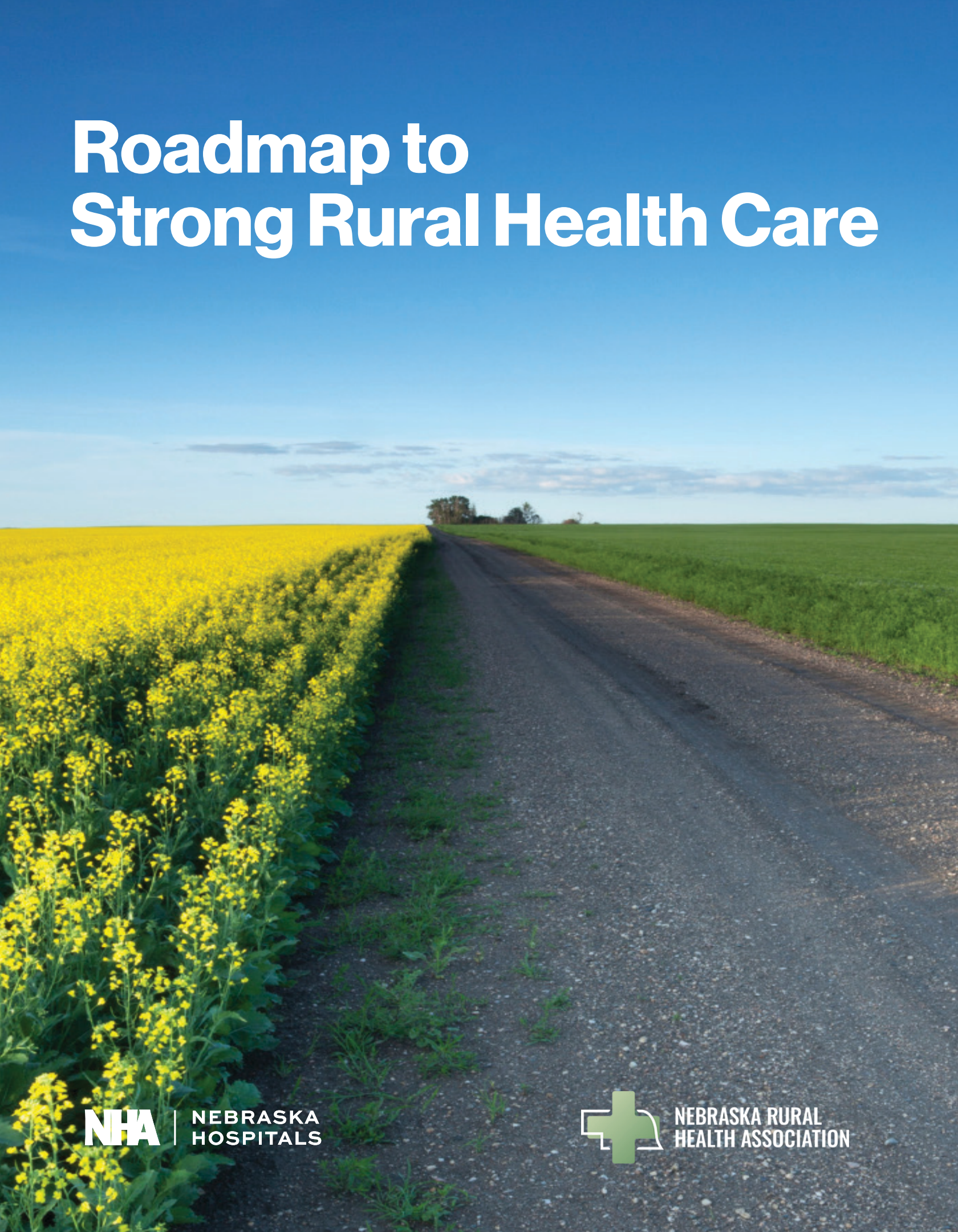
Roadmap to Strong Rural Health Care



NHA | NEBRASKA HOSPITALS

NEBRASKA RURAL HEALTH ASSOCIATION

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Executive Summary

In rural communities across the U.S., hospitals and health systems are cornerstones for the health and well-being of the patients and communities they serve. Rural hospitals and health systems provide much needed access to affordable, quality health care for patients close to home, and operate as economic anchors in their local communities, supporting good paying jobs and infusing the local economy with spending on goods and services. In 2020, rural hospitals supported one in every 12 rural jobs nationwide, as well as $220 billion in economic activity.

Rural hospitals make up about 35% of all hospitals nationally, but over 68% of Nebraska hospitals. Nearly half of rural hospitals have 25 or fewer beds, with just 16% having more than 100 beds. Given that rural hospitals tend to be much smaller, patients with higher acuity often travel or are referred to larger hospitals nearby.

Rural hospitals face significant staffing shortages versus urban areas. Only 10% of physicians in the United States practice in rural areas despite rural populations accounting for 14% of the population. Nearly 70% of the primary care Health Professional Shortage Areas (HPSAs) are located in rural or partially rural areas.

Given their unique constraints, rural hospitals and health systems often need to be resourceful in pursuing opportunities that improve both financial stability and viability. Access to capital is important to stabilizing a vulnerable hospital or advancing an innovative one. For some rural hospitals, partnerships, collaborations, mergers or affiliations also can be a good option. Many rural hospitals were already in precarious financial positions even before the COVID-19 pandemic, and the pandemic has exacerbated the challenges that many rural hospitals were already experiencing, including workforce shortages, limited access to critical supplies and an aging infrastructure.

About Us

NHA | NEBRASKA HOSPITALS

The Nebraska Hospital Association is the influential and unified voice for Nebraska's hospitals and health systems. The NHA has a statewide membership of 92 member hospitals and over 50,000 employees. Through collaborative leadership, our members rely on the NHA for data, education, advocacy and more to advance Nebraska hospitals' ability to provide exceptional, quality care to Nebraska's patients and communities. As partners, the NHA is able to assist in not only the development of strong, healthy communities, but be a leading resource for our members on changes in health care trends, regulations, legislation and other issues. The NHA has been a vital part of our member hospitals' missions since our founding in 1927. Through the years our purpose remains the same: be the influential and unified voice of Nebraska's hospitals and health systems.

NEBRASKA RURAL HEALTH ASSOCIATION

The Nebraska Rural Health Association (NeRHA) is the result of a shared vision among health care providers across Nebraska, who recognize the value of uniting in support of rural health care throughout our state. Our grassroots, non-profit organization is powered and driven by our members: a wide variety of medical professionals and organizations invested in the health and wellness of rural Nebraskans. Together, our NeRHA members and leaders work to identify health concerns across our state, and collaborate on strategies to improve services in our communities.

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Sustaining Rural Hospitals and Clinics

Provider Rate Increase

For strong rural health care, Nebraska needs to support legislation that increases reimbursement and makes payments in a prompt and timely manner.

> **Nebraska hospitals remain steadfast in their commitment to compassionately care for every Nebraskan and to turn no one away; these essential facilities cannot weather the current workforce and inflation crises without adequate financial support.**

In the last two years alone, our hospitals reported labor costs up over 20%, supplies up 15-20%, food and utilities up 10%, and the cost of drugs up more than 35%. Nationally, hospital costs per patient grew more than 20% from pre-pandemic levels.

Nebraska hospitals receive anywhere from 60% to 80% of their revenue from government payers, like Medicare and Medicaid; reimbursement rates for these programs are set by federal and state government. For 2023, the Centers for Medicare and Medicaid Services (CMS) increased the Medicare inpatient payment rate 3.2% and the State of Nebraska increased the Medicaid reimbursement rate a mere 2%. As a result, Nebraska hospitals will receive a minimal payment increase while costs have soared over 20% in the last two years.

Medicaid plays a critical role for Americans who live in smaller communities and rural areas. Almost half of all children living in these areas receive their health coverage through Medicaid. Plus, rural areas of Nebraska tend to have older, poorer, and sicker populations. That means they often have a higher percentage of patients covered by Medicare and Medicaid.

With regard to health insurance, rural residents are more likely to enroll in high-deductible health plans, placing a disproportionate uncompensated cost burden on Critical Access Hospitals (CAHs), 53% of which are currently facing financial stress.

We support legislation that would increase Medicaid provider reimbursement rates for all hospitals. Without these increases, hospitals will have to make difficult financial decisions affecting services and impacting access to care.

Medicare and Medicaid reimburse hospitals for the same services for Critical Access Hospitals (CAHs) as for other acute care hospitals; however, their payments are based on their costs and the share of those costs that are allocated to Medicare and Medicaid patients. CAHs receive cost-based reimbursement for inpatient and outpatient services provided to those patients. The problem is that it can take up to 24 months for CAHs to receive reimbursements.

The Nebraska Legislature needs to pass legislation that increases the upfront per diem rates for Critical Access Hospitals so they do not have to wait months or even years for reimbursement.

Rural Health Clinics

The Rural Health Clinic (RHC) program is intended to increase access to primary care services for patients in rural communities. RHCs can be public, nonprofit, or for-profit health care facilities. To receive certification, they must be located in rural, underserved areas. They are required to use a team approach of physicians working with non-physician providers, such as nurse practitioners (NP), physician assistants (PA), and certified nurse midwives (CNM) to provide services. The clinic must be staffed at least 50% of the time with an NP, PA, or CNM (requirement waived during COVID-19 public health emergency). RHCs are required to provide outpatient primary care services and basic laboratory services.

Health Care Services Requirements

An RHC must:

- Directly provide routine diagnostic and lab services
- Have arrangements with 1 or more hospitals to provide medically necessary services unavailable at the RHC
- Have drugs and biologicals available to treat emergencies
- Provide these lab tests on site:
  - Stick or tablet chemical urine exam or both
  - Hemoglobin or hematocrit
  - Blood sugar
  - Occult blood stool specimens exam
  - Pregnancy tests
- Primary culturing to send to a certified lab
- Not be primarily a mental disease treatment facility or a rehabilitation agency
- Not be a Federally Qualified Health Center (FQHC)

RHC visits must be:

- Medically necessary
- Medical or mental health visits, qualified preventive health visits, or face-to-face visits between the patient and an RHC practitioner
- A qualified RHC service needing an RHC practitioner

RHC visits can take place at:

- An RHC
- A patient's home, including an assisted living facility
- A medicare-covered Part A skilled nursing facility
- The scene of an accident
- Hospice

RHC visits can't take place at:

- Inpatient or outpatient hospital department, including a Critical Access Hospital
- Facility with specific requirements excluding RHC visits

Rural Health Clinics (RHC) have become an essential Medicare provider type in rural communities. The RHC program should be modernized through the following policy changes:

Permanently enable
all RHCs to serve as distant-site providers for purposes of Medicare telehealth reimbursement and to set reimbursement for these services at their respective all-inclusive rate (AIR). Additionally, these services should be counted as a qualified encounter on the Medicare cost report.

Modernize
physician, physician assistant, and nurse practitioner utilization requirements to allow for arrangements consistent with State and local laws relative to practice, performance, and delivery of health services.

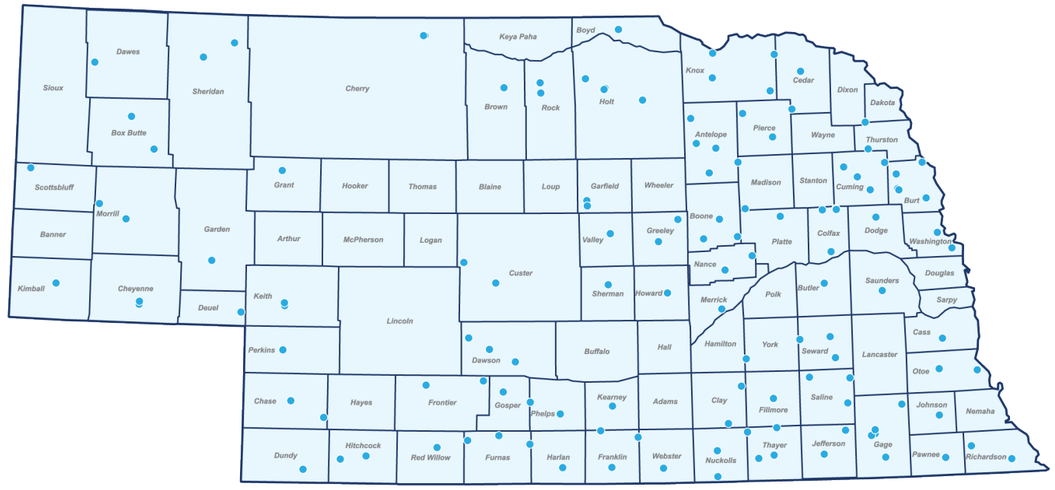
Continue
cost-based reimbursement without a per-visit cap in exchange for requiring provider based RHCs reporting of quality measures. Provider-based RHCs would use the higher rate to pay for their participation in a quality program.

Create
an option for low-volume facilities (perhaps those meeting frontier and/or volume threshold) to automatically be eligible to receive a provider-based designation exception to address low-volume issues.

Include
the provision of behavioral health services under the existing primary care 50% threshold requirements given the shortage of rural mental health providers and the importance of primary care and behavioral health integration.

Remove
outdated laboratory requirements.

Medicare Certified Rural Health Clinics
138 as of December 2022



The NHA and NeRHA support the following actions related to the RHC program to strengthen and support the designation:

- RHCs must be included as an important entity in payment reforms including Accountable Care Organizations (ACO), Patient-Centered Medical Homes (PCMH), and Regional Care Collaborative Organizations.
- Expand eligibility requirements for existing RHCs located in areas that lose their Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA) designation because of population or provider changes. Geographic distance, provider type, patient transportation requirements and limitations, and other proven access considerations should be included in evaluating access to health care in the certification criteria.
- Provide sufficient funding for timely initial and follow-up certification surveys to assure access.
- Require Medicare Advantage plans to reimburse for flu and pneumococcal vaccines at the RHC's cost per vaccine, as calculated on the most recent Medicare cost report.
- RHCs should be eligible for the 340B Drug Pricing Program.

340B Drug Pricing Program

The 340B Drug Pricing Program is under attack by pharmaceutical manufacturers. If this program is weakened, hospitals and health services in rural Nebraska will suffer.

The federal 340B Drug Pricing Program is a drug price control program that allows qualifying providers, generally hospitals, specialty clinics and their associated outpatient facilities serving uninsured and low-income patients in rural communities, to purchase outpatient drugs from manufacturers at discounted prices.

Qualifying providers, known as Covered Entities (CEs), are allowed to bill and collect the full price for drugs from patients' insurance companies. Buying drugs at a discounted rate and billing the full price allows hospitals to generate revenue to serve their communities. The surplus funds (called 340B funds) allow providers to reduce the financial burden of medications or other medical care for uninsured, under-insured, and low-income patients.

63 Nebraska hospitals currently utilize the 340B Drug Pricing Program; most of these are Rural Critical Access facilities.

For strong rural health care, Nebraska needs to support the following actions to strengthen and support the 340B Drug Pricing Program:

Protect
the 340B drug savings program to ensure vulnerable communities have access to more affordable drug therapies by reversing harmful policies and holding drug manufacturers accountable to the rules of the program, especially as it relates to community pharmacy arrangements.

Review
existing policies around Medicare payment for 340B-acquired drugs and limitations on covered entities' use of contract community pharmacies.

Expand
the 340B Drug Pricing Program to include inpatient drugs for CAHs and other safety net providers.

Eliminate
the group purchasing organization (GPO) prohibition.

Maintain
a patient definition consistent with the way medicine is practiced in rural communities to ensure robust access to the 340B Drug Pricing Program. Critical Access Hospitals (CAH) should be made eligible for the full 340B Drug Pricing Program, without the exclusion of orphan drugs.

Rural Emergency Hospital Model (REH)

We recommend partnering with the state to explore opportunities for CAHs to transition to REH instead of closing their doors permanently.

Hospital closure in a community can mean the loss of both a local emergency department and public EMS. For those communities that maintain EMS agencies, longer transportation times, due to distances between emergency departments, have been shown to adversely affect health outcomes with higher mortality rates attributed to increased driving times.

Over the past 8 years, two Critical Access Hospitals have permanently shut their doors in Nebraska. CMS reimbursement rates are insufficient and have not kept up with inflation. Studies show that Nebraska has several hospitals on the cusp of closing which would have a negative impact on their communities.

A trend of hospital closures since 2010 has reduced the ability for many rural Americans to receive the timely care needed to survive a health emergency.

One solution to prevent hospital closures and retain access to emergency services is the creation of the Rural Emergency Hospital (REH) designation under the Consolidated Appropriations Act of 2021. The REH designation allows rural hospitals to maintain outpatient and emergency department payment from Medicare without a requirement of inpatient acute care services.

The REH model is thought to be advantageous for small, independently owned rural hospitals with low inpatient volumes, low net patient revenues, and a recent history of financial distress. Patient transfers from a REH location to a designated trauma center will rely heavily on community EMS providers that are often trained volunteers in rural settings.

For strong rural health care, Nebraska needs to support assisting Critical Access Hospitals that may be interested in converting to the REH model instead of closing their doors due to financial constraint.

Medicare Advantage Reform

We support legislation strengthening oversight of Medicare Advantage (MA) ensuring CAHs are fairly reimbursed and streamlining prior authorization requirements under MA plans.

Medicare Advantage plans have become an increasingly popular option among older Americans, offering privatized versions of Medicare that are frequently less expensive and provide a wider array of benefits than the traditional government-run program offers.

Enrollment in Medicare Advantage plans has more than doubled over the last decade, and half of Medicare beneficiaries are expected to choose a private insurer over the traditional government program in the next few years.

Medicare Advantage, a fast-growing alternative to original Medicare, is run primarily by major insurance companies. The health plans have enrolled nearly 27 million members, or about 45% of people eligible for Medicare, according to an industry trade group formerly known as America's Health Insurance Plans.

When patients enroll in a Medicare Advantage plan, they often give up the freedoms that come along with traditional Medicare in exchange for additional benefits. Once enrolled, beneficiaries find out that the additional benefits have very limited coverage and finding a doctor or hospital that accepts the plan can be difficult.

With these limits, patients may end up footing the bill for health care services that they thought their plan would cover. Additionally, plans change annually. So, one year your plan might have additional benefits, and the next year they can be eliminated entirely.

With Medicare Advantage plans, staying in network is key to paying the lowest possible costs for health services. Going out of network could mean high fees or no coverage. Even with a Preferred Provider Organization plan, patients will end up paying more to see doctors that are not in their plan's network.

It is essential for patients to know that the hospitals and doctors can leave a plan's network anytime. Thus, hospitals and doctors may be in-network one month, but out-of-network the next month.

Additionally, Medicare Advantage plans often have deductible, copay, and coinsurance amounts that are much higher than traditional Medicare with a Medicare Supplement plan.

CAHs are cost reimbursed in terms of traditional Medicare services. Under Medicare Advantage, the CAH would not be cost reimbursed. The methodology for Medicare Advantage is a prospective reimbursement which will likely mean that the CAH will not receive their full cost of care. Most CAHs do not participate in Medicare Advantage networks due to the differences in the reimbursement methodology.

When patients enroll in a Medicare Advantage plan, they often give up the freedoms that come along with traditional Medicare in exchange for additional benefits.

For strong rural health care, Nebraska needs to support action to improve the oversight of MA plans and the ability of CMS to enforce existing regulations that are intended to ensure appropriate beneficiary access to medically necessary services. Specifically, we aim to prohibit MA plans from using medical necessity criteria that is more restrictive than the criteria used for patients enrolled in traditional Medicare.

Prior Authorization Fixes

We support standardized prior authorization requirements and processes. We support legislation that ensures necessary oversight to stop inappropriate prior authorization and payment delays and denials.

Prior authorization is a process used by insurance companies to determine whether a medical treatment, procedure, or medication is covered under a patient's insurance plan. It involves a review of the medical necessity of the treatment or procedure, as well as the appropriateness of the proposed course of treatment. Prior authorization is often required for certain types of treatments to ensure that they are not overused or used in situations where they may not be necessary. The process can be time-consuming and may delay the start of treatment.

Delays in prior authorization in health care can cause several issues for patients and providers.

Issues include:

Delays in treatment:
The process of obtaining prior authorization can take several days or even weeks, which can delay the start of treatment for patients who need it urgently. This can be especially problematic for patients with chronic conditions or serious illnesses.

A study published in the Journal of Managed Care Medicine found that the average time for prior authorization approval was 17.2 days, with some cases taking up to 45 days.

A survey by the National Patient Advocate Foundation found that 65% of patients reported that prior authorization had a financial impact on them, including increased out-of-pocket costs and higher insurance premiums.

Additional paperwork:
Prior authorization often requires a significant amount of paperwork, which can be burdensome for both patients and providers. It can also lead to errors or incomplete information, which can further delay the process.

Patient dissatisfaction:
A survey by the Kaiser Family Foundation found that 70% of patients were dissatisfied with the prior authorization process and felt it was too time-consuming and confusing.

Inadequate patient care:
Prior authorization can limit the treatment options available to patients, which can affect the quality of care they receive. This can be especially problematic for patients with complex medical needs.

Telehealth Parity

For strong rural health care, Nebraska needs state legislation that creates full payment parity for telehealth services, ensuring that the reimbursement rate for a telehealth consultation shall be the same as for a comparable in-person consultation. This change will help ensure patient access as well as market viability of telehealth medicine.

Telehealth expands access to services which may not otherwise be sustained locally due to provider recruitment or retention difficulties, low patient volume, or inadequate local resources. It also holds great potential to address health care disparities, which have long existed in rural communities, due to geographic isolation, an aging population, and race and ethnicity. As technology has improved and people are increasingly comfortable with the delivery of care through virtual connections, the utilization of telehealth services has dramatically increased.

By allowing these facilities to serve as distant-site providers, Congress greatly expanded the access to care for rural populations. Congress should allow RHCs and Federally Qualified Health Centers (FQHCs) to permanently serve as distant-site providers, and should instruct CMS to reevaluate their reimbursement and coding methodologies for telehealth services.

We recommend the following Medicare policy and program actions to improve telehealth implementation in rural areas:

- Telehealth waivers enacted during the COVID-19 PHE should be extended permanently.
- Congress should authorize RHCs and FQHCs to serve as distant-site providers permanently.
- CMS should change the reimbursement so that providers are reimbursed at their AIR. Not only would this create greater parity in the true cost of providing services, but it would also better incentivize rural providers to utilize these flexibilities. Increased utilization will improve quality of life for rural patients.
- CMS should reevaluate the payment model for RHC and FQHC reimbursement. Under current statute, RHCs and FQHCs are reimbursed at a PPS rate.
- Invest in health care infrastructure by expanding access to virtual care technologies and rural broadband, strengthening the capacity and capability for emergency preparedness and response, assisting hospitals in "right-sizing" to meet the needs of their communities, and ensuring adequate financing mechanisms are in place for hospitals and health systems, including training of the workforce.

White Bagging Policies

For strong rural health care, Nebraska needs legislation to ensure that patent access to quality care and drug therapies is not compromised through white bagging and brown bagging insurance practices.

Health insurance companies are dictating new policies limiting patient choice and reducing access to care for critical specialty medications administered at our hospitals.

This new insurance practice - called “white bagging” - requires that certain medications be dispensed by a separate pharmacy outside the hospital, often owned by the insurance company. Patients do not get to choose if their medications are “white bagged”; this is all dictated by health insurance companies.

White bagging is causing significant delays in patients getting their medications and even resulting in hospitals being sent the wrong dose or the wrong medication. In some instances, hospitals don’t receive the shipment on time, if ever, and are forced to cancel and reschedule patient procedures until the next dose arrives. This leaves many hospitals in Nebraska at risk of liability and costs associated with this flawed process.

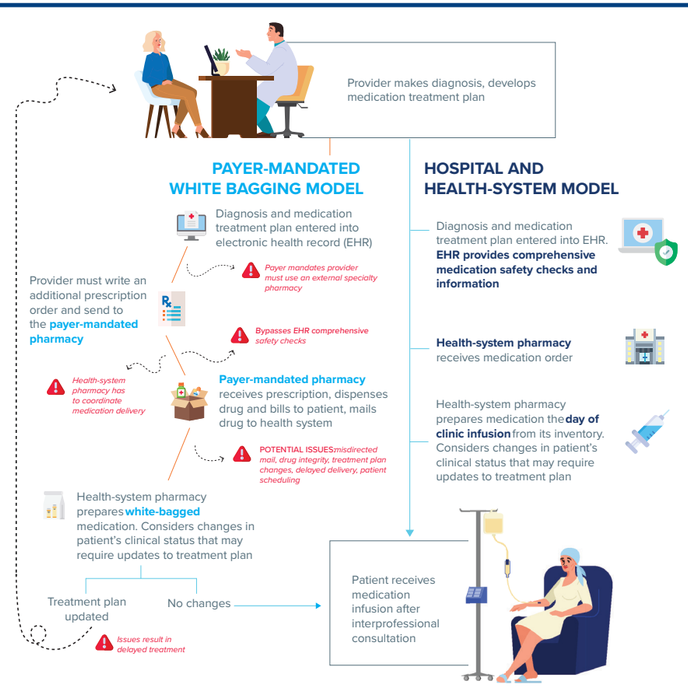
White bagging also causes serious, potentially dangerous disruptions to patient care and removes patient choice at the time they deserve it most. This disruption to care is happening right now to patients across the country, including in Nebraska, because insurance companies are making decisions that belong to doctors and their patients.

> **White bagging ... bypasses all the checks and balances that are built into the pharmacy’s system. Drug interaction checking, dose weight checking; all of those things are bypassed.**

Source

White bagging a growing concern for Health Systems. ASHP. (2021, March 23). from American Society of Health-Systems Pharmacists

How does white bagging work?



Growing Our Rural Health Care Workforce

Current Workforce

The NHA and NeRHA support legislation to reduce barriers that exist in Nebraska to attract and retain a sufficient workforce.

According to the Nebraska Center for Nursing, Nebraska will experience a workforce shortage of 5,435 nurses by 2025. Seventy-three of Nebraska's 93 counties have less than the national average ratio of registered nurses to patients. Sixty-six of Nebraska's counties have been deemed medically underserved. Nine counties in Nebraska have no registered nurses. Recruitment and retention of health professionals has long been a persistent challenge for rural providers.

The shortage of primary care services has detrimental effects on the overall health of rural populations. For example, health outcomes in rural areas are significantly lower compared to more densely populated regions. Additionally, while clinical care shortages exist across the care continuum, the shortage of behavioral health and substance abuse professionals in rural populations is immense. Clinician shortages are difficult to fill as rural hospitals find it challenging to recruit and retain qualified practitioners.

A recent survey of Nebraska hospitals reported that 93 percent of our hospitals are facing workforce shortages.

- **25% of the nursing workforce is 55 years old and older.**
- **2020 recorded the highest RN turnover rate in the last 10 years.**
- **It is estimated that every 6 years, a hospital will have an entirely new RN staff.**
- **94% of RNs report some degree of burnout, while 36% percent of RNs report a high level of burnout.**
- **10% are planning to leave the profession.**

Future Workforce

For strong rural health care, Nebraska needs to provide funding for Career and Technical Education (CTE) programs and Career Technical Student Organizations (CTSO) to enable high school students to explore health care professions.

Career and Technical Education (CTE)

Career and Technical Education (CTE) has been an important part of education in Nebraska. For over a century, as part of comprehensive high schools and post-secondary institutions, CTE has provided students with necessary academic, technical, and career readiness skills for post-secondary education and employment. But Nebraska and our world continue to evolve. Moving from a reliance on the steam engine to the everyday use of the search engine, rapid changes in artificial intelligence, automation, globalization, shifting demographics, and increased emphasis on educational accountability have provided the impetus for strengthening the design and delivery of CTE in Nebraska.

Nebraska receives federal CTE funds from the Perkins V grant every year. This federal money, which is estimated to be around $1.2 billion for 2023, is split among all 50 states based on population size. Because of Nebraska's smaller population size, it receives a lesser amount of federal Perkins V funds than most other states.

Once the state receives the Perkins V money, it is split between state funds and local funds. The local funds then are divided even further between secondary (high schools) and post-secondary (colleges), leaving only $3.4 million this year for around 240 high schools across the state.

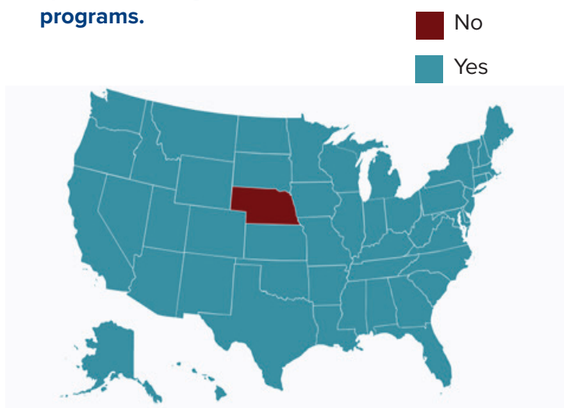
Nebraska is estimated to receive $8 million in Perkins V funds for this upcoming fiscal year. Nebraska is the only state that doesn't provide designated, increased funding for career and technical education. It's an issue that state leaders are just now catching up to as they realize the impact that career and technical education (CTE) funding has on not only schools but the workforce as well.

Career and Technical Student Organizations (CTSOs)

Nebraska has seven Career Technical Student Organizations (CTSOs) that are extensions of classroom instruction — applying classroom learning to real-world experiences. CTSOs are not clubs, they are connected to middle school, high school, and post-secondary instructional programs and are integral to the classroom.

The seven Nebraska CTSOs are **FFA** (agriculture), **HOSA** (health care), **Educators Rising** (education), **FBLA** (business), **DECA** (marketing), **FCCLA** (nonprofit & technical), and **SkillsUSA** (technical and skills and service). CTSOs have thousands of Nebraska students as members, but each CTSO relies on student activity fees, volunteers, and sponsors for support. Additional funding by the state would allow the CTSOs involvement in more schools across the state and prepare them for entering the workforce quicker.

Nebraska is the only state that does not provide specific funding for career and technical education programs.



Education Pipeline

The NHA and NeRHA support legislation that provides teaching institutions grants to increase access to clinical sites and graduate more nurses in Nebraska.

Grants Available for Nursing Students

The NHA helped pass legislation in 2022 that secured $5,000,000 in funding through the American Rescue Plan Act (ARPA) for scholarships for Nebraska nursing students.

Any Nebraska resident currently enrolled or intending to enroll in a Nebraska Certified Nursing Assistant (CNA), Licensed Practical Nurse (LPN), Associate Degree in Nursing (ADN), or accelerated Bachelor of Science in Nursing (BSN) program is eligible to apply for $2,500 per semester. Qualified applicants will receive scholarships on a first-come, first-served basis each semester until their nursing program is complete or the ARPA funds run out.

Upon completion of a qualified nursing program, scholarship recipients will be required to practice nursing in Nebraska for a minimum of two years.

These scholarships will help to reduce barriers to entry in the nursing field and grow Nebraska's public health workforce. Each scholarship recipient will play a vital supporting role in rebuilding Nebraska's public health infrastructure and will advance the state's recovery from COVID-induced nursing shortages.

All current and prospective CNA, LPN and accelerated BSN students are encouraged to contact the Nebraska Department of Health and Human Services (DHHS).

Community College/Capacity

The NHA worked with stakeholders to secure $60 million in funding from the Legislature that will go to various projects to strengthen and grow a post-pandemic skilled workforce and substantially increase their ability to train the next workforce of Nebraska. This funding will provide for the acquisition, construction, and upgrades of several educational institutions across the state to up-skill and re-skill the population, especially in low income, underserved, and disproportionately impacted communities.

Loan Repayment Programs

The NHA and NeRHA supports DHHS programs that will help health professionals with student loan repayment programs, providing up to $200,000 in student loan repayment for qualified health care providers who agree to work in rural and underserved communities. The two programs are the Nebraska Loan Repayment Program (NLRP) and the National Health Service Corps Nebraska State Loan Repayment Program (NHSC SLRP).

Incentive programs are an important tool to recruit and retain health care providers in needed areas. According to studies on the economic impact of rural health care, one primary care physician in a rural community creates 23 jobs annually. On average, 14 percent of total employment in rural communities is attributed to the health sector.

The NLRP offers loan repayment assistance for primary care, mental, dental, and certain allied health professionals who agree to practice for three years in a state-designated shortage area in Nebraska. Doctors and dentists are eligible for up to $180,000 in loan relief, while other medical professions are eligible for up to $90,000. Due to the availability of American Rescue Plan Act (ARPA) funds, no local match is required at this time and those who have previously participated in the state program can apply for a second award.

The NHSC SLRP offers loan repayment assistance for primary care, dental, and mental health professionals who agree to practice for a minimum of two years at an NHSC site in Nebraska. The length of participation is capped at four years and providers cannot apply for another award after reaching the four-year maximum. Awards are also available for Pharmacists and – new this year – Registered Nurses (RNs must have bachelor's level training). Doctors, dentists, and pharmacists are eligible for up to $50,000 in loan relief per year, while other medical professions are eligible for up to $25,000 per year. Currently, no local match is required.

The NHA was successful in working with the Legislature in 2022 to ensure that no local match was required.

Rural Health Complex - $60 million

The NHA worked with the University of Nebraska System to secure $60 million in funding that will go towards construction of a joint University of Nebraska at Kearney (UNK) and University of Nebraska Medical Center (UNMC) Rural Health Complex to be located on the UNK campus.

The new facility will include state-of-the-art classrooms, extensive simulation and clinical skills laboratories for pre-clinical education and complex clinical scenarios and simulated primary care spaces. It will bring new options to the UNK campus, including medicine, medical nutrition, genetic counseling and respiratory care – all high-need areas in rural Nebraska. A Master of Health Administration degree will be added to complement UNK's undergraduate program, and discussion is underway for the UNMC College of Pharmacy to offer a joint degree program with UNK.

It is estimated that nearly 85% of the students who graduate from this facility begin their careers in Nebraska.

> **"Adding a second health science-focused building at UNK creates opportunities for students who want to both pursue – and practice – their health careers closer to home, which help us build a stronger rural workforce, increase access to rural care and help communities thrive," said Dr. Jeffrey P. Gold, Chancellor of the University of Nebraska Medical Center. "In short, it will transform lives for generations."**

Clinical Training Sites

The success of the health care system is dependent on the availability of properly educated and trained professionals. The work a health care professional does is demanding and exacting. It requires skill, focus and attention to detail. Health care careers are some of the most respected, exciting, rewarding and fulfilling careers one can have.

The pandemic disrupted the education of clinicians-in-training, creating an immediate need for health care organizations to revamp and ramp up training for new clinicians to address gaps and accelerate onboarding. For the longer term, fundamental shifts in how care is likely to be delivered affects the training, retraining, and upskilling of both current and future clinicians. The need for greater engagement, workforce agility and clinical education equity also requires health care organizations creativity with in-person and virtual learning opportunities and greater support for diverse learning styles.

A key part of nursing education is participating in clinicals which is basically following real nurses around and interacting with real patients. This is an invaluable opportunity for nursing students to get hands-on experience with patients in the workplace. But not all hospitals are able to accommodate the demand from nursing education programs throughout their facility. Nebraska is suffering from limited clinical sites for nursing students, and those limitations are posing problems at nursing schools that are having to limit their student enrollments.

The NHA and NeRHA supports LB586 that provides grant funding that expands nurse clinical training and nurse facility sites in rural communities and across the state. These efforts ensure hospitals and health systems have the necessary workforce to continue to care for patients in our communities. It is vital the state assists in the funding to expand nursing, allied health, and clinical support education programs in Nebraska.

Improving Access to Post-Acute Hospital Care in Rural Nebraska

Long-Term Services And Rural Support for Seniors

For strong rural health care, Nebraska needs reimbursement that supports high-quality caregivers and nursing care.

Since 2017, 36 nursing homes and 28 assisted living facilities closed in Nebraska.

Nebraska had 225 licensed long-term care facilities in May 2016, according to state licensing officials. The most recent report listed 206 facilities.

In rural Nebraska, if a long-term care (LTC) facility is at full capacity or closes, residents have to relocate dozens, if not hundreds of miles to get care. The distance disrupts that person's support network that he or she is accustomed to and it is burdensome on his or her family. You could spend your whole life in rural Nebraska and need to be uprooted from everything you know because of the lack of staffed nursing home beds.

Many long-term care facilities do not generate enough revenue to pay staff competing wages. With limited staffing capabilities, they are unable to take on additional residents. Without additional residents, the facilities can't break even. Workforce recruitment and retention has been a persistent challenge for long-term care facilities, and the chronic Medicaid underfunding has left providers struggling to compete for qualified caregivers.

Rural seniors with unmet personal and health care needs may be prematurely forced into assisted living or nursing homes because they are unable to live independently in their own home or community. The shift to institutionalization not only restricts consumer choice and satisfaction, but it is a major cost driver for state Medicaid programs.

Medicaid is the nation's largest payer for long-term care services. Older individuals and adults with disabilities represent about one-quarter of all Medicaid enrollees; however, they account for approximately 70 percent of all Medicaid spending. Containing costs and ensuring high-quality, accessible, Long-Term Services and Support (LTSS) is critical for rural Nebraska.

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Difficult to Transfer Patients

Delays in patient discharges to post-acute care settings have become a growing challenge for our hospitals. While difficult to place patients is not a new issue, COVID-19 has exacerbated the situation and created a large volume of patients who are ready for discharge from hospitals but cannot find an appropriate bed in a post-acute care setting. Addressing transition delays and optimizing the flow of patients throughout our health care system is an ongoing priority for the NHA and our members.

We propose the following solutions:

New payment models for post-acute facilities to open and operate specialized units.

Nebraska hospitals continue to report they are operating at or beyond capacity. Large health systems, Critical Access Hospitals, rural nursing homes, and many more organizations are facing staffing shortages and an overload of complex patients. Behavioral health, bariatric, and complex wound care are a few types of specialized care that are identified gaps in Nebraska's post-acute settings. Enhancing reimbursement for post-acute facilities to care for these targeted patient populations would bridge the gap and assist with the transition of those patients from a hospital to an appropriate post-acute setting.

Grant program for post-acute facility investments to care for complex patients, including capital improvements, training and education, and durable medical equipment.

Many Critical Access Hospitals and rural post-acute settings have open beds available for admissions; however, organizations have identified other barriers that prevent them from having the ability to safely care for the patient. Opportunities for capital infrastructure and patient care needs include bariatric equipment, wound supplies, tracheostomy capabilities, and much more. Many small facilities need additional training, education, and certification for staff to care for patients with complex conditions appropriately. This opportunity has the potential for growth in small facilities, which will include expanding services and skills to accept more complex patients into their organizations.

Improve guardianship capacity, wait list transparency, and prioritization of hospitalized patients.

Guardianship has been identified as a NHA theme and opportunity for improvement within the Transitions of Care Council. When patients are deemed incapacitated by their primary care provider, the process of guardianship begins, most often after an acute hospitalization. When a provider determines that a patient is unable to make their own decision, a member from the discharge planning team starts the guardianship application process. This lengthy process takes, at a minimum, 4-8 weeks. With chronic hospital staffing concerns and a smaller guardian-to-ward ratio than other states, prioritizing hospitalized patients should be a priority.

Hospital reimbursement for holding medically cleared patients awaiting discharge to post-acute settings.

Patients are being held in hospital beds for many reasons unrelated to their medical care. As hospitals are faced with complex patients, many are unable to safely discharge patients that have been medically cleared. Hospitals are facing barriers such as guardianship, Medicaid application processing, private payer approvals, and more. Medically cleared patients are occupying hospital beds and staff time while the hospital is not receiving reimbursement for the care for weeks and months. A reimbursement system would allow for hospitals to continue planning for a safe discharge, while limiting the financial burden that these roadblocks are causing.

Establish Medicaid Reimbursement for Long-Term Acute Care Hospitals.

Long-term acute care hospitals (LTACHs) are facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures. These patients are typically discharged from intensive care units and require more care than they can receive in a rehabilitation center, skilled nursing facility, or at home. Without this care available in Medicaid, patients receive rehabilitation services in acute care hospitals that are not designed to meet their specialized rehabilitation needs. This also takes additional resources away from acute care hospital capacity.

Top 15 Barriers to Discharging Patients to Post-Acute Settings:

1. Staffing/capacity constraints at post-acute care facilities
2. Delayed response from insurer
3. Denial of request for authorization from insurer
4. Need for Behavioral Health/Substance Abuse Disorders care and services
5. Medicaid application delay
6. Need for specialized medical services
7. Lack of access to necessary community services
8. COVID-19 status
9. Lack of payment
10. Pre-Admission Screening and Resident Review (PASRR) delays
11. Lack of guardianship / conservatorship / health care proxy
12. Insurer does not provide post-acute coverage
13. Lack of secondary payment
14. Transportation unavailable
15. Vaccination status

Last year, Nebraska hospitals had over 35,500 avoidable days of patients that were in the wrong care setting because they could not be discharged to the appropriate level of care.

Improving Rural Well-Being

Rural Mental Health

Rural farmers are the backbone of America, providing $389 billion of agricultural products in the United States, yet attention and support for our agricultural community's well-being has been chronically overlooked.

Rural populations have a significantly higher suicide rate than urban areas and available information indicates the suicide rate among farmers is 3.5 times higher than the general population.

Solutions need to consider robust funding of research, building the rural health care workforce, and addressing barriers to well-being through consideration of the social determinants of health.

For strong rural health care, Nebraska needs to support the following actions to address rural mental health and well-being:

- Ensure high quality broadband internet access to secure telehealth services, educational opportunities, and professional development of rural farmers and their families.
- Continue to fund community-led mental health education and training emphasizing leadership and inclusion of the rural agricultural workforce and their support network.
- Invest in rural mental health and health care workforce through incentive programs for practitioners, developing cultural competency, and reducing barriers to practice in rural areas.
- Increase research efforts in the United States to build awareness of and solutions for supporting mental health in the agriculture industry.

Maternal Health

The majority of rural women give birth at their local hospitals and therefore rely on local maternity services. Current workforce and hospital closure trends suggest that disparities in access to maternity care will only increase in coming years if no action is taken.

Nebraska must support the following actions to ensure that women in rural areas continue to have access to maternity services:

Incentivize the expansion of Medicaid eligibility for pregnant women.

Use flexibilities in the Medicaid program to address barriers to rural practice of Obstetric (OB) services including: protections for low volume providers; liability insurance costs and tort reforms; incentives to address a decreased focus of OB care within primary care practice; and resources to support C-sections including an OB-GYN, surgeon, and/or anesthesiologist.

Support local perinatal regionalization and access to OB care policies that keeps struggling facilities open in order to keep maternity services local for rural women, such as the Save Rural Hospital Act, with a focus on the smallest hospitals that do not typically provide OB services.

Incentivize the integration of rural EMS programs, community health workers, other nontraditional providers specializing in maternal care, and hospitals to support maternity care in maternal health professional shortage areas.

Expand use of telehealth and other technologies to facilitate the delivery of maternity and pediatric services so that women can receive care in facilities within their own community.

Make efforts to create a designation for areas that lack maternity providers – a professional shortage area for maternity providers.

Expand scope of practice and reimbursement for advanced practice providers (e.g. family physicians, nurse practitioners, physician assistants, nurse midwives, certified midwives) and non-traditional providers (e.g. doulas, community health workers) in order to maintain or improve access to local maternity care for rural women.

Support rural training programs, including inter-professional team building, such as TeamSTEPPS, and simulation training, such as the American Academy of Family Physicians' Advanced Life Support in Obstetrics course (ALSO) and the Centers for Disease Control and Prevention's Hear Her campaign.

Develop and support rural-specific obstetrics-focused residency programs.

Supports rural family practice physicians in providing maternity services, including providing more rural residencies for family practice physicians that allow residents to perform more deliveries.

Incentivize clinicians to practice in rural communities by expanding rural-focused family physician and general surgeon programs with OB fellowship training.

Leverage the Nebraska Department of Human Services Loan Repayment program for primary care, mental, dental and certain allied health professionals practicing in shortage areas in Nebraska.

Preserving Lifesaving Services

Emergency Medical Services

Nebraska must have strong Emergency Medical Services (EMS) in rural communities. Both the NHA and NeRHA support state funding for simulation in motion (SIM) trucks that can provide essential training for rural EMS, hospitals, and clinics.

EMS

EMS plays a critical role in rural areas. It is increasingly difficult for ambulance services to respond to emergencies in rural America due to workforce shortages and growing financial crisis. About a third of rural EMS agencies in the U.S. are in immediate operational jeopardy because they can't cover their costs, largely from insufficient Medicaid and Medicare reimbursements.

Those reimbursements cover, on average, about a third of the actual costs to maintain equipment, stock medications and pay for insurance and other fixed expenses. Private insurance pays considerably more than Medicaid, but because of low call volumes, EMS agencies aren't able to make up the difference in reimbursement.

NHA recognizes the critical role that Emergency Medical Services (EMS) play in rural areas. It is increasingly difficult for ambulance services to respond to emergencies in rural America due to workforce shortages and growing financial crisis.

Simulation in Motion-Nebraska

SIM-NE is a statewide, mobile education system that takes state-of-the-art, hands-on training to emergency medical service providers in rural areas across the state, including health professionals in hospitals. SIM-NE provides free or low-cost training via four 44-foot-long trucks customized to replicate real-life emergencies to enhance life-saving skills for those in rural areas.

SIM-NE's fleet, launched in June 2017, is stationed in Scottsbluff, Norfolk, Kearney and Omaha. Rather than have learners in greater Nebraska travel to larger cities, the trainers go to them. This allows training to be team-based as learners train side-by-side with the people they normally work with during an emergency response.

"The ability to drive this simulator out to their parking lot means they don't have to travel two, three hours to the large city and send their whole department to get this training," said Phillip Oelschlager, who is SIM-NE's Southeast Regional Coordinator and Lead Trainer.

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