COLORADO RURAL HEALTH CENTER
The State Office of Rural Health

Colorado Rural Health Center 2021 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 2021.

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. In fact, as of 2020, eighteen rural hospitals in Colorado are at risk of closure by currently operating with a negative profit margin. 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. **Evaluate the efficacy of EAPG payment system in rural.**
    a. Push HCPF to go back to cost-based reimbursements for CAHs instead of EAPG.
    b. Work with HCPF to revise rural rates and help them understand why these revised rates are necessary.
    c. Push for a carve-out for implants, as they are the most expensive devices.
2. **Stop "bad debt" reimbursement cuts and stop Medicare Sequestration for rural hospitals.**
    a. Push for a permanent waiver for sequestration.
    b. Rural hospitals serve more Medicare patients, leaving them more vulnerable to across the board rate cuts.

REGULATORY IMPEDIMENTS- 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. Push for legislation that creates and enforce a reasonable credentialing deadline for insurers. The requirements should emulate Medicare and Medicaid, which is 30 days or less. Further, approval of new providers by the payers needs to be back dated to the day the provider's application was submitted.
    b. Push for legislation that requires an average claim be paid in 20 days, with sanctions for insurance companies that take longer than 30 days.
    c. Push for legislation that guarantees same-day approval for benefits, procedures, screenings, etc. The legislation should mirror the requirements for Medicare, which has 14 days for approval, otherwise they pay interest.

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.
3. **Eliminate or adjust the CAH Average length of stay.**
    a. There has been a relaxation of this for COVID, so perhaps we can advocate for a permanent codification of this temporary rule.

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. Push for the continuation and enhancement of current provider financial incentives, the Rural & Frontier Primary Care Tax Credit, and expand this program to the broadest variety of primary care providers possible.
    d. Streamline and standardize J1 visa licensing requirements to mirror requirements with US-born providers.
    e. 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. **Cultivate a homegrown healthcare workforce.**
    a. Create a program that cultivates and incentivizes a "homegrown" rural healthcare workforce, possibly in the form of community matching grants. Work with local schools on vocational training, allow for training to count toward school credit. New Mexico has had a shortage of college students, and as a result has shifted toward vocational training in high school.
    b. Push for better utilization of technology in rural schools to increase access to specialized training. Rural schools can't take on vocational training without support and will need a connection with higher ed., technology companies, etc.
4. **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.
    d. Create additional incentives for providers who work in high-cost areas.

PRIMARY CARE- Patients with affordable and continuous access to primary care services reduce healthcare spending across payers. Unfortunately, rural Colorado is facing a shortage of primary care providers, including physical, mental and oral health providers. Sustainable funding, transportation options, and unique workforce solutions are needed to address primary care access and affordability in rural Colorado.

1. **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 a 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.

2. **Providing mental health services in rural Colorado is met with unique challenges. 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.**
    a. Subsidize hiring of mental health professionals, similar to how FQHC's are supported.
    b. Push for reimbursement of all mental health providers by all payers, for example LPCs are not currently reimbursed by Medicare. LCSWs are reimbursed by Medicare, however there is a shortage of these providers in both urban and rural.
    c. Expand provider incentive programs to mental health providers.
    d. Advocate to streamline the process of becoming an MA. There is a shortage of MA's and the certification process is onerous.
3. **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.
4. **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.
5. **Advocate to streamline the process of becoming a Medical Assistant (MA).**

a. These providers serve a unique ad critical role in the delivery of primary care services however, there is a shortage of MA's and the certification process is onerous.
b. Advocate for alternative learning and training options for potential MAs, including the utilization of remote learning.

MEDICAID AND MEDICARE COVERAGE-Medicare and Colorado Medicaid together serve as the largest insurers in Colorado. In rural Colorado, these rates of pubic insurance enrollment are even higher, and many provider do not cap or turn away patients with this coverage. However, neither payer supports the financial sustainability of rural healthcare facilities.

1. **Address reimbursement for rural healthcare facilities and align reimbursement models across payers.**
    a. Urge CMS and CO Medicaid to utilize value-based payments that reflect the needs of a community and the limitations of rural healthcare facilities. For example, the CHART model is a promising first step, but the parameters around participating need to be more broad.
    b. Gather financial information from members around value-based payment models, CHART model, etc. to use as lobbying and advocacy tools.
    c. Push for rural hospitals to be reimbursed similar to the Medicare cost-based methodology.

COVID-19- Rural hospitals and clinics in Colorado were already facing a financial crisis before COVID-19. In fact, 18 of 42 rural hospitals in the state were operating with negative profit margins in 2020. At the peak of COVID-19, rural hospitals and clinics are reporting over 50% revenue loss due to significant decreases in patient volume. This is occurring at the same time as expenses are increasing, especially for PPE and other supplies. Some facilities report paying as much at triple the usual cost for PPE and other supplies. Rural healthcare providers cannot sustain operations under the current conditions and funding constraints. Rural healthcare facilities need sustained access to forgivable funding with reasonable terms and conditions in order to weather this unprecedented global health crisis.

1. **Push for equitable access to PPE and testing supplies for rural healthcare facilities**.
    a. Advocate for a revision of the PPE and testing allocation system, which currently puts large facilities at the top of the list, regardless of need. Or even more simply, advocate for a system that gives CAHs higher priority.
2. **Advocate for continued access to state and federal COVID relief funds.**

a. Push for more flexible and clear guidance of federal COVID relief funds for use by rural healthcare facilities.
b. Push for federal financial aid to come in the form of a grant rather than loans with unmanageable repayment penalties.

3. **COVID-19 has presented rural health facilities with unique opportunity to demonstrate how the relaxation of certain rules and regulations can increase access to care and financial sustainability.**
    a. Push for the continuation of COVID-related provider relaxed regulations and staffing ratios, including telehealth regulations, the 96 hour rule, and RHC supervisory rules.

CONSUMER HEALTHCARE COSTS & AFFORDABILITY-Rural Coloradans face some of the highest healthcare costs in the state. In fact, rural Coloradans experience health insurance premiums 32% higher on average that urban Coloradans. However, legislative remedies to these issues have painted all healthcare providers with the same brush, rather than recognizing the distinct differences among different types of healthcare providers and the private insurance industry. As a result, rural healthcare providers are being unfairly targeted and regulated, which may have the inverse impact of increasing consumer healthcare costs.

1. **Rural healthcare facilities are safety net providers and economic drivers. Hospital transparency requirements do not recognize these critical point and as such should be revised.**
    a. Push for the repeal or rural exemption of Colorado hospital transparency requirements.
    b. Push for changes in the Colorado hospital transparency requirements that more accurately reflect each patients actual cost of care.
    c. Push for the creation of a consumer hotline to address questions about coverage, costs, etc. across payers.

QUALITY PROGRAMS & REPORTING- 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), rural healthcare facilities should not be forced to take on monetary risk. CAHs and RHCs 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. **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.

2. Utilize equitable data and submission requirements

a. Push for the standardization of reporting requirements across programs.
b. Create a standardized entry data repository platform that will reduce time spent on reporting and diminish redundant reporting.
c. Push for uniform quality data reporting that increases communication across programs.
d. Push for new program standards programs that mirror measures already being used. Advocate against the continual creation of new measures.
e. Push for the contingency of staff support if a new mandatory program is created.
f. Create provider grants or financial incentives for participation in programs to offset additional staffing costs.
g. Push for greater technical support from mandatory programs.
h. Push for a requirement that any new program or report also indicate the time it takes to complete and reimburse for those charges. Reimbursement may be difficult to negotiate, so at the very least advocate for rural safety net providers be reimbursed for their time.
i. 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.

HIT & TECHNOLOGY INFRASTRUCTURE- 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. **Push for greater access and utilization of tele-ICU.**
    a. This would allow patients to stay longer in rural care settings. Receiving care in familiar settings may increase healthcare outcomes, and also supports the sustainability of the rural healthcare facility.
3. **Reduce 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.
4. **Continue to push for ALL payers to pay in-person rates for telehealth services, including Medicare, Medicaid and private insurance.**
    a. Gather and disseminate information about the comparable costs of in-person care vs. telehealth to use as a lobbying and advocacy tool.
    b. Develop a rural hospitals a network to compete with lower cost telehealth providers. Take advantage of technological advances, streamline costs and training, and pool resources to drive down underlying costs of telehealth.
    c. Push for telehealth funding for equipment and technical assistance.
    d. Push for the creation of incentives, tax or otherwise, that will mitigate upfront telehealth implementation costs.
    e. Push for state reimbursement for the purchase of equipment that will be used to serve Medicaid patients. Argue if the state wants to save money on telehealth, they need to provide the platform and support.
    f. Explore other funding options, including public or private grants, or explore a partnership with the Colorado Broadband Commission.
    g. Push for funders to loosen their telehealth grant funding opportunities, which are currently very specific and limited. Advocate for broader funding on a regional basis, for example funding XX hospitals in XX regions.

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.

PRIVATE HEALTH INSURANCE COVERAGE-While rural Colorado healthcare providers serve patients with higher rates of public insurance, they are still subjected to sometimes unfair treatment by private insurance companies. Lower volumes in CAHs and RHCs lead to less preferential treatment. This results in rural healthcare providers seeing lower negotiated rates and longer wait times for approvals and credentialing.

1. **Address excessive wait times for credentialing, locums reimbursement, and coverage approvals.**
    - **a.** Push for a state or federal mandate that requires insurance companies to follow the same rules as Medicare with respect to reimbursing for substitute providers under the locums tenens provisions.
    - b. Collect aggregate data from members about claims and approval waiting period. Utilize the data to connect with the Division of Insurance as an association, rather than requiring members to separately reach out with complaints.
    - c. Research and explore whether current state and federal laws regulating network adequacy can be better enforced.

SUBSTANCE USE DISORDERS Substance abuse has long been prevalent in rural areas, with a renewed focused 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-support 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.