IDEAS
ACTION
RESULTS

Confronting Rural America's Health Care Crisis

BPC RURAL HEALTH TASK FORCE POLICY RECOMMENDATIONS

April 2020

Bipartisan Policy Center

BPC RURAL HEALTH TASK FORCE MEMBERS

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CO-CHAIR
Former Senate Majority Leader
Co-Founder, BPC

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CO-CHAIR
Former Governor of Mississippi

Olympia Snowe
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Senior Fellow, BPC
Board Member, BPC
Former Senator, Maine

Tommy Thompson
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Senior Fellow, BPC
Former Secretary of HHS
Former Governor of Wisconsin

Georges Benjamin, M.D.
Executive Director, American Public Health Association

David Blair
Chairman, Accountable Health Solutions Inc.
Board Member, BPC

Henry Bonilla
Former Representative, TX-23

Kent Conrad
Former Senator, North Dakota

Karen DeSalvo, M.D.
Chief Health Officer, Google
Senior Fellow, BPC
Former Acting Assistant Secretary for Health, HHS
National Coordinator for Health Information Technology, HHS

Bill Frist, M.D.
Partner and Chairman, Cressey & Company
Senior Fellow, BPC
Former Senate Majority Leader

Chris Jennings
Founder and President, Jennings Policy Strategies
Senior Fellow, BPC

Jennifer M. McKay, M.D.
Medical Information Officer and Physician, Avera Health

Keith Mueller
Director, RUPRI Center for Rural Health Policy Analysis

Karen Murphy
Executive Vice President, Chief Innovation Officer, and Founding Director, Steele Institute for Health Innovation, Geisinger

Tom Tauke
Former Representative, IA-2

Gail Wilensky
Senior Fellow, Project HOPE
Former Administrator of the Health Care Financing Administration (now CMS)

STAFF

Morgan Bailie
Project Coordinator, Health Project

Tyler Barton
Research Analyst, Health Project and Prevention

Joann Donnellan
Senior Advisor, Communications

Katherine Hayes
Director, Health Policy

G. William Hoagland
Senior Vice President

Dena McDonough
Associate Director, Health Project

Anand Parekh, M.D.
Chief Medical Advisor

Marilyn Serafini
Director, Health Project

HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

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BPC would also like to thank the members of the Honorary Congressional Task Force on Rural Health who provided insight into the complex challenges rural communities face in accessing quality health care, Senator Chuck Grassley (R-IA), Senator Tina Smith (D-MN), Senator Bill Cassidy (R-LA), Senator Angus King (I-ME), Congressman Jodey Arrington (R-TX), and Congresswoman Xochitl Torres Small (D-NM).

DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders or its board of directors.

Site Visits

Over the course of this project, BPC and the Rural Health Task Force visited a number of rural facilities across the United States. We heard from health care administrators, medical providers, and hospital and clinic staff about the health care challenges and needs in their community. These site visits were instrumental in developing thorough policy recommendations. BPC would like to thank the following:

Dartmouth-Hitchcock Health
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Knoxville Hospital and Clinics
Knoxville, IA

MaineHealth
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Springfield, TN

Stephens Memorial Hospital
Norway, ME

UnityPoint Health
Des Moines, IA

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Executive Summary

The rapid spread of the new coronavirus has awakened the nation to the dire access problems that have long plagued rural communities and has underscored the need for immediate change. The COVID-19 pandemic has highlighted the fragility of the rural health care system, in which hundreds of hospitals have already closed or are in imminent risk of folding. The pandemic now threatens to heap additional financial pressures onto these hospitals, leaving millions in fear that they won't receive care.

COVID-19 prompted a flurry of legislative and regulatory action in early 2020, marking the first important steps in addressing access to care through telehealth. Some of these actions align with recommendations in this report. However, these measures were generally limited to temporary fixes, while the problems need long-term attention.

The Bipartisan Policy Center's Rural Health Task Force has developed recommendations over the last year to stabilize and improve the urgent problems challenging rural communities and to do it permanently. Launched in June 2019, the task force consists of health care experts, business leaders, physicians, and former elected officials. The aim was to produce policy recommendations to stabilize and transform rural health infrastructure, promote the uptake of value-based and virtual care, and ensure access to local providers.

The recommendations in this report are the product of extensive outreach, including roundtable discussions with experts and stakeholders, public comments, and multiple site visits in Iowa, Maine, Vermont, Wisconsin, Tennessee, and New Hampshire.

Even before coronavirus struck, rural Americans experienced significant gaps in care and a unique set of circumstances. They often must travel long distances to see a doctor or visit the emergency room. Rural communities struggle to recruit and retain health care providers and many areas aren't equipped with broadband. This makes it difficult for residents to make use of telehealth and virtual care technologies.

The rural population is older, sicker, and less likely to be insured or seek preventive services.[i,ii] According to the Centers for Disease Control and Prevention, this population is more likely than their urban counterparts to experience potentially preventable death from five leading causes: heart disease, cancer, unintentional injuries, chronic lower respiratory disease, and stroke.[iii] Maternal and infant mortality rates are also on the rise in these areas.

The steady stream of recent hospital closures launched rural health care into the national spotlight; COVID-19 has only drawn further attention to the plight of these hospitals and communities. Since January 2010, 126 rural hospitals have closed, and an additional 557 are currently at risk.[iv] Of the rural hospitals that closed from 2005 through 2017, 43% were more than 15 miles away from the next closest hospital and 15% were more than 20 miles away.[v] According to the Government Accountability Office, rural residents delay or neglect to seek care if they have to travel longer distances to access services after a local hospital has closed.[vi] This is particularly problematic for those who are geographically isolated, elderly, or low income.

The loss of a hospital in remote areas may lead to a decline in the number of local providers and reduced access to critical and specialist services, including obstetric and maternal care. Local economies are also significantly impacted. On average, the health sector makes up 14% of employment in rural communities, with hospitals typically being among the largest employers. The average Critical Access Hospital, or CAH, employs 127 people with an annual payroll of $6 million.[vii] Other data show that hospitals in larger rural communities have an average of 520 employees, while those located in smaller, more isolated areas employ an average of 138 staff.[viii]

In March 2020, as coronavirus evolved into a pandemic, Congress voted to temporarily waive telehealth requirements for Medicare providers, allowing the Centers for Medicare and Medicaid Services, or CMS, to reimburse clinicians for telehealth visits with patients at home in an area with a designated emergency. The Trump administration has built on this effort and temporarily expanded access to care by providing regulatory flexibility around the use of telehealth for all Medicare beneficiaries. The flexibilities that have been utilized to address this public health emergency highlight opportunities for permanent improvements to rural health care access.

In addition to addressing telehealth, the task force recommendations include short-term stabilization for struggling rural hospitals and multiple pathways to transform into models that are customized to meet the needs of individual communities. For example, following a comprehensive community needs assessment, a hospital might transform into a stand-alone emergency department with new outpatient capacity. A community that lost its hospital might see a new emergency department as part of its existing Federally Qualified Health Center, or FQHC.

The report also includes recommendations for enhanced payments to keep obstetric units open, and tax credits to encourage physicians and advanced practice clinicians, or physician assistants and nurse practitioners, to stay in rural communities.

The task force's proposals build on BPC's 2018 report, Reinventing Rural Health Care: A Case Study of Seven Upper Midwest States. That report described the

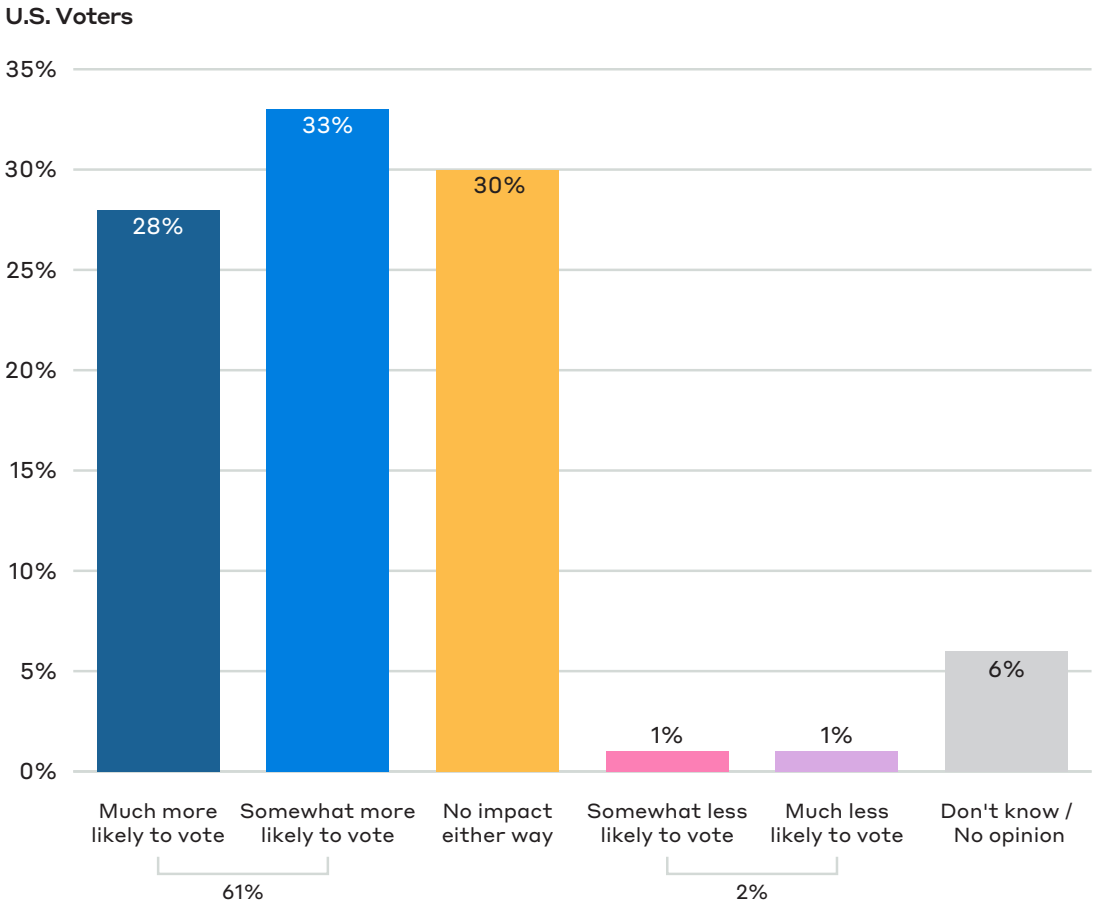
challenges of rural health care access and delivery, and highlighted opportunities for improvement, including:

- **Rightsizing Health Care Services to Fit Community Needs**: In order for communities to build tailored delivery services, policies need to be flexible and not just have a one-size-fits-all approach.
- **Creating Rural Funding Mechanisms**: Funding mechanisms and payment models should reflect the specific challenges that rural areas face, such as small population size and high operating costs per unit of service.
- **Building and Supporting the Primary Care Physician Workforce**: With the appropriate services and funding, rural communities can build a health care workforce that suits their needs.
- **Expanding Telemedicine Services**: As workforce models change, rural health professionals should be equipped with the tools necessary to provide quality care to patients.

Understandably, rural health care has emerged as an important issue going into the 2020 presidential and congressional elections. According to a poll by BPC and the American Heart Association, conducted with Morning Consult, a strong majority of voters in the United States said increasing access to health care in rural areas is important to them. In fact, 3 in 5 voters said they would be more likely to choose a candidate in the 2020 election who prioritized access to health care in rural America. Not surprisingly, we have seen rural health efforts from the Trump administration, Democratic presidential candidates, and Congress.[ix,x]

As part of our survey, more than half of rural residents (54%) said access to medical specialists, such as cardiologists or oncologists, is a problem in their local community, and more than one-quarter (27%) said it is difficult to access behavioral health professionals. Rural Americans are also more likely than their urban and suburban counterparts to agree that availability of appointments (56% vs. 50%) and the distance to receive care (50% vs. 37%) are barriers to health care.

Three in five voters (61%) would be more likely to vote for a candidate in the 2020 election cycle who says he or she will address access to health care in rural America. *Would you be more or less likely to vote for a candidate in the 2020 election cycle who says he or she will address access to health care in rural America, or would it have no impact on your vote either way?*



Source: BPC/American Heart Association poll (Morning Consult), 2019

Given the greater challenges to delivering health care services in rural areas, the task force recognizes that stabilizing and improving the situation will require new expenditures. While the first-year direct costs of recommendations in this report have not been fully estimated, those that have been are likely to exceed $1 billion. Therefore, Appendix A details possible ways in which to offset the cost of these proposals.

The collective issues that challenge rural health care span well beyond what the task force was able to consider for this report. For example, hospitals in states that did not expand Medicaid under the Patient Protection and Affordable Care Act, or ACA, are closing at a higher rate than those in expansion states.[xi] While insurance coverage is beyond the scope of this work, BPC offered additional recommendations in its 2020 report: Bipartisan Rx for America's Health Care.[xii] Additionally, the task force felt that broadband access, maternal

health, long-term care, oral health, and health care in Native American communities warrant more comprehensive consideration than was feasible in this report.

In addition, the task force acknowledges that what influences the health of rural Americans extends well beyond health care. While this report does not take a comprehensive look at rural social determinants of health including nutrition and housing, or specific rural public health topics including obesity, tobacco use, social isolation, or opioid use disorder, it does take into account that optimizing health outcomes will require tackling these challenges in addition to implementing the recommendations herein.

The task force offers the following recommendations.

RECOMMENDATIONS

1. STABILIZING AND TRANSFORMING RURAL HEALTH CARE INFRASTRUCTURE (PAGE 18)

1A. STABILIZING RURAL HOSPITAL AND CLINIC INFRASTRUCTURE (PAGE 19)

Provide immediate financial relief to rural hospitals.

- Provide rural hospitals relief from Medicare sequestration payment reductions (from FY2021-2023) and Medicare bad debt payment reductions (from FY2021-2023).
- Increase reimbursement for Medicare Critical Access Hospital, or CAH, services by 3% starting in FY2021.
- Re-establish the CAH necessary provider designation process.
- Make available capital infrastructure grants or loans that rural hospitals could use to modify service lines or improve structural or patient safety.

Make certain rural hospital designations or payment adjustments permanent.

- Take rural facilities out of the ongoing extender and needing to be renewed cycle.
- Make the Medicare Dependent Hospital designation permanent.
- Make permanent adjustments for rural hospitals receiving low-volume payments.
- Allow Sole Community Hospitals to permanently receive additional payment for outpatient services.

Allow new flexibilities around rural hospital care delivery and expand opportunities for rural hospitals and clinics to coordinate service offerings.

- Evaluate whether to modify and update the CAH 96-hour patient length of stay rule and provide increased flexibility around physician certification requirements.
- Clarify rules around co-location or shared space agreements that allow rural hospitals to partner with other health care providers.
- Enact payment reforms to shore up rural health clinics and expand access to advanced practice clinician services in rural clinics.
- Increase the Medicare-capped reimbursement rate for physician-owned rural health clinics.
- Allow advanced practice clinicians to work up to their state scope of practice in rural health clinics.

1B. TRANSFORMING RURAL HOSPITAL AND CLINIC INFRASTRUCTURE (PAGE 26)

Support rural communities in conducting a community needs assessment and developing an action plan.

- Establish a process for rural facilities and communities to develop a Hospital Transformation Plan as a first step in the transformation process.

Establish a Series of New Rural Transformation Models.

- Establish a new Rural and Emergency Outpatient Hospital designation that recognizes the shift away from inpatient centric care.
- Establish an Extended Rural Services Program.
- Advance new multi-payer, global budget models.
- Promote Centers for Medicare and Medicaid Innovation, or CMMI, initiatives to increase coordination and integration of rural hospital and clinic services.

Support Opportunities to Advance Rural Health Care Quality.

- Require all rural hospitals to begin reporting on a core set of rural relevant quality measures.
- Study and offer recommendations on establishing a quality reporting program for rural health clinics.

2. TRANSFORMING CLINICIAN PAYMENT AND DELIVERY IN RURAL AREAS (PAGE 40)

Eliminate barriers to the adoption of value-based care.

- Exempt chronic care management services from beneficiary cost-sharing requirements.
- Exempt rural Medicare beneficiaries from the prohibition against same-day services.
- Increase the number of rural-specific CMMI demonstrations and expedite national expansion of promising models.
- Leverage patient engagement incentives to decrease rural bypass and incentivize local care utilization.

Improve reimbursement for clinicians practicing in rural areas.

- Provide a nominal payment update for rural clinicians reporting data under the Quality Payment Program.
- Extend bonus payments for new advanced Alternative Payment Model participants.
- Exclude enrolled accountable care organization beneficiaries when determining the regional benchmark in rural areas.
- Evaluate Merit-based Incentive Payment System, or MIPS, data to ensure that rural providers are not disadvantaged by the structure of the program.

Reduce administrative burden for providers.

- Direct CMS to utilize readily available claims data to assess quality performance.
- Decrease qualifying participation thresholds for rural providers operating under advanced Alternative Payment Models, Rural Health Clinics, and Federally Qualified Health Centers.

3. IMPROVING ACCESS TO QUALITY MATERNAL CARE IN RURAL AREAS (PAGE 47)

Ensure access to obstetric and perinatal services in rural areas.

- Increase reimbursement rates for rural hospital obstetric units.
- Enhance the Federal Medical Assistance Percentage rate for rural hospital obstetric units.
- Increase funding of maternal health training programs for primary care providers.
- Direct the Centers for Disease Control and Prevention to improve rural maternal mortality data surveillance.

4. ENSURING AN ADEQUATE RURAL HEALTH CARE WORKFORCE (PAGE 52)

Improve utilization of currently available workforce.

- Evaluate the potential effect of expanding reimbursement to additional types of providers in rural and Native communities.
- Add marriage and family therapists and licensed mental health counselors to the list of Medicare-covered providers.
- Remove regulatory and legislative barriers that prevent non-physician providers from practicing at the top of their license.
- Eliminate the U.S. Drug Enforcement Administration, or DEA, buprenorphine waiver requirement.
- Direct CMS to assign a medical specialty to advanced practice nurses and physician assistants.

Strengthen the Health Resources and Services Administration rural workforce programs.

- Require a comprehensive evaluation of all rural HRSA programs.
- Allow federal funding for Rural Training Tracks to be dispersed prior to the program start date.

Expand federal rural workforce recruitment and retention initiatives.

- Exempt Indian Health Service loan repayment funds from federal income tax.
- Establish a federal tax credit for providers practicing in rural areas.
- Reauthorize the J-1 visa waiver program and increase caps for doctors practicing in rural areas.
- Direct the National Advisory Committee on Rural Health and Human Services to evaluate and develop recommendations for interagency coordination.

5. BREAKING DOWN BARRIERS TO TECHNOLOGY IN RURAL COMMUNITIES (PAGE 59)

Support efforts to expand broadband and collect accurate broadband data in rural and tribal areas.

- Continue to prioritize connecting rural areas with broadband through anchor institutions and direct-to-home services.
- Ensure effective implementation of the Broadband Deployment Accuracy and Technological Availability Act.

Remove restrictions that prevent full utilization of currently available technology in areas without broadband access.

- Expand telehealth services to include non-face-to-face services.
- Allow virtual visits as substitutes to office visits at lengths beyond the currently allowed 5- to 10-minute check-ins.
- Expand asynchronous services beyond images to include written information shared by phone or through text and email.

Expand the list of authorized sites of service for telehealth.

- Include the home of an individual in the list of authorized originating sites for telehealth in rural areas.
- Pass the Rural Health Clinic Modernization Act of 2019 and the CONNECT for Health Act of 2019.

Streamline licensure requirements.

- Authorize licensed clinicians to provide inter-state services to Medicare beneficiaries.

Prioritize rural-specific training curricula for the health IT workforce.

- Direct the Office of the National Coordinator for Health Information Technology, or ONC, to prioritize rural-specific training curricula for the health IT workforce.

Introduction

An increasing number of rural hospital closures is drawing national attention to the already well-known challenges of delivering quality and timely health care to those living in rural communities. Today, 60 million Americans living in rural areas are at increased risk of dying from heart disease, cancer, stroke, and chronic lower respiratory disease. Despite worsening health and elevated maternal and infant mortality rates, a total of 126 rural hospitals have closed since 2010; an additional 557 hospitals are at high-to-medium risk of folding.[xiii] Additionally, hospitals in states that did not expand Medicaid under the Patient Protection and Affordable Care Act, or ACA, are closing at a higher rate than those in expansion states.[xiv]

At the same time, rural communities are struggling to recruit and retain doctors and other medical providers, forcing patients to travel long distances to receive care. And broadband access continues to lag behind in these areas, preventing rural medical providers from utilizing innovative tools, such as remote patient monitoring, electronic health records, and telehealth, to treat their patients. Even when broadband is available, regulatory barriers prohibit the full use of technology. The urgent need to break down barriers to technology has become a central focus in the response to the new coronavirus, and policymakers should build on their important early efforts.

As rural health care has emerged as an important issue throughout the 2020 election campaign, BPC's Rural Health Task Force offers bipartisan solutions for stabilizing the rural health infrastructure, ensuring access to local care, and promoting healthy rural communities. The group approached these issues through the lens of fiscal responsibility; potential offsets for the costs of these recommendations are highlighted in Appendix A of this report.

The recommendations in this report address fundamental and immediate problems in rural areas by ensuring the provision of appropriate inpatient and community-based services, addressing workforce shortages, improving access to maternal health care, and optimizing the use of technology to meet those goals. These policies offer a necessary step forward to stem the steady stream of rural hospital closures and the loss of access to care in remote areas.

Recommendations

1. STABILIZING AND TRANSFORMING RURAL HEALTH CARE INFRASTRUCTURE

Congress and the Department of Health and Human Services must address the steadily increasing number of hospital closures in rural areas through short-term and long-term solutions. Patient characteristics, reimbursement rates, and the volume of services provided directly influence the financial viability of hospitals and may contribute to closures. Both a decline in the size of rural populations and changes to how health care is delivered have led to increased financial instability.

Health care has historically centered on inpatient hospital services, and reimbursement systems have been tied to this care. However, many services traditionally provided to inpatients are now furnished in the community setting. This dramatic shift to the outpatient setting has left hospitals wrestling with inelastic overhead costs and a significant loss of revenue.

Adding to rural hospitals' financial difficulties, so-called rural bypass results in a loss of higher revenue patients and an increase in costlier episodes. Indeed, rural residents seeking care for acute illnesses, which cost more to treat, are most likely to stay local.[xv] Conversely, those with higher-paying commercial insurance often choose to forgo local care and travel greater distances for elective services.[xvi]

In response to these complex challenges, BPC and the Rural Health Task Force have delineated a multi-part approach. The proposals below are divided into two sections: section 1A details short-term stabilization measures for existing hospitals, while section 1B details longer-term incentives for hospital transformation. These two subsections are intended to work alongside each other and in conjunction with the proposals in the remaining sections of this report.

1A. STABILIZING RURAL HOSPITAL AND CLINIC INFRASTRUCTURE

TO ENSURE CONTINUED ACCESS TO CRITICAL RURAL HOSPITAL AND CLINIC SERVICES, CONGRESS OR THE SECRETARY OF HHS SHOULD:

- Provide immediate financial relief to rural hospitals.
- Make certain rural hospital designations or payment adjustments permanent.
- Allow new flexibilities around rural hospital care delivery and expand opportunities for rural hospitals and clinics to coordinate service offerings.
- Enact payment reforms to shore up rural health clinics and expand access to advanced practice clinicians in rural clinics.

Starting in the 1980s, small rural hospitals faced increasing financial pressure resulting from a number of factors, including low occupancy rates, weak local economies, unsustainable levels of uncompensated care and competition from other hospitals. At the same time, Medicare implemented an inpatient prospective payment system, or IPPS, that began to impose stricter limitations on hospital reimbursement as part of a broader effort to control health care costs. These combined pressures contributed to roughly 200 rural hospitals closing between 1980 and 1988.[xvii]

Against this backdrop, Congress established a series of special rural hospital programs and designations intended to bolster rural hospitals by providing additional financial protections. These included the Critical Access Hospital, or CAH,[xviii] Sole Community Hospital, or SCH,[xix] and Medicare Dependent Hospital, or MDH[xx] programs. Medicare also implemented new payment adjustments for low-volume hospitals.[xxi] See Appendix B for a full description of these designations. These programs or designations have allowed certain hospitals to receive tailored reimbursement under Medicare, if they meet criteria related to geographic location, the number of inpatient beds, and distance to other hospitals, among other items.

The rural designations have played an important role in ensuring access to care in rural and frontier communities. Currently, there are roughly 1,300 CAHs,[xxii] 402 SCHs,[xxiii] 138 MDHs,[xxiv] and about 500 hospitals receiving low-volume payment assistance. Rural hospitals provide care to the roughly one-fifth of the nation's population that live in rural communities and are a critical source of care for vulnerable and underserved populations.[xxv]

Today, each rural hospital designation is governed by unique payment rules. CAHs are reimbursed 101% of reasonable costs for inpatient and outpatient services.[xxvi] SCHs are paid the higher of the Medicare IPPS rate or a base rate set in statute. MDHs are paid the higher of an IPPS rate or a blended payment rate. Low volume hospitals receive an add-on payment based on a sliding scale, per-discharge calculation.[xxvii]

While the special rural designations have played an important role in maintaining access to rural hospital care, recent rural hospital closures suggest that ongoing financial pressures resulting from Medicare payment reductions (e.g. Medicare sequestration and bad debt), shifts in health care delivery away from inpatient care, and dwindling rural populations have once again placed rural hospitals on shaky financial footing. According to the Medicare Payment Advisory Commission, rural hospitals including CAHs, on average, had a negative (-4.9%) Medicare operating margin in 2018. When CAHs are excluded from the calculation, the Medicare operating margin for all other rural hospitals was negative (-6.6%) in 2018.[xxviii]

Congress has also established special programs focused on strengthening access to primary and preventive care in rural communities. These include the Rural Health Clinic, or RHC, and Federally Qualified Health Center, or FQHC, programs. RHCs and FQHCs must meet certain statutory criteria related to serving underserved or rural areas, among other qualifications, and are also subject to unique reimbursement structures. RHCs are paid an all-inclusive, per visit rate under Medicare.[xxix] FQHCs are paid the lesser of 80% of charges or the FQHC prospective payment system rate.[xxx] Today, there are more than 4,500 RHCs[xxxi] and 1,362 FQHCs across the country.[xxxii]

The following proposals are intended to develop and promote policies that will strengthen and stabilize access to CAH, other small rural hospital, and RHC services. Transformation of rural health care delivery must be carefully considered and will take time. Given this, the following proposals offer immediate solutions to stem the tide of rural hospital and clinic closures. Many of these policies are short term in nature and are intended to provide a bridge to longer-term reforms.

These proposals build on the current law rural payment structures with the overarching goal of strengthening financial viability and providing new flexibility around care delivery to these facilities.

Provide Immediate Financial Relief to Rural Facilities

To immediately enhance the financial stability of rural hospitals and clinics, Congress and the secretary of HHS should:

- **Provide rural hospitals relief from Medicare sequestration (from FY2021-2023) and Medicare bad debt (from FY2021-2023) payment reductions.**
- **Increase reimbursement for Medicare Critical Access Hospital services by 3% starting in FY2021.**
- **Re-establish the CAH necessary provider designation process.**
- **Make available capital infrastructure grants or loans that rural hospitals could use to modify service lines or improve structural or patient safety.**

The Budget Control Act of 2011 (P.L. 112-25) established Medicare sequestration.[xxxiii] This legislation required a 2% payment reduction for Medicare fee-for-service discharges, as well as CAH discharges, beginning April 1, 2013. The sequestration policy has been extended several times in legislation.[xxxiv] However, in response to the additional financial strain related to the coronavirus pandemic, Congress temporarily waived sequestration from May through December 31, 2020 for all health care providers, including rural hospitals. Sequestration reductions will be re-instated after this date and are currently set to expire in 2030.

Regarding Medicare bad debt policies, prior to 2013, Medicare reimbursed hospitals 70% to 100% of beneficiary bad debt costs, depending on hospital designation. Bad debt costs include unpaid coinsurance and deductibles. In 2012, the Middle Class Tax Relief and Jobs Creation Act (P.L. 112-96)[xxxv] phased down reimbursement to 65% of bad debt costs for all hospitals.

This proposal would provide rural hospitals relief from Medicare sequestration for the remainder of FY2021-FY2023 and bad debt payment reductions in FY2021-2023. These policies would provide immediate relief to financially struggling, small rural hospitals. To provide a sense of how much these policies could cost, it is estimated Medicare sequestration reduced payments to rural hospitals by roughly $574 million in 2017.[a] To fully eliminate the sequestration reductions for all rural hospitals, it could cost roughly this amount per year.

This proposal would also increase reimbursement for Medicare CAH services by 3% starting in 2021. Under current law, CAHs are paid 101% of reasonable costs under Medicare. However, because of sequestration reductions, facilities receive 99% of cost, which means reimbursement does not allow facilities to break even. Building on the sequestration relief outlined above, this proposal would increase CAH reimbursement by an additional 3% to allow CAHs to have a net reimbursement of 104% of cost. This increase will help ensure ongoing hospital solvency and financial stability for these critical health care facilities.

a Sequestration impact is a rough estimate based on BPC staff analysis, using data from June 2019 MedPAC: A Data Book: Health Care Spending and the Medicare Program, charts 6-3 and 6-4.

In addition, the proposal would direct the secretary of HHS to re-establish the "necessary provider" designation process, which prior to 2006 allowed small rural hospitals that were otherwise ineligible for CAH status to apply for the CAH designation.[b,xxxvi] Such program would allow eligible rural hospitals to begin receiving Medicare cost-based reimbursement and would also require hospitals to downsize – 25 inpatient beds or fewer or a total of 25 inpatient plus swing beds – as a condition of converting to a CAH. A swing bed is a hospital bed that can be used for either acute hospital or skilled nursing facility level care. Such conversion would be time-limited to no more than five years, but could be extended by the secretary if a Hospital Transformation Plan has been completed and demonstrates ongoing need to maintain the facility.

Finally, the proposal would direct the secretary of HHS to make available capital infrastructure grants or loans that rural hospitals could use to modify service lines or improve structural or patient safety as another means to strengthen rural facilities. This funding could be combined with, or only be made available to – at the secretary's discretion – those facilities that otherwise don't qualify for funding under rural health capital infrastructure programs, such as the U.S. Department of Agriculture's Community Facilities Direct Loan and Grant Program[xxxvii] or the Hospital Mortgage Insurance for Hospitals Program offered by the U.S. Department of Housing and Urban Development.[xxxviii]

Under this proposal, an eligible facility could apply for up to $100,000 in grant or loan funding. Total program funding would be capped at $25 million, which means up to 250 struggling hospitals could apply over the course of the program. The program would begin in FY2021 and funding would be available until expended. Such funding could also be used to support rural hospital transformations laid out in the next section.

Make Certain Rural Hospital Designations or Payment Adjustments Permanent

To increase long-term financial stability and maintain access to rural hospital care, Congress should:

- **Take rural facilities out of the ongoing extender and needing to be renewed cycle.**
- **Make the Medicare Dependent Hospital, or MDH, designation permanent.**
- **Make permanent adjustments for rural hospitals receiving low-volume payments.**
- **Allow Sole Community Hospitals, or SCHs, to permanently receive additional payment for outpatient services.**

For many of the rural hospital designations or programs, such as MDH, SCH, and low-volume, certain aspects of their Medicare reimbursement or their entire rural designation currently must be reauthorized or renewed by Congress every few years. This lack of certainty has contributed to the financial instability of rural hospitals.

This proposal would take rural facilities out of the ongoing extender and needing- to-be-renewed cycle by offering rural hospitals payment and designation stability, until which time they could decide to transition to a new payment or delivery model.

Such ideas include making the MDH designation a permanent hospital payment category. Under the proposal, MDHs would be required to continue meeting current law eligibility rules to maintain the MDH designation, including being located in a rural area, having 100 inpatient beds or fewer, and having a patient caseload of at least 60% of Medicare patients. According to MedPAC, the cost of maintaining the MDH designation is roughly $100 million per year above what facilities would be paid if they were otherwise subject to and reimbursed under the traditional Medicare inpatient prospective payment system.[xxxix] The most recent reauthorization of the MDH program cost roughly $865 million in Medicare spending over five years.[xl]

This proposal would also allow rural hospitals receiving low-volume payment adjustments to permanently receive these adjustments. However, the secretary would be given discretion to determine the appropriate annual patient discharge level that would ensure access to care. Under current law, low-volume hospitals receive a sliding scale, low volume payment adjustment starting at 25% for fewest discharges down to 0% for those with 3,800 annual patient discharges and higher. Prior to the Bipartisan Budget Act of 2019 (P.L. 115-123), the low-volume adjustment was capped at 1,600 patient discharges per year. When the low-volume payment adjustments were capped at 3,800 annual patient discharges, the cost of the low volume payment adjustments was roughly $1.7 billion over five years.[xli] These payment adjustments have helped stabilize rural hospitals with low-patient volumes but are set to expire in 2023.

The final proposal would allow SCHs to permanently receive additional payment (7.1%) for outpatient services. This payment adjustment was authorized pursuant to a study authorized by Congress, which found rural SCHs have substantially higher costs.[xlii] Making this adjustment permanent would provide financial stability and is in-line with broader policies to support the delivery of outpatient care in rural communities.

Three years after date of enactment of the above proposals, the secretary could consider requiring a Hospital Transformation Plan be submitted – as outlined later in the document – in order for a facility to extend or retain the financial relief outlined above. Such assessment would provide valuable information about how given facilities impact access to care in a particular community and

whether further changes or transformations are required to strengthen availability, quality or access to care.

Allow New Flexibilities Around Rural Hospital Care Delivery and Expand Opportunities for Rural Hospitals and Clinics to Coordinate Service Offerings

To expand and strengthen access to care in rural communities, Congress or the secretary of HHS should:

- **Evaluate whether to modify and update the CAH 96-hour patient length of stay rule, and provide increased flexibility around physician certification requirements.**
- **Clarify rules around co-location or shared space agreements that allow rural hospitals to partner with other health care providers.**

Under current law, CAHs must maintain an average length of patient stay of 96 hours or fewer for acute patients.[xliii] Stakeholders have identified that the 96-hour limit creates barriers to care for patients who require longer stays, such as those admitted related to mental health conditions or seasonally around influenza or related illness. However, the time limit has been more difficult to reach for hospitals that have eliminated maternity care.

The proposal would direct the secretary of HHS to evaluate how the 96-hour rule impacts access to care in CAHs and if this timeframe is clinically appropriate based on the range of patients served in CAHs. As part of this evaluation, the secretary would make recommendations on whether the 96-hour rule should be revised and should specifically evaluate how the average length of stay in CAHs compares to hospitals paid under the Medicare prospective payment system. In making such recommendations, the secretary must evaluate the impact on federal spending related to any recommended change. Related to this issue, on March 13, 2020, CMS announced that the agency would temporarily waive requirements around the 96-hour patient length of stay limit in order to provide flexibility in care delivery and increase capacity in CAHs during the COVID-19 crisis.[xliv]

In addition, the proposal would waive the current law policy that requires physicians to certify, upon admission, that rural patients would stay in a CAH no longer than 96 hours. Waiving this rule would provide physicians additional flexibility in determining whether a patient should be admitted to a CAH and in some cases, avoid patients being unnecessarily transferred to a facility outside the local community. A similar recommendation is included in current legislative proposals pending before Congress.[xlv]

Finally, the proposal would also direct the secretary to clarify rules around co-location or shared space agreements that allow rural hospitals to partner with other health care providers or specialists – such as behavioral health

providers, cardiologists, home health services, etc. – to allow a broader range of service offerings.

Enact Payment Reforms to Shore up Rural Health Clinics and Expand Access to Advanced Practice Clinician Services in Rural Clinics

To ensure continued access to quality rural health clinic care in rural and frontier communities, Congress should:

- **Increase the Medicare-capped reimbursement rate for physician-owned rural health clinics.**
- **Allow advanced practice clinicians to work up to their state scope of practice in rural health clinics.**

Today, there are roughly 4,500 rural health clinics serving rural communities across the country. Although the total number of these clinics has steadily increased in recent years and a considerable number of them have revised their structure from lower-paid independent clinics to higher-paid, provider-based models, nearly 400 RHCs have closed since 2012.[c,xlvi] These closures have reduced access to care for 3.8 million rural residents and impacted roughly 3,600 jobs in affected communities.[xlvii]

The majority of RHC closures have been independent, physician-owned RHCs that currently receive capped Medicare payments at a rate of $86.31 per visit,[xlviii] compared to hospital-owned RHCs that receive an average uncapped rate of $206 per visit in 2020.[xlix] To qualify for the hospital-owned rate, an RHC must be attached to a hospital with fewer than 50 beds.

Independent, physician-owned RHCs play an important role in medically underserved communities, including offering patients access to primary care and preventive services that may otherwise not be available. RHCs also help attract physicians, physician assistants, or PA, nurse practitioners, or NP, and other providers that otherwise may not be in a geographically isolated area and may become even more critical in communities that shutter their rural hospital.

To ensure continued access to independent, physician-owned RHCs, this proposal would increase the current Medicare capped reimbursement rate to $115 per visit, as supported by recently introduced legislation.[l]

The proposal would also allow PAs and NPs, or advanced practice clinicians, to work up to their state scope of practice in terms of service delivery. In addition, it would allow master's trained mental health providers to provide services in RHCs as a way to expand access to mental health care in rural communities. Finally, the proposal would allow RHCs to begin operating as a telehealth distant site of

c 312 independent RHCs have shifted to provider-based models since 2012.

service, which would connect patients with primary care physicians and specialists in other locations.[li] Recent legislation related to the coronavirus pandemic would allow RHCs to begin operating as a telehealth distant site of service, but only on a temporary basis during the national emergency.[lii]

1B. TRANSFORMING RURAL HOSPITAL AND CLINIC INFRASTRUCTURE

TO ENSURE RURAL COMMUNITIES HAVE ACCESS TO SUSTAINABLE, QUALITY RURAL HOSPITAL AND CLINIC SERVICES, CONGRESS OR THE SECRETARY OF HHS SHOULD:

- Support rural communities in conducting a community needs assessment and developing an action plan.
- Establish a series of new rural transformation models, including:
  - ◊ A Rural Emergency and Outpatient, or REO, hospital designation that recognizes the shift away from inpatient centric care
  - ◊ An Extended Rural Services Program
  - ◊ Multi-payer, global budget models
  - ◊ Other Center for Medicare & Medicaid Innovation, or CMMI, initiatives to increase coordination and integration of rural hospital and clinic services
- Support opportunities to advance rural health care quality.

This proposal would establish several new transformation models or pathways that rural hospitals could pursue based on which option best fits their community need and would be sustainable into the future.

In recent years, proposals have been introduced that would allow rural hospitals to shift to new payment and care delivery models. However, these initiatives have often been limited in that they would only offer one payment option for transformed hospitals, which may not be viable in certain rural communities and may not provide hospitals flexibility to determine the best payment and care structure for patients served. The goal of the proposal is to set forth new care models that ensure rural patients have access to health care that fits their local needs, rather than a one-size-fits-all solution.

Each of the models or transformation pathways outlined below would offer rural facilities the chance to transform to a new delivery or payment structure.

No rural hospital would be required to transform, but the facility would need to meet certain eligibility criteria to qualify. In addition, over time, facilities would be allowed to transition between models –for example, from the REO designation to participating in a global budget model – if they met the required program criteria and if such transition had the potential to strengthen access to care and improve health outcomes in a given rural community.

Eligibility to transform to a new model would be based on submission of the Hospital Transformation Plan as well as meeting the criteria of the new models outlined below. The secretary would be required to review and make a determination on whether an entity is eligible to transform within six months of receiving an entity's transformation plan.

The secretary would be granted authority to waive the required submission of a Hospital Transformation Plan if the secretary deemed that requiring such submission could unduly jeopardize access to care in a given community. The secretary would also have authority to allow an entity to submit an assessment or plan at the same time or after receiving approval to enter a new transformation model, if the secretary deemed appropriate to ensure continued access to care in a given community. Finally, a submission of a community needs assessment or plan would not be required for any model being tested by CMMI, including those described below. However, the secretary could require such submission under these or similar models, if deemed appropriate.

Support Rural Communities in Conducting a Community Needs Assessment and Developing an Action Plan

To support rural communities as they work to strengthen and transform their rural hospital infrastructure, Congress should:

- **Establish a process for rural facilities and communities to develop a Hospital Transformation Plan as a first step in the transformation process.** This process would include an evaluation of the local health infrastructure and development of an action plan to address identified needs. The Hospital Transformation Plan would be used to determine which hospital transformation model might be most beneficial for a given community. It would also serve as an important tool to determine which health care delivery models would improve health and increase access to care for residents of the community and larger region, where possible.

In order to apply to participate in one of the transformation models outlined below, an eligible entity, representative, or group of representatives of the local community would have to complete an assessment of local community health care needs and develop an action plan on how to address such needs. The assessment and plan could be completed by an individual hospital or health system or could be initiated by local or state government or other community

leaders. In all cases, input would have to be sought from the local and state public health department, as well as a robust set of stakeholders, outlined below.

Such assessment must, at minimum, include information regarding a series of factors, including:

- Population and demographic trends within the local community and region, if available
- The current availability, as well as projected community need, for inpatient hospital services; outpatient and ambulatory services; diagnostic and lab services; post-acute and community services; emergency medical services; oral and dental care; preventive and population health services
- Current availability and projected community need for tribal or veteran health and wellness services

Such assessment could also include information on:

- The current availability and projected community need for non-clinical services, such as food support, housing assistance, transportation, linguistic, and other services that impact the health care status of the impacted population
- A statement that outlines any overarching gap in local community or regional services as well as a statement that identifies the highest priority services that have the potential to improve overall health and wellness of the local region

The assessments must include a minimum of five-year projections, but where possible 10-year projections, on each of the required factors outlined above.

Based on the information collected, eligible entities would need to submit a Hospital Transformation Plan that outlines goals and where possible, action steps for improving or maintaining access to care, strengthening quality of care, better coordinating care across the local or regional health care delivery system, and addressing other community needs or gaps identified in the assessment. Such assessment and plan would have to be made publicly available.

In developing the Hospital Transformation Plan, input would have to be solicited from representatives of local hospitals, physicians, allied health professionals, private and public payers, as well as patients and consumers. This includes representative of those who are medically-underserved, low-income, or from minority populations, such as tribal representatives and other relevant stakeholders including local or regional social service organizations. In addition, input would need to be solicited from the public through an open and transparent process; the input would have to be documented and considered in the assessment and plan.

Eligible entities could supplement their assessment and plan with community needs assessments and plans that have been completed at the state level in

coordination with state or local public health departments. In cases where local or state-level information is available and up-to-date – meaning it has been compiled within the last five years – the secretary could deem this information relevant to meet all or a portion of the requirements outlined above. In addition, entities could submit information otherwise collected for the current law Community Needs Assessment, as outlined in section 9007 of the Affordable Care Act (P.L. 111-148)[liii] to meet all or part of this requirement. These flexibilities would decrease administrative burden and costs related to collecting such information.

Eligible entities would also update the Hospital Transformation Plan every 10 years as a condition for maintaining eligibility to participate in the transformation models outlined below. In addition, the secretary of HHS could require a brief progress report be submitted five years after such assessment and plan was submitted. The progress report would outline progress to-date on addressing the community needs and goals laid out in the original action plan.

Finally, the secretary would be directed to make the Health Resources and Services Administration, or HRSA, funding and technical assistance and support available to applicants seeking to develop, or who are in the process of developing or updating a Hospital Transformation Plan.

Establish a Series of New Rural Hospital Transformation Models

To ensure rural communities have access to rural hospital care that is sustainable and meets local community health care needs, Congress or the secretary of HHS should:

- **Establish a new Rural and Emergency Outpatient Hospital designation that recognizes the shift away from inpatient centric care.**
- **Establish an Extended Rural Services Program.**
- **Advance new multi-payer, global budget models.**
- **Promote CMMI initiatives to increase coordination and integration of rural hospital and clinic services.**

Establish a new Rural Emergency and Outpatient Hospital Designation that Recognizes the Shift Away from Inpatient Centric Care

The proposal would direct the secretary to establish a new Medicare rural hospital designation called a Rural Emergency and Outpatient, or REO, hospital starting in 2023. The REO model would offer struggling rural hospitals a new care delivery model focused on outpatient and emergency care. However, REO facilities could choose to offer other services, such as extended care services, as outlined below. REO hospitals would be given a choice of reimbursement options that are intended to offer communities flexibility to select a payment structure that would be sustainable and meet their community need. REO hospitals would be required to meet a set of eligibility criteria, as described below.

REO Eligibility and Service Requirements

To be eligible to apply for the REO designation, an entity would have to:

- Be a CAH or other rural hospital or rural facility, or have met this criterion but closed within the last five years.
- Be located at least 35 miles from other, similar facilities, but the secretary could waive or modify this distance requirement based on the findings included in a given Hospital Transformation Plan.
- Have protocols in place to transfer patients to inpatient facilities, including related to transferring patients for maternal care services.
- Be approved to operate under this designation by the state in which it is located.
- Have the resources required of a level IV trauma center or higher.
- Employ health care staff that meet certain trauma training qualifications
- Have in effect a transfer agreement with a level I or II trauma center.

In terms of service offerings, REO hospitals:

- Would need to provide 24-hour emergency medical care and observation care that does not exceed an annual per patient average such as 24 hours or more than one or two midnights.
- Could offer outpatient services, but would not be required to do so.
- Could not provide acute inpatient hospital care, unless the below criteria were met. However, eligible hospitals could allow patients to stay overnight on enhanced observation status for the purpose of stabilizing patients and helping avoid unnecessary transfers to other, higher-level or higher cost hospitals or to hospitals outside the geographic area.
- Could use enhanced observation beds to provide services such as infusion, injections, wound care, pre- and post-operative care, and other similar services deemed appropriate by the secretary.
- Could offer acute inpatient care – with a 10 bed maximum – if the Hospital Transformation Plan determined that such services were needed to ensure adequate access to care in a local community or region and specifically if acute inpatient care was not otherwise available within in a certain geographic distance, such as 35 miles.
- Would need to offer backup physician services, which could be offered via telephone or telehealth.
- Could offer extended care services, included skilled nursing facility care as a separate, licensed unit – similar to what CAHs can do today.
- Could use fixed grant dollars to offer a range of wellness, preventive, mental health, substance abuse and opioid use disorder services, oral health services, maternal health, and end-stage renal disease care and post-acute

services, such as home health care. Funding could also be used to offer social supports, such as transportation, including for maternal care services, food or housing assistance.

- Could receive reimbursement to transport patients to another hospital. Under the model, either the hospital or rural ambulance provider would be eligible for reimbursement.

Payment Structure for new REO hospitals. Once a hospital qualified to become a REO based on meeting the above criteria, the facility could elect one of the below reimbursement structures. These include:

- **Payment Level A: Cost-based reimbursement of 110% percent of reasonable costs.**
- **Payment Level B: Medicare outpatient prospective payment, or OPPS, reimbursement for emergency and outpatient services combined with a fixed grant payment option to cover other costs and services.**[d] Under this model, eligible hospitals would receive a flexible, annual grant payment of $500,000 per hospital. As an alternative, this proposal may also simply provide the secretary of HHS authority to set the fixed payment rate and require the rate take into account additional costs related to serving a low-volume area. According to MedPAC, if the fixed grant fund was $500,000 per facility, this spending could be offset by the reductions in Medicare inpatient spending that would occur as facilities discontinued inpatient care.[liv]
- **Payment Level C: Medicare OPPS reimbursement for emergency and outpatient services combined with a per patient per month, or PMPM, payment based on number of anticipated patients in an expected catchment area.** This is another version of a fixed payment; however, the payment would be more closely tied to number of patients projected to be served in a given year.

  The secretary could offer extra incentives for hospitals to select the PPS/fixed grant (Level B) or PPS/PMPM (Level C) options. These payment structures could help move facilities – over time - closer to the concept of a global or capitated payment as they become accustomed to receiving a fixed payment to cover some portion of costs. Providing a fixed payment would allow more flexibility around care delivery and less incentive to increase volume just for the sake of increasing reimbursement.

- **Payment Level D: A global payment model that combines funding of all federal payers**. This option would allow an individual hospital or rural hospital system, including multiple rural hospitals, to receive an annual, lump sum payment that could be flexibly used to cover the cost of eligible services.

d This model is structured based on a recommendation put forth by the Medicare Payment Advisory Commission, June 2018 Report to Congress: Medicare and the Health Care Delivery System.

Under this model, the facility or system would receive an annual, fixed amount based on a retrospective spending level that is adjusted by a growth factor deemed appropriate by the secretary. Such global payment could also be adjusted to reflect projected changes in population or health status of individuals served or other factors deemed appropriate by the secretary.

Under all of the above models, the secretary could offer additional payment for services that are deemed particularly "at risk" of decline, such as obstetric, maternal and pre-natal care, including via remote patient monitoring, as appropriate.

Additional Considerations:

Nothing in this proposal would preclude a facility from applying to convert back to a Critical Access Hospital or other rural hospital designation, if it was determined in the future that this conversion was necessary to ensure appropriate access to inpatient hospital care in a local community.

The proposal also includes measures to encourage recruitment and retention of health care workforce in new REO hospitals. Specifically, the proposal would authorize REO hospitals to qualify as National Health Service Corps sites, which would allow placement of physicians and other providers in REO facilities.

In addition, teaching hospitals would receive Medicare Graduate Medical Education, or GME, credit for the time medical residents and interns spend rotating into REO hospitals.

Role of Rural Health Clinics under the new REO hospital model:

Today, rural health clinics that are affiliated with a CAH receive uncapped Medicare reimbursement that averages $206 per visit.

Under this proposal, RHCs that were attached to a CAH prior to converting to a REO would be grandfathered in at the uncapped rate. This would allow REO hospitals to continue offering rural health clinic services, including vital primary and preventive care services, to their community.

For any RHC that is added to a REO hospital, such facility would receive a new rate that is somewhere between the current capped rate ($86.31 per visit) and the current average uncapped rate ($206 per visit). Such rate would be determined by the secretary and set at a level to ensure adequate access to rural health clinic services.

The proposal would also direct the secretary to study and make recommendations on whether to apply a revised rate to all hospital-based RHCs as a way to appropriately close the payment differential that currently exists between payment for services received at RHCs that are owned by rural hospitals and those that are physician-owned. The study would also evaluate how payment modifications could impact access to care and rural communities' ability to attract needed health care professionals.

Cost Impact:

There are no currently available cost estimates on the above proposal. However, in its June 2018 report, MedPAC suggested a bare-bones version of the proposals to shift CAHs to Medicare outpatient payment system reimbursement – as outlined in Payment Paths B and C above – would cost roughly $5 million per year to operate and would increase Medicare spending by less than $50 million per year.[lv]

In addition, it is expected that beneficiary out-of-pocket costs would decline if a facility shifted from a cost-based CAH model to an outpatient, prospective payment model. This would occur because beneficiary copayments would no longer be tied to the often higher, cost-based charge and instead be based on a percentage of the lower, prospective payment rate.[lvi]

Establish an Extended Rural Services Program

This model would be available as another transformation option that would help ensure rural patients maintain access to necessary acute care hospital services in communities where a rural hospital has closed or is reducing capacity.

Under this option, the secretary would be directed to establish a new Extended Rural Services, or ERS, program. This program would allow rural FQHCs and RHCs to begin offering hospital level services that otherwise might not be available as a result of a recent hospital closure or a local hospital reducing capacity. Rural hospitals would also be eligible to participate in the ERS program, if they formed an FQHC or eligible RHC, either prior to or in tandem with applying for this new program.

This program would aim to utilize existing rural infrastructure by allowing services to be added to local FQHCs and RHCs. It would also allow communities to re-purpose existing rural hospital buildings that have closed or are in the process of downsizing. Such program could also provide opportunities to retain health care providers who might otherwise leave the community when the local rural hospital closes. The program would be established as a new section of the Public Health Service Act and would not amend current law Section 330 program rules or financing related to FQHCs or current law that governs RHCs.[lvii]

Today, approximately 43% of FQHCs – 600 clinics – are located in rural communities and serve roughly 1 in 5 rural residents.[lviii,lix] As noted in other sections of the report, there are approximately 4,500 rural health care clinics serving rural communities nationwide.[lx]

Under this program, eligible entities would include:

- **Federally Qualified Health Centers**, as defined in Section 330 of the Public Health Services Act[lxi]) that are located in rural areas or populations

- **Rural health clinics**
- **Rural hospitals** that are struggling or closed within the last five years and are willing to form a FQHC or eligible RHC prior to or in tandem with, applying to the ERS program.

All organizations applying to participate in the ERS program would have to demonstrate they or their community are in the process of, or have completed and submitted, a community needs assessment and plan, as discussed elsewhere in this document. The secretary could deny application if an assessment or plan was not submitted or if such plan did not adequately demonstrate community need to transform to the ERS model.

Under the program, participating entities would need to provide at least one of the following services but could provide all of them. These services include urgent care; 24/7 emergency room care; observation stays; and certain specialty services, as determined appropriate by the secretary. Eligible entities could have up to 10 beds maximum to be used for the purposes of observation stays, if the need for such capacity is identified in the relevant community needs assessment and plan.

In order to participate in the ERS program, eligible entities would need to make all services available to all patients, regardless of ability to pay; charge uninsured and underinsured patients below 200% of the federal poverty level based on a sliding fee scale; and have in place a quality assurance program.

For those entities that participate in the ERS program, grant funding as well as Medicare and Medicaid reimbursement would be made available. All payments related to ERS services would be separate and distinct from any current law payments for FQHCs or RHCs.

Specifically, to support communities in determining whether and how to design a sustainable ERS program, the secretary would be directed to make available up-front, one-time planning grants for entities to evaluate the feasibility of participating in the ERS program. Entities would be eligible to apply for these grants at the same time a community needs assessment is being done or after one is completed. Such grant could be used to assist in planning costs, to support community engagement in decision-making and for general business planning purposes. Entities would be eligible to receive this funding, but not required to apply to participate in ERS if they determine such model is not feasible.

For those entities that participate in the ERS program, the secretary would provide either Medicare hospital inpatient prospective payment system reimbursement for any current law hospital services provided by an ERS participant or establish a new Medicare PPS for such purpose. The secretary could consider providing Medicare DSH payments to ensure grant funds are well targeted and not diverted to offset any Medicare shortfalls.

For purposes of Medicaid payment, the secretary would be directed to develop a prospective payment system that reflects reasonable costs in the geographic area for which services are provided. Such payments could include Medicaid disproportionate share hospital payments.

The secretary would also establish ongoing grant funding to cover the costs of serving the uninsured and underinsured. Such funding would be calculated based on historical levels of treating uninsured and underinsured patients for like services in the local geographic area and would be calculated on a projected per capita basis.

Finally, eligible ERS participants could receive benefits under the Federal Torts Claims Act, which means ERS providers would not need separate malpractice insurance related to participating in the program. ERS participants would also be eligible to participate in the 340B drug discount program as it relates to the services provided in the ERS model.[lxii]

Advance New Multi-Payer, Global Budget Models

The proposal would also direct CMMI to develop proposals that encourage and incentivize multiple payers and providers to come together in rural communities – on the local, state and regional level – to advance health care transformation and reduce health care spending where appropriate.

Similar to proposals above, the secretary could consider making resources available to support local or regional efforts to assess community need in a given community. Such resources could also be made available to help communities model and develop business plans around global budget initiatives, as deemed appropriate by the secretary. Further, the secretary could consider making submission of a community needs assessment and plan a requirement of participation in global budget or multi-payer demonstration or program.

Over the last decade, CMMI and a handful of states have begun testing multi-payer, global budget models. These models focus on improving care coordination across providers and services, as well as improving health care quality outcomes, while also controlling health care expenditures.

One example is in the state of Maryland, which established an alternative payment system for hospital services more than 30 years ago. This system was made possible by a Medicare waiver that exempts Maryland hospitals from the Medicare inpatient and outpatient prospective payment systems. Under this system, the state of Maryland sets hospital payment rates that are then adopted by all parties.[lxiii]

Building on this model, CMMI established the Maryland All-Payer model in 2014. This initiative aimed to go beyond rate setting by testing a model focused on total cost of hospital care on a per capita basis. This initiative tested global budgets for

certain Maryland hospitals, as well as set quality improvement and hospital readmission and hospital-acquired conditions goals, among other metrics.[lxiv]

In 2019, CMMI launched the Maryland Total Cost of Care initiative. This model expands beyond hospital care by holding the state of Maryland accountable for Medicare services provided to all Maryland beneficiaries, including primary care services and other non-hospital services. Under this model, per capita cost growth in the state will be capped and quality incentives are included. This initiative is set to sunset on December 31, 2026.[lxv]

CMMI also authorized the start of a new, multi-payer global budget model in the state of Pennsylvania, starting in 2017.[lxvi] This initiative, called the Pennsylvania Rural Health Model, is a 6-year demonstration that provides payment of a global budget by all payers for rural acute care hospitals and CAHs in the state. The model will assist rural hospitals in maintaining financial viability while making the necessary investments in care redesign to improve quality and lower overall costs. The global budget includes inpatient and outpatient services, as well as swing beds for CAHs. CMS began funding the state in 2018 for model preparation and provides biweekly payments to participant hospitals based on historical costs.

In this model, hospitals must have 75% payer participation in Performance Year One (2019) and 90% participation in years two through six. The state must achieve $35 million in Medicare savings over the course of the demonstration and prevent costs from exceeding the rural national growth rate for Medicare beneficiaries. All-payer costs must not exceed the state's historical compound annual growth rate of 3.38%.

The model also aims to drive increases in access to care, decreases in mortality specifically related to substance abuse, and increases in preventive care and improvement in chronic disease management. Thirteen hospitals currently participate in the model and no results have been posted on the program to date.

CMMI has also launched a State Innovation Model Initiative. The federal initiative partners with states to test multi-payer health care payment and delivery reform models. CMMI has tested two rounds of this initiative. In the first round it awarded nearly $300 million to entities in 25 states to test new delivery models. Round two of the program awarded $660 million to 28 states, two territories, and the District of Columbia to implement state innovation plans. This initiative is ongoing.[lxvii]

As CMMI continues to track progress on all of these models and similar programs, this proposal would encourage the secretary to use lessons from these initiatives to establish multi-payer, global budget initiatives that are tailored to rural communities and have the potential to improve care coordination and quality of care as well as reduce health care costs, where possible.

Promote CMMI Initiatives to Increase Coordination and Integration of Rural Hospital and Clinic Services

Across the country, rural hospitals and RHCs or FQHCs are seeking opportunities to better coordinate or integrate care across rural communities as a way to leverage scarce workforces and other resources, and increase service offerings for rural patients. While these models may hold promise, there are many barriers to fully integrating rural hospitals and RHCs or FQHCs because of different statutory, regulatory and governance structures.

This proposal would direct the secretary to develop and test new models that would reduce barriers to integration, where appropriate, and improve coordination across rural services. Such models would allow communities to maintain the current rural hospital, while also potentially streamlining and improving access to necessary rural health services.

In addition, the secretary could consider requiring participating entities to submit a community needs assessment and plan as part of any CMMI collaboration model or demonstration to ensure collaboration will increase access to care and quality in a given rural community or region.

Support Opportunities to Advance Rural Health Care Quality

To support rural communities' ability to advance quality improvement and improve patient health outcomes, congress or the secretary of HHS should:

- **Require all rural hospitals to begin reporting on a core set of rural relevant quality measures.**
- **Study and offer recommendations on establishing a quality reporting program for rural health clinics.**

Under current law, CAHs and some small, rural hospitals are not required to report on quality performance; therefore, payment is not tied to tracking quality performance or to quality of care delivered. Rural health clinics are also not subject to quality reporting requirements.[lxviii]

Historically, rural hospitals have not reported on quality because of statistical issues around low volume or lack of rural-relevant measures in the field. However, rural hospital quality measure reporting has increased in recent years. As of 2019, 99% of CAHs report information on at least one quality measure and 93% report on at least three quality measures.[lxix] In addition, quality measurement has advanced in recent years, including the recent approval by the National Quality Forum, or NQF, of a rural relevant set of quality measures.[lxx]

Specifically, NQF released a report in 2018 that highlighted 20 quality measures that a multi-stakeholder group identified as a potential starting place for rural

hospitals and clinicians to begin tracking and reporting on quality. The set of selected rural measures were required to be relevant across rural settings, NQF-endorsed, and resistant to measurement challenges around low-case volume. The report specifically recommended measures related to mental health, substance abuse, medication reconciliation, diabetes, hypertension, and hospital readmission, among other items.[lxxi] To date, Congress has not directed the secretary to require rural hospitals report on the selected measures.

This proposal would direct the secretary to require rural hospitals to report on – at minimum – a narrow set of rural-relevant measures as a way to advance quality of care in rural communities. Reporting requirements would be phased in over five years and the number of required measures would be minimal, but phased up over time as rural hospitals build their internal administrative structure to collect and report quality outcomes data.

Such proposal would allow the secretary to determine the appropriate measures to include in the rural reporting program and encourage the secretary to consider the measures identified by multi-stakeholders in the 2018 National Quality Forum work referenced above. Such measures would be risk-adjusted for social determinants of health, where possible and appropriate, and would also include access to care measures, where available. The proposal would require the secretary to ensure the required rural measures be aligned across Medicare, Medicaid, and other payers as a way to minimize reporting burden on rural facilities.

In addition, the proposal would direct the secretary to assess whether topped out measures, such as measures that are no longer useful for larger or urban providers to report because they are already successful on the metric and there is little room left for gains, should remain in the system for purposes of rural reporting. There have been recent examples of the secretary retiring quality measures, including those related to emergency department care, outpatient services, and immunization, which could continue to be beneficial to track in rural communities.[lxxii] This proposal would direct the secretary to take into account potential quality improvements in rural areas before deciding to retire a given quality measure.

For rural hospitals that report on required quality measures within given timeframes, the proposal would direct the secretary to provide an annual payment bonus, such as 0.5% or 1%.

In addition, the proposal would include modest funding to support administrative costs and technical assistance to rural hospitals around setting up quality measurement tracking systems and reporting. This could include funds specifically to support nurse training and data collection infrastructure. In addition, the secretary would be directed to identify a central repository within HRSA for technical assistance to help streamline adoption of quality reporting systems.

The secretary would be directed to update the Medicare Hospital Compare website to make it easier for consumers, health care providers, and others to evaluate and compare quality performance across rural health settings.

Finally, this proposal would direct the secretary to make recommendations on establishing Medicare and Medicaid quality reporting programs for rural health clinics. Such study would evaluate the state of rural health clinic quality measurement and make recommendations on necessary measure development and considerations around what structures would need to be in place to support RHC quality reporting and participation.

2. TRANSFORMING CLINICIAN PAYMENT AND DELIVERY IN RURAL AREAS

TO ENSURE ACCESS TO HIGH-QUALITY, LOCAL CARE, CONGRESS OR THE SECRETARY OF HHS SHOULD:

- Eliminate barriers to the adoption of value-based care.
- Improve reimbursement for clinicians practicing in rural areas.
- Reduce administrative burden for providers.

Community-based health care providers face challenges beyond those experienced in the facility setting. Clinicians are increasingly assessed by their adoption of quality improvement activities and reductions in spending, both of which are difficult to achieve in low-volume rural settings. Reimbursement structures benefiting those moving toward value-based models or taking on greater financial risk are becoming more common nationally, but less so in rural parts of the country.

Congress spurred the shift to value-based care through enactment of the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA.[lxxiii] This legislation offered a means to reward providers for basing care on value as opposed to volume of services. Annual payment updates were eliminated for non-hospital services paid under Medicare Part B and replaced with the Quality Payment Program, or QPP, which ties quality to reimbursement and offers the potential for payment increases. The QPP has two-pathways: the Merit-based Incentive Payment System, or MIPS, and Advanced Alternative Payment Models, or APM. These pathways vary in the degree of financial risk to the clinician.

While rural providers have expressed a strong desire to engage in these health care transformation efforts, the ability to participate in the QPP has been difficult.[lxxiv] High overhead and a low volume of billable services result in tight financial margins and insufficient funding to meet operating costs for many rural practices. Additionally, the increasing reliance on robust outpatient care coordination activities continues to overwhelm small and solo providers, demonstrating that the priorities and efficiencies effectively managed in high-volume practices may translate poorly to these settings.

The inherent barriers to value-based payment further aggravate revenue insecurity and are often impractical. Rural providers can play a role in the transformation toward a value-based health care system. However, the focus must remain on improved quality for achieving greater value, as there may be limited opportunity for reducing costs.[lxxv] The realities of rural care delivery must be considered when evaluating its capacity for systemic improvements.

Greater legislative and regulatory flexibility will be necessary to allow rural providers to keep pace with changing reimbursement structures.[lxxvi] The path toward global budgets and population health has neglected to adequately account for the lack of funding opportunities, model accessibility, and IT infrastructure in rural areas. Until adequate model options are accessible to rural providers, improvements should be made to the current reimbursement system.

Eliminate Barriers to the Adoption of Value-based Care

To increase the uptake of services that improve care for the chronically ill, the secretary of HHS should:

- **Exempt chronic care management services from beneficiary cost-sharing requirements.**

Chronic care management, or CCM, services can assist in care coordination activities for those living with chronic conditions. Providers who actively manage care in concert with collaborating providers improve both care quality and the patient experience.[lxxvii] These services benefit all Medicare patients, but may have a greater impact in rural areas, where the population is older relative to that of urban settings.

However, beneficiary cost-sharing responsibility has resulted in limited uptake of CCM services. A significant barrier to the adoption of these services is the unclear value of non-face-to-face services for patients. Actions to address this issue have been taken for other services. Because of the long-term benefit of receiving preventive care, Congress passed legislation in 2008 that eliminated cost-sharing for preventive services under Medicare and authorized the secretary of HHS to categorize additional services as preventive.[lxxviii] In 2010, the ACA required commercial insurers to fully cover the cost for certain services designated by the U.S. Preventive Services Task Force, or USPSTF.[lxxix] Because chronic care

management has been shown to reduce hospitalizations and emergency department visits for high utilizers, the secretary and the USPSTF should examine whether CCM services meet the criteria for preventive care.[lxxx]

A 2017 CMMI evaluation found significant reduction in the growth of Medicare expenditures for beneficiaries receiving CCM services compared to beneficiaries with similar risk profiles who were not receiving CCM. The study found that $52 million in Medicare expenditures for CCM services resulted in $36 million in net savings.[lxxxi] This represents a return on investment of 69%. Assuming the federal government had covered the average 20% beneficiary cost-sharing, we find that the increase in federal spending would still net 35% in savings.[e] The Congressional Budget Office, or CBO, estimates eliminating beneficiary responsibility would cost $790 million over 10 years.[lxxxii] However, resultant savings are not considered. Applying a 35% return, as experienced in the earlier evaluation, the $790 million upfront federal investment would result in a $276 million decrease in overall spending.

In response to the new coronavirus pandemic, the Office of the Inspector General within HHS offered clinicians the option to eliminate beneficiary cost-sharing for telehealth services for the duration of the public health emergency. This flexibility will increase access to high value-care and should extend to other non-face-to-face services, such as CCM. Congress should pass the Improving Chronic Care Management Act (H.R. 3436) to fully eliminate beneficiary cost-sharing for CCM services.[lxxxiii]

To address unique challenges to accessing care for those residing in rural areas, the secretary of HHS should:

- **Exempt rural Medicare beneficiaries from the prohibition against same-day services.**

Medicare currently prohibits billing for same-day visits by a provider or group of providers treating a single condition.[lxxxiv] This restriction is unduly burdensome for those rural residents who must travel significant distances to receive subspecialist care, integrated mental health, and substance use treatment. The prohibition is also at odds with the current health care landscape of increased specialization, integration, and consolidation. Moreover, removing the need for patients to travel unnecessarily is in-line with efforts to provide patient-centered care. There are instances when same-day visits are warranted, and CMS has acknowledged the need for greater flexibility.[lxxxv]

The secretary should eliminate the prohibition on billing same-day services for those living in rural areas. The regulatory change should follow the exception that exists for medical and mental health visits provided at RHCs and FQHCs, as the provision of care in rural areas extends beyond specific diagnoses and facility designations.

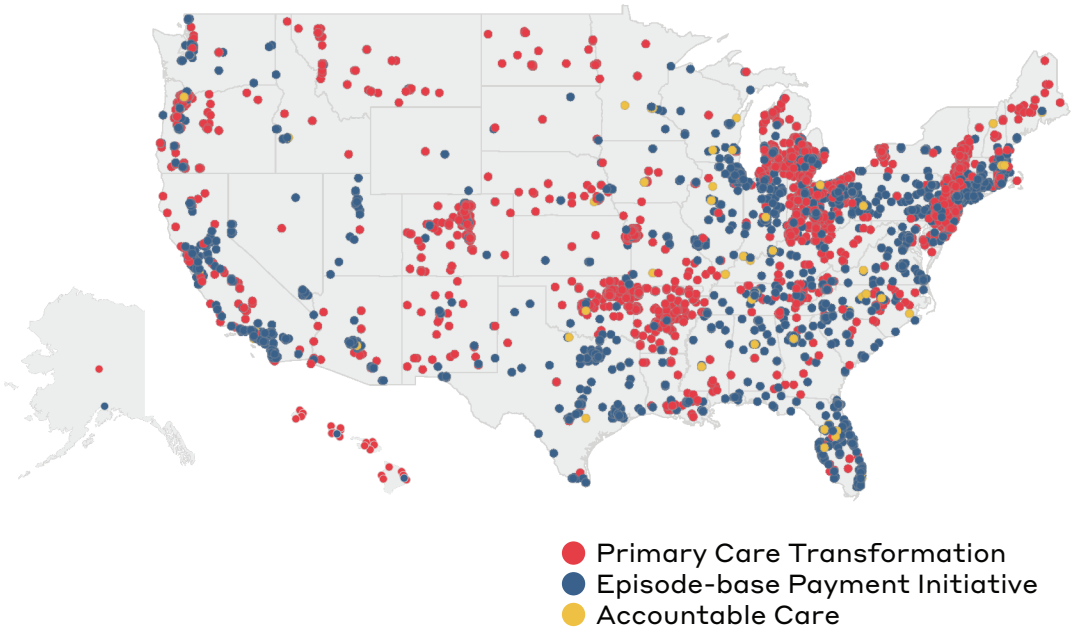
e Total savings of $88 million minus $65 million in federal spending ($52 million is 80% of total cost) equals $23 million net savings. $23 million divided by $65 million results in an ROI of 35%.

To create adequate opportunity for rural providers to transition from volume to value, the secretary of HHS should:

- **Increase the number of rural-specific CMMI demonstrations and expedite national expansion of promising models.**

The heterogeneity of rural communities requires innovative and varied options to increase the adoption of value-based care. Few models address the unique characteristics of patient populations outside of metropolitan areas, and opportunities to participate in value-based care are severely limited in rural settings (*see Figure 2*). Rural providers are largely excluded because they are often unable to absorb the increased financial and administrative stress of newer models. However, this eliminates potential opportunities for rural practices to engage in care transformation efforts.

Figure 2: Geographic Distribution of CMMI Value-based Models



Rural areas typically have fewer CMMI models.

Source: CMS Innovation Center Model Participants data set, March 2020.

CMMI should examine early rural demonstrations, such as the Accountable Care Organization Investment Model and other state initiatives, and quickly extend those models that have demonstrated success to all regions. At the same time, CMMI should offer smaller scale options with greater flexibility. Current models requiring clinicians to meet a minimum beneficiary or reimbursement threshold may preclude participation by small practices and independent providers. CMMI must assess future policy changes through a rural lens to ensure adequate consideration of these communities.

To maintain quality care and continued access to local services, the secretary of HHS should:

- **Leverage patient engagement incentives to decrease rural bypass and incentivize local care utilization.**

A 2008 study found that up to 32% of rural residents elect to forgo local services and receive their primary care at distant sites.[lxxxvi] This so-called rural bypass results in a loss of service volume that threatens the ability of local providers to generate revenue that is sufficient to meet operating costs. More importantly, declining patient volume correlates with decreased quality.[lxxxvii] Providing an incentive to rural residents to receive care locally can increase patient volume, improving both the quality of care and the financial viability of local practices. Medicare should give beneficiaries the opportunity to select a local primary care provider. That provider would be required to maintain certain quality standards, as defined by CMS. Using tiered co-payments, beneficiaries should have discounted cost-sharing for visits to their chosen provider, while continuing to pay standard cost-sharing for out-of-town primary care services.

Improve Reimbursement for Clinicians Practicing in Rural Areas

To ensure providers continue to offer services in rural areas, the secretary of HHS should:

- **Provide a nominal payment update for rural clinicians reporting data under the Quality Payment Program.**
- **Extend bonus payments for new advanced APM participants.**

Medicare providers billing under the Physician Fee Schedule no longer receive an annual payment update. Only mandatory and voluntary participants of the QPP have the potential to receive payment increases. In 2026, a 0.25% nominal payment update will be reintroduced for QPP providers reporting under MIPS.

Payment adjustments under the 2019 payments for Year One of the QPP ranged from +1.88% to -4%. Although the majority of participants received positive adjustments, small practices received 19% of all negative payment adjustments. Small, rural practices in lower volume settings may be ill-equipped to successfully participate in MIPS.[lxxxviii] The costs of the additional staff and technology necessary for participation are more acutely felt and there is a greater risk of receiving a negative payment reduction. Under this proposal, rural providers who are required to participate in the QPP or choose to voluntarily report data should receive a 0.25% nominal payment update.

MACRA instituted a 5% incentive payment for advanced APM participation in the first six years of the program. The intent was to offset the upfront investment and ongoing administrative costs of participation and make

advanced APM participation more attractive than reporting under MIPS. However, there has been a lag in the development of advanced APMs. The bonuses are due to expire in 2022, which does not offer sufficient time to incentivize participation. This is particularly true for inexperienced, rural providers facing significant start-up costs. To encourage greater adoption of advanced APM models, the secretary or Congress should offer new advanced APM participants bonus payments for a set period of time, for example six years, from the time of enrollment in the model or consider providing rural participants a higher bonus payment, for example 6%, to better reflect increased costs of implementation in rural areas.

To account for specific factors affecting rural practice when assessing performance, the secretary of HHS should:

- **Exclude enrolled accountable care organization beneficiaries when determining the regional benchmark in rural areas.**
- **Evaluate MIPS performance data to ensure that rural providers are not disadvantaged by the structure of the program.**

An ACO is a provider-led organization that assumes financial responsibility for the care of a defined population. ACOs are less likely to enter rural markets because they are disadvantaged in areas where a greater percentage of the population is attributed to an ACO. Because spending reductions achieved by ACOs can also lower regional costs, the current performance benchmark does not adequately capture or reward efficiencies and care improvements.[lxxxix] This rural glitch was not fully addressed by a recent change to the benchmarking methodology that will average national and regional inflation. Congress should direct the secretary of HHS to exclude attributed beneficiaries from the regional spending benchmark, as described in the Rural ACO Improvement Act (S. 2648) and the Accountable Care in Rural America Act (H.R. 5212).[xc,xci]

Reimbursement at the clinician level may also be flawed for rural providers. Early data from the QPP shows that rural providers who were required to participate in MIPS received a disproportionate share of negative payment adjustments.[xcii] Further examination of this data is necessary to assess the extent to which inherent program components, such as practice size, place rural participants at a disadvantage. Moreover, mandatory rural participants should receive temporary exemption from negative payment adjustments until the evaluation and necessary program updates are complete.

Reduce Administrative Burden for Providers

To eliminate the unnecessary regulatory burden that is placed on providers, the secretary of HHS should:

- **Direct CMS to utilize readily available claims data to assess quality performance.**
- **Decrease qualifying participation thresholds for rural providers operating under advanced Alternative Payment Models, Rural Health Clinics, and Federally Qualified Health Centers.**

Many providers are required to perform burdensome quality measure collection that is tied to reimbursement. However, current data submission reflects care delivery processes and neglects to account for practice variation. The requirements reward administrative reporting rather than patient outcomes.

Clinicians required to participate in the QPP are not responsible for reporting data for the cost performance category because CMS has the ability to generate that information internally. Similarly, there should also be a shift of responsibility for quality data reporting from the provider. Under this proposal, CMS should leverage quality data and other inputs to provide clinical performance feedback to rural clinicians.

CMS already does this for providers participating in a Medicare Shared Savings Program ACO and MIPS clinicians receiving payment for certain defined episodes, such as joint replacement. These clinicians receive relative performance data, including complications, emergency department visits, and hospitalizations, which may highlight decreasing quality. However, a provider that is unable to participate in these models does not receive actionable feedback and remains ignorant of any need to update care delivery patterns. Provider performance data is necessary for continuous quality improvement and its value extends to all care delivery, regardless of the payment mechanism.

In 2021, CMS will begin a new MIPS Value Pathway that will incorporate claims data, providing additional performance feedback. However, the MVP does not sufficiently decrease complexity and provider reporting burden.[xciii] The secretary should further simplify the QPP, while continuing to support quality improvement. Once providers have received feedback and been given sufficient time to make improvements, CMS should use this information to apply tiered annual payment updates. These updates would be commensurate with performance, without requiring additional reporting.

Providers that treat a sufficient volume of patients through an advanced APM, RHC, or FQHC are currently exempt from MIPS reporting requirements.[xciv] However, the qualifying participation threshold for exemption is difficult to meet in areas with a lower volume of patients and fewer opportunities to capture attributed beneficiaries. The secretary should lower qualifying participation thresholds for rural providers offering services through APMs, RHCs, or FQHCs to decrease reporting burden.

3. IMPROVING ACCESS TO QUALITY MATERNAL CARE IN RURAL AREAS

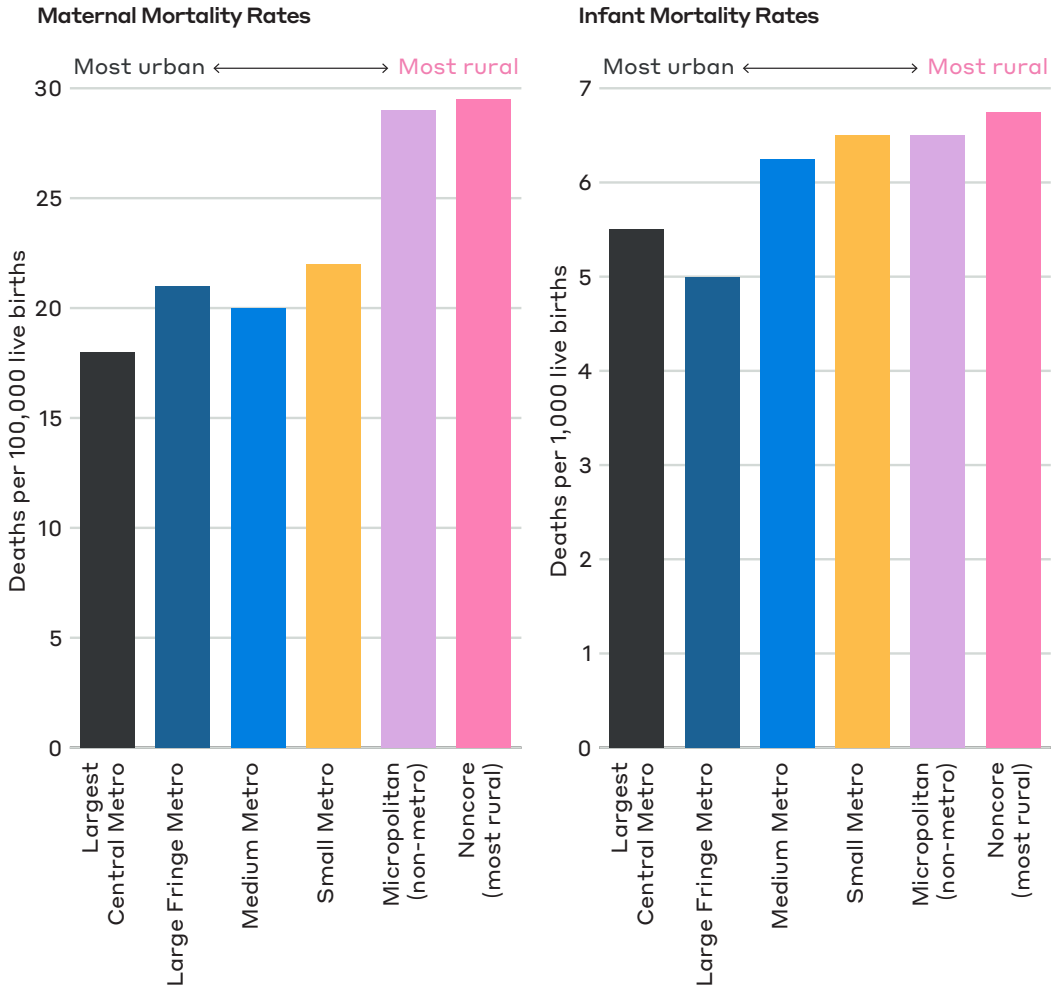
TO EXPAND ACCESS TO OBSTETRIC AND PERINATAL SERVICES IN RURAL AREAS, CONGRESS SHOULD:

- Increase reimbursement rates for rural hospital obstetric units.
- Enhance the Federal Medical Assistance Percentage rate for rural hospital obstetric units.
- Increase funding of maternal health training programs for primary care providers.
- Direct the Centers for Disease Control and Prevention to improve rural maternal mortality data surveillance.

Between 2004 and 2014, 9% of rural hospitals closed obstetric units, leaving more than half of rural counties in the United States without hospital-based maternal care.[xcv] According to one study, the elimination of previously available services in rural areas led to a 5% sustained increase in the number of preterm births – likely relating to a lack of adequate prenatal care – and a 2-3% increase in the number of deliveries occurring in hospitals without obstetric services. In addition, the incidence of out-of-hospital births increased from 1.2% to 1.6%, reflecting a 33% increase.[xcvi]

Nationally, maternal mortality has more than doubled over the past two decades, with rural areas faring worse than urban areas (see Figure 3).[xcvii,xcviii] The cause of this is multifactorial, but evidence shows that a recent loss of rural obstetric services directly correlates with poor clinical outcomes and increased infant and maternal mortality.[xcix]

Figure 3: Maternal and Infant Mortality Rates are Highest in Rural Areas



Source: Dina Fine Maron, "Maternal Health Care Is Disappearing in Rural America." Feb. 15, 2017. Data based on: Centers for Disease Control and Prevention, Maternal and Infant Mortality Rates, 2015.

Low birth volume factors largely into the loss of obstetric services. The national birth rate has declined 19% since 2007.[c] This decrease in deliveries nationwide has an additive effect with other characteristics that have lowered birth volume in rural communities, such as the smaller size and older age of the population. Evidence clearly links lower birth volume to decreased clinical competence and poor maternal and neonatal outcomes.[ci] As a result, many rural hospitals have closed their obstetric units when the number of deliveries fell, citing concerns of decreased clinical quality.

Some rural hospitals also receive insufficient revenue to cover the costs of providing obstetric care, which is partially due to the payer mix.[cii] While lower volume translates into lower revenue, Medicaid rates are a major factor. Medicaid is the dominant payer for maternal care, covering 50-60% of all births in the rural U.S.[ciii] However, the National Rural Health Association estimates that Medicaid reimbursement for obstetric services is approximately one-half the rate of commercial insurance and falls short of covering costs.[civ] In addition,

the costs of providing care are higher in rural facilities because of the mismatch between high overhead and lower volume.[cv] One Tennessee hospital told the BPC Rural Health Task Force that Medicaid rates only covered 63% of the cost of providing obstetric care in that facility. Hospital executives in Iowa said, despite the importance of providing obstetric services, hospitals in their communities were sometimes faced with the financial choice of cutting that unit or closing the entire hospital.

The loss of hospital-based obstetric units produces a ripple effect that threatens the existence of local clinicians to provide prenatal and postpartum care. Only 19.2% of family practice physicians perform deliveries and less than half of rural counties have an obstetric or gynecological workforce.[cvi,cvii] There is little reason to expect this to change in the coming years, as medical residents continue to choose subspecialties that offer higher reimbursement in urban settings.

Most rural facilities do not have the capacity or patient volume to support local specialty training programs. Ultimately, increasing the number of clinicians offering prenatal and postpartum care will be necessary to reduce maternal morbidity and mortality.[cviii]

The lack of a sufficient maternal workforce in rural areas also affects women both before and after birth. The American College of Obstetricians and Gynecologists recommends prenatal office visits with increasing frequency throughout pregnancy, which is not always feasible for those having to travel for care.[cix] One 2016 study surveyed 306 rural hospitals in 9 states and found that rural women traveled up to 65 miles to receive prenatal care after their local obstetric unit closed.[cx] For women who live in rural communities, this led to delayed initiation of prenatal care.[cxi]

Women are at an elevated risk of death for one year following pregnancy, due to the significant physiological changes that occur, and approximately 70% of women report at least one physical problem during that time.[cxii,cxiii] The CDC estimates that approximately 1 in 3 pregnancy-related deaths occurs during the postpartum period, or the 12 months following a pregnancy.[cxiv]

Health insurance coverage is also a major factor affecting maternal health outcomes.[cxv] Current federal and state legislative efforts to address pregnancy-related coverage are under consideration. The Helping MOMS Act of 2019 (H.R. 4996) and the MOMMIES Act (S.1343) include an increased Federal Medical Assistance Percentage, or FMAP, rate to incentivize states to extend Medicaid coverage to 12 months postpartum.[cxvi] However, a streamlined pathway to full coverage would be preferable to any options offering a short-term coverage period with a fixed expiration.

For the purposes of this report, the task force focused on recommendations relating to obstetric services. This was done with the understanding that this is merely one component of a much larger issue requiring broader examination.

Ensure Access to Obstetric and Perinatal Services in Rural Areas

To provide adequate reimbursement for obstetric care in rural hospitals, Congress and the secretary of HHS should:

- **Increase reimbursement rates for rural hospital obstetric units.**
- **Enhance the Federal Medical Assistance Percentage rate for rural hospital obstetric units.**

In order to prevent the closure of obstetric units in rural areas, a targeted increase in reimbursement for hospital-based maternal care is warranted. As previously discussed, the federal government provides cost-based reimbursement for services received at certain rural facilities to offset the increased cost of providing care in those areas. However, because more than half of all deliveries in the rural United States are covered through Medicaid, cost-based reimbursement is not guaranteed.[cxvii] Fewer than half of all states provide cost-based reimbursement for CAHs, and non-CAH rural hospitals only receive cost-based reimbursement in two states.[cxviii] In addition, there is great variability in payment rates across states. New Hampshire Medicaid payments are the lowest in the country and are 49% below the mean.[cxix] As a result, many rural hospitals receive payment that only covers a fraction of the cost of providing obstetric care.

The Children's Health Insurance Program, or CHIP, covers maternal care for uninsured women who do not qualify for Medicaid.[cxx] The federal government provides an enhanced FMAP, or E-FMAP, rate for CHIP services that is based on the formula used to calculate the federal match for the Medicaid program. Federal contribution varies by state with higher reimbursement given to states with lower incomes.[cxxi] A provision in the ACA increased the E-FMAP by 23% for some CHIP expenditures from FY2016-2019, which was extended one year by a continuing resolution.[cxxii] The increase for FY2020 is set at 11.5%.

The secretary of HHS should set reimbursement rates for obstetric care in rural Health Professional Shortage Areas, or HPSAs, at the national median commercial rate. Congress should also take action to incentivize states to adopt this higher reimbursement rate for obstetric services through an E-FMAP rate that mirrors the rates and policies of CHIP E-FMAP.

To enable rural primary care clinicians to receive additional obstetric care qualifications, Congress should:

- **Increase funding of maternal health training programs for primary care providers.**

According to the CDC, approximately 700 women die each year due to complications relating to pregnancy.[cxxiii] Of the maternal deaths occurring between 2013 and 2017, 3 out of 5 were potentially preventable. Critical to reducing maternal deaths is access to consistent quality care by clinicians trained in recognizing and

treating the most common complications of pregnancy. In the 49% of United States counties lacking obstetric and gynecological care, primary care providers make up the front line of care for expectant mothers.[cxxiv] The loss of obstetric units in rural areas and increasing maternal mortality rates have highlighted the need to better equip primary care providers.

States have directed funding from Title V Maternal and Child Health (MCH) Block Grants and state department of health and Medicaid funds towards increasing the obstetric skills of those who are not obstetricians in the local workforce. A variety of state training programs have been developed, including the California Maternal Quality Care Collaborative, or CMQCC. In 2010, California formed this partnership to address maternal morbidity and mortality. Part of their work included an Obstetric Hemorrhage Toolkit, which established best practices through provider training. The toolkit reduced severe maternal morbidity by 20.8% in participating hospitals in the two years following its release in 2014.[cxxv] Since the establishment of the CMQCC, California has seen a 55% decrease in maternal deaths.[cxxvi]

HRSA administers federal programs that also provide funding for various medical education training programs and residencies across the health care workforce. However, designated funding for obstetric care training in rural areas is lacking, and some policymakers have proposed solutions. The Rural MOMS Act (S. 2373) would increase funding by directly providing HRSA with $15 million over five years to provide grants for rural obstetric clinical training and coordinated maternal care regionalization.[cxxvii]

Congress should increase MCH and HRSA funding for educational training programs that equip clinicians with the necessary skills to provide primary care based prenatal care, diagnostics, and appropriate referral guidelines for high-risk maternal care.

To increase understanding of the factors contributing to maternal mortality, Congress should:

- **Direct the Centers for Disease Control and Prevention to improve rural maternal mortality data surveillance.**

In 2019, the CDC released new clinical and non-clinical data on maternal mortality. These data, which include the major causes of maternal mortality, were voluntarily provided by 14 states and local Maternal Mortality Review committees. Key findings included preventable and varied causes of death across racial and ethnic groups. While mental health conditions, such as suicide and drug overdose, are the leading causes of pregnancy-related deaths among white women, black women most often die from cardiomyopathy and other cardiovascular conditions.[cxxviii] These important findings highlighted the need to better identify rural drivers of maternal deaths in all states.

Congress should direct and provide funding for the CDC to enhance rural maternal mortality data surveillance.

4. ENSURING AN ADEQUATE RURAL HEALTH CARE WORKFORCE

TO BUILD A SUSTAINABLE RURAL WORKFORCE, CONGRESS OR THE SECRETARY OF HHS SHOULD:

- Improve utilization of currently available workforce.
- Strengthen the Health Resources and Services Administration rural workforce programs.
- Expand federal rural workforce recruitment and retention initiatives.

The instability of the rural health infrastructure creates unique challenges for workforce recruitment and retention. By 2032, there will be a projected shortage of more than 55,000 primary care physicians in the United States.[cxxix] Urban settings fare slightly better with 53 primary care physicians per 100,000 compared to 40 per 100,000 in rural areas.[cxxx] However, the need for primary care clinicians is present in all settings.

The aging workforce is partly to blame. Many current primary care providers are nearing retirement: a 2009 study found that almost 30% of primary care providers practicing in rural areas were aged 56 or older, while only 20% were age 39 or younger.[cxxxi] Compounding the problem, the vast majority of future physicians are choosing to train in specialties and subspecialties. In 2019, only 12% of medical students entered primary care residencies.[cxxxii] Moreover, the primary care shortage is echoed across provider types, including advanced practice clinicians, dentists, pharmacists, and behavioral health professionals.[cxxxiii] (See Figure 4.)

Figure 4: Per Capita Rates of Health Professionals

Profession	Providers per 100K, Rural Areas	Providers per 100K, Urban Areas
Primary Care Physicians	40	53
Nurse Practitioners	28	36
Physician Assistants	23	34
Dentists	22	30
Specialists	30	263

Rural communities have far fewer clinicians per capita than do urban communities, particularly when it comes to specialists.

Source: About Rural Health Care National Rural Health Association, 2014

A major factor in the shortage of rural clinicians is the lack of familiarity with rural areas. Indeed, clinicians are more likely to practice where they grew up and where they trained. Federal policymakers have made some progress in recruiting clinicians to rural areas through investments in rural graduate medical education, or GME, and a variety of workforce development programs, although the problem is far from solved. Medicare is the major funding source for GME. However, the Balanced Budget Act of 1997 capped Medicare GME funding and it has not kept pace with the workforce deficit.

HRSA administers additional federal programs, the majority of which broadly address HPSAs. Although 60% of these HPSAs are in rural regions, there is far greater provider participation in urban settings. Despite targeted grant funding, loan repayment programs, or LRPs, and technical assistance, rural communities are not recruiting a sufficient health care workforce, nor are they retaining those who do initially come.

Here we highlight several avenues for supporting a sustainable rural health care workforce through increased training, recruitment, and retention. The most expedient options tap into the existing supply of workers by eliminating regulatory and administrative barriers to providing care. Long-term solutions will require flexibility and a greater focus on pipeline and training programs that have been demonstrably effective in the sustainable development of a rural workforce.

Improve Utilization of Currently Available Workforce

To include additional health providers in care delivery, the secretary of HHS or Congress should:

- **Evaluate the potential effect of expanding reimbursement to additional types of providers in rural and Native communities.**
- **Add marriage and family therapists and licensed mental health counselors to the list of Medicare-covered providers.**
- **Remove regulatory and legislative barriers that prevent non-physician providers from practicing at the top of their license.**
- **Eliminate the DEA buprenorphine waiver requirement.**

The growing workforce shortage has highlighted the need to increase utilization of existing clinicians, who have been shown to improve outcomes or lower costs. Barriers to this include exclusion from the list of approved Medicare providers, state scope of practice restrictions, and a resistance to increased costs to the federal government where the long-term effect of these services is difficult to quantify or predict.

The secretary of HHS should assess the impact of expanding Medicare reimbursement to additional provider types, such as pharmacists and social workers. Providers should be examined in terms of both cost and the potential for improved outcomes. The evaluation would clarify the total value created by the coverage of additional providers and the effect of state limitations on the ability of these providers to utilize the full extent of their training. Based on these findings, the secretary would make the determination for which clinicians should be reimbursed. Medicare coverage for members of the care team whose benefit has already been documented should not require additional evaluation. For example, community health workers and doulas should be included as Medicare providers based on previous examination demonstrating their ability to significantly improve health outcomes.[cxxxiv,cxxxv]

In addition, marriage and family therapists, or MFT, and licensed mental health counselors have master's or doctoral level training for treating mental and behavioral conditions and at least two years of clinical experience.[cxxxvi] MFTs currently provide care in more than one third of rural counties in the U.S. and are included, with mental health counselors, in the Public Health Service Act. They may receive placement through the National Health Service Corps, yet Medicare does not currently reimburse for their services.[cxxxvii]

Congress should pass the bipartisan, bicameral legislation (S. 286/H.R. 945) to amend the Social Security Act by including MFTs and licensed mental health counselors as Medicare-approved providers.[cxxxviii] According to CBO, this would have a direct cost to the Medicare program of $400 million over 10 years.[cxxxix] However, this figure does not take potential long-term savings into account.

Regulatory and legislative barriers may also prevent the currently available workforce from fully performing certain skills. Patients in rural areas often rely on non-physician clinicians for a significant portion of their care. Advanced practice clinicians and social workers are able to address unmet need where a more highly trained workforce is unavailable. Despite generally uniform professional educational and training requirements, providers may still have state-defined limitations to the services they are able to provide. Congress should provide clear directives to the secretary of HHS to clarify regulations and incentivize states to enable non-physician providers to practice at the top of their license.

Similarly, the treatment of opioid use disorder with FDA-approved medications, or M-OUD, is limited by federal regulations. Use of buprenorphine is the standard of care for M-OUD, but its utilization requires an additional waiver from the Drug Enforcement Administration. Notably, no such waiver is required to prescribe the opioids that have led to the current crisis. For providers who already possess DEA licensure, this requirement creates an administrative barrier that limits access to buprenorphine.

Congress should remove federal barriers to M-OUD care by passing the Mainstreaming Addiction Treatment Act (S. 2074/H.R. 2482). This bipartisan legislation removes the additional DEA waiver requirement for M-OUD treatment and allows community health aides and community health practitioners in tribal areas to dispense prescriptions issued through telehealth by an authorized provider at a distant site.[cxl]

To accurately reflect the primary care workforce needs in rural areas, the secretary of HHS should:

- **Direct CMS to assign a medical specialty to advanced practice nurses and physician assistants.**

Medicare categorizes NPs and PAs as primary care providers regardless of their actual specialty. For example, PAs and NPs in surgical settings are classified as primary care providers. This may interfere with HPSA determinations and workforce needs by overestimating the number of primary care providers in an area. The secretary should direct CMS to assign a specialty classification to these providers.

Strengthen the Health Resources and Services Administration Rural Workforce Programs

To maximize the effectiveness of rural relevant federal workforce programs, Congress should:

- **Require a comprehensive evaluation of all rural HRSA programs.**

HRSA funds multiple programs that support the recruitment and retention of qualified health professionals in rural areas. However, certain programs and educational opportunities may be more effective in ensuring that rural workforce needs are being adequately met. An unbiased organization, such as the Government Accountability Office, or GAO, or the National Academy of Sciences, should conduct a comprehensive evaluation of all HRSA programs to determine the relative value of the individual programs for addressing rural health workforce needs and identify any unobligated funds. The evaluators should include recommendations regarding which programs should be prioritized and which should be altered or sunset. Additionally, targeted maternal and tribal health workforce programs must be developed to specifically address these populations.

To increase rural residency training opportunities, Congress should:

- **Allow federal funding for Rural Training Tracks to be dispersed prior to the program start date.**

Rural training tracks, or RTTs, are critical to attracting residents to rural areas, as providers are more likely to remain where they train. RTTs allow residents to spend about 50% of their time training in rural areas. Nearly 40% of residents who participate in family medicine RTTs remain in rural practice seven years after completing the program.[cxli] RTTs often lead to a stable rural practice and increased access to care. RTTs are funded through Medicare GME payments and HRSA grant funding. Establishing RTTs can be an expensive venture for small rural facilities. Currently, HRSA funding for RTTs can only be distributed once the program officially starts. RTTs depend on state government subsidies, local hospital and clinic support, or grant funding to support development costs. RTTs need a concrete funding vehicle upfront to support the demand for more RTTs.

Expand Federal Workforce Recruitment and Retention Initiatives

To incentivize providers to practice in rural and tribal areas, Congress should:

- **Exempt Indian Health Service loan repayment funds from federal income tax.**
- **Establish a federal tax credit for providers practicing in rural areas.**
- **Reauthorize the J-1 visa waiver program and increase caps for doctors practicing in rural areas.**

Tax credits and relief from income taxes have long been used as direct incentives for various policy objectives and should be employed to bolster the rural health workforce. Currently, providers who receive student loan repayment for placement in Indian Health Service, or IHS, facilities have to pay

federal income tax on those funds. In contrast, the National Health Service Corps, or NHSC, placements are exempt from federal and state income tax. Congress should pass the Indian Health Service Health Professions Tax Fairness Act of 2019 (S. 2871) to create an exemption for IHS providers.[cxlii]

The federal government has funded various programs to address the health care workforce shortage. These initiatives are largely administered by HRSA, which aims to address the needs of all HPSAs, including those in rural and other underserved communities. Despite the efforts of HRSA and significant federal investment, access to care has not demonstrably improved in many rural areas. For example, the Teaching Health Center Graduate Medical Education, or THCGME, trains primary care doctors in nonhospital and community-based settings. While 82% of THCGME residents train in medically underserved areas, only 20% practice solely in rural settings. LRPs, such as NHSC, have been successful at recruiting clinicians, but less effective at retaining them.

To help with retention, Congress should institute a federal rural practitioner tax credit to augment the efforts of other federally-administered HRSA programs. A 5-year annual federal tax credit should be offered to physicians and advanced practice clinicians choosing to work in rural HPSAs. Under this model, federal dollars would only be spent if providers practice in rural HPSAs. The federal tax credit, for example $10,000, $15,000, and $20,000, should be tiered based on provider type. To ensure a consistently targeted benefit for underserved rural areas, the rural HPSA designation should be updated every five years.

Some states have already successfully instituted such tax incentives. For example, Oregon established a Rural Practitioner Tax Credit in 1989, which offers an average of $8.5 million annually in tax credits for providers practicing in rural areas of the state.[cxliii] The $3,000, $4,000, or $5,000 annual tax credit is tiered – with those working farthest from an urban center receiving the maximum amount. New Mexico offers a $3,000 or $5,000 tax credit that prioritizes certain provider types. A 2016 review of relevant workforce programs in Oregon demonstrated that while the NHSC LRP was successful at attracting providers to the area, it had minimal effect on retention.[cxliv] Conversely, the Rural Practitioner Tax Credit increased the likelihood that a provider would stay in the area, but was not a significant tool for recruitment.[cxlv] Notably, task force members believed that the combination of the programs had a synergistic effect on both recruitment and retention.

Another policy lever that should be expanded to attract providers to rural practice are J-1 visas. The Conrad 30 program provides each state with up to 30 J-1 visa waivers to authorize international medical graduates to stay in the U.S. for an additional three years to practice in HPSAs. Research shows that between 2001 and 2010, 41 states gave waiver priority to primary care slots.[cxlvi] However, the need for primary care continues to increase and the current workforce is insufficient to meet that need, particularly in rural areas. Given

the growing physician shortage, state waivers should be increased to 50 with priority given to rural areas.

The Conrad State 30 & Physician Access Reauthorization Act (S.948) would reauthorize the program until 2021 and increase state waivers from 30 to 35.[cxlvii] While this increase would provide some relief, care gaps continue to grow and recruitment to rural areas lags behind need. It is important to raise the cap further to allow states to maximize the benefits of the J-1 Visa program. Increasing state waivers does not necessitate more federal funding.

To expand efforts aiding in workforce retention, the secretary of HHS should:

- **Direct the National Advisory Committee on Rural Health and Human Services to evaluate and develop recommendations for interagency coordination.**

Interagency collaboration should be leveraged to reduce barriers to practicing in rural areas. The National Advisory Committee on Rural Health and Human Services should lead an analysis that highlights opportunities for coordination between HHS, the Department of Labor, and the Department of Housing and Urban Development. For example, coordination with the DOL should enable the creation of bridge programs that support career progression for licensed providers. This would allow allied health providers employed in rural settings to build upon their training without leaving their positions. Similarly, HUD should be engaged to address the lack of provider housing in certain areas, which is a particular barrier to IHS placement in Native communities.

5. BREAKING DOWN BARRIERS TO TECHNOLOGY IN RURAL COMMUNITIES

TO INCREASE ACCESS TO HEALTH CARE SERVICES IN RURAL AREAS, CONGRESS OR HHS SHOULD:

- Support efforts to expand broadband and collect accurate broadband data in rural and tribal areas.
- Remove restrictions that prevent full utilization of currently available technology in areas without broadband access.
- Expand the list of authorized sites of service for telehealth.
- Streamline licensure requirements.
- Prioritize rural-specific training curricula for the health IT workforce.

Health IT has enormous potential to expand access to clinicians, support those working in more remote areas, and enable continuous quality improvement. Innovative tools, such as remote patient monitoring, electronic health records, and telehealth, have been used successfully to assist clinicians and promote patient-centered care. Moreover, technology is instrumental to data-driven health and health care improvement. Value-based care depends on the continuous assessment of quality and outcomes, yet many health facilities in rural areas lack access to the telecom and health IT infrastructure necessary to track quality metrics and expand access to services. For example, according to the Federal Communications Commission's 2019 Broadband Deployment Report, 26% of rural Americans and 32% of Americans on tribal land lacked access to broadband, compared to 1.7% of urban Americans, by the end of 2017.[cxlviii]

Additionally, in rural facilities where advanced technology is currently available, legislative and regulatory barriers limit the use of innovative care models such as telehealth and remote patient monitoring. These barriers are particularly troublesome in rural areas where care access is already strained. For example, site of service restrictions often interfere with the ability to offer services. Greater flexibility is needed to appropriately provide care in the home or through telehealth and virtual consults. CMS recently issued regulations that introduce exceptions for certain risk-based health care delivery models, allowing greater use of telehealth and virtual communication services. However, for rural providers unable to bear the substantial downside risk of these models, services supporting a patient-centered approach to care remain inaccessible.

Congress and the administration temporarily waived many Medicare restrictions for telehealth as part of the March 2020 funding bill in response to the COVID-19 public health emergency. This action eased geographic and site of service restrictions and expanded service to individuals who are not already established patients. While the flexibilities offer short-term solutions during a crisis, the recommendations below offer permanent legislative and regulatory improvements that enable rural areas to keep pace with advancing technology.

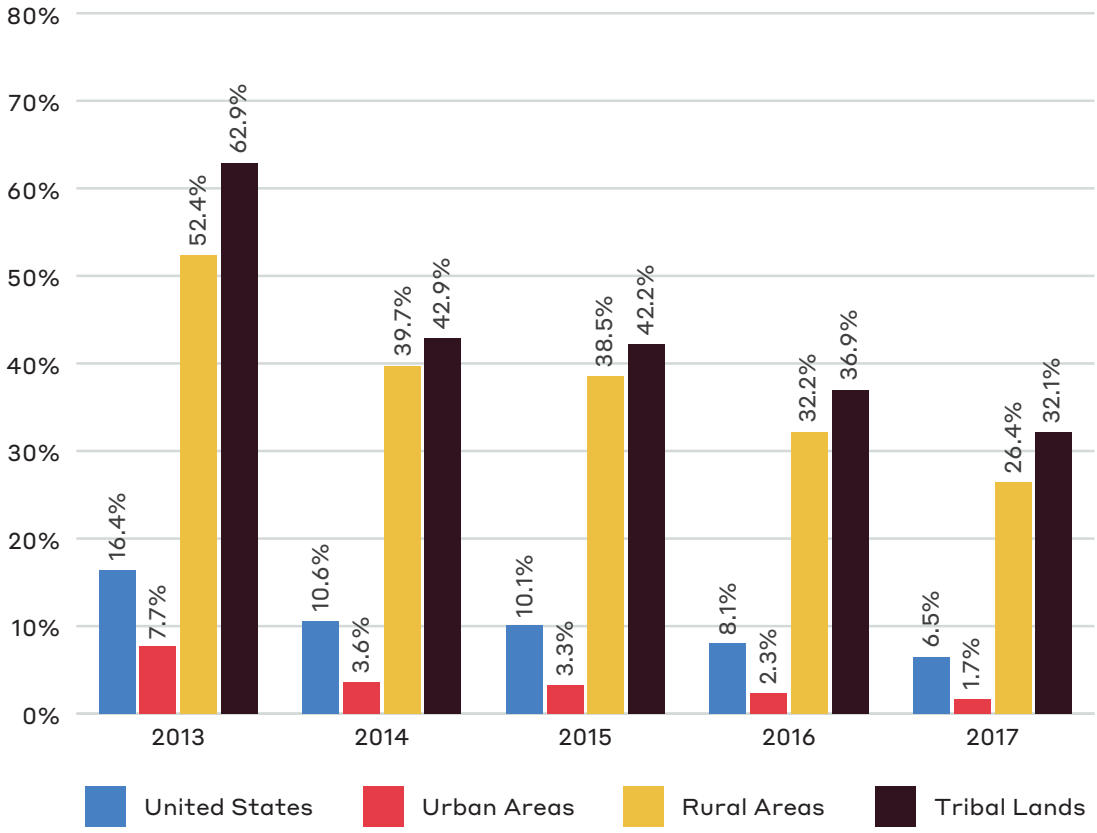
Support Efforts to Expand Broadband and Collect Accurate Broadband Data in Rural and Tribal Areas

To meet rural technology infrastructure needs, Congress, the FCC, the USDA, and other federal, state, or local entities able to provide broadband services should:

- **Continue to prioritize connecting rural areas with broadband through anchor institutions and direct-to-home services.**

According to the Federal Communications Commission's 2019 Broadband Deployment Report, 26% of rural Americans and 32% of Americans on tribal land lacked access to broadband, compared to 1.7% of urban Americans, by the end of 2017 as shown in Figure 5.[cxlix] Without access to broadband, rural settings will continue to lag behind their urban counterparts and face challenges in meeting quality reporting requirements. However, meeting the telecommunication needs of rural areas is a costly endeavor. The Schools, Health & Libraries Broadband Coalition and CTC Technology & Energy estimates that creating the infrastructure to expand broadband access through community anchor institutions, such as libraries, health centers, and schools, would cost between $13 billion and $19 billion.[cl]

Figure 5: Percent of Population without Access to Fixed Terrestrial Broadband at Speeds of 25Mbps/3Mbps



Rural areas and Tribal lands consistently lack access to broadband.

Source: FCC 2019 Broadband Deployment Report

Extending broadband access to rural homes is estimated to be much more costly—between $40 billion and $61 billion.[cli,clii] Rural areas currently receive federal funding to bring broadband into communities through the FCC, USDA, and other grant programs; additional funds are available through user fees, state match to federal spending, or from public-private partnerships. Continued support of broadband expansion efforts and capital expenditures is necessary to ensure rural providers have appropriate resources to keep pace with current and future quality reporting requirements.

To improve data collection standards and ensure accurate representation of broadband needs, Congress and the administration should:

- **Ensure effective implementation of the Broadband Deployment Accuracy and Technological Availability Act.**

Prior to the recent passage of the Broadband Deployment Accuracy and Technological Availability Act (H.R. 4229/ S. 1822), or Broadband DATA Act, broadband coverage data was self-reported by internet service providers based on census block data. Census block data as a unit of geography allowed internet

service providers to report the entire area as able to obtain broadband even if only one person in that area was covered. The self-reporting methodology contributed to the broadband mapping inaccuracy and ultimately less broadband access for rural Americans.

The Broadband DATA Act proposed new broadband data collection methods. It requires the FCC to collect granular broadband service availability data and organize a competition for independent data collectors to challenge FCC broadband coverage data. Additionally, the bill tasks FCC with creating requirements on data collection conducted by broadband providers. Finally, the bill asks GAO to identify locations where broadband can be installed to enhance the quality of the data.[cliii] CBO estimates the implementation of this act would result in a gross cost of $52 million over the 2020–24 period.[cliv] Effective implementation of this legislation is crucial to providing an accurate depiction of broadband services and ensuring capital expenditures help rural areas most in need

Remove Restrictions That Prevent Full Utilization of Currently Available Technology in Areas Without Broadband Access

To allow full use of currently accessible technology in rural areas, Congress and HHS should:

- **Expand telehealth services to include non-face-to-face services.**
- **Allow virtual visits as substitutes to office visits at lengths beyond the currently allowed 5-to 10-minute check-ins.**
- **Expand asynchronous services beyond images to include written information shared by phone or through text and email.**

Telehealth services are currently available to established patients in rural areas when performed through live video. With the exception of Alaska and Hawaii, previously collected information is not acceptable. CMS recently introduced an alternative to this so-called store-and-forward restriction by creating new virtual care codes that allow providers to bill for reviewing previously recorded images.[clv] These asynchronous telemedicine services are particularly well-suited for specialist consultation and for reviewing imaging and other diagnostic studies. CMS also introduced exceptions for Medicare Advantage, or MA, and higher risk ACOs to bill for remote patient monitoring and other virtual care.[clvi] However, MA plans and ACOs are uncommon in rural communities. Additionally, without broadband access, these innovative services remain inaccessible to those in rural settings.

Patients who only have access to more traditional forms of electronic communication, such as telephone, text message, fax, and email, are unable to benefit from telehealth, as it is statutorily defined. Until adequate broadband

connectivity is available nationwide, care provided through any available means of technology-based communication must be considered sufficient for reimbursement. The secretary must update policies to eliminate restrictions on the full use of current technology for beneficiaries living in rural areas. CMS should allow virtual visits as substitutes for office visits at lengths beyond the currently allowed 5- to 10-minute check-ins and should expand the definition of reimbursable asynchronous services to include written information shared by phone, text, and email. In addition, Congress should update the telehealth definition to include non-face-to-face services.

The administration relaxed certain restrictions to enable greater use of technology during the COVID-19 pandemic. Patients can now use their telephones for telehealth services; HHS will not enforce penalties for Health Insurance Portability and Accountability Act, or HIPAA, violations by providers acting in good faith when using FaceTime, Skype, or similar platforms. These actions support the need to create flexibilities that allow full utilization of currently available technology on an ongoing basis.

Expand the List of Authorized Sites of Service for Telehealth

To provide greater accessibility of telehealth services, Congress should:

- **Include the home of an individual in the list of authorized originating sites for telehealth in rural areas.**
- **Pass the Rural Health Clinic Modernization Act of 2019 and the CONNECT for Health Act of 2019.**

Current law limits payment of telehealth and virtual communication services to specific sites of service.[clvii] Greater flexibility for telehealth services is given for substance use disorder, stroke, end-stage renal disease treatment, and for certain risk-bearing arrangements, through exemption from geographic and originating site restrictions. Similar flexibility should be offered for rural areas to increase the use of telehealth and virtual communication services. Specifically, rural areas should be exempt from the originating site restrictions that prevent patients from receiving telehealth services in the home. The Mental Health Telemedicine Expansion Act (H.R. 1301) offers this flexibility for mental health services but it should be broadened to include medical services.[clviii]

As part of the COVID-19 emergency funding bill, Congress temporarily broadened the telehealth regulations to allow a patient's home to serve as an originating telehealth site in an area with a designated emergency.[clix] However, the task force believes this solution should be permanent and not require a waiver. CBO estimates this telehealth expansion would increase Medicare costs by about $490 million over 10 years.[clx]

Similarly, RHCs currently may not serve as distant sites for telehealth services. Although the Social Security Act specifies that RHCs are permissible originating sites, they are not included on the list of approved distant sites where the telehealth provider is located. In 2017, the National Advisory Committee on Rural Health and Human Services recommended adding RHCs to the list of CMS-authorized distant sites. Members of Congress have introduced bipartisan, bicameral legislation that supports this change in both the Rural Health Clinic Modernization Act of 2019 and the CONNECT for Health Act of 2019.[clxi,clxii] Moreover, President Trump's 2021 budget proposal would allow both RHCs and FQHCs to serve as distant sites.[clxiii] Such action would support care coordination efforts and increase access to providers.

Streamline Licensure Requirements

To alleviate barriers to accessing qualified providers and increase access to providers across state lines, Congress should:

- **Authorize licensed clinicians to provide inter-state services to Medicare beneficiaries.**

Providers offering telehealth services are currently held to licensure requirements in the state where a patient is located. In order to treat patients across state lines, providers must obtain licenses for each state. In 2017 and 2018, the Federal Trade Commission Economic Liberty Task Force examined options for increasing licensure portability and incentivizing participation in interstate licensure compacts. The task force found interstate compacts simplify, expedite, and reduce the costs of obtaining multiple licenses in order to practice in multiple or neighboring states.[clxiv] However, it also suggested that a mutual recognition model allowing providers to maintain a single license to practice in all member states is especially effective for telecom-based work and emergency services crossing state lines.

Congress should pass legislation authorizing licensed providers in a state to provide services to Medicare beneficiaries in another state. Moreover, for the purposes of providing telehealth in rural areas or HPSAs, services should be considered to have been furnished at the location of the provider, or distant site, rather than the patient, or originating site. This should apply to matters of both licensure and liability. Although members of Congress introduced two bills to accomplish this (S.2662 and H.R. 3077) in the 113th Congress, neither passed.[clxv,clxvi] The Telemental Health Expansion Act of 2019 (H.R. 5201) and Mental Health Telemedicine Expansion Act (H.R. 1301) would remove the site restriction but would not address non-mental health services.[clxvii,clxviii]

Prioritize Rural-Specific Training Curricula for the health IT Workforce

To ensure rural providers have appropriate health IT training resources, the secretary of HHS should:

- **Direct the Office of the National Coordinator for Health Information Technology to prioritize rural-specific training curricula for the health IT workforce.**

In 2012, the Washington, Wyoming, Alaska, Montana, Idaho Rural Health Research Center surveyed rural primary care practices across 13 states and found that 70% of respondents used electronic health records and health IT, but nearly two-thirds required additional staff training. One of the most frequently cited workforce barriers was the availability of training at the community college and baccalaureate level.[clxix] Moreover, providers identified issues retaining qualified staff in a competitive market and limited resources for training, both in funding and availability of time to complete trainings.[clxx]

The American Recovery and Reinvestment Act of 2009 authorized $2 billion for health IT programs. The Office of the National Coordinator for Health Information Technology, or ONC, set aside $120 million of that funding to expand existing academic programs to include more health IT-focused work.[clxxi,clxxii] ONC provides health IT curricula resources for educators, some of which grantees of the Federal Office of Rural Health Policy's, or FORHP, rural health IT program developed and revised.[clxxiii]

While these programs and training materials have elevated the availability of training for a health IT workforce overall, only a few acknowledge the additional challenges of broadband access and outstanding workforce retention issues in rural areas. Rural-specific programs like "It's a HIT!" originally funded in 2013 through FORHP and operated by the Prairie Health Information Technology Network, modified the ONC curriculum for rural areas to target full-time health care workers.[clxxiv] HHS and ONC should prioritize rural-focused training curricula for the health IT workforce when further revising the curriculum.

Conclusion

BPC's recommendations represent rigorous and politically viable solutions to the current health care crisis in rural America. Moreover, the work and consensus of this bipartisan task force underscores the ability of Congress and HHS to adopt and implement these recommendations, even in a highly partisan political climate. These recommendations seek to stabilize the rural health care infrastructure, promote the uptake of value-based care, and ensure access to local providers.

While the task force recognizes that stabilizing the rural health care infrastructure will require new expenditures, BPC and the Rural Health Task Force believe these to be attainable goals. Included in Appendix A are possible ways in which to cover the cost of capital infrastructure, increased reimbursement rates and coverage, and funding for workforce development.

Additionally, the task force felt that broadband access/virtual care, maternal health, and heath care in Native American communities warrants a more comprehensive consideration than was feasible in this report. Connecting rural areas through broadband deployment is costly but necessary in enhancing access to care and moving toward value-based care. Access to prenatal and postpartum care is important for managing the risks that drive maternal deaths.[clxxv] Native American communities face higher rates of chronic disease, lower life expectancy, and disproportionate levels of poverty.[clxxvi] Additional barriers to care for all rural communities – including lack of insurance coverage, inability to afford care, geographic isolation, and other social determinants of health – must also be addressed.[clxxvii]

The recommendations included in this report address fundamental and immediate problems in rural areas. These policies offer a necessary step forward to stem the steady stream of rural hospital closures and loss of access to care in rural areas. BPC's leaders thank Congress and HHS for making rural health a priority and look forward to continued work on rural health issues.

Appendix A: Possible Pay Fors

End Surprise Medical Billing	Congress could prohibit surprise medical billing and have the payers pay out-of-network providers the median in-network rate. (Original HELP proposal – S. 1895)	$24.9 billion over 10 years
End "pay-for-delay" deals that keep generic drugs off market (H.R. 2375, S. 64)	Congress could prohibit brand name drug companies from compensating generic drug and biosimilar drug makers to delay the entry of a generic or biosimilar into the market, an action referred to as a "pay-for-delay" deal. (Included in H.R. 2375, S. 64)	$613 million over 10 years
Impose a new excise tax on nicotine used in vaping	Congress could impose a new excise tax on nicotine used in vaping at a rate of $50.33 per 1,810mg of nicotine. It could also require occupational taxes on manufacturers of the same. (Included in H.R. 4742)	$9.882 billion over 10 years
Include the value of coupons in determination of average sales price for drugs, biologicals, and biosimilars under Medicare Part B	Congress could require manufacturers to include the value of coupons provided to individuals with private insurance in calculating the ASP for a drug, biological, or biosimilar in Medicare Part B. (Included in S. 2543)	$1.45 billion over 10 years
Institute a Medicare Part B rebate by manufacturers for drugs or biologicals with prices increasing faster than inflation.	Congress could require manufacturers to pay a rebate for drugs and biologicals for which the ASP increases faster than inflation, as measured by the Consumer Price Index for all Urban Consumers (CPI-U) in Medicare Part B. (Included in S. 2543)	$10.69 billion over 10 years
Institute Medicare Part D rebate by manufacturers for certain drugs with prices increasing faster than inflation	Congress could require manufacturers to pay a rebate for Part D drugs for which the list price, based on the WAC, increases faster than inflation, as measured by CPI-U. (Included in S. 2543)	$57.476 billion over 10 years
Eliminating Medicare Advantage "Double Quality Bonuses"	Congress could eliminate the cap on Medicare Advantage (MA) benchmark amounts and the doubling of quality increases in specific counties. Explanatory Note, per the Medicare Payment Advisory Commission: Current law contains two special adjustments to the county MA benchmarks that make the benchmarks inequitable across counties. These adjustments are based on older, inequitable, administratively set payments. Both of these adjustments affect MA benchmarks primarily for high-quality plans and often offset one another. Eliminating both the cap on benchmarks and the doubling of quality increases would make the benchmark-setting process simpler and more equitable, while leaving overall payments at roughly the same level. There would be a reduction of roughly 0.1% of MA program spending	$3.5 Billion Over 10 Years (2017 estimate)

Increasing the Medicare Advantage Coding Intensity Adjustment and Accounting for Encounter Data	Congress could change the yearly increase to the MA minimum coding intensity adjustment from 0.25 percentage points to 0.67 percentage points until the minimum adjustment plateaus at 8.76%. Under a revised approach to this policy, future year scheduled coding intensity adjustment increases discussed above could be cancelled if CMS determines that encounter data and related claims information reported by the MA plans can verify that MA vs. Medicare FFS coding differences can be explained by actual patient acuity rather than coding patterns.	$18 Billion Over 10 Years (2017 estimate)
Hold a spectrum auction	For funding for rural communities to expand access to broadband, Congress could require the FCC and the Rural Broadband Auctions Task Force to raise money through an additional spectrum auction – selling the licenses for electromagnetic spectrum.	Dependent on amount of spectrum sold.
Hold a reverse auction	To deploy broadband in unserved or underserviced areas, the FCC can lower associated costs through reverse auctions. In a reverse auction, broadband providers out-bid one another by claiming the lowest amount of government funding required to build to the established standard of broadband infrastructure. These auctions can be structured to incentivize higher broadband performance speeds and include rural electrical co-ops and utility service companies as bidders.	Dependent on auction

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Appendix B: Rural Provider Designations

Facility Type	Statutory Definition	Medicare Payment Rate	Number of Facilities
Critical Access Hospital (CAH)	CAHs must be located in a rural area and more than 35 miles from the nearest hospital, with some exceptions; must have 25 or fewer inpatient beds or 25 or fewer total inpatient plus swing beds; have an average annual length of stay of 96 hours or fewer; and have 24-hour emergency care service using on-site or on-call staff.	CAHs are paid 101% of reasonable costs for most inpatient and outpatient services.	1,246
Sole Community Hospital (SCH)	Hospitals can qualify based on various criteria, including: located 35 miles from nearest like hospital; located between 25-35 miles from other hospitals, but hard to access during parts of the year due to weather; the hospital is rural and travel time to nearest hospital is at least 45 minutes.	SCHs are paid on the higher of the IPPS rate or a base year federal rate.	402
Low Volume Rural Hospital	For FY2019-2022, a hospital must have fewer than 3,800 total patients discharges per year and be located more than 15 miles from the nearest hospital.	Low-volume hospitals receive a sliding scale, per discharge add-on payment.	500 (approx.)
Medicare Dependent Hospital (MDH)	Must be located in a rural area; 100 inpatient beds or fewer; not be otherwise classified as a sole community hospital; at least 60% of the hospital's inpatient discharges were Medicare Part A patients – a key criteria that identifies these facilities as "Medicare dependent".	MDHs are paid based on the higher of the IPPS rate or a blended rate based on a statutorily defined based year.	138
Rural Health Clinic (RHC)	Must be located in a non-urban area that is also certified as a federally-designated shortage area. RHCs are subject to various requirements, such as employing an NP or PA that works at the clinic at least 50% of the time clinic is open, must offer lab services, and have drugs and biologics available for emergencies. Covered RHC services can be provided in RHCs, at a patent's residence, in a nursing home, or at the scene of an emergency.	All inclusive, per visit rate that is updated annually by an inflationary index.	4,500 (approx.)

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