

October 5, 2023

Chairman Jason Smith
House Ways and Means Committee
1139 Longworth House Office Building
Washington, DC 20515

Dear Chairman Smith and Members of the Committee,

The National Rural Health Association (NRHA) thanks the Chairman and members of the Committee for putting forth this request for information on rural health care. We appreciate the chance to provide information and policy solutions on important issues facing rural health care and look forward to working together to increase access to quality care for rural residents.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. NRHA works to improve rural America's health needs through government advocacy, communications, education, and research.

Rural health care needs support more than ever. Using hospitals as a proxy for the wellbeing of rural health care generally, [156 rural hospitals](#) have closed since 2010. [Over 450](#) more rural hospitals are considered vulnerable to closure with 45% operating in the red. The average operating margin among rural hospitals is [1.8%](#). Congress must invest in rural health to ensure providers remain open and accessible to rural residents. [Approximately 80%](#) of rural America is medically underserved and seeing historic workforce shortages. As of June 2023, rural areas make up [65%](#) of primary care health professional shortage areas (HPSAs) and 67% and 60% of all dental and mental health HPSAs respectively. As the Committee states, rural residents face unique barriers to accessing health care and tend to be older, sicker, and poorer than their urban counterparts. The policy solutions in our response would have a significant impact on access, affordability, and provider stability.

Geographic Payment Differences.

Low wage index policy.

Rural hospitals have significantly lower wage indices than urban hospitals. When controlling for number of beds, net patient revenue, Medicare payment classification, average daily census, and percent Medicare patients, the average rural wage index is [0.1261](#) points less than urban hospitals. Small rural hospitals have the lowest hospital wage indices in the nation, and the highest wage indices are found among urban hospitals. The median wage index is [lowest](#) for rural hospitals with 25 or fewer beds, less than \$25 million in net patient revenue, and in [more remote areas](#), and highest for urban hospitals in every Census region.

The low wage index policy has [closed disparities](#) between high-wage, predominantly urban, and lower-wage, predominately rural hospitals. Congress should codify CMS' low wage index policy, which increases payments for hospitals falling below the 25th percentile of the IPPS wage index. This policy is temporarily extended through FY 2024 pending an appellate court decision wherein CMS' authority to promulgate this policy is being examined. Congress should take steps to protect the low wage index policy by affirmatively granting CMS authority to implement the policy through FY 2030. [Extending the policy](#) will help CMS and Congress evaluate its effectiveness without being skewed by COVID-19 wage data. Relatedly, [H.R. 3635/S. 803](#), the Save Rural Hospitals Act, would equalize Medicare payments by establishing a national minimum wage index floor to ensure that rural hospitals receive fair payment for the care that they provide.

Lugar status.

Lugar Status enables rural hospitals to redesignate to receive wage index adjustments that better reflect the labor costs in the area. For wage index purposes, hospitals in Lugar counties are considered urban because of commuting patterns from rural areas into neighboring urban counties. However, CMS has incorrectly tied together Lugar status, direct GME (DGME), and indirect medical education (IME) programs, subsequently harming rural medical education. IME payments are based on the ratio of resident physicians to the number of beds in a hospital, with a limit on how many residents are reimbursed. Traditionally, rural hospitals are granted an exemption from limitations and may start new residency training programs. CMS has put forth an interpretation of the Lugar statute that considers all Lugar hospital as urban for all purposes, including IME. NRHA strongly believes that CMS' interpretation is incorrect. NRHA voiced this concern in more detail in our FY 2024 [Inpatient Prospective Payment System comment](#). Congress must adopt clarifying language in the statute to resolve this issue.

Sustainable Provider and Facility Financing.

Public payer mix.

One factor that contributes to lower payment for rural providers is a predominantly public payer mix with less employer-sponsored coverage. Because rural areas skew older, Medicare is a dominant payer. Additionally, Medicaid and CHIP [cover](#) about one in five adults and almost half of children. Providers also see higher rates of uninsured and self-pay patients, contributing to more uncompensated care. When Medicare and Medicaid rates are not sufficient to cover the cost of care, this has an outsized impact on rural providers across the country. The [lower volume](#) of services that rural facilities provide puts further strain on facilities due to: 1) the need to spread fixed costs associated with providing care over fewer patients; and 2) considerably more instability from year to year in demand for inpatient services than larger hospitals.

Rural hospitals.

As the Committee notes, there is a patchwork of Medicare payment designations aimed at supporting rural hospitals. Each designation is designed to alleviate a particular challenge for a subset of rural hospitals. For example, the CAH designation was meant to curb rural hospital closures by reimbursing at 101% of reasonable costs, while low-volume hospitals (LVH) receive a payment adjustment to account for extremely low patient volumes. While it is necessary to truly fix rural health care financing challenges, overhauling the current framework of different payment designations is likely not a feasible path forward. NRHA suggests that Congress direct the Government Accountability Office (GAO) to assess the effectiveness of current rural hospital and provider designations. The outcome of this study should then be used to inform changes to rural hospital payment mechanisms. Congress should also give HHS the authority to act upon the evidence-based findings in the assessment to fix rural provider payment.

In a year set to surpass the highest number of rural hospital closures, incremental changes can help keep providers open in the meantime. [H.R. 833](#), Save America's Rural Hospitals Act, includes several critical fixes for rural hospitals that would improve financial stability and ease administrative burdens, including: exempting rural hospitals from Medicare sequestration; reinstating hold harmless provisions for Sole-Community Hospitals (SCH); and reversing cuts to bad debt for critical access hospitals (CAHs). For CAHs in particular, their reimbursement at 101% of reasonable costs is actually at 99% given sequestration, meaning they are currently providing services to Medicare beneficiaries at a loss.

NRHA also suggests reopening necessary provider status for CAHs, which ended in 2006. The Rural Hospital Closure Relief Act, [S. 1571](#), should be introduced in the House to waive the 35-mile rule and bring back necessary provider status with certain parameters. Additionally, both Medicare Dependent Hospital (MDH) and LVH designations and payment adjustments should be made permanent rather than continually face the uncertainty of their designation. The House should support [H.R. 833](#) and pursue a companion bill to [S. 1110](#), the Rural Hospital Support Act to do so. S. 1110 would also update the base years for SCHs and MDHs to FY

2016, a change that has not been made since the early 2000s. Last, another change to support the long-term health of facilities would be to reimburse SCHs and MDHs paid under the hospital specific rate for uncompensated care with hospital specific payment adjustments. SCHs and MDHs paid the IPPS rate receive this adjustment and those paid under their hospital-specific rate should receive the same financial protection.

Medicare cost report methods date back to 1965 and have remained largely unchanged since. Cost report allocation is the foundation of all strategic initiatives in a rural hospital. Estimates suggest that with exclusions Medicare covers 92% of hospital cost, not 101% (plus an additional -2% cut with sequestration). Often subsidiary services are non or low margin yet are critical for population health initiatives such as home health agencies, nursing homes, Meals on Wheels programs, early childhood intervention, supportive home care, assisted living, childcare, senior housing, and geriatric psychiatric services. One meaningful change to how CAHs can be reimbursed is to allow all costs associated with contracting with physicians to be included on the cost report. This divergence between the total cost of contracting with a physician and what Medicare allows as a reasonable cost creates challenges in physician staffing. This constrains hospitals' ability to staff in ways that will allow them to advance local patient care while stabilizing their finances. Further, Congress should direct CMS to establish a working group to address key issues such as waiver or modification of CAH cost allocation regulations to allow greater integrated community services and review of cost exclusions that further reduce reimbursement to hospitals for essential services.

Support for rural provider capital and technical assistance (TA) is key. In many cases, Medicare reimbursement is not sufficient to cover the cost care, and rural hospitals accept a loss when providing Medicare services, as discussed above. This leaves little room for rural hospitals to pay for overhead costs and keep up with infrastructure and technology improvements. The House should reintroduce the [Hospital Revitalization Act](#) in the 118th Congress to provide for a grant program that assists hospitals with the costs of upgrading physical infrastructure and expanding facility capacity. Other than physical upgrades, rural hospitals require support to purchase or upgrade EHR technology to meet interoperability standards. [H.R. 4713](#), the Rural Hospital Technical Assistance Program Act, was introduced recently and would authorize a program that has supported almost 20 rural hospitals through TA to date. The program assists in improving their financial position, increasing operational efficiencies, implementing quality improvements, addressing workforce recruitment and retention, and more. Further, [H.R. 833](#) reauthorizes the critical Medicare Rural Hospital Flexibility program, which provides TA to CAHs, Rural Emergency Hospitals (REHs), and rural PPS hospitals.

Rural Emergency Hospital fixes.

NRHA supports the REH model as an option for some hospitals to remain open and keep health care in the community. We acknowledge that converting to REH may not be the solution for all struggling hospitals, but the program could use several legislative changes to make it more accessible for hospitals that otherwise cannot make the transition currently. Namely, NRHA urges Congress to add REHs as covered entities in the 340B statute. Some hospitals that are exploring conversion have put it off because they would lose their 340B savings. NRHA members have also expressed concerns over losing swing bed capacity and inpatient psychiatric distinct part units. Some hospitals that would benefit from converting are barred due to statutory date and other eligibility restrictions: hospitals that closed prior to December 27, 2020; providers that essentially furnish REH services (Frontier Extended Stay Clinics and hospitals that converted to outpatient provider-based entities); rural hospitals that reduced their bed count below 50 after December 27, 2020; and hospitals designated as rural by their state that did not have active reclassification with CMS under 42 C.F.R. § 412.103. The payment methodology could be improved by extending the 5% add-on payment for all OPPTS services to non-OPPTS services paid under other fee schedules as well. In addition, a one-time upfront payment to support infrastructure improvements would be valuable for aging hospitals considering conversion.

Price transparency.

NRHA is concerned by [recent legislative efforts](#) to increase and expand hospital price transparency. Complying with the price transparency requirements is costly and burdensome for rural facilities. Rural hospitals that cannot afford to comply may be subject to expensive and automatic civil monetary penalties. NRHA supports amending the hospital price transparency statute to exempt rural hospitals. In the meantime, we also support CMS offering one on one technical assistance to rural hospitals and granting a grace period for review and compliance with requirements.

Rural Health Clinics.

Rural Health Clinics (RHCs) are a bedrock of the rural health safety net. Over [5,300 RHCs](#) across 45 states provide vital access to primary care services to rural residents. [RHCs serve](#) 37.7 million patients per year which is more than 11% of the entire population and over 60% of the 60.8 million Americans that live in rural areas. The RHC statute has not been updated since Congress passed it in 1977 but health care practice and delivery have changed. [H.R. 3730/S. 198](#), the RHC Burden Reduction Act, includes several important updates to help RHCs operate with less administrative burden and better serve patients. This legislation comes at little or no cost to taxpayers but would have significant impacts on RHCs.

[NRHA urges](#) Congress to address harmful modifications to the provider-based RHC payment methodology that occurred in the CAA, 2021, which caused unintended consequences for provider-based RHCs and jeopardizes access to care. NRHA recommends that Congress implement a quality measure reporting program in exchange for enhanced reimbursement to offset the payment methodology change. On average, RHCs have been less involved in quality measure reporting and value-based care initiatives than other Medicare designations. Through this policy, Congress will receive data on the RHC program that has been historically unavailable. Additionally, this will keep the provider-based RHC program stable for the creation of additional RHCs affiliated with small rural hospitals to meet future needs. House legislation from the 117th Congress, [H.R. 5883](#), the Rural Health Fairness in Competition Act, provides a framework for addressing this issue in the current Congress. For more information, please see our [letter](#) to House and Senate leadership from the 117th Congress.

Medicare Advantage (MA).

Nationally, MA enrollment has [surpassed](#) traditional Medicare enrollment, with the rate of MA growth [higher](#) in nonmetropolitan counties than in metropolitan counties. MA penetration in rural areas varies by community, but overall [40%](#) of rural Medicare beneficiaries are enrolled in an MA plan. This growth in MA plans, which are considered commercial payers, is contributing to higher administrative burden for rural providers and a dismantling of the critical rural provider designations previously discussed.

MA plans are not required to adhere to Medicare provider designations and are treated as commercial payers. For rural cost-based providers, like CAHs, MA reimbursement can be worse than their traditional Medicare rate of 101% of reasonable costs. RHCs face similar reimbursement challenges with an estimated 55 – 60% of RHCs receiving significantly less from MA plans than traditional Medicare. CAHs and RHCs have fewer resources to negotiate payment with plans and have rates that are typically below what traditional Medicare pays. The difference in reimbursement degrades the value of these safety net designations as MA beneficiary shares grow. Federally Qualified Health Centers (FQHCs) are largely protected from inadequate MA payment. FQHCs receive wrap-around payments from Medicare to make up for the discrepancy between MA plans' rates and their traditional Medicare rate. Congress must consider a similar solution for CAHs and RHCs to protect their viability as safety net providers. Another option is to mandate floor payments that MA plans must pay to rural cost-based providers to ensure parity between MA and traditional Medicare reimbursement. Further, MA patient days should be considered as Medicare days on CAH, RHC, MDH, and LVH cost reports and settlements.

The Committee must consider legislation to set minimum standards for MA plans to help limit rural provider burden. Rural providers are currently expending significant time and resources on MA-related issues, taking away valuable time from already limited staff. Small, rural providers do not have the bandwidth or leverage to negotiate properly with MA plans to get adequate reimbursement. Beyond low reimbursement rates, rural providers struggle to get paid. Medicare pays providers within 30 days; however, MA plans do not have to abide by a timeline. NRHA members have noted that they may wait as long as 90 days – or three times as long – to receive payment from MA plans. For rural safety net providers that are operating on thin margins, this lag in payment is unacceptable. Even after receiving prior approval and providing beneficiaries services, NRHA members have noted that MA plans are denying claims. Bigger, more well-resourced facilities likely have dedicated staff to deal with these complexities, but rural providers do not.

Last, NRHA has heard complaints that MA plans steer beneficiaries away from local care. MA plans often limit beneficiary choice by steering them to certain providers, disrupting historic patterns of care. Oftentimes the providers chosen by MA plans are not local and therefore more inconvenient for rural beneficiaries seeking care. Keeping care local is a key goal in rural health care delivery and MA plans should not drive beneficiaries to urban settings to receive care or treatment.

Emergency medical services (EMS).

EMS agencies [operate](#) in a patchwork across the country, with financing and organization varying from state to state and even by locality. It is increasingly difficult for ambulance services to respond to emergencies in rural America due to workforce shortages and growing financial crisis. Rural ambulance response times are more than double that of urban ambulances and [nearly 10%](#) of patients wait over 30 minutes for EMS personnel to arrive. About a third of rural EMS agencies in the U.S. are in immediate operational jeopardy because they cannot cover their costs, largely from insufficient Medicaid and Medicare reimbursements, which pay on average a third of actual EMS costs. Private insurance pays considerably more than Medicaid, but because of low call volumes, EMS agencies are not able to make up the difference in reimbursement. Thus, the federal government must help support EMS funding through sustainable reimbursement mechanisms. As a short-term measure, NRHA supports [H.R. 1666/S. 1672](#) to permanently increase Medicare payments for ground ambulance services in rural areas.

340B Drug Pricing Program.

The 340B Drug Pricing Program is a lifeline that allows rural safety net providers to keep their doors open and furnish critical services by stretching scarce federal resources. Rural hospitals and clinics operate on thin margins and 340B savings help them keep needed services local for patients. NRHA developed a [set of principles](#) that should guide Congress in any 340B reform to ensure rural access to the program is protected. NRHA urges Congress against any limitations on the number and location of contract pharmacies with which rural covered entities work. Many rural covered entities are too small to support an in-house pharmacy and must rely upon outside pharmacies. Given the geographic spread of rural areas, patients of rural covered entities travel farther, and thus multiple contract pharmacies should be available to ensure rural access. Second, CAHs and SCHs require relief from the orphan drug exclusion, which only applies to rural hospitals and thus comes at an unfair cost for rural patients that require lifesaving treatments such as oncology treatment. NRHA supports clear statutory restrictions on pharmaceutical benefit managers (PBMs) and payers' ability to treat 340B covered entities differently as outlined in [HR. 2534](#), the PROTECT 340B Act. These actors have increasingly discriminated against 340B patients, covered entities, and contract pharmacies. NRHA also asks that Congress add the new REH provider type to the 340B statute as a covered entity. NRHA members cite 340B eligibility as the top concern when deciding whether to convert to an REH.

Aligning Sites of Service.

Site neutral payment policies will disadvantage rural providers. While addressing the cost of care for rural residents is critical, it is essential that rural provider viability is not inadvertently impacted. Paying off-

campus rural providers less than the full OPPS rate contributes to destabilizing rural health care delivery. Off-campus provider-based departments (PBDs) may be the only source of care in many rural communities and thus play a critical role in keeping care local and ensuring that rural patients can receive the services that they need. Any decline in payments threatens a rural provider's ability to keep their doors open. Higher costs of PBDs in rural hospitals may be attributed to the need to spread fixed costs across a lower volume of services. Additionally, hospitals often furnish more complex care and must meet more stringent regulatory requirements than physicians' offices. Hospitals are highly regulated and the burdens that are associated with compliance should be accounted for in payment. The site neutral rate does not account for the type of care furnished nor the resources needed at off-campus PBDs.

NRHA urges the Committee to consider exempting all rural hospitals from across-the-board site neutral policies. CMS made strides to exempt sole community hospitals (SCH) from site neutral payments on the basis that access, not the payment differential, led to higher patient volumes at SCH off-campus PBDs. NRHA strongly believes that this is the case for all rural hospitals' off-campus PBDs. In NRHA's [comment](#) on the calendar year 2022 OPPS proposed rule, we asked CMS broaden their exemption to rural hospitals with less than 100 beds, MDHs, and LVHs.

If Congress pursues site neutral policies, NRHA emphasizes the need to exempt rural hospitals and off-campus PBDs. Any savings generated from site neutral payment should be reinvested in the rural health care infrastructure to enact the policy solutions and legislation presented in our response. Savings could also be redirected to help rural providers address their patients' social determinants of health, like transportation or food insecurity. Many safety net providers that offer transportation or other services for patients absorb this cost because it is not reimbursable but is a huge benefit to their patient population. Removing barriers to care and addressing some social risk factors that impact health will reduce costs in the long-term because patients are receiving preventive services.

Health Care Workforce.

Graduate Medical Education (GME).

[Only 2%](#) of residency training occurs in rural areas, despite research showing that training physicians in rural areas increases their likelihood of practicing in a rural community. NRHA shares the Committee's concerns about graduate medical education (GME) slot allocation. For example, the CAA, 2021, set aside 10% of all slots to hospitals located in a rural area.¹ However, only 5.9% of GME slots went to 5 geographically rural hospitals during the first round of awards while 42 hospitals reclassified as rural received 42% slots.² Distribution to these reclassified hospitals is technically following the law; however, NRHA is concerned with this allocation of GME slots set aside for rural training to geographically urban hospitals. Further, it appears the reclassified hospitals that received slots under the first round of distribution are not training residents in rural areas. Analysis shows only 3% of reclassified facilities will use slots to train residents for 50% or greater time in rural areas and 6% for rural training less than 50% of time, with the remaining 92% doing no formal rural training.³ Unfortunately, this is allowed because of the reference to § 1886(d)(8)(E) in the legislative text. NRHA urges the Committee to remedy this issue by removing reclassified hospitals from the statute and in the future only allowing hospitals that are geographically rural, or classified as rural under § 1886(d)(2)(D), to receive slots set aside for rural training.

¹ The CAA, 2021, set aside 10% of all slots to hospital located in a rural area¹ defined by § 1886(d)(2)(D) or those treated as rural under § 1886(d)(8)(E).

² Only 5 geographically rural hospitals received 23.74 GME slots during the first round; however, 42 hospitals that reclassified as rural under 42 U.S.C. § 1886(d)(8)(E) received 168 slots.

³ Using rural referral centers as a proxy, 34 RRCs received slots and only one trains residents in a rural area for at least 50% of the time. Two additional RRCs train residents in rural areas but for less than 50% of their training. The remaining 31 RRCs do not train residents in rural areas.

Rural hospitals typically do not have the capacity to create, or grow, residency programs because they operate on narrow margins and require a predictable source of funding for the program. To increase rural physician training in the short term, Congress must authorize the Rural Residency Planning and Development Program (RRPD). RRPD has shown incredible results as a pilot program by increasing the number of rural residency programs, standing up 39 new accredited programs and 515 additional residency positions since 2018. It is essential that this very successful program is formally authorized in order to support rural residency capacity as outlined in [S. 2840](#). Further, NRHA supports [H.R. 834/S. 230](#), the Rural Physician Workforce Production Act, which tackles the geographic maldistribution of physicians in rural areas stemming from the current structure of Medicare-funded GME. The bill would lift GME caps, remove Medicare limits on rural resident training growth, extend equitable federal funding to rural hospitals, and establish an elective per resident payment initiative.

IME fix.

SCHs and MDHs are paid the greater of the IPPS rate or a hospital specific rate. SCHs and MDHs with teaching programs that are paid at their hospital specific rate are eligible only to receive DGME payments, not IME payments. These hospitals should receive the same incentives to train residents as those that are paid under the federal IPPS rate. This inequity cannot persist at a time when rural areas are seeing [historic physician shortages](#) and SCHs and MDHs are an important lever for increasing rural training.

Obstetric care.

Rural communities face a dangerous lack of access to obstetric (OB) care. In 2023, [23 hospitals](#), mainly rural, have closed or announced that they will close their OB units. For example, within a two-month period, one CAH and two PPS hospitals in Indiana announced that they are closing their OB units. Six to eight more Indiana hospitals have openly noted that they are planning or considering closing theirs as well. This is exacerbating an already dire situation in which [over half of rural hospitals](#) have no OB unit. Rural communities also see OB workforce shortages with an [estimated](#) 58.7% of rural counties lacking an obstetrician, 81.7% lacking advanced practice midwives, and 56.9% lacking family physicians who deliver babies.

Lack of access and OB provider availability in rural areas is concerning because maternal morbidity and mortality rates are increasing, particularly for rural women. Fortunately, [most pregnancy-related deaths](#) are preventable, meaning that policy changes are critical to reversing recent trends. NRHA supports a number of actions to improve and sustain OB and maternal health care. Congress must pass [H.R. 4605/S. 948](#), the Healthy Moms and Babies Act, to improve maternal and child health by increasing services, supports, and access to coordinated care and technology in rural areas. Second, the House should introduce a companion to [S. 1851](#), the Midwives for MOMS Act, which would expand midwifery programs at colleges and nursing schools. Rural areas typically rely on practitioners other than obstetricians because of workforce constraints, meaning midwives can fill in critical gaps. Last, NRHA urges Congress to consider legislation on OB readiness, a concept that refers to a hospitals' ability to manage OB emergencies without a dedicated OB unit. Legislation should include grants from HHS to grow OB readiness training and equipment in rural and underserved areas.

Utilizing all health professionals.

Nurses and non-physician practitioners (NPPs), like nurse practitioners (NPs) and physician assistants (PAs), are a crucial component of rural health care. Emphasizing practice autonomy is a proven strategy to recruit NPs to rural areas. [H.R. 2713/S. 2418](#), the Improving Care and Access to Nurses Act (ICAN) modernizes Medicare and Medicaid policies by removing barriers to practice for nurses and NPPs while also lowering costs. For example, ICAN would remove costly supervision requirements for nurse anesthetists and allow nurse practitioners to supervise residents in a skilled nursing facility, among other needed updates. Further,

supporting partnerships between community colleges and local health care organizations will help decrease the rural-urban nursing disparity, since these programs are cost-effective and broadly available in rural areas.

Rural communities rely on many different practitioners to receive care. For example, pharmacists are often important touchpoints to the health care system for rural residents. About 9 in 10 Americans live within five miles of a community pharmacy which makes pharmacists more accessible than primary care physicians in many rural areas. They can provide clinical services like immunizations, blood pressure and glucose monitoring, chronic care management, and wellness and prevention services. To protect Medicare beneficiaries during cold and flu season, NRHA urges Congress to pass [H.R. 1770/S. 2477](#), the Equitable Community Access to Pharmacists Services Act to allow Medicare reimbursement for pharmacists' services related to respiratory illnesses.

The National Health Service Corps (NHSC) program helps bring providers to rural areas through loan repayment and scholarships. To further incentivize pharmacists to practice in rural and underserved areas, NRHA encourages pharmacists to be added to NHSC. Currently, pharmacists are only eligible under the NHSC Substance Use Disorder Workforce program, not NHSC generally. We also urge Congress to pass [H.R. 4829](#), the Physical Therapist Workforce and Patient Access Act, to add physical therapists (PTs) to NHSC. The legislation would also provide CHCs the option to hire PTs as full-time employees and allow FQHCs to bill Medicare and Medicaid for PT services – a benefit that is already covered for patients served by CHCs.

Behavioral health.

Almost a [quarter](#) of rural adults reported having any mental illness in 2021. The prevalence of mental health and substance use may be similar in rural and urban areas, but access to treatment and providers varies. Immediate actions to expand the rural behavioral health workforce would be to introduce a House companion to [S. 923](#), the Better Mental Health Care for Americans Act. Additionally, to assure that rural patients retain access to evidence-based treatment for opioid use disorder (OUD), the House must pass [H.R. 5163](#), the Telehealth Response for E-prescribing Addiction Therapy Services Act. This bill allows patients to receive a medical exam via telehealth, including audio-only, in order to get a buprenorphine prescription for OUD. About [three quarters](#) of rural counties lack a buprenorphine provider, so telehealth prescribing is key to expanding access to areas without a practitioner.

Nursing home minimum staffing standards.

NRHA has significant concerns about the effect of the [CMS proposal staffing standards](#) on rural nursing homes participating in the Medicare and Medicaid programs. NRHA appreciates CMS' commitment to improving patient safety, while acknowledging the unique challenges rural long term care facilities face related to staffing. The proposed extended compliance timelines and the exemption process for rural facilities will only postpone implementation of mandates that many rural areas will not be able to meet. NRHA believes that these one-size-fits-all requirements will threaten the viability of rural nursing homes amidst a wave of closures over the past several years, further jeopardizing access to post-acute care for rural residents.

This proposal comes at a time when the rural long-term care sector is facing historic labor shortages, inflation, and inadequate Medicaid payment rates. [Over 200,000](#) more long-term care workers are needed to meet pre-pandemic staffing levels. On top of record-low workforce numbers, rural communities saw almost [500 rural nursing homes close](#) between 2008 and 2018. This trend is not slowing. In fact, the long-term care landscape is worse in certain predominantly rural states such as Montana where [16%](#) of the state's nursing homes closed in 2022. In the same year in Iowa, [13 of 15](#) nursing homes closures occurred in rural areas. A lack of post-acute care beds has ripple effects in rural health care. Patients are unable to get access to acute care in their local communities because hospitals cannot discharge patients who no longer require inpatient care but cannot safely return home. Minimum staffing levels will debilitate nursing homes and

intensify placement challenges, putting patient safety and access to care at risk in rural communities throughout America.

NRHA strongly supports initiatives to improve quality for rural older adults. However, strict staffing mandates are not the answer to quality in the current environment. Congress and the Administration must focus on fixing supply before mandating staffing levels. Congress should look to improve the nursing workforce and home- and community-based services (HCBS) to lessen the pressure on rural nursing homes and improve patient outcomes. The House must reintroduce the [Better Care Better Jobs Act](#) in the 118th Congress to establish planning grants, quality measures, and technical assistance for HCBS improvements through CMS and state Medicaid programs. This legislation also called for increasing the FMAP for HCBS in states that develop plans and meet specified benchmarks for improvements. Additionally, during the PHE, CMS removed the requirement that RHCs in an area without a current home health shortage needed a written request and justification in order to provide home nursing services. Congress should consider removing this requirement entirely and allow RHCs to utilize home nursing services to reach their patients without the administrative burden of providing a request and justification.

Innovative Models and Technology.

Public Health Emergency (PHE) flexibilities.

One silver lining of the Public Health Emergency (PHE) was that rural providers were freed from administrative burdens and outdated regulations. Rural providers often wear many different hats and spend precious time with administrative tasks that could be spent on patient care. NRHA [urged](#) Secretary Becerra to continue some PHE flexibilities earlier in the year, but some require legislative action. NRHA calls on the Committee to implement these flexibilities permanently to make rural health care administration and delivery more efficient.

NRHA asks that Congress permanently end the 96-hour average length of stay rule for CAHs. Relatedly, NRHA urges Congress to remove the condition of payment that requires physicians to certify upon admission that a patient can reasonably expect to be discharged within 96 hours. Annual average lengths of stay and certification requirements are too prohibitive as rural hospitals need flexibility to treat patients as clinically appropriate in a local setting, while adjusting to larger system fluctuations like infectious disease surges and delays in post-acute placement as described above. We ask that the Committee advance [H.R. 1565](#), the Critical Access Hospital Relief Act, out of Committee. For the average length of stay, the Committee should introduce legislation immediately to remove this outdated rule.

NRHA views the requirement for beneficiaries to have a 72-hour qualifying hospital stay before admission to a SNF as an outdated barrier to placing beneficiaries in the appropriate care setting. This requirement should be removed. Due to advances in treatment for many conditions, like joint replacements, hospital stays and recovery are more short-term. In the past, a procedure would have a longer length of stay in acute care before transfer, but oftentimes that is not the case now and hospitals should be able to appropriately move beneficiaries to rehabilitative care. Congress should also allow for direct admission to hospital swing beds for patients who do not require acute care and otherwise meet SNF admission criteria for many of the same reasons. This would help rural beneficiaries receive care when showing signs of declining health without waiting to deteriorate further or get sicker. Preventively allowing patients in swing beds would ultimately achieve cost savings for providers, the government, and beneficiaries while supporting patient safety and access.

Telehealth.

During the PHE, several Medicare telehealth flexibilities were in place and were subsequently extended through the end of 2024 by Congress. Retaining these flexibilities is essential to patient access in rural communities. NRHA urges Congress to continue these flexibilities permanently. In particular, it is critical that

RHCs and FQHCs remain eligible distant site providers and receive payment parity to in-person services. For RHCs and FQHCs, providing reimbursement for telehealth services at a lower rate than in person makes telehealth unsustainable in the long-term given their cost-structure and volumes of services. RHCs and FQHCs maintain a brick-and-mortar location in addition to furnishing care via telehealth, meaning that they must continue to pay the overhead of operating a physical location plus staff regardless of the mode of care delivery, as well as pay for a telehealth platform. In order to maintain and increase access, there must be payment parity between telehealth and in-person.

Another telehealth priority is retaining audio-only telehealth. Older adults typically have lower technology literacy and less access to technology that can support audio-video telehealth. In addition, rural areas still face broadband access challenges. [Nearly 1 in 4](#) rural Americans cite internet access as a problem in their community. Even where broadband is built out, it may not be affordable for residents or may not have the capacity to support synchronous, audio-video technology. Keeping audio-only leaves the option open for practitioners to decide that it is clinically appropriate to use this technology for beneficiaries who otherwise would not be able to access care. Please see our [Farm Bill requests letter](#) for more information on improving broadband accessibility in rural communities.

Innovative models.

Fee-for-service (FFS) reimbursement does not align with the reality of operating rural hospitals and providers, mainly due to low patient volumes. Value-based care, or population-based payment models, have the potential to solve for rural low-volume challenges that come along with FFS payment. However, CMS' Innovation Center (CMMI) has struggled to properly include rural providers in its models, in some circumstances due to statutory barriers. In particular, Congress charged CMMI with developing and testing new payment and service delivery models that must achieve cost savings. The decades of underinvestment in rural health care delivery makes achieving cost savings virtually impossible. Alternative payment methodologies for rural providers and higher acuity patient mix can create additional barriers to model integration. In some cases, CMMI has explicitly excluded some rural providers from taking part in their models. Most recently RHCs were cut out of the new Making Care Primary model and NRHA [expressed](#) its deep disappointment in this choice. Another barrier is the requirement on the number of attributed beneficiaries for providers which cuts out rural because of sparsely populated patient populations and lower volumes.

Congress should direct investments to building out and supporting rural providers in value-based care. The Committee should grant greater authority to the HHS Secretary, through CMMI, to develop and implement voluntary alternative rural payment models. Such models should include a global budget or enhanced cost-based reimbursement. In addition, NRHA believes that exempting rural providers from CMMI's cost-savings mandate would alleviate some barriers to entry in innovative demonstration projects. Congress must equip CMMI with the authority to waive the cost savings requirement in order to develop rural-centric models or to allow rural providers to engage in CMMI models broadly without achieving cost savings at the outset.

Thank you for the opportunity to weigh in on this important issue. Please contact Alexa McKinley (amckinley@ruralhealth.us) with any questions or for more detail on any of the information above. NRHA would welcome a meeting with the Committee to discuss our response and put forth viable policy solutions to improve rural health care for patients and providers.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association