Center *for* Rural Health

Rural Health Policy: Rural Health Within the US Health Policy Process

NURS 586 Rural Health Programs and Research

June 21, 2022

UND College of Nursing and Professional Disciplines

Presented by Brad Gibbens, Deputy Director and Assistant Professor

Center *for* Rural Health
The University of North Dakota
School of Medicine & Health Sciences

1

Center *for* Rural Health

- Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND
- One of the country's most experienced state rural health offices
- UND Center of Excellence in Research, Scholarship, and Creative Activity
- Home to seven national programs
- Recipient of the UND Award for Departmental Excellence in Research

Focus on
- Educating and Informing
- Policy
- Research and Evaluation
- Working with Communities
- American Indians
- Health Workforce
- Hospitals, Public Health, EMS, Primary Care, and other systems.

ruralhealth.und.edu

2

2

Center *for* Rural Health

Todays Objectives:

1. To better understand the relationship between the rural setting and health policy.
2. To gain insight into current rural health policy issues.
3. To understand how health policy is developed.

3

3

Center *for* Rural Health

It is always about the community

This is what shapes rural health – viable health systems, access to quality health care, improving population health contributes to community health AND is a driver for rural health policy.

4

4

Center *for* Rural Health

The Importance of Values

Ultimately our values guide our perceptions toward health, health care, our view of the importance of "community", and the development of public health policy

"It is not what we have that will make us a great nation, it is how we decide to use it"
Theodore Roosevelt

"Vision is the art of seeing things invisible"
Jonathan Swift

"Americans can always be relied upon to do the right thing…after they have exhausted all the other possibilities"
Sir Winston Churchill

5

5

Culture and Values and Public Policy

- Culture drives policy and policy affects culture
- Policy needs legitimacy –public belief
- However, conflict in policy is inevitable and natural
- Since values frequently conflict –political environment "sorts" things out
- Politics is a creative allocation of resources within a context of competing values
- Value screens or how we interpret policy choices through our own values
- Data and facts vs. values and beliefs – understanding within the context of prevailing values – masking, vaccine
- Policy framing – the use of metaphors to convey values

6

6

Center *for* Rural Health

Rural Health- An Overview

- Rural Health focuses on **population health** –CHNA as a tool to understand and take action
- Rural Health focuses on **infrastructure** that contributes to population health
- Rural Health ***is not*** urban health in a rural or frontier setting
- Rural Health can be framed as a **health equity or fairness issue**
- Rural Health can be framed as **interdependent/collaborative** or community engagement
- Rural Health is dependent on **viable communities** and viable communities can include a strong rural health system inclusive of **community sectors**
    - Education, economic/business, government, faith-based, and health/human services
    - Thus, rural health policy also is associated with rural economic development, human services, transportation, housing, and other policy categories.
- Rural Health is changing – **"volume to value"** – new payment and delivery mechanisms designed to better address population health, improve care, and (just maybe) reduce or control costs.
- Rural Health exists in a larger **environment** which has an affect on the community and the rural health infrastructure; however, the **community can take action** (engagement) that in turn **impacts the environment.**

7

7

Center *for* Rural Health

Significant Areas of Interest Addressed in Rural Health Policy

- **Reimbursement/Payment/MONEY (System redesign) –** dollars associated with what is done and/or what results (newer focus)
- **Health Workforce –** continuous problem but exacerbated during pandemic- post pandemic? Is it post or are there continuous phases. Workforce is seen as # 1 issue.
- **Health Care Quality and Performance** – relationship to health reform – early 2000's.
- **Population Health –** significant within health reform –health policy relates to health status as does economic policy, housing, education, judicial, transportation, human services
- **Telehealth-** similar to workforce impacted by the pandemic.
- **The Silos – the Health System, infrastructure, moving parts** –
    - Where? Rural and urban, system integration to provide access (bottom-line).
    - Who? Types of provider groups, independent or system, Amazon, Walmart, CVS
    - How ? Provider arrangement, payment streams
    - Logical system or is it? Heath care and policy structure, fragmented. Incremental
    - Health policy touches all elements
    - Again **ROLE OF OUR VALUES**

8

8

Center *for* Rural Health

Significant Areas of Interest Addressed in Rural Health Policy

- **Silos of a Health System**
  - **Hospitals** (private for-profit, non-profit, specialty, rural (CAH, PPS, SCH, MDH)-alphabet soup-independence of the rural system survives or part of larger, urban based systems.
  - **Physicians -**Primary care, specialty, PA, independent, group, large system, and now private business – Amazon, Walmart, etc.
  - **Nurses** – RN, APN, LPN –shortage/maldistribution, also private business, impact of pandemic
  - **Clinics –** CHC, RHC, multi-disciplinary, independent or hospital, "sliding fee"
  - **Nursing homes** – aging, community based services, role of the NH going forward
  - **EMS –** an array of provider categories, organizational arrangements, and in rural heavy reliance on the volunteer model. And finally quality metrics comes to rural EMS.
  - **Behavioral and Mental Health-** renewed focus, workforce concerns, access/access/access.
  - **Payors** – Medicare, Medicaid, commercial, CHIP, IHS, veterans – new APMs (volume the value).
  - **Pharmaceutical –**implication for rural with 340 B
  - **Overall, an interesting and <u>complex blend of public/private levers.</u>**
  - **Health policy tends to be focused on the silos. We think in increments and create incremental policy.**
  - **Can we say what our health policy is or is it more focused on describing our payment system, our hospital policy, our workforce policy?**
  - **We will see later much of it is associated at the federal level based on a intentional fragmentation of committees.**

9

9

10

10

Key Concepts in Health Reform

- **2 Primary Changes: Insurance** and **Health System Redesign**
- **Population health** – improve outcomes

emphasize prevention, care coordination,
less hospital admissions/readmissions,
less inappropriate ED visits

- **Social determinants of health**
- **Volume to value** (changing how we pay for services to be less volume and more value – quality and outcomes)
- **Accountable Care Organization** (ACO) is an example: National Rural Accountable Care Consortium (Caravan Health – 7 now 8 ND CAHs) - 22% of ND CAHs are associated with an ACO.
- More interest in CIN, CPC+, in ND Blue Alliance

11

Center *for* Rural Health

Population Health

"Health outcomes of a group of individuals, including the distribution of such outcomes within the group."(Kindig, *What is Population Health?*)

- Significant focus in health reform (ACA) –conceptual driver of health reform policy and "system redesign" – CMMI created by the ACA (ACO, CHART)
- Groups in a population health approach can be based on geography, race, ethnicity, age, language, or other arrangements of people
- Focus – Health Outcomes (what is changed, what are the impacts, what results?)
- What determines the outcomes (determinants of health)?
- What are the public policies and the interventions that can improve the outcomes?
- What is or can be done in a rural health system to address population health?

12

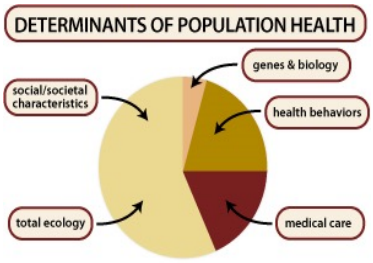
12

Population Health Provides the Best Definitional Framework

It focuses on measurable outcomes from multiple sectors

- Clinical outcomes
- Education levels
- Poverty rates
- Environmental factors

Creating a holistic picture of a community's health



13

Population Health in the Affordable Care Act

- **CMS Innovation Center** – development and testing of innovative health care payment and service delivery models (better care, better health, and lowered costs through improvements in the health system)
- Generate new models (in an experimental stage in health policy)
  - **Alternative Payment Models**
    - This is value based or movement from "volume to value" (care coordination).
    - Accountable Care Organizations (ACO)- Shared Savings is most common- 8 CAHs in ND (561 Shared Savings Medicare ACOs nationally in 2018 now about 500 in 2022) – saved Medicare $1.7 B in 2018 and $4 B in 2020 ($2 B pay back to providers).
    - MACRA and MIPS (system change an alternative payment models – clinicians).
    - New in 2019 five new Primary Care Initiatives (PCI) – grow out of CPC+.
    - Simultaneous focus on increase quality and lowering cost.
    - Accepting risk – Trump administration is "risk on steroids."
    - Continued under Biden.
    - CHART -rural model, CMS
    - ACO REACH –rural model, CMS.
- **BCBSND Blue Alliance**

14

Center *for* Rural Health

Social Determinants

World Health Organization definition:

"the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."

15

15

Center *for* Rural Health

SDOH Toolkit

16

Center *for* Rural Health
The University of North Dakota
School of Medicine & Health Sciences

16

Population Health Impacted by 2021 Infrastructure Act

•$1.2 trillion – physical infrastructure that can improve population health

•"Once in a generation investment…think long term"

•Focus

- Clean drinking water – replace lead water pipes
- Roads and bridges
- Air quality
- Plug orphan oil wells
- High speed internet –broadband – telehealth access –new Affordable Connectivity Program – rural and tribal impact
- Electric transmission –invest in a clean energy power grid

17

General Observations on the Health Care System

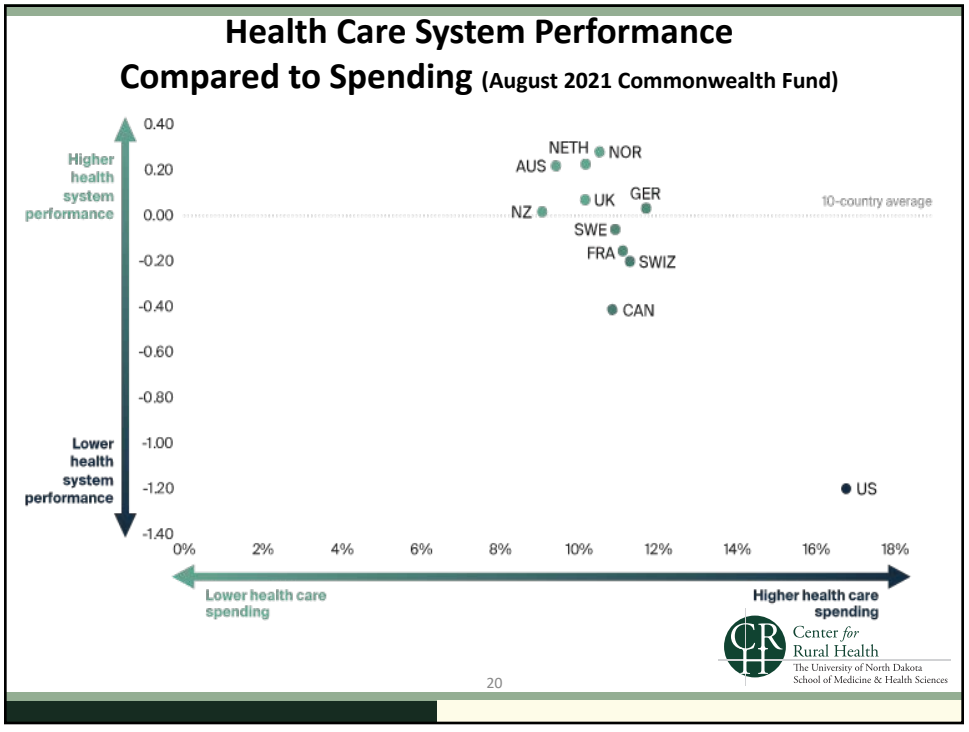
- Most people give too much credit to health care/clinical care when thinking of their health and not realizing it is likely 10-20% of health status.
- US spends more on health care than any other country at about $4 Trillion a year ($12,500 per capita vs. Germany, $6,700; France, $5,500; Canada, $5,400; United Kingdom, $5,200; and Japan, $4,700. (2020 data). (Source Commonwealth Fund)
- 19% of US GDP – Germany, 11%; Canada, 11%, and GB, 10%.
- We spend more yet health outcomes are lower.
  - Lower life expectancy with the US at 78.6 years and Switzerland at 83.6 years. (Varies by race). American Indian is about 73 years.
  - US has highest chronic disease burden.
  - US has highest suicide rate.
  - US has highest rates of obesity.
  - US residents visit medical providers less frequently.
  - US second highest rate of hospitalization for hypertension and diabetes.

18

Center for Rural Health
The University of North Dakota School of Medicine & Health Sciences

18

19


Health Care System Performance
Compared to Spending (August 2021 Commonwealth Fund)
Higher health system performance
Lower health system performance
0.40
0.20
0.00
-0.20
-0.40
-0.60
-0.80
-1.00
-1.20
-1.40
NETH
NOR
AUS
UK
GER
NZ
SWE
FRA
SWIZ
CAN
US
10-country average
0%
2%
4%
6%
8%
10%
12%
14%
16%
18%
Lower health care spending
Higher health care spending
Center for Rural Health
The University of North Dakota School of Medicine & Health Sciences
20

20

Center *for* Rural Health

It is always about the community

This is what shapes rural health – viable health systems, access to quality health care, improving population health contributes to community health – strong and independent communities AND is a driver for rural health policy.

21

21

Center *for* Rural Health

ND CHNA Issues (2017-2019)

- Results below are for the 36 CAHs (CRH assisted 31 or 86%)
- 25 major themes
- 139 ranked needs (range 2 to 5 ranked needs per CHNA, average 3.9)
- Issues

Substance Abuse (behavioral health)	30 CHNA
Mental Health	30 CHNA
Attracting and Retaining Young Families	16
Having Enough Child Daycare providers	11
Ability to Retain Primary Care Providers	11
Availability of Resources to Help Elderly Stay in Homes	6
Not Enough Jobs with Livable Wages	5
Cancer	4
Obesity	4
Affordable Housing	3
Bullying/Cyberbullying	3
Cost of Health Insurance	3
Access to Healthcare	1
Domestic Violence	1

22

22

Center *for* Rural Health

How does the health policy process work to advance rural health concerns and needs or how does rural health work within the process or use that process?

23

Center *for* Rural Health

Health Policy – The Formal Side

- **Executive – Legislative Process (Congress and the Federal Agencies)**
  - **Obama** White House Rural Council to Strengthen Rural Communities ; **Trump** Task Force on Agriculture and Rural Prosperity**; Biden** ARP, Infrastructure, telehealth, targeted rural funding.
  - Biden Administration's almost weekly briefings related to rural –health, infrastructure, economic development, technology, and more.
  - **Senate Rural Health Caucus** – history in North Dakota - 1985
  - **House Rural Health Care Coalition** - 1987
  - Congressional policy making –**incremental, fragmented,** no single committee of jurisdiction for health. Multiple committees deliberately creates multiple power sources***. (KEY LESSON)***
  - **Committees with jurisdiction for health policy**
    - Senate Finance,
    - Senate HELP,
    - Senate Energy and Natural Resources,
    - S&H Indian Affairs, (Senator Hoeven)
    - S&H Judiciary,
    - Senate Veteran''s Affairs (Senator Cramer)
    - House Ways and Means,
    - House Energy and Commerce (Congressman Armstrong)
    - S&H Appropriations (Senator Hoeven),
    - S&H Budget Committees (Senator Cramer, previous role of Senator Conrad as Chair)

24

Center *for* Rural Health

Health Policy – The Formal Side

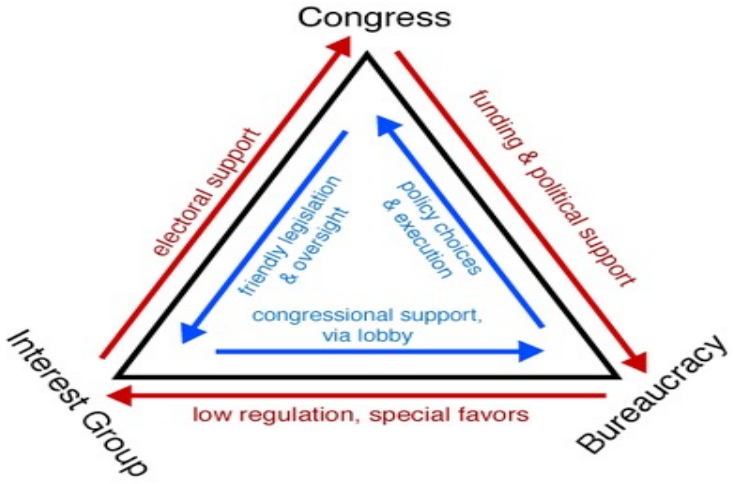
- **Executive – Legislative Process (Congress and the Federal Agencies)**
  - **Federal Agencies**
    - **US Department of Health and Human Services**
      - ✓ HRSA and within it – Office of Rural Health Policy- SORH, FLEX, Rural Health Grants, Rural Health Advisory Council, Bureau of Primary Health Care – Community Health Centers, Bureau of Health Professions – healthcare workforce issues, Bureau of Clinician Recruitment and Services – National Health Service Corps
      - ✓ Centers for Medicare and Medicaid Services (CMS) – Medicare reimbursement and rules, **CMS Innovation** Grants for health reform
      - ✓ Indian Health Service (IHS). ACL (formerly AOA)- Nutrition and development
    - **Department of Agriculture –** Rural Development program has Community Facility loan/loan guarantee/grant program for capital improvement
    - **Department of Housing and UUSDHUD** – HUD 242 program for capital loans to rural hospitals
    - **Veterans Administration** – access to care, VA hospitals, VA CBOC (community based outpatient clinics, mental health
    - **Department of Transportation** –Infrastructure Act
    - **Department of Justice** – legal framework for how health providers operate and relate to each other.
    - Department of Education – Rural Low Income Schools, Rural Education Achievement.

Each federal department is a separate appropriations that is a function of Senate and House Appropriations Committee. Appropriations are constrained by the two Budget committees.

25

Center *for* Rural Health

Iron Triangle of Public Policy



26

26

Center *for* Rural Health

Health Policy – The Informal Side

- **Setting the Agenda (prior to formal policy formulation and during development)**
  - **Advocacy**
    - **Interest groups play significant role**
      - ✓ Content experts – know the details – provide information (fact sheets, reports, meetings with staff, calls from staff)
      - ✓ Represent a point of view
      - ✓ Relied upon by policy staff – develop close working relationships
      - ✓ Interest groups want to be relied upon, "at the table"
    - **Important Rural Health Interest Groups**
      - ✓ National Rural Health Association (NRHA)
      - ✓ National Organization of State Offices of Rural Health (NOSORH)
      - ✓ RUPRI (other federally supported rural health research centers)
      - ✓ American Hospital Association (and state associations- **NDHA)**
      - ✓ State Rural Health Associations - **NDRHA**
      - ✓ American Medical Association (and state associations and subgroups)
      - ✓ American Nursing Association (and state associations)
      - ✓ American Public Health Association (and state associations)

27

Center *for* Rural Health

Health Policy – The Informal Side

- **Managing and influencing the agenda**
  - Control the information flow – resource to staff
  - Information – formal testimony, research, fact sheets but also behind the scene
  - Be honest and reliable (*VERY IMPORTANT is YOUR CREDIBILITY*) – your utility to staff is your reliability and your information
  - If you don't know say you don't know but will find out
- **Re-setting the agenda**
  - Continuous involvement with interest groups to prepare for next round
  - Continuous involvement with policy staff -- preparing them, helping them to see the implications of policy, determining what needs to be changed, provide evidence and data
  - Common questions –"What does this mean in North Dakota" "Is there an impact for us"

28

29

29

Center *for* Rural Health

So Really, How Does Rural Health Policy Work or Happen?

- **Advocacy**
  - Interest groups determine their agenda – internal process "point of view"
  - Interest groups sometimes form alliances with others – share agendas, "back-scratching" – to build greater numbers
  - Message framing – what messages work on policy makers, what do they like to hear, what format or communication strategy works best
    - ➢ Research shows for rural message framing concepts like "fairness" and "interdependence" work
      - ✓ People who live in rural ND should have the same expectation for quality care as urban, have reasonable access to care - ***fairness***
      - ✓ Rural providers use networks and collaborate – avoid duplication, efficiency, effectiveness –***interdependence***
      - ✓ Rural organizations tend to work together, health care as part of the social and economic fabric of a community - ***interdependence***
      - ✓ Under ACA movement to outcome based or pay for performance frame as "merit pay" to providers
  - Redundancy and repetition of messages are "positive" in policy – say the same thing over and over, try to have others (alliance partners) say your message.
  - We emphasize community, people (patients/community members, fairness, collaboration, cooperation, and economic impact

30

Importance of Having Partners

- **Strength in numbers –** more voices with same message
- **Redundancy in policy can actually be good –** more voices, same message
- **An association if it is the primary advocate needs it members involved (elected officials like "real people") but also other associations and their members) –** CAH administrators on hill visits
- **Identify the commonality of issues and forge alliance around that subject – may be secondary for other association but can add to their message**
  - Hospital Association and SORH – rural health outreach grant funding
- **Need to be willing to make compromises –** more and more important
- **Willingness to support partner on their issues makes it easier for them to support you on your issues –** their primary is your secondary issue, and your primary is their secondary issue, "you got to give to get in politics"

31

Center *for* Rural Health

So Really, How Does Rural Health Policy Work or Happen?

- **Role of Research**
  - NRHA works to create SRHC and HRHC leads to FORHP which creates research centers, SORH, Flex (also led to SRHA)
  - PPS and shakeout of rural hospitals came from lack of any national rural health infrastructure (no independent academically based rural health research centers)
  - CRH Bush grant on research led to the model FORHP used for research centers
  - First ORHP research centers in 1987 (CRH was first generation)
  - 8 Rural Health Research Centers and Policy Analysis Initiatives
  - **Rural Health Research Gateway – located at UND Center for Rural Health**
    - "One stop shop (located at CRH) for :Research projects, publications (peer reviewed, policy briefs, fact sheets, annotated literature reviews, maps, and other products.
    - IA (Rupri) Maine, Minnesota, North Carolina, South Carolina, Tennessee, Texas, and Washington
    - **Research topics: -81 separate research areas**
      - Abuse Aging Coronavirus Case Management CAH Disability
      - EMS Environmental and ag health Health disparities Health care access
      - Health care finance Hospitals Medicare Maternal Health Minority health
      - Nurse/NP Obesity Oral health Pharmacy Public health Quality
      - SDOH Telehealth Veterans Wellness Woman's health Workforce

32

Five Key Points on Policy Advocacy

- **Policy is a continuous process**
  - Congressional sessions begin and end, but the process of forming policy, influencing policy, changing policy, advocating for policy is ongoing
  - ACA is not the final Act in health reform – each Congress and President will make changes (every year multiple bills just on Medicare which goes back to 1965
- **Important to have partners, allies, coalitions, alliances– forge relationships, cultivate relationships – some short term, some long lasting**
  - Organizations similar and even dissimilar to your organization
  - Relationships with policy makers and staff
- **Extremely important to be a *resource* to policy staff**
- **Recognize there is a relationship between policy formulation and implementation with research and evaluation –** rural paid price in early '80's because no formal advocacy or policy structure
- **Important to have a legislative champion/advocate**

33

Center *for* Rural Health

What are some examples of successful rural health policy?

34

Center *for* Rural Health

Rural Health Policy in Action

- **Rural Hospital Flexibility Program – "Flex program"**
- **Rural Hospital Models – waiver, CAH, FESC, FCHIP, REH**
- **Affordable Care Act**
  - **Medicaid Expansion**
  - **APM – Value**
  - **Quality**
- **Health Workforce**
  - **NHSC**
  - **Rural Training tract**
  - **AHEC**
- **Rural Health and COVID-19**

35

Center *for* Rural Health

Rural Health Policy in Action

National Rural Health Agenda -2023

- CDC Office of Rural Health
- Maternal Health Services
- Permanently expand telehealth
- Expand Medicaid GME
- Supplemental appropriations to NHSC and Nurse Corps for LR
- Expand nursing workforce
- Extend moratorium on Medicare Sequestration to rural hospitals –PH Emer.
- Support safety net hospitals beyond Public Health Emergency "Save Rural Hospital Act"
- Modernize RHC payment
- Ensure 340 b Drug Pricing Program
- Appropriation increases
  - SORH, Flex, FORHP, NHSC, AHEC

36

Center *for* Rural Health

Rural Health Policy in Action

Alternative Hospital Models

- 1974 – USDHEW – paper on using LPN not RN if 0 census
- 1987 - New York Rural Health Care Services Development Project
- 1988 National Rural Health Care Act of 1988
  MedCAF (Medical Care Access Facility) service)
- 1988 Medical Assistance Facility (MAF) Montana Medicare Demonstration (operated about 10 years)
- 1988 Wyoming Medical Assistance Facility (MAF)
- 1988 California Alternative Rural Hospital Act
- 1989 Florida Emergency Care Hospital
- 1989 Rural Health Care Transition Grant (1989-1992)
- 1990 EACH/PCH (Essential Access Community Hospital/Primary Care Hospital) Grant Program
- 1999 **Critical Access Hospital (CAH)** (intended to be transition)
- 2010 Frontier Community Health Integration Project (FCHIP)
- 2021 Rural Emergency Hospital (REH)

37

Center *for* Rural Health

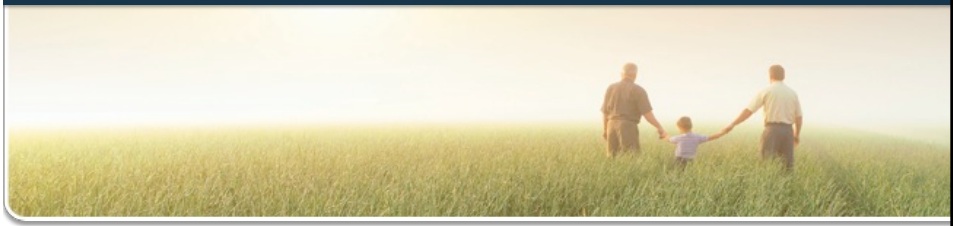
New Models to be Explored – Rural Health Policy – Payment and Delivery System Innovation

- COH Community Outpatient Hospital – 2015 (bill)
- REACH Rural Emergency Access Community Hospital – 2017 (bill) – <u>Enacted in 2021 as REH.</u>
- Global Budget –PA (started in 2018).
- Green Mountain Care – VT.
- CHART Community Health Access and Rural Transformation Model -2020.
- ACO REACH -2022.
- Study of Nursing Agencies (travel nurses) –Senator Cramer.

38

38

Rural Health Research Gateway



The Rural Health Research Gateway provides access to all publications and projects from seven different research centers. Visit our website for more information.
www.ruralhealthresearch.org

Sign up for our email or RSS alerts!
www.ruralhealthresearch.org/alerts

Shawnda Schroeder, PhD
Principal Investigator
701-777-0787 • shawnda.schroeder@med.und.edu

Center for Rural Health
University of North Dakota
501 N. Columbia Road Stop 9037
Grand Forks, ND 58202

RHRC Rural Health Research & Policy Centers

39

RHIhub Rural Health Information Hub

Customized Assistance

Tailored Searches of Funding Sources for Your Project

Foundation Directory Search

FREE Service!

info@ruralhealthinfo.org

1-800-270-1898

40

41

41

Center *for* Rural Health

Contact us for more information!

1301 North Columbia Road, Stop 9037
Grand Forks, North Dakota 58202-9037
701.777.2569 (desk for Brad)
Brad.gibbens@med.und.edu
701.777.3848 • ruralhealth.und.edu

42

Center *for* Rural Health
The University of North Dakota
School of Medicine & Health Sciences

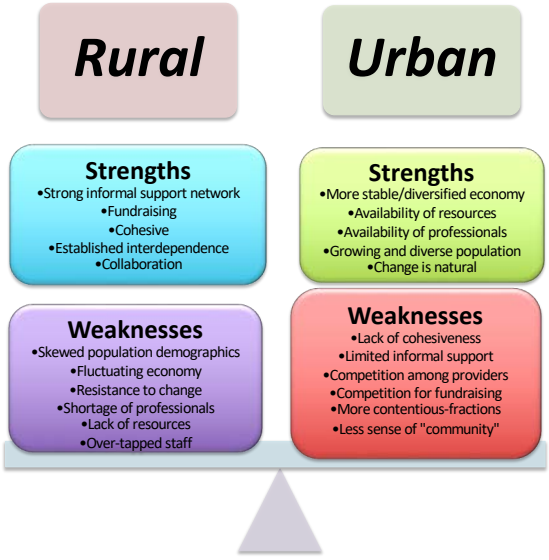
42

Additional Slides not Discussed in Presentation

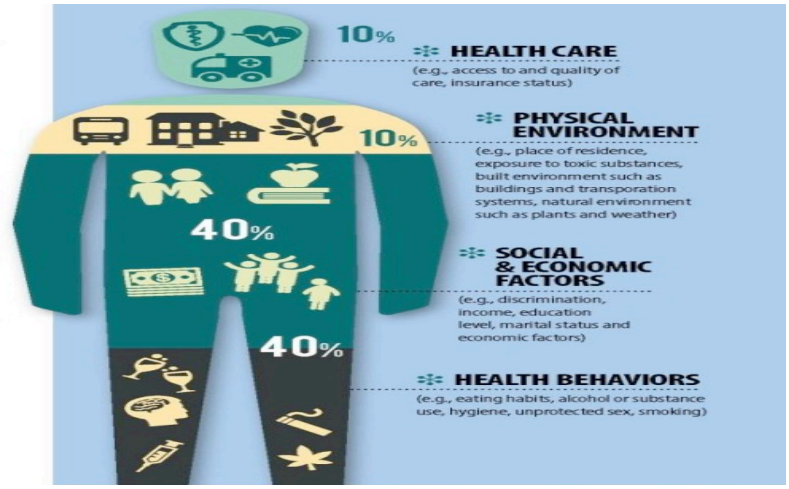
Center for Rural Health
The University of North Dakota School of Medicine & Health Sciences

43

Rural and Urban Strengths and Weaknesses



44



45

CHART Community Health Access and Rural Transformation Model -2020

- CMMI
- Guidance week of September 14, 2020.
- Significant payment and delivery system change and reform.
- Another volume to value process targeted at rural America.
- CMMI "rural markets are more likely to be subject to challenges: hospital closure, financial barriers, and workforce constraints." (also transportation, limited plan choices, and narrow health plan networks).
- CMMI "the current volume-based system will not address these issues." Need: Community-based solutions to realign service delivery, meet unique community needs; solution built on previous successes that adopt value-based models.
- Two options:
  - **Community Transformation Track**
  - **ACO Transformation Track**

46

Center *for* Rural Health
The University of North Dakota School of Medicine & Health Sciences

46

Center *for* Rural Health

Community Transformation Track

- $75 million upfront investment in 15 rural communities ($5 million each) to develop local transformation plans.
- CMS providing regulatory and operational flexibility, technical assistance, and **payment restructuring to participating hospitals from a volume system to one of "stable, monthly payment." (global budget concept, "capitated payment amount" -CPA)**
- Lead Organization – a single entity comprised of a single county or set of contiguous or non-contiguous counties of census tracts. Must be rural.
- Lead Organization can be a state Medicaid agency, SORH, local public health departments, IPA, and Academic Medical Centers. Work with hospitals.
- Cooperative Agreement funding up front. $2 million of the $5 immediately. Rest contingent on progress.

47

47

Center *for* Rural Health

Community Transformation Track

- **CPA prospectively set annual payment to hospitals** – stable revenue with incentives to reduce fixed costs and avoid readmissions.
- Operational and regulatory flexibility – Medicare waivers (CDM incentives to patients and cover cost of patient transportation).
  - Waive certain CoP
  - Waive 3 day inpatient stay prior to admission to SNF
  - Telehealth expansion
  - Post discharge visits
  - Care Management Visits
  - CAH 96 hour rule
- Lead Organization develop and convene Advisory Council
- Participating hospital must be acute care, CAH, special rural designation
- State Medicaid is a required partner –sub-recipient of CA funding.

48

48

Center *for* Rural Health

Rural Health Policy in Action

- **Rural Hospital Flexibility Program – "Flex program"**
  - Purpose to provide TA to CAHs – deliberate policy to couple a new designation with a TA approach
  - Alliance of NRHA, NOSORH, AHA, SORHs, and State RHA
  - Each state worked with their congressional offices
  - 1st year grant for $200,000 went to SORHs in eligible states
  - Flex funded at $26 million a year
    - Grants to 45 eligible states
    - Flex Monitoring Team (RHRC research related to Flex and rural hospitals – evaluation leads to better data for congressional advocacy)
  - Flex is administered, like SORH, through FORHP
  - NRHA, NOSORH, and AHA push every year continued appropriation for Flex
  - CRH keeps in front of Congressional Offices

49

Center *for* Rural Health

Rural Health Policy in Action

- **Rural Health and the Affordable Care Act**
  - Basically, every health interest group had a stake
  - NRHA position papers and fact sheets
  - Formed core set of expectations
    - Health workforce
    - Provider reimbursement
    - Protect (and even expand) rural safety net – CAH, RHC, CHC
    - Access for rural people – financial concerns, but also availability of providers and financial viability rural health providers
  - NRHA worked with AHA and NOSORH
  - State level work with congressional offices on needs and impact
  - CRH emphasized health workforce, safety net, availability of providers, and financial viability of rural health providers and systems

50

Center *for* Rural Health

Rural Health Policy in Action

- **Rural Health and COVID-19**
  - Shut down in March 2020 of hospital outpatient and electives – about 2 months (no revenue) – Public Health hit hard, front line.
  - **CARES Act (NRHA and NOSORH advocate for funding and regs)**
    - CMS- Provider Relief Fund – about $68 Billion to hospitals ($11 B for CAH and RHC)
    - Medicare Accelerated Payment Program (loan and payback)
    - SBA -Paycheck Protection Program – also payback
    - HRSA -COVID SHIP - $3.2 million to ND CAHs
    - Telehealth waivers – location, payment, added services allowed, see patients in their home- (big push to keep this)
    - Waiver on 96 hour and 25 bed for CAHs if a surge
    - 3 day SNF rule
    - PPE and testing to the states
    - ND SORH and Flex money to help CAHs manage the dollars
  - Focus going forward on rural health policy – try to keep what we like – telehealth

51