National Rural Health Association

2024 Policy Agenda

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

NRHA serves as the primary resource on rural health for federal legislation, regulations and federally sponsored rural health initiatives and programs. NRHA's policy agenda outlines rural health policy priorities for action by Congress, federal regulatory agencies, the White House, states, and the broader health care industry.

2024 NRHA Priorities:

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

Priority Area 1: Investing in a Strong Rural Safety Net

Rural health safety net designations and programs expand access to health care, improve health outcomes, and increase the quality and efficiency of health care delivery in rural America. Over one hundred and sixty-five rural hospitals have closed, or discontinued inpatient services, since 2010. Over 50% of rural hospitals are operating with negative margins and therefore vulnerable to closure. Often one of the largest employers in a rural community, hospitals provide access to care, as well as jobs and other economic opportunities. NRHA supports the following actions to strengthen and support the rural health safety net:

- Provide stabilizing relief for rural providers to abate the rural hospital closure crisis.
- Stop Medicare cuts to rural providers and address administrative barriers.
- Allow providers to utilize innovative technology and improve access through continuing the telehealth advancements made by Congress and the Administration during the public health emergency (PHE).
- Protect the 340B Drug Pricing Program from ongoing attacks by pharmaceutical manufacturers.
- Modernize the Rural Health Clinic (RHC) program by updating payment policies; expanding team-based care; and incorporating essential services such as behavioral health.
- Test opportunities to improve regional and local health planning to improve distribution of essential services and improve community support for rural health services.
- Identify models of care to better support the safety net needs of frontier and isolated rural communities.
- Support proposals to increase access to Medicaid coverage across the United States.
- Test new payment models in rural areas and sustainable system design.

Priority Area 2: Reducing Rural Health Care Workforce Shortages

Maintaining an adequate supply of healthcare providers remains one of the key challenges in rural care. Nearly seventy percent of rural counties are Health Professional Shortage Areas. With far fewer physicians per capita, the maldistribution of health care providers between rural and urban areas

results in unequal access to care and negatively impacts rural health. The COVID-19 pandemic exacerbated the workforce shortage in rural America. NRHA supports the following actions to help recruit, train, and obtain health care professionals in rural areas:

- Remove barriers that limit rural resident training and grow training opportunities through vehicles like rural residency training tracks programs and residency development.
- Address the shortages rural providers face in maintaining an adequate workforce through programs like the National Health Service Corps (NHSC), Nurse Corps Loan Repayment Program (NCLRP), and Title VII and VIII workforce training programs.
- Test new models of team-based care to maximize the capacity of the rural workforce to serve people living in rural areas.
- Allow policies that allow trained professionals to work at the top of their licensure.

Priority Area 3: Addressing Rural Declining Life Expectancy and Rural Health Equity

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

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

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NRHA Policy Positions

Definition of Rural: NRHA strongly recommends that definitions of rural be specific to the purposes of the programs in which they are used and that these are referred to as programmatic designations, rather than definitions of rural. Programs targeting rural communities, rural providers, and rural residents do so for particular reasons, and those reasons should be the guidance for selecting the criteria for a geographic 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 that is not created to fit that program. (*April 2012*) *Additional Policy recommendations are available in NRHA's Policy Brief: Frontier Definition (Feb. 2016)*

Rural Public Health Funding: NRHA strongly recommends that public health funding be targeted to rural communities for the purposes of improving rural residents' health status and decreasing rural health disparities. Public health program funding opportunities should include criteria that target funding to rural communities in proportion to the percentage of rural residents residing within the state or eligible jurisdiction. In addition, rural communities should be defined using the same criteria used by the Federal Office of Rural Health Policy for rural health grant programs under the 330A Outreach Grant Program. This targeted allocation of public health resources will ensure that public health programs reach rural residents who experience disproportionately higher mortality rates and poorer health status than urban residents. *(September 2016)*

Systemic Racism: NRHA stands in solidarity with communities of color as we fight against the systematic, individually mediated, and internalized racism deeply embedded within our country and its institutions. Structural racism is a public health crisis, and its effects are detrimental to the physical and mental health of all individuals and communities. It is an underlying condition contributing to health inequities and the disproportionate burden of morbidity and mortality borne by racial minorities. NRHA stands against the racial injustices that continue to plague our country, and we are committed to our mission to advocate with all communities of color, especially those in rural America. As a health-focused organization, it is our duty to ensure these communities have equitable access to environmental justice, education, housing, employment, and health care. We will continue to support the work of our Health Equity Council to ensure racism is addressed throughout our initiatives and policy work. *(June 2020)*

Federal Programs

Census Data Impact on Rural Health

The U.S. Census Bureau collects demographic, socioeconomic, and business data on the U.S. population through several methods. Data from the U.S. Census Bureau are extensively used by rural communities for describing and assessing health disparities. For example, a rural, nonprofit hospital may use county-level ACS data to describe the sociodemographic characteristics of their catchment area as part of a community health needs assessment. To alleviate privacy concerns, most data is now collected at the census block level. Because this is not a granular interpretation of the data, rural communities are often not well represented in these larger data blocks. NRHA recommends the following policy actions to ensure rural data is best collected:

- Provide better transparency on the differential privacy process to enable researchers to better understand the extent of variation and lack of fitness of data, particularly for rural areas.
- Work towards the use of differential privacy in U.S. Census Bureau data.
- Provide an avenue for researchers to access data absent these differential privacy and synthetic constraints while still maintaining confidentiality.

Additional recommendations are available in NRHA's Policy Brief: Rural Census Data and Privacy (Feb. 2022).

Community Facilities Direct and Indirect Loan Programs (USDA)

The Community Facilities Direct Loan and Grant Program (CFL) provides essential, affordable funding to develop community facilities in rural areas. The requirements of the CFL portfolio are legislated and designed to mitigate risk of default. However, NRHA believes the application process for the USDA Community Facilities Direct and Indirect Loan Program is overly burdensome and requires meeting stringent underwriting requirements. Capital starved rural facilities are not generally in a situation to be able to meet program requirements for a three-year history of a positive bottom line on financial status, making vulnerable rural providers ineligible. Actions should be taken to simplify the application and underwriting requirements. As providers rebound from the COVID-19 pandemic, capital funding for modernization is a top necessity, especially as 21st century technologies are becoming more commonplace in health care delivery. NRHA encourages Congress to explore additional capital investment programs, similar to the Hill Burton program, in which facilities receive grants for construction and modernization in return for providing reduced-cost care.

Discretionary Grant Rural Health Carve Out

NRHA supports addressing urban bias in research, data, and funding by allocating rural carve-outs in federal programs aimed at improving health care access and social determinants of health (SDOH) such as broadband, transportation, housing, minority populations, and childcare. Federal agencies should include a proportional designated percentage, or "carve out" for rural residents in funding opportunities. This ensures equitable distribution of resources to impact the over 60 million Americans living in rural areas. Because rural communities account for 20 percent of the American population, NRHA recommends that percentage be allocated for rural usage in federal dissemination of funding.

Federal programs serving rural populations 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. Federal programs should require demonstration of rural partnerships and distribution of resources to rural

communities to fund projects aimed at improving health in rural communities. For example, many grants within the Federal Office of Rural Health Policy require a consortium of partners, 66 percent of which must be in a rural community to ensure resources reach rural populations. Further, federal programs should ensure that rural areas are eligible for programs by reducing or eliminating population size requirements.
Additional Policy recommendations available in NRHA's Policy Briefs: Rural Carve-out Funding (Sept 2021) and *Urban bias in rural data sets (Feb. 2023)*

Impact Statement on Rural Health
Any legislative or regulatory proposal to change a federal program should require a rural health impact statement that includes an impact analysis, as appropriate, on 1) rural safety net providers; 2) rural primary care providers; 3) rural hospitals; 4) FQHCs and RHCs; 5) local rural economies; 6) the geographic locations of affected rural residents; and 7) tribal governments and organizations. Designated rural funding should include resources to support an adequate evaluation plan. A consistent approach to evaluation will demonstrate how effectively the funding is used, provide accountability for the rural funding, and capture the impact on rural residents.
Additional Policy recommendations available in NRHA's Policy Brief: Rural Carve-out Funding (Sept 2021)

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

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

Rural Datasets
NRHA supports increased investment and validity of rural data infrastructure. Rural realities are often masked through a failure to collect or present data that adequately describes local conditions. Federal agencies should consistently disaggregate data so that the rural context is evident. Data sets provided by state and federal agencies should expand designations for "rural" to include various levels of rurality, such as frontier communities, remote communities, colonias, and reservations. USDA Rural-Urban Continuum Codes should be broadened from "non-metro" to be more inclusive and representative of rural and frontier communities. As much as possible, detailed information should be included in the data sets (such as specific Rural-Urban Continuum Codes, Urban Influence Codes, etc.). Online databases should be easily accessible for researchers and the rural public. Further, the U.S. General Services Administration should include rural variables in the data hosted on data.gov. Federal program standardized measures used in data collection on rural populations should be tested to ensure they accurately reflect rural experiences and are appropriate in a rural context. Federal agencies should ensure equitable allocation of resources using rural definitions. NRHA supports authorization of an

office within the Centers for Disease Control and Prevention to address rural health disparities, support rural public health infrastructure, and lead targeted research efforts in collaboration with local stakeholders to avoid underrepresentation of rural populations.
Additional policy recommendations available in NRHA's Policy Brief: Urban bias in rural data sets (Feb. 2023)

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. Targeted funding and technical assistance should be available to rural health care facilities through the Rural Development title and burdensome application and underwriting requirements should be removed to help these facilities access USDA assistance. Doing so requires an expansion of authority and an increase in authorized, mandatory funding for these activities. USDA should provide technical and funding support for the continued development and maintenance of the National Rural Development Partnership and State Rural Development Councils and encourage these entities to include rural health care issues in their work programs. Congress and USDA should also continue to fund and expand the capacity of the Rural Health Liaison to facilitate communication and connection between USDA and other health-related agencies.

Congress should support rural communities in the upcoming Farm Bill reauthorization by passing:

- H.R. 4713, the Rural Hospital Technical Assistance Program Act, to authorize the USDA Technical Assistance Program to identify and address hospital needs to improve financial performance and quality outcomes.
- H.R. 5989, the Rural Health Care Facilities Revitalization Act, to authorize rural health facilities to use federal agricultural funds to ensure their long-term financial stability.
- S. 3309, the Rural Partnership and Prosperity Act, which would bring investments to rural communities through grants, including technical assistance grants, that would be flexible to meet the needs of each rural community.

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

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

Additional recommendations are available in the NRHA Policy Brief: Community Health Initiative Success Stories Impact (Feb. 2021)

Rural Health Services Research

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

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

State Offices of Rural Health (SORH)

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

Title VII and VIII Health Professionals Training Programs

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.

- **Area Health Education Centers:** NRHA recognizes the important role Area Health Education Centers (AHEC) play in providing valuable health care workforce development and health education services to rural and frontier areas, especially for the allied health workforce. NRHA supports continued funding for AHEC programs.
- **Geriatric Training Programs:** NRHA recognizes the importance for providers to be trained in care for older adults living in rural areas. NRHA supports the reauthorization of education and training programs relating to geriatrics.
- **Health Careers Opportunity Program:** NRHA knows that having culturally competent providers is particularly important to rural and frontier areas. NRHA supports the reauthorization of the Health Careers Opportunity Program (HCOP).
- **Nurse Reinvestment Act**: NRHA supports programs authorized in the Nurse Reinvestment Act to ensure benefits to rural areas.

Health Care Workforce

Behavioral Health Workforce

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

- Development and expansion of recruitment and retention enhancements, such as loan repayments and scholarships, should be developed to attract behavioral health care professionals to rural areas. Existing workforce development programs should be expanded with the aim to bolster the rural behavioral health workforce, focusing on attracting, training, recruiting, and retaining behavioral health providers.
- SAMHSA should work with graduate training programs in behavioral health to develop skill-based curriculums that deal with rural environments and their increasing diversity.
- Congress should reauthorize the former NIMH clinical training program, relocate the program at SAMHSA, and authorize programs to integrate primary health care with behavioral health care training.
- Paraprofessionals and emerging professions can also augment the behavioral health workforce in rural areas. For example, Behavioral Health Aides (BHAs), Peer Support Specialists, and Community Health Workers can be utilized as care coordinators, bridge cultural gaps, and reduce stigma associated with behavioral health care.

Specific recommendations are available in NRHA's policy brief: The Future of Behavioral Health (Feb 2015)

Community Health Workers

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

NRHA supports changes made in the calendar year 2024 Medicare Physician Fee Schedule to allow Medicare reimbursement for certain CHW services related to community health integration. In addition, NRHA supports the following actions to continue to strengthen and advocate for the integration of the CHW model in rural communities.

- Support and advocate for the employment of CHWs in rural hospitals, CAHs, RHCs, FQHCs, private practices, social service entities, non-profit organizations, faith-based organizations, schools, academic institutions, and other community-based organizations.
- Support, participate, and advocate for the establishment of a national scope of practice for CHWs.
- Advocate and research reimbursement and funding mechanisms to support the CHW model in rural areas.
- Support and advocate for policies that allocate resources for CHW workforce development, including training.
- Promote the provision of incentives (e.g., financial) for agencies that hire CHWs (e.g., rural county health departments, state departments of rural health) in rural settings.
- Support and advocate for comprehensive evaluation of CHW programs—including cost saving, client outcomes, and CHW scope of practice.

- Support the establishment of a national rural health clearinghouse for innovation-based practice models, toolkits, and other shared technical resources for CHW models in rural areas.
- Support the creation of a repository of CHW training programs across the U.S.— particularly those programs that provide training in remote, rural areas.
- Support and investigate CHW certification and/or credentialing and its potential impact on rural CHWs and communities.

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

Health Professional Shortage Areas

Health Professional Shortage Areas (HPSAs) are be geographic areas, populations, or facilities. These areas have a shortage of primary, dental, or mental health care providers. As of the fourth quarter of 2023, 70% of all primary care and dental HPSAs, and 67% of all mental health HPSAs are in rural areas. While HPSAs are a useful measure of workforce shortages, NRHA supports adding a factor to the HPSA scoring process that reflects the rurality of the location. This addition will ensure that the unique access problems associated with rural locations are considered when identifying the relative need of a HPSA. NRHA recommends this factor be added to all HPSA disciplines (primary care, mental health, and dental health HPSAs) and added to all HPSA designation types (geographic-, population-, and facility-based HPSAs). We believe this factor should reflect a variable range of rurality, and could include either, or a combination, of the following:

- Rural-Urban Commuting Area (RUCA) codes establish multiple levels of rural isolation from the nearest urban centers.
- Frontier and remote areas are characterized by a combination of low population size and high geographic remoteness, and Frontier and Remote area (FAR) codes define the remoteness and population size of these geographies. These codes can help identify places that are distant from necessary health care services. FAR codes are determined on a half-kilometer by half-kilometer grid and are easily aggregated at a granular level. FAR codes have four levels; level one FAR codes identify geographies where a relatively large number of people live far from cities providing "high order" goods and services, and level four FAR codes identify geographies where a much smaller population finds it hard to access "low order" goods and services.

NRHA further suggests that the Bureau of Health Workforce at HRSA establish a separate HPSA scoring process for small rural and frontier HPSAs. The scoring process must prioritize and accurately reflect the needs of areas with small populations.

Health Professions Workforce Training

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

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

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

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

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

Health Workforce Burnout and Resiliency

- Implement resilience strategies as outlined in the Surgeon General's advisory addressing health worker burnout, such as reducing administrative burdens, implementing team-based models, improving equity and reducing discrimination in the workplace, and building relationships with the community.
- Health organizations should offer a diversification of benefits such as expanding tuition assistance to be transferable to children, wellness programs and benefits, community service allowances, and referral and appreciation bonuses.
- Recruitment and retention gaps in communities should be identified and addressed. Communities should have sufficient childcare options, employment opportunities for providers' spouses, and affordable housing options available to support workforce needs.
- Grants should be made available for health professionals to help create evidence-based strategies to reduce burnout of doctors and other health professionals.
- A national campaign should be launched to encourage health professionals to prioritize their mental health and to use available mental and behavioral health services.

Additional recommendations are available in NRHA's Policy Briefs: Retaining Rural Health Care Professionals: Strategies to Reduce Burnout (Feb. 2023)

Health Workforce and Economic Development

In rural communities, there is a higher level of awareness that health care and the community's overall vitality are innately linked. Rural health care systems and leaders can play a role in community and economic development by bringing together stakeholders in education, behavioral health, housing, food, transportation, and government. NRHA supports the following recommendations regarding rural economic development:

- Create consistent funding that targets rural workforce development.
- Develop and support policies that promote rural workforce flexibility to align with industry and community needs.
- Develop policies that improve equity, foster diversity, and encourage a rural workforce that represents the population that it serves.

Additional recommendations can be found in NRHA's Policy Brief: Health Care's Role in Rural Economic Development: Addressing Workforce Needs (Feb. 2023)

J-1 Visa Waiver

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

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

Medicare Graduate Medical Education in Rural America

Rural-based Medicare GME programs are critically important in the training of competent rural family physicians. The geographic maldistribution of primary care physicians is a problem in the United States. Rural areas particularly lack access to primary care physicians and other specialties compared to urban and suburban areas. Medicare is the only stable national source of GME funding in comparison to other grant funding such as HRSA-run programs and Medicaid GME funding. Rural hospitals operate on narrow margins and cannot commit to ongoing residency training costs without a predictable source of funding. The Government Accountability Office (GAO) recently released a study on physician workforce, stating that "use of federal efforts intended to increase GME training in rural areas was often limited and challenging."

In December 2020, Congress passed the Consolidated Appropriations Act (CAA), 2021, which included a provision to increase the number of rural residency slots by 1,000 with 10% of slots set aside for rural. In the FY 2022 Inpatient Prospective Payment System (IPPS) rule, CMS adhered to NRHA's request to implement the 200 slots per year by prioritizing hospitals with training programs in areas demonstrating the greatest need for providers, as determined by HPSAs. While the CAA, 2021, new residency slots is a step in the right direction, NRHA continues to advocate with HHS and Congress to ensure additional workforce provisions advance.

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

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

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

- Cumulative rural training experience for all medical students and residents with an interest in rural practice should be at least six months in duration. Curriculum content should include knowledge and skill acquisition with demonstrated competency in a full range of areas

especially relevant to rural practice. In addition, educators should emphasize adaptability, improvisation, collaboration, and endurance.

- Rural ambulatory sites eligible for GME reimbursement through Medicare should be broadly defined. Ambulatory care entities that train health professional students and residents should receive reimbursement for indirect, as well as direct, costs of training. Such reimbursement will require the development of a new formula for estimation of the indirect costs of training in the ambulatory setting, apart from those used to support other aspects of the academic medical center.
- Correct an ACA flaw restricting payments for physician residents in rural hospitals. By implementing regulations from the ACA, CMS has restricted Medicare from covering the costs of training resident physicians at a CAH, and this has restricted efforts to expand the training of medical professionals in rural communities.
- Remove barriers that limit rural resident training, and do not count rotating residents in residency caps. A major limitation in funding of rural GME exists because of CMS's interpretation of residency cap statutes. Regulation should promote training in rural communities to increase the number of physicians who would practice in rural areas. CMS should revise regulations to allow: 1) an urban hospital to expand its cap for the purposes of establishing a new RTP; and 2) not count residents who train in rural areas against the cap placed on urban facilities.
- Urban or other teaching hospitals sponsoring RTPs should be allowed to recover costs through Medicare whenever they bear all, or a substantial amount, of the costs of resident education, including when residents are located at hospital sites that do not claim direct and/or indirect costs through Medicare.
- Legislation should be enacted to require CMS to pay Indirect Medical Education (IME) reimbursement to the following types of institutions that do not currently receive such payments: SCHs that are paid based on their hospital specific rate; MDHs, for the hospital specific portion of their inpatient Medicare payments; and CAHs. The existing payment system discourages participation in GME, at rural facilities though these programs are among the most effective in placing graduates in rural practice.
- The Accreditation Council on GME should allow flexibility in the development and curricula of rural training programs in adapting to local resources.
- Exclude urban hospitals reclassified under Section 1886(d)(8)(E) of the Social Security Act from qualifying for the "greater than 50 percent rural training" requirement of new RTP programs under Section 127 of the CAA, 2021.
- Pursue new legislation to better targeting GME funding using sub-country RUCA codes or Census block definitions and changing the requirement for greater than 50 percent training to more than 18 months for all specialties for RTPs.
- Require outcome data for all GME funding that identifies rural community practice as an intended outcome.

Additional recommendations are available in NRHA's Policy Briefs: Rural Track Program Funding: An Erosion in Definitions of Rural Places Requires New Action (Feb. 2023), Toward a Sustainable and Diversified Rural Health Workforce (Feb. 2022), and the joint NRHA and AAFP Policy Brief – Rural Practice: Graduate Medical Education (April 2014)

National Health Service Corps

NRHA supports strengthening the NHSC program through expanded community and site development as well as creation of other tools to increase retention. NRHA supports increasing the role played by the NHSC in meeting mental and behavioral health care needs in rural and frontier areas. NRHA also

supports the addition of general surgeons, optometrists, and pharmacists to the list of health care professions included in the NHSC programs.

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

Workforce Pathway Programs

One of the factors most closely associated with health care professionals choosing to practice in a rural area is being raised in a rural area.[3] Therefore, strategies to engage a pipeline of K-12 rural students are vital to addressing rural workforce shortages. NRHA recommends that Congress and HHS:

- Expand health career programming for students in rural communities through AHECs.
- Enhance federal and state-supported higher education programs to assure that lower income students with promise from rural communities pursuing a health career are identified early and receive assistance through grants, scholarships, tuition waivers and other opportunities, given their financial disadvantage.
- Establish a best practice clearinghouse that will ensure innovations directed toward rural health pipelines are shared so that they can be replicated.

Additional recommendations are available in NRHA's Policy Brief: Addressing the National Rural Health Care Worker Shortage with a Focus on Kindergarten Through 12th Grade Educational Strategies (Dec. 2023)

Health Insurance Coverage

Supporting Rural Coverage

Health insurance coverage leads to access to care, better health outcomes, and increased work participation as well as stimulates the economy. NRHA supports the following actions to improve rural coverage:

- Support partnerships with rural organizations to assist with health coverage outreach and enrollment efforts.
- Partner with providers and patients to highlight how enhanced coverage improves health and providers' bottom lines.
- Stimulate innovative outreach and enrollment strategies tailored to rural communities.
- Advocate for federal funding subsidies to reduce the cost of health insurance.
- Reduce administrative barriers to enrolling in health care to make the system easier for providers and patients to navigate.

Additional recommendations are available in the NRHA Policy Brief: Health Care's Role in Rural Economic Development: How Work Support Programs Improve Health and Stimulate Rural Economies (Feb. 2023)

Children's Health Insurance Program

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

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

Network Access Standards

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

Managed Care

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

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

See the Medicare Advantage (MA) section of this document for MA specific recommendations.

Medicaid Expansion

Medicaid plays a critical role for the 52 million nonelderly children and adults living in the most rural areas in the United States. Medicaid is the nation's largest public insurance provider and plays a central role in helping to fill gaps in private coverage in rural areas. By expanding Medicaid, the 10 non-expansion states can not only help millions of their residents in need of affordable health care but also increase the chances that rural hospitals can stay open. State governments could help close the gap by pursuing Medicaid expansion—which would decrease their hospitals' uncompensated care burden. To encourage this, Congress could reinstate 100 percent federal matching for any state that chooses to adopt the Affordable Care Act Medicaid expansion. Rural hospitals in states that have not expanded Medicaid recorded a median operating margin of -0.3 percent, compared to +0.8 percent for rural facilities in expansion states. Expanding Medicaid would help state budgets, hospitals, and providers by increasing funds to states and decreasing uncompensated care. States that do not expand Medicaid coverage in accordance with the ACA should be exempted from the scheduled cuts in Medicaid disproportionate share funding under the ACA and subsequent legislation.

Medicaid Reforms

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

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

- Medicaid reforms must support the principles of population health. Proposals to reform Medicaid must be evaluated based on their likely impact on patient and population health, specifically including the health of rural patients and populations.
- Medicaid reforms 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 reforms, 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 reforms (including reimbursement strategies) must support the development and maintenance of a network of essential rural providers, including primary medical, oral, behavioral health providers, maternal health professionals, emergency care providers, transportation providers, and long-term care providers, to assure effective and continued local access by beneficiaries.
- Medicaid reforms 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 implementation must consider the fact that Medicaid is disproportionately important to rural economies, not just for Medicaid beneficiaries but to maintain a viable health care system that serves and contributes to the entire rural community.
- Medicaid reforms should address the considerable variation in Medicaid programs across states lines in the numbers of people and services they cover.
- Medicaid implementation, including approving state plans and waivers, must not abdicate its moral, legal, and financial responsibilities to rural, Medicaid eligible populations and to support the development of sustainable rural health systems.
- Medicaid reforms must address the fact that rural Americans are more likely to be low-wage workers, more likely to be unemployed, and have fewer job options than urban Americans, making rural Medicaid enrollees more susceptible to lose coverage under work requirement policies. As the system currently stands, Medicaid work requirements can cause an adverse effect on rural providers and residents. Medicaid work requirements can weaken rural hospitals' financial positions in states that implement these requirements as a condition of coverage and may contribute to further rural hospital closures and poorer rural health outcomes.

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

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

Evaluation of Medicaid reform proposals, including evaluation of requests for waivers or changes by state Medicaid programs, must include a Rural Impact Study that identifies anticipated impacts on rural areas and contains specific proposals for mitigation of any disproportionate negative impact on rural beneficiaries, health care providers, or health care delivery systems. Medicaid programs at the federal and state levels should participate in and use the results of targeted research that further documents and defines rural-specific potential impacts of reform proposals and identifies models of care delivery and provider payment that will promote sustainable rural health care delivery systems and improved outcomes for rural beneficiaries.
Additional recommendations are available in the NRHA Policy Brief: Medicaid Reform: A Rural Perspective (Sept. 2012)

Medicaid 1115 Waivers

Worse health outcomes among rural populations can be partially attributed to the unique SDOH that they face. Medicaid Section 1115 waivers present states with the ability to create and test novel programs via pilots, delivery system reform, or enhanced benefit packages to improve the health

of their state's beneficiaries. NRHA recommends that states collaborate with CMS to standardize data collection and sharing procedures to allow states to identify the needs of rural beneficiaries. NRHA encourages state Medicaid programs to partner with other state, tribal, and local agencies to identify the needs of vulnerable rural populations and improve care coordination. States should engage rural communities and stakeholders when developing, implementing, and monitoring their 1115 demonstration projects.
Additional recommendations are available in the NRHA Policy Brief: Improving the social determinants of health in rural America through Medicaid Section 1115 waivers (Dec. 2023)

Medicaid Services: Eye, Oral, and Podiatric
CMS should provide funding and resources to increase access for vision, dental, and podiatric health care services for children and adults living in rural and frontier areas, including funding for ocular, oral, and podiatric health services infrastructure.

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

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

Uninsured
Residents of rural counties still lack insurance at higher rates than those living in urban areas. About 13.3 percent of people in rural counties lacked health insurance compared with 10.8 percent for mostly urban counties. NRHA is deeply concerned about the number of uninsured and underinsured individuals and families in rural America and supports policies to address this issue. Any current law or future legislative proposal to expand the availability of health insurance must include equitable benefits for rural residents.

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

Rural Health Systems and Facilities

Behavioral Health Services

Rural residents experience many more obstacles to obtaining behavioral health services, which results in distinct mental health disparities compared to urban residents. To build a comprehensive policy framework around rural behavioral health reform, expanding the availability, accessibility, affordability, and acceptability of behavioral health services must encompass all major components of a multi-pronged approach.

NRHA supports behavioral health parity, recognizing that comprehensive behavioral health services are an integral part of basic primary health care. Comprehensive behavioral health services include counseling, psychotherapy, social services, peer and professionally facilitated groups, as well as medication. NRHA supports the following actions to strengthen and support behavioral health services in rural areas:

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

HRSA, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institute of Mental Health (NIMH) should be authorized to form a joint task force to address issues of access to mental health in rural areas. This group should be charged with addressing the collection of current, accurate data on the rural mental health workforce, revising the criteria for mental health professional shortage area designation, and addressing access to mental and behavioral health services for the rural uninsured and underinsured. Funds should be committed for the formation of at least one extramural rural mental health research center dedicated to addressing these issues.
Additional recommendations are available in NRHA's Policy Briefs: *Mental Health In Rural Areas-February 2022* and *Future of Rural Behavioral Health – February 2015*.

Chronic underinvestment in mental health services and escalating patient needs coupled with workforce shortages has led to increased psychiatric boarding in emergency departments, particularly among rural youth. NRHA proposes the following policy recommendations to reduce boarding times and improve mental health outcomes in rural communities:

- Improving mental health data collection systems in rural areas, specifically as it relates to youth psychiatric emergency department boarding.
- Expanding collaborative and integrated outpatient care by expanding HHS' role, evaluating the payment structure of collaborative care reimbursement codes, and requiring demonstrated collaboration to receive federal funding.
- Expanding telepsychiatry services and developing partnerships with local rural hospitals.
- Optimizing bed registries in rural facilities.

Additional recommendations are available in NRHA's Policy Brief: Policy Solutions Addressing Psychiatric Boarding of Youth in Rural Settings (Dec. 2023)

Certified Community Behavioral Health Clinics

Certified Community Behavioral Health Clinics (CCBHC) represent an opportunity for states, through their Medicaid program, to improve the behavioral health of their citizens by: providing community-based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care. Rural areas would benefit from the expansion of more CCBHCs considering that over 4,000, or almost 70%, of all mental health professional shortage areas (HPSAs) are rural or partially rural. Additionally, because rural populations tend to be poorer or have lower socioeconomic status, they would benefit from CCBHCs requirement to serve anyone who requests mental health or substance abuse care, regardless of ability to pay.

NRHA supports continued use of the CCBHC model to address financing shortfalls through inclusive Medicaid payment rates however modifications need to be made to make the model viable in rural areas. Additionally, behavioral health funding needs to be available to a broad range of provider types including CAHs, RHCs, and FQHCs.

Community Health Center Program

Approximately 1 in 7 rural residents are served by the Community Health Center (CHC) Program. HRSA should explicitly consider rural specific barriers, such as geography, lack of providers, and lack of transportation when allocating federal funding for the CHC program. This would significantly increase the geographic diversity of CHCs.

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

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

Community Paramedicine

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

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

- State and federal governments should establish reimbursement systems under Medicare and Medicaid. Guidance should be provided to private insurers on paying for treat-and-discharge EMS care and community paramedicine.
- As community paramedicine continues to evolve, regulations should not stifle innovation.
- Community paramedicine programs must be engaged in reporting performance based on evolving common performance indicators and definitions. Standards should not be established until there is sufficient data on performance outcome measures.
- Encourage ACOs and healthcare systems to provide community benefit grants to support the development of local community paramedicine and EMS system based expanded care delivery models.
- Community paramedics should be trained by accredited colleges and universities using standardized curricula.

Additional recommendations are available in the NRHA Policy Briefs: Principles for Community Paramedicine Programs (Sept. 2012) and *Rural EMS Workforce (Feb. 2021)*

Critical Access Hospitals

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

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

- The 35-mile standard currently required for cost-based reimbursement for CAH ambulance services should be eliminated.
- The ability of states to designate necessary providers as a means of meeting the CAH location requirements should be reinstated with appropriate qualifying criteria.
- NRHA supports adherence to the intent of Congress that CAHs be permitted to have up to 25 acute care and swing beds. CAHs should be permitted to meet this requirement using an average annual census rather than an inflexible cap.
- NRHA supports allowing CAHs to relocate and retain their CAH status without further review from CMS when the CAH moves within five miles of its existing location.
- CMS should revisit regulations and interpretative guidelines governing relocation of CAHs, which require a CAH to meet the necessary provider criteria under which it was originally certified, and which defines new facility construction as a relocation. CAHs designated as necessary providers should not be threatened with decertification for a failure to produce documentation providing that they were designated a necessary provider.
- Any CAH that reverts to being a hospital paid under the PPS model should be assigned their former PPS provider number and retain the base year hospital specific rates applicable to that PPS provider number.
- Direct physician supervision should be required only when indicated by clear clinical evidence. If any federal panel or entity is to determine physician supervision levels by procedure, then representation on such panel or entity should be expanded to include physicians that practice primarily in small, rural hospitals.
- The 96-hour physician certification and 96-hour average length of stay requirements should be removed. Lessons learned from the COVID-19 PHE, as well as chronic shortages in post-acute care availability, show that these are no longer relevant for CAHs. From the creation of the CAH designation until late 2013, an annual average of 96-hour stays allowed CAHs flexibility within

the regulatory framework in alignment with Congressional intent. The change in policy of strict enforcement of a per stay 96-hour Condition of Payment requirement creates unnecessary red-tape and barriers for CAHs. The rule limits access to health care in rural areas, restricts rural provider decision-making and eliminates important flexibility to allow general surgical services. This in turn, puts CAHs in a position where high quality and qualified local providers cannot provide care for their patients and as a result, patients have had to seek care far from home.

- The 72-hour, or 3-day, qualifying length of stay at a hospital for admission to a swing bed or SNF should be removed to facilitate more efficient and safer admission of beneficiaries that need skilled care.

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

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

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

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

NRHA supports the following actions to strengthen and support CAHs participation in the 340B program:

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

Critical Access Hospital Quality Reporting

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

CAH quality measures need to be standardized metrics (core measures) and be rural relevant measures. Standardized metrics would consist of a core set of measures used by States, the Flex Program, CMS, payers and hospital associations. CAH transition to quality reporting should focus on: 1) development of

rural-relevant measures, 2) alignment of measurement efforts, 3) measure selection process, and 4) pay-for-performance considerations.
Additional recommendations are available in NRHA's policy brief Public Reporting of Hospital Quality in Rural Communities: An Initial Set of Key Issues (Jan. 2012).

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

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

- Eliminate the 35-mile standard currently required for cost-based reimbursement for CAH ambulance services.
- Permanently extend the three percent rural and 22.5 percent super rural add-on payments most recently reauthorized by Congress in 2022.
- Support the development of a supplemental fee schedule that ensures appropriate reimbursement for rural ambulance services. The timeline for analysis of the costs of providing ambulance services in rural areas should be accelerated and, in the interim, rural providers should be held harmless vis-à-vis the ambulance fee schedule.
- Address the rising cost and decreasing availability of general and property (including vehicle) insurance for EMS services.
- Provide guidance to private insurers on paying for treat-and-discharge EMS care and community paramedicine.
- Recommend that procedures performed by EMS providers in conjunction with and as a result of a telehealth visit by a Qualified Healthcare practitioner be allowed to be billed using "incident to" billing practices even if the procedures occur simultaneously with the telehealth visit.
- Extend the 340B Drug Pricing Program to ambulance services whose service areas include rural areas.
- Encourage federal and state legislators to support alternate funding models for EMS and emergency care delivery in rural areas such that payments are not contingent on transporting a patient.
- Advise CMS to incentivize Accountable Care Organizations (ACOs) to partner with rural EMS agencies to deliver integrated health care.
- Encourage ACOs and health care systems to provide community benefit grants to support the development of local community paramedicine and EMS system based expanded care delivery models.
- Support federal and state funding to address the need to strengthen and integrate emergency medical services with rural health care services and providers. Federal funding would support such activities as innovative demonstrations, improved training, research, telehealth, preventive health and personnel recruitment for rural and frontier areas.

- Create a federal office to support EMS. Providers, state EMS departments, and SORHs should be adequately supported by federal agencies through policy development, data systems, appropriate curricula and access to grants.
- Support the use of rural economic impact models that account for losses in state revenue when health care services are lost in rural areas. These models can be used to allocate state funds to support the rural EMS workforce and emergency care access.

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

- Urge the Center for Medicare and Medicaid Innovation (CMMI) to support demonstration projects around expanded scope of service and practice EMS beyond the Emergency Triage, Treatment, and Transport (ET3) project.
- Facilitate the development of a federal interdepartmental task force between the Departments of Defense, Education, and Labor (and in particular the Veterans' Employment and Training Services [VETS]) to create a mechanism for formal recognition of military training in medical care that would transfer those educational experiences into civilian educational and licensure opportunities. Support national educational associations in developing guidance for academic institutions for accepting these credits. Provide guidance for state licensing boards to accept these academic accomplishments towards licensure.
- Incentivize states and health care systems to use the Informed Community Self Determination process to drive the development of rural emergency care.
- Support EMS professional associations and academic institutions to research the causes of professional burnout in EMS and to implement solutions to the crisis.
- Make non-public emergency EMS workers eligible for the Public Safety Officers' Death Benefit Program.
- Support the reauthorization of SAMHA's Title XII EMS Trauma grant program. Continue to provide funding through the SIREN Act and other mechanisms to support education, particularly asynchronous and distance learning, for rural EMS licensure and continuing education programs.

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

Long-Term Care

NRHA recommends the following actions to support rural long term care providers and patients:

- Developing a unified mechanism for funding long-term care through universal, publicly funded comprehensive coverage, including cost sharing, provided in a manner similar to Medicare.
- Adjusting reimbursement rates to account for the higher costs and lower patient volumes in rural areas.
- Making regulatory flexibilities for small, rural long-term care facilities in order to consider their unique circumstances and limited resources.
- Increasing compensation and implementing ranked pay increases for long-term care staff.
- Improving or expanding the availability of respite-care benefit or other direct-service benefits under Medicare.

Additional recommendations are available in NRHA's Policy Brief: Rural Long-Term Care Services and Supports (Dec. 2023)

Emergency Preparedness

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

In addressing these rural needs, the variability, surge capacity, capabilities, and needs of health infrastructures must be taken into consideration. Mental health needs of populations affected by disasters must be addressed. The protection of the environment, the food and water supply, and the health and safety of rescue and recovery workers must be assured. Availability of, and accessibility to, health care, including medications and vaccines, for individuals exposed, infected, or injured in disaster events must be assured.

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

- Create an Office of Rural Health within Federal Emergency Management Agency (FEMA) to ensure a continued focus on rural health issues.
- Authorize the Office of Rural Health within the CDC.
- Develop funding and program requirements flexible enough to allow appropriate solutions, according to the local rural needs, while adhering to evidence based approaches that can be applied across communities.
- Designate a regional health care point of contact to establish regional partnerships for preparedness and response as needed. A database should be created for consistent information sharing from federal and/or state resources to address lack of current consistency across counties, state or federal.
- Health professionals, volunteers/first responders, and the public must be educated to better identify, respond to, and prevent the adverse health consequences of disasters and promote the visibility and availability of health professionals in the communities that they serve.
- Hospitals and rural primary care providers must be included as first responders for planning, funding, and training purposes. These providers will need additional resources to fulfill their role in the emergency response system. As not all areas are directly served by hospitals, flexibility in funding will also be needed.
- Disaster Mental Health must be included as part of a comprehensive strategy of preparedness response in every rural community. Practices such as cognitive behavioral therapy as well as psychological first aid should be explored. These local services should be provided with appropriate reimbursement.
- Availability of, and accessibility to health care resources, including medications and vaccines, for individuals exposed, infected, or injured in disaster events must be assured throughout the state in connection with the national strategic stockpile. Local response entities should have a plan in place for communication and distribution.
- Support the development of disaster plans that address the unique culture of rural communities.
- Support policies that address the need for robust communications infrastructure, including phone, internet, broadband, and telemedicine capabilities to make disaster response more effective.

Additional recommendations are available in the NRHA Policy Briefs: Emergency Preparedness in Rural Communities (Feb. 2023), Rural Health Preparedness Policy Brief (Feb. 2021) and Emergency Preparedness for Rural Communities (July 2019)

Home Health Care

CMS should include a meaningful low-volume adjustment to its prospective payment system for home health services which targets additional payments to a range of low-volume providers. Rural providers with low utilization have a lower number of cases across which to spread the cost of overhead or high-cost cases. Such an adjustment, when properly implemented, can address these financial challenges. Additionally, CAH-based home health agencies should have the option to be paid 101 percent of cost-based reimbursement or the otherwise applicable rate under the prospective payment system.

Maternal Health

An estimated half a million rural women give birth in US hospitals each year. The majority of rural women give birth at their local hospitals and therefore rely on local maternity services. By 2030, HRSA anticipates the need for obstetric care in rural areas to grow even more, with the anticipated supply for OB/GYNs to only 50% of rural America's needs. Current workforce and hospital closure trends suggest that disparities in access to maternity care will only increase in upcoming years if no action is taken.

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

- Encourage states to adopt the option to provide pregnancy-related Medicaid coverage a full year postpartum.
- Use flexibilities in the Medicaid program to address barriers to rural practice of OB services including: protections for low volume providers; liability insurance costs and Tort Reforms; incentives to address a decreased focus of OB care within primary care practice; and resources to support C-sections including an OB-GYN, surgeon, and/or anesthesiologist.
- Support local perinatal regionalization and access to OB care policies that keeps struggling facilities open in order to keep maternity services local for rural women, such as the Save Rural Hospital Act, with a focus on the smallest hospitals that do not typically provide OB services.
- Support policies that support women during pregnancy including transportation and housing.
- Create regional, multidisciplinary emergency obstetric quality improvement teams.
- Incentivize the integration of rural EMS programs, community health workers, other non-traditional providers specializing in maternal care (e.g. doulas), and hospitals to support maternity care in maternal health professional shortage areas.
- Use of telehealth and other technologies to facilitate the delivery of maternity and pediatric services so that women can receive prenatal, postpartum, and low-risk obstetric care in facilities within their own community.
- Establish alternative payment models for obstetrics and delivery similar to the NC Pregnancy Medical Home.
- Encourage hospitals, as funding and collaborating network provisions allow, to stock maternal monitoring equipment and technology for antepartum surveillance.
- Continue and expand funding for the federal Health Resources and Services Administration Rural Maternity and Obstetrics Management Strategies grant program, which collects data on rural hospital obstetric services, builds networks to coordinate continuum of care, leverages telehealth and specialty care, and improves financial sustainability.

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

- Expand scope of practice and reimbursement for advanced practice providers (e.g., family physicians, nurse practitioners, physician assistants, nurse midwives, certified midwives) and

non-traditional providers (e.g., doulas, community health workers) subject to state regulations for professional practice in order to maintain or improve access to local maternity care for rural women.
- Support rural family practice physicians in providing maternity services, including developing and supporting rural-specific obstetrics-focused residency and fellowship programs.
- Support rural training programs, including interprofessional team building, such as TeamSTEPPS, and simulation training, such as the American Academy of Family Physicians' Advanced Life Support in Obstetrics course (ALSO), Advanced Cardiovascular Life Support (ACLS) course, Neonatal Resuscitation Program (NRP) course, Basic Life Support in Obstetrics (BLSO) course, and CDC's Hear Her campaign.
- Leverage the National Health Service Corps Loan Repayment program to fill workforce shortage areas.
- Address the high costs of malpractice insurance may make it more economically viable for family practice physicians to continue providing obstetrics care in rural areas.

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

Rural Obstetric Readiness.

As the number of rural hospitals without obstetric units increases and the rural maternity provider gap continues to widen, the first point of hospital care for a growing number of pregnant patients is the emergency department. This highlights the need to address obstetric readiness in rural hospitals to equip them to manage obstetric emergencies during pregnancy, labor, and delivery even if they do not have comprehensive obstetric services. NRHA supports the following:

- Federally require and fund training for annual obstetric recertification training for all rural providers in emergency departments; regular simulation training for various obstetric procedures and emergencies; and ultrasound training for providers in emergency departments.
- Encourage formal relationships between rural emergency department providers and regional specialists for telemedicine consultations and opportunities to rotate to higher-volume facilities for exposure.
- Recruitment of the doula workforce.
- Increase Medicaid reimbursement for rural hospitals and regional obstetrical consultants for telehealth visits and consultations.

Additional recommendations are available in NRHA's Policy Brief: Obstetric Readiness in Rural Communities Lacking Hospital Labor and Delivery Units (Feb. 2023)

Medicare Dependent Hospital Program

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

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

- The MDH program should be made permanent, with no sunset date.
- The 60 percent Medicare utilization threshold should be revised to 50 percent.
- Hospitals classified as MDHs should be paid for their inpatient operating and capital costs using the same methodologies used for SCHs.

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

Opioid Use Disorder and Substance Use Disorder

Abuse of prescription and illicit opioids has become a top priority public health issue, and its effects on rural communities cannot be understated. Rural adults have higher rates of use for tobacco and methamphetamines, while prescription drug and heroin use has grown in towns of every size. The substance use treatment admission rate for nonmetropolitan counties was highest for alcohol as the primary substance, followed by marijuana, stimulants, opiates, and cocaine. Effective, evidence-based treatment of substance use and opioid use disorders is urgently needed in small towns across America. However, multiple barriers stand in the way of appropriate treatment availability and quality. These include a inadequate rural mental health and substance abuse treatment infrastructure, lack of regional coordination of treatment resources, lack of support of rural physicians providing substance abuse treatment, administrative barriers against the most effective form of opioid abuse treatment, and a shortage of rural physicians who provide medications for opioid use disorder (MOUD).

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

- Make MOUD (buprenorphine or methadone) an option in all rural communities by removing barriers to treatment.
- Improve the availability of MOUD prescribers, chemical dependency professionals, and mental health professionals in rural areas.
- Improve availability of outpatient mental health, recovery, and peer recovery services in rural settings.
- Improve availability of inpatient facilities that treat substance use disorders.
- Allow patients to be induced on buprenorphine while in inpatient settings so as to improve continuity between inpatient and outpatient treatment and reduce side effects and treatment dropout.
- Provide funding for research on treatment of opioid issues specifically in rural settings to better document what works in these environments and develop innovative solutions to this burgeoning problem.

More broadly, substance use disorder (SUD) can be especially hard to combat in rural communities due to limited resources for prevention, treatment, and recovery. The substance use treatment admission rate for nonmetropolitan counties was highest for alcohol as the primary substance, followed by marijuana, stimulants, opiates, and cocaine. Substance use disorders can result in increased illegal

activities as well as physical and social health consequences, such as poor academic performance, poorer health status, changes in brain structure, and increased risk of death from overdose and suicide.

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

Oral Health

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

- Medicaid and Medicare should include comprehensive oral health coverage as a mandatory service for eligible beneficiaries. Medicaid reimbursement must also be increased to give this benefit actual meaning.
- Oral health providers should be encouraged to practice to the top of their licensure to help abate the chronic shortfall of rural oral health providers.
- Use of financial incentives, such as student loan forgiveness, equipment purchasing grants and loans, assistance in establishing clinic facilities, and programs providing specialized training, to attract more dentists to rural areas. Part of these programs funding should be contingent on the providers serving a minimum percentage of Medicaid beneficiaries and uninsured patients. These programs should be funded at an adequate level to allow them to succeed.
- Rural hospitals and other rural health hubs should be allowed and encouraged to establish dental clinics and oversee dental students and residents.
- States offering services through mobile dental units should increase the number of mobile dental units in service and increase the number of visits those units make to a specific community to provide more consistency in residents' dental treatment.
- Federal and state governments should encourage public oral health education, including education about the benefits of fluoride supplementation and water fluoridation, roles of diet and nutrition in cavity control, oral disease risk reduction, tobacco cessation and alcohol control, oral and facial injury prevention, and appropriate use of dental services. These efforts should be provided through culturally sensitive and appropriate materials and venues including public schools.
- Funding should be provided to support demonstrations and comprehensive evaluations of innovative state efforts to expand access to oral health services for rural and frontier populations and to disseminate information on programs found to be effective.

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

NRHA believes rural communities should have access to the most appropriately trained dental health professionals relative to the size and demographics of the community. In frontier Alaska, tribal programs experience a 25 percent annual vacancy rate and 30 percent annual turnover rate for dentists. Alaska Native children have 2.5 times more dental disease than all U.S. races. Additionally, the geography of Alaska increases the cost of providing dental care, and many villages face economic conditions that make support of a full-time dentist unfeasible. Therefore, NRHA fully endorses the provision of oral health care via dental health aides and therapists in small, frontier communities.

Additional recommendations are available in NRHA's Policy Briefs: Improving Rural Oral Health Access (May 2018) and Meeting Oral Health Care Needs in Rural America (Feb 2013) and NRHA Policy Statement: Dental Health Professionals in Alaska Rural Communities (2006)

Patient Centered Medical Home

The Patient-Centered Medical Home (PCMH) is a provider-based model for care coordination that can be implemented within a primary care practice. NRHA supports a PCMH that facilitates partnerships between patients, their providers and when appropriate the patient's family and significant other. *More information about Health Homes in rural areas is available in the NRHA policy position, "Patient Centered Health Home" (Oct. 2008).*

Pharmacy

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

NRHA urges Congress to make permanent COVID-19 PHE related waivers to ensure that access to pharmacy care is eligible in rural communities. Other health care providers, such as nurses and physician assistants, are reimbursed directly through Medicare Part B. But pharmacists administer vaccines and COVID-19 treatments through temporary federal contracts. Now that the PHE has ended, pharmacists will no longer be able to provide many of the services Americans have come to rely on during the pandemic. However, these services must be expanded. Pharmacists play a major role in rural health care delivery, and it is critical to allow them to practice at the top of their licensure.

Public Health and Public Health Infrastructure

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

- Support continued investment for the NHSC and NCLRP to address the health workforce shortages in rural America. Support a carveout for rural providers as they are more likely to face workforce shortages compared to their urban counterparts.
- Ensure rural providers have access to the highly qualified providers they need as the rural health care safety net rebuilds in a post-COVID-19 world.
- Support expanded engagement of rural public health professionals in rural systems of care.

The National Rural Health Association strongly recommends that public health funding be targeted to rural communities for the purposes of improving rural residents' health status and decreasing rural health disparities. Public health program funding opportunities should include criteria that target funding to rural communities in proportion to the percentage of rural residents residing within the state or eligible jurisdiction. In addition, rural communities should be defined using the same criteria used by FORHP for rural health grant programs under the 330A Outreach Grant Program. This targeted

allocation of public health resources will ensure that public health programs reach rural residents who experience disproportionately higher mortality rates and poorer health status than urban residents. Additional Policy recommendations are available in NRHA's Policy Briefs*: Rural Public Health (February 2022)*

Quality

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

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

- Adopt an integrated, prioritized approach to addressing both personal and population health needs at the community level.
- Establish a stronger quality improvement support structure to assist rural health systems and professionals in acquiring knowledge and tools to improve quality.
- Enhance the human resource capacity of rural communities, including the education, training, and deployment of health care professionals, and the preparedness of rural residents to engage actively in improving their health and health care.
- Monitor rural health care systems to ensure that they are financially stable and provide technical assistance in securing the necessary capital for system redesign related to quality improvement efforts.
- Invest in building a data information and communications infrastructure, which has enormous potential to enhance health and health care over the coming decades.
- Provide sufficient flexibility in quality reporting to allow quality reporting to work for rural populations of all sizes through the development of rural-relevant strategies, techniques, benchmarks and best practices.
- Recommend rural-relevant quality measures that focus on the top five chronic diseases including the National Quality Form metrics to improve rural health.
- Ensure rural health providers receive technical assistance through State Offices of Rural Health to mitigate the limitations of small rural practices.
- Relax regulations that allow all rural facilities to integrate care while being reimbursed on the cost-based model, including reimbursement for social determinants of care.

Additional recommendations to support rural providers increase quality and value can be found in NRHA Policy Briefs: *Quality Improvement in Rural Health Care (Feb. 2023)*, *Quality of Rural Health Care (Sept. 2012)*, *and Comprehensive Quality Improvement in Rural Health Care (Feb. 2015).*

Rural Health Clinics

With over 5,200 rural health clinics (RHC) in the US, RHCs have become an essential Medicare provider type in rural communities. The RHC program should be modernized through the following policy changes:

- Permanently enable all RHCs to serve as distant-site providers for purposes of Medicare telehealth reimbursement and to set reimbursement for these services at their respective all-inclusive rate (AIR). Additionally, these services should be counted as a qualified encounter on the Medicare cost report.

- Modernize physician, physician assistant, and nurse practitioner utilization requirements to allow for arrangements consistent with State and local law relative to practice, performance, and delivery of health services.
- Continue cost-based reimbursement without a per-visit cap in exchange for requiring provider-based RHCs reporting of quality measures. Provider-based RHCs would use the higher rate to pay for their participation in a quality program.
- Create an option for low-volume facilities (perhaps those meeting frontier and/or volume threshold) to automatically be eligible to receive a provider-based designation exception to address low-volume issues.
- Include the provision of behavioral health services under the existing primary care 50% threshold requirements given the shortage of rural mental health providers and the importance of primary care and behavioral health integration.
- Remove outdated laboratory requirements.
- Updating the RHC statute to ensure changes by the Census Bureau do not impact the program. The Census Bureau no longer uses the term "urbanized area," which is included in the RHC statute. To ensure the program's intent remains, it is critical that the language be modified to say "urban area" instead.

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

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

Specific Recommendations can be found in the NRHA policy brief: Rural Health Clinics (February 2022)

Sole Community Hospitals

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

- A full market basket update for SCHs, as well as a full market basket update for the target amount applicable to SCHs, should be provided annually.
- A payment-to-cost ratio floor should be established to further improve outpatient PPS payments for qualifying hospitals.

- Continue to periodically provide additional, more current base years for purposes of determining inpatient SCH specific rates.
- SCH outpatient service 7% add-on payments should continue.
- Update the provision that allows additional reimbursement to an SCH that experiences a decrease in inpatient volume of more than 5% for circumstances beyond its control, to include not only operating costs but capital costs as well.
- Compute hospital-specific rates without retroactive application of budget neutrality factors.
- Support paying DSH payments as an add-on to the SCH hospital-specific payment rates using the current formula applied to the federal payment rate, with no cap.
- Address reductions in the hospital specific rate related to DRG creep under the MSDRG system (also referred to as documentation and coding adjustments).
- Address DRG recalibration adjustments that are supposed to be budget neutral, but generally have a negative impact on rural hospitals.

340B Program

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

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

- Review existing policies around Medicare payment for 340B-acquired drugs and limitations on covered entities' use and number of contract community pharmacies.
- Eliminate the orphan drug exclusion for rural hospitals.
- Eliminate the DSH threshold for SCHs.
- Maintain a patient definition consistent with the way medicine is practiced in rural communities to ensure robust access to the 340B program.
- Enforce 340B program rules to require manufacturers to continue providing 340B drugs to all qualifying covered entities, including contract pharmacies.
- Eliminate the group purchasing organization (GPO) prohibition.

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

Value-Based Payment

The Center for Medicare & Medicaid Innovation (CMMI) tests various payment and delivery models that aim to attain the highest level of health for all people while reducing health care costs. NRHA recommends that CMMI focus and refine existing CMMI models to engage rural providers. NRHA supports creating rural-designed payment models that are more amenable to rural providers by accounting for smaller patient populations, the increased financial risk for rural providers, and financial reserves to cover losses when transitioning to value-based payment. NRHA supports CMMI investing in initial development and capacity building for rural health systems, requiring grantees to use model funds for strategic planning, and targeted rural technical assistance.

Additional recommendations are available in NRHA's Policy Brief: Center for Medicare & Medicaid Innovation Initiatives to Address Rural Health and Health Disparities (Feb. 2023)

Vaccinations

Over the past several years, there has been a considerable reduction in immunization rates among some populations, including rural communities. Data show that vaccination rates in rural communities lag considerably compared to larger suburban and urban areas. While these disparities exist across the life course, the gaps are most prevalent among children. NRHA supports the following framework to improve pediatric vaccination rates:

- Allocate federal and state resources for the development of local action plans when immunization rates in rural communities are disparately lower than county, state, or national rates.
- Ensuring funding for the sustainability of the Vaccines for Children program.
- Encouraging states to collect immunization data on a more disaggregated level; standardize the data collection; and modernize the vaccine reporting system for benchmark purposes and progress plans.
- Incentivize rural providers to routinely integrate the administration of pediatric immunization as appropriate and in alignment with relevant scopes of practice.
- Advocate for parity in coverage and reimbursement among insurance companies, regardless of provider type administering the vaccinations.

Additional recommendations are available in NRHA's Policy Brief: Pediatric Vaccination Rates in Rural America (Dec. 2023)

Rural Health Financing and Payment

Low-Wage Medicare Wage Index Adjustments

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

Medicare Advantage

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

NRHA supports efforts from CMS to address improper prior authorization denials. A Department of Health and Human Services Office of Inspector General report found that MA plans sometimes delayed or denied prior authorization requests that met Medicare coverage rules. NRHA believes that CMS must ensure that MA beneficiaries can access the same medically necessary care as their traditional Medicare counterparts. Rural Medicare beneficiaries are disadvantaged when compared with their urban counterparts in that they face obstacles in accessing care, including longer distances to healthcare facilities, lower median incomes, higher disability rates (leading to greater need for care), and healthcare workforce shortages. Denying medically necessary care for MA beneficiaries increases health disparities and worsens health equity outcomes, especially for those in rural communities. Relatedly, NRHA also supports implementing more stringent network adequacy standards for rural counties in a plan's service area to ensure access to necessary services.

NRHA recommends that CMS continues to monitor MA plans' deceptive or misleading marketing practices and ensure transparency around MA plans. Marketing tactics by MA plans may mislead beneficiaries as to what benefits are offered or what out-of-pocket costs would be incurred. NRHA encourages CMS to review MA plans' advertising practices to ensure beneficiaries have accurate information when choosing to enroll in an MA plan. NRHA further recommends that CMS provide beneficiary education including full detailed information on what MA plans cover, and what beneficiaries will be gaining and losing when choosing between MA and traditional Medicare. NRHA believes that CMS should require that the beneficiaries know the limitations they may have in certain communities, such as the network constraints in rural communities, if they chose an MA plan.

The following actions would positively impact rural providers as MA penetration continues to grow in rural areas:

- Allow CAHs to include inpatient days associated with MA patients in cost reports.
- Extend bad debt payments for rural providers that are incurred due to beneficiary services under MA plans equivalent to what occurs under traditional Medicare.
- Ensure that rural providers, like RHCs, are reimbursed equally between MA and traditional Medicare beneficiaries through a wrap-around payment or equivalent like supplemental payments made to Federally Qualified Health Centers.
- Require MA plans to adopt and implement the CMS HPSA Bonus Payment Program (10% bonus payment paid out automatically on a quarterly basis for all MA billings).
- Require MA plans to reimburse rural hospitals within 14 business days of receiving a clean claim.

Additional recommendations are available in NRHA's Policy Brief: Medicare Advantage Growth and Its Impact on Rural Healthcare (Dec 2023)

Medicare Bad Debt

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

Medicare Inpatient Prospective Payment System

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

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

Medicare Outpatient Prospective Payment System

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

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

- Exempt Medicare Dependent Hospitals and Rural Referral Centers from the site-specific Medicare Physician Fee Schedule policy for off-campus provider-based departments.

Medicare Physician Fee Schedule

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

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

Medicare Sequestration

In 2011, Congress passed legislation instituting a two percent sequestration reduction to all Medicare fee-for-service payments. Reductions in Medicare reimbursement due to sequestration, in addition to reductions in bad debt payments, largely impact the financial viability of rural hospitals. NRHA's research partner, Chartis, has forecasted that sequestration policies have an annual impact of $430 million in lost revenue for rural providers. This policy has a disproportionate impact on cost-based providers, such as CAHs, who are paid below their actual costs due to sequestration. Throughout the majority of the COVID-19 PHE, sequestration was halted. This relief proved critical for providers and NRHA urges this relief to be reinstated, particularly for rural providers, permanently. Further, NRHA urges Medicare sequestration not be used as a pay for in future legislative vehicles. Congress should be looking for ways to halt Medicare sequestration not extend it as we saw through passage of the Bipartisan Infrastructure Law in 2021.

Medicare Shared Savings Program

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

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

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

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

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

Medicare Wage Indexes

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

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

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

Price Transparency

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

Professional Liability Insurance Reform

NRHA supports addressing the rising cost and decreasing availability of malpractice insurance through appropriate legislative and regulatory mechanisms. The cost of malpractice insurance is a barrier to health care access in rural areas, as the cost negatively affects recruitment and retention of physicians and other scarce health professionals. Additionally, the medical liability system will undergo changes with the emergence of new technologies, including Electronic Health Records (EHRs). New liabilities should be mitigated through specific training and liability risk caps during EHR transition periods. *Additional recommendations are available in NRHA's Policy Brief—Professional Liability Reform (Sept. 2012)*

Rural Emergency Hospital Model

Congress created the Rural Emergency Hospital (REH) designation, established in Section 125 of the Consolidated Appropriations Act, 2021. The REH designation launched on January 1, 2023. The REH model is designed to address a persistent rural need for emergency and other outpatient services at-risk following hospital closures and to slow the alarming rate of closure crisis and maintaining health care access to some of the most disadvantaged and marginalized communities in our country. The hospitals most likely to transition to this designation are in already poor financial standing.

In November 2022, CMS released the final conditions of participation (CoPs) and payment policies for the REH model. Overall, conditions of participation provided flexibility for REHs and closely mirrored several CAH CoPs. REHs may furnish any outpatient services according to community needs and have discretion on how to staff the REH within certain parameters. REHs will be paid the OPPS rate plus an additional 5% for all OPPS services in addition to monthly facility payments. For calendar year 2023, REHs will receive $272,866 per month and this will be increased each year by the market basket update. At least 68 rural hospitals are predicted to consider conversion to become an REH. Considering the robust payment policies, NRHA expects that this number will be on the higher end of any predictions.

NRHA supports the following actions to continue to strengthen the REH model:

- Amending the 340B statute to add REHs as an eligible provider.
- Applying the additional 5% payment to non-OPPS services such as laboratory services.
- Authorizing REHs to operate inpatient psychiatric and inpatient rehabilitation distinct part units.
- Employ flexibilities around swing beds as an exception to the prohibition on acute inpatient care services.

Additional recommendations are available in NRHA's Policy Paper – Rural Emergency Hospital Conversion (Feb. 2022)

Rural Hospital Innovation

Today the stability of the rural health safety net is tenuous. Rural hospital closures stand at close to 170 since 2010, with another 450 vulnerable to closure. Of those closures, 53% were rural PPS hospitals and 47% had CAH status. Long term, reforms to the rural hospital infrastructure are critical to create a more sustainable system of care.

Unfortunately, in February 2022, the Biden Administration announced the removal of the Accountable Care Organization (ACO) Transformation Track within the Community Health Access and Rural Transformation (CHART) Model. NRHA had been hopeful that the CHART ACO Model would be modeled after the successful CMS ACO Investment Model (AIM) to encourage further participation from rural and

underserved providers who may be more risk-adverse due to low margins. NRHA remains committed to working with CMS to ensure the successful AIM program is expanded.

NRHA recommends expanding the success of the CMS Pennsylvania Rural Health Model. Under one of the most successful rural innovation models to date, CMS and other participating payers pay participating rural hospitals on a global budget—a fixed amount, set in advance—to cover all inpatient and hospital-based outpatient items and services. Participating rural hospitals work to redesign the delivery of care for their beneficiaries and improve quality of care and better meet the health needs of their local communities. Key to the success of this model is having the state, acting through its Department of Health, as a key partner in jointly administering this Model with CMS.

Prevention, Primary Care, and Clinical Services

Chronic Disease Prevention

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

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

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

A true foundational shift in the delivery of preventive medicine and behavioral health services cannot occur without payment reform. In addition to supporting preventive care programming offered by various organizations and agencies, NRHA supports the exploration and implementation of payment reform that promotes preventive care and enhances chronic disease management. This would include adequate telemedicine reimbursement for the originating site to develop a care plan with the consultation of specialists.
Additional recommendations are available in the NRHA Policy Briefs: Structural Factors that Impact Rural Life Expectancy (Feb. 2022).

Firearm Safety

More Americans died of firearm-related injuries in 2020 than any other year on record, according to the CDC. In fact, firearm-related injuries were the leading cause of death for individuals 1 to 44, accounting for more than twice as many deaths as motor vehicle traffic accidents. Additionally, most rural households have at least one firearm, and approximately half of rural gun owners reported acquiring their first firearm before the age of 18. NRHA supports firearm safety and risk reduction efforts in rural communities with the following policy recommendations:

- Include firearm safety education in curricula for health professional programs.
- Encourage the development and implementation of specific training for rural EMS and emergency department staff to manage shooting incidents.
- Feature 988 mental health hotline and 911 emergency hotline information on ammunition and firearm storage boxes.

- Conduct background checks on every individual prior to their purchase of any firearm at a gun show and/or auction.

Additional recommendations to support firearm safety can be found in NRHA's Policy Brief: Firearm Safety in Rural America (Feb. 2022).

Food and Nutrition

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

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

- Covering produce prescription programs in all Medicare plans.
- CMS should develop resources for rural providers to update health care coding infrastructure to support integration of food as medicine into clinical care.
- Providing resources to help health care providers become educated on food insecurity and nutrition screenings, including providing reimbursement under Medicare and Medicaid for these services.
- Enforcing health insurers requirement to provide obesity-related services with no cost-sharing.
- Expanding Medicare coverage of obesity prevention and treatment services to include coverage of anti-obesity medication and intensive behavioral therapy services provided by a dietitian or nutritionist outside of a primary care setting.
- Eliminate unnecessary restrictions in the Supplemental Nutrition Assistance Program (SNAP) like the prohibition on purchasing hot and prepared food with SNAP dollars.
- Develop methods to promote consumption of healthy and nutritious foods among the SNAP recipient population and to encourage farmer participation in accepting SNAP and WIC.
- Prioritize the full funding of SNAP and technical assistance aimed at outreach for SNAP enrollment in rural communities.
- Advocate for state policies that eliminate asset tests that determine SNAP eligibility.
- Incentivize states to update disaster SNAP plans to enable quick access to enhanced SNAP resources and waivers for a streamlined enrollment process.
- Expand eligibility for the High Obesity Program by lowering the threshold for obesity in a county from 40 percent to 35 percent.

Require CDC to establish a program to improve health outcomes and reduce health inequities by awarding grants to eligible organizations to build capacity for addressing SDOH. *Additional recommendations are available in the* NRHA Policy Briefs: *Obesity Prevention and Treatment in Rural America (Feb. 2023)*, *Health Care's Role in Rural Economic Development: How Work Support Programs Improve Health and Stimulate Rural Economies (Feb. 2023)*, *Rural Obesity (Oct. 2020)*, *and Food and Nutrition (Jan. 2011)*

Health Literacy

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

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

HIV/AIDS

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

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

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

Population Health

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

- Permitting and encouraging coordination and collaboration.
- Providing sufficient resources to rural communities to address the broad range of health care and non-health care services and components that are necessary to make meaningful change to population health.
- Providing adequate reimbursement to allow and incentivize providers to provide coordinated wellness, preventive, and acute care services to improve population health.
- Eliminating existing silos that create barriers to coordinated efforts to improve population health.
- The development of a rural pilot program to test the use of Z codes to measure rural SDOH.
- Clarifying guidance and providing standards for collecting information on SDOH, and ensuring information sharing is facilitated across payers and beneficiary programs
- Identifying the SDOH resource needs of health providers by encouraging and incentivizing the use of Z codes

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

Z Codes for Social Determinants of Health

SDOH are non-clinical conditions that affect a wide range of health, functioning, and quality of life outcomes and risks. Z codes were introduced in ICD-10-CM as reason codes to capture factors that influence health status and contact with health services, such as SDOH. Collecting Z codes could strengthen quality improvement activities, identify factors that influence health outcomes, and more conclusively determine and characterize health disparities in rural populations. However, rural providers have faced barriers and lack the resources needed to identify and report Z codes. To support more robust coding of Z codes, NRHA suggests:

- Developing a rural pilot to test the use of Z codes to measure rural SDOH.
- Clarifying guidance and providing standards for collecting SDOH information.
- Facilitating information sharing across payers and beneficiary programs (SNAP, TANF, and WIC).
- Incorporating language to provide a safe harbor to protect providers when they identify and document Z codes but are unable to provide services to address those conditions/concerns.

Additional recommendations are available in NRHA's Policy Brief: Integrating Z Coding for Social Determinants of Health and Its Impact on Rural Areas (Feb. 2023)

Rural Populations

American Indian and Alaska Native Health Care

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

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

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

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

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

Border Health

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

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

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

Care for Older Adults

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

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

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

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

Farmer Mental Health

Rural farmers are the backbone of America, providing $389 billion of agricultural products in the United States, yet attention and support for our agricultural community's well-being has been chronically overlooked. Rural populations have a significantly higher suicide rate than urban areas and available information indicates the suicide rate among farmers is 3.5 times higher than the general population. Solutions need to consider robust funding of research, building the rural health care workforce, and addressing barriers to wellbeing through consideration of the SDOH.

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

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

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

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

Health disparity generally refers to a higher burden of illness, injury, disability, or mortality experienced by a population or group of people. The health disparity is linked with social, economic and/or environmental disadvantages based on race or ethnicity, religion, socioeconomic status, gender, age, mental health, sexual orientation, geographic location, or characteristics historically linked to discrimination or exclusion. *NRHA Policy Statement (September 2014)*

Rural residents face significant health disparities as compared to non-rural populations, and resources should be allocated towards addressing these geographic disparities. While disparities exist among rural populations in general, it is also clear that Black, Indigenous, and people of color (BIPOC) living in rural areas face even greater challenges and a special emphasis should be placed upon addressing those needs. Such disparities are evident in the rural hospital closures, which reveal a pattern of disproportionate impact on rural BIPOC communities.

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

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

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

LGBTQIA+ Health Care

LGBTQIA+ populations have historically faced health disparities linked to stigma and discrimination. These individuals have a higher prevalence of mental health disorders and are less likely to disclose their sexual orientation or pursue treatment due to past discrimination. These disparities can be exacerbated in rural communities because of limited choices in health services and closer social networks. NRHA recommends the following policy recommendations to improve access to health care for rural and frontier LGBTQIA+ individuals:

- Enhance and establish policies to create more protections for LGBTQIA+ individuals seeking health care in rural areas.
- Begin collecting information and research specifically on LGBTQIA+ individuals within rural communities regarding health care challenges and how it may affect overall health and outcomes.
- Create inclusive medical and behavioral health guidelines and recommendations in promoting and including pronoun usage in rural health care settings or modifying health information technology and electronic medical records to include pronoun and gender identities.

Additional policy recommendations are available in NRHA's Policy Brief: LGBTQIA+ Health in Rural America (Feb. 2022)

Veterans

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

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

manner that maximizes the ability to deliver timely services to all veterans located within a particular VISN.
- Continue to invest in research and application of telemedicine technologies to advance care, particularly mental health, and brain injury care, for rural veterans.
- Establish policies to invest in Community-based participatory research (CBPR) with rural veterans and their families, including establishing public-private partnerships for CBPR and use of promising practices to support organizational capacity growth in rural institutions to support veterans.

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

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

Women's Health

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

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

Technology

Broadband Access

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

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

- Advance policy solutions increasing public support for broadband services and the removal of federal and state licensing, credentialing, and reimbursement restrictions that impede on utilization of telemedicine, telehealth, and distance learning services.
- Develop policy solutions which enhance access to broadband services for all Americans, particularly in rural America.
- Include representatives from rural areas in program development and policy implementation regarding broadband infrastructure.
- Create multipliers for rural institutions receiving government funding or grants when they combine funds to improve digital inclusion, equity, and dignity of the individual they serve.
- Use hospitals and health systems as a data source to collect information on opportunities to improve broadband access.
- Allocate funds through the National Telecommunications and Information Administration for telehealth projects that close the digital divide in rural communities.

Additional information is available in the NRHA Policy Briefs: Health Care's Role in Rural Economic Development: How Broadband Can Improve Health Outcomes (Feb. 2023) and Telehealth in Rural America (July 2019)

Cybersecurity

Rural healthcare organizations are in urgent need of increased cybersecurity measures to address the growing threats and vulnerabilities present with the increase of digital patient records. Rural health facilities face limited funding, infrastructure, resources, and personnel to successfully achieve the level of cybersecurity needed to protect patient information. NRHA recommends the following actions:

- Establishing regional cybersecurity support centers through collaboration between state and local governments and healthcare associations and technology providers.
- Strengthening cybersecurity education and training through partnerships between state, local, and Federal governments, academic institutions, and professional organizations.
- Fostering collaboration and information sharing between rural healthcare organizations, government agencies, and cybersecurity experts.

Additional recommendations are available in NRHA's Policy Brief: Cybersecurity – A Path to Increase Rural Healthcare Preparedness (Dec. 2023).

Health Information Technology

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

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

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

NRHA further recommends the following actions to improve electronic medical record software interoperability:

- Establish requirements for EMR vendors to enact a common language or share existing APIs between EMR systems to ensure interoperability.
- Promote the allocation of funding to resource-poor rural hospitals, community health centers, rural health clinics, and other rural health providers for the purpose of upgrading and purchasing infrastructure that allows EMRs to fully utilize API interfaces and become interoperable.
- Support federal legislation that enforces standardized security measures for all electronic medical record software.
- Establish and train an IT staff member at each regional hospital dedicated to the maintenance and optimization of API and EMR interoperability software.

Additional Policy recommendations are available in NRHA's Policy Brief: Prioritizing the Expansion of EMR Interoperability Software to Rural Communities, May 2023 and Medicare Electronic Health Record Incentive Program (Feb 2017)

Telehealth

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

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

- Telehealth waivers enacted during the COVID-19 PHE should be extended permanently.
- Congress should authorize RHCs and FQHCs to serve as distant-site providers permanently.
- CMS should reevaluate the payment model for RHC and FQHC reimbursement. Under current statute, RHCs and FQHCs are reimbursed at a PPS rate. NRHA believes that CMS should change the reimbursement so that providers are reimbursed at their AIR. Not only would this create greater parity in the true cost of providing services, but it would also better incentivize rural providers to utilize these flexibilities. Increased utilization will improve quality of life for rural patients.

- CMS should authorize licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, speech-language pathologists, EMS, and community paramedics to furnish the brief online assessment and management services as virtual check-ins and remote evaluation services.
- NRHA believes a national telehealth advisory committee should be created to develop guardrails that address telehealth/telemedicine definitions for usage and quality for all settings. Included on this committee should be rural representation.
- Amend CAH conditions of participation to allow for telehealth emergency care.

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

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

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

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