



# **National Rural Health Association**

2011 Legislative and  
Regulatory Agenda





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*The National Rural Health Association has adopted this agenda outlining health care policy issues. This agenda is intended to promote legislative and regulatory issues for action by Congress, federal regulatory agencies, the White House, states, and the health care industry.*

### **Access Standards**

The NRHA supports access 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. The Department of Health and Human Services' oversight of the Medicare and Medicaid programs and the Children's Health Insurance Program, as well as legislation and regulations concerning patient protections should, at a minimum, address these issues.

### **Area Health Education Centers (AHEC)/Health Education and Training Centers (HETC)**

The NRHA recognizes the important role AHECs and HETCs play in providing valuable health care workforce development and health education services to underserved areas. The NRHA supports the reauthorization of these programs.

### **Border Health**

The U.S. - Mexico border region no longer exists in isolation from the rest of both the United States and Mexico. The young and highly mobile populations found in this region will require investments to ensure that health problems do not migrate to other regions of both countries. This will in turn create challenges and strains to existing structures in providing services for these newly-arrived populations. 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 includes: development of innovative health program models for the region administered through the U.S.-Mexico Border Health Commission, and funding the Office of Rural Health Policy's border health programs and research.

The U.S. - Mexico Border Health Commission funding level should be increased in order to develop and implement new border health programming that will address the

growing health needs of the region and the Healthy Border 2020 Objectives.

The Office of Rural Health Policy (ORHP) has been given the primary border health responsibility within HRSA, but has received little funding for this role. The ORHP funding level for border health should be increased to support its activities and to establish a border health research program similar to 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: Border Health (January 2010)*

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

The Department of Health and Human Services 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 (S-CHIP).

CMS should enforce the federal statutory requirement that states fund programs to provide acceptance and initial processing of Medicaid applications for children at federally qualified health centers (FQHCs) and disproportionate share hospitals. CMS should also require that states support these services for S-CHIP applications.

CMS should provide enhanced matches for Medicaid and S-CHIP outreach, including Medicaid out stationing at FQHCs, Rural Health Clinics (RHCs), disproportionate share hospitals and other community-based programs.

Repeal the provision that prohibits federal and state employees from participating in the S-CHIP program.

Repeal the requirement on "crowd out," allowing S-CHIP 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.

The NRHA supports the expansion of the S-CHIP program for family coverage.

## **Chronic Disease Prevention**

High-risk populations are disproportionately located in rural and underserved areas. These populations must be targeted in health education, chronic disease prevention, and healthy lifestyle modification before any initiative in rural health improvement can be effective. Educational programs targeting high risk populations to encourage taking personal responsibility for health and actively seeking 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 poor, minorities, and ethnic groups that are shown statistically to be at higher risk for certain chronic medical conditions.

Access to local prevention programming should be improved for rural populations. To provide enhanced access, the 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 d) support of programs that recognize the influence of friends and family as participants in an individual's behavior change.

The NRHA supports existing programs that are based on proven evidence-based research. Effective programs may include those that target lifestyle modification, community development and support, and education-focused initiatives.

A true foundational shift in the delivery of preventive medicine cannot occur without payment reform. In addition to supporting preventive care programming offered by various organizations and agencies, the NRHA supports the exploration and implementation of payment reform that promotes preventive care and enhances chronic disease management.

In regards to oral chronic disease prevention, the 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 the NRHA Policy Brief: Prevention of Chronic Disease (May 2010)*

## **Community Access Program**

The NRHA supports reauthorization of this program.

## **Community Health Center (CHC) Program Including Federally Qualified Health Centers (FQHC) and Migrant Health Centers**

The Department of Health and Human Services should more explicitly consider rural specific barriers, such as geography, lack of providers and lack of transportation when allocating federal funding. This would significantly increase the geographic diversity of Community Health Centers.

The Health Resources and Services Administration (HRSA) should encourage CHCs to provide integrated mental health services to rural and frontier areas.

The CHC program should be modified to allow development of health centers in frontier areas.

Congress should ensure that rural CHCs receive equitable Medicare reimbursement.

The significant impact of proposed changes to Medicare reimbursement policy to the FQHC and Rural Health Clinic programs must be addressed by CMS. The NRHA encourages CMS to incorporate the Association's formal comments and suggestions in any future rulemaking.

## **Critical Access Hospitals (CAH)**

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.

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.

CAHs should be made eligible for the full 340B Drug Pricing Program, without the exclusion of orphan drugs. In addition, the 340B Drug Pricing Program should be expanded to include inpatient drugs

NRHA supports allowing CAHs to relocate and retain their CAH status without further review from the Centers for Medicare and Medicaid Service 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.

NRHA supports paying disproportionate share hospital (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.

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 in order to properly distribute payment responsibility between patients and the Medicare program. The current system results in a disproportionately high percentage of the cost reimbursement being paid by patients.

Any CAH that reverts to being a hospital paid under the Prospective Payment System (PPS) should be assigned their former PPS provider number and retain the base year hospital specific rates applicable to that PPS provider number.

The ability of CAHs to open off-campus provider based locations should not be restricted beyond existing provider based regulations.

All CAHs otherwise eligible for the CRNA pass-through exemption should not be restricted from program participation due to location in a Lugar County.

The 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. 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 should qualify for the same Electronic Health Records (EHR) incentive payments as PPS hospitals. Alternatively, the NRHA supports efforts to compensate CAHs for the disparity in incentive payments for health IT adoption in order to adequately fund the EHR system, including ongoing maintenance and operating costs.

CAHs that otherwise qualify for cost reimbursement of CRNA services should be allowed to include CRNA on-call pay as a reimbursable cost.

Provider taxes that CMS has approved for Medicaid Federal Financial Participation (matching) are Medicare allowable costs and Medicaid payments should not be used to reduce the amount of such allowable costs.

CAHs should be protected from payment reductions imposed by the Independent Payment Advisory Board.

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

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

The NRHA strongly recommends that definitions of rural and frontier be specific to the purposes of the programs in which they are used and that these are referred to as 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.

### **Emergency Medical Services (EMS)**

NRHA supports addressing the rising cost and decreasing availability of general and property (including vehicle) insurance for EMS services.

The time line 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. The NRHA supports the development of a supplemental fee schedule that ensures appropriate reimbursement for rural ambulance services.

The NRHA supports 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.

NRHA supports reauthorization of HRSA's Title XII EMS-Trauma grant program.

The 35-mile standard currently required for cost-based reimbursement for CAH ambulance services should be eliminated.

Federal agency support of EMS should be coordinated. Providers, state EMS, and state offices of rural health should be adequately supported by federal agencies through policy development, data systems, appropriate curricula and access to grants.

The NRHA supports extending the 340B drug pricing program to ambulance services whose service areas include rural areas.

Non-public emergency EMS workers should be eligible for the Public Safety Officers' Death Benefit Program.

The NRHA supports efforts to increase quality and safety for air and ground transports.

EMS providers should be paid the higher of the rural or the urban rates for services provided in the non-urbanized areas (outlying areas) of CBSAs.

### **Emergency Preparedness**

Major tenets for preparedness can be legislated and resources can be centrally located, but funding and requirements will need to be flexible enough to allow appropriate solutions, according to the rural local needs.

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. In addressing these rural needs, the variability, surge capacity, capabilities and needs of health infrastructures must be taken into consideration. Furthermore, the most rural, frontier areas may lack even the basic health and infrastructure access.

Availability of, and accessibility to, health care, including medications and vaccines, for individuals exposed, infected, or injured in terrorist attacks must be assured.

Health professionals, volunteers/first responders, and the public must be educated to better identify, respond to, and prevent the adverse health consequences of terrorism 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.

The NRHA supports efforts to utilize bioterrorism and emergency preparedness resources to build public health capacity in rural areas. Bioterrorism and other public health emergencies have the potential to impact rural areas both directly (e.g., agro-terrorism) and indirectly, as residents evacuate targeted urban areas. A strong public health infrastructure will be needed to effectively respond to both of these scenarios. Further, a strong public health infrastructure will also serve rural communities in the

event of other emergencies, such as natural disasters and infectious disease outbreaks, while enhancing the ability to improve community health status through everyday provision of essential public health services.

*Additional recommendations are available in the NRHA Policy Brief: Rural Health Preparedness (January 2002)*

### **Eye Care**

The 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.

The NRHA recognizes the importance of vision and eye care for all rural Americans, including children, as adopted in the NRHA Policy Brief: *Primary Eye Care in Rural America (October 2007)*.

### **Federal Commissions**

The NRHA supports proportional rural representation on all federal health care-related commissions, task forces and advisory groups. The NRHA also recommends that such federal commissions encourage input and consultation from the Secretary of Health and Human Service's 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.

### **Federal Workers Compensation**

The Federal Workers Compensation program should be amended so that all appropriate rural health providers can offer care and be reimbursed for federal workers. The definition of eligible provider should be expanded to include all those individuals licensed to provide a service authorized by the Federal Workers Compensation program.

### **Frontier Definition**

The NRHA supports a single, recognized definition for "frontier" that takes into account population density, distance in miles to the nearest service market, and time in minutes to the nearest service market.

### **Geriatric Training Programs**

NRHA supports the reauthorization of education and training relating to geriatrics.

### **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.

### **Health Careers Opportunity Program**

NRHA supports the reauthorization of this program.

### **Health Disparities with an Emphasis on the Needs of Rural Minorities**

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 rural minorities face even greater challenges and a special emphasis should be placed upon addressing those needs.

As the Department of Health and Human Services continues to implement the provisions of the Minority Health and Health Disparities Research and Education Act of 2000, the NRHA supports resources being directed toward rural populations, with an emphasis on the needs of minority, ethnic and other underserved populations in rural and frontier areas.

Those who have poor literacy and health literacy as outlined in the Health Literacy section of this document can also impact health disparities.

### **Health Home**

The NRHA supports a Patient-Centered Health Home that facilitates partnerships between patients, their providers and when appropriate the patient's family and significant other as described in the NRHA policy position, *"Patient-Centered Health Home"* (October 2008).

### **Health Information Technology (health IT)**

Congress should require vendors of information systems used in rural communities to incorporate national standards for health IT into their systems. This includes systems used in all care settings to assure interoperability with both a larger network and within rural facilities.

Regional networks provide benefit to rural health care systems in providing economies of scale in the implementation of health IT. Federal and state government should assure the infrastructure and policy framework is in place to allow these networks to form.

Federal anti-kickback statutes and the Stark laws often limit adoption of health IT by limiting the ability of rural hospitals, which are many times in the strongest position to invest in health IT, to provide support to other providers. Stark and other applicable laws should be liberalized to allow rural hospitals to serve as the convener or hub for rural networks.

Rural health facilities need assistance in planning for, purchasing, and supporting health IT. ARRA/HITECH funding for rural hospitals and eligible professionals should be enhanced to address the unique challenges faced by rural providers and patients. Therefore, existing funding mechanisms need to be enhanced and new ones specifically focused on rural America should be created.

To facilitate the seamless exchange of information among rural health care providers, incentive payments for implementing EHR should be expanded to include payments to Home Health Agencies, Hospices, Skilled Nursing Facilities, emergency medical services, and any other providers eligible for Medicare and/or Medicaid payments.

The importance of integrating broadband access and health IT should be a priority for any federal health IT program or effort. Factors unique to rural America, such as long distances between health care providers and broadband network hubs, should be addressed with special consideration. Additionally, the importance of wireless broadband access to rural health providers, such as EMS who cannot utilize wired connections, should be included in federal broadband efforts.

### **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.

### **Health Literacy**

Those who have poor literacy and health literacy skills may be at risk of making decisions that could adversely affect their health. The NRHA encourages efforts and collaborations that work to promote health literacy

### **Health Professional Shortage Area and Medically Underserved Population Designations**

The significant impact of proposed changes in the methodology for defining Health Professional Shortage Areas and Medically Underserved Populations on sustaining access to health care in rural and frontier areas must be addressed by the Bureau of Primary Health Care (BPHC) as it redrafts its proposed underserved area methodology. The NRHA encourages the BPHC to incorporate the Association's formal comments and suggestions in its new designation methodology.

### **Health Professions**

The 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. The NRHA further supports increased emphasis and resources being directed toward Title VII and VIII programs that foster interdisciplinary training and support development of health professions training programs in, and in collaboration with, rural communities.

Additional recommendations are available in the NRHA Policy Brief: Rural Health Professions (January 2004)

### **HIV/AIDS**

Provisions contained in the reauthorized Ryan White CARE Act, should ensure that programs implemented under this Act recognize the unique needs of organizations and communities serving individuals at-risk and living with HIV and AIDS in rural and frontier areas. Additionally, the NRHA encourages increase resources provided through

the Act for provision of care and services in rural and frontier communities.

The NRHA supports efforts to fight HIV/AIDS in rural areas consistent with NRHA's Issue Paper: HIV/AIDS in Rural America: Disproportionate Impact on Minority and Multicultural Populations—*Epidemiology of AIDS in Rural America (July 2004)*

#### **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 and is implemented in a manner consistent with this intent. 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.

The NRHA is opposed to reductions in payment for home health services under Medicare.

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.

#### **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.

#### **Increased Access to Medicaid and Other Federal Assistance for Eligible Medicare Beneficiaries**

The 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 in enrolling in Medicaid, the Qualified Medicare Beneficiaries (QMB) program, and other federal programs that assist low-income Medicare beneficiaries in accessing health care.

#### **Indian Health Care**

The NRHA supports the Indian Health Care Improvement Act Amendments of 2001 (IHCIA) and the reauthorization of the Indian Health Service.

The Indian Health Service should reimburse the same percentage of costs as paid by Medicare for services provided by CAHs.

*Additional recommendations are available in the NRHA Policy Brief: American Indian and Alaskan Native Health (November 2006)*

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

The NRHA supports the continuation and expansion of the J-1 Visa Waiver program.

#### **Long Term Care**

The NRHA recommends ongoing assessment of payment to skilled nursing facilities (SNFs), including an assessment of the impacts on rural SNFs, and variation in impacts by size, ownership and geographic isolation.

The NRHA recommends that prior to establishing any geographic reclassification of SNFs, the HHS Secretary should complete analysis regarding the ingredients of the wage index, implications of using the hospital wage index versus a separate index for SNFs, and effects on rural SNFs and the beneficiaries they serve.

CMS should establish a process to allow SNFs to seek geographic reclassification as soon as possible.

CAH-based skilled nursing facilities should receive 101 percent of cost-based reimbursement.

*Additional recommendations are available in the NRHA Issue Paper: Long-Term Care in Rural America (May 2001)*

#### **Managed Care (Medicaid and Medicare)**

NRHA believes that rural Americans who are enrolled in Medicare Advantage plans or in other insurance programs paid for by Medicare, Medicaid, S-CHIP and by private-paid insurance programs should have a right of 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 S-CHIP, 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.

NRHA supports requiring Medicare Advantage (MA) plans to pay CAHs and rural health clinics 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 and rural health clinics for Medicare bad debt and to ensure timely payment of claims, consistent with reimbursement under traditional fee-for-service Medicare.

The Federal Office of Rural Health Policy should be given expanded authority to provide technical assistance and outreach on ways that rural providers can collaborate in the review of MA contracts.

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 the elderly to provide assistance in enrolling in MA plans and state insurance commissioners' offices and CMS should provide stronger oversight to protect beneficiaries

### **Medicaid Reform**

The federal Medicaid definition of "mandatory populations" should include elderly, disabled and long-term care.

Federal Medicaid policy should also recognize the health needs of special populations creating a uniform set of benefits that are not subject to variations across states.

NRHA supports state flexibility in principle; however, turning Medicaid into a block grant program is likely to have a disproportionate impact on rural beneficiaries and rural providers. NRHA supports the continuation of Medicaid as a program where all individuals who meet eligibility requirements are covered. NRHA also supports a basic level of benefit protection for mandatory and optional beneficiaries, inclusion of elderly and disabled in

the definition of "mandatory population," and inclusion of long-term care in the definition of "mandatory benefits". Any current or future federal Medicaid reform proposals should include provisions for a rural impact study prior to any full scale implementation, including a study of state practices with block granted programs in the past.

Health care services under Medicaid, including specialist and long-term care, should emphasize local treatment to the highest extent possible.

Federal Medicaid policy should seek better coordination between Medicaid and the S-CHIP program.

Federal Medicaid reform should seek better coordination of enrollment and benefits for dual-eligible beneficiaries.

Federal Medicaid reform should restore some type of "Boren Amendment" protections for rural providers.

Implementation of the Deficit Reduction Act of 2005 must be monitored closely to assess the affect of new requirements and state options on access to Medicaid for rural residents.

*Additional recommendations are available in the NRHA Policy Brief: Medicaid Reform: A Rural Perspective (May 2007)*

### **Medicaid Reimbursement**

CMS should enforce the provision contained in the Balanced Budget Act of 1997 that requires states to provide quarterly supplemental payments to providers where the amount of the reimbursement under Medicaid managed care differs from the amount paid through cost-based reimbursement in cooperation with providers in the state.

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.

Medicaid reimbursement to rural providers (physicians, hospitals and others) should be adequate to provide and maintain access to appropriate maternity care. Medicaid Managed Care programs should not be used to circumvent state cost-reimbursement mandates.

The definition of eligible provider should be expanded to include all those individuals licensed to provide a service authorized by the Medicaid program.

#### **Medicare and Medicaid Federally Mandated Services**

Collaboratively, the Center for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) should provide funding and resources to increase access for eye care, oral and podiatric health services for children and adults living in rural and frontier areas, including funding for ocular and oral and podiatric health services infrastructure.

#### **Medicare Cost Report**

The Department of Health and Human Services should simplify the Medicare cost report.

#### **Medicare Dependent Hospital Program**

The Medicare Dependent Hospital (MDH) program should be made permanent prior to the expiration of the program's authorization. MDH is scheduled to expire for discharges occurring on or after October 1, 2012.

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 the year described above. The 60 percent 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 sole community hospitals.

Congress should continue to periodically provide additional, more current base years for purposes of determining inpatient MDH specific rates.

The NRHA supports updating 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.

NRHA supports the computation of hospital-specific rates without retroactive application of budget neutrality factors.

NRHA supports paying 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.

NRHA opposes the severe hospital specific rate reductions imposed by CMS related to DRG creep under the MSDRG system, also referred to as documentation and coding adjustments.

#### **Medicare Fee Schedule**

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.

An urban/rural differential based on the geographic payment cost index for rural FQHCs should be eliminated and prohibited.

The NRHA urges CMS to provide adequate Medicare reimbursement for all types of mental health professionals providing services otherwise covered by Medicare based on state licensure laws.

Geographic variation in physician payment should be based only on actual physician expenses.

#### **Medicare Graduate Medical Education (GME)/Workforce Training Payments**

Rural ambulatory sites eligible for graduate medical education reimbursement through Medicare should be broadly defined.

Urban or other teaching hospitals sponsoring rural training tracks should be allowed to recover costs through Medicare whenever they bear all or substantially all 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.

The Department of Health and Human Services should pay Indirect Medical Education (IME) reimbursement to the following types of institutions that do not currently receive such payments: Sole community hospitals that are paid based on their hospital specific rate; Medicare Dependent Hospitals, for the hospital specific portion of their inpatient Medicare payments; and CAHs. The existing payment system discourages participation in graduate

medical education (GME), at rural facilities though these programs are among the most effective in placing graduates in rural practice.

The Accreditation Council on Graduate Medical Education should allow flexibility in the development and curricula of rural training programs in adapting to local resources.

Congress and CMS should simplify GME funding and link such funding to outpatient, as well as inpatient care.

The NRHA supports removal of the cap on GME funding for residency positions in 1) new rural residency programs located in rural areas, 2) existing residency programs, regardless of location, provided they have a recent multi-year track record of placing a high proportion of graduates in rural practice, and 3) residency programs that meet the definition of rural training tracks or integrated rural training tracks endorsed by the NRHA.

#### **Medicare Inpatient Prospective Payment System (PPS)**

NRHA supports removal of the cap on Medicare disproportionate share hospital payments to rural PPS hospitals.

Ambulatory care entities that train health professions 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.

NRHA supports making permanent the temporary improvements to the Medicare inpatient payment adjustment for low-volume hospitals included in §3125 of the PPACA.

Medicare should pay its fair share of capital expenses.

NRHA opposes the severe payment reductions imposed by CMS related to DRG creep under the MSDRG system, also referred to as documentation and coding adjustments.

Recommendations addressing Medicare payments for GME or workforce training are found in the Medicare GME section of this document.

Hospitals that otherwise qualify for cost reimbursement of CRNA services should be allowed to include CRNA on-call pay as a reimbursable cost.

Provider taxes that CMS has approved for Medicaid Federal Financial Participation (matching) are Medicare allowable costs and Medicaid payments should not be used to reduce the amount of such allowable costs.

#### **Medicare Outpatient Prospective Payment System (PPS)**

The NRHA supports making 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.

The NRHA supports continuing 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 Prescription Drug Benefit**

The NRHA will continue to monitor implementation of the Medicare Prescription Drug Benefit for areas of concern to rural providers and beneficiaries, and we will put forth policy recommendations as warranted. Specific issue areas that we will be monitoring include: the financial effect on rural pharmacies caused by the use of mail order to fill prescriptions, including whether there is a level playing field between mail-order and community pharmacies for reimbursement, days supply, and co-pay methodologies; the amount and timing of payments from prescription drug plans and Medicare Advantage to rural pharmacies; continued access to rural pharmacies for Medicare beneficiaries; continuous access to an affordable plan for Medicare beneficiaries with comparable benefits in the event that plans drop coverage; access to plans with benefits comparable to those offered to urban beneficiaries; enforcement of network adequacy standards and the potential need for modifications if the current standards are not sufficient to ensure adequate networks in rural communities; and other issues as they arise.

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

The NRHA supports continued authorization of the Medicare Rural Hospital Flexibility Grant Program.

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

### **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 Medicare Advantage payments should be modified to reflect only wage rates relevant to those specific services.

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.

### **Mental/Behavioral Health Services**

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

State Medicaid agencies contracting with managed behavioral health organizations must require contractors to monitor mental health services provided to rural beneficiaries. To decrease relapse rates, increased funding is recommended for case management, social clubs and community-based support groups.

The Health Resources and Services Administration (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 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.

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.

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.

Incentives should be made to support rural mental/behavioral health providers in obtaining & utilizing interoperable Health I.T. systems.

### **National Health Service Corps (NHSC)**

The 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. The NRHA supports increasing the role played by the NHSC in meeting mental and behavioral health care needs in rural and frontier areas. The NRHA also supports the addition of optometrists and pharmacists to the list of health care professions included in the NHSC programs. The NRHA believes 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, in order to encourage practice or work in rural and underserved areas.

### **National Institute for Occupational Safety and Health's Agricultural Safety Initiative**

The NRHA supports the continued efforts of the National Institute for Occupational Safety and Health's (NIOSH) Agricultural Safety Initiative. The NIOSH-designated Agricultural Centers program performs research, education and prevention in the agricultural community, aimed at reducing the remarkably high rates of occupational injury and fatality in farming. NIOSH is a part

of the Centers for Disease Control and Prevention, which is funded via DHHS.

### **Nurse Reinvestment Act**

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

### **Oral Health**

Financial incentives, such as student loan forgiveness, equipment purchasing grants and loans, assistance in establishing clinic facilities, and programs providing specialized training, should be used to attract more dentists to rural areas. These programs should be funded at an adequate level to allow them to succeed.

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.

Medicaid and Medicare coverage should include oral health as a mandatory service for eligible beneficiaries.

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.

*Additional recommendations are available in the NRHA's Policy Brief: Meeting Oral Health Care Needs in Rural America – April 2005*

### **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.

*Additional recommendations are available in the NRHA's Policy Brief – Pharmacy – May 2009.*

The 340B Drug Pricing Program, which provides discounts to safety net hospitals and other providers, should be expanded and simplified to eliminate unnecessary administrative burdens. These burdens are barriers to entry for qualifying smaller rural hospitals. The changes should expand the program to include inpatient drugs, eliminate the orphan drug exclusion for certain facilities, and eliminate the DSH threshold for SCHs and RRCs.

### **Physician Supervision**

Federal laws and regulations should take a common sense approach to physician supervision requirements in small, rural hospitals (PPS and CAH). Direct physician supervision should be required only when indicated by clear clinical evidence. Furthermore, if any federal panel or entity is to determine physician supervision levels by procedure, than representation on such panel or entity should be expanded to include physicians that practice primarily in small, rural hospitals.

*Additional recommendations are available in the NRHA's Policy Brief – Physician Supervision (May 2010)*

### **Professional Liability Insurance Reform**

The NRHA supports addressing the rising cost and decreasing availability of malpractice insurance through appropriate legislative and regulatory mechanisms, as the cost of malpractice insurance is increasingly a barrier to access to health care in rural areas, e.g., the cost negatively affects recruitment and retention of physicians and other scarce health professionals.

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

Congress, as well as the Department of Health and Human Services, should ensure that rural local public health providers have the capacity and training necessary to respond to public health needs in rural communities.

The NRHA believes that all residents and all communities should have comparable access to agencies and individuals that assure the provision of the essential public health services. Whether provided locally or on a regional basis, by governmental agencies or the private sector, every resident has the right to expect access to the full

complement of essential public health services in their community.

The NRHA supports greater flexibility in the use of public health resources to respond to local public health priorities. The current public health system is limited by categorical funding which often forces it to address state and federal priorities rather than local needs. Public health works best when it is responsive to locally identified priorities. Funding streams need to support, rather than inhibit, this responsiveness.

The NRHA recognizes that public health is a common good and that there is a governmental responsibility to assure access to essential public health services in every community. Regardless of who actually provides the service, there is a governmental responsibility to provide oversight and the governmental public health infrastructure must be strengthened to support this role.

The NRHA supports enhanced training and continuing education of the rural public health workforce that is accessible to them in their rural communities, and that is appropriate for their current level of training and experience. A key ingredient to assuring adequate public health services is a competent public health workforce. Whether employed in the public or private sector, public health workers must be well versed in their field.

The NRHA supports strengthening communication systems and technological capacities within the rural public health system. In order to effectively manage public health emergencies, conduct disease surveillance, or simply receive up-to-date public health information, rural public health must have access to advanced communications systems and technologies.

The NRHA supports the continuation of federal reimbursement of emergency health services furnished to undocumented aliens as created in Section 1011 of the Medicare Modernization Act.

The NRHA encourages public, private, federal, state and local agencies, organizations, and associations to support the creation and use of “Rural Healthy People 2020” health care goals and objectives.

## **Quality**

The NRHA supports efforts to address rural health quality consistent with the Institute of Medicine report *Quality through Collaboration* (November 2004).

Specific recommendations on rural quality are available in the NRHA Policy Brief: *Quality of Rural Health Care* (December 2003)

Specific recommendations on public reporting of rural hospital quality are available in the NRHA Policy Brief: *Public Reporting of Hospital Quality in Rural Communities: An Initial Set of Key Issues—May 2005*

## **Research on Rural Health**

The Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention and the Bureau of the Census should be required to negotiate interagency agreements with agencies and offices within the Department of Health and Human Services 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 the Department of Health and Human Services.

The Department of Health and Human Services should allocate the necessary funding to the Agency for Healthcare Research and Quality for research and dissemination of best practices relevant to the scale and context of typical rural facilities.

The NRHA supports consistently disaggregating data by the Department of Health and Human Services 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 NRHA supports increased appropriations to AHRQ, CMS and 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.

### **Rural Community Hospital Proposal**

The NRHA supports a Medicare payment reform proposal for hospitals with 50 available beds or less. These hospitals would have the option of being paid their reasonable costs plus a reasonable operating margin.

### **Rural Development**

The 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.

The United States Department of Agriculture (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 Economic Development**

The White House should create an Office of Rural Policy. It should have linkages to offices in each federal department (within HRSA for HHS) and explicitly organized according to the four pillars requisite for economic development: Education, entrepreneurship, social infrastructure, and public infrastructure.

The Federal government should support the documentation and research of linkages between rural health and economic development. The Office of Rural Health Policy at HRSA would be an appropriate location for this program.

*Additional recommendations are available in the NRHA’s Policy Brief – Rural Economic Development – May 2009.*

### **Rural Health Clinics (RHC)**

RHCs should be eligible for the 340B Drug Pricing Program.

Eliminate the Medicare and Medicaid cost per visit limit or increase limit to approximate actual cost.

Provide additional guidance to implement a meaningful productivity standard exceptions process.

Provide sufficient funding for timely initial and follow-up certification surveys to assure access to the program and compliance with regulations.

Require minimum Medicare Advantage reimbursement at Medicare RHC rates, or provide federal wrap around payments.

In states that have adopted a definition of “rural,” allow the state definition be used to achieve or retain RHC designation.

Licensed mental health professionals should be considered as eligible RHC providers.

The significant impact of proposed changes to location requirements and Medicare reimbursement policy to the RHC and Federally Qualified Health Center programs must be addressed by CMS. The NRHA encourages CMS to incorporate the Association’s formal comments and suggestions in any future rulemaking.

RHC physicians and other professionals should be eligible for Medicare EHR incentive payments, as well as Medicaid incentive payments.

Cost based reimbursement should be continued for RHCs that would no longer be covered by Medicaid if decertified.

All RHCs should receive Medicare Part B Reimbursement for lab, technical component of x-ray and EKG services.

### **Rural Health Outreach and Network Grants**

The NRHA supports continued reauthorization of the Rural Health Outreach and Network Grant Program.

### **Safety Net Providers**

The 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.

The NRHA supports providing reimbursement to all safety net providers sufficient to cover the cost of providing services.

The NRHA supports creating a pilot grant program to allow support to all safety net providers including for-profits and Rural Health Clinics with charity care and/or sliding fee scales.

The NRHA supports providing more flexible regulations for rural health entities along with decreased paperwork and requirements.

The NRHA supports acting to save all safety net providers that are in danger of collapsing through grant assistance or loan support.

### **Sole Community Hospitals (SCH)/Rural Referral Centers (RRC)**

A full market basket update for RRCs and SCHs, as well as a full market basket update for the target amount applicable to SCHs, should be provided.

A payment-to-cost ratio floor should be established to further improve outpatient PPS payments for qualifying hospitals.

Congress should continue to periodically provide additional, more current base years for purposes of determining inpatient SCH specific rates.

SCHs should be paid 101 percent of reasonable costs for inpatient services.

SCH outpatient service add-on payments should continue.

RRCs should be paid for inpatient services on the same basis as SCHs, i.e., based on the higher prospective payment rate or a cost-based rate determined using a hospital-specific target amount, or, alternatively, based on 101 percent of reasonable costs for inpatient services.

The RRC qualifying criteria (beds, discharges, and case mix index criteria) should be updated so more hospitals can qualify for RRC status and the special treatments available to hospitals with the RRC designation.

The NRHA supports updating 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.

NRHA supports the computation of hospital-specific rates without retroactive application of budget neutrality factors.

NRHA supports paying disproportionate share hospital 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.

NRHA opposes the severe hospital specific rate reductions imposed by CMS related to DRG creep under the MS DRG system, also referred to as documentation and coding adjustments.

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

The NRHA supports strengthening rural communities and providers through continuation and expansion of the SORH program.

### **Small Hospital Improvement Program (SHIP)**

The NRHA supports continuation of the SHIP program including flexible funding to address quality and patient safety initiatives.

### **Telehealth**

Reimbursement for services provided through telehealth should be made based upon medical effectiveness and utilization and not based upon or limited to particular delivery platforms or location. The NRHA supports Medicare reimbursement for telehealth consults utilizing store-and-forward technology.

Medicare law should be expanded to allow anything currently covered by Medicare to be reimbursed when provided through telehealth by appropriately licensed or credentialed providers otherwise eligible for Medicare reimbursement.

A telemedicine payment methodology should be provided that models those in place for conventionally delivered services such that a professional fee is paid to all providers necessary to that particular encounter, including a technical fee to the facilities to cover costs associated with the technology at rates to be determined by the Secretary of Health and Human Services and related to costs of

equipment, space, personnel and communications. Additionally, a separate Medicare billing code for telehealth consultations should be implemented to assist in monitoring the utilization of telehealth.

The Regional and National Telehealth Resource funded by the Office for the Advancement of Telehealth in the Office of Health Information Technology, HRSA should be supported and expanded.

The Federal government should adopt a policy to allow telemedicine providers to receive deemed status and to allow for health care facilities receiving telehealth services to perform credentialing by proxy (delegated credentialing). If a provider is already credentialed at a Medicare-participating facility (usually his or her home site), that credential would be sufficient for providing telemedicine services at another facility. The privileging process would still be conducted by the originating health care facility.

The geographical patient requirements of receiving care in a health professional shortage area (HPSA) and non-metropolitan statistical areas (MSA) should be lifted.

Separate billing procedures for telemedicine should be eliminated.

Care provided by a physical therapist, respiratory therapist, occupational therapist, speech therapist and social worker should be reimbursed.

A fair-market reimbursement system for originating telehealth sites should be implemented.

Reimbursement for store-and-forward applications should be provided.

### **Training Rural Health Care Providers**

NRHA supports the reauthorization and expansion of the Quentin Burdick Rural Interdisciplinary Training Grant Program, operated by the Bureau of Health Professions, Health Resources and Services Administration (HRSA). Other funded training programs of HRSA should be encouraged to increase interdisciplinary training.

In implementing its workforce development programs, the Department of Labor should specifically address the unique barriers to health care workforce development in

rural and frontier communities and assure that programs funded by the Department of Labor assist rural and frontier communities in overcoming these barriers.

### **Uninsured**

The NRHA is deeply concerned about the rising number of uninsured and underinsured 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**

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

### **Universal Service Program**

The NRHA supports expanding the Universal Service program to more appropriately fund the use of telehealth services currently being utilized by rural health care providers and beneficiaries.

The FCC's pilot program to build networks for health care services should be monitored for its effectiveness and impact on the overall Universal Service program. Future programs should be developed to better utilize Universal Service funds to expand access to health information technology and networks for rural providers.

The types of rural health care providers eligible to participate in the Universal Service program also should be expanded to include rural home health care agencies, skilled nursing facilities, public health agencies, EMS, and other health care providers without regard to their tax status. Consortia of such providers should also be eligible in their own right.

As current utilization of this program is low, outreach and education issues should be addressed to encourage greater participation in the program.

## **Veterans**

The NRHA supports the Veterans Administration's (VA) efforts to increase access points for rural veterans through telehealth systems for access to sub-specialty care, particularly for mental health services.

The VA should increase access to health and mental health services for rural veterans through contracts with local rural health providers as well as expansion of VA outreach models of care, i.e. Outreach Clinics, CBOCs, and current subcontracting with existing providers. This should include extending CBOC contracts to health care providers in rural communities.

The NRHA supports the full funding of the Office of Rural Health in the VA.

The NRHA encourages increased health professions training and rotations in outreach facilities that serve rural veterans in both the VA and civilian health care system in rural communities.

The NRHA strongly encourages federal and state initiatives to increase the number of mental health professionals trained in the special needs of rural veterans and their families.

Specific recommendations are available in NRHA's Rural Veterans Policy Brief: Rural Veterans: A Special Concern for Rural Health Advocates (February 2007)

## **Workforce Shortages**

The NRHA supports workforce training programs such as the Title VII and VIII Training Programs, Area Health Education Centers/Health Education and Training Centers, Community Access Programs, the Health Careers Opportunity Program and Geriatric Programs that are referenced throughout this document.

Recommendations addressing Medicare payments for GME or workforce training are found in the Medicare GME section of this document.

Expansion of federal and state supported higher education financing for disadvantaged rural students seeking health careers is needed.

Efforts to encourage rural students to seek health careers need to be supported. Such efforts could include

mentoring programs, pre-health professions rural interest groups and support for math and science competencies in primary and secondary schools.

The location of health professions education in rural communities and linkages of federal and state medical school funding to the distribution of practicing rural health professionals is necessary.

The widely predicted physician workforce shortage will exacerbate the already significant access difficulties in rural America. Any legislative or regulatory actions or programs must address the disproportionate impact that the shortage will have on rural communities and populations.

Recurring 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, should be reimbursed on a cost-based status.

The NRHA recognizes the essential need for rural clinician educators/mentors in assuring future health professionals to care for the health of rural America. The NRHA supports recognizing and rewarding the value of our rural clinical health profession educators in mentoring and educating future health care professionals.

*Additional recommendations are available in the NRHA's Policy Brief: Rural Clinical Experiential Experience (May 2010)*



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