

National Rural Health Association 2017 Legislative and Regulatory Agenda

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

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)

NRHA recognizes the important role AHECs play in providing valuable health care workforce development and health education services to rural and frontier areas. NRHA supports continued authorization and funding to the authorized level of AHEC 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 Federal Office of Rural Health Policy (FORHP) 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 (Jan. 2010)

Broadband Access

NRHA supports broadband policies that acknowledge high-speed online access as a necessity, not a luxury. All communities deserve a chance to participate in our digital future.

NRHA supports policies and efforts that address this digital divide, especially the lack of a basic accessible model for all of rural America. This model will enable us to create local jobs, encourage rural innovation, and help build the investment in rural communities. Broadband services are now a basic infrastructure for our nation. We need it to remain competitive in the world.

NRHA supports policy development and actions which will remove barriers such as public support for necessary broadband services, Federal and state licensing, credentialing and reimbursement restrictions that impede increasing use of telemedicine, telehealth and distance learning services.

NRHA advocates for a national policy that would enable a redesign of the present telecom subsidy models, universal access policies that would enable all citizens' access to an affordable and appropriately configured broadband system.

Additional information is available in the NRHA policy brief: Broadband Access in Rural America (Sept. 2012)

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 (SCHIP).

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.

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, 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.

NRHA supports existing programs that are based on proven and accepted 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 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.

In regards 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 the NRHA Policy Brief: Prevention of Chronic Disease (May 2010)

Community Access Program

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 behavioral 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.

All Medicare payment policy changes for FQHCs and Rural Health Clinics should take into account the critical importance of these facilities to the rural health care safety net. FQHCs and Rural Health Clinics must be funded appropriately.

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 healthcare dollars and improve patient outcomes using emergency medical services (EMS) providers in an expanded role.

Community paramedicine will continue to evolve over the next decade. Regulations, especially early regulations, should not stifle innovation or gap filling during this evolution. Standards should not be established until there is sufficient data on performance outcome measures. Community paramedicine programs must be engaged in reporting performance based on evolving common performance indicators and definitions.

Community Paramedics should be trained by accredited colleges and universities using standardized curricula.

State and federal governments should establish reimbursement systems under Medicare and Medicaid.

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

Critical Access Hospitals (CAH)

The CAH designation and its Medicare cost reimbursement methodology must be protected. Medicare prospective payment systems, designed for larger facilities, cannot adequately compensate small, low volume rural hospitals. Converting CAHs back to PPS hospitals would close most of these facilities, destabilize much of the nation's rural health care delivery system and compromise access to care for millions living in rural areas.

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.

CAHs designated at necessary providers should not be threatened with decertification for a failure to produce documentation providing they were designated a necessary provider. Such documentation was never required to be created as a part of the initial process of certification and was thus often never created.

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.

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 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.

Critical Access Hospital Quality 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. Rural relevant measures should reflect 1) care decision making, 2) processes for stabilizing and transporting patients and 3) care integration.

All CAHs should be encouraged to report in order to improve quality of care and for CAH benchmarking, but we understand 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 much needed technical assistance and resources to facilitate CAH reporting.

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).

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 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.

Elder Care

In addition to access challenges confronted by all rural Americans, the rural elderly are also limited in access to assistance with activities of daily living (ADLs) such as bathing, cooking, etc, and instrumental activities of daily living (IADLs) such as transportation. 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.

Efforts should be made to increase coordination for ADLs and IADLs assistance as well as rural relevant case management of chronic diseases.

Elected officials, planners and business leaders in communities with large elder populations need to ensure local access to essential health services for the elderly along with adequate elder housing, transportation and social support.

The rural health care delivery system should also consider how to formally link 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.

National policies related to health care need to take into account the distribution of elderly in rural areas. Incentives for health care providers who specialize in elders, need to include long-term incentives, which extend beyond the payment of school loans.

NRHA will pursue specific advocacy programs that ensure rural elders have access to all the services they require.

Additional recommendations are available in the NRHA Policy Brief: Elder Health in Rural America (Feb. 2013)

Electronic Health Record Implementation

NRHA supports revision of current legislation to correct for disparities involving rural entities including exclusions in funding set forth by the initial legislation.

NRHA supports the development of integrative partnerships with informatics resources to align rural entities with technical resources to support adoption of EHR technology.

NRHA supports the extension of federal timelines to rural facilities and providers recognizing the challenges of noted legislative hindrances, inadequate funding sources, lacking technologic availability, and workforce deficits which make implementation delayed in rural populations.

Rural Health Clinics should be entitled to receive Medicare EHR incentive payments in addition to Medicaid incentive payments. Rural ambulance providers should also be eligible for incentive payments.

Medicare EHR incentive payments should also be available for facilities to participate in electronic Health Information Exchanges.

Medicare and Medicaid EHR incentive payments for eligible professionals practicing in health professional shortage areas should be made permanent, so that new professionals entering the industry and practicing in a shortage area have access to this additional funding as they become meaningful users of EHR technology.

Additional recommendations are available in the NRHA Policy Brief: Electronic Health Record Implementation and Meaningful Use Adoption in Rural Hospitals and Physician Clinics (Jan. 2012)

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

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.

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.

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 disaster events 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 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.

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.

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 (April 2011)

Eye Care

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.

NRHA recognizes the importance of vision and eye care for all rural Americans, including children.

Federal Commissions

NRHA supports proportional rural representation on all federal health care-related commissions, task forces and advisory groups. 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.

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.

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.

Federal, state, and local governments should adopt policies that encourage local food production, healthy eating habits, and local development.

Additional recommendations are available in the NRHA Policy Brief: Food and Nutrition (Jan. 2011)

Frontier Definition

See full definition on pg. 4

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. Furthermore, CMS should expand the FESC program requirements to allow more clinics to participate in the program. Mileage and provider requirements should be relaxed to give more flexibility to isolated communities looking to participate in this program.

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

Future of Rural Health Care

Opportunities are emerging in public policy and the private sector to change the organization, financing, and delivery of rural health care services. What might appear to be threats to rural health care, such as challenges to current payments or new administrative requirements, may instead be opportunities to update and improve outdated and unsustainable service configurations.

Regardless of the specific form that rural payment models eventually may take, there are key relationships and resources that must be present in a community for it to survive and thrive through the transition period to the future.

The National Rural Health Association's Rural Health Congress has developed a comprehensive analysis of these relationships and resources for hospitals, clinics, health centers, public health advocates, physicians, and mental health providers. All policy-makers, at the federal, state, and local level, should take into account the unique factors outlined in that document prior to making any

changes to the regulation of and payment to rural health care providers.

NRHA will develop a fast-track demonstration project that recognizes community needs, builds on the existing rural provider foundation and maintains the rural health safety net. This demonstration project, if funding can be obtained, will help create a bridge between the rural system of today and the health reformed system of tomorrow.

NRHA's full analysis, "The Future of Rural Health" was approved by NRHA's Rural Health Congress in February, 2013.

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

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 lifestyle and health behaviors, 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 rural minorities 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 minority communities.

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, 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.

Develop and support culturally and linguistically competent health care service programs—especially child care—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.

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

In addition, the federal government should support well-designed research studies to document linkages between welfare policy, rural health, and rural economic development among multicultural and multiracial communities.

NRHA supports an increased focus on recruiting and retaining practitioners with minority and multicultural backgrounds. This should be done through innovative initiatives that focus on rural multiracial and multicultural students at the pre-college, college and professional school levels.

NRHA supports the development and dissemination of culturally and linguistically attuned career community initiatives targeting minority populations. Professional schools should also develop, support, and evaluate admissions policies and procedures that do not have any biases based on race or geographic origin.

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)

Health Home

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 NRHA policy position, "*Patient-Centered Health Home*" (Oct. 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.

Congress should ensure rural providers are not penalized when the HIT program does not meet new standards and should provide sufficient time and resources to allow compliance. Compliance with updated standards should provide sufficient flexibility to rural providers based on available products and resources.

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. These existing incentive payments should be

expanded to assist those that will need to purchase or upgrade systems in the future.

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. 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), or other relevant agency, as it redrafts its proposed underserved area methodology. NRHA encourages the BPHC to incorporate the Association's formal comments and suggestions in its new designation methodology.

Health Professions

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.

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

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 persons living with HIV/AIDS in order 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 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 persons living with HIV/AIDS. The Centers for Medicare and Medicaid Services 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)

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.

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

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

Historic and persistent underfunding of the Indian health care system has resulted in problems with access to care, including primary health care, specialty medical care, long-term care, and emergency services.

Despite the legal requirement to provide health care to American Indians and Alaska Natives (AI/ANs), AI and 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 AI/ANs.

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 and unique legal relationship with the Indian people.

If new legislation creates special programs to address health disparities, inequities or access to care, the legislation must include AI/ANs in lists of target groups.

NRHA will seek opportunities to improve access to all Medicare and SCHIP programs for eligible AI/ANs by including provisions that address access barriers identified by CMS and its Tribal Technical Advisory Group.

CMS should 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.

NRHA supports the Indian Health Care Improvement Act Amendments (IHCIA) as adopted in the Affordable Care Act and the reauthorization of the Indian Health Service.

The Indian Health Service should be reimbursed at least at the same percentage of costs as paid by Medicare for services provided by CAHs.

J-1 Visa Waiver

NRHA supports the continuation and expansion of the J-1 Visa Waiver program. FMGs seeking entry into the US for GME should be required seek classification as J1 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)

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

Medicaid reform, however designed and implemented, must not harm patient health or 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, and behavioral health providers, emergency care providers, transportation providers, and long-term care providers, to assure effective and continued local access by beneficiaries.

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.

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 take into account 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 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.

In implementing Medicaid reform, including approving state plans and waivers, the federal government 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 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.

States that do not expand Medicaid coverage in accordance with the Affordable Care Act (ACA) should be exempted from the scheduled cuts in Medicaid disproportionate share funding under the ACA and subsequent legislation.

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

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.

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. 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.

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.

The fee schedules applicable to outpatient laboratory and therapy services provided by rural PPS hospitals significantly underpay these hospitals providing lower volumes of outpatient services. An appropriate adjustment factor should be applied to both fee schedules for services provided by rural PPS hospitals.

NRHA recognizes Radiology Physician Assistants (RPA) as an important member of the rural team providing radiology services, particularly those using remote Radiologist services via tele-radiology. As such, services performed by the RPA and their supervising Radiologist should be covered for reimbursement under the Medicare Fee Schedule.

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

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 in Rural America

Cumulative rural training experience for all medical students and residents with an interest in rural practice should be at least six (6) months in duration. Curriculum content should include knowledge and skill acquisition with demonstrated competency in the following areas especially relevant to rural practice:

Maternity care; Pediatric and newborn care; Orthopedics and sports medicine, including basic fracture care; Surgical and procedural skills, including colposcopy, ultrasound and endoscopy; Trauma and other emergency care and stabilization, including training in programs such as ACLS, ATLS, CALS, NRP,

PALS, and ALSO; Critical care in a rural setting; Occupational health and safety, including recreation, agriculture, mining, and forestry; Behavioral health and psychiatry, including access issues unique to rural practice; Practice management in a small practice setting and system integration; Telemedicine, the electronic health record, and other electronic tools and resources; Public Health, including basic definitions, resources for rural health, access and barrier issues, funding and delivery of rural health care, interprofessional teams in rural health, health outcomes and disparities in rural populations, strategies for delivery of care, and cultural competence; and Community-oriented primary care.

In addition to these practice focuses, educators should emphasize adaptability, improvisation, collaboration, and endurance.

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

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.

NRHA supports the reauthorization and permanent funding of the Teaching Health Center (THC) model of training.

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 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 ACA and subsequent legislation.

Medicare should pay its fair share of capital expenses.

NRHA opposes the severe payment reductions imposed by CMS related to DRG creep under the MS-DRG 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)

NRHA supports reinstating and 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.

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

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 monitor 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

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 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.

This program should:

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.

NRHA also encourages CMS and CMMI to develop a meaningful demonstration program that reflects the realities and needs of rural America.

Additional recommendations and rural MSSP program details are available in the NRHA Policy Brief: Rural Hospital Participation in the Medicare Shared Savings Program (Feb. 2013)

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

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 as appropriate. Appropriate use of paraprofessionals and telemedicine should be utilized to expand available resources and expand access and affordability.

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 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.

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.

Development and expansion of recruitment and retention enhancements, such as loan repayments, bonuses, and other perks, 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.

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

Additional recommendations are available in NRHA's Policy Brief – Future of Rural Behavioral Health – February 2015.

National Health Service Corps (NHSC)

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 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

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

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. 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.

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.

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.

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.

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. Additionally, 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 in order to provide more consistency in residents' dental treatment.

Additional recommendations are available in NRHA's Policy Brief: Meeting Oral Health Care Needs in Rural America – February 2013

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.

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. These burdens are barriers to entry for qualifying smaller rural hospitals. The changes should expand the program to include inpatient drugs, eliminate the GPO prohibition, eliminate the orphan drug exclusion for certain facilities, and eliminate the DSH threshold for SCHs and RRCs. The program should maintain a patient definition consistent with the way medicine is practiced in rural communities to ensure robust access to the 340B program. The 340B program guidelines must be crafted to allow participating entities to stretch scarce resources.

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

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, 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)

Population Health

The move to increased focus on value, from the focus on volume, must be developed with rural populations in mind. NRHA supports the shift to keeping populations well rather than only caring for the sick.

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 component that are necessary to make meaningful change to population health;

adequate reimbursement to allow and incentivize providers to provide coordinated wellness, preventive, and acute care services to improve population health; and

existing silos that create barriers to coordinated efforts to improve population health must be eliminated.

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

Professional Liability Insurance Reform

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.

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)

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.

Quality

Policy related to rural quality should focus on the unique characteristics of rural health care and help rural providers:

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;

Invest in building an information and communications infrastructure, which has enormous potential to enhance health and health care over the coming decades; and

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.

In support of this, NRHA supports the NQF Quality Report of September 2015 and strongly encourages CMS to adopt the recommendations for use in all quality reporting programs.

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).

Regulatory Compliance

CMS must be mindful of how imposition of regulatory requirements affect rural health care providers. While NRHA supports efforts to guarantee program integrity, the

Recovery Audit Contractor program, “2-midnight rule,” 96-hour condition of payment requirements, and physician supervision rules, among others, create a disproportionate burden on rural providers and the patients they serve. These and other unnecessary regulatory burdens should be identified and eliminated.

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.

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.

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

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

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 NRHA’s Policy Brief – Rural Economic Development – May 2009.

Rural Health Clinics (RHC)

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

Congress should eliminate the Medicare and Medicaid cost per visit limit or increase limit to the approximate actual cost.

Congress should provide legislative guidance for the future of existing RHCs that are located in areas that lose their MUA or 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.

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.

CMS should allow RHC providers to bill and be reimbursed for chronic care management services.

The significant impact of proposed changes to location requirements and Medicare reimbursement policy to the RHC and Federally Qualified Health Center programs must be considered by CMS before implementing any such changes.

RHC status should be continued for any RHC that would no longer be covered by Medicaid or Medicare if decertified.

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

The federal government should provide guidance on RHC subcontracting with community health centers through the New Access Point grant funding program. FQHCs should also be given guidance encouraging subcontracting arrangements.

RHCs must be included as an important entity in payment reforms including ACOs, PCMH, and Regional Care Collaborative Organizations.

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

Rural Health Outreach, Network, and Training Track Grants

NRHA supports continued reauthorization of the Rural Health Outreach and Network Grant Program and the establishment of a Rural Training Track Network Development Grant.

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

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.

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

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 annually.

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.

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)

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

Small Hospital Improvement Program (SHIP)

NRHA supports continuation of the SHIP program including flexible funding to address quality and patient safety initiatives. Small rural hospitals need this funding to counter the myriad challenges inherent to working in sparsely populated areas with limited access to capital.

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. 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. Medicare should, wherever feasible, replicate the current systems and models used by the Veterans Health Administration.

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.

While respect for each state's licensure and scope of practice laws should be maintained, the facilitation of a provider's ability to appropriately practice across state lines should be encouraged through federal legislation.

The geographical patient requirements of receiving care in a health professional shortage area (HPSA) and non-metropolitan statistical areas (MSA) should be lifted. The current requirements have negative impacts on the access rural residents have to specialized medical services. These requirements neglect the realities of access barriers for beneficiaries. The geographical eligibility should be expanded to patients living in or receiving care in an MSA county with less than 30,000 residents.

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.

To truly reduce call requirements and eliminate emergency-provider workforce shortages, EMTALA regulations should be changed to allow a telehealth physician to meet the physician requirements for emergency care at Critical Access Hospitals. CAH conditions of participation should allow for telehealth emergency care.

Physicians and practitioners should be allowed to provide distant-site telehealth services in rural health clinics.

Specific recommendations are available in NRHA's policy brief: 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)

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 interprofessional 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

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

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, NRHA supports the goal of universal health coverage and access to care for all.

Universal Service Program

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.

Veterans

The VA should develop and implement policies that encourage use of the Non-VA Care Program in a consistent manner across all VISNs and that reflect a "best interest of the veteran" standard for utilization determinations. Additionally, the VA should 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.

The VA should 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.

The VA should evaluate and review its policies concerning contracting with local rural health providers to operate and manage CBOCs as a means to increase access points of care for rural veterans.

The VA should expand training programs for non-VA rural providers on evidence based military, deployment and post-deployment health and mental health diagnoses and treatment.

The VA must develop a benefit education outreach program that provides clear information for patients and providers on what services, especially emergency services,

are covered by VHA. Materials need to be readily accessible, easy to understand, and structured to encourage rather than deter seeking of care, especially needed emergency care. The VA must include rural specific materials addressing the challenges of accessing care in rural communities.

The VA must develop a consistent methodology for assigning definitions of urban, rural and highly rural that uses a variety of recognized classification schemes in order to ensure classifications are assigned in a manner that maximizes the ability to deliver timely services to all veterans located within a particular VISN.

The VA must continue to invest in research and application of telemedicine technologies to advance care, particularly mental health and brain injury care, for rural veterans.

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 may need to 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: A Special Concern for Rural Health Advocates (Feb. 2014)

Women’s Health

NRHA Supports programs providing continuing education opportunities to rural physicians focused on particular populations, such as pregnant and nursing women, the elderly, patients with chronic pain, patients with substance use problems, victims of intimate partner violence and the mentally ill.

The federal government and individual state and local governments should support Rural Training Tracks within health education programs, particularly those training primary care, geriatric, women’s health, and mental health providers. Specific efforts to ensure that an adequate number of practitioners offering obstetrics and

gynecological services are practicing in rural America should be undertaken.

NRHA supports programs that provide resources and support intervention services in rural communities to help victims of intimate partner violence. NRHA also supports programs that provide outreach and education to rural women to increase their awareness of the signs of and treatments for mental illness.

The federal government and state and local governments should work in unison to ensure timely delivery of prenatal care to all rural women.

Congress should 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. Additionally, CMS should ease restrictions on cost reports that prevent hospitals and other providers from offering women’s health care services.

States should continue and expand family planning funding and services within the state Medicaid programs.

The federal government should ensure the expansion of family planning funding and services to Federally Qualified Health Centers and Rural Health Clinics, commensurate with community need.

Additional Policy recommendations are available in NRHA’s Policy Brief: Rural Women’s Health (Jan. 2013)

Workforce Shortages

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.

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, should be reimbursed on a cost-based reimbursement basis.

NRHA recognizes the essential need for rural clinician educators/mentors in assuring future health professionals to care for the health of rural America. 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 NRHA's Policy Brief: 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/policy-documents>