

## 2022 Policy Agenda

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**Mission:** The National Rural Health Association (NRHA) is a national membership organization whose mission is to provide leadership on rural issues through advocacy, communications, education and research.

NRHA serves as the primary resource and advocate on rural health issues for federal legislation, regulations and federally sponsored rural health initiatives and programs. The NRHA has adopted this policy agenda outlining rural health care issues. This document is intended to promote rural health policy issues for action by Congress, federal regulatory agencies, the White House, states, and the broader health care industry.

### 2022 NRHA Priorities:

- **Addressing Rural Declining Life Expectancy and Rural Health Equity**
- **Reducing Rural Health Care Workforce Shortages**
- **Investing in a Strong Rural Safety Net**

### Priority Area 1: Addressing Rural Declining Life Expectancy and Rural Health Equity

Rural residents often encounter barriers to health care that limit their ability to obtain the care they need. Individuals living in rural areas are more likely to die of the four leading causes of death (heart disease, cancer, stroke, and chronic lower respiratory disease). COVID-19 has devastated the financial viability of rural practices, disrupted rural economies, and eroded availability of care. Medical deserts are appearing across rural America, leaving many without timely access to care. Unfortunately, rural communities also see disparities in health care outcomes caused by social determinants of health coupled with the aforementioned geographic challenges. NRHA supports the following actions to strengthen and support the health of individuals in rural areas:

- Address health disparities and inequities in rural communities
- Ensure access to health care coverage for people living in rural areas
- Invest in public health and emergency preparedness
- Prioritize health education, chronic disease prevention, infectious disease control, and care management as part of rural health improvement
- Ensure that rural women have access to obstetric and maternal health care support

### Priority Area 2: Reducing Rural Health Care Workforce Shortages

Rural areas struggle to recruit and retain an adequate health care workforce. Seventy-seven percent of rural counties are Health Professional Shortage Areas, and nine percent have no physicians at all. With far fewer physicians per capita, the maldistribution of health care providers between rural and urban areas results in unequal access to care and negatively impacts rural health. The COVID-19 pandemic exacerbated the workforce shortage in rural America. NRHA supports the following actions to help recruit, train, and obtain health care professionals in rural areas:

- Remove barriers that limit rural resident training and grow training opportunities through vehicles like rural training tracks.

- 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.

### Priority Area 3: Investing in a Strong Rural Safety Net

The federal investment in rural health programs is a small portion of federal health care spending, but it is critical to rural Americans. These safety net programs expand access to health care, improve health outcomes, and increase the quality and efficiency of health care delivery in rural America. Nearly 140 rural hospitals have closed since 2010. Rural hospitals provide access to care, as well as jobs and other economic opportunities; these hospitals are often one of the largest employers in a rural community. NRHA supports the following actions to strengthen and support the rural health safety net:

- Test new payment models of care in rural areas and sustainable system design.
- Provide stabilizing relief for rural providers to abate the rural hospital closure crisis exacerbated by COVID-19.
- Allow providers to utilize innovative technology and improve access through continuing the telehealth advancements made by Congress and the Administration during the public health emergency (PHE).
- Protect the 340b drug pricing program from ongoing attacks by pharmaceutical manufacturers.
- Stop Medicare cuts to rural providers and address administrative barriers.
- Modernize the Rural Health Clinic (RHC) program by updating payment policies; expanding team-based care; incorporating essential services such as mental health, substance use, and oral health; and enhancing the ability to serve uninsured and other vulnerable populations.
- Improve coordination across Medicare rural provider designations (e.g. Critical Access Hospital (CAH), Federally Qualified Health Centers (FQHC), RHCs, etc.) to reduce unnecessary duplication and competition.
- Test opportunities to improve regional and local health planning to reduce unproductive competition, improve distribution of essential services, and improve community support for rural health services.
- Identify models of care to better support the safety net needs of frontier and isolated rural communities.
- Support proposals to increase access to Medicaid coverage across the United States.

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## Federal Programs

### **Community Facilities Direct and Indirect Loan Programs (USDA)**

The Community Facilities Direct Loan and Grant Program (CFL) provides essential, affordable funding to develop community facilities in rural areas. The requirements of the CFL portfolio are legislated and designed to mitigate risk of default. However, NRHA believes the application process for the USDA Community Facilities Direct and Indirect Loan Program is overly burdensome and requires meeting stringent underwriting requirements. Capital starved rural facilities are not generally in a situation to be able to meet program requirements for a three-year history of a positive bottom line on financial status, making vulnerable rural providers ineligible. Actions should be taken to simplify the application and underwriting requirements. Further, NRHA encourages Congress to explore additional capital investment programs, similar to the [Hill Burton program](#), in which facilities receive grants for construction and modernization in return for providing reduced-cost care.

### **Definition of Rural and Frontier**

NRHA strongly recommends that definitions of rural and frontier be specific to the purposes of the programs in which they are used in the context of programmatic designations and not as definitions. Programs targeting these communities do so for particular reasons, and those reasons should be the guidance for selecting the criteria for a programmatic designation (from among various criteria and existing definitions, each with its own statistical validity). This will ensure that a designation is appropriate for a specific program while limiting the possibilities that other unrelated programs adopt a definition, which is not created to fit that program.

[\*Additional Policy recommendations are available in NRHA's Policy Brief: Frontier Definition \(Feb. 2016\)\*](#)

### **Federal Commissions**

NRHA supports proportional rural representation on all federal health care-related commissions, task forces and advisory groups. NRHA recommends that such federal commissions encourage input and consultation from the Secretary of Health and Human Services' National Advisory Committee on Rural Health and Human Services. Additionally, such federal commissions should adequately address the impact of their considerations and recommendations on the rural health care delivery system.

### **Medicare Rural Hospital Flexibility Program**

NRHA supports continued authorization of the Medicare Rural Hospital Flexibility (Flex) Grant Program funding to encourage the development of cooperative systems of care in rural areas, joining together CAHs, Rural Emergency Hospitals (REHs), emergency medical service (EMS) providers, clinics, and health practitioners to increase efficiencies and quality of care.

NRHA supports continuation of the Flex and SHIP programs. These grants are used by states to implement new technologies, strategies and plans in CAHs. CAHs provide essential services to communities and essential jobs to the rural economy. These grants provide crucial funding for updating equipment, implementing new sustainable care delivery models, and enhancing the quality of care provided. We ask the Labor-Health and Human Services (HHS)-Education appropriations subcommittee to recognize the necessity of these grants and continue to support this important program, while extending the program authority and appropriation as mentioned above. Small rural hospitals need this funding to counter the myriad challenges inherent to working in sparsely populated areas with limited access to capital.

[\*See the Critical Access Hospital \(CAH\) section of this document for CAH specific recommendations.\*](#)

## **Grants and Programs for Rural Health**

Federal programs should place increased emphasis, both internally and in external funding and monitoring activities, on assuring that the various federal programs and grantees work together at the federal, state, and community levels to increase efficiency, minimize duplication of effort and services, and maximize the positive community impact of available resources. Additionally, encourage federal agencies to include a proportional designated percentage, or “carve out” for rural residents in funding opportunities. This ensures equitable distribution of resources to impact the over 60 million Americans living in rural areas.

[Additional Policy recommendations available in NRHA's Policy Brief: Rural Carve-out Funding \(Sept 2021\)](#)

## **Health Infrastructure**

Funding should be provided, through a combination of grants, loan guarantees, and/or principal and interest forgivable loans, to support expansion, upgrade, and/or renovation of rural health facilities, including Health Information Technology (Health IT) and ambulance services.

## **Impact Statement on Rural Health**

Any legislative or regulatory proposal to change a federal program should require a rural health impact statement that at a minimum includes an impact analysis on 1) rural safety net providers; 2) rural primary care providers; 3) rural hospitals; 4) FQHCs and RHCs; 5) local rural economies; 6) the geographic locations of affected rural residents; and 7) tribal governments and organizations.

Designated rural funding should include resources to support an adequate evaluation plan. A consistent approach to evaluation will demonstrate how effectively the funding is used, provide accountability for the rural funding, and capture the impact on rural residents.

[Additional Policy recommendations available in NRHA's Policy Brief: Rural Carve-out Funding \(Sept 2021\)](#)

## **Research on Rural Health**

NRHA supports consistently disaggregating data by HHS so that the rural context is evident. Rural realities are often masked through a failure to collect or present data that adequately describes local conditions.

The Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), and the Census Bureau should negotiate interagency agreements with agencies and offices within HHS for the purpose of providing access to data sets, including information needed in analysis of variation within rural areas. Such data sets also should be made available for intramural and extramural research conducted or supported by HHS.

NRHA supports increased appropriations to AHRQ, CMS the Health Resources and Services Administration (HRSA) and the National Institutes of Health (NIH) that are accessible for investigator-initiated research, with requirements to report use of those funds to support research designed to improve the delivery of services in rural areas. Specifically, AHRQ should allocate funding for research and dissemination of best practices relevant to the scale and context of typical rural facilities.

## **Rural Development**

NRHA supports the continued strengthening of provisions of Title VII of the Farm Security Act, the “Rural Development” title. This should be done to support community capacity building, technical assistance, and decision support mechanisms for communities. Special attention should be given to the health care delivery sector in regionally appropriate planning. Doing so requires an expansion of

authority and an increase in authorized, mandatory funding for these activities. USDA should provide technical and funding support for the continued development and maintenance of the National Rural Development Partnership and State Rural Development Councils and encourage these entities to include rural health care issues in their work programs.

### **Rural Health Community-Based Division Grants**

NRHA supports continued funding for Rural Health Community-Based Division (CBD) grant programs within HRSA's Federal Office of Rural Health Policy (FORHP). This is the only funding source that allows rural communities to address locally identified health needs with flexibility and should be maintained. These three-year grants fund community-based projects to increase access to care and improve rural community health by focusing on quality improvement, increasing health care access, coordination of care, and integration of services. Typical projects include efforts to address diabetes, obesity, health promotion, health screening, HIV prevention, and mental health. Programs have brought care that would not otherwise have been available to more than 2 million rural citizens across the country. In fact, this is the only federal health care program that allows rural communities to expand access, coordinate services, and improve the quality of health care services based on individual community need.

NRHA urges increased capacity of rural health care delivery systems by authorizing permanent funding of CBD grant programs. Further, changes due to the CARES Act (i.e., urban entities are now eligible to receive CBD funding to provide services in rural areas) should be analyzed to understand the impact of CBD funding eligibility. HRSA should work to amplify CBD grant program success stories to support rural health transformation and develop consistent measures of return on investment across programs.

*Additional recommendations are available in the NRHA Policy Brief- [Community Health Initiative Success Stories Impact \(Feb. 2021\)](#)*

### **State Offices of Rural Health (SORH)**

NRHA supports strengthening rural communities and providers through continuation and expansion of the SORH program. State offices of rural health exist in all 50 states and help rural communities build and maintain health care delivery systems. They accomplish this mission by collecting and disseminating information, providing technical assistance, helping to coordinate rural health interests state-wide and by supporting efforts to improve recruitment and retention of health professionals. NRHA urges continued support for this program.

### **Universal Service Fund (USF)**

NRHA supports expanding the USF, particularly the Rural Health Care fund, to provide additional resources to expand the scope of telehealth services being utilized by rural health care providers and beneficiaries.

## **Health Insurance Coverage**

### **Children's Health Insurance**

HHS should take major steps to ensure low-income children in rural and frontier areas are provided access to health care through the State Children's Health Insurance Program (SCHIP). NRHA supports the following actions to strengthen and support the SCHIP program in rural areas:

- Expand the SCHIP program for family coverage.

- Repeal the provision that prohibits federal and state employees from participating in the SCHIP program.
- Repeal the requirement on "crowd out," allowing SCHIP wrap around coverage for otherwise insured children. This would allow children who have medical insurance to get coverage for services for which they are not insured, such as dental services.
- CMS should enforce the federal statutory requirement that states fund programs to provide acceptance and initial processing of Medicaid applications for children at FQHCs and disproportionate share hospitals.
- CMS should provide enhanced match for SCHIP outreach, including Medicaid out stationing at FQHCs, RHCs, disproportionate share hospitals (DSH) and other community-based programs.

### **Network Access Standards**

NRHA supports public and private health insurance network access adequacy and provider sufficiency standards that establish a goal of assuring the provision of primary care services within 30 minutes' travel time from the patient's place of residence. HHS's oversight of Medicare, Medicare Advantage (MA), Medicaid, SCHIP, as well as legislation and regulations concerning patient protections should, at a minimum, meet this standard. Overly narrow networks may maximize efficiency for insurers but can have a detrimental impact on rural areas due to not enough providers to handle demand, and access to services in a reasonable distance. Network access adequacy efforts should support more than one network to provide "competition" among plans. Provider sufficiency standards within a network should ensure reasonable wait times for appointments and reduce geographic barriers for subscribers of a network.

### **Managed Care**

NRHA believes that rural Americans who are enrolled in MA plans or in other insurance programs paid for by Medicare, Medicaid, SCHIP, and by private insurance programs, should have access to health care services, including geographic access and access to culturally competent care and services. The goal that communities have culturally competent providers is particularly important to rural and frontier areas.

Rural health providers should have the opportunity to contract with any managed care programs participating in Medicare, Medicaid, or SCHIP, without reductions from current revenues. The relevant public program should be responsible for differences between negotiated fees (which must be at least the Medicare standardized payment) and existing total Medicare, Medicaid, or SCHIP payment. Medicaid managed care program implementation must include network adequacy standards that assure participation by essential rural providers and reimbursement levels that both adequately reflect the costs incurred by these providers and offer the financial incentives necessary to assure access to care in rural communities.

NRHA supports requiring MA plans to pay CAHs and RHCs at 101 percent of costs including any final settlement costs, or 105 percent of costs in lieu of the final settlement of costs. In addition, MA plans should be required to reimburse CAHs, rural PPS hospitals, and RHCs for Medicare bad debt and to ensure timely payment of claims, consistent with reimbursement under traditional fee-for-service Medicare. At no point, should MA plans reimburse rural providers at rates lower than traditional Medicare. The managed care programs must also not impose more stringent billing, coding, or documentation guidelines than those imposed by federal or state Medicare or Medicaid guidelines. The approval process of MA plans and amendments needs to be transparent, including web-based access to the details of the approved applications. Congress should increase funding for local organizations

serving older adults to provide enrollment assistance in MA plans. State insurance commissioners' offices and CMS should provide stronger oversight to protect beneficiaries.

### **Medicaid Expansion**

Medicaid plays a critical role for the 52 million nonelderly children and adults living in the most rural areas in the United States. Medicaid is the nation's largest public insurance provider and plays a central role in helping to fill gaps in private coverage in rural areas. By expanding Medicaid, the 12 non-expansion states can not only help millions of their residents in need of affordable health care but also increase the chances that rural hospitals can stay open. State governments could help close the gap by pursuing Medicaid expansion—which would decrease their hospitals' uncompensated care burden. To encourage this, Congress could reinstate 100 percent federal matching for any state that chooses to adopt the Affordable Care Act Medicaid expansion. Rural hospitals in states that have not expanded Medicaid recorded a median operating margin of -0.3 percent, compared to +0.8 percent for rural facilities in expansion states. Expanding Medicaid would help state budgets, hospitals, and providers by increasing funds to states and decreasing uncompensated care. States that do not expand Medicaid coverage in accordance with the ACA should be exempted from the scheduled cuts in Medicaid disproportionate share funding under the ACA and subsequent legislation.

### **Medicaid Reform**

NRHA advocates evidence-based, thoughtful Medicaid reform that: improves access to high quality health care; assures equitable treatment of rural beneficiaries, providers, and communities; and saves money by focusing reform on promoting increasing coordination of care and sustaining rural health care delivery systems.

NRHA supports the following actions to strengthen and support the Medicaid program in rural areas:

- Medicaid reform must support the principles of population health. Proposals to reform Medicaid must be evaluated based on their likely impact on patient and population health, specifically including the health of rural patients and populations.
- Medicaid reform must be effectively integrated with other insurance and health system reforms to assure that all rural residents have access to affordable health insurance coverage and high-quality health care.
- Medicaid reform, however designed and implemented, must assure that rural beneficiaries are treated equitably as compared to non-rural beneficiaries in eligibility, coverage, benefits, and quality of care.
- Medicaid reform (including reimbursement strategies) must support the development and maintenance of a network of essential rural providers, including primary medical, oral, behavioral health providers, emergency care providers, transportation providers, and long-term care providers, to assure effective and continued local access by beneficiaries.
- Medicaid reform must support programs promoting better coordination and integration of care that will improve rural patient outcomes and satisfaction, at the same time as increasing efficiency and decreasing costs.
- Medicaid reform implementation must consider the fact that Medicaid is disproportionately important to rural economies, not just for Medicaid beneficiaries but to maintain a viable health care system that serves and contributes to the entire rural community.
- Medicaid reform should address the considerable variation in Medicaid programs across states lines in the numbers of people and services they cover.



- Medicaid reform implementation, including approving state plans and waivers, must not abdicate its moral, legal, and financial responsibilities to rural, Medicaid eligible populations and to support the development of sustainable rural health systems.

Medicaid funding reform initiatives, particularly those addressing the allocation of funding responsibility between federal and state governments, must recognize the limited ability of many states to generate state revenue to support Medicaid programs. Funding reform initiatives must:

- a) Safeguard existing federal and state-level funding mechanisms that allow states to maintain effective coverage and access to care under Medicaid; and
- b) Encourage development and implementation of innovative federal and state-level funding mechanisms that can reduce the burden on state budgets without reducing Medicaid coverage and access to care.

Evaluation of Medicaid reform proposals, including evaluation of requests for waivers or changes by state Medicaid programs, must include a Rural Impact Study that identifies anticipated impacts on rural areas and contains specific proposals for mitigation of any disproportionate negative impact on rural beneficiaries, health care providers, or health care delivery systems. Medicaid programs at the federal and state levels should participate in and use the results of targeted research that further documents and defines rural-specific potential impacts of reform proposals and identifies models of care delivery and provider payment that will promote sustainable rural health care delivery systems and improved outcomes for rural beneficiaries.

[\*Additional recommendations are available in the NRHA Policy Brief: Medicaid Reform: A Rural Perspective \(Sept. 2012\).\*](#)

### **Medicare and Medicaid Services: Eye, Oral, and Podiatric**

Collaboratively, CMS and HRSA should provide funding and resources to increase access for vision, dental, and podiatric health care services for children and adults living in rural and frontier areas, including funding for ocular, oral, and podiatric health services infrastructure.

### **Rural Medicare Beneficiary Coinsurance Equity**

NRHA recommends a change in existing policy that requires Medicare beneficiaries at CAHs to pay more in coinsurance than patients who receive the same care at larger acute care hospitals. Under current law, when a patient goes to a CAH they are billed 20 percent of charges submitted to the CMS. In other hospital settings, because they're reimbursed through a different fee schedule, patients are billed 20 percent of the fee schedule determined by CMS for that procedure. Unfortunately, what this looks like on the ground is rural patients being charged more for coinsurance because of where they obtain care geographically. NRHA recommends adjusting these requirements for CAH services, without harming providers or rural beneficiaries.

### **Medicare Beneficiaries Medicaid Outreach and Other Federal Assistance**

NRHA supports CMS funding for national, state, and community outreach efforts to ensure that eligible low-income and disabled Medicare recipients in rural and frontier areas are provided assistance to enroll in Medicaid, the Qualified Medicare Beneficiaries (QMB) program, and other federal programs that assist low-income Medicare beneficiaries in accessing health care.

### **Uninsured**

Residents of rural counties still lack insurance at higher rates than those living in urban areas. About 16 percent of people in rural counties lacked health insurance compared with 12.9 percent for mostly

urban counties. NRHA is deeply concerned about the rising number of uninsured and underinsured individuals and families in rural America and supports policies to address this issue. Any current law or future legislative proposal to expand the availability of health insurance must include equitable benefits for rural residents.

### **Universal Access to Health Care**

NRHA continues to support both new and ongoing rural health initiatives. NRHA also reaffirms its commitment to comprehensive health care for all people living and working in rural America. Because rural populations are disproportionately affected by both the lack of health insurance coverage and access to quality, affordable and appropriate care, NRHA supports the goal of universal health coverage and access to care for all.

## **Rural Health Systems and Facilities**

### **Behavioral Health Services**

Substance use disorders have long been prevalent in rural areas. Rural adults have higher rates of use for tobacco and methamphetamines, while prescription drug and heroin use has grown in towns of every size. The substance use treatment admission rate for nonmetropolitan counties was highest for alcohol as the primary substance, followed by marijuana, stimulants, opiates, and cocaine. Rural residents experience many more obstacles to obtaining behavioral health services, which results in distinct mental health disparities compared to urban residents. To build a comprehensive policy framework around rural behavioral health reform, expanding the availability, accessibility, affordability, and acceptability of behavioral health services must encompass all major components of a multi-pronged approach.

NRHA supports mental and behavioral health parity, recognizing that comprehensive mental and behavioral health services are an integral part of basic primary health care. Comprehensive mental and behavioral health services include counseling, psychotherapy, social services, peer and professionally facilitated groups, as well as medication.

NRHA supports the following actions to strengthen and support behavioral health services in rural areas:

- State Medicaid agencies contracting with managed behavioral health organizations must require contractors to monitor mental health services provided to rural beneficiaries.
- Medicare reimbursement for full costs should be required for all mental health workers located in Mental Health Professional Shortage Areas (MHPSAs) and licensed or credentialed by their state or tribe.
- Incentives should be made to support rural mental and behavioral health providers in obtaining and utilizing interoperable health information technology systems.
- Appropriate use of paraprofessionals and telemedicine should be utilized to expand available resources and expand access and affordability.
- Support use of stipends and paid internships to address behavioral healthcare shortages for students working toward health and human services degrees who are completing internships at rural hospitals, clinics, and mental health agencies, such as HRSA's Behavioral Health and Workforce Education and Training Program (BHWET).
- Expand NHSC eligibility to include bachelor-level social workers (LSWs) providing behavioral health services in rural areas.

HRSA, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institute of Mental Health (NIMH) should be authorized to form a joint task force to address issues of access to mental health in rural areas. This group should be charged with addressing the collection of current, accurate data on the rural mental health workforce, revising the criteria for mental health professional shortage area designation, and addressing access to mental and behavioral health services for the rural uninsured and underinsured. Funds should be committed for the formation of at least one extramural rural mental health research center dedicated to addressing these issues.

[Additional recommendations are available in NRHA's Policy Brief – Future of Rural Behavioral Health – February 2015.](#)

### **Certified Community Behavioral Health Clinics**

Certified Community Behavioral Health Clinics (CCBHC) represent an opportunity for states, through their Medicaid program, to improve the behavioral health of their citizens by: providing community-based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care. The CCBHC model prioritizes comprehensive care coordination and provides critical services for individuals with serious mental illness (SMI), those with severe substance use disorders, children and adolescents with serious emotional disturbance (SED), and those with co-occurring mental, substance use or physical health disorders.

NRHA supports continued use of the CCBHC model to address financing shortfalls through inclusive Medicaid payment rates.

### **Community Health Center Program**

Approximately 1 in 5 rural residents are served by the Community Health Center (CHC) Program. HHS/HRSA should explicitly consider rural specific barriers, such as geography, lack of providers and lack of transportation when allocating federal funding for the CHC program. This would significantly increase the geographic diversity of CHCs.

NRHA supports the following actions to strengthen and support the CHC program in rural areas:

- HRSA should encourage CHCs to provide integrated behavioral health services to rural and frontier areas.
- Congress should ensure that rural CHCs receive equitable Medicare reimbursement. All Medicare payment policy changes for FQHCs should consider the critical importance of these facilities to the rural health care safety net.

### **Community Paramedicine**

Community paramedicine programs offer the opportunity to increase access to primary and preventive care, provide wellness interventions within the medical home model, decrease emergency department utilization, save health care dollars, and improve patient outcomes using EMS providers in an expanded role.

NRHA supports the following actions to strengthen and support the community paramedicine programs in rural areas:

- State and federal governments should establish reimbursement systems under Medicare and Medicaid.
- As community paramedicine continues to evolve, regulations should not stifle innovation.

- Community paramedicine programs must be engaged in reporting performance based on evolving common performance indicators and definitions. Standards should not be established until there is sufficient data on performance outcome measures.
- Community paramedics should be trained by accredited colleges and universities using standardized curricula.

[Additional recommendations are available in the NRHA Policy Brief: Principles for Community Paramedicine Programs \(Sept. 2012\)](#)

### **Critical Access Hospitals**

There are nearly 1,350 CAHs in the US. CAHs have become an essential Medicare provider type in rural communities. Medicare prospective payment systems, designed for larger facilities, cannot adequately compensate small, low-volume rural hospitals.

NRHA supports the following actions related to CAH Medicare conditions of participation to strengthen and support the designation:

- The 35-mile standard currently required for cost-based reimbursement for CAH ambulance services should be eliminated.
- The ability of states to designate necessary providers as a means of meeting the CAH location requirements should be reinstated with appropriate qualifying criteria.
- NRHA supports adherence to the intent of Congress that CAHs be permitted to have up to 25 acute care and swing beds. CAHs should be permitted to meet this requirement using average annual census rather than an inflexible cap.
- NRHA supports allowing CAHs to relocate and retain their CAH status without further review from CMS when the CAH moves within five miles of its existing location.
- CMS should revisit regulations and interpretative guidelines governing relocation of CAHs, which require a CAH to meet the necessary provider criteria under which it was originally certified, and which defines new facility construction as a relocation. CAHs designated as necessary providers should not be threatened with decertification for a failure to produce documentation providing they were designated a necessary provider.
- Any CAH that reverts to being a hospital paid under the PPS model should be assigned their former PPS provider number and retain the base year hospital specific rates applicable to that PPS provider number.
- Direct physician supervision should be required only when indicated by clear clinical evidence. If any federal panel or entity is to determine physician supervision levels by procedure, then representation on such panel or entity should be expanded to include physicians that practice primarily in small, rural hospitals.

[Additional recommendations are available in NRHA's Policy Brief – Physician Supervision \(May 2010\)](#)

NRHA supports the following actions related to Medicare payment to strengthen and support CAHs:

- Pay DSH payments to CAHs. The current DSH add-on percentage would be applied to the CAH's Medicare inpatient reimbursable cost to determine the DSH payment. CAHs would not be subject to a cap on the DSH add-on percentage.
- Permanently remove sequestration cuts to CAH payments.
- CAH Medicare outpatient co-payments should be based on 20 percent of the CAH's interim payment rates rather than 20 percent of the CAH's charges to properly distribute payment responsibility between patients and the Medicare program. Alternatively, based CAH Medicare outpatient co-payments on 20 percent of the national average outpatient PPS reimbursement as

a percent of charges for all PPS hospitals, to promote consistency in CAH co-payment rates around the country. The current system results in a disproportionately high percentage of the cost reimbursement being paid by patients.

- NRHA supports modification to the principles of reimbursement governing cost report preparation to permit extensive discrete costing with respect to non-CAH services such as home health, long-term care, medical office buildings, etc. Current cost report principles result in excessive overhead allocations to these services, compared to the administrative and general burden to the CAH for operating these services. The intent of such increased discrete costing is to reduce the amount of CAH overhead allocated to these services and thereby reduce CAHs' financial incentive to terminate these services.
- CAHs that otherwise qualify for cost reimbursement of certified registered nurse anesthetist (CRNA) services should be allowed to include CRNA on-call pay as a reimbursable cost.

NRHA supports the following actions related to the Medicaid program to strengthen and support CAHs:

- Medicaid should pay CAHs at least the same percentage of costs as Medicare for services provided to Medicaid beneficiaries.
- Medicaid managed care programs should not be used as a method of circumventing state cost reimbursement mandates.

NRHA supports the following actions to strengthen and support CAHs:

- CAHs should be made eligible for the full 340B Drug Pricing Program, without the exclusion of orphan drugs.
- The 340B Drug Pricing Program should be expanded to include inpatient drugs for CAHs and other safety net providers.

*Additional recommendations can be found in the Medicare Rural Hospital Flexibility Program ("Flex") section of this document.*

### **Critical Access Hospital Quality Reporting**

All CAHs should be encouraged to report quality metrics to improve quality of care and for CAH benchmarking. NRHA understands the burden of reporting for small hospitals is very high in comparison to larger hospitals. As such, quality reporting should not be subject to individual, voluntary reporting, but required for CAHs receiving Flex funding. In return the Flex program will provide the needed technical assistance and resources to facilitate CAH reporting.

CAH quality measures need to be standardized metrics (core measures) and be rural relevant measures. Standardized metrics would consist of a core set of measures used by States, the Flex Program, CMS, payers and hospital associations. CAH transition to quality reporting should focus on: 1) development of rural-relevant measures, 2) alignment of measurement efforts, 3) measure selection process, and 4) pay-for-performance considerations.

[\*Additional recommendations are available in NRHA's policy brief Public Reporting of Hospital Quality in Rural Communities: An Initial Set of Key Issues \(Jan. 2012\).\*](#)

### **Critical Access Hospital 96- hour Rule**

The CAH 96-hour rule creates a condition of repayment that requires a physician to certify that a patient can reasonably be expected to be discharged or transferred within 96 hours. CAHs already must meet a separate condition of participation, which requires that acute inpatient care provided to patients not exceed 96 hours per patient on an average annual basis. The Administration should extend the COVID-19 flexibilities for rural hospitals through permanently removing the Condition of Payment

requirements that Critical Access Hospitals length of stay be limited to 96 hours. From the creation of the CAH designation until late 2013, an annual average of 96-hour stays allowed CAHs flexibility within the regulatory framework in alignment with Congressional intent. The change in policy of strict enforcement of a per stay 96-hour Condition of Payment requirement, creates unnecessary red-tape and barriers for CAHs throughout rural America. The rule limits access to health care in rural areas, restricts rural provider decision-making and eliminates important flexibility to allow general surgical services. This in turn, puts CAHs in a position where high quality and qualified local providers cannot provide care for their patients and as a result, patients have had to seek care far from home.

### **Emergency Medical Services**

NRHA recognizes the critical role that Emergency Medical Services (EMS) play in rural areas. It is increasingly difficult for ambulance services to respond to emergencies in rural America due to workforce shortages and growing financial crisis. About a third of rural EMS agencies in the U.S. are in immediate operational jeopardy because they can't cover their costs, largely from insufficient Medicaid and Medicare reimbursements. Those reimbursements cover, on average, about a third of the actual costs to maintain equipment, stock medications and pay for insurance and other fixed expenses. Private insurance pays considerably more than Medicaid, but because of low call volumes, EMS agencies aren't able to make up the difference in reimbursement.

NRHA supports the following actions to strengthen and support EMS services:

- Eliminate the 35-mile standard currently required for cost-based reimbursement for CAH ambulance services.
- Support the development of a supplemental fee schedule that ensures appropriate reimbursement for rural ambulance services. The timeline for analysis of the costs of providing ambulance services in rural areas should be accelerated and, in the interim, rural providers should be held harmless vis-à-vis the ambulance fee schedule.
- Support federal and state funding to address the need to strengthen and integrate emergency medical services with rural health care services and providers. Federal funding would support such activities as innovative demonstrations, improved training, research, telehealth, preventive health and personnel recruitment for rural and frontier areas.
- Support the reauthorization of HRSA's Title XII EMS Trauma grant program.
- Address the rising cost and decreasing availability of general and property (including vehicle) insurance for EMS services.
- Create a federal office to support EMS. Providers, state EMS departments, and SORHs should be adequately supported by federal agencies through policy development, data systems, appropriate curricula and access to grants.
- Extend the 340B drug pricing program to ambulance services whose service areas include rural areas.
- Support efforts to increase quality and safety for air and ground transports.
- Pay EMS providers the higher of the rural or the urban rates for services provided in the non-urbanized areas (outlying areas) of core-based statistical areas (CBSA).
- Encourage federal and state legislators to support alternate funding models for EMS and emergency care delivery in rural areas such that payments are not contingent on transporting a patient.
- Support the use of rural economic impact models that account for losses in state revenue when health care services are lost in rural areas. These models can be used to allocate state funds to support the rural EMS workforce and emergency care access.

- Provide guidance to private insurers on paying for treat-and-discharge EMS care and community paramedicine.
- Advise CMS to incentivize Accountable Care Organizations (ACOs) to partner with rural EMS agencies to deliver integrated health care.
- Encourage ACOs and health care systems to provide community benefit grants to support the development of local community paramedicine and EMS system based expanded care delivery models.

NRHA supports the following actions to expanded EMS workforce and expanded role for EMS services:

- Urge the Center for Medicare and Medicaid Innovation (CMMI) to support demonstration projects around expanded scope of service and practice EMS beyond the Emergency Triage, Treatment, and Transport (ET3) project.
- Facilitate the development of a federal interdepartmental task force between the Departments of Defense, Education, and Labor (and in particular the Veterans' Employment and Training Services [VETS]) to create a mechanism for formal recognition of military training in medical care that would transfer those educational experiences into civilian educational and licensure opportunities.
- Support national educational associations in developing guidance for academic institutions for accepting these credits.
- Provide guidance for state licensing boards to accept these academic accomplishments towards licensure.
- Incentivize states and health care systems to use the Informed Community Self Determination process to drive the development of rural emergency care.
- Support EMS professional associations and academic institutions to research the causes of professional burnout in EMS and to implement solutions to the crisis.
- Make non-public emergency EMS workers eligible for the Public Safety Officers' Death Benefit Program.
- Continue to provide funding through the SIREN Act and other mechanisms to support education, particularly asynchronous and distance learning, for rural EMS licensure and continuing education programs.
- Recommend that procedures performed by EMS providers in conjunction with and as a result of a telehealth visit by a Qualified Healthcare practitioner be allowed to be billed using "incident to" billing practices even if the procedures occur simultaneously with the telehealth visit.

*Additional recommendations are available in NRHA's policy briefs- [Rural EMS Workforce: A Call to Action \(Feb. 2021\)](#) and [EMS Services in Rural America: Challenges and Opportunities \(May 2018\)](#).*

### **Emergency Preparedness**

The rural health infrastructure (which includes workforce, EMS, laboratory, and information systems) and components of the public health system (which includes education and research) must be strengthened to increase the ability to identify, respond to and prevent problems of public health importance. A strong public health infrastructure will also serve rural communities in the event of other emergencies, such as natural disasters and infectious disease outbreaks, such as COVID-19, while enhancing the ability to improve community health status through everyday provision of essential public health services.

In addressing these rural needs, the variability, surge capacity, capabilities, and needs of health infrastructures must be taken into consideration. Mental health needs of populations affected by



disasters must be addressed. The protection of the environment, the food and water supply, and the health and safety of rescue and recovery workers must be assured. Availability of, and accessibility to, health care, including medications and vaccines, for individuals exposed, infected, or injured in disaster events must be assured.

NRHA supports the following actions to strengthen and support emergency preparedness in rural areas:

- Create Offices of Rural Health within the Center for Disease Control and Prevention (CDC) and Federal Emergency Management Agency (FEMA) to ensure a continued focus on rural health issues.
- Funding and requirements need to be flexible enough to allow appropriate solutions, according to the local rural needs, while adhering to evidence based approaches that can be applied across communities.
- A regional health care point of contact should be designated to establish regional partnerships for preparedness and response as needed. A database or listserv should be created for consistent information sharing from federal and/or state resources (depending on the crisis). Currently there is no consistency across counties, state or federal.
- Health professionals, volunteers/first responders, and the public must be educated to better identify, respond to, and prevent the adverse health consequences of disasters and promote the visibility and availability of health professionals in the communities that they serve.
- Hospitals and rural primary care providers must be included as first responders for planning, funding, and training purposes. These providers cannot be expected to absorb the costs of disaster preparedness alone and will need additional resources to fulfill their role in the emergency response system. As not all areas are directly served by hospitals, flexibility in funding will also be needed.
- Disaster Mental Health must be included as part of a comprehensive strategy of preparedness response in every rural community. Practices such as cognitive behavioral therapy as well as psychological first aid should be explored. These local services should be provided with appropriate reimbursement.
- Availability of, and accessibility to health care resources, including medications and vaccines, for individuals exposed, infected, or injured in disaster events must be assured throughout the state in connection with the national strategic stockpile. Local response entities should have a plan in place for communication and distribution.

*Additional recommendations are available in the NRHA Policy Briefs: [Rural Health Preparedness Policy Brief \(Feb. 2021\)](#) and [Emergency Preparedness for Rural Communities \(July 2019\)](#)*

### **Frontier Extended Stay Clinic**

The Frontier Extended Stay Clinic (FESC) model should be used as a foundation to create a permanent extended stay primary care provider type. Mileage and provider requirements should be relaxed to give more flexibility to isolated communities to allow additional providers to participate in the designation.

*[More information about the FESC program is available in NRHA's Policy Brief: The Future of the Frontier Extended Stay Clinic \(Feb. 2014\).](#)*

### **Home Health Care**

CMS should include a meaningful low-volume adjustment to its prospective payment system for home health services which targets additional payments to a range of low-volume providers. Rural providers with low utilization have a lower number of cases across which to spread the cost of overhead or high-cost cases. Such an adjustment, when properly implemented, can address these financial challenges.



Additionally, CAH-based home health agencies should have the option to be paid 101 percent of cost-based reimbursement or the otherwise applicable rate under the prospective payment system.

### **Maternal Health**

An estimated half a million rural women give birth in US hospitals each year. The majority of rural women give birth at their local hospitals and therefore rely on local maternity services. As of 2014, only 45% of rural counties had obstetric (OB) services, down from 54% in 2004 showing a rapid decline. Current workforce and hospital closure trends suggest that disparities in access to maternity care will only increase in upcoming years if no action is taken.

NRHA supports the following actions to ensure that rural women continue to have access to maternity services.

- Incentivize the expansion of Medicaid eligibility for pregnant women.
- Use flexibilities in the Medicaid program to address barriers to rural practice of OB services including: protections for low volume providers; liability insurance costs and Tort Reforms; incentives to address a decreased focus of OB care within primary care practice; and resources to support C-sections including an OB-GYN, surgeon, and/or anesthesiologist.
- Develop strategies targeted toward Black women in rural areas to address their heightened risk of dying during pregnancy because of the shortage of hospitals and doctors, disproportionate rates of poverty, glaring health disparities, and persistent structural racism in the medical field.
- Addressing the high costs of malpractice insurance may make it more economically viable for family practice physicians to continue providing obstetrics care in rural areas.
- Support local perinatal regionalization and access to OB care policies that keeps struggling facilities open in order to keep maternity services local for rural women, such as the Save Rural Hospital Act, with a focus on the smallest hospitals that do not typically provide OB services.
- Support policies that support women during pregnancy including transportation and housing.
- Incentivize the integration of rural EMS programs, community health workers, other non-traditional providers specializing in maternal care (e.g. doulas), and hospitals to support maternity care in maternal health professional shortage areas.
- Use of telehealth and other technologies to facilitate the delivery of maternity and pediatric services so that women can receive care in facilities within their own community.
- Establish alternative payment models for obstetrics and delivery similar to the NC Pregnancy Medical Home.

NRHA supports the following actions to ensure access to rural maternity health care workforce.

- Efforts to create a designation for areas that lack maternity providers – a professional shortage area for maternity providers.
- Expand scope of practice and reimbursement for advanced practice providers (e.g. family physicians, nurse practitioners, physician assistants, nurse midwives, certified midwives) and non-traditional providers (e.g. doulas, community health workers) subject to state regulations for professional practice in order to maintain or improve access to local maternity care for rural women.
- Support rural training programs, including interprofessional team building, such as TeamSTEPPS, and simulation training, such as the American Academy of Family Physicians' Advanced Life Support in Obstetrics course (ALSO) and the Centers for Disease Control and Prevention's Hear Her campaign.
- Develop and support rural-specific obstetrics-focused residency programs.

- Supports rural family practice physicians in providing maternity services, including providing more rural residencies for family practice physicians that allow residents to perform more deliveries.
- Incentivize clinicians to practice in rural communities by expanding rural-focused family physician and general surgeon programs with OB fellowship training.
- Leverage the National Health Service Corps Loan Repayment program to fill workforce shortage areas.

*Additional recommendations are available in NRHA's Policy Briefs- [Rural Obstetric Unit Closures and Maternal and Infant Health \(Feb. 2021\)](#) and [Access to Rural Maternity Care \(Jan.2019\)](#).*

### **Medicare Dependent Hospital Program**

The Medicare Dependent Hospital (MDH) program plays an important role in rural hospital designations and should be made permanent. To be classified as an MDH, a rural hospital under 100 beds must have at least 60 percent of its days or discharges covered by Medicare Part A during two of the last three most recently audited cost reporting periods.

NRHA supports the following actions to strengthen and support the MDH program:

- The MDH program should be made permanent, with no sunset date.
- The 60 percent Medicare utilization threshold should be revised to 50 percent.
- Hospitals classified as MDHs should be paid for their inpatient operating and capital costs using the same methodologies used for SCHs.
- Pay disproportionate share hospital payments as an add-on to the MDH hospital-specific payment rates using the current formula applied to the federal payment rate, with no cap.
- Continue to periodically provide additional, more current base years for purposes of determining inpatient MDH specific rates.
- Update the provision that allows additional reimbursement to an MDH that experiences a decrease in inpatient volume of more than 5% for circumstances beyond its control, to include not only operating costs but capital costs as well.
- Apply the computation to update hospital-specific rates without retroactive application of budget neutrality factors.
- Address reductions in the hospital specific rate related to the Diagnosis Related Group (DRG) creep under the Medicare Severity Diagnosis Related Groups (MS-DRG) system (also referred to as documentation and coding adjustments).
- Address DRG recalibration adjustments that are supposed to be budget neutral, but generally have a negative impact on rural hospitals

### **Opioid Use Disorder and Substance Use Disorder**

Abuse of prescription and illicit opioids has become a top priority public health issue, and its effects on rural communities cannot be understated. Effective, evidence-based treatment of opioid use disorders is urgently needed in small towns across America. However, multiple barriers stand in the way of appropriate treatment availability and quality. These include a decaying rural mental health and substance abuse treatment infrastructure, lack of regional coordination of treatment resources, lack of support of rural physicians providing substance abuse treatment, administrative barriers against the most effective form of opioid abuse treatment, and a shortage of rural physicians who provide Medication Assisted Treatment (MAT).

NRHA supports the following policies in order to address and reverse the current nationwide opioid epidemic that has hit hardest in vulnerable rural communities.

- Make MAT (buprenorphine or methadone) an option in all rural communities by removing barriers to treatment.
- Improve the availability of MAT prescribers, chemical dependency professionals and mental health professionals in rural areas.
- Improve availability of outpatient mental health, recovery, and peer recovery services in rural settings.
- Improve availability of inpatient facilities that treat substance use disorders.
- Allow patients to be induced on buprenorphine while in inpatient settings so as to improve continuity between inpatient and outpatient treatment and reduce side effects and treatment dropout.
- Make Naloxone available to every patient suffering from an opiate use disorder and to concerned friends, loved ones and other bystanders who have been properly trained in its use.
- Provide funding for research on treatment of opioid issues specifically in rural settings to better document what works in these environments and develop innovative solutions to this burgeoning problem

More broadly, substance use disorder (SUD) can be especially hard to combat in rural communities due to limited resources for prevention, treatment, and recovery. The substance use treatment admission rate for nonmetropolitan counties was highest for alcohol as the primary substance, followed by marijuana, stimulants, opiates, and cocaine. Substance use disorders can result in increased illegal activities as well as physical and social health consequences, such as poor academic performance, poorer health status, changes in brain structure, and increased risk of death from overdose and suicide.

[\*Additional recommendations are available in NRHA's Policy Briefs: Treating the Rural Opioid Epidemic \(Feb 2017\) and Rural Communities in Crisis-Strategies to Address the Opioid Crisis \(April 2016\).\*](#)

### **Oral Health**

NRHA recognizes that rural communities often lack adequate oral health care and subsequently miss out on the benefits of good oral health as well. As such, NRHA supports the following actions to strengthen and support oral health services in rural areas:

- Medicaid and Medicare coverage should include oral health as a mandatory service for eligible beneficiaries. Medicaid reimbursement must also be increased to give this benefit actual meaning.
- Oral health providers should be encouraged to practice to the top of their licensure to help abate the chronic shortfall of rural oral health providers.
- Use of financial incentives, such as student loan forgiveness, equipment purchasing grants and loans, assistance in establishing clinic facilities, and programs providing specialized training, to attract more dentists to rural areas. Part of these programs funding should be contingent on the providers serving a minimum percentage of Medicaid beneficiaries and uninsured patients. These programs should be funded at an adequate level to allow them to succeed.
- Rural hospitals and other rural health hubs should be allowed and encouraged to establish dental clinics and oversee dental students and residents.
- States offering services through mobile dental units should increase the number of mobile dental units in service and increase the number of visits those units make to a specific community to provide more consistency in residents' dental treatment.
- Federal and state governments should encourage public oral health education, including education about the benefits of fluoride supplementation and water fluoridation, roles of diet

and nutrition in cavity control, oral disease risk reduction, tobacco cessation and alcohol control, oral and facial injury prevention, and appropriate use of dental services. These efforts should be provided through culturally sensitive and appropriate materials and venues including public schools.

- Funding should be provided to support demonstrations and comprehensive evaluations of innovative state efforts to expand access to oral health services for rural and frontier populations and to disseminate information on programs found to be effective.

In regard to oral chronic disease prevention, NRHA supports: a) awareness of oral disease disparities in underserved populations, b) the value of preventive interventions for all levels of behavior change such as oral hygiene instruction, dental sealants as appropriate, and fluoridation of community water supplies, c) awareness of the relationship of oral and general health, and d) work with stakeholders to improve access to oral health care.

[Additional recommendations are available in NRHA's Policy Briefs: Improving Rural Oral Health Access \(May 2018\) and Meeting Oral Health Care Needs in Rural America \(Feb 2013\)](#)

### **Patient Centered Medical Home**

The Patient-Centered Medical Home (PCMH) is a provider-based model for care coordination that can be implemented within a primary care practice. NRHA supports a PCMH that facilitates partnerships between patients, their providers and when appropriate the patient's family and significant other.

[More information about Health Homes in rural areas is available in the NRHA policy position, "Patient Centered Health Home" \(Oct. 2008\).](#)

### **Pharmacy**

NRHA supports an increase in the multiplier for the Average Manufacturers Price (Medicaid) to provide an equitable prescription reimbursement for low volume rural pharmacies critical to geographic access to pharmaceutical services. Issues around reimbursement, workforce, and recognition of the role of pharmacist as a distinct provider of clinical services all need to be addressed to ensure rural access to appropriate pharmacy care in rural areas.

### **Public Health and Public Health Infrastructure**

Congress, as well as HHS, should ensure that rural local public health providers have the capacity and training necessary to respond to public health needs in rural communities. Throughout the COVID-19 PHE, rural providers were tested to their limit when it came to workforce and infrastructure capacity. Not only did the already evident workforce shortage become further exacerbated, but the lack of health infrastructure also became increasingly evident. NRHA believes it is imperative for Congress and HHS to look beyond the PHE and ensure that rural providers are adequately prepared to support their communities by supporting the following actions to strengthen and support health services in rural areas:

- Support a one-time supplemental appropriation injection into the NHSC and NCLRP to address the health workforce shortages in rural America. Support a carveout for rural providers as they are more likely to face workforce shortages compared to their urban counterparts.
- Ensure rural providers have access to the highly qualified providers they need as the rural health care safety net rebuilds in a post-COVID-19 world.
- Support expanded engagement of rural public health professionals in rural systems of care.
- Provide additional funding to rural providers and rural health care programs in any future infrastructure package. The public health infrastructure in rural America needs great

improvement, especially when it comes to broadband access. As technology continues to evolve, so does America's utilization of telehealth, especially in rural America.

*[Additional Policy recommendations are available in NRHA's Policy Brief: Rural Public Health \(Feb. 2016\)](#)*

## **Quality**

Policy related to rural quality should recognize the unique characteristics of rural health care and increase the value of care provided to individuals living in rural areas. In support of this, NRHA supports the National Quality Forum (NQF) Quality Report of September 2015 and strongly encourages CMS to adopt the recommendations for use in all quality reporting programs.

NRHA supports the following actions to strengthen and support rural providers participating in quality efforts:

- Adopt an integrated, prioritized approach to addressing both personal and population health needs at the community level.
- Establish a stronger quality improvement support structure to assist rural health systems and professionals in acquiring knowledge and tools to improve quality.
- Enhance the human resource capacity of rural communities, including the education, training, and deployment of health care professionals, and the preparedness of rural residents to engage actively in improving their health and health care.
- Monitor rural health care systems to ensure that they are financially stable and provide assistance in securing the necessary capital for system redesign related to quality improvement efforts.
- Invest in building a data information and communications infrastructure, which has enormous potential to enhance health and health care over the coming decades.
- Provide sufficient flexibility in quality reporting to allow quality reporting to work for rural populations of all sizes through the development of rural-relevant strategies, techniques, benchmarks and best practices.

*Additional recommendations to support rural providers increase quality and value can be found in [NRHA Policy Brief: Quality of Rural Health Care \(Sept. 2012\)](#) and [Comprehensive Quality Improvement in Rural Health Care \(Feb. 2015\)](#).*

## **Rural Health Clinics**

RHCs have become an essential Medicare provider type in rural communities. The RHC program should be modernized through the following policy changes:

- Permanently enable all RHCs to serve as distant-site providers for purposes of Medicare telehealth reimbursement and to set reimbursement for these services at their respective all-inclusive rate (AIR). Additionally, these services should be counted as a qualified encounter on the Medicare cost report.
- Modernize physician, physician assistant, and nurse practitioner utilization requirements to allow for arrangements consistent with State and local law relative to practice, performance, and delivery of health services.
- Continue cost-based reimbursement without a per-visit cap in exchange for requiring provider-based RHCs reporting of quality measures. Provider-based RHCs would use the higher rate to pay for their participation in a quality program.
- Create an option for low-volume facilities (perhaps those meeting frontier and/or volume threshold) to automatically be eligible to receive a provider-based designation exception to address low-volume issues.

- Include the provision of behavioral health services under the existing primary care 50% threshold requirements given the shortage of rural mental health providers and the importance of primary care and behavioral health integration.
- Remove outdated laboratory requirements.

NRHA supports the following actions related to the RHC program to strengthen and support the designation:

- RHCs must be included as an important entity in payment reforms including Accountable Care Organizations (ACO), Patient-Centered Medical Homes (PCMH), and Regional Care Collaborative Organizations.
- Expand eligibility requirements for existing RHCs located in areas that lose their Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA) designation because of population or provider changes. Geographic distance, provider type, patient transportation requirements and limitations, and other proven access considerations should be included in evaluating access to health care in the certification criteria.
- In states that have adopted a definition of “rural,” allow the state definition to be used to achieve or retain RHC designation.
- Provide sufficient funding for timely initial and follow-up certification surveys to assure access to the program and compliance with regulations.
- Develop a meaningful productivity standard exceptions process.
- Require minimum MA reimbursement at Medicare RHC rates, or provide federal wrap around payments.
- Require MA plans to reimburse for flu and pneumococcal vaccines at the RHC’s cost per vaccine, as calculated on the most recent Medicare cost report.
- RHCs should be eligible for the 340B Drug Pricing Program.

[Specific Recommendations can be found in the NRHA policy brief: Rural Health Clinics \(April 2014\)](#)

### **Rural Referral Centers**

Rural Referral Centers (RRC) have become an essential Medicare provider type in rural communities.

NRHA supports the following actions related to strengthen and support the RRC designation:

- A full market basket update for RRCs should be provided annually.
- Pay RRCs for inpatient services on the same basis as SCHs, i.e., based on the higher of the federal prospective payment rate or a hospital-specific rate.
- Update the RRC qualifying criteria (beds, discharges, and case mix index criteria) so more hospitals can qualify for RRC status and for the special treatments available to hospitals with the RRC designation.
- Address reductions in the hospital specific rate related to DRG creep under the MS DRG system (also referred to as documentation and coding adjustments).
- Address DRG recalibration adjustments that are supposed to be budget neutral, but generally have a negative impact on rural hospitals.

### **Safety Net Providers**

NRHA believes the rural safety net is in extreme jeopardy and requests the immediate attention of public policy officials. The health care safety net in rural areas includes those health care providers (public health, mental health, hospitals, practitioners, clinics, health centers, pharmacy, and ambulance services) that deliver health care services to the uninsured, Medicaid, and other vulnerable patients.

NRHA supports the following actions to strengthen and support the rural safety net:

- Provide reimbursement to all safety net providers sufficient to cover the cost of providing services.
- Create a pilot grant program to allow support to all safety net providers including for-profits and RHCs with charity care and/or sliding fee scales.
- Provide more flexible regulations for rural health entities along with decreased paperwork and requirements.
- Provide grant assistance or loan support to rural safety net providers that are in eminent danger of closure.

### **Sole Community Hospitals**

Sole Community Hospitals (SCH) have become an essential Medicare provider type in rural communities. NRHA supports the following actions related to strengthen and support the SCH designation:

- A full market basket update for SCHs, as well as a full market basket update for the target amount applicable to SCHs, should be provided annually.
- A payment-to-cost ratio floor should be established to further improve outpatient PPS payments for qualifying hospitals.
- Continue to periodically provide additional, more current base years for purposes of determining inpatient SCH specific rates.
- SCH outpatient service add-on payments should continue.
- Update the provision that allows additional reimbursement to an SCH that experiences a decrease in inpatient volume of more than 5% for circumstances beyond its control, to include not only operating costs but capital costs as well.
- Compute hospital-specific rates without retroactive application of budget neutrality factors.
- Support paying DSH payments as an add-on to the SCH hospital-specific payment rates using the current formula applied to the federal payment rate, with no cap.
- Address reductions in the hospital specific rate related to DRG creep under the MS DRG system (also referred to as documentation and coding adjustments).
- Address DRG recalibration adjustments that are supposed to be budget neutral, but generally have a negative impact on rural hospitals.

### **340B Program**

The 340B Drug Pricing Program, which provides discounts to safety net hospitals and other providers, should be maintained, expanded, and simplified to eliminate unnecessary administrative burdens, which are barriers to entry for qualifying smaller rural hospitals. The 340B Drug Pricing Program is pivotal to the financial success of many health care safety-net providers, especially in rural America. The program helps rural providers across the country, including more than 1,000 rural hospitals, stretch scarce resources to provide more comprehensive services and care for more patients. The 340B program guidelines must be crafted to allow participating entities to stretch scarce resources.

NRHA supports the following actions to strengthen and support the 340b program for rural providers:

- Review existing policies around Medicare payment for 340B-acquired drugs and limitations on covered entities' use of contract community pharmacies.
- Expand the program to include inpatient drugs.
- Eliminate the group purchasing organization (GPO) prohibition.
- Eliminate the orphan drug exclusion for certain facilities.



- Make permanent the rural SCH exception from the Medicare OPPS 340B payment cuts.
- Eliminate the DSH threshold for SCHs and RRCs.
- Maintain a patient definition consistent with the way medicine is practiced in rural communities to ensure robust access to the 340B program.
- Enforce 340B program rules to require manufacturers to continue providing 340B drugs to all qualifying covered entities, including contract pharmacies.

[Additional recommendations are available in NRHA's Policy Briefs: Utilization of the 340B Drug Pricing Program in Rural Practices \(July 2019\)](#)

## Rural Health Financing and Payment

### Low-Wage Medicare Wage Index Adjustments

The current methodology of the Medicare Area Wage Index often results in disproportionately low Medicare payments to hospitals in rural and low-wage areas. CMS has made changes to address long-standing rural hospital concerns for hospitals with low-wage structures. The change was originally envisioned as a four-year period that would allow these rural low-wage facilities to, in effect, catch up and use the extra revenue to increase their wage structures and, over time, increase their wage index. NRHA recommends extending the adjustment period, particularly in light of the long-term financial shocks that will affect rural hospitals due to the pandemic and the 2–3-year delay in the wage index rates to reflect the high labor costs during COVID-19. As a long term fix, NRHA recommends establishment of an area wage adjustment floor of 0.85 for all rural hospitals. NRHA believes this will help rural providers both financially and in terms of recruiting necessary health professions workforce.

### Medicare Bad Debt

NRHA recommends reversing cuts to reimbursement of bad debt for CAHs and rural hospitals. Increasing the cut or eliminating bad debt reimbursement would disproportionately affect rural hospitals that treat high numbers of low-income Medicare beneficiaries. Rural hospitals have Medicare bad debt percentages that are 60 percent higher than urban hospitals, on average. NRHA supports legislation to make changes to the bad debt a rural hospital is liable for from 30 percent to 15 percent or less. Another alternative is to pay bad debts related to dual eligible patients (crossovers) at 100%. Providers are unable (by law) to pursue collection of patient liabilities of Medicaid patients.

### Medicare Inpatient Prospective Payment System

NRHA supports the following actions to strengthen and support the rural providers paid under the Medicare Hospital Inpatient Prospective Payment System (IPPS):

- Removal of the cap on Medicare disproportionate share hospital payments to rural PPS hospitals.
- Make permanent the temporary improvements to the Medicare inpatient payment adjustment for low-volume hospitals included in §50204 of the Bipartisan Budget Act of 2018.
- Address the payment reductions related to DRG creep under the MS-DRG system (also referred to as documentation and coding adjustments).
- Permanently remove sequestration cuts to rural PPS hospital payments.
- Allow hospitals that otherwise qualify for cost reimbursement of CRNA services to include CRNA on-call pay as a reimbursable cost.

### Medicare Outpatient Prospective Payment System

NRHA supports the following actions to strengthen and support the rural providers paid under the Medicare Hospital Outpatient PPS:



- Reinstatement and make permanent the hold harmless provision for rural hospitals under 100 beds and all sole community hospitals, while maintaining the current add-on payment paid to sole community hospitals.
- Continue evaluation of the impact of the outpatient PPS and exploring options for alternative payment mechanisms that will ensure the future financial stability of rural hospitals.

### **Medicare Physician Fee Schedule**

NRHA supports the following actions to strengthen and support the rural providers paid under the Medicare physician fee schedule (PFS):

- Physician assistants, nurse practitioners, and clinical nurse specialists practicing in rural and underserved areas should be reimbursed at a 100 percent level of the fee schedule for primary care physicians in rural and underserved areas, and direct reimbursement to such providers should be protected.
- Geographic variation in physician payment should be based only on actual physician expenses.
- Provide adequate Medicare reimbursement for all types of mental health professionals providing services otherwise covered by Medicare based on state licensure laws.
- An appropriate adjustment factor should be applied to both the outpatient laboratory and therapy services fee schedules for services provided by rural PPS hospitals. The fee schedules for services provided by rural PPS hospitals significantly underpay these hospitals providing lower volumes of outpatient services.
- Services performed by Radiology Physician Assistants (RPA) and their supervising Radiologist should be covered for reimbursement under the Medicare Fee Schedule. NRHA recognizes RPAs as an important member of the rural team providing radiology services, particularly those using remote Radiologist services via tele-radiology.
- An urban/rural differential based on the geographic payment cost index for rural FQHCs should be eliminated and prohibited.

### **Medicare Sequestration**

In 2011, Congress passed legislation instituting a two percent sequestration reduction to all Medicare fee-for-service payments. Reductions in Medicare reimbursement due to sequestration, in addition to reductions in bad debt payments, largely impact the financial viability of rural hospitals. NRHA's research partner, Chartis, has forecasted that sequestration policies have an annual impact of \$430 million in lost revenue for rural providers. This policy has a disproportionate impact on cost-based providers, such as CAHs, who are paid below their actual costs due to sequestration. Since the onset of the COVID-19 public health emergency, sequestration has been halted. NRHA urges this relief to be continued, particularly for rural providers, permanently.

### **Medicare Shared Savings Program**

NRHA supports the development of a rural shared savings program that recognizes the unique attributes of the rural delivery system and assigns rural beneficiaries accordingly. NRHA also encourages CMS and CMMI to develop a meaningful demonstration program that reflects the realities and needs of rural America.

NRHA supports the following actions to strengthen and support the rural providers participating in the Medicare Shared Savings Program (MSSP):

- Assign all Medicare beneficiaries to rural communities that provide a plurality of primary care within the community to a Community Care Organization (CCO), with shared savings payments made for patients who receive care within the CCO.

- Provide advanced payments to all CCOs to support infrastructure development and chronic disease management, including a Per-Member, Per-Month stipend.
- Follow the remaining principles of the MSSP, while being more prescriptive in the implementation to suit the needs of rural providers.
- Modify policy/regulations to allow CAHs, RHCs, and FQHCs to participate in federal advanced payment models without excessive financial or administrative burden.
- Develop hybrid payment schemes for CAHs, RHCs, and FQHCs that allow for some ongoing cost-based reimbursement during a transitional period to value-based payments in order to incentivize transformational change and ease the financial risk.
- Authorize CMMI to immediately develop demonstration projects designed for rural health care facilities that reward comprehensive primary care. Such demonstration projects should include: human-centered design approach that works for end users; technical assistance to develop comprehensive primary care programs that include behavioral health and community integration; tools to support transitional financial risk management; and tools to support population health management.
- Align reporting systems and requirements among Medicare, Medicaid, and commercial payers to ease the reporting burden for performance measures and promote interoperability.
- Identify and implement rural-relevant performance measures.

[Additional recommendations and rural MSSP program details are available in the NRHA Policy Briefs: Volume to Value Transition for Rural Health Systems \(Oct. 2020\) and Rural Hospital Participation in the Medicare Shared Savings Program \(Feb. 2013\)](#)

### **Medicare Wage Indices**

NRHA opposes any wholesale change of the area wage index computation methodology that reduces payments to rural hospitals or other rural providers in the aggregate or harms any particular group of rural hospitals or other rural providers. Rural providers should be held harmless if there is a significant change in the wage index computation methodology.

NRHA supports the following actions to strengthen and support the rural providers participating in the Medicare wage indices:

- The hospital wage index should be changed to reflect only legitimate differences in area wage rates, not average per employee expenditures that are biased toward urban areas.
- Use of the hospital wage index should be limited to hospital inpatient services. The currently mandated use for outpatient services, home health care, long-term care, and MA payments should be modified to reflect only wage rates relevant to those specific services.
- CMS should extend the “lowest-quartile” wage index policy implemented in 2019, until a more equitable wage index for rural areas is developed and implemented.

### **Price Transparency**

CMS has issued price transparency regulations effective January 1, 2021, for all hospitals, including CAHs. The price transparency requirements are problematic for rural hospitals, with little benefit to patients due to their complexity. Rural hospitals have been impacted by the implementation of the requirement to disclose negotiated rates for their services. Unlike large urban systems, rural hospitals have little bargaining power when negotiating rates with managed care plans.

NRHA requests the following changes to the price transparency program on behalf of rural providers:

- Exempt rural hospitals, including CAHs, from implementation of the standard charge disclosure requirements moving forward.

### **Professional Liability Insurance Reform**

NRHA supports addressing the rising cost and decreasing availability of malpractice insurance through appropriate legislative and regulatory mechanisms. The cost of malpractice insurance is a barrier to health care access in rural areas, as the cost negatively affects recruitment and retention of physicians and other scarce health professionals. Additionally, the medical liability system will undergo changes with the emergence of new technologies, including Electronic Health Records (EHRs). New liabilities should be mitigated through specific training and liability risk caps during EHR transition periods.

[Additional recommendations are available in NRHA's Policy Brief—Professional Liability Reform \(Sept. 2012\)](#)

### **Rural Emergency Hospital Model Development**

Congress created the Rural Emergency Hospital (REH) designation, established in Section 125 of the Consolidated Appropriations Act, 2021, to be launched by January 1, 2023. NRHA is optimistic the REH model will address a persistent rural need for emergency and other outpatient services at-risk following hospital closures, and go a long way toward slowing the alarming rate of closure crisis and maintaining health care access to some of the most disadvantaged and marginalized communities in our country. Approximately 68 rural hospitals (or 5 percent) of rural hospitals are predicted to consider conversion to become a REH. The hospitals most likely to transition to this designation are in already poor financial standing. As such, NRHA recommends continuation of existing CoPs for rural PPS and CAHs instead of creating new CoPs. Further, it is imperative that CMS understands that strong reimbursement and financial payments are the crux of success for this model. The pathway to converting to the REH designation needs to be seamless through a simplified application process and technical assistance through the HRSA Flex Program for robust planning and community engagement.

[Additional recommendations are available in NRHA's Medicare CY 2022 Hospital Outpatient PPS Comments \(Sept. 2021\)](#)

### **Rural Hospital Innovation**

Today the stability of the rural health safety net is tenuous. Rural hospital closures stand at 138 since 2010, with another 453 vulnerable to closure. Of those closures, 53% were rural PPS hospitals and 47% had CAH status. The rapid spread of COVID-19 in rural areas has further destabilized the ability of rural hospitals to meet the needs of their communities. Long term, reforms to the rural hospital infrastructure are critical to create a more sustainable system of care.

The Biden Administration should continue to test and implement sustainable payment models for rural providers. In Spring 2022, CMS anticipates making applications available for the Community Health Access and Rural Transformation (CHART) Accountable Care Organization (ACO) Model. The CHART ACO model should be modeled after the CMS ACO Investment Model (AIM) to encourage participation from rural and underserved providers who may be more risk-averse due to low margins. Further, model success should be evaluated more significantly on improvements in quality and access, rather than reduced costs, given the underserved nature of these communities.

NRHA recommends expanding the success of the CMS Pennsylvania Rural Health Model. Under one of the most successful rural innovation models to date, CMS and other participating payers pay participating rural hospitals on a global budget—a fixed amount, set in advance—to cover all inpatient and hospital-based outpatient items and services. Participating rural hospitals work to redesign the

delivery of care for their beneficiaries and improve quality of care and better meet the health needs of their local communities. Key to the success of this model is having the state, acting through its Department of Health, as a key partner in jointly administering this Model with CMS, rather than requiring individual hospitals create networks as structured in the CHART model.

## Prevention, Primary Care and Clinical Services

### Chronic Disease Prevention

High-risk populations are disproportionately located in rural and underserved areas. These populations must be prioritized in health education, chronic disease prevention, infectious disease control, and healthy lifestyle modification as part of rural health improvement. NRHA encourages lawmakers and regulatory entities to address social determinants of health (job opportunities, broadband access, housing, etc.) to ensure that rural populations have equitable health care outcomes. Educational programs addressing social determinants of health and equitable opportunities to improve health through screenings and lifestyle modification programs, as well as programs that support disease treatment and monitoring, should be encouraged by lawmaking and regulatory entities. Specific groups to be targeted include people living in poverty, indigenous people, people of color, and other racial or ethnic groups that are shown statistically to be at higher risk for certain chronic medical conditions because of structural racism.

Access to local prevention programming should be improved for rural populations. To provide enhanced access, NRHA supports and encourages: a) targeted and directed prevention initiatives to those populations outlined as high risk for chronic illness; b) working with rural communities to link with effective national, state, or county prevention programs and making them available to more people; c) supporting utilization of locations that are easily accessible, such as schools, churches, work places, community centers, and various health care facilities and support of programs that recognize the influence of friends and family as participants in an individual's behavior change.

NRHA supports evidence-based programs that are based on proven and accepted research. Effective programs may include those that improve the social determinants of health that have negatively impacted rural communities. Increases are needed in early detection through screening for diagnosis of cancer and other disease for rural communities, along with referrals and access to treatment.

A true foundational shift in the delivery of preventive medicine and behavioral health services cannot occur without payment reform. In addition to supporting preventive care programming offered by various organizations and agencies, NRHA supports the exploration and implementation of payment reform that promotes preventive care and enhances chronic disease management. This would include adequate telemedicine reimbursement for the originating site to develop a care plan with the consultation of specialists.

### Food and Nutrition

Healthy eating is associated with reduced risk for many diseases, including heart disease, cancer, and stroke. Healthy eating in childhood and adolescence is important for proper growth and development and can prevent health problems such as obesity, dental caries, and iron deficiency anemia. Federal, state, and local governments should adopt policies that encourage local food production, healthy eating habits, local development of foods, and affordability and accessibility to food.

NRHA supports a focus on locally produced, high quality foods for consumption in public and private institutions and homes. By encouraging local communities to focus on their local food production and distribution, food related activities can play a significant role in local economic development, as well as promoting greater security, health and self-reliance within the local rural community.

*Additional recommendations are available in the [NRHA Policy Briefs: Rural Obesity \(Oct. 2020\)](#) and [Food and Nutrition \(Jan. 2011\)](#)*

### **Health Literacy**

Those who have poor literacy and health literacy skills may be at risk of not adhering to treatment that could adversely affect their health. NRHA encourages efforts and collaborations that work to promote health literacy. Approximately 15.8 percent of rural immigrants speak English, but just 2.5 percent of rural citizens do not. NRHA supports the following actions to support health literacy for rural populations.

- Support and expand local efforts to provide adult education, English language instruction, and culturally and linguistically appropriate health information services in the community.
- Increase basic research and the development, implementation, and evaluation of practices and interventions to improve health literacy

### **HIV/AIDS**

Persons living with HIV/AIDS (PLWHA) who reside in rural areas face unique challenges. HIV control efforts must transcend geographic borders and must cover the full spectrum of prevention, detection of new cases, and treatment for all PLWHAs to achieve the goals of the National HIV/AIDS Strategy. It is imperative to expand the focus to rural America which is increasingly being affected by the HIV epidemic.

Efforts to increase the efficacy of HIV/AIDS prevention, detection, and treatment efforts in rural America are of primary importance. NRHA supports increased funding to safety net providers (Ryan White medical providers and providers accepting Medicaid) for rural PLWHAs. CMS should “risk-adjust” Medicare capitation payments and require states to adjust Medicaid capitation payments for services delivered to rural PLWHAs.

*[Additional recommendations are available in the NRHA Policy Brief: HIV/AIDS in Rural America: Disproportionate Impact on Minority and Multicultural Populations \(April 2014\)](#)*

### **Population Health**

The move to increase focus on value, from the focus on volume, must be developed with rural populations in mind. NRHA supports the shifting focus to population health management, which focuses on improving the individual experience of care, reducing per capita cost of care, and improving the health of populations. To achieve this shift, policies must be created to support the changes required in the system to allow for a focus on the health of the population, including:

- Permitting and encouraging coordination and collaboration.
- Providing sufficient resources to rural communities to address the broad range of health care and non-health care services and components that are necessary to make meaningful change to population health.
- Providing adequate reimbursement to allow and incentivize providers to provide coordinated wellness, preventive, and acute care services to improve population health.
- Eliminating existing silos that create barriers to coordinated efforts to improve population health.

[Additional recommendations to support rural providers improve population health can be found in NRHA Policy Brief: Population Health in Rural Communities \(Feb. 2015\).](#)

## Key Rural Populations

### **American Indian and Alaska Native Health Care**

Historic and persistent underfunding of the Indian Health Service (IHS) has resulted in problems with access to care, including primary health care, specialty medical care, long-term care, and emergency services. The federal delivery of health services and funding of tribal and urban Indian health programs to maintain and improve the health of Indians is required by the federal government's historical treaty obligations with the American Indian and Alaskan Native (AI/AN) people.

Despite the legal requirement to provide health care to the AI/AN people, AI/AN health care services continue to be inadequate, complex, and multifaceted; and the health care status continues to decline. Most AI/ANs do not have private insurance, relying on government to fulfill its legal obligations to the tribes.

NRHA supports the Indian Health Care Improvement Act Amendments (IHCIA) and increased funding and resources to IHS. In addition, NRHA supports the following actions to strengthen and support services to AI/AN populations:

- Improve access to all Medicare and SCHIP programs for eligible AI/ANs by including reforms that address access barriers identified by CMS and its Tribal Technical Advisory Group.
- Include AI/AN in any list of target groups for special programs created to address health disparities, inequities, or access to care.
- Assess proposed legislative and regulatory changes that impact tribes and conduct meaningful tribal consultation prior to submitting legislative changes, issuing new regulations, and policies that affect AI/ANs.
- Ensure IHS reimbursement rates are at least at the same percentage of costs as paid by Medicare for services provided by CAHs.

*Additional Policy recommendations are available in NRHA's Policy Brief: [American Indian and Alaska Native Health \(Feb 2016\)](#)*

### **Border Health**

The U.S.-Mexico border region does not exist in isolation from the rest of the United States and Mexico. The young and highly mobile populations found in this region will require investments to ensure that their needs are met. This will in turn create challenges and strains to existing structures in providing services for these border residents. The border region could serve as a model for the provision of culturally appropriate services to these populations which can be replicated in other regions (e.g., Appalachia and Delta Regions). The blueprint for addressing the regional health care needs include:

- Development of innovative health program models for the region administered through the U.S.-Mexico Border Health Commission. The U.S.-Mexico Border Health Commission funding level should be increased to develop and implement new border health programming that will address the growing health needs of the region and the Healthy Border 2020 Objectives.
- Funding the FORHP border health programs and research. FORHP has been given the primary border health responsibility within HRSA but has received little funding for this role. The FORHP funding level for border health should be increased to support its activities and to establish a

border health research program like one for rural health that would assist in the development of health policies for the U.S.-Mexico border region.

*Additional information is available in the NRHA policy brief: [Addressing Health and Health Care Needs in the United-States- Mexico Border Region \(May 2018\)](#) and [Immigrant Health Policy \(May 2018\)](#)*

### **Care for Older Adults**

In addition to access challenges confronted by all rural Americans, older adults living in rural areas are also limited in access to assistance with activities of daily living (ADL) such as bathing and cooking, and instrumental activities of daily living (IADL) such as cooking and laundry. Furthermore, access to health care for prevention, identification, treatment, and management of chronic diseases such as cardiac artery disease, chronic respiratory disease and type-two diabetes is necessary for elders to lead productive independent lives.

NRHA supports the following actions to strengthen and support older adults living in rural areas:

- Rural health researchers and policymakers should assess the entry of Medicare Advantage Dual-Eligible Special Needs Plans into rural areas, identify potential barriers, and adopt policies that encourage or expand the reach of these plans to rural beneficiaries.
- Congress should pass legislation that adds comprehensive dental, vision, and hearing coverage to Medicare, so individuals can afford needed care and providers can receive the reimbursement necessary to serve these communities.
- State Medicaid programs should directly pay and provide greater support to caregivers in rural areas to help with continuity of care. Several barriers to care for rural caregivers would be alleviated with funding to pay for comparative supportive care services that urban counterparts have access to, including respite care, transportation services, agency aides and/or nurses.
- Increase coordination for ADLs and IADLs assistance as well as rural relevant case management of chronic diseases.
- Formally link the rural health care delivery system with other communities to allow for easy access to and transition of care when it is necessary to seek health services outside of the community.
- Create incentives for health care providers who specialize in older adults, need to include long-term incentives, which extend beyond the payment of school loans.
- Develop specific advocacy programs that ensure rural older adults have access to all the services they require.
- Because technology has proven to play a substantial role in meeting social needs in rural areas, rural internet and broadband infrastructure must meet demand.
- HHS should work with states to address poor nutrition and health outcomes by promoting resources that help overcome food insecurity in rural communities, through Community Health Workers/meals-on-wheels programs in rural areas to provide outreach to shut-in seniors.
- Existing informal social support structures within rural communities should become more formalized, replicating the efforts of programs like those endorsed by the Senior Corps.

*Additional recommendations are available in the NRHA Policy Briefs: [The Impact of Aging Baby Boomers in Rural America \(Feb. 2021\)](#), [Rural America's Senior Citizens \(Oct. 2020\)](#) and [Elder Health in Rural America \(Feb. 2013\)](#)*

### **Farmer Mental Health**

Rural farmers are the backbone of America, providing \$389 billion of agricultural products in the United States, yet attention and support for our agricultural community's well-being has been chronically overlooked. Rural populations have a significantly higher suicide rate than urban areas and available



information indicates the suicide rate among farmers is 3.5 times higher than the general population. Solutions need to consider robust funding of research, building the rural health care workforce, and addressing barriers to wellbeing through consideration of the social determinants of health.

NRHA supports the following actions to address rural farmer mental health:

- Reduce tariffs on rural commodities and stabilize product cost to alleviate financial burden on rural farmers.
- Ensure high quality broadband internet access to secure access of affordable, accessible telehealth services, educational opportunities, and professional development of rural farmers and their families.
- Continue to fund community-led mental health education and training emphasizing leadership and inclusion of the rural agricultural workforce and their support network.
- Invest in rural mental health and health care workforce through incentive programs for practitioners, developing cultural competency, and reducing barriers to practice in rural areas.
- Increase research efforts in the United States to build awareness of and solutions for supporting mental health in the agriculture industry.

*Additional recommendations are available in the NRHA Policy Brief- Increases in Suicide Rates Among Farmers in Rural America (Feb. 2021)*

### **Health Disparities with an Emphasis on the Needs of Black, Indigenous, and People of Color Living in Rural**

A population having health disparities is one that exhibits/demonstrates significantly poorer health status, life expectancy, access to and quality of care such as those associated with social and ethnic discrimination, poverty, geography, or marginalization. Rural residents face significant health disparities as compared to non-rural populations, and resources should be allocated towards addressing these geographic disparities. While disparities exist among rural populations in general, it is also clear that Black, Indigenous, and people of color (BIPOC) living in rural areas face even greater challenges and a special emphasis should be placed upon addressing those needs. Such disparities are evident in the rural hospital closures, which reveal a pattern of disproportionate impact on rural BIPOC communities.

NRHA supports the following actions to address health disparities for rural BIPOC:

- Direct resources toward rural populations, with an emphasis on the needs of BIPOC and other underserved populations in rural and frontier areas.
- Develop and support culturally and linguistically competent health care service programs in rural communities through competitive grants, focusing on social entrepreneurship and job creations amongst multicultural and multiracial populations. This could include CHCs, RHCs, FQHCs, migrant health clinics and tribal health services.
- Support well-designed research studies to document linkages between structural racism, welfare policy, rural health, and rural economic development among multicultural and multiracial communities.
- Increased focus on recruiting and retaining practitioners with BIPOC and multicultural backgrounds. This should be done through innovative initiatives that focus on rural BIPOC students at the pre-college, college, and professional school levels.
- Support the development and dissemination of culturally and linguistically attuned career community initiatives targeting BIPOC populations.

*Additional recommendations are available in the [NRHA Policy Briefs: Deleterious Impact on Rural Multiracial and Multicultural Populations Related to the Devolution of Welfare Programs \(April 2011\)](#) and [Recruitment and Training of Racial/Ethnic Health Professionals in Rural America \(Feb. 2013\)](#)*



## Veterans

NRHA supports the Department of Veterans Affairs (VA) following actions to strengthen and support services for rural veterans:

- Develop and implement policies that encourage use of the Non-VA Care Program in a consistent manner across all Veterans Integrated Service Networks (VISNs) and that reflect a “best interest of the veteran” standard for utilization determinations.
- Evaluate and expand its network of fee-based specialty providers within the Non-VA Care program to ensure alignment with the most prevalent out-patient specialty needs of rural veterans.
- Standardize and streamline policies regarding use of non-VA providers to better facilitate provider participation in the “Non-VA Care Program” and to expedite and expand access for veterans to locally provided health care services, particularly specialty services.
- Evaluate and review its policies concerning contracting with local rural health providers to operate and manage Community-Based Outpatient Clinics (CBOC) to increase access points of care for rural veterans.
- Expand training programs for Non-VA rural providers on evidence-based military, deployment and post-deployment health and mental health diagnoses and treatment.
- Develop a benefit education outreach program that provides clear information for patients and providers on what services, especially emergency services, are covered by the Veterans Health Administration (VHA). Materials need to be readily accessible, easy to understand, and structured to encourage rather than deter seeking of care, especially needed emergency care. Include rural specific materials addressing the challenges of accessing care in rural communities.
- Develop a consistent methodology for assigning definitions of urban, rural, and highly rural that uses a variety of recognized classification schemes to ensure classifications are assigned in a manner that maximizes the ability to deliver timely services to all veterans located within a particular VISN.
- Continue to invest in research and application of telemedicine technologies to advance care, particularly mental health, and brain injury care, for rural veterans.
- Establish policies to invest in Community-based participatory research (CBPR) with rural veterans and their families, including establishing public-private partnerships for CBPR and use of promising practices to support organizational capacity growth in rural institutions to support veterans.

NRHA supports these additional actions to strengthen and support services for rural veterans:

- The United States Department of Housing and Urban Development (HUD) must continue efforts to implement policies to expand the classification of “chronic homeless” to maximize the number of rural homeless veterans eligible for homeless services within HUD, VA, and other federal, state, and local programs.
- Legislation aimed at increasing access to local care should be reexamined to ensure that options are available for all rural veterans. Regulations promulgated to implement such legislation must interpret the law in such a way as to guarantee flexibility for these veterans.

*Specific recommendations are available in NRHA’s Rural Veterans Policy Brief: [Rural Veterans and their Families \(July 2019\)](#) and [Rural Veterans: A Special Concern for Rural Health Advocates \(Feb. 2014\)](#)*

## Women’s Health

Rural women have health care needs with a number of contexts, including chronic disease and prevention; maternal, child health, and perinatal care; elderly and aging issues; and behavioral health. NRHA recommends the following policy and program action to improve the access to health care services for rural and frontier women:

- Develop continuing education opportunities for rural physicians focused on issues facing women across the life span, such as pregnant and nursing women, older adults, patients with chronic pain, patients with substance use problems, victims of intimate partner violence and persons with mental illness.
- Support rural training tracks (RTTs) within health education programs, with specific efforts to ensure an adequate number of training slots offered obstetrics and gynecological services.
- Provide resources and support intervention services in rural communities to help victims of intimate partner violence. Support programs that provide outreach and education to rural women to increase their awareness of the signs of and treatments for mental illness.
- Ease restrictions on cost reports that prevent hospitals and other providers from offering women's health care services.
- Continue to provide adequate funding for Title X of the Public Health Service Act with a specific emphasis on reducing unplanned pregnancies among rural women, particularly among those under the age of 18.
- Continue and expand family planning funding and services within the state Medicaid programs.
- Ensure the expansion of family planning funding and services to FQHCs and RHCs, commensurate with community need.

*Additional Policy recommendations are available in NRHA's Policy Brief: [Rural Women's Health \(Jan. 2013\)](#)*

## Technology

### **Broadband Access**

Broadband allows for effective telehealth delivery. Policy makers must continue to advance broadband coverage nationally to all rural communities. However, many rural communities have poor broadband coverage. NRHA supports policies and efforts that address this digital divide, especially the lack of a basic accessible model for all of rural America. Increased broadband access will enable us to create local jobs, encourage rural innovation, and help build reinvestment in rural communities.

NRHA recommends the following actions to improve broadband access to rural areas:

- Advance policy solutions increasing public support for broadband services and the removal of federal and state licensing, credentialing, and reimbursement restrictions that impede on utilization of telemedicine, telehealth, and distance learning services.
- Develop policy solutions which enhance access to broadband services for all Americans, particularly in rural America.

*Additional information is available in the NRHA policy brief: [Telehealth in Rural America \(July 2019\)](#)*

### **Health Information Technology**

Health information technology (HIT) is an important tool to improve the quality, safety, effectiveness, and delivery of health care services in rural communities. NRHA recommends the following actions to improve HIT adoption in rural areas:

- Require vendors of information systems used in rural communities to incorporate national standards for HIT into their systems. This includes systems used in all care settings to assure interoperability with both a larger network and rural facilities.

- Provide sufficient time and resources to ensure rural providers can comply with national HIT standards.
- Assist rural health facilities planning for, purchasing, and supporting HIT. Enhance existing funding mechanisms to provide additional support for rural America.
- Expand incentive payments for implementing EHR to include home health agencies, hospices, skilled nursing facilities, EMS, and any other providers eligible for Medicare and/or Medicaid payments, to facilitate the seamless exchange of information among rural health care providers. These existing incentive payments should be expanded to assist those that will need to purchase or upgrade systems in the future.

[Additional Policy recommendations are available in NRHA's Policy Brief: Medicare Electronic Health Record Incentive Program \(Feb 2017\)](#)

## **Telehealth**

NRHA supports making permanent and expanding the telehealth regulatory waivers and reimbursement programs enacted during the COVID-19 PHE. Within the CARES Act, Congress provided the ability for RHCs and FQHCs to serve as distant-site providers for telehealth services. By allowing these facilities to serve as distant-site providers, Congress greatly expanded the access to care for rural populations. Congress should allow RHCs and FQHCs to permanently serve as distant-site providers, and in doing so they should instruct CMS to reevaluate their reimbursement and coding methodologies for telehealth services.

NRHA recommends the following Medicare policy and program actions to improve telehealth implementation in rural areas:

- Telehealth waivers enacted during the COVID-19 PHE should be extended permanently.
- Congress should authorize RHCs and FQHCs to serve as distant-site providers permanently.
- CMS should reevaluate the payment model for RHC and FQHC reimbursement. Under current statute, RHCs and FQHCs are reimbursed at a PPS rate. NRHA believes that CMS should change the reimbursement so that providers are reimbursed at their AIR. Not only would this create greater parity in the true cost of providing services, but it would also better incentivize rural providers to utilize these flexibilities. Increased utilization will improve quality of life for rural patients.
- CMS should authorize licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, speech-language pathologists, EMS, and community paramedics to furnish the brief online assessment and management services as virtual check-ins and remote evaluation services.
- NRHA believes a national telehealth advisory committee should be created to develop guardrails that address telehealth/telemedicine definitions for usage and quality for all settings. Included on this committee should be rural representation.
- Allow for the virtual presence of a supervising physician or practitioner using interactive audio/video real-time communication technology to diagnose. This would increase access to diagnostic services in rural areas where onsite physician supervision is currently required for rural providers.
- Amend CAH conditions of participation to allow for telehealth emergency care.

Additionally, NRHA recommends the following policy and program actions to improve telehealth implementation in rural areas:

- Support and expand the Regional and National Telehealth Resource funded by the Office for the Advancement of Telehealth at HRSA.
- Allow the facilitation of a provider's ability to appropriately practice across state lines, while maintaining each state's licensure and scope of practice laws.

*Specific recommendations are available in NRHA's policy brief: [Rapid Response Telehealth \(December 2020\)](#), [Telehealth in Rural America \(July 2019\)](#); [Telemedicine Reimbursement \(May 2018\)](#), [Geographic Restrictions for Medicare Telehealth Reimbursement \(May 2011\)](#), [Emergency Medical Treatment and Active Labor Act and Telehealth in Critical Access Hospitals \(May 2011\)](#), and [Streamlining Telemedicine Licensure to Improve Rural America \(Feb. 2013\)](#)*

## Health Care Workforce

### Area Health Education Centers

NRHA recognizes the important role Area Health Education Centers (AHEC) play in providing valuable health care workforce development and health education services to rural and frontier areas, especially for the allied health workforce. NRHA supports continued authorization and funding to the authorized level for AHEC programs.

### Behavioral Health Workforce

NRHA supports the following actions to strengthen and support behavioral health services in rural areas:

- Development and expansion of recruitment and retention enhancements, such as loan repayments and scholarships, should be developed to attract behavioral health care professionals to rural areas. Existing workforce development programs should be expanded with the aim to bolster the rural behavioral health workforce, focusing on attracting, training, recruiting, and retaining behavioral health providers.
- SAMHSA should work with graduate training programs in behavioral health to develop skill-based curriculums that deal with rural environments and their increasing diversity.
- Congress should reauthorize the former NIMH clinical training program, relocate the program at SAMHSA, and authorize programs to integrate primary health care with behavioral health care training.

### Community Health Workers

Community Health Workers (CHW) have the unique opportunity and ability to facilitate culturally appropriate care and services to help bridge the gap between rural Americans and the health care field. Rural Americans face a unique combination of factors that create disparities in health care. Economic factors, cultural and social differences, educational shortcomings, lack of recognition by legislators, and the isolation of living in remote areas impede rural Americans' abilities to lead normal, healthy lives. Incorporation of CHWs within the healthcare team reduces health care costs.

NRHA supports the following actions to strengthen and advocate for the integration of the CHW model in rural communities.

- Support and advocate for the employment of CHWs in rural hospitals, critical access hospitals, rural health clinics, federally qualified health centers, private practices, social service entities, non-profit organizations, faith-based organizations, schools, academic institutions, and other community-based organizations.
- Support, participate, and advocate for the establishment of a national scope of practice for CHWs.

- Advocate and research reimbursement and funding mechanisms to support the CHW model in rural areas.
- Support and advocate for policies that allocate resources for CHW workforce development, including training.
- Promote the provision of incentives (e.g., financial) for agencies that hire CHWs (e.g., rural county health departments, state departments of rural health) in rural settings.
- Support and advocate for comprehensive evaluation of CHW programs—including cost saving, client outcomes, and CHW scope of practice.
- Support the establishment of a national rural health clearinghouse for innovation-based practice models, toolkits, and other shared technical resources for CHW models in rural areas.
- Support the creation of a repository of CHW training programs across the U.S.— particularly those programs that provide training in remote, rural areas.
- Support and investigate CHW certification and/or credentialing and its potential impact on rural CHWs and communities.

[Specific recommendations are available in NRHA's policy brief: \*Community Health Workers- Recommendations for Bridging Healthcare Gaps in Rural America \(Feb 2017\)\*](#)

### **Eye Care**

NRHA recognizes the importance of vision and eye care for all rural Americans, including children. NRHA supports the inclusion of optometrists in the list of health care professions included in the NHSC program as explained in the NHSC section of this document.

### **Geriatric Training Programs**

NRHA recognizes the importance for providers to be trained in care for older adults living in rural areas. NRHA supports the reauthorization of education and training programs relating to geriatrics.

### **Health Careers Opportunity Program**

NRHA knows that having culturally competent providers is particularly important to rural and frontier areas. NRHA supports the reauthorization of the Health Careers Opportunity Program (HCOP).

### **Health Professions Training**

NRHA supports reauthorization of Titles VII and VIII of the Public Health Service Act, providing for health professions and nursing education programs, consistent with NRHA's Health Professions Policy Brief. NRHA further supports increased emphasis and resources being directed toward Title VII and VIII programs that foster interprofessional training and support development of health professions training programs in, and in collaboration with, rural communities.

### **J-1 Visa Waiver**

NRHA supports the continuation and expansion of the J-1 Visa Waiver program. Foreign medical graduates (FMG) seeking entry into the U.S. for graduate medical education (GME) should be required to seek classification as J-1 nonimmigrant aliens.

[Additional information on the J-1 Visa Waiver can be found in the NRHA Policy Brief, \*FMG/ J1 Visa Waiver Physicians \(Feb. 2014\)\*](#)

### **Medicare Graduate Medical Education in Rural America**

Rural-based Medicare GME programs are critically important in the training of competent rural family physicians. The geographic maldistribution of primary care physicians is a problem in the United States. Rural areas particularly lack access to primary care physicians and other shortage specialties compared

to urban and suburban areas. Medicare is the only stable national source of GME funding, in comparison to other grant funding such as HRSA-run programs and Medicaid GME funding. Rural hospitals operate on narrow margins and cannot commit to ongoing residency training costs without a predictable source of funding. The Government Accountability Office (GAO) recently released a study on physician workforce, stating that “use of federal efforts intended to increase GME training in rural areas was often limited and challenging.”

In December 2020, Congress passed the Consolidated Appropriations Act (CAA), 2021, which included a provision to increase the number of rural residency slots by 1,000. In the FY 2022 Inpatient Prospective Payment System (IPPS) rule, CMS adhered to NRHA’s request to implement the 200 slots per year by prioritizing hospitals with training programs in areas demonstrating the greatest need for providers, as determined by HPSAs. While the CAA, 2021, new residency slots is a step in the right direction, NRHA continues to advocate the executive branch and legislative branch to ensure additional workforce provisions advance.

Physician rotation in rural residencies programs in CAHs and rural PPS hospitals has been proven to dramatically improve workforce shortages in rural and frontier locations. NRHA supports the executive branch’s removal of the cap on GME funding for: 1) residency positions in new rural residency programs located in rural areas, 2) existing residency programs, regardless of location, provided they have a recent multiyear track record of placing a high proportion of graduates in rural practice, and 3) residency programs that meet the definition of RTTs or integrated RTTs endorsed by NRHA.

On Capitol Hill, NRHA is working to advance S. 1893, the Rural Physician Workforce Production Act to address challenges related to rural GME broadly. While the CAA, 2021, included provisions to improve access to residency slots in rural communities, NRHA believes it is necessary to revamp and re-evaluate the GME program, and S. 1893 does just that. Most importantly, the bill allows for reforms to rural GME payments to ensure hospitals’ ability to pay for rural residency training and it allows CAHs and SCHs to obtain residency slots. NRHA believes these rural friendly changes, coupled with further action from the executive branch, will ensure rural communities have access to the physicians they need.

NRHA supports the following actions to strengthen and support GME training in rural areas:

- Cumulative rural training experience for all medical students and residents with an interest in rural practice should be at least six months in duration. Curriculum content should include knowledge and skill acquisition with demonstrated competency in a full range of areas especially relevant to rural practice. In addition, educators should emphasize adaptability, improvisation, collaboration, and endurance.
- Rural ambulatory sites eligible for GME reimbursement through Medicare should be broadly defined. Ambulatory care entities that train health professional students and residents should receive reimbursement for indirect, as well as direct, costs of training. Such reimbursement will require development of a new formula for estimation of the indirect costs of training in the ambulatory setting, apart from those used to support other aspects of the academic medical center.
- Correct an ACA flaw restricting payments for physician residents in rural hospitals. By implementing regulations from the ACA, CMS has restricted Medicare from covering the costs of training resident physicians at a CAH, and this has restricted efforts to expand the training of medical professionals in rural communities.
- Remove barriers that limit rural resident training, and do not count rotating residents in residency caps. A major limitation in funding of rural GME exists because of CMS’s interpretation

of residency cap statutes. Regulation should promote training in rural communities to increase the number of physicians who would practice in rural areas. CMS should revise regulations to allow: 1) an urban hospital to expand its cap for the purposes of establishing a new RTT; and 2) not count residents who train in rural areas against the cap placed on urban facilities.

- Urban or other teaching hospitals sponsoring RTTs should be allowed to recover costs through Medicare whenever they bear all, or a substantial amount, of the costs of resident education, including when residents are located at hospital sites that do not claim direct and/or indirect costs through Medicare.
- Legislation should be enacted to require CMS to pay Indirect Medical Education (IME) reimbursement to the following types of institutions that do not currently receive such payments: SCHs that are paid based on their hospital specific rate; MDHs, for the hospital specific portion of their inpatient Medicare payments; and CAHs. The existing payment system discourages participation in GME, at rural facilities though these programs are among the most effective in placing graduates in rural practice.
- The Accreditation Council on GME should allow flexibility in the development and curricula of rural training programs in adapting to local resources.

[Additional recommendations are available in the joint NRHA and AAFP Policy Brief – Rural Practice: Graduate Medical Education \(April 2014\)](#)

### **National Health Service Corps**

NRHA supports strengthening the National Health Service Corps (NHSC) program through expanded community and site development as well as creation of other tools to increase retention. NRHA supports increasing the role played by the NHSC in meeting mental and behavioral health care needs in rural and frontier areas. NRHA also supports the addition of general surgeons, optometrists, and pharmacists to the list of health care professions included in the NHSC programs.

NRHA believes a permanent expansion of the NHSC is critical given the fact that the program currently serves only a small percentage of the need for health care in underserved areas. States should participate fully, both financially and programmatically, in all available health professions loan reimbursement programs, including state loan repayment programs, to encourage practice or work in rural and underserved areas.

### **Nurse Reinvestment Act**

NRHA supports programs authorized in the Nurse Reinvestment Act to ensure benefits to rural areas.

### **Health Professions Workforce Training**

NRHA supports health professions workforce training programs such as the Title VII and VIII Training Programs, Area Health Education Centers (AHEC), the Health Careers Opportunity Program (HCOP) and Geriatric Programs that are referenced throughout this document.

In addition, NRHA supports the following actions to strengthen and support health professional workforce training in rural areas:

- Support legislative or regulatory actions to address the disproportionate shortage on rural communities and populations.
- Expansion of federal and state supported higher education financing for disadvantaged rural students seeking health careers.



- Support efforts to encourage rural students to seek health careers, including mentoring programs, pre-health professions rural interest groups and support for math and science competencies in primary and secondary schools.
- Link health professions education in rural communities and federal and state medical school funding to the distribution of practicing rural health professionals.
- Support training programs that address the full range of health care workforce, including allied health.
- Allow cost-based reimbursement for recruiting costs of primary care physicians, general surgeons and other provider-based physicians operating out of rural hospitals and facilities, such as CAHs, SCHs, MDHs, and RHCs.
- Support recognizing and rewarding the value of rural clinical health profession educators in mentoring and educating future health care professionals.

*Additional recommendations are available in NRHA's Policy Briefs: [Quality of Life Impacts the Recruitment and Retention of Rural Health Providers \(Feb 2015\)](#) and [Health Care Workforce Distribution and Shortage Issues in Rural America \(Jan. 2012\)](#)*

**All policy briefs, papers, and statements referenced in this document are available at NRHA's website: <https://www.ruralhealthweb.org/advocate/policydocuments>**