



BIPARTISAN POLICY CENTER

# Reinventing Rural Health Care

*A Case Study of Seven  
Upper Midwest States*

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## DISCLAIMER

This report is the product of BPC staff. The findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's founders, its board of directors, or the individuals who attended the scoping roundtables and participated in interviews, who are listed in the Appendix.



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## Executive Summary

In 2017, the Bipartisan Policy Center and the Center for Outcomes Research and Education (CORE) spoke with over 90 national thought leaders and key stakeholders about the current state of rural health care in Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming (the Upper Midwest). BPC and CORE used these discussions to determine the real-world implications of existing federal policies, to understand ongoing health care challenges, and to identify opportunities for improvement in rural health care access and delivery.

### WHAT WE LEARNED

Rural health issues affect more than just the Upper Midwest region and the seven states included in this effort. Furthermore, these issues do not exist in isolation – they are interdependent and build off each other. The nation cannot just fix one part of rural health care; the whole system needs to be addressed.

1

#### Rightsizing Health Care Services to Fit Community Needs

*Not every rural community needs to have a Critical Access Hospital (CAH); communities should tailor available services to the needs of the community, which for many rural areas are driven by changing demographics.*

**BOTTOM LINE:** In order to build tailored delivery services, policies need to be flexible and not just have a “one-size-fits-all” approach. The **Rural Emergency Acute Care Hospital Act** envisions transforming CAHs in certain communities from small inpatient care centers to new models, such as rural emergency centers.

2

#### Creating Rural Funding Mechanisms

*Once the right system and services have been identified for a community, funding mechanisms and payment models should reflect the specific challenges that rural areas face – such as small population size and high operating costs.* Sparse populations mean a smaller number of patients, so reimbursement metrics must take into account low patient volumes. Rural health care providers are eager to participate in value-based alternative-payment models, but they need workable approaches and metrics.

**BOTTOM LINE:** Policymakers should consider the unique challenges faced in rural areas when developing metrics and funding mechanisms. Rural health systems should work together in order to secure appropriate funding mechanisms and implement innovative models.





3

## Building and Supporting the Primary Care Physician Workforce

*With the appropriate services and funding, rural communities can build sustainable and diverse workforces.* Rural health can no longer survive on the back of one physician serving an entire community 24/7. Building and supporting the primary care physician workforce should be a high priority, and the expectation of care quality should be the same in rural as in more urban areas of the country. Also, alternative providers practicing at the top of their licenses, such as nurse practitioners and physician assistants, can fill vital primary care roles in the community. The health care workforce in rural communities should reflect the complex physical, behavioral, and social needs of their members. Communities should *start young* and *think local* for recruitment with pipeline programs that encourage interest in the health sector in local middle- and high-school students. Universities and colleges should reserve spots in medical programs for rural residents.

**BOTTOM LINE:** Communities should focus on right-sizing the health care workforce for their needs. Health care administrators are starting to think creatively by employing case managers, community-health workers, and in-home providers to help meet the needs of the community; policies should support these efforts.

4

## Expanding Telemedicine Services

*Finally, health professionals working in rural areas need the right tools for success.* Telemedicine is one tool that can be used to support both rural patients and rural providers. Not only do these services improve access by connecting remote patients with specialists located elsewhere, but they provide much-needed peer support to rural health professionals who often work in professional isolation. Telemedicine may prove to be critical in improving provider recruitment and retention, though challenges remain with broadband availability and reimbursement.

**BOTTOM LINE:** As workforce models change, rural health systems need to equip health professionals with the tools necessary to provide quality care to patients. Telemedicine is a promising way to increase patient access and create a peer network for rural providers.

## WHY DOES THIS MATTER TO POLICYMAKERS?

Due to its complex nature, coordinated federal, state, and local efforts will be needed to support improvements to rural health care. This requires the bipartisan effort of policymakers from all 50 states.

# WHAT'S THE CURRENT POLICY TRAJECTORY?

## A FEW HIGHLIGHTS OF CURRENT ACTIVITIES AND PROPOSALS:

### 1. Not Every Rural Community Needs A Critical Access Hospital (CAH)

The **Save Rural Hospitals Act** proposes providing financial relief to rural hospitals by eliminating the Medicare sequester for rural hospitals and by providing a permanent extension of rural and super-rural ambulance payments, as well as by establishing a new designation for rural hospitals that allows them to transform into outpatient-care hospitals.

### 2. Strengthen Financial Viability

Under one **draft legislative proposal developed by the National Rural Health Association** to give CAHs an on-ramp to move into value-based payments, participating CAHs would receive a 2 percent increase in Medicare reimbursement for submitting quality data and would be required to join an accountable care organization (ACO) within three to five years.

On the regulatory front, **the Centers for Medicare & Medicaid Services' Center for Medicare & Medicaid Innovation (CMMI)** has significant authority and funding to test (and expand, if successful), innovative models to improve health care quality and value. CMMI launched Pennsylvania's Rural Health Model in 2017 to test global budgeting and community-specific transformation plans in rural Pennsylvania.

Legislative and federal-agency efforts are supported by the work of outside organizations, in some cases under contracts with federal agencies. For example, The **National Quality Forum** is developing rural-specific quality performance measures that can be used as a basis for value-based reimbursement in rural areas.

### 3. Build A Sustainable & Diverse Workforce

Proposals to build and sustain a diverse rural health care workforce, such as in the **Strengthening Our Rural Health Care Workforce Act of 2016**, include:

- **Graduate Medical Education (GME) proposals**, which would distribute GME positions to rural institutions and would reauthorize the Primary Care Residency Expansion Program and the Area Health Education Center program, as well as expand loan-forgiveness programs to dental therapists and community paramedics.
- **Residency reimbursement proposals**, which would require Medicare to reimburse medical residency training that occurs in Critical Access Hospitals.

### 4. Provide The Right Tools (Telemedicine)

The **CHRONIC (Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care) Care Act** would expand the use of telemedicine for treatment of stroke and dialysis patients, and for use in ACOs. The bill would explicitly allow Medicare Shared Savings Programs and ACOs to receive allowable telemedicine services in the home. The CHRONIC Care Act unanimously passed the Senate in September 2017.

**The CONNECT (Creating Opportunities Now for Necessary and Effective Care Technologies) for Health Act of 2017** would expand the use of telemedicine within Native American, rural health clinic, and federally qualified health-center sites. It would create a remote patient-monitoring (RPM) benefit for certain high-risk patients and would allow the use of telemedicine and RPM in global bundled payments.

The **Centers for Medicare & Medicaid Services (CMS)** has expanded telehealth reimbursement, including through new Medicare billing codes, in 2018 physician payment regulations.

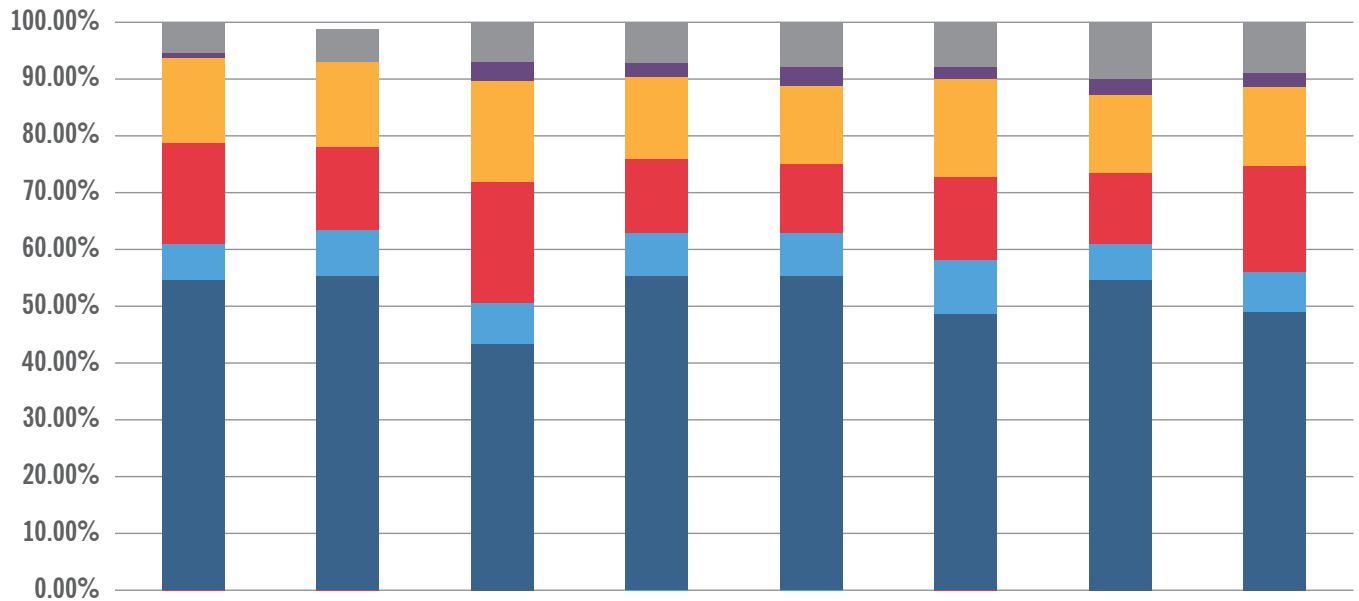




## Introduction

As debates in Washington continue over how to best deliver quality, affordable health care, unique considerations must be given to the obstacles faced by rural communities. A new study from the Centers for Disease Control and Prevention (CDC) reveals that the 46 million Americans living in rural areas are at greater risk of dying from five leading causes – heart disease, cancer, unintentional injuries, chronic lower-respiratory disease, and stroke – than their urban counterparts.<sup>1</sup> Age-adjusted death rates from unintentional injuries are 50 percent higher for rural than for urban populations.<sup>2</sup> Rural residents rank worse on many health metrics, such as obesity rates and tobacco use; and suicide rates in rural areas have historically been higher than in urban areas, a gap that appears to be widening.<sup>3</sup> Private insurance accounts for the largest share of health coverage in rural areas, though nonelderly individuals in rural areas are less likely to have private coverage compared with those in urban and other areas (61 percent vs. 64 percent and 66 percent, respectively).<sup>4</sup> Medicaid and the Children’s Health Insurance Program (CHIP) help to fill these gaps in private coverage, though coverage rates vary by state (see Table 1 for a snapshot of the states examined). Shortages of health care workers and geographic challenges – including terrain, harsh winters, and distance to emergency services – make it all the more difficult for people living in rural areas to address these health challenges.

**Table 1: Health Insurance Coverage in Seven Upper Midwest States and the United States**



	Iowa	Minnesota	Montana	Nebraska	North Dakota	South Dakota	Wyoming	United States
Uninsured/ IHS Only	5.23%	5.91%	7.02%	6.93%	7.71%	7.83%	9.71%	9.00%
Other Public	0.97%	0.00%	3.40%	2.20%	3.56%	2.30%	2.87%	2.00%
Medicare	14.80%	15.10%	17.74%	14.97%	13.37%	16.74%	13.64%	14.00%
Medicaid/CHIP	18.39%	14.49%	21.51%	13.03%	12.18%	14.84%	12.61%	19.00%
Non-Group	6.17%	8.18%	6.96%	7.47%	7.81%	9.60%	6.54%	7.00%
Employer	54.43%	55.37%	43.33%	55.39%	55.37%	48.69%	54.61%	49.00%

Source: Kaiser Family Foundation estimates based on the Census Bureau's March Current Population Survey (CPS: Annual Social and Economic Supplements), 2014-2017.<sup>a</sup>

**a Definitions:**

Medicaid: Includes those covered by Medicaid, the Children's Health Insurance Program (CHIP), and those who have both Medicaid and another type of coverage, such as dual eligibles who are also covered by Medicare.

Medicare: Includes those covered by Medicare, Medicare Advantage, and those who have Medicare and another type of non-Medicaid coverage where Medicare is the primary payer. Excludes those with Medicare Part A coverage only and those covered by Medicare and Medicaid (dual eligibles).

Employer: Includes those covered by employer-sponsored coverage either through their own job or as a dependent in the same household.

Other Public: Includes those covered under the military or Veterans Administration.

Non-Group: Includes individuals and families that purchased or are covered as a dependent by non-group insurance.

Uninsured: Includes those without health insurance and those who have coverage under the Indian Health Service only.





For all these reasons, the Bipartisan Policy Center and the Center for Outcomes Research and Education (CORE) launched an effort in 2017 to better understand the needs, opportunities, and innovative efforts of those working on the ground in rural communities to improve patient care. During this project, BPC focused on seven states in the Upper Midwest region of the United States with predominantly rural areas: Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming. While Minnesota and Iowa have done fairly well in overall health rankings, each of these states faces unique challenges with respect to their health status and systems of care delivery, especially for their rural populations. North Dakota ranks 36th in obesity prevalence among adults, and Nebraska and Iowa are tied at 37th, with each of these states having over 31 percent of their populations qualifying as obese. North Dakota and Wyoming have some of the highest smoking rates in the country at 19.8 percent and 18.9 percent, respectively, and Wyoming falls in the bottom three states for the number of primary care physicians per 100,000 population.<sup>5</sup> See Table 2.

**Table 2: Key Demographics of Seven Upper Midwest States**

State	Population (Rank)	Pop. Density Per Sq. Mi. (Rank)	% Age 65+	Obesity % Adults (Rank)	Smoking % Adults (Rank)	Primary Care Physicians Per 100,000 Population (Rank)	Mental Health Providers Per 100,000 Population (Rank)	# CAHs	Medicaid Expansion
Iowa	3,134,693 (30)	54.8 (36)	16.4%	32.0% (37)	16.7% (22)	142.3 (23)	134.7 (44)	82	Yes
Minnesota	5,519,952 (22)	68.9 (30)	15.1%	27.8% (17)	15.2% (14)	162.3 (14)	216.8 (25)	78	Yes
Montana	1,042,520 (44)	7.1 (48)	17.7%	25.5% (6)	18.5% (33)	113.6 (44)	265.2 (16)	48	Yes
Nebraska	1,907,116 (37)	24.6 (43)	15.0%	32.0% (37)	17.0% (23)	150.7 (19)	233.0 (21)	64	No
North Dakota	757,952 (47)	11.7 (46)	14.5%	31.9% (36)	19.8% (37)	140.5 (25)	165.4 (37)	36	Yes
South Dakota	865,454 (46)	11.1 (47)	16.0%	29.6% (23)	18.1% (32)	125.8 (38)	50.5 (31)	38	No
Wyoming	585,501 (50)	6.0 (49)	15.0%	27.7% (16)	18.9% (34)	105.7 (48)	310.2 (12)	16	No
United States	323,127,513	91	15.2%	29.9%	17.1%	149.7	218	1,341	-----

**Source:** U.S. Census Bureau. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2016 (NST-EST2016-01). Population Division. December 2016.

United Health Foundation. America's Health Rankings. Annual Report 2017.

U.S. Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. 2016.

American Medical Association. Special data request for active state-licensed physicians provided by Redi-Data, Inc. September 18, 2017.

U.S. Department of Health and Human Services. National Plan and Provider Enumeration System. Centers for Medicare & Medicaid Services. 2016.

U.S. Census Bureau. Annual Estimates of the Resident Population: April 1, 2010, to July 1, 2016. 2016.

The Flex Monitoring Team. Number of CAHs by State. July 12, 2017.

Kaiser Family Foundation. Status of State Action on the Medicaid Expansion Decision. November 8, 2017.

BPC focused on rural health care systems and infrastructure, because making sure that people who live in remote areas have access to a basic standard of care is the first step in creating an effective health system that can address immediate needs as well as larger population-health challenges. BPC hosted roundtables in three cities – Billings, Montana; Sioux Falls, South Dakota; and Omaha, Nebraska – convening key stakeholders to gather examples of effective state and local efforts to improve rural health care, to explore barriers to optimizing care delivery, and to identify promising areas for potential bipartisan cooperation. Additionally, BPC worked with CORE to conduct approximately 30 interviews with rural health experts across the political spectrum and from all over the country (see Appendix A). These conversations focused on three key topic areas identified as being critical to the future of care delivery in rural areas: (1) models of health care payment and delivery for critical-access hospitals (CAHs) and other rural providers; (2) rural-provider workforce and training; and (3) the appropriate practice of telemedicine, both within and across states.

This paper details the findings from our outreach efforts. It begins by providing context for the current policy debate and offers a detailed account of the different issues and perspectives that are shaping that debate. It then highlights key points and takeaways from the roundtables and interviews and identifies the challenges and opportunities for advancing rural health policies.



## Legislative and Regulatory History

Over the last two decades, two forces have largely set the stage for today's rural health care policy landscape: the scope of the rural health care system itself and a more national movement to address patient safety and delivery reforms.

First among these forces is the pressing need to shore up the rural health care system. As rural communities continue to lack access to physicians and rural hospitals and as health centers struggle to keep their doors open, strengthening the financial viability of the rural health care system has remained priority number one for rural communities and rural lawmakers.

To meet this goal, federal policymakers have focused first and foremost on revising how Medicare reimburses for rural hospital, physician, community health center, rural health clinic, and other rural services. Legislation has been enacted over the last 15 years that has improved payment for rural health services, and this legislation continues to be a central focus as lawmakers grapple with whether special rural Medicare payment programs should be maintained or reformed.

Other legislation has worked hand in hand with Medicare reimbursement policy to strengthen the rural workforce – such as the National Health Service Corps program, which helps create a more robust worker pool, and policies that expand the use of telehealth and other technologies as a way to increase access to care in rural communities. For the most recent fiscal year, the federal government spent approximately \$156 million in discretionary appropriations for rural health grants and other rural health programs authorized by the Public Health Service Act and administered through the Health Resources and Services Administration.<sup>6</sup> Providers working in rural areas may access these and other federal resources, such as those available through the U.S. Department of Agriculture, the Indian Health Service, or the Substance Abuse and Mental Health Services Administration to address some gaps in their communities.<sup>7</sup> What's more, the adoption and use of electronic health records has grown to 95 percent among CAHs due in part to Medicare's and Medicaid's "meaningful-use" incentive payments authorized by the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009.<sup>8</sup> Taken together, these policies and programs have focused on improving care in rural communities as a necessary step before larger rural health care reforms could be contemplated.

The second force affecting the rural health care policy landscape also emerged in recent years: This one called for reforms to the broader health care system. The release of various reports in the new millennium – such as *To Err is Human*<sup>9</sup> and *Crossing the Quality Chasm*<sup>10</sup> – focused the public and policymakers on the urgent need to improve patient safety and reform the health care delivery system. A key focus became moving the health care system away from paying based on volume and toward paying for value and quality of services. The question was whether rural health care providers had the necessary resources and expertise to participate in such delivery reform efforts.

Ultimately, policymakers decided that rural communities were not ready to fully participate in new delivery models or programs. Rural communities have largely been excluded from quality and delivery initiatives based on the rationale that rural delivery reforms would not be successful until the underlying rural health care system was strengthened and access to rural health care was stabilized and improved. The posture of “stabilize first and then consider innovating” set the stage for the rural legislative and regulatory effort of recent years and continues to impact the rural health policy outlook in the current Congress and administration.

## A LOOK BACK

To understand today’s rural policy environment, it may help to look back at rural policy conversations that began nearly two decades ago.

In 2001, the Medicare Payment Advisory Commission (MedPAC) released a report that focused solely on rural Medicare policy. This report, “The Report to Congress: Medicare in Rural America,”<sup>11</sup> suggested that rural health care providers were consistently and uniformly underpaid compared with their urban counterparts. This analysis spurred rural policymakers to come together and begin working on proposals to strengthen Medicare funding for rural health care providers. Excerpts from this report include perspectives from MedPAC commissioners.

For example:

“The fragility of the rural health care system calls for continued vigilance and special care to ensure that Medicare policies do not weaken rural medicine inadvertently and that, where appropriate, they reflect the special circumstances confronting rural beneficiaries and providers.”<sup>12</sup>

And:

“The financial status of rural hospitals continues to be a source of concern for policymakers. Rural hospitals have had lower Medicare inpatient margins than urban hospitals throughout the 1990s, and the gap has widened from less than a percentage point in 1992 to 10 percentage points in 1999. This pattern applies not just to inpatient care, but across all major lines of Medicare business, with rural hospitals’ overall Medicare margin dipping below zero. This growing imbalance in Medicare financial performance has occurred despite special programs targeted to rural hospitals with specific characteristics such as rural referral, Medicare dependent, critical access, and sole community hospitals. Although some of the difference in performance may be within hospitals’ control, the size of the gap suggests that the payment system does not recognize factors that have a greater effect on the costs of rural hospitals.”<sup>13</sup>

To begin tackling rural health challenges, key lawmakers reinvigorated caucuses devoted to rural health that had long been dormant in the House and Senate. These caucuses served as a platform for rural lawmakers – from both sides of the aisle – to work together to craft a set of bipartisan rural health legislative proposals.

Notably, the House and Senate Rural Health Caucuses were led by senior lawmakers from key jurisdictions who were well-positioned to push forward a set of salient policies.<sup>b</sup> The Rural Health Caucuses worked with key stakeholders, including the National Rural Health Association, the American Hospital Association, individual rural health systems, rural health experts from many universities (such as the University of Iowa’s Rural Policy Research Institute), and a host of other stakeholders to develop a set of rural legislative proposals.

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<sup>b</sup> Leaders of the House and Senate Rural Caucuses included then-Sens. Tom Harkin (D-IA), Craig Thomas (R-WY), and Kent Conrad (D-ND); current Sen. Chuck Grassley (R-IA); former Rep. Earl Pomeroy (D-ND); and current Rep. Jerry Moran (R-KS), among a long list of others.





Rural proposals centered on Medicare payment reforms that would increase revenue for low-volume and small rural hospitals, including sole community hospitals and CAHs. Other proposals would have authorized grant funding for the development of telehealth resource networks, for improved payment for certain physician services, and for rural health clinics, among other items.<sup>c</sup>

Over time, a package of Medicare rural proposals gained momentum and support as broader Medicare reforms – namely, adding a prescription-drug benefit to Medicare – were debated.

Ultimately, rural lawmakers were successful in enacting a host of rural hospital, rural health clinic, and rural physician policies as part of the Medicare Modernization Act of 2003 (P.L. 108-173).<sup>d</sup> These policies were estimated to bring an unprecedented roughly \$20 billion in new Medicare funding to rural communities over the period of 2004 through 2013.<sup>14</sup> Importantly, this package of rural health policies set the stage for Medicare rural policy “extender” debates that continue today.

## **AFTER RURAL MEDICARE PACKAGE BECOMES LAW, NEXT FEW YEARS FOCUSED ON EXTENDING THE RURAL POLICIES**

After the rural payment policies were enacted into law, the next few years (from 2004 to 2006) focused largely on extending or maintaining these provisions as a way to ensure stable funding for rural health care services under Medicare.

In many ways, maintaining the Medicare policy rural extenders became the sole legislative priority of rural stakeholders and policymakers, leaving little room for focus on broader rural health policy reforms in the coming years.<sup>e</sup>

This dynamic remained in place as the Congress turned toward larger health insurance reform efforts.

## **HEALTH REFORM DEBATE AND SHIFTING FOCUS TOWARD DELIVERY SYSTEM REFORM**

In 2007, emerging debates around health insurance reform presented the next opportunity for policymakers to examine the stability of rural health care systems and needed reforms.

As work on what would eventually become the Affordable Care Act (ACA)<sup>15</sup> got underway, coverage expansions through the individual and small-group health insurance markets and Medicaid received most of the national attention. Impacts vary by state, but rural areas across the country have seen gains in private insurance and Medicaid-coverage rates, as well as reductions in the rates of uninsured residents, while still grappling with premium growth and other market challenges. As part of the ACA, policymakers also decided that health care delivery system reform should go hand in hand with broader efforts to reform the health insurance marketplace.

Central to the delivery system reform effort was moving the Medicare program away from paying based on volume and toward paying based on quality and value. Efforts specifically focused on developing “value-based purchasing” policies that would tie provider payment to quality performance. Other proposals focused on establishing new care delivery and payment models, such as accountable care organizations (ACOs) and payment bundling models.

From the very beginning of health reform efforts, rural health care stakeholders and policymakers questioned whether rural communities were ready to participate in new quality and care delivery models from an infrastructure, resource, or systems perspective. At the same time, policymakers were facing an honest struggle: determining how to make new delivery reforms work for the larger, more resourced health systems and providers.

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<sup>c</sup> Specific examples of bipartisan legislation stemming from this effort included the Rural Health Care Improvement Act of 2001 (S. 1030 and H.R. 2157, 107th Congress) and later the Health Care Access and Rural Equity Act, (S. 816, 108th Congress) introduced by senior rural lawmakers.

<sup>d</sup> Full name of legislation is: Medicare Drug, Improvement, and Modernization Act of 2003.

<sup>e</sup> Medicare policy rural extenders were included in numerous Medicare proposals, including: the Medicare Improvements for Patients and Providers Act (MIPPA, P.L. 110-275); Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309); American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240); and Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93).

Ultimately, most ACA delivery system reform proposals either outright excluded rural health care providers or allowed rural providers to participate with little financial risk. The hope was that, over time, smaller and rural providers could adopt these models once the programs had been tested and further refined to be workable for rural communities.

At the same time, the ACA did include new policies intended to provide ongoing support for the rural health care workforce. Noteworthy examples included payment increases (10 percent in Medicare from 2011 to 2015, and 10 percent in Medicaid in 2013 and 2014) for primary care physicians and general surgeons practicing in health-professional shortage areas, and proposals to redistribute unused graduate-medical-education residency slots to states with a high ratio of their population living in a health-professional shortage area, among other priorities.<sup>16, 17</sup> The ACA also included a host of policies to support health workforce education as well as investments in prevention and public health.

However, these policies impacted both urban and rural areas, as opposed to the more rural-targeted approach in the Medicare Modernization Act of 2003. In addition, the ACA did not include substantive policies related to expanding or supporting the use of telehealth or other remote-monitoring technologies in rural communities. This all leads to today's environment.





# The State of Rural Health Care: Linking Challenges, Opportunities, and Policy

## INTRODUCTION

Seven states were targeted for this project: Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming. Combined, the states have a population of nearly 14 million people or 4 percent of the country, with nearly the lowest population densities per square mile of any states in the nation – four of the studied states rank 46 through 49 in population density. Four of these states expanded their Medicaid programs under the ACA, while three chose not to expand. Of the nearly 1,340 CAHs in the United States, one-quarter (362) are located in the seven states. For these and other key characteristics, see Table 2.

Between August and November 2017, a series of 28 key informant and stakeholder interviews and three roundtables that consisted of 14 to 27 attendees each were conducted across the seven states. Participants in the roundtables and interviews included national thought leaders and representatives from universities and colleges, state health departments, large and small hospital systems, clinics, professional associations, congressional offices, and federal agencies. The goal of these discussions was to contextualize the real-world implications of the federal policies currently in place, take stock of ongoing health care challenges for rural communities, and identify opportunities for improvement. These groups of providers, administrators, and policy experts were dedicated to serving their communities and offered valuable insights into how to better align policy to improve rural health care.

**Overview of Findings:** Across the interviews and roundtables, participants converged on one overarching, fundamental point: Delivering health care in rural communities is a distinct undertaking from delivering health care in other parts of the country. This distinction tends to go unacknowledged in health policy, which often puts rural areas at a disadvantage. Within the broader conversation around what differentiates rural health care systems and communities from those for which policies are generally designed, four key themes emerged that identified the defining features of rural health care systems and communities that require policy attention:

1. A need to generate opportunities that allow rural communities to define their own needs and service sets.
2. A need to create funding mechanisms that account for rural realities and allow for innovation.
3. A need to optimize the full array of health professionals to support a more sustainable and diverse workforce.
4. A need to provide health professionals with the tools and technology for success.

Throughout these conversations, BPC gathered crucial context around the challenges rural stakeholders face. Stakeholders are actively implementing creative solutions to remove barriers using the resources at their disposal, and they are incorporating new ways of thinking about what their communities need, what organizational and workforce models might best serve them, and what new technologies can be leveraged to improve their systems.

**Reporting Results:** In the pages to follow is a summary of these findings on the four defining features of current rural health care that emerged across the interviews and roundtables. There is a catalogue of the specific challenges facing stakeholders and reflections on their efforts and ideas to address those challenges. There is also a review of the current policy initiatives that support stakeholder-identified needs and that identify the gaps between the policy and stakeholder needs.







## Re-Focusing on Unique Community Needs

### KEY TAKEAWAYS

- Rural communities have unique strengths, challenges, and needs – there is not a one-size-fits-all policy that will address all rural health challenges.
- Not every rural community needs a CAH; communities should figure out what their needs are today and will be in the future, and right-size their local delivery systems.
- Flexible policies that support locally-driven health care solutions are required to support these efforts.

### CURRENT CHALLENGES

**Rural Communities have a Spread-Out, Aging Patient Population:** The unique demographics of rural communities present a distinct set of challenges in rural health care. Stakeholders underscored that their communities continue to be underserved and that patients continue to struggle to receive necessary care. These challenges are well known and include long distances from care facilities, few local specialists, and workforce shortages that either preclude access entirely or compromise quality by overwhelming local providers with too many patients. The lack of access to necessary care can have devastating consequences.

Stakeholders emphasized behavioral health as an area in which the impact has been profound. For example, in one small community, a stakeholder described an alarming increase in the suicide rate and complete lack of access to psychiatrists. Given the rapidly aging populations in some of these rural areas, a lack of access to nursing homes is a rising concern: Rural populations are struggling financially, and nursing-home Medicaid reimbursements do not cover the costs of care, particularly for states experiencing budget cuts. Stakeholders were also concerned with the difficulties providing ambulance services to their communities; because rural populations are so spread-out, such services are necessary, but many communities lack even the volunteers to staff the ambulance services. (In these rural states, as many as 80 percent of emergency-medical-services workers are volunteers.) Furthermore, the lack of public-transportation infrastructure can also present challenges around transportation for nonemergent care. Obstetrics shortages were expressed as a concern both for access to maternity and prenatal care (and potentially poor maternal and infant outcomes

as a result), and for attracting young parents-to-be – including health care providers – into communities that lack these services.

Participants pointed out that while urban systems are focused on overutilization, they have the opposite challenge in rural areas. Several providers offered anecdotes from their practices where underutilization was a matter of life and death and how a lack of ongoing disease management or prevention not only resulted in costly hospitalizations – as they might in an urban setting – but included the price tag of the life-flight to get a rural patient to a hospital able to handle complicated cases.

## Background on Critical Access Hospitals

The Hill-Burton program, authorized in 1946, provided federal funding for construction of public and nonprofit hospitals in rural communities. The program led to a significant increase in the number of rural hospitals in the country, particularly in the South. In 1983, responding to significant increases in Medicare hospital spending, Congress mandated use of fixed predetermined reimbursement rates for hospitals through the Medicare Hospital Prospective Payment System (PPS). Following the adoption of PPS, many rural hospitals closed in the 1980s and 1990s. In response to growing concerns over rural health care access, CMS implemented the Medicare Rural Hospital Flexibility Program of 1997 (Flex Program), which authorized payment of inpatient and outpatient services on a “reasonable cost basis” for hospitals designated as Critical Access Hospitals (CAHs). To be classified a CAH, a hospital must have no more than 25 inpatient beds and must be at least 15 miles by secondary road and 35 miles by primary road from the nearest hospital.

**CAHs are Central to Many Rural Areas, but Not Essential:** The most common service model in rural areas is the Critical Access Hospital (CAH), due to current regulations and available reimbursement (see box above). For many years, CAHs have been the leading health care delivery model in rural areas. CAHs traditionally provide emergency, inpatient, and outpatient services. However, there is rising concern over the closure of these hospitals.<sup>18</sup> Participants in this project struggled to reconcile their opinions that CAHs are no longer the most efficient way of delivering care in rural areas with concerns that closing the hospitals would still create access issues for communities and would have a negative effect on local economies. Having the ability to adjust the CAH model to fit the needs of individual communities was frequently brought up in interviews; for example, some communities need the local hospital to have inpatient beds, while others do not.



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**CAHs and Rural Hospitals are Tied to the Local Economy:** Stakeholders described how many of these hospitals are the economic lynchpins in their communities, and frequently the main employer in the area. A closure of a rural hospital does not solely reduce access to care, but can also substantially impact the local economy through job loss and stifling growth. This leads to instances in which some communities might not be able to support a hospital, but the hospital is necessary for supporting the community, resulting in a conundrum with differing opinions and a lack of clarity on what should happen next.

## SOLUTIONS AND OPPORTUNITIES: RETHINKING THE SERVICE SET

**Rightsizing can meet local needs while reducing inefficiency:** Stakeholders generally agree that a full-service Hospital may not be appropriate for a community, but recognize the need to maintain vital emergency services for the surrounding communities: hospital ‘right-sizing’ was a common topic throughout interviews and roundtables, particularly as it relates to closures of CAHs. Multiple stakeholders believe that hospitals should gauge the specific community they are serving and adjust the CAH’s services to better suit the true needs of the local area. For cases where a full-service hospital is not necessary, stakeholders see the potential for a new organizational form, with services that lie on the spectrum between hospital and



primary care. Hospital stakeholders indicated that many Hospitals would welcome, rather than resist, the opportunity to shift their service set in this manner. In addition, stakeholders talked about strengthening the foundation of primary care, highlighting that that primary care and preventive care does not just begin and end with outpatient clinics: Hospitals and other organizations can help create a culture of prevention and play a role in population health improvement.

**Encouraging Local Care Strengthens Rural Communities:** A concern for many rural communities was the ‘out migration’ of residents to health systems in other areas. In order to maintain the CAHs in their communities, hospitals need to adjust their services so they can use their facilities in a way that allows them to care for patients locally for longer as a way to increase financial viability and better manage patient care. Suggestions include adjusting rules around swing beds, or allowing acute-care patients to stay longer than 96 hours, on average, before a transfer to another hospital, as current regulations require.

**Flexible Policies are Necessary to Support a Community-Focused Effort:** Rural stakeholders emphasized that there can be no “one-size-fits-all” policy; even rural communities and health care organizations vary substantially, and this variation should be considered when attempting to engage in systems re-design. Locally-driven innovative solutions were widely pitched as the most effective way to make progress on rural health care issues, and stakeholders want policies to be flexible enough to be adapted to each community; community needs assessments were identified as one way to determine what services a particular area needs the most. Stakeholders clarified that they were not proposing unreasonably bucking standards and regulations entirely, and conceded that overly-complex policy solutions can be problematic in their own way. Nonetheless, the need for flexibility to engage in systems re-design that meets the specific needs of their communities was a near universal theme in both the interviews and the roundtables.

The issue of the mismatch between blanket policy and varying community and organizational needs applies directly to rural hospitals. Policy discourse around CAHs and other rural inpatient facilities tends to be monolithic, and ignores the fact that hospitals need different kinds of support and stipulations. We learned that some CAHs are already far along in their transformation efforts, while others lag far behind and are in serious danger of failure (with most falling somewhere in between). These different cohorts require different kinds of policy support.

## CURRENT FEDERAL POLICY MOMENTUM

Legislative proposals have been put forth to address the issue of CAH closures and to promote the reconceptualization of hospitals’ roles in rural communities:

- **The Rural Emergency Acute Care Hospital Act:** Key policymakers such as Senator Grassley (R-IA) have introduced proposals to start a conversation on “new models” for rural health systems. Specifically, the “Rural Emergency Acute Care Hospital Act (S.1130)” envisions transforming certain CAHs from small centers of inpatient care to rural emergency centers under the theory that not all communities need or can afford to maintain the broader set of services offered by CAHs.
- **The Save Rural Hospitals Act:** The Save Rural Hospitals Act (H.R.3225) was introduced in the 115th congress with bipartisan sponsorship from U.S Reps. Sam Graves (R-Mo.) and Dave Loebsack (D-Iowa). It proposes to provide rural hospitals with financial relief by eliminating any Medicare sequester for rural hospitals, and it provides a permanent extension of the Medicare rural ambulance and “super-rural” ambulance add-on payments.<sup>f</sup> It will also establish a new hospital designation for CAHs that would allow them to provide emergency and outpatient care.

**From Understanding the Needs of the Community to Funding the System.** Once communities are able to understand the unique needs of their own residents and build a system that is reflective of those needs, health care systems need to fund the services they hope to provide. However, funding for rural health care can be unstable and lead to undesirable impacts because it has not been adapted to unique rural needs. Funding must be planned appropriately and executed carefully.

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<sup>f</sup> Beginning in 2014, and extended regularly through “Medicare extender” legislation, the Social Security Act (SSA) provides for Medicare bonus payments for ground ambulance services that originate in qualified rural areas (called “super-rural” areas – areas that represent the lowest quartile of population density). The SSA also provides for a temporary increase in the Medicare ambulance fee schedule rates for ground ambulance services otherwise established for the year, including those originating in a rural area – in addition to the super-rural add-on payment. See: SSA §1834(l)(12)(A); 42 U.S.C. §1395m(l)(12)(A) and SSA §1834(l)(13)(A); 42 U.S.C. §1395m(l)(13)(A).





## Create the Rural Funding Mechanisms

### KEY TAKEAWAYS

- Current reimbursement reforms are designed for higher-volume areas, and rural delivery systems can't participate, widening the equity gap.
- Rural communities want opportunities to innovate, and need funding mechanisms that reflect their realities.
- Networking and collaboration among rural organizations that create economies of scale and improve coordination are vehicles for innovation.

### CURRENT CHALLENGES

**There Is Not Enough Volume for Value:** Many hospitals simply do not have the volume required for financial sustainability. In South Dakota, we heard that the Average Daily Census (the measure that hospitals use to track the number of patients per day), was around 5 individuals for CAHs. Stakeholders indicated that small populations and low patient volume not only threaten the financial sustainability of hospitals, it also precludes most rural health care organizations from participating in transformation initiatives more generally: an exclusion that they perceive will tangibly widen the gap between them and the more urban systems. This exclusion is also perceived as symbolic, sending a detrimental message to rural delivery systems: There is little confidence in their abilities, and they have been deemed too unsophisticated to innovate.

There are multiple challenges for rural health care delivery organizations in the transformation arena. First, one of the pillars of innovation – pay-for-performance – ties dollars to quality metrics, which can be particularly variable and misleading in situations with a low patient volume. As one stakeholder explained, if a rural hospital only has two patients, and one of them falls, then the fall rate comes in at 50 percent. This makes accountable care organization (ACO) participation extraordinarily difficult for rural organizations. Moreover, because few rural ACOs exist, rural organizations that wish to join an ACO often have difficulty finding partners, and sometimes look out-of-state to do so. A few stakeholders representing rural hospitals that were participating in ACOs did report improvement in coordinated care as a result of the initiatives, but were financially dependent upon the urban hospitals within their networks because their low volume made shared savings impossible.





**Some Communities Have Health Care Assets, but Coordination Isn't Happening:** Many rural regions have multiple federal programs and entities that don't work with one another, and especially don't work with private CAHs and other parts of the rural health care infrastructure. This is a critical barrier for advancing rural health systems: Coordinated care is a fundamental principle of health reform, a key tenet of new financing models, and a way to produce financial resources to support organizational investment and transformation. Several stakeholders noted that, in a small rural community with a limited volume of patients available to sustain local health care organizations, lack of collaboration, or direct competition between entities can be detrimental to all parties – including the patient. Participants described how coordination with the Veterans Affairs (VA) hospitals or the Indian Health Service (IHS) can be particularly difficult; for example, providers at IHS hospitals cannot attend rounds at local non-IHS hospitals, even if their patients have been transferred to the other hospital and would benefit from continuity in care. While the expansion of new payment models into rural delivery systems might encourage consolidation into large health systems or smaller-scale hospital networks, there are barriers to doing so. These include Medicare requirements on the distribution of payment for overhead from hospitals to outpatient facilities, and perceptions by some federal agencies that consolidation is anti-competitive.

Even in cases where different organizations do seek to collaborate, there are technical barriers regarding electronic health records (EHR) that make coordination difficult. Many organizations have different EHR systems which will not “talk” to one another (i.e. they are not “interoperable”), which adds another layer of difficulty to sharing and communicating patient information. One stakeholder expressed a desire that all health care organizations use the same EHR system, although also acknowledged how expensive it is to switch to a new system.

**A Lack of Payment Diversification:** In most rural areas, a large percentage of the reimbursements hospitals receive come from Medicaid and Medicare, with some participants estimating that approximately 80% of rural hospital payments come from these sources; additional sources of reimbursement include other federal programs, such as IHS. Very little of the total reimbursements come from private payers. This lack of diversity in the payment mix means that already-vulnerable CAHs are particularly susceptible to any changes in Medicaid and Medicare reimbursement or payment system transformations; without the buffer of payment from private payers, cuts to the programs can have a substantial impact on rural care providers and organizations.

Further, because of the number of uninsured or underinsured individuals in rural areas, CAHs perform a great deal of “charity care” for which they do not receive reimbursement. Medicaid expansion helped prevent some CAHs from closing by reducing the amount of bad debt the hospitals accumulate when treating uninsured patients. Stakeholders from states that did not expand Medicaid indicated that unreimbursed care causes hospitals significant problems, which could be alleviated with higher rates of Medicaid coverage for individuals within the state. Potentially exacerbating these challenges, ACA-mandated cuts to Medicaid Disproportionate Share Hospital (DSH) payments – used to offset the costs of uncompensated hospital care – are scheduled to go into effect beginning this year: \$2 billion in FY 2018, growing by \$1 billion annually until cuts reach \$8 billion in FY 2024 and 2025.

## **SOLUTIONS AND OPPORTUNITIES: PAYMENT SHOULD BE REFLECTIVE OF RURAL REALITIES**

**Rethinking the Metrics:** Rural stakeholders are eager for opportunities to participate in demonstration programs to test innovative payment models and employ new quality standards, with the caveat that participation requires rural-specific metrics or some protection against downside risk. There was broad agreement that policies should account for the disproportionate administrative burden of applying for and holding demonstration grants as well as more general quality reporting. These are large administrative tasks; unlike urban organizations, small, understaffed rural organizations rarely have the staff and resources to handle this type of reporting, and therefore need to invest substantial resources into developing this capacity in order to participate in the programs at all. Rural organizations are less likely to have available full-time employees to absorb the administrative burden the programs would require. We heard many examples of hospital administrators and other providers having to “wear multiple hats;” the scope of their roles can increase untenably because they shoulder additional tasks when their organization does not have the ability to hire someone else to perform the job.

**Encouraging Innovative Payment Models:** In addition, stakeholders indicated that they were unable to participate in many of the CMS Center for Medicare and Medicaid Innovation (CMMI) models, not only because many of these programs require value-based payment (VBP), but also because many rural organizations do not meet the minimum number of patients required to participate. For example, Comprehensive Primary Care Plus (CPC+) program is a model that would strengthen rural primary care organizations, but rural organizations lack the minimum number of patients (150 attributed Medicare fee-for-service beneficiaries) required to be part of the program. Moreover, as mentioned above, participating in these models also requires the capacity to meet reporting guidelines, which is often burdensome.

As it stands, the cost-based reimbursement used to support CAHs can prevent hospitals from investing in population health-oriented programs. One stakeholder indicated that, since a focus on improving the health of the community is not reimbursable and actually may decrease patient volume even further, the CAHs have no incentive to, for example, set up a community wellness center.

Although we heard some examples of rural health care organizations hoping to wait out overarching transformation efforts and continue to deliver care as they currently are, this was an infrequent approach. Most stakeholders recognized the benefits of ACOs, VBP models, and other related innovation demonstrations, and want a chance to do similar transformation work, as long as the models and metrics are viable for their situations.

**Networking and Collaborative Partnerships:** Stakeholders described how connecting rural health care organizations to larger health systems creates economies of scale and can remove barriers around volume-related penalties under quality metrics. Networks were cited as a vehicle for rural ACO participation, and further facilitate the ability of rural health care organizations to participate in demonstration programs because networks can incorporate the support of the consolidated entity to help manage grant administration and reporting burdens. A larger network is also more likely to bring all organizations under its umbrella on to the same EHR system allowing organizations to share information.

Some stakeholders represented rural organizations that were already taking advantage of creating such networks. The benefits were not limited to the opportunity to participate in demonstration programs: We heard examples of how networks and other cross-organizational collaboratives can leverage scarce resources when they are combined across partners, from equipment (e.g., mobile screening units) to personnel (e.g., locum networks of nurses, or specialists hired by multiple hospitals). The larger entity can also negotiate better rates from payers that can be passed along to smaller, rural hospitals. We also learned how these networks made organizations more financially stable, because the system as a whole provided a buffer against single organizations having poor financial performance in a year.

In some cases, these networks have resulted in community-oriented systems that are well-poised to make real impacts on population health (one of the goals of delivery system transformation in general). For example, organizations have created close ties with community partners, either by putting community leaders on hospital boards, or by establishing a degree of shared governance between adjacent hospitals and community health clinics. Stakeholders warned, however, that creating the formal or informal organizational ties required to benefit from a network is difficult work; they identified leadership as a critical component to successful partnership building and overall innovation.

## A Networked System with Flexibility for Rural Organizations

Mercy Health Network (MHN) is a system of health care services providing care to 30 percent of Iowans. The regional system based in West Des Moines, IA consists of 43 hospitals and 230 clinics in Iowa and surrounding states. MHN employs a successful balance between supporting their rural organizational partners and allowing them the flexibility to meet the needs of their community. MHN provides management services, group purchasing, and payer contracting as well as features a centralized patient transfer system so the rural hospitals can track their patients if they are sent to a larger, urban facility. The entity also manages a \$10 million CMS Innovation (CMMI) grant that was awarded to test ideas on how to improve rural population health, removing the administrative burden from the rural hospitals themselves. The centralization benefits the participating rural hospitals but does not require rural hospitals to relinquish control. MHN appreciates the fact hospitals are a source of community pride and has designed symbiotic relationship options which create access to the benefits of health system scale while preserving local control and autonomy.

## CURRENT FEDERAL POLICY MOMENTUM

- **Draft Legislation Establishing a CAH VBP Program:** The National Rural Health Association, with other partners, has helped develop draft legislation to establish a CAH VBP program. The program is designed to give CAHs an on-ramp to move into VBPs. Under the proposal, CAHs participate voluntarily, and would receive a 2 percent increase in Medicare reimbursement for submitting quality data. (They are currently not required to do any quality reporting.) The additional reimbursement would be intended to help them prepare for years three to five, in which they would be required to join an ACO.



- **Rural Extenders:** In late 2017 and early 2018, we again saw the very set of Medicare payment policy “rural extenders” that originated in the Medicare Modernization Act under debate as part of broader conversations on extending the Children’s Health Insurance Program (CHIP) and other expiring policies and programs.<sup>19</sup> Once again, these considerations do not include debate around transformative rural health care policies. However, other federal bills and other policy measures (described below) have already been proposed to reverse the carve-out of rural health systems in demonstration and innovation opportunities, and to encourage rural participation in quality-based payment models, including ones that would adapt measures to be more appropriate for rural areas.
- **Legislative Approaches:** A new crop of rural congressional leaders has emerged who together are focused on further strengthening the rural health care system. Last Congress, several senators introduced a set of three bills that broadly addressed challenges in rural health care.<sup>20</sup> Given stakeholders’ expressed desire for more opportunities to participate in delivery system reform, of particular relevance was one piece of this legislation that would set forth a process to establish a core set of quality measures relevant to rural health care services and communities. The legislation would also provide additional grant funding for technical assistance related to quality-measurement activities in CAHs and would tie this funding to reporting on quality performance over time. In addition, the legislation would direct CMMI to test VBP models for rural providers. The legislation does not include any new or additional quality-reporting requirements for rural providers.
- **The National Quality Forum:** The National Quality Forum (NQF) recently convened a set of rural stakeholders tasked with examining quality measurement in rural systems. This effort led to the release of an NQF rural-focused report that set forth a series of steps to move rural providers into quality performance programs.<sup>21</sup> Stemming from this work, NQF will soon begin a project to develop a “core set of rural measures” that will be rural-relevant and could serve as a basis for tying rural health care provider quality performance to payment and new delivery models.<sup>g</sup>
- **Rural Innovation Models:** Several stakeholders identified Pennsylvania’s Rural Health Model that launched in 2017 through CMMI as a thoughtful approach to rural health care reimbursement that could be scalable to other states because of the design of its global budget model and the opportunity for rural hospitals to create community-specific transformation plans. As such, Pennsylvania could serve as a model for other CMMI-based demonstrations around VBP for rural providers. Stakeholders cautioned that Pennsylvania’s experience should be carefully evaluated; any expansions of new payment models should be supported by evidence, since the impact of the innovations are still unclear.

## Pennsylvania’s Rural Health Model & CMMI Demonstration Program

PA will receive \$25 million over 4 years from CMMI to support the implementation of an all-payer global budget model for rural hospitals. Participating hospitals, including both CAHs and acute care hospitals in rural PA, will use the global budget model to assess whether the predictable nature of the budget allows them to invest in quality and preventive care. Hospitals will receive a fixed amount, set in advance, for inpatient and outpatient hospital-based services; this will be paid monthly by Medicare fee-for-service and other participating payers. All-payer global budgets for each hospital will be prospectively set each year based on historical net revenue for the services.

As part of the program, hospitals will redesign delivery so that it is better tailored to their communities; each hospital will plan changes by preparing a Rural Hospital Transformation Plan that will be approved by the state and by CMS. The purpose of the delivery redesign is to improve quality of care, increase access to preventive care, and create savings to the Medicare program for the rural communities.

PA will use CMS funds to oversee the model, aggregate and analyze data, submit reports, administer global budgets, and approve Transformation Plans, as well as provide other supports to participating hospitals. The program launched at the beginning of 2017 and will conclude at the end of 2023.

<sup>g</sup> More information on this work available at: [http://www.qualityforum.org/MAP\\_Rural\\_Health\\_Workgroup.aspx](http://www.qualityforum.org/MAP_Rural_Health_Workgroup.aspx).

- **Additional Policy Efforts:** While these efforts have been underway, there has also been policy work related to developing the infrastructure to allow rural health providers to participate in new quality and delivery models. Other legislation has been introduced to expand rural beneficiary participation in ACOs by allowing beneficiary assignment to ACOs to also include services received at rural health clinics and federally qualified health centers (FQHCs).<sup>22</sup>

**From Payment Transformation to Creating a Thriving and Diverse Health Workforce.** Reinventing the payment models to better reflect rural needs ensures that organizations will be financially stable enough so that the right workforce can be recruited, trained, and hired, and gives organizations space to develop innovative workforce models, as well.





## Building a Sustainable and Diverse Workforce

### KEY TAKEAWAYS

- Rural providers are overwhelmed and burned out, but it's hard to recruit new providers to adequately meet the community's needs.
- The medical education system isn't providing much relief – there are limited opportunities for students to become interested in rural practice.
- There are viable solutions on the table that need more support, such as local “pipeline” programs and expanding new workforce models.

### CURRENT CHALLENGES

**Rural Providers Need Help, but It's Hard to Find and Retain:** While stakeholders understand that not every community can employ a wide-ranging degree of specialists for niche services, there are still workforce shortages for the providers that communities do need. We learned that these shortages are related to challenges around recruiting and retaining health care staff in rural areas; limited employment opportunities for providers' spouses, geographic and professional isolation, and insufficient housing choices all depress interest in rural health practice, particularly for providers with families. We also learned this shortage exists across the care staff spectrum, including primary and specialty care providers, nurses, technicians, ambulance drivers, and case managers. Some stakeholders cited comparatively lower pay as a disincentive for providers to practice in rural areas, which has led to the compounded disadvantage of having to offer higher salaries to recruit providers to rural organizations, despite having fewer resources than urban systems. Providers also move to rural areas with their families, so rural organizations are often competing not just on salaries, but on housing accommodations and educational quality.

Retention poses another substantial challenge for rural health care communities, according to stakeholders: Even after a new provider or care staff is recruited and integrated into an organization, many tend to leave within a few years due to burnout and isolation. Many physicians are not trained for or exposed to rural practice during their residency, so often the realization that they are the only practitioners for a large area is overwhelming, given the expectation that they will be “on call” 24/7 and that they will need to oversee the ICU and ER, even if they were only trained in family practice or primary care.



**Medical Education Ignores Rural-Specific Training and Opportunities:** In recent years, rural workforce shortages or specifically, the role of Medicare Graduate Medical Education (GME) have not been a key focus of policymakers. We heard from some stakeholders that one problematic aspect of current GME policies relate to medical residency caps, established by the Better Budget Act of 1997. Because medical schools have a limited number of residency slots, they often reserve them for specialists, as these residencies pay more than primary care. This leaves limited residency slots for training primary care physicians. Moreover, residents are committing to employers earlier and earlier; rural hospitals need to begin recruiting while students are in medical school in order to be competitive, which is often difficult given rural hospitals' lack of resources.

We also heard that getting future doctors exposure to rural health care is limited. One participant explained that over 80 percent of medical students are trained between DC and Boston. With most practicing within 100 miles of where they trained, it makes sense that there is a shortage of rural health care providers. Furthermore, some felt that the current medical school culture (the "hidden curriculum") downplays the importance of primary care by not exposing their students to as many practitioners in this area as they do in sub-specialties.

## **SOLUTIONS AND OPPORTUNITIES: MEDICAL EDUCATION AND WORKFORCE TRANSFORMATION**

**There are Opportunities to Create Rural-Focused Medical-School and Graduate Medical-Education Programs:** Stakeholders with expertise in workforce development highlighted the need for more rural-residency tracks to alleviate workforce shortages. These tracks are opportunities for new providers to be exposed to rural practice and increase the chances that they would choose a rural location to practice in. Students from rural areas are more likely to choose and to stay in rural practice. Initiatives are underway to recruit more rural students to medical school as well; for example, the WWAMI program (an acronym representing the states it serves) reserves spots for rural applicants from Washington, Wyoming, Alaska, Montana, and Idaho in order to give opportunities for those students to practice in rural medicine. The program also offers training tracks that include rural clinic rotations so that students are exposed to rural medical practice while in school.

Participants also expressed a need for GME programs to offer more opportunities for residents to be exposed to the rural health care setting. GME funding often flows to specialty programs, causing a shortage of primary care programs and, in particular, rural-focused programs. The funding mechanisms for these programs should be examined so that there are more opportunities for rural exposure.

### **Creating Educational Opportunities for Rural Residents**

WWAMI states - Washington, Wyoming, Alaska, Montana, and Idaho - partner with the University of Washington School of Medicine to educate a fixed number of medical students from, and for, their state. At one of the roundtables, we heard that because Wyoming and Montana have no medical schools, the partnership is critical to helping these states educate their future physicians. The WWAMI program reserves twenty seats each year for qualified Wyoming residents and thirty seats each year for qualified Montana residents. Students complete the initial phase of study in their home state university: in Washington State, University of Washington or Gonzaga University; University of Wyoming; University of Alaska-Anchorage; Montana State University; and University of Idaho. After the initial Foundations Phase, a 12-month Patient Care Phase, and a 15-month Career Explore and Focus Phase, students complete clinical rotations in a variety of sites within the five-state region. Many of the program participants return to practice medicine in their home states.

**Local Pipeline Programs Need Support:** Stakeholders also look to longer-term solutions to invest in future providers. Pipeline programs that encourage rural students' interest in health care were identified as particularly important; these programs provide an opportunity for middle through high school students to be exposed to the health care industry and career opportunities. The programs are important to long-term recruitment strategies in rural areas because providers and care staff willing to live and work in rural and frontier areas, despite the unique challenges, usually come from rural areas themselves. Stakeholders stated that it is necessary for high school students to get involved in their community and feel connected, so that they want to come back to live and work there after they are done with school.



## Home-growing the Next Generation of Rural Providers

We learned about how hospitals and health systems are investing in the future rural workforce by engaging younger members of their community. Campbell County Health in Gillette, Wyoming offers “Camp Med” as a way to get 11-12 year olds exposed to the field of health care. In North Dakota, Trinity Health has adopted many strategies, including donating their old medical equipment to a middle school lab so that students learn about the field. Stakeholders believe pipeline programs offer a broader sense of career opportunities, and encourage local youth to strive for greater educational and professional achievement.

Stakeholders in states or communities with pipeline programs indicated that these efforts were largely funded by state or local dollars, including investment from private organizations. There is no federal support for these programs, and many are created through local partnerships between local health centers, schools, and universities and colleges. Pipeline programs are more than just for recruiting; they are an opportunity for students to learn and become interested in a medical career through hands-on experience (shadowing at the local health center) or be sponsored by a local organization to obtain a medical degree.

**Embracing New Workforce Models = More Human Resources:** Stakeholders accept the reality that rural areas cannot support a large number of highly-paid physicians, particularly specialists, as part of the health care workforce, and are instead developing creative solutions to best serve their community using human resources that already exist. All the Upper Midwest states we examined have expanded the scope of practice for Nurse Practitioners to allow them to function as independent providers without direct supervision by a physician. Other states are also considering expanding pharmacists’ scope of practice so that they can coordinate medication management. Stakeholders mentioned that these efforts can be thwarted by various provider associations seeking to limit what type of practitioner can perform certain services.

In addition to expanding the scope of practice of traditional medical providers, rural areas are seeing the importance of investing in providers to address social needs, as well as medical ones. Organizations are considering hiring community health workers (CHWs), case managers, and care coordinators who can mitigate patient access issues by traveling to them, and help to better connect them to medical and other types of resources. This type of service is especially important in addressing the rapidly aging rural population; nursing homes are expensive to reimburse, and most community members prefer to stay in their homes. Having in-home models of care supported by a mobile service staff can ensure that these community members are aging safely in their homes for as long as possible. Incorporating CHWs into the care model, in particular, was identified as a promising step in addressing non-clinical needs of patients that often drive over-utilization; while many organizations wish to employ CHWs, they do not have the funds to do so, and grants do not provide sustainable support. Reimbursement for CHWs and other types of providers will need to be addressed before services from such providers are affordable. Stakeholders see the potential for Medicare to be used as the “lever” to expand the non-traditional workforce. If Medicare employs more flexible billing practices that support roles like CHWs, stakeholders suspect that other payers would do the same.

## CURRENT FEDERAL POLICY MOMENTUM

Beginning in the last Congress, policymakers have come together to develop a new set of ideas to increase access and improve quality, many of which focus on the expansion of telemedicine and, to some extent, on bolstering the rural workforce:

- **Series of Bills from Rural Health Care Congressional Leaders:** In the previous section we discussed a series of bills introduced by Senate Rural Health Caucus leaders. These bills include provisions to alleviate access issues in rural areas. Specifically, they would revise rules to allow transportation services in Medicaid as a way to strengthen access to care in rural communities and would prioritize rural transportation projects within the Department of Transportation. In addition, the legislation would establish an Interagency Task Force on Rural Health Information Technology focused on increasing internet access in rural areas.

The legislation would also set forth a host of policies related to the rural workforce. Proposals include revising medical residency and rural training track programs to expand the list of eligible participating facilities, proposals to direct the Secretary to distribute any used graduate medical education (GME) positions to rural institutions and provisions to reauthorize the Primary Care Residency Expansion Program and the Area Health Education Centers program. The legislation also would expand loan forgiveness programs to include dental therapists and community paramedics as a way to increase access to these services in rural and underserved communities.

- **Workforce Legislation:** Other legislation has also been recently introduced related to the rural health care workforce. This includes legislation that would require Medicare to reimburse medical residency training that occurs in Critical Access Hospitals.
- **Other Legislation:** Legislation has also been introduced related to expanding access to specific services in rural areas, including hospice and anesthesiology care.<sup>23</sup> Finally, there is also legislation pending to reauthorize funding for Medicare low-volume hospital and Medicare Dependent Hospital (MDH) programs.<sup>24</sup>

**From a Home-Grown Workforce to Providing Rural Health Professionals with the Right Tools.** For many new health professionals, working in a rural setting comes with unique challenges not faced in urban areas. Rural health professionals benefit from the right tools that allow them to do their job on par with their urban counterparts.





## The Tools and Technology Needed for Success

### KEY TAKEAWAYS

- Telemedicine technology helps providers by connecting them to a peer network that helps prevent isolation and burn-out in rural practitioners.
- Remote access to specialists improves access for patients and decreases the number of patient transfers, which is beneficial to both the patient and the local hospital.
- Despite its enormous potential, barriers like lack of training, reimbursement standards, and broadband connectivity exist for expanding telemedicine services in a rural area.

### CURRENT CHALLENGES

**Education and Training on Telemedicine is Lacking:** Providers and support staff who are not exposed to telemedicine can be reluctant to use it. Some medical schools, such as the University of South Dakota via Avera eCare eHelm and the University of Iowa, are starting to incorporate training on telemedicine into their curriculum.

**There are Concerns about Duplication of Services:** Stakeholders cautioned that telemedicine services had the potential to replace or duplicate local capacity to the detriment of the community; the services should be carefully implemented so that they augment and support local capacity only.

We also learned that some of the friction around expansion of telemedicine comes from provider groups who are concerned that telemedicine will cut into their market share of patients. As we heard so often throughout the interviews and the roundtables, rural communities are often collateral damage in this fight: Market share is an urban-oriented concern in which telemedicine would increase choice and therefore competition for patients. In rural communities, providers are the scarce commodity.

Participants also pointed out that tele-services are limited for patients in need of inpatient care, and reimbursement for in-home telemedicine services or facilities where patients can receive treatment are still necessary, even if telemedicine services are offered, particularly for behavioral health care.

**Reimbursement Models Lag Behind the Technology:** Reimbursement was frequently identified by stakeholders as a major barrier: Payment approaches vary depending on the type of payer (private, Medicare, Medicaid) and the type of service. For example, not all payers have parity between telemedicine and in-person visit reimbursements and there are no standards regarding how to reimburse both the virtual provider and the on-site provider (or host hospital). Private payers often change their policies on reimbursement, and both private and public payers implement limits on what types of telemedicine services they will reimburse. For example, Medicare fee-for-service restrictions set limitations related to geography or rules around defining the home as an “originating site.”

Some, but not all, states have begun to address some of these deficiencies; four states in the Upper Midwest have parity laws for telemedicine services (MT, ND, NE, and MN), Iowa has a proposed parity law, and South Dakota and Wyoming have no legislative activity regarding parity.

**Licensure Laws Can Limit Telemedicine’s Reach:** State licensure rules can prevent providers from practicing virtually across state lines. Some states have joined compacts, such as the Nurse Licensure Compact (NLC) or the Interstate Medical Licensure Compact (IMLC) for physicians. These compacts work in several ways; while the NLC offers reciprocity for nurses across signatory states, the IMLC simply expedites the licensure process for physicians, who must still be separately licensed in each state.

**The Infrastructure Doesn’t Always Exist:** In some cases, telemedicine use is infeasible because rural and frontier areas lack the broadband Internet access necessary for the services. Laying new lines, fixing cut lines, and increasing speed are necessary steps to adoption of the services. Broadband is also expensive. Currently, the Universal Service Administrative Co. (USAC) Rural Health Care Program provides \$400 million in reduced rates for broadband and telecom services, and rural organizations rely on these funds to afford tele-services. Unfortunately, the funding cap was reached in 2016; as more organizations claim these reductions, including now-eligible long-term care organizations, USAC will have to apply higher rates to each entity to stay within the spending cap. Stakeholders are now concerned that if their rates increase, telemedicine services will become prohibitively expensive for rural areas. The Federal Communications Commission (FCC) has defined fixed residential (as opposed to mobile/wireless) broadband Internet access as having connections with 25 megabits per second (Mbps) download speeds and 3 Mbps upload speeds. According to the FCC’s 2016 *Broadband Progress Report*, 39 percent of rural Americans (23 million people), and 41 percent of Americans living on Tribal lands (1.6 million people) lack access to 25 Mbps/3 Mbps. By contrast, only 4 percent of urban Americans lack access to 25 Mbps/3 Mbps broadband. See Table 3 for broadband access in seven Upper Midwest states and the United States.

**Table 3: Broadband Internet Access in Seven Upper Midwest States and the United States, 2016**

State	All areas			Urban areas			Rural areas		
	Pop. Without Access	% of Total Pop.	Rank	Pop. Without Access	% of Total Pop.	Rank	Pop. Without Access	% of Total Pop.	Rank
United States	33,981,660	10%	--	10,551,623	4%	--	23,430,037	39%	--
Iowa	451,148	15%	32	76,830	4%	26	374,318	37%	21
Minnesota	641,787	12%	25	59,140	1%	3	582,647	43%	29
Montana	317,581	31%	49	54,888	9%	46	262,693	61%	42
Nebraska	304,018	16%	34	94,847	6%	40	209,171	51%	36
North Dakota	97,315	14%	31	11,294	2%	8	86,021	37%	21
South Dakota	92,406	11%	22	9,962	2%	8	82,444	26%	15
Wyoming	137,922	23%	44	10,802	3%	18	127,120	63%	46

**Note:** Broadband internet access is defined by the Federal Communications Commission as having access to internet download speeds of at least 25 megabits per second (Mbps) and upload speeds of 3 Mbps (25 Mbps/3 Mbps) for fixed internet services.

\*For rank (among all 50 states), a higher number represents higher proportion of the population without access.

**Source:** Federal Communications Commission. 2016 Broadband Progress Report. Appendix E – Americans Without Access to Fixed Advanced Telecommunications Capability by County. December 2016.





## SOLUTIONS AND OPPORTUNITIES

**With Thoughtful Implementation, Telemedicine Can Augment Local Capacity:** There was broad agreement that an effective way to support and augment the rural health care workforce is to supplement local services by connecting to remotely located providers using telemedicine technology. Telemedicine connects patients directly with providers who they would not otherwise have had access to. Hospital stakeholders offered anecdotes on how trauma telemedicine has saved lives in instances where the virtual connection of providers have afforded severe trauma patients precious minutes. Improving access to care improves local capacity to avoid patient transfers to larger hospitals in more populated areas, as well as out-migration of patients, where community members who travel to a larger town for specialty care choose to receive all of their care in the other place, rather than in their own community. Keeping community members in local health care centers bolsters the financial viability of those centers, and allows patients to stay near family and friends.

**Telemedicine Provides Support for Isolated Providers:** Stakeholders expressed belief that telemedicine services mitigate the access problem from both sides: On one hand, they connect local providers with other providers for education or consultation, reducing the sense of isolation. In places where access is limited because of the number of providers, telemedicine can offer relief for overworked rural practitioners, and stakeholders noted that telemedicine services address provider isolation by making a rural provider part of a virtual care team.

**Teleservices are Broad and Comprehensive:** Examples of the benefits of using telemedicine to connect patients with providers included tele-psychiatry services that can help alleviate the dangerous shortage of behavioral-health providers in rural areas. There has been success with remotely providing other behavioral-health services, such as medication-assisted treatment for patients with substance-use disorders. Also, because of the stigma around mental health care and the size of rural towns, patients could be dissuaded from seeking in-person treatment. As a result, tele-behavioral health improves access to treatment. In a small town, everyone would know whose car is in the parking lot of a behavioral health provider's office, but telemedicine delivered at a primary care facility or in a patient's home preserves privacy.

It should be acknowledged, however, that currently proposed federal bills, while making progress in some areas such as stroke and dialysis care, do not address the behavioral-health shortage concerns underscored by stakeholders.

## CURRENT FEDERAL POLICY MOMENTUM

- **The Chronic Care Bill:** The bipartisan Creating High Quality Results and Outcomes Necessary to Improve Chronic Care Act of 2017 ("CHRONIC Care Act" (S.870)) was developed over a two-year process with significant stakeholder input. The CHRONIC Care Act includes provisions to expand the use of telehealth for treatment of stroke and dialysis patients and also for use in ACOs. The legislation also seeks to expand the use of telehealth in Medicare Advantage plans.

Under current law, the Medicare program restricts payment for telehealth services based on the type of service provided, the location of services, the type of institution, and the type of health care provider. While there is nothing to preclude use of telehealth in ACOs, current law does not allow for a separate telehealth payment. The CHRONIC Care Act would lift geographic requirements as they relate to telehealth use in ACOs and explicitly allow beneficiaries assigned to Medicare Shared Savings Programs (MSSPs) or ACOs to receive allowable telehealth services in the home.

Regarding telehealth services for stroke patients (also called "telestroke" services), Medicare will currently pay for telehealth services furnished by a physician at a distant site only if the beneficiary is located in a rural health professional shortage area or county outside a metropolitan statistical area. The CHRONIC Care Act would lift this restriction by allowing Medicare reimbursement for telestroke services regardless of the geographic location of the beneficiary when they receive such care.

The CHRONIC Care Act includes a similar proposal related to dialysis care. Current law requires beneficiaries receiving home dialysis to receive a monthly assessment by certain clinicians. This assessment can be done via telehealth if the patient's visit occurs at a physician's office, in a hospital-based dialysis facility, or in a health-professional shortage area or in a county outside a metropolitan statistical area. The CHRONIC Care Act would expand the eligible sites to include freestanding dialysis facilities or a patient's home, and it expands the eligible geographic locations.

Finally, the legislation would modify rules regarding Medicare Advantage by explicitly allowing participating plans to include the provision of telehealth services in their annual bid amounts as a way to increase use of telehealth in the program.

The CHRONIC Care Act unanimously passed the Senate in late September 2017 and appears on track for enactment during the current Congress. While this is an important effort, the legislation does not make significant changes to how telehealth can be used (or reimbursed) in the broader, Medicare fee-for-service system.

- **The CONNECT for Health Act of 2017:** The bipartisan CONNECT for Health Act of 2017 (S. 1016) went even further than the CHRONIC Care Act by proposing a broader range of telehealth policy reforms. The legislation included ACO, telestroke, dialysis, and Medicare Advantage provisions that were similar to those eventually included in the CHRONIC Care Act (as described above).

In addition, the CONNECT for Health Act would expand the use of telehealth within Native American, rural health clinic, and federally qualified health center sites. The bill would also create a remote patient monitoring (RPM) benefit for certain high-risk patients and would allow use of telehealth and RPM in global bundled payments. The legislation also lifts some current restrictions on tele-mental health. Finally, it would study the use of telehealth and RPM within all current Department of Health and Human Services demonstrations and pilots.

- **The Centers for Medicare and Medicaid Services (CMS)** included provisions in two of its final 2018 payment rules aimed at expanding the provision of telehealth services in the Medicare program.<sup>25, 26</sup> These include new Medicare Physician Fee Schedule billing codes for remote monitoring and for telemedicine use related to lung-cancer screening, health risk assessments, psychotherapy for crisis, chronic care management, and interactive complexity. Also, the use of telehealth services can now help physicians meet clinical-practice improvement activities and receive incentive payments through the Quality Payment Program established as part of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

During the 115th Congress, many similar or companion telehealth bills were also introduced in the House, and those related to home dialysis, telestroke, and others are making their way through the House legislative process.<sup>27</sup>





## Conclusions

BPC's conversations with rural stakeholders revealed that they are committed to correcting rural/urban inequities around access, quality, professional development and job satisfaction for providers, sustainability, and opportunities to innovate as organizations/systems. In many ways, they have forged ahead with limited policy support and are already creatively addressing these problems using the resources at their disposal. They acknowledge that to improve rural health care, the necessary steps will be: rearranging the status quo and incorporating new thinking about what services communities need and how to best fund them; selecting workforce models that best serve the community; and identifying new technologies and tools that can be leveraged in these systems – all steps they are excited to embrace.

As the entire health care delivery system continues to evolve, the questions remain as to what policies will emerge to further strengthen the rural health care system. Taken together, there have been important policies enacted, along with others currently under consideration, which will improve access to care in rural communities; most of these efforts have enjoyed strong bipartisan and bicameral support. In many ways, these new policies are responsive to the collective concerns and ideas for progress posed by stakeholders in the interviews and roundtables. However, BPC also identified several gaps between what stakeholders need from federal policy and what is currently on the table.

The current proposed legislation addresses and supports some of the needs of rural delivery systems, as identified by stakeholders. These bills are somewhat piecemeal in their design: They are largely topic-focused, emphasizing telehealth or CAHs or quality metrics. Yet our stakeholder conversations revealed a significant number of interdependencies relevant for policy design, either because they show how smaller changes can be leveraged as the building blocks for larger transformation, or how the implementation of small changes might be dependent on the implementation of larger ones. A depiction of the challenges, opportunities, and interdependencies between them can be found in Appendix B. For example:

- Concern is rising around closures of CAHs and other rural hospitals. Reimagining new forms for CAHs and a more holistic picture of health services in the community not only mitigates the issue of hospital closure, it also provides an opportunity for hospitals to become more focused on primary care and prevention, and would accelerate delivery system transformation overall. It also gives an opportunity for the community to weigh in on the services the CAH would offer and the type of providers who would staff their local health center – as well as opportunities for better integration with the existing public health infrastructure and across multiple funding streams.

- Reimbursement is a multifaceted issue. For example, the challenges within telemedicine – the lack of standardization around who gets paid what and concerns about over-utilization and abuse – are relevant under a fee-for-service payment model. As such, rural movement toward VBP models are intrinsically related: Telemedicine might best be expanded underneath a capitated payment model, where it will be treated like an investment on the part of payers to improve quality. There is a similar connection with workforce development: Community health worker positions can be funded by payers under a capitated payment model. All of these issues link, full circle, to the structure and funding of local hospitals.
- Training the next generation of rural care providers ties into other developments in rural health care: Universities and residencies should expose providers early to rural environments and the tools (such as telemedicine) that could equip them to serve rural communities more effectively.
- Telemedicine connects patients with providers that they would not otherwise have access to, but stakeholders also emphasized that one of its primary benefits is its ability to alleviate workforce-retention issues by helping rural providers feel more connected to peers, reducing isolation, and mitigating the risk of poor patient outcomes due to inexperience. Telemedicine was seen as having the potential for compounded improvement on rural health care; many stakeholders were currently using telemedicine services through contracts with Avera Health and were touting the benefits of telemedicine after experiencing them firsthand.

More comprehensive policy that carefully considers the relationships between delivery system transformation and topic-specific issues like CAHs and telemedicine, as well as those topics' relationships with one another, will likely produce more effective results. In addition to identifying existing interdependencies, there are likely opportunities to *create* connections to drive change. What if the design of rural-specific quality measures included metrics and incentives for telemedicine? Or if the design could accommodate the need for new workforce models by changing hospital reimbursement? There is an opportunity to raise similar questions and identify new ideas, especially with input from rural stakeholders themselves. With the lessons learned from these discussions, and the commitment and energy of policymakers from rural and non-rural areas alike, the rural health system can be improved so that access to and quality of health care is not decreased simply because of geography.





# Appendix A: Roundtable Participants

The Bipartisan Policy Center would like to acknowledge all those who took the time to attend our roundtable discussions and participate in interviews with our team. Their contributions helped shape the direction and content of this report and we are grateful for their effort.

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Sakakawea Medical Center  
Coal County Community Health Center

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National Conference of State Legislatures

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**Ann Byers**

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**Kevann Campbell**

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Wyoming Primary Care Association

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Montana Hospital Association

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**Maggie Elehwany**

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Avera Health

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Margaret A. Cargill Philanthropies

**Chris Hopkins**

Montana Health Network

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University of Nebraska Medical Center

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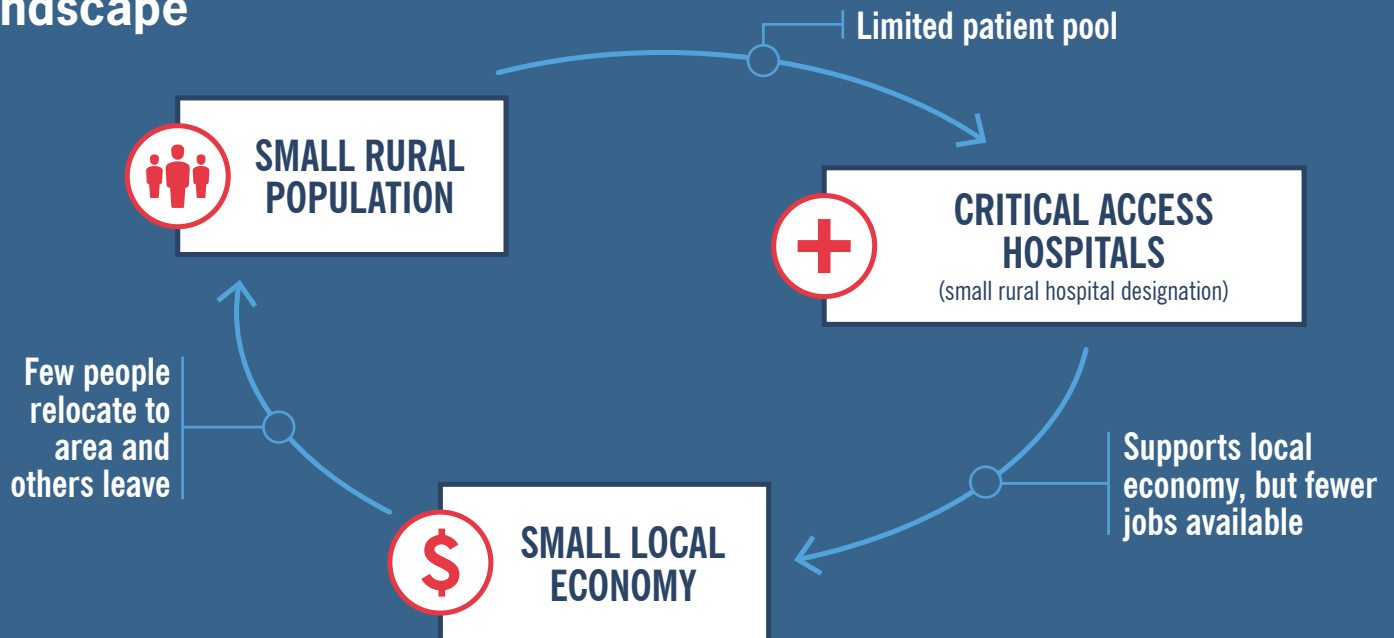
**William Yost, M.D.**

UnityPoint Health

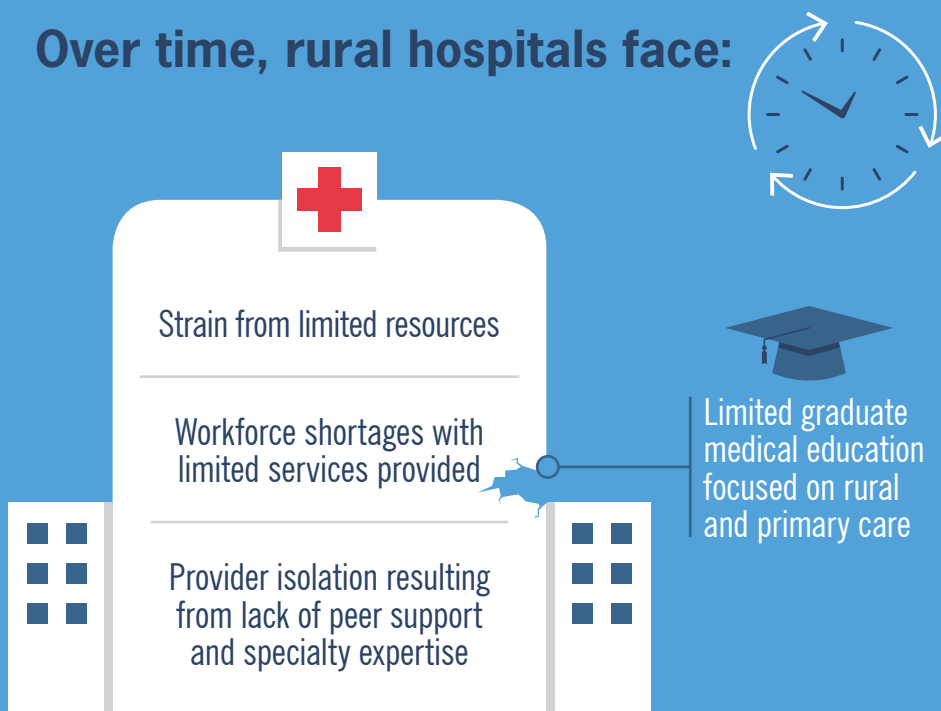
# Appendix B: Rural Health Care Challenges, Opportunities, and Interdependencies

The Bipartisan Policy Center hosted a series of roundtables and interviews with stakeholders to assess the challenges and gaps in rural health care across **seven Upper Midwest states: Iowa, Nebraska, Minnesota, Montana, North Dakota, South Dakota, and Wyoming.** The series concentrated on three major areas of focus – the rural health care provider workforce, critical access hospitals, and telemedicine. Often, policy solutions in these areas take a siloed approach to reform. However, **BPC found many inter-dependencies between the key challenges and opportunities that demand a more holistic approach to reform.**

## Landscape



## Over time, rural hospitals face:



## FOUR PRIORITY AREAS FOR RURAL HEALTH TRANSFORMATION

- Right-sizing hospitals and services to meet community needs
- Modernizing reimbursement and supporting innovation
- Developing workforce pipeline programs
- Utilizing telemedicine to connect providers



# Four Priority Areas for Rural Health Transformation

**Concern is rising around closures of critical access hospitals (CAHs) and other rural hospitals.**

Re-imagining new forms for CAHs and a more holistic picture of health services in the community not only mitigates the issue of hospital closure, it also provides an opportunity for hospitals to become more primary care - and prevention-focused and would progress delivery system transformation overall. It also gives the opportunity for the community to weigh in on the services the CAH would offer and the type of providers staffing their local health center, as well as opportunities for better integration with the existing public health infrastructure and across multiple funding streams.

**Reimbursement is a multi-faceted issue.**

For example, the challenges around telemedicine – the lack of standardization around who gets paid what, and concerns about over-utilization and abuse – are relevant under a fee-for-service payment model. As such, rural movement toward value-based payment (VBP) models are intrinsically related: telemedicine might best be expanded underneath a capitated payment model, where it will be treated like an investment on the part of payers to improve quality. There is a similar connection with workforce development: community health worker positions can be funded by payers under a capitated payment model. All of these issues link, full-circle, to the structure and funding of local hospitals.

**Training of the next generation of rural care providers ties into other developments in rural health care.**

Universities and residencies should expose providers early to rural environments and the tools (such as telemedicine) that could equip them to serve rural communities more effectively.

**Telemedicine connects patients with providers that they would not otherwise have access to.**

Stakeholders also emphasized that one of its primary benefits is its ability to alleviate workforce retention issues through helping rural providers feel more connected to peers, reducing isolation, and mitigating the risk of poor patient outcomes due to inexperience. Telemedicine was seen as having the potential for compounded improvement on rural health care; many stakeholders were currently using telemedicine services through contracts with Avera Health, and were touting the benefits of telemedicine after experiencing them firsthand.

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