base funding, fair Medicaid rates and payment for treatment-in-place and alternate destinations when appropriate
  - Support for medical direction, on-call stipends and training for paid and volunteer crews
  - Coverage for interfacility transports, including specialty transfers
- **Telehealth and connected care**
  - Payment parity for tele-stroke, tele-ICU, tele-OB/NICU, tele-psych and tele-EMS consults
  - Grants for broadband, equipment and secure platforms
  - Simple credentialing and cross-site privileges for remote specialists
- **Rural workforce recruitment and retention**
  - Loan repayment, housing stipends and relocation support
  - J-1 waivers and efficient licensing for qualified international clinicians
  - Grow-your-own pipelines with local colleges and high schools

- **Safe transport, transfers, and regional coordination**
  - Time targets for acceptance and transport authorization based on clinical need
  - Covered air and ground ambulance when services are not available locally
  - Regional transfer centers and real-time bed and specialty visibility
- **Capital and facility modernization**
  - Grants and financing for ED upgrades, maternity stabilization, behavioral health space, diagnostic equipment and EHRs
  - Right-sized regulatory requirements for low-volume settings

WE OPPOSE

- **Cuts or policy shifts that threaten rural access**
  - Base rate reductions or loss of supplemental programs without a replacement
  - Network designs that steer patients away when local care is appropriate
- **One-size-fits-all mandates**
  - Staffing, reporting or facility standards that ignore low volume and long distances
  - New administrative steps without funding or realistic timelines
- **Restrictions that undermine EMS and transfers**
  - Unfunded limits on air or ground transport coverage
  - Rules that delay medically necessary interfacility transfers
- **Barriers to telehealth**
  - Site-of-service limits or lower payment that make remote care unsustainable

ALWAYS ON WATCH

- **Network adequacy and transport coverage**
  - OB, anesthesia, surgical, pediatric and behavioral health networks, plus covered air and ground transport
- **Facility designations and financing**
  - Critical Access, Rural Emergency Hospital and other designations that affect rates and viability
- **EMS workforce and medical direction**
  - Volunteer pipeline, training support and liability protections
- **Broadband and technology reliability**
  - Redundancy for outages, secure platforms and device availability

- **Maternal and behavioral health access**
    - OB service continuity, perinatal regionalization, detox and psych bed availability

EVALUATION CHECKLIST

- ☐ **Does it keep care local when safe and appropriate?**
    - Reasonable travel times and access to essential services
- ☐ **Does it support EMS readiness and timely transfers?**
    - Clear decision clocks and covered transport
- ☐ **Is funding adequate and predictable for small-volume providers?**
    - Rates, supplements and practical transition plans
- ☐ **Are requirements workable for rural operations?**
    - Simple documentation, right-sized reporting, realistic timelines
- ☐ **Does it enable telehealth and specialty access?**
    - Parity payment, easy credentialing and reliable connectivity

Last reviewed:

August 2025

Quality and patient safety

POSITION

AzHHA supports practical quality and patient safety policies that measurably reduce harm and improve outcomes without overwhelming clinicians with paperwork.

We advocate for a core set of evidence-based measures that are aligned across payers, ensure fair risk adjustment and have clear specifications with reasonable lead times. We promote infection prevention, antimicrobial stewardship and proven clinical pathways for high-risk conditions, along with transparent public reporting that patients can understand and that takes into account small-volume and rural realities.

We oppose duplicative metrics, sudden specification changes and punitive penalties that divert resources from improvement. The goal is safer care, better results and reporting that helps teams learn and apply their learning.

WE SUPPORT

- **Evidence-based measures aligned across payers**
  - One core set of measures, where possible
  - Retire duplicative or low-value metrics and focus on outcomes that matter to patients
  - Clear specifications, stable definitions and ample notice before changes
- **Infection prevention and antimicrobial stewardship**
  - Practical hospital-associated infection (HAI) definitions, timely feedback and support for prevention bundles
  - Access to pharmacy, lab and infection prevention staff to act on data
  - Stewardship programs that balance resistance risks with timely treatment
- **Safety culture and learning systems**
  - Blame-free reporting, root cause analysis and rapid cycle improvement
  - Near-miss tracking and sharing lessons across units and facilities
  - Patient and family engagement in safety planning when appropriate
- **Clinical pathways and high-risk condition bundles**
  - Sepsis, maternal safety, falls, pressure injury, venous thromboembolism (VTE), medication safety pathways and care coordination
  - Diagnostic excellence initiatives that improve handoffs and test follow-up
  - Standardized communication tools to reduce errors

- **Fair and transparent public reporting**
  - Risk adjustment that reflects acuity and social risk
  - Context notes for small-volume hospitals and rural facilities
  - Simple, plain-language displays so the public can understand results

WE OPPOSE

- **Conflicting or low-value reporting that drains resources**
  - Measuring proliferation without evidence of benefit
  - Frequent reporting changes with little or no notice
- **Punitive approaches that reduce capacity for improvement**
  - Penalties that pull funding from safety work
  - Public scoring without risk adjustment or volume context
- **Administrative rules that pull clinicians from the bedside**
  - Duplicative documentation, portal-only submissions and manual re-entry
  - Audits that demand large record pulls without a clear purpose

ALWAYS ON WATCH

- **State reporting mandates and public dashboards**
  - Alignment with federal programs, clear specifications and stable timelines
- **Priority clinical initiatives**
  - Sepsis, maternal safety, readmissions, diagnostic safety and medication safety
- **Risk adjustment and small-volume protections**
  - Methods that reflect case mix and rural realities
- **Data quality and exchange**
  - Clean encounter data, timely lab and pharmacy feeds and workable privacy safeguards
- **Use of AI and decision support**
  - Transparency, bias monitoring and human oversight in clinical tools

EVALUATION CHECKLIST

- ☐ **Will it measurably improve outcomes or reduce harm?**
  - Clear clinical pathway or bundle, with a way to track results
- ☐ **Are measures aligned and feasible to report?**
  - Minimal duplication, stable specifications and simple submission

- **Is risk adjustment appropriate and fair?**
    - Accounts for acuity, social risk and small-volume settings
- **Does it support learning rather than only punishment?**
    - Feedback loops, near-miss reporting and improvement resources
- **Are resources and timelines realistic?**
    - Staff time, training, IT needs and a reasonable go-live date

Last reviewed:

August 2025

Regulatory and administrative simplification

POSITION

AzHHA advocates for clear, consistent rules and simple workflows, enabling clinicians to concentrate on patient care. We promote consolidated reporting, standardized definitions and predictable rulemaking with sufficient lead time for implementation.

We promote modern licensure and credentialing, electronic prior authorization and documentation with Application Programming Interfaces (APIs) and attachments, and privacy-protective data sharing that works effectively across systems.

We oppose unfunded mandates, conflicting requirements across agencies or plans, retroactive claw-backs and audits that penalize technical errors without offering a way to fix them. The goal is to reduce red tape, minimize surprises and establish policies hospitals can implement without diverting staff from patient care.

WE SUPPORT

- **Consolidated reporting and standard definitions**
  - One portal or shared formats where possible
  - Aligned deadlines and clear data dictionaries
  - Retirement of duplicative or low-value reports
- **Reasonable timelines and modernized licensure processes**
  - Service-level targets for initial licenses and renewals
  - Temporary permits and reciprocity so clinicians can start sooner
  - Simple, predictable background check processes
- **Clear, predictable rulemaking and guidance**
  - Plain-language manuals and FAQs
  - Adequate lead time before changes take effect
  - Early stakeholder input and testing
- **Data-sharing that protects privacy and supports coordination**
  - HIPAA-consistent exchange using minimum necessary data
  - Practical consent models and trusted exchange frameworks
  - Avoiding conflicting requirements across programs
- **Fair, risk-based audit and review standards**
  - Notice, reasonable sample sizes, and a path to cure
  - Education first for technical errors, sanctions only for patterns or intent
  - Clear citation of criteria on any denial or claw-backs

- **Simple prior authorization and documentation workflows**
  - Standard forms, electronic attachments and APIs
  - Clinician-to-clinician, with review when needed, conducted by experts in the relevant field
  - No repetitive re-entry of the same data
- **Digital health and telehealth compliance clarity**
  - Site-of-service flexibility, credentialing by proxy where allowed
  - Acceptance of e-signatures and secure electronic consent
- **Alignment across agencies and programs**
  - Consistent rules between health, insurance, behavioral health and Medicaid
  - One interpretation for the exact requirement statewide

WE OPPOSE

- **Unfunded mandates and conflicting requirements**
  - New reports or formats without funding or clear value
  - Definitions that differ by agency or plan
- **Retroactive enforcement and surprise audits**
  - Claw-backs for clerical errors long after payment
  - Shifting rules applied to already completed care
- **Burdens that pull clinicians from the bedside**
  - Portal-only submissions without APIs or support
  - Frequent form changes with little notice
- **Unnecessary attestations and documentation**
  - Physician-only attestations for routine items staff can handle
  - Wet-ink signatures where e-signatures are lawful
  - Engaging in activities reserved for the federal government, such as immigration verification
- **Inconsistent plan or regional interpretations**
  - Different rules for the same policy across payers or regions

ALWAYS ON WATCH

- **Rule packages and licensure updates**
  - Commercial health insurance and Medicaid changes that affect hospital operations
- **Audit protocols and documentation standards**
  - Pre-pay and post-pay methods, sample sizes and appeal steps

- **Data exchange and privacy rules**
    - Electronic health information definitions, content standards and consent
- **Prior auth modernization**
    - State or federal standards for timelines, transactions and reporting
- **Public reporting and penalty structures**
    - New dashboards, posting rules and enforcement approaches
- **Emergency waivers and flexibilities**
    - How flexibilities are triggered, applied and sunset

EVALUATION CHECKLIST

- ☐ Does it reduce administrative time and cost without harming safety?
- ☐ Are definitions, forms and timelines clear and consistent across agencies and plans?
- ☐ Is there funding, technical support or a realistic transition for new requirements?
- ☐ Does it avoid retroactive penalties and offer a path to cure technical errors?
- ☐ Is privacy protected, and is data exchange feasible with the current IT?
- ☐ Can small and rural hospitals comply without undue burden?

Last reviewed:

August 2025

Maternal and child health

POSITION

AzHHA advocates for policies that ensure moms, newborns and children receive timely, coordinated care throughout the perinatal and pediatric stages.

We support safe regionalization and transportation, continuous coverage through 12 months postpartum and reliable access to obstetrics, anesthesia, neonatal intensive care, pediatric subspecialists and behavioral health services. We promote evidence-based screening and follow-up, LARC availability at delivery without unnecessary barriers and family-centered practices that keep parents and babies together when it is safe.

We oppose payment cuts, network gaps and administrative rules that delay transfers, postpartum care or pediatric access. Our goal is to promote healthy pregnancies, ensure safe deliveries, provide strong foundations for children and offer practical support to rural communities.

WE SUPPORT

- **Perinatal regionalization and safe transport**
  - Clear maternal and neonatal levels of care with transfer agreements
  - 24/7 consult lines, rapid obstetric and neonatal transport and bed-to-bed handoffs
  - Family-centered policies that keep moms and babies together when safe
- **Coverage and access across the continuum**
  - Continuous prenatal through 12-month postpartum coverage
  - Timely access to OB, anesthesia, NICU, pediatric subspecialty and high-risk clinics
  - LARC availability at delivery without prior authorization barriers
  - Postpartum Discharge Transition
- **Maternal mental health and SUD treatment**
  - Screening and treatment for depression, anxiety and substance use
  - Integrated care with warm handoffs to community supports and recovery services
- **Screening, follow-up and quality bundles**
  - Newborn metabolic, hearing, and CCHD screening with fast result follow-up
  - AIM safety bundles for hemorrhage, hypertension, sepsis and VTE

- Technology such as home BP monitoring and remote follow-up for high-risk pregnancies

- **Workforce and telehealth**
  - Recruitment and training for OB, midwifery, neonatology, anesthesia and perinatal nursing
  - Tele-OB, tele-NICU and remote fetal and neonatal consults, especially for rural hospitals
  - Ongoing, regularly scheduled simulation training in rural areas to ensure ongoing skill building that improves patient outcomes

WE OPPOSE

- **Cuts or closures that reduce essential services**
  - Payment cuts or policies that force OB or NICU closures without regional alternatives
  - Narrow networks that delay high-acuity maternal or neonatal care
- **Administrative and coverage barriers**
  - Prior authorization hurdles for postpartum care, behavioral health, or LARC at delivery
  - Rules that delay medically necessary transfers or transport approval
- **Punitive or family-separating policies**
  - Criminalization of pregnancy outcomes or substance use that deters care
  - Practices that separate moms and newborns without clinical need

ALWAYS ON WATCH

- **Maternal morbidity and mortality review actions**
  - Implementation of MMR recommendations and hospital reporting expectations
- **Network adequacy and transport**
  - OB, anesthesia, neonatology and pediatric subspecialist networks, plus covered transport
- **Licensure and level-of-care rules**
  - Hospital perinatal designation standards and survey requirements
- **Drug and product availability**
  - Supply for obstetric emergencies and infant immunizations, including RSV products
- **Telehealth and remote monitoring policy**
  - Coverage for tele-OB, tele-NICU and home BP or glucose monitoring

- **Family support and social services**
    - Coordination with WIC, home visiting, and child safety agencies that affect care plans

EVALUATION CHECKLIST

- ☐ Does it improve timely access to prenatal, delivery, postpartum, NICU and pediatric specialty care?
- ☐ Does it advance safety and outcomes through evidence-based bundles and reliable follow-up?
- ☐ Does it reduce financial and social barriers for families, including coverage continuity and travel burden?
- ☐ Does it protect rural Arizona through transport support, workforce solutions and viable local services?
- ☐ Does it respect privacy, consent and family-centered care while enabling coordinated services?

Last reviewed:

August 2025

Pharmacy and 340B

POSITION

AzHHA advocates for policies that ensure patients have access to affordable medications and maintain the viability of hospital pharmacy services.

We support a robust 340B program with transparent rules, fair and nondiscriminatory reimbursement and contract pharmacy options that enhance access, particularly in rural and underserved communities. We promote practical compliance, including simple claim identifiers, reasonable audits with notice and a chance to address issues and secure data exchange that prevents duplicate discounts while protecting privacy.

We oppose manufacturer restrictions on 340B dispensing, PBM or payer cuts and fees targeting 340B, mandatory white or brown bagging that jeopardizes safe care and retroactive claw-backs or confusing audits.

Our goal is to ensure safe and reliable access to medication for patients and to establish a pharmacy infrastructure that supports care throughout Arizona.

WE SUPPORT

- **340B program integrity and access for eligible hospitals**
  - Clear, consistent patient definition and eligible site rules
  - Use of savings to expand access, reduce patient costs and reduce uncompensated care
  - Reasonable audit standards with notice, clear findings and fix-it timelines
- **Fair pharmacy and payer policies**
  - Nondiscriminatory reimbursement for 340B claims
  - No special fees or lower rates just because a claim is 340B
  - Recognition of hospital-based specialty and infusion pharmacy services
- **Contract pharmacy options when they improve access**
  - Availability of community and specialty contract pharmacies where hospital sites are limited
  - Clean data-sharing to prevent duplicate discounts without exposing protected patient information
  - Simple, consistent claim identifiers that work across payers

- **Safe medication access and shortage mitigation**
  - Rapid substitution pathways during shortages
  - Support for biosimilar adoption when clinically appropriate
  - Funding for pharmacy readiness, including rural and critical access facilities.

WE OPPOSE

- **Restrictions that limit 340B savings used for patient care**
  - Manufacturer restrictions on contract pharmacy dispensing or requirements for nonstandard data
  - Policies preventing hospital child-site participation once criteria are satisfied
- **Payer and PBM practices that target 340B**
  - Lower reimbursement or extra fees tied to 340B status
  - Mandatory white bagging or brown bagging that disrupts safe, coordinated care
  - Accumulator or maximizer programs that undermine patient assistance
- **Retroactive takebacks and opaque audits**
  - Claw-backs months after payment for technical issues
  - Audits without clear standards, due process or a path to cure

ALWAYS ON WATCH

- **Federal and state rulemaking and enforcement**
  - HRSA audits, dispute resolution and guidance on patient definition and child sites
  - Medicare and Medicaid policies that affect 340B billing and modifiers
- **Medicaid duplicate discount compliance**
  - Clear carve-in and carve-out rules for FFS and MCOs
  - Consistent claim identifiers and data exchange that prevent duplicate discounts
- **PBM and payer policies**
  - Network participation terms, specialty pharmacy carve-outs and DIR-equivalent fees
  - Reimbursement of floors and transparency requirements
- **Drug shortages and specialty therapies**
  - Allocation practices, substitution pathways and continuity for oncology, rheumatology and rare disease drugs

EVALUATION CHECKLIST

- ☐ **Does it protect or expand patient access to affordable medications?**
  - Lower out-of-pocket costs and reliable supply
- ☐ **Is reimbursement fair and free of 340B-only cuts or fees?**
  - No discriminatory rates, DIR-like charges or retroactive clawbacks
- ☐ **Are compliance requirements clear and workable?**
  - Simple claim identifiers, reasonable audits and strong privacy protections
- ☐ **Does it preserve viable contract pharmacy options where they improve access?**
  - Especially in rural and underserved areas
- ☐ **Will it help manage shortages and support safe administration?**
  - Flexibility to substitute, use biosimilars appropriately and maintain coordinated care

Last reviewed:

August 2025

Coverage, networks and telehealth

POSITION

AzHHA advocates for broad, timely in-network access and equitable telehealth coverage that benefits patients and hospitals.

We support network standards that consider geography and care complexity, protections for continuity of care during network changes and transparent information so that patients understand what is covered and the associated costs.

We endorse payment parity for telehealth when clinically appropriate, flexible site-of-service options and straightforward rules for practicing across state lines.

We oppose narrow networks that delay essential care, payment policies that penalize virtual care without considering its value and confusing practices related to prior authorization or directory listings.

Our goal is to ensure predictable coverage, provide clear information and offer safe in-person or virtual options that maintain access throughout Arizona, including rural communities.

WE SUPPORT:

- **Network adequacy standards that reflect geography and acuity**
  - Time and distance standards that fit urban, rural and frontier realities
  - In-network access to OB, NICU, trauma, behavioral health, oncology and other hospital-based specialties
  - Out-of-network protections at in-network cost when in-network care is not available in time
- **Telehealth parity and cross-site flexibility**
  - Payment parity when telehealth is clinically appropriate, including audio-only when needed
  - Site-of-service flexibility so care can be provided from the home, clinic or hospital without billing barriers
  - Coverage for e-consults, remote patient monitoring and tele-triage where they improve access
  - No arbitrary in-person visit requirements for ongoing telehealth care

- **Consumer protections that prevent surprise gaps**
    - Continuity of care for patients in active treatment, pregnancy or complex conditions
    - Plain-language benefit explanations, upfront cost estimates and accurate provider directories with accountability
    - No mid-year network terminations without notice and patient protections

WE OPPOSE:

- **Narrow networks that delay or deny needed care**
    - Tiering or steerage that limits access to essential hospital services
    - Contracting tactics that carve out hospital-based specialties or emergency services
- **Payment rules that penalize virtual care when appropriate**
    - Across-the-board rate cuts for telehealth regardless of clinical equivalence
    - Site-of-service restrictions that block hospital-based telehealth or remote reads
- **Policies that confuse patients about costs and coverage**
    - Opaque prior authorization for telehealth, hidden fees or misleading directory listings
    - Definitions that make it hard to know who is genuinely in the network

ALWAYS ON WATCH

- **Provider directory accuracy and continuity of care rules**
    - Real-time updates with penalties for inaccuracies
    - Guaranteed continuity when networks change or contracts end
- **Cross-state practice and licensing changes**
    - Participation in compacts and efficient temporary privileges
    - Telehealth prescribing standards aligned with federal law
- **Technology and broadband access in rural communities**
    - Funding for broadband, equipment and secure platforms
    - Language access and accessibility standards for telehealth
    - Support for tele-EMS, tele-psychiatry and remote imaging reads

EVALUATION CHECKLIST

- ☐ **Does it expand timely in-network access or provide safe out-of-network options when needed?**
  - Shorter waiting times and reasonable travel standards
  - Explicit patient protection when networks are inadequate
- ☐ **Are telehealth services covered and paid fairly when clinically appropriate?**
  - Payment parity and simple workflows
  - No unnecessary in-person requirements
- ☐ **Will patients get clear, accurate information up front?**
  - Real-time directory accuracy and plain-language costs
  - Transparent prior auth criteria and status
- ☐ **Does it protect rural Arizona and high-acuity access?**
  - Standards that fit distance and volume realities
  - Support for specialty access, transport and broadband

Last Reviewed:

August 2025

Cybersecurity and artificial intelligence

POSITION

AzHHA supports policies that protect patients, safeguard hospital operations, and enable responsible innovation. Cybersecurity and artificial intelligence (AI) are now core to patient safety, financial stability and equitable access. We support voluntary adoption of recognized cybersecurity frameworks, coordinated threat sharing and state or federal investments that help hospitals, primarily rural and essential facilities, build resilience.

For AI, we support responsible, clinician-led tools that improve outcomes, efficiency and access without duplicative or punitive regulation. We oppose policies that penalize victims of criminal cyberattacks, impose overlapping regulatory regimes or restrict safe AI use that can improve care.

WE SUPPORT

- **Voluntary alignment with trusted cybersecurity frameworks**
  - Adoption of federal Health and Public Health Cybersecurity Performance Goals (CPGs)
  - Use of NIST standards, zero-trust practices and accepted sector best practices
  - Reasonable expectations that scale by hospital size and risk profile
- **Coordinated threat-sharing and incident readiness**
  - Information-sharing with HHS, CISA, MS-ISAC, AHA and state partners
  - Real-time alerts, playbooks and technical assistance during active threats
  - Incident response pathways that minimize downtime and protect continuity of care
- **Funding and workforce support**
  - Dedicated state and federal programs for cybersecurity infrastructure, staffing and training
  - Capital and operational support for rural and essential hospitals
  - Cyber insurance availability at sustainable costs
- **Responsible, clinician-led use of AI**
  - Use of AI tools that support diagnostics, workflows, scheduling, clinical decisions and triage
  - Guardrails aligned with HIPAA, NIST AI risk management and FDA safety standards
  - Hospital autonomy to validate, monitor and scale use cases without vendor lock-in

- **Closing the "AI adoption gap"**
  - Grants, technical support and procurement models that make AI accessible to smaller hospitals
  - Shared services, consortium models and statewide pilot programs

WE OPPOSE

- **Penalties for cyberattack victims**
  - Payment reductions or punitive sanctions when hospitals suffer criminal attacks despite reasonable safeguards
  - Policies that treat victim organizations as perpetrators
- **Overlapping or contradictory regulations**
  - Fragmented state and federal mandates that force hospitals to choose between compliance and care
  - Vendor requirements that exceed patient safety standards without evidence of benefit
- **Unsafe or discriminatory AI policies**
  - Tools that ignore bias or lack human oversight
  - Administrative burdens that block adoption without improving safety
  - Vendor models that are opaque, unexplainable or unmonitored
- **Accountability is placed solely on hospitals**
  - Cybersecurity and AI requirements that do not extend to vendors, third-party partners or payers
  - Contract terms that shift risk and liability to providers without transparency

ALWAYS ON WATCH

- **Incident reporting and breach response rules**
  - Timelines, liability and enforcement approaches for cyber events
  - Requirements for notifying patients and regulators
- **AI safety and licensing**
  - State and federal rulemaking tied to clinical decision support, workflow automation and data use
- **Vendor transparency**
  - Access to training data profiles, bias controls, audit logs and security posture

- **Critical infrastructure dependencies**
    - EHR downtime, ransomware response, cloud outages and recovery protocols
- **Insurance and financial pressure**
    - Cyber insurance availability, premium spikes, carve-outs and exclusions

EVALUATION CHECKLIST

- ☐ Does it strengthen patient safety or operational resilience?
- ☐ Does it provide funding or technical support rather than unfunded mandates?
- ☐ Are expectations risk-based and scalable for rural and essential hospitals?
- ☐ Are vendors and third parties held accountable for security and bias, not just hospitals?
- ☐ Are privacy protections consistent with HIPAA and evidence-based AI governance?
- ☐ Does it improve access to innovation rather than deepen the digital divide?

Last Reviewed:

November 2025

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