

Colorado Rural Health Center 2020 Policy Priorities

The following policy priorities were developed through feedback from CRHC members and Board of Directors. Along with the CRHC Mission & Vision, these priorities will serve as a foundation for the CRHC Policy Program and are intended to guide lobbying and advocacy efforts throughout 2020.

REIMBURSEMENT-Rural healthcare facilities across Colorado serve as economic engines in their communities. However, their sustainability is threatened by low reimbursement rates that do not always cover the costs of care. Additionally, new payment systems and programs, however well-intended, offer a one-size-fits-all structure that does not meet the needs and capacity of rural healthcare facilities.

- 1. Address reimbursement for rural healthcare facilities and align reimbursement models across payers.**
 - a. Provide cost-based reimbursement across payers for rural healthcare facilities.
 - b. Capitated rates do not cover costs for actual services provided, leaving rural providers on the hook for additional costs.
- 2. Evaluate the efficacy of EAPG payment system in rural.**
 - a. The EAPG payment system is eroding the payment structure designed to keep facilities open.
 - b. By nature of where CAHs are located and their structure, they do not have as many high-acuity cases. CAH's are paid less under the current EAPG system due to their lower volume of high-acuity encounters.
 - c. Policymakers need to study costs to administer EAPG vs. emulating cost-based reimbursement.
- 3. Stop "bad debt" reimbursement cuts and stop Medicare Sequestration for rural hospitals.**
 - a. Rural hospitals serve more Medicare patients, leaving them more vulnerable to across the board rate cuts.
 - b. Rural hospitals have absorbed \$318 million in cuts under sequestration and "bad debt" reimbursement cuts have meant \$180.3 million in lost revenue for rural hospitals.
 - c. As of 2019, twenty two rural hospitals in Colorado are at risk of closure by currently operating with a negative profit margin.

STATE & FEDERAL REGULATIONS- There are many contradictory and constantly changing state and federal regulations that complicate healthcare administration in rural. Many rural healthcare facilities struggle to keep their doors open with current funding and staffing, which leaves few resources to address and comply with constantly changing quality and payment

programs. Policymakers must consider unintended consequences and the capacity of rural healthcare facilities when creating changes to the regulatory framework.

- 1. Standardize payments and processes to emulate CMS.**
 - a. Establish credentialing time limits across payers to expedite the process.
 - b. When possible, standardize and streamline reporting requirements across payers and programs.
- 2. Change regulations to allow true integration of care.**
 - a. Remove the regulations around co-mingling. These regulations are barriers to integrating care in rural communities and require the facilities to put money into creating infrastructure that doesn't need to exist.
 - b. Remove regulations around staffing to allow a CAH, RHC and LTC to share staff among all facilities when connected. This allows for greater efficiency and reduced costs.

WORKFORCE-The rural healthcare workforce is facing shortages of providers, administrators and support staff. While some communities have found success in fostering and hiring homegrown staff, it still takes on average 1-3 years to recruit a physician in rural Colorado. State and Federal partners can support the healthcare and economic landscape in rural Colorado by supporting measures to increase the recruitment and retention of the healthcare workforce.

- 1. Increase the healthcare workforce in rural Colorado by investing in education and incentives for a variety of healthcare positions.**
 - a. Establish a state-supported or matched scholarship fund to fuel the workforce pipeline.
 - b. Expand loan repayment programs to all rural providers. Increase both the funding and the scope of providers who are eligible for loan repayment. The program is already very competitive, consider weighting those with rural roots higher on applications.
 - c. Streamline and standardize J1 visa licensing requirements to mirror requirements with US-born providers.
 - d. Develop incentives for non-medical staff, including access to scholarships, loan repayment, and affordable housing.
- 2. Invest in rural healthcare provider retention by creating incentives and reducing burnout.**
 - a. Create state support to bring the Community Apgar Program (CAP) to rural Colorado. CAP allows rural healthcare facilities to identify and prioritize factors important to recruiting and retaining physicians, specific to their hospital, and more recently, factors that contribute to a successful training of health professions students.

- b. Invest in leadership training and development programs for rural providers and administration to build confidence and increase connection with fellow rural colleagues.
 - c. Create opportunities for the development of quality support staff, including scholarships, loan repayment and opportunities for leadership development.
- 3. Develop opportunities for healthcare workers and their families to thrive in and contribute to rural communities.**
- a. Create solutions for the lack of rural public transportation.
 - b. Develop and enhance economic development initiatives that support vibrant, diverse and sustainable rural communities.
 - c. Address housing shortages and affordability in rural areas. Some providers and workforce staff are traveling long distances for employment, further amplifying the need for affordable housing and public transportation options.

MENTAL & BEHAVIORAL HEALTH-The entire state of Colorado is facing a mental health crisis, however the severity is greater and the circumstances are different in rural Colorado. Stigma is high and resources are low, especially the mental health workforce in rural. Further, many state and federal programs to support mental health delivery in rural is grant-driven and short-lived. Sustainable funding, transportation options, and unique workforce solutions are needed to address mental health access and affordability in rural Colorado.

- 1. Increase and broaden reimbursement for mental health services.**
- a. Across the state, workforce shortages in mental health have persisted because of low reimbursement rates from Medicare, Medicaid and some private payers. Without higher rates, rural healthcare facilities can't afford to offer these services.
 - b. Broaden the scope of providers who may be reimbursed for mental health services. Medicare, for example, does not reimburse for mental health services provided by a Licensed Professional Counselor, amplifying the already critical shortage of Licensed Clinical Social Workers.
- 2. Address medical transportation shortages in rural Colorado.**
- a. Establish state supported transportation for emergent and non-emergent mental health services. Whether an individual is seeking inpatient mental health services or an appointment with a counselor, there are very few resources to connect rural Coloradans to the mental health services they need.
 - b. Clarify liability around 72 hour hold transports. There are no inpatient mental health beds in rural Colorado; the only way these facilities may be accessed is via transport to an urban center. Healthcare facilities and law enforcement officials struggle to securely hold, transport and be reimbursed for individuals experiencing mental health crisis.

- 3. Increase the mental health workforce and support innovative delivery models of mental health services.**
 - a. Rural communities do not have the patient volumes or resources to support robust mental health services in every community. However, shared staffing models, telepsychology and support for staff training can enhance what services rural communities already have.
 - b. 24 rural counties do not have a licensed addiction counselor, 22 rural counties do not have a licensed clinical social worker, and 22 rural counties do not have a psychologist.
 - c. Support and expand scholarships and loan repayment for mental healthcare providers who commit to work in a rural area.
 - d. Because of workforce shortages, primary care providers in rural areas often provide mental health services. These providers need training, support and enhanced reimbursement for providing these additional services.

HOSPITAL TRANSFORMATION PROGRAM (HTP)

CRHC believes that rural hospitals should not be put in the position to take on risk because currently 22 are operating in the red and any loss of payment could result in closure of the facility and therefore decreased community access to local healthcare.

Rural hospitals are willing to participate in collection of data to showcase the quality of care being provided at their facility. However, due to the nature of low volume and unique payer mix (high percentage of Medicare and Medicaid), critical access hospitals (CAH) should not be forced to take on monetary risk. CAHs were created to provide access to care and keep essential services in their community and cannot afford lose money and provide more resources to the state without funding to support it.

1. Utilize equitable data and submission requirements

- a. In instances where patient outcomes are dependent upon successful collaboration with a hospital's designated RAE, and collaboration is unsuccessful due to documented RAE negligence, the hospital cannot be penalized for these poor outcomes.
- b. CAHs should be benchmarked with other CAHs versus at the state-wide level which includes urban hospitals. Further, CAHs located in a frontier county should only be benchmarked against those in a frontier county
- c. Low patient volumes should be addressed by reducing the risk that CAHs take on. For example, if CAHs are required to collect six measures then that should count for 60 points and the other 40 points should be automatically provided to them. Further, frontier hospitals should only be measured on three measures

that count for 30 points and the other 70 points being automatically provided to them. Change the point system and current algorithm to be agreeable for CAHs.

- d. Exact definition of inclusion and exclusion criteria that Medicare uses should be the standard for HTP measures (for example, Readmissions and Closing the Referral Loop)
 - e. For the readmission measure, instead of combing all of the chronic diseases together into one measure these should be broken out to allow CAHs a greater number of measures to choose from dependent on their individual patient needs.
 - f. How does HTP plan to align metrics with community input ? In many cases the input the community provided as a need is not address through HTP priorities?
- 2. Recognize deficiencies in workforce, time and resources through disbursement of the Rural Support Fund.**
1. Support hospitals' time and expense for the following activities (which theoretically will make transformational impact):
 - i. Billing and coding audits
 - ii. Leadership training, development and coaching
 - iii. Financial consulting
 - iv. Planning and creation of new service lines
 - v. Facilitation and/or convening of community and partner meetings with key stakeholders in community
 - vi. Travel stipends for hospital staff to attend meetings outside of their community (mainly at HCPF or CRHC offices) to help offset the barrier of getting to important meetings where their voices can be heard
 - b. Support CRHC as the state office of rural health and rural health association for the state to provide outreach in the form of communication and marketing for the above mentioned activities as well as facilitate/coordinate them for the hospitals
 - c. Prioritization Methodology to receive rural support funding
 - i. Rural hospitals that are both:
 1. Designated as a CAH
 2. Financially distressed according to latest iVantage Report
 - ii. Rural hospitals in financial distress according to latest iVantage Report

Designated as a CAH

SPECIALTY CARE-Rural populations are more likely to have to travel long distances to access healthcare services, particularly specialty care. Additionally, rural communities often have more elderly residents who have chronic conditions requiring multiple visits to specialists. This can be a significant burden in terms of travel time, cost, and time away from the workplace. Moreover, Medicare and Medicaid are notoriously difficult in proving timely access to specialty care, further amplifying the need for these services as untreated conditions become more acute. Many specialty care providers will not accept publically insured patients at all or no new patients.

- 1. Increase reimbursement for specialty care.**
 - a. CAHs and RHCs need cost-based reimbursement for dental services in order to retain the services in-house.
 - b. Insurance coverage for dental services is very limited.
 - c. Medicaid reimbursement for specialty care is poor or non-existent.
 - d. Medicaid waiting periods for access to specialty care can take months and often requires patients to travel long distances.
- 2. Remove reimbursement and regulatory burdens for providing specialty care through telemedicine.**
 - a. Public and private payers do not provide adequate reimbursement for CAHs and RHCs to provide telemedicine.
 - b. Conflicting and ever-changing regulations create confusion for CAHs and RHCs in terms of what telemedicine services they may provide and be reimbursed.
 - c. Start-up costs for telemedicine equipment, software and connectivity can be prohibitive.
 - d. Broadband access is not sufficient or equitable across rural Colorado, despite major state and federal investments.
- 3. Address workforce shortages of specialists.**
 - a. Specialty care in rural is especially difficult to recruit for due to large coverage areas, low volumes and lacking community amenities.
 - b. Dental care is not a traditional area of recruitment for CAHs, especially for children.
 - c. Similar to incentives for other healthcare providers and support staff, Colorado must invest in recruitment and retention of specialists in rural areas of the state.

HIT & REPORTING- Health information technology (HIT) has the ability to improve the quality, safety, effectiveness, and delivery of healthcare services in rural communities. HIT can connect rural patients and providers in remote locations to specialists in urban areas. However, implementing, maintaining, updating, and optimizing HIT can be an ongoing challenge for rural facilities and providers with limited resources and expertise.

- 1. Provide technical support and funding for rural healthcare facilities to adopt and maintain Electronic Health Records (EHR).**
 - a. EHR programs are numerous and expensive. Rural hospitals and clinics need support with the costs of EHR implementation, reporting and consulting.
 - b. Rural healthcare facilities have limited workforce and resources to dedicate to EHR maintenance and compliance. If a hospital is able to find a qualified person, it is often very expensive to retain them.
 - c. The process of entering and extracting data is very manual, further increasing the time and staffing costs of EHR connectivity.
- 2. Lessen reporting requirements for rural healthcare facilities.**

- a. Many reporting requirements overlap among state and federal programs. Streamlining requirements to mirror CMS would lessen the burden on rural providers.

SUBSTANCE USE DISORDER-Substance abuse has long been prevalent in rural areas, with a renewed focus in the last few years due to the opioid epidemic. In fact, nine of ten Colorado counties with the highest overdose death rate are rural counties. Rural adults have higher rates of alcohol abuse, tobacco use, and methamphetamine use, while prescription drug abuse and heroin use has grown in towns of every size. Substance abuse can be especially hard to combat in rural communities due to limited resources for prevention, treatment, and recovery.

1. Increase access to detox, treatment and recovery services.

- a. Rural Colorado needs more inpatient beds, however this is not a profitable service offering. Reimbursement across payers must increase to support expanding these services.
- b. Intensive outpatient care is effective in treating addiction while keeping individuals in their communities. Sustained funding for these programs is necessary to sustain continuity of care for a difficult patient population.

2. Clarify duties and liabilities for healthcare providers and law enforcement and provide support for appropriate transport.

- a. Due to confusion around liability, lack of resources and poor reimbursement, hospitals and law enforcement officials are resistant to treat or transport patients with SUD.
- b. Hospitals and jails are inappropriate settings for individuals experiencing SUD. There is a need for state or federally-supported transport to more appropriate care settings that do not leave hospitals and law enforcement at odds.
- c. Programs, such as Law Enforcement Assisted Diversion (LEAD) are effective yet the funding is not sustainable.

3. Support innovative SUD delivery models that have proven successful but need sustainable funding.

- a. The Colorado Hospital Association developed the Alternatives to Opioid (ALTO) Program achieved an average 36% reduction in the administration of opioids in Emergency Departments.
- b. MAT services have increased across the state with the adoption of federal waivers for providers who prescribe buprenorphine. Unfortunately, only 8 percent of providers who can prescribe buprenorphine are in rural counties.
- c. Telemedicine is an opportunity and a barrier to treating SUD. Reimbursement is poor, billing is difficult and only certain providers are approved for tele-psychiatry, which is costly.

Additional priorities identified but not discussed:

- 1. Social determinants of health**
- 2. Price transparency**
- 3. Prescription drug costs**
- 4. Public healthcare coverage**
- 5. Special populations**