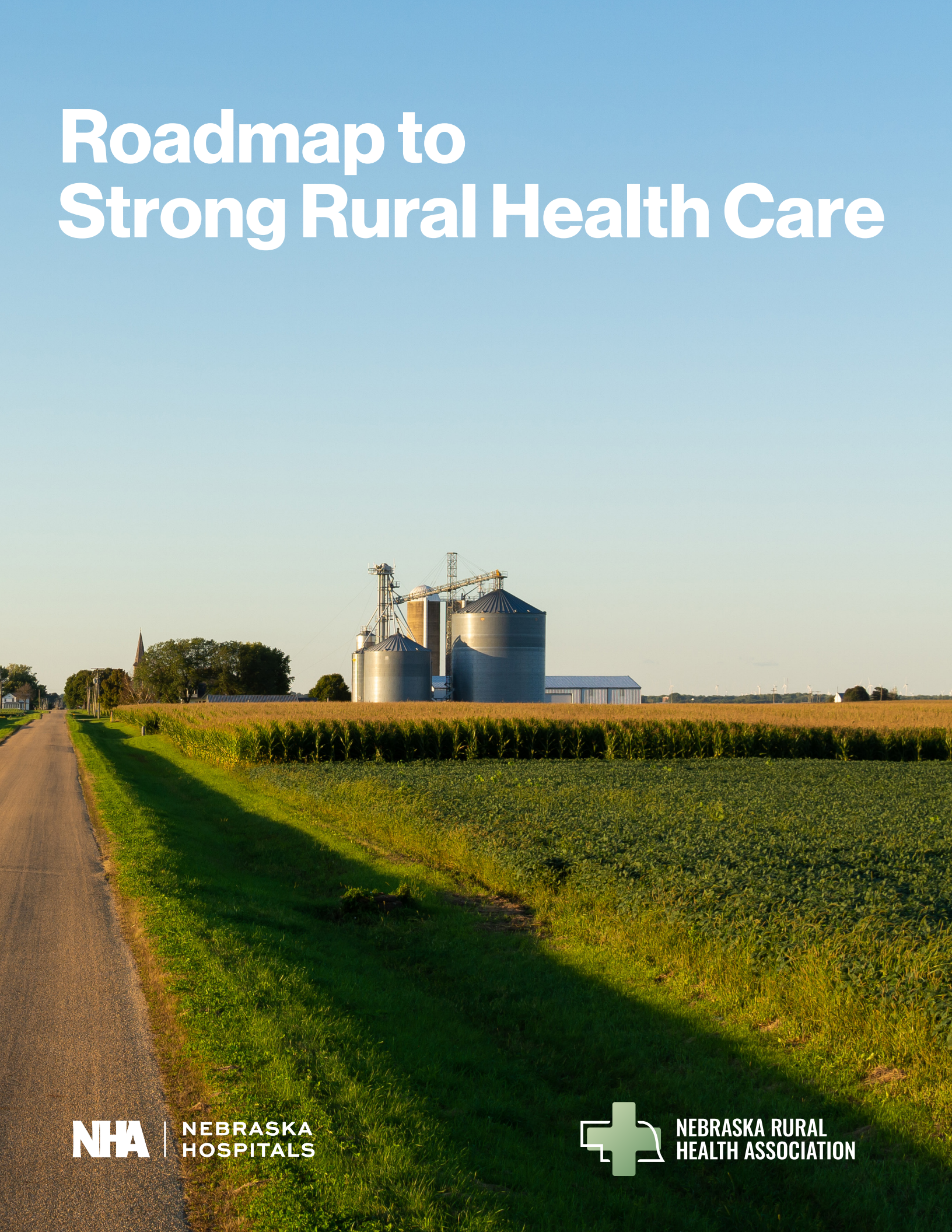
Roadmap to Strong Rural Health Care



NHA | NEBRASKA HOSPITALS

NEBRASKA RURAL HEALTH ASSOCIATION

Executive Summary

Two years ago, the Nebraska Hospital Association partnered with the Nebraska Rural Health Association on the first of its kind *Roadmap to Strong Rural Health Care* in Nebraska. The *Roadmap* presented a combination of state and federal issues and the actions needed to strengthen and support rural health care in our state.

These past two years have seen significant progress towards addressing the challenges identified in our first roadmap. We are proud of the passage of LB 1087 (2024) to sustain hospitals by establishing appropriate Medicaid reimbursement, the passage of LB 256 (2024) to provide telehealth parity, and the expansion of several initiatives to address statewide workforce shortages. However, there is more work to be done to protect and sustain our rural hospitals and clinics, enabling them to deliver the care rural patients deserve.

Strong hospitals help create strong communities. Rural hospitals 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. Not only do hospitals directly employ thousands of Nebraskans, but the economic activity they generate supports other local businesses. In fact, for every dollar spent at a hospital, the local economy receives $1.50 back. In 2020, rural hospitals supported one in every 12 rural jobs nationwide, as well as $220 billion in economic activity.

Rural hospitals are particularly critical in Nebraska. Rural hospitals make up about 35 percent of all hospitals nationally, but over 68 percent of hospitals in Nebraska. Nebraska has more rural residents living at least 25 minutes away from an ambulance than all but two other states. Approximately 16 percent of Nebraska mothers must travel at least 30 minutes to find a maternal care provider, about twice the national rate.

Ongoing shortages in the health care workforce exist across rural Nebraska. Fourteen of the state's 93 counties do not have a primary care physician. Eighty-five of Nebraska's rural communities are considered medically underserved areas for primary care services alone. Projections show Nebraska will experience a workforce shortage of over 5,000 nurses in 2025. Rural hospitals and health systems face unique challenges and constraints that require unique solutions.

About Us

NHA | NEBRASKA HOSPITALS

The Nebraska Hospital Association is the trusted and influential 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 advocacy, data, education, and more to advance Nebraska hospitals' ability to provide exceptional, quality care to Nebraska's patients and communities. The NHA has been a vital part of our member hospitals' missions since our founding in 1927.

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

Protecting Services Through Sustainable Medicaid Rates

In early 2024, a survey of Nebraska hospitals showed that about half were operating in the red, including nearly 60 percent of small, rural hospitals. Rising workforce and pharmaceutical costs increasingly squeezed hospitals already burdened by Medicaid and Medicare reimbursement rates far below the cost of services provided.

Inadequate Medicaid reimbursement, combined with medical inflation, forced Nebraska hospitals to eliminate or reduce needed services, especially in rural communities. Something had to be done.

LB1087 sought to address this crisis by increasing hospital reimbursements without creating any new burden on Nebraska taxpayers. The bill was introduced by Senator Mike Jacobson, prioritized by Senator Christy Armendariz, and passed the Nebraska Legislature with overwhelming support, securing a 45-0 vote. Governor Jim Pillen signed the bill into law on March 27, 2024, marking a significant milestone for the state's health care systems. With an emergency clause, the law took effect immediately and the State Directed Payment Program began to be implemented.

Under the State Directed Payment Program, hospitals pay an initial assessment which the state then uses to draw down additional federal funds. These federal funds allow Nebraska's Medicaid program to pay hospitals adequate rates without any increase to state expenditures. This program is estimated to generate over $260 million annually in additional funding for Nebraska's rural hospitals.

According to Senator Jacobson, LB1087 "is one of the most impactful and transformative pieces of legislation that we passed this session. This program allows our state to dramatically increase reimbursement rates to hospitals without costing our state general fund any additional dollars. It will have a dramatic impact on reimbursement rates, hospital services, and ultimately on the availability of health care across the state."

Nebraska's rural hospitals can anticipate positive outcomes over the coming years including lowered risk of closures, increased financial stability, investments in services and most importantly, better health outcomes for rural patients.

In short, the State Directed Payment Program presents a lifeline to our hospitals and the Nebraskans they serve and will be of critical importance in the years to come.

PROTECT THE STATE MEDICAID DIRECTED PAYMENT PROGRAM

Enhance 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 operate in rural, underserved areas. They must use a team approach to provide services, with physicians working with non-physician providers, such as nurse practitioners (NP), physician assistants (PA), and certified nurse midwives (CNM). The clinic must be staffed at least 50% of the time with an NP, PA, or CNM. RHCs are required to provide outpatient primary care services and basic laboratory services.

62% OF THE RURAL POPULATION IN THE U.S. IS SERVED BY RHCS

Rural Health Clinics play a pivotal role in improving access to local care in our state — including primary care, laboratory, and chronic disease management.

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

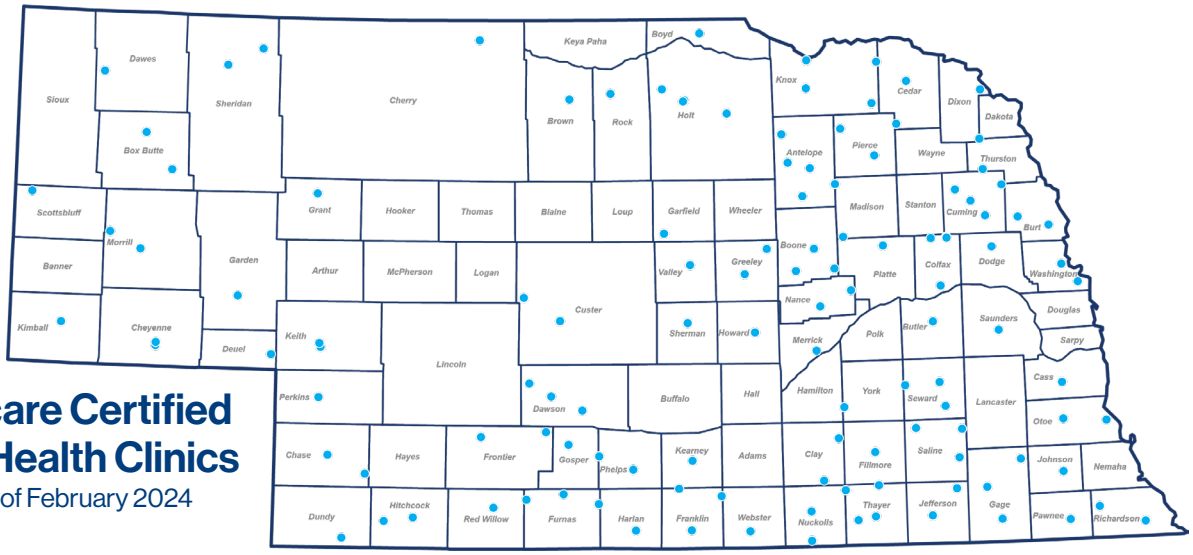
RHC visits can take place at:

- 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

Wherever a patient lives in Nebraska, they deserve equal access to health care.



Medicare Certified Rural Health Clinics

127 as of February 2024

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.

The NHA and NeRHA support the following actions to strengthen and support RHCs:

Pass the Rural Health Clinic (RHC) Burden Reduction Act (s. 198/H.R. 3730)

- Modernizes the Rural Health Clinic (RHC) program and provides important regulatory relief for RHCs by amending outdated staffing, laboratory requirements, definitional requirements related to census definition, and primary care thresholds to increase access to behavioral health services.

Pass the CONNECT for Health Act (S. 2016/HR 4189)

- Expand coverage of telehealth services through Medicare and make permanent COVID-19 telehealth flexibilities for Rural Health Clinics and community health centers.

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.

Require
Medicare Advantage plans to adequately reimburse RHCs for services including for flu and pneumococcal vaccines at the RHC's cost per vaccine, as calculated on the most recent Medicare cost report.

Eligibility
for the 340B Drug Pricing Program.

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.

Continue
to provide sufficient funding for timely initial and follow-up certification surveys to assure access.

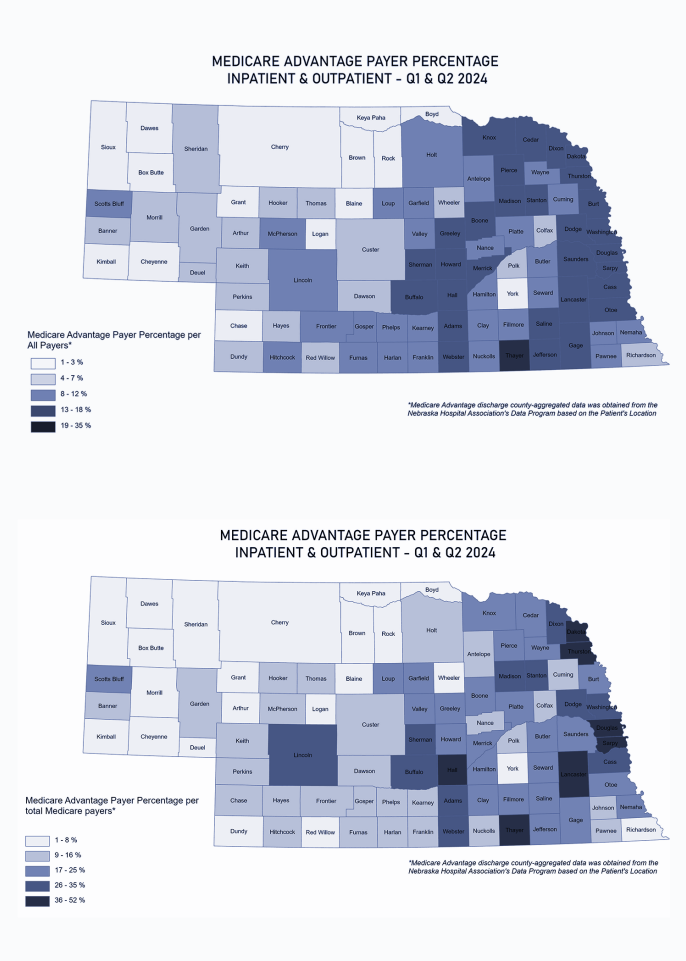
Create
an option for low-volume facilities (perhaps those meeting frontier and/or volume threshold) to automatically be eligible to receive a provider-based designation exception to address low-volume issues.

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.

Reform Medicare Advantage

Increased Medicare Advantage (MA) enrollment threatens the financial model supporting many rural hospitals. Critical Access Hospitals (CAHs) are entitled to cost-based reimbursements from most public health payers. However, MA undermines this designation by providing inadequate payments even while increasing costs related to claims collection and prior authorizations. In Nebraska, 68 percent of hospitals are designated as CAHs. When surveyed, every one of these hospitals reported that increased MA enrollment will harm their financial stability.

Rural hospitals are the backbone of Nebraska's communities, providing essential care and driving local economies. They offer good-paying jobs, purchase goods and services locally, and serve as critical lifelines for Nebraskans. Our health care teams should not have to choose between financial survival and delivering necessary care.



Cost-based reimbursement is essential to rural hospital viability as CAHs care for a costlier patient population on average, often including older patients with multiple comorbidities. As the frequent principal source of health care services in rural communities, CAHs often have high fixed costs spread over a lower volume of services. MA plans, unlike traditional Medicare, do not have a process for ensuring CAH payments reflect the actual cost of services provided to Medicare patients. With a doubling of nationwide MA enrollment in the past decade and no accompanying change in CMS' cost reporting or CAH reimbursement process, the shortfall in Medicare payments to CAHs has been significant.

The support provided by Medicare through various supplemental payment programs, such as Medicare Dependent or Low-Volume hospitals, is based on the cost of services each hospital provides to Medicare patients. However, CMS does not include MA patients in these calculations. As the MA program has expanded, it has resulted in reduced Medicare payments to CAHs and undermined rural supplemental payment programs, affecting the financial health of rural hospitals. Rather than ensuring services to MA patients are paid at cost, MA payments to CAHs will vary based on contractual arrangements, with a default arrangement to pay the CAH as an out-of-network provider. The law provides no standards for MA plans to pay any certain amount or use any particular method for paying in-network CAHs. Non-contracted CAHs report significant delays in receiving MA payments.

NEBRASKA CRITICAL ACCESS HOSPITALS REPORT THAT IF THEIR PATIENT SERVICE AREA CONTINUES TO EXPERIENCE MEDICARE ADVANTAGE ENROLLMENT, IT MAY BECOME NECESSARY TO...

In addition, MA plan practices routinely deny access to care through restrictive admission criteria, prior authorization denials, limitations on covered services, and denied claims. These practices can delay patients from receiving essential medical care, adversely affecting rural patients' health, and creating additional administrative burdens for resource-limited rural providers. In traditional Medicare, care decisions are made between the doctor and the patient. Under MA, these care decisions must be mediated by the MA plans themselves.

CMS recently took initial steps to address some concerns with improper prior authorization denials by MA plans. In a final rule published in April 2023, CMS clarified that MA plans must comply with the general coverage and benefit decisions under traditional Medicare and cannot reverse decisions during a beneficiary's course of treatment. However, this rule does not resolve all concerns related to prior authorization denials.

Another issue faced by under-resourced rural providers is the increased administrative burden associated with MA. These providers often have limited resources and personnel to handle the administrative requirements imposed by private insurance plans. The additional paperwork, documentation, and reporting can be overwhelming, potentially diverting resources and attention away from patient care.

OF NEBRASKA HOSPITALS REPORTED PRIOR AUTHORIZATION REQUIREMENTS BY MEDICARE ADVANTAGE NEGATIVELY IMPACT PATIENTS BY DELAYING NECESSARY CARE

OF NEBRASKA'S CRITICAL ACCESS HOSPITALS SAY AN INCREASE IN MEDICARE ADVANTAGE PLANS WILL CHALLENGE THEIR FUTURE FINANCIAL POSITION

Finally, a lack of competition among MA plans in many rural communities diminishes provider leverage in negotiating Medicare-equivalent rates. With only one or two MA plans available in most counties, providers have limited options to choose from, making it difficult to negotiate favorable reimbursement rates. This lack of competition can further weaken the financial position of rural providers and hinder their ability to sustain their operations.

Addressing these issues is crucial. The NHA and NeRHA recommend:

- Streamlining prior authorization requirements under Medicare Advantage plans. This includes increasing transparency on services that require prior authorization, standardizing the format and process to transmit requests and responses, improving the timeliness of responses, requiring more detailed and complete denial notices, and streamlining appeals processes.
- CMS should include MA plan data in the Medicare Cost Report, which would ensure that Critical Access Hospitals can be adequately reimbursed for services provided to MA patients. This would help preserve health care services in rural communities.
- Require cost-based reimbursements or gap payments similar to those provided to FQHCs from Medicare Advantage plans.
- Congress should pass legislation increasing oversight of the MA program, including greater data collection and reporting on plan performance, and more streamlined pathways to report suspected violations of federal rules.

Stop Harmful Prior Authorization Practices

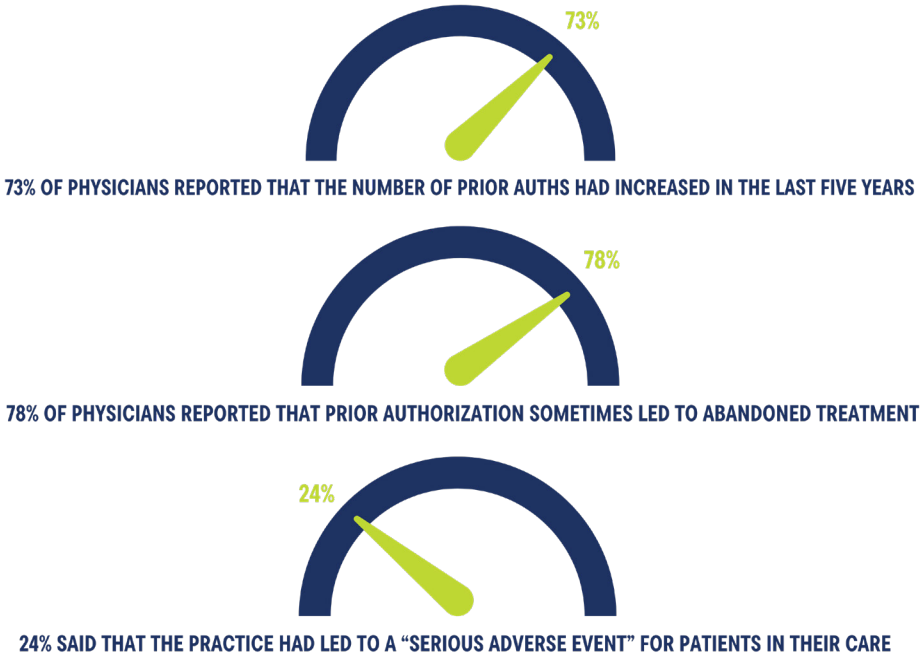
Prior authorization, also known as preauthorization or precertification, is a process that requires health care providers to get approval from a health plan before a patient receives a service. It is intended to reduce health care costs by ensuring all treatments are medically necessary and covered by each patient's insurance.

Prior authorization poses significant challenges for rural hospitals and clinics, as well as rural patients. The administrative burden of completing complex forms and navigating bureaucratic processes diverts valuable resources and time away from patient care. Delays caused by prior authorization can hinder timely treatment, especially in urgent situations, leading to worse patient outcomes. Additionally, denials of coverage due to prior authorization can strain the financial stability of rural health care providers who already operate on thin margins. These factors contribute to the closure of rural health care facilities, leaving communities without access to essential medical services.

The use of prior authorization and Artificial Intelligence (AI) by insurance companies can also harm patient care. AI algorithms can be used to make decisions based on limited data but are often programmed to maximize insurance company profits. This practice of valuing profits over patients can be particularly problematic in complex cases where a physician's clinical judgment is crucial.

A 2023 survey from the American Medical Association found that 73 percent of physicians reported that the number of prior authorizations for medical services had increased either somewhat or significantly in the last five years. The survey also found that 78 percent of physicians reported that prior authorization sometimes led to abandoned treatment, and 24 percent said that the practice had led to a "serious adverse event" for patients in their care, including hospitalization, permanent impairment, or death.

A survey of physicians from the American Medical Association found that...



Reforms are needed to mitigate these issues. The NHA and NeRHA support standardized and transparent prior authorization requirements and processes, and legislation to ensure necessary oversight to stop inappropriate prior authorization and payment delays and denials.

Protect the 340B Community Benefits Program

The 340B Community Benefits Program (340B) is a lifeline that allows rural safety net providers to stretch scarce federal resources and provide vital services to their communities. This program is under attack by pharmaceutical manufacturers and pharmaceutical benefit managers (PBMs), with recent restrictions hurting already struggling hospitals and clinics.

The federal 340B Program is a drug price control program that allows qualifying providers, generally hospitals and other facilities which serve 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 reinvest those savings in their communities. The 340B funds allow providers to reduce the financial burden of medications or other medical care for uninsured, under-insured, and low-income patients and reinvest those dollars into community programs like starting new services for the elderly population, sustaining rural nursing homes, and operating mobile clinics, daycares, nursing homes, wellness centers, and more.

67 Nebraska hospitals currently utilize the 340B Community Benefits Program and most of these are rural critical access hospitals.

The NHA and NeRHA support the following actions as well as significant state legislation to strengthen and support the 340B Program.

Protect
the 340B Community Benefits Program to ensure vulnerable communities have access to more affordable drug therapies. Reverse harmful policies and hold 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 pharmacist.

Expand
the 340B Community Benefits Program to include inpatient drugs for Critical Access Hospitals (CAH) and other safety net providers.

Eliminate
the group purchasing organization (GPO) prohibition.

Ensure robust access
to the 340B Community Benefits Program by maintaining a patient definition consistent with the way medicine is practiced in rural communities. CAHs should be made eligible for the full 340B Community Benefits Program, without the exclusion of orphan drugs.

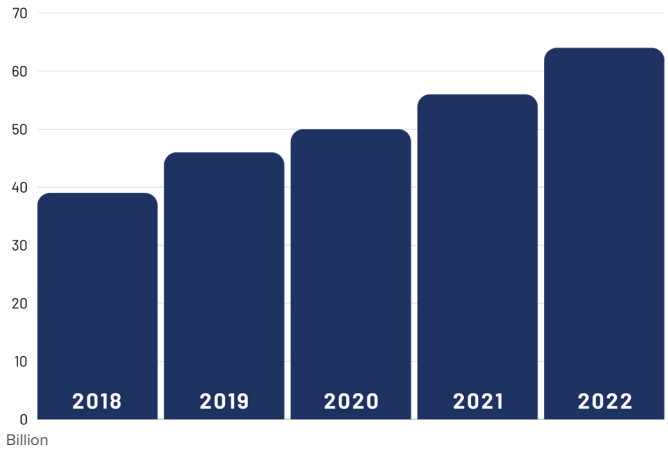
Allow
REHs to participate in the 340B Community Benefits Program.

Ensure
that a rebate model is not allowed by drug manufacturers.

Rein in Pharmacy Benefit Managers

Pharmacy Benefit Managers (PBMs) have existed since the 1960s, when they were created to help insurance companies manage prescription drug costs. Often called the "middleman" of the US pharmaceutical industry, PBMs today are third party administrators that exist between community pharmacies and insurance companies, as well as between insurance companies and drug manufacturers. PBMs negotiate the terms for prescription drug access for hundreds of millions of Americans and wield enormous power over patients' ability to access and afford their prescription drugs. In short, PBMs significantly influence what drugs are available and at what price.

PBM EARNINGS ARE SKYROCKETING



A 2024 study by the Federal Trade Commission found that pharmacies affiliated with the largest three PBMs are often paid 20 to 40 times NADAC, and significantly more than unaffiliated pharmacies.

PBMs make enormous profit on the back of rural hospitals while squeezing patients and independent pharmacies. Just a few PBMs control almost the entire prescription drug market. Through years of consolidation, the largest PBMs either own or are owned by the nation's largest health insurers. The three largest PBMs are Fortune 50 companies and control 76 percent of the market.

Integration with mail-order pharmacies and insurance companies allows PBMs to own or have considerable influence over distinct parts of the pharmaceutical supply, enabling them to steer patients towards their own affiliated pharmacies. PBMs can prioritize directing prescriptions to their own pharmacies within their network even if it means a patient must travel further or pay more, leaving independent pharmacies with fewer customers.

PBMs can offer unaffiliated independent pharmacies and rural hospitals less favorable reimbursement rates and contracts, ultimately squeezing them out of the market and limiting patient choice. This practice harms smaller health care providers in rural areas with limited choices and can impact independent pharmacies' ability to stay in business and serve their communities. PBMs put profits before patients at every turn.

PBMs can require that high-cost drugs be shipped from their specialty pharmacies to practices, where clinicians then administer the drugs to patients. This practice is called "white bagging." Patients do not get to choose if their medications are "white bagged."

White bagging causes significant delays in patients getting their medications and even results 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. For patients, interruptions and delays can lead to missed workdays, long drives to have the medication administered, all while possibly having to turn around and go back home with nothing to show for it. White bagging also causes serious, potentially dangerous disruptions to patient care and removes patient choice at the time they deserve it most.

PBMs operate with little transparency and accountability. They profit from a business model rife with conflict and engage in tactics that can drive up costs. The NHA and NeRHA encourage action to provide much needed regulation of PBMs.

Strengthen the Rural Emergency Hospital Model (REH)

In 2024, Warren Memorial Hospital in Friend, Nebraska became the first Rural Emergency Hospital in the state. The REH designation is one solution to prevent hospital closures and retain access to emergency services. The REH designation, established by the Consolidated Appropriations Act of 2021, allows rural hospitals to maintain outpatient and emergency department payments from Medicare without a requirement for inpatient acute care services.

REH Service Requirements:

- 24-Hour emergency & observation services
- Laboratory services
- Diagnostic radiologic services
- Discharge planning Pharmacy
- Additional outpatient & telehealth services

Facilities Eligible for REH Status:

- Critical Access Hospitals and rural PPS hospitals with fewer than 50 beds that were in operation on December 27, 2020
- Facilities that closed after December 27, 2020, are eligible to re-open as an REH if they meet REH Conditions of Participation

Once at risk of imminent closure, Warren Memorial Hospital has experienced growth since the transition. Now the focus is on outpatient care and emergency services. In return, they receive a 5% boost to Medicare outpatient reimbursement and more than $3.2 million a year to sustain operations from the federal government, allowing them to grow in ways that weren't possible before. The hospital has added two more providers and has plans for a $3 million renovation to their operating room to offer more outpatient surgeries.

CMS currently recognizes REH as outpatient clinics due to language discordance between the REH Act and CMS Medicaid language. NHA and NeRHA support revisions to REH language to allow REH recognition as a hospital provider per CMS Medicaid language.

Estimates show that other Critical Access Hospitals in Nebraska could benefit from transitioning to an REH designation with changes to the model instead of closing their doors due to financial constraint. The NHA and NeRHA support federal legislation to allow more Critical Access Hospitals in Nebraska to consider the redesignation.

The Rural Emergency Hospital Improvement Act (S. 4322)

- Authorizes REHs to provide swing bed services
- Allows DPUs for inpatient psychiatric and inpatient rehabilitation and allows obstetric labor and delivery units
- Creates waiver program to allow facilities operating similarly to an REH to convert
- 5% add-on payment for laboratory services under Clinical Laboratory Fee Schedule
- Makes REHs eligible for SHIP grants and to serve as National Health Service Corps sites

Rural 340B Access Act (S. 8144 /H.R. 8144)

- Allows inclusion of REHs as eligible for 340B, making it a more viable option for providers and helping to keep rural ERs operational.

Growing Our Rural Health Care Workforce

Nebraska's Health Care Workforce Shortage

Nebraska is in the midst of a health care workforce crisis.

According to the Nebraska Center for Nursing, Nebraska will experience a workforce shortage of over 5,000 nurses in 2025. Already, 73 of Nebraska's counties are operating with registered nurse-to-patient ratios below the national average, including 66 which have been deemed medically underserved. Nine counties in Nebraska have no registered nurses at all. This crisis is not just impacting nursing. This nursing shortage is representative of a larger shortage of health professionals.

Fourteen of the state's 93 counties do not have a primary care physician. Eighty-five of Nebraska's rural communities are considered medically underserved areas for primary care services alone.

A sufficient, healthy workforce is foundational to maintaining access to high quality care. Recruitment and retention of health professionals has long been a challenge for rural providers. Through innovative approaches and collaboration, this crisis can be addressed, and future ones averted.

Bolster the Future Workforce

For strong rural health care, Nebraska should continue to provide funding for Career and Technical Education (CTE) programs and Career Technical Student Organizations (CTSOs) 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. CTE funding is crucial for the Nebraska workforce because it provides necessary training and skills development for secondary and post-secondary students, equipping graduates with real-world technical knowledge and career readiness skills enabling them to readily enter high-demand, high-skill jobs to address the state's workforce needs.

Nebraska receives federal CTE funds from the Perkins V grant every year. This federal money, which is estimated to be around $1.5 billion for fiscal year 2025, is split among all 50 states based on population size. These dollars are then split between state programs, post-secondary educational institutes like community colleges and high schools. When all is said and done, high schools outside of the Omaha and Lincoln metro areas receive only about $1.8 million.

Prior to 2023, Nebraska was the only state that did not provide designated funding for CTE. LB610 addressed this shortcoming by appropriating $5.216 million in cash funds to the Nebraska Department of Education for both FY23-24 and FY24-25 for Career & Technical Education (CTE) programs. The funds will be distributed between secondary & post-secondary schools according to the formula used for federal Perkins funds with each district receiving at least $7,500.

Career and Technical Student Organizations (CTSOs)

Nebraska's seven CTSOs help students develop skills and experiences that prepare them for college and careers. CTSOs are not clubs, but are connected to middle school, high school, and post-secondary instructional programs and connect classroom learning to real-world experiences. The seven Nebraska CTSOs are **FFA** (agriculture), **HOSA** (health care), **Educators Rising** (education), **FBLA** (business), **DECA** (marketing), **FCCLA** (nonprofit & technical), and **SkillsUSA** (technical skills and service). CTSOs have thousands of Nebraska students as members, but each CTSO relies on student activity fees, volunteers, and sponsors for support.

In addition to supporting CTE, LB610 also included $200,000 for both FY23-24 & FY24-25 to be evenly distributed between the various CTSOs. Continued state funding will allow CTSOs to reach more students in more schools and prepare them for entering the workforce.

Continue LB227 Workforce Programs

The Nebraska Center for Nursing (NCN) was created by the Nebraska Legislature in 2000 to address the nursing shortage in the state. The NCN partnered with the Nebraska Hospital Association (NHA) via funding from LB227 (2023), which has supported the work of the NCN as carried out by partners at the NHA.

The projects created through this partnership were designed to make both an immediate and long-standing impact on the health care workforce issues facing Nebraska. The projects are divided into 6 categories: simulation, shared clinical model, clinical practice instructor education, nursing student travel and housing, statewide onboarding, and student nurse internship.

Simulation

The simulation expansion program involved conducting a needs assessment of Nebraska colleges and universities to determine the need for simulation manikins to enable additional or expanded nursing student clinical experiences. Nebraska approved nursing schools and hospital-based programs will receive simulation manikins, software updates, and professional development in simulation training for nursing faculty. Schools who receive equipment must provide the opportunity for hospital use at no cost.

Program Objectives:

- Create opportunities for simulation when clinical specialty spots are limited.
- Increase the overall number of clinical learning spots through the use of simulation.
- Enhance nursing curriculum with simulation manikins.
- Provide nursing faculty with professional development in simulation.

Shared Clinical Model

The creation of the shared clinical model is the result of approval of an NCN Licensure Innovation Proposal. This model is designed to expand clinical sites and clinical staff instructors, increasing the number of nursing students in the pipeline. The support coordination monitoring (SCM) allows our expert ADNs and BSNs to serve as clinical practice instructors and provide direct instruction and guidance to student nurses in the clinical field setting.

Using staff nurses as Clinical Site Instructors will provide an untapped pipeline of clinical instructors. Hospitals, Critical Access Hospitals (CAHs), Long-Term Care (LTC) facilities, and Rural Health Clinics (RHC) serve as clinical sites.

Program Objectives:

- Create Practice Academic Partnerships intended to establish and improve relationships between academic institutions and hospitals.
- Increase the overall number of clinical learning spots in rural Nebraska.
- Increase the overall number of nursing students clinically served in rural Nebraska.
- Increase in rural health employment, attributed specifically to this program.
- Provide educational curriculum for nursing faculty and identify three target educational courses for the clinical practice and clinical education nurses while enhancing student learning.

Clinical Practice Instructor Education

As part of the shared clinical model, the clinical practice instructor (CPI) may hold an ADN or BSN degree. One responsibility of the CPI is to commit to taking three previously identified nursing education courses at the master's level over a two- year period from an approved Nebraska nursing program. CPIs will have the three courses paid for at a maximum of $1000 per course and a $650 allowance for books per course.

Program Objectives:

- Provide educational curriculum for nursing faculty and identify three target educational courses for the clinical practice and clinical education nurses while enhancing student learning.
- Partner with Nebraska four-year academic institutions who offer the focus educational curriculum.

Nursing Student Travel and Housing

Nursing students will have the opportunity to receive reimbursement for travel and housing when participating in the expansion of clinical sites through the NHA and NCN Collaborative Innovative Approach. This approach will increase the number of clinical learning spots through the use of new affiliated agreements and partnerships between schools of nursing and NHA rural hospitals.

Program Objectives:

- Create opportunities for new clinical sites by paying for travel and as needed temporary housing to enable those clinical experiences.
- Increase the overall number of clinical learning spots through the use of the Shared Clinical Model.
- Enhance student nurse clinical opportunities in rural areas.

Clinical Training Sites

Currently, Nebraska nursing students must repeat compliance training at each clinical site location they attend. Included in this training is basic nationally required training such as HIPAA, Patient Privacy, Fire and Life Safety training, etc. Completing separate training modules at each clinical site can inhibit academic settings utilizing additional clinical sites, as it results in nursing programing using 8 hours of clinical opportunities for redundant paperwork.

Program Objectives:

- Identify a vendor to buildout platform.
- Create competency modules meeting training requirements for all Nebraska hospital-based clinical sites.
- Onboard all nursing students to platform around one centralized set of competencies.
- Create an environment of compliance and consistent onboarding.

Student Nurse Internship

The proposal involves building upon the partnerships established in the Shared Clinical Model while expanding opportunities for students to further their interest and skills in a particular patient care setting.

NHA member organizations must show commitment to students by expanding internship opportunities within their organizations. This includes partnering with the NHA and NCN Collaborative on innovative approaches to increase nursing student opportunities and collaborating to support students in meeting internship requirements. The NHA will also provide guidance to enhance students' experiences throughout their internships.

Program Objectives:

- Create relevant internship opportunities for nursing students intended to enhance the nursing students clinical experience leading to increased new graduate clinical skills, comfort, and retention.
- Provide rural hospitals with an opportunity to host nursing students and develop relationships with that student that lead to local job placement upon graduation from a nursing program.
- Provide a paid internship that provides the nursing student with clinically relevant income intended on reducing the number of students who leave nursing school related to the inability to pay for courses or living expenses.
- Increase the overall number of nursing students working in NHA member organizations during nursing school.
- Enhance student nurse internship opportunities in rural areas.

Improving Access to Post-Acute Hospital Care in Rural Nebraska

Challenges to Long-Term Care

Long-term care involves a variety of services designed to meet a person's health or personal care needs when they can no longer perform everyday activities on their own. Long-term care (LTC) services can include personal care, meals, transportation, social activities, and exercise. Support needs can range from limited assistance to complex nursing interventions. Assistance may be offered in a variety of settings including care in the home, small group settings with community support, and nursing home and assisted living facilities.

There is a growing nursing home and assisted care crisis, especially in rural areas of Nebraska. In just the past three years, 29 facilities have closed their doors, leaving 20 counties without a single care facility. These closures persist even in the face of rising demand. Seventy percent of people who reach age 65 will eventually develop severe needs, and 48 percent will receive paid care. Inadequate funding, workforce issues, and high costs have all contributed to these closures.

LTC closures negatively affect the ability of hospitals to appropriately discharge patients once their acute care needs have been met. Lacking an appropriate destination, these patients sometimes linger unnecessarily in hospital beds, oftentimes with the hospital receiving little or no compensation. This increases health care costs while delaying patients from receiving care in an appropriate setting.

Establishing More Age-Friendly Health Systems

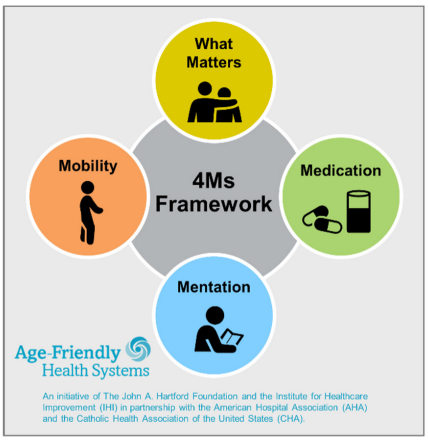
Every patient deserves quality care that is appropriate to their individual needs, regardless of age. Age-Friendly Health Systems is an initiative designed to improve the care of older adults. It was developed by the John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI), in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

Age-Friendly Health Systems aim to:

- Follow an essential set of evidence-based practices,
- Cause no harm; and
- Align with What Matters to the older adult and their family caregivers.

Age-Friendly Health Systems implement evidence-based, best practices, to increase the quality of care for elderly patients. Age-Friendly Health Systems does this by focusing on the 4M's:

- What Matters
- Medication
- Mentation
- Mobility



What Matters
Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication
If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility
Ensure that older adults move safely every day in order to maintain function and do What Matters.

According to the US Census Bureau, the US population aged 65+ years is expected to more than double over the next 40 years, from 49 million in 2012 to an estimated 94 million in 2060. Focusing on the 4M's not only increases the quality of care to these patients but delivers it with the patient's goals and concerns at the forefront.

Outcomes from Age-Friendly:

There is very extensive research that shows the positive outcome related to Age-Friendly both nationally as well as in Nebraska. In 2023, when comparing Age-Friendly Certified Hospitals to Non-Age-Friendly Certified Hospitals, there were noticeable differences in outcomes:

- Age-Friendly Facilities had a 20% lower readmission rate than the state average. This equates to an approximate savings of $1.8 Million and over 180 extra hospital days prevented.
- Age-Friendly Facilities had an over 25% lower Adverse Drug Event rate than the state average. In addition to saving patients' lives, this will save hospitals about $750,000 for every one-hundred extra days in hospital.

Personal care services (PCS) are services that help eligible beneficiaries stay in their homes and communities instead of living in institutional settings, such as nursing homes. Personal care services include home-based services such as assistance with personal hygiene, mobility, feeding and activities of daily living. The NHA and NeRHA support legislation for the expansion of family members as Personal Service Providers.

Senior Life Solutions is a CMS-approved outpatient program specifically designed to help older adults (typically 65 and older) in rural communities who are experiencing symptoms of anxiety, depression, and other mental health disorders. They partner with critical access hospitals to develop a sustainable program that improves the lives of patients while contributing a stable revenue source. The NHA and NeRHA support programs such as Senior Life Solutions as a global program for both Medicare and Medicare Advantage plans.

Improving Rural Well-Being

Addressing Social Determinants of Health

Rural areas are more likely to be affected by social determinants of health and inequities that prevent proper health care access and impact health outcomes, such as:

Higher Rates of Unemployment and Poverty
Rural median incomes average 20 percent below urban areas, and 16 percent of children in rural Nebraska live in poverty.

Access to Safe and Affordable Housing
6 percent of homes in rural areas are considered of inadequate quality.

Access to Healthy Food
15 percent of rural households are food insecure.

Access to Child Care and Early Childhood Development
36 percent of rural Nebraskans live in a childcare desert.

Access to Safe and Affordable Transportation
Rural residents have greater transportation difficulties reaching health care providers, often traveling twice the distance compared to urban residents for care.

Improving Rural Mental Health

Mental health encompasses social, emotional, and psychological well-being. Its effects can impact nearly all aspects of daily living, including physical health, as well as increase the risk of developing conditions such as diabetes, heart disease, and other illnesses.

While rates of mental illness are similar in rural areas compared to urban areas, there is a higher risk of suicide in rural communities, with nearly twice as many suicides in the most rural counties compared to urban.

Rural areas experience a severe lack of access to and availability of the full range of behavioral health care services, challenges with mental health care workforce recruitment and retention, and technology barriers impacting telehealth visits. These challenges contribute to a more vulnerable and resource poor rural population compared to urban peers.

Nebraska has 5 designated geographic mental health shortage areas, covering 88 counties. About 295.7K residents are underserved, or 14.9 percent of the state's population.

Lack of high-speed internet can be a hindrance to using telehealth to access mental health care. 53 percent of rural Americans lack access to 25 Mbps/3 Mbps of bandwidth, the benchmark for internet speed. According to the Nebraska Broadband Office, 12–15 percent of Nebraska locations are unserved or underserved by broadband, which means that approximately 105,000 households lack acceptable internet access. The majority of these unserved and underserved locations are in rural areas.

The NHA and NeRHA support the following actions to support our rural community's 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.

Caring for Rural Mothers

In Nebraska, 46 percent of rural hospitals are without OB services. Approximately 16 percent of Nebraska mothers must travel at least 30 minutes to a care provider. Nationally, fewer than 10 percent of mothers live that far from care.

Most women living in rural areas give birth at their local hospitals and therefore rely on local maternity services. 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:

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

Support Emergency Medical Services

Emergency Medical Services (EMS) plays a critical role in rural areas. Nebraska is one of three states with the highest rates of rural residents living more than a 25 minute drive from where an ambulance is stationed.

It is increasingly difficult for ambulance services to respond to emergencies in rural America due to workforce shortages and growing financial crises. 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 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 can't make up the difference in reimbursement.

NHA and NeRHA recognize the critical role that Emergency Medical Services (EMS) play in rural areas and recommend the federal government help support rural EMS funding through sustainable reimbursement mechanisms.

Remove the CMS 35-mile radius rule for cost-based reimbursements. CMS currently requires the provider-based location to be located within 35 miles of the main provider for cost-based reimbursement. Rural EMS services should be reimbursed based on their actual costs incurred for each patient transport, receiving payment directly tied to the expenses they face in providing care, rather than a set fee per service.

The **Community Paramedicine Act** would formally authorize a federal grant program dedicated to providing rural and urban communities the funding necessary to offer centralized, mobile, and preventative care through local paramedics, an initiative in health care known as Community Paramedicine.

Protection of Air Ambulance Services for Americans authorizes payment changes under Medicare for air ambulance services to allow for temporary increases in the Medicare rate to assist those air ambulance programs serving underserved communities, rural communities, or those that lack adequate emergency healthcare resources.

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