National Rural Health Association

July 14, 2025

Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

RE: Request for Information – Deregulation

Submitted electronically via regulations.gov

Dear Secretary Kennedy,

The National Rural Health Association (NRHA) thanks you for the opportunity to respond to this request for information (RFI) on deregulation (FR Doc. 2025–08415). NRHA appreciates efforts across the Administration to lower regulatory burdens and reduce costs for rural providers.

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. We work to improve rural America's health needs through government advocacy, communications, education, and research.

NRHA proposes that the Administration address the following areas that create unnecessary and undue burden for rural providers and patients:

1. What HHS regulations and/or guidance meet one or more of the following seven criteria identified in E.O. 14219? Should they be modified or repealed? What would be the impact of this change, especially the costs and savings?
Rural health care providers are often tasked with doing more with fewer staff and resources, including complying with burdensome regulatory requirements. The stability of the rural health safety net is tenuous: since 2010, almost 190 rural hospitals have closed or stopped inpatient services, 46% of rural hospitals operate with negative margins, and 432 are identified as vulnerable to closure.[1] NRHA identified several areas where easing reporting requirements for rural hospitals would help them be able to focus on patient care and reduce administrative costs.

Hospital Price Transparency. Price transparency regulations require hospitals to post machine-readable files of standard charges and provide cost estimates for at least 300 shoppable services. Compliance requires significant financial and staffing investments, often diverting resources from patient care. Rural hospitals report spending tens of thousands of dollars to maintain compliance with the transparency rules, while rural patients are not accessing or utilizing this data. Rural

[1] Michael Topchik, et al., *2025 rural health state of the state: Instability continues to threaten rural health safety net*, CHARTIS CENTER FOR RURAL HEALTH (Feb. 2025) https://www.chartis.com/sites/default/files/documents/CCRH%20WP%20-%202025%20Rural%20health%20state%20of%20the%20state_021125.pdf.

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providers are not in the best position to provide cost information to patients on this scale and should be exempt from price transparency regulations.

HIPAA Security Rule. In January 2025, HHS put forth a proposed rule that would make significant changes to the 1996 HIPAA Security Rule to strengthen cybersecurity protections for electronic protected health information (ePHI).[2] The proposed rule has not been finalized and NRHA asks that HHS not move forward with publishing a final rule. In the proposed rule, HHS explicitly declined to include considerations or flexibilities for rural hospitals and clinics despite acknowledging that they will have a more difficult time complying with the proposed regulations.[3] The bulk of the proposed regulations prescribe intense documentation requirements while removing existing flexibilities for addressing cybersecurity risks, which are needed by many under-resourced rural hospitals.

340B Program Child Site Waiver. Amidst growing documentation burdens from manufacturers, rural 340B covered entities need regulatory relief. HHS should reinstate a prior 340B waiver to allow hospitals to provide 340B drugs to patients at an off-site outpatient facility (a "child site") even if the covered entity's child site is not yet listed on the most recently filed Medicare cost report and registered with HRSA's Office of Pharmacy Affairs (OPAIS). This waiver was in place during the PHE and raised no concerns around abuse by covered entities. Cost reporting and OPAIS registration may not occur until almost two years after a child site opens, thus this policy deprives covered entities of the ability to purchase 340B drugs at these sites for an extended period of time after opening, even though the Medicare program may consider these sites part of the hospital immediately upon opening.

Streamline swing bed reporting. Certain small, rural hospitals receive approval from the Centers for Medicare and Medicaid Services (CMS) to use their inpatient beds for either acute care or skilled nursing facility (SNF) services. This allows rural hospitals to provide post-acute care in the community where there is no long-term care facility or otherwise a shortage of SNF beds. However, the documentation burden for critical access hospital (CAH) swing bed patients closely mirrors SNF-level MDS reporting, which is not appropriate for CAHs. A simplified format tailored to CAH swing bed use should be adopted.

Reduce redundancies in ABN documentation. Advanced Beneficiary Notice (ABN) is notice given to beneficiaries to alert them that Medicare is not likely to cover an item or service. ABNs are often required when service denials are unlikely, leading to a paperwork burden for providers that must notify the beneficiary. HHS should allow recurring service ABNs to be bundled for routine care.

2. What regulations should we reconsider as we look to achieve some of the policy objectives outlined in Executive Order 14212, "Establishing the President's Make America Healthy Again Commission," to focus on reversing chronic disease?

Medicare Annual Wellness Visits (AWVs). AWVs are important tools to increase beneficiaries' awareness and use of preventive care, yet rural health clinics (RHCs) and FQHCs are not able to bill Medicare for AWVs in conjunction with a medical visit provided on the same day. As a result, RHCs

[2] *See* HIPAA Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information, 90 Fed. Reg. 898 (Jan. 6, 2025).
[3] *Id.* at 918-19.

and FQHCs are not incentivized to furnish AWVs because they either provide the service without adequate reimbursement or ask a beneficiary to return for an AWV on another day. Returning on another day is a burden for older and lower-income beneficiaries who no longer drive or do not have access to reliable transportation, particularly in remote rural areas. NRHA asks CMS to allow RHCs and FQHCs same-day billing for annual wellness visits under Medicare.

Simplify Telehealth Provision, Documentation and Billing. RHCs and federally qualified health centers (FQHCs) were granted distant site provider status to provide telehealth to Medicare beneficiaries during the COVID-19 public health emergency (PHE) and their ability to furnish telehealth services to beneficiaries has been extended several times since the end of the PHE. Further, these providers receive significantly less for furnishing a telehealth visit compared to an in-person encounter, in contrast to all other provider types that receive payment on par with in-person rates. Improved access to telehealth ultimately plays a role in the early detection, treatment, and management of chronic disease. Telehealth expands opportunities for ongoing patient engagement, timely follow-ups, and coordination of care, all of which are essential to preventing disease progression and avoiding costly hospitalizations. Permanently simplifying telehealth provisions would not only reduce administrative burden but also support long-term strategies to reverse the chronic disease epidemic in underserved rural communities.

In the 2025 Medicare Physician Fee Schedule final rule, the Centers for Medicare and Medicaid Services (CMS) floated the proposal of modifying the definition of an RHC encounter by adding telehealth visits at 42 C.F.R § 405.2463.[3] While CMS did not finalize that proposal, the agency used its authority to extend RHC and FQHC telehealth capabilities through 2025 even without a congressional extension of Medicare telehealth flexibilities.

NRHA believes it is within CMS' authority to pursue its proposal to add telehealth visits to the definition of an RHC or FQHC encounter at § 405.2463 and permanently allow RHCs and FQHCs to furnish telehealth services. Currently, RHCs and FQHCs must bill telehealth services with the code G2025. Instead of receiving their all-inclusive rate for telehealth services, the reimbursement amount is based on the average amount for all Medicare telehealth services paid under the physician fee schedule (PFS), weighted by volume for those services. This change would simplify telehealth billing and documentation requirements as they would no longer be required to use G codes and modifiers, thus removing burdens and also decreasing the frequency of denials and improving payment accuracy.

3. For more general deregulatory consideration under E.O. 14192, are there additional HHS regulations and/or guidance that are confusing or unnecessarily complicated; require an excessive number of reports or unreasonable record keeping, or information that is not needed or used effectively; impose requirements on the wrong individual or group; carry excessive penalties; are conflicting (examples include but are not limited to conflicts between HHS and State regulations, public and private sectors); impede access to or delivery of care or services; impede efforts to innovate are obsolete; and/or otherwise interfere with the public or private sector's ability to address chronic health conditions or otherwise promote the health and wellbeing of Americans? Should they be modified or repealed? What would be the impact of this change, especially the costs and savings?

Obstetric Services Conditions of Participation (COP) Requirements: Between 2011 and 2021, 267 rural hospitals ceased providing obstetrical (OB) care, representing 25% of rural America's OB units.[4] These closures are threatening access to care and contributing to the rural maternal health crisis. Unfortunately, as rural hospitals face difficult financial situations, closing service lines is an intermediary step before closing the hospital. Given the low volume of births in rural areas, coupled with financial challenges and workforce shortages generally experienced by rural hospitals, OB units are one of the first service lines to be ended.

Despite the crisis of obstetric access in rural America, CMS finalized new obstetric services COPs in the calendar year 2025 Outpatient Prospective Payment System (OPPS) rule without any exceptions for rural hospitals.[5] COPs are not the answer to improving maternal health in rural areas. NRHA is concerned that complying with the new COPs will have a chilling effect on rural hospitals that still provide obstetric services and lead to more unit closures. Several requirements go into effect January 1, 2026, while others go into effect January 1, 2027.

In tandem with the obstetric services COPs, CMS added new requirements to the Quality Assessment and Performance Improvement (QAPI) program COPs related to obstetric care improvement.[6] Effective January 1, 2027, all hospitals including rural hospitals, must incorporate information from state or local maternal mortality review committees, participate in data collection and monitoring for obstetric services, and utilize QAPI programs to assess and improve health outcomes and disparities among obstetric patients.

For rural hospitals with low delivery volumes and already-limited obstetric staffing, layering new federal mandates on top of state and regional reporting frameworks imposes administrative burdens without demonstrable improvements in care quality. NRHA asks for an exemption of these requirements for rural providers and instead align obstetric reporting with existing maternal health improvement programs.

Separate from the OB requirements, CMS also imposed new COPs for emergency services readiness, again without regard for how rural hospitals may struggle to comply.[7] NRHA contends that the additional provisions under § 482.55 and § 485.618 for emergency services readiness are redundant as hospitals and CAHs must meet existing emergency care COPs and comply with EMTALA, both of which aim to achieve the same patient safety goals as the proposed COPs. These provisions will go into effect July 1, 2025.

Emergency Readiness COPs. The recently finalized emergency COPs are duplicative of existing Medicare COPs for emergency care, EMTALA requirements, and state-level emergency preparedness mandates. Many rural hospitals and CAHs already participate in regional emergency response coalitions and maintain preparedness protocols to meet both federal and state standards. The addition of new federal requirements under § 482.55 and § 485.618 imposes unnecessary

[4] Topchik, et al., *Rural America's OB Deserts Widen in Fallout From Pandemic*, Chartis (2024), 1, https://www.chartis.com/sites/default/files/documents/rural_americas_ob_deserts_widen_in_fallout_from_pandemic_12-19-23.pdf.
[5] 42 C.F.R. §§ 482.59, 485.649.
[6] 42 C.F.R. §§ 482.21, 485.641.
[7] 42 C.F.R. §§ 482.55, 485.619.

administrative and staffing strain without improving patient safety or care coordination. NRHA urges CMS to rescind these duplicative provisions for rural facilities and instead recognize existing participation in state-certified emergency preparedness programs or drills as satisfactory to meet emergency readiness requirements. Such an approach preserves emergency care capacity in rural areas while easing documentation and compliance burdens.

Hospital Price Transparency Standards. CMS's hospital price transparency rules, which require publication of machine-readable charge files and cost estimates for shoppable services. Many states, such as Colorado, Virginia, Texas, and Wisconsin already have state-level hospital price transparency requirements. Federal level efforts are duplicative of state initiatives in this space. Additionally, Rural hospitals report that compliance diverts significant administrative and financial resources, despite little to no engagement with the posted information by rural patients. NRHA is concerned that the congressional intention for price transparency is not being met. NRHA recommends exempting small rural hospitals from these requirements.

Federally Qualified Health Center (FQHC) Reporting Standards. Federally Qualified Health Centers (FQHCs) are subject to immense and growing administrative burdens under the Uniform Data System (UDS) and Federal Tort Claims Act (FTCA) processes. UDS reporting requires extensive data collection, including hundreds of diagnoses and clinical quality measures. These requirements are time-consuming and labor-intensive, especially for rural FQHCs with limited staffing capacity. NRHA recommends reducing the number of measures required, specifically in Tables 6A, 6B, and 7 to no more than 15 core metrics that are most relevant to rural patient populations. Table 6A, which tracks diagnoses and services across 34 reporting lines, should also be shortened and simplified to reduce error-prone data entry. To the extent possible, CMS and the Health Resources and Services Administration should work together to streamline reporting for FQHCs and allow for cross-agency sharing of information to relieve rural FQHCs from reporting burdens.

Roll back SNF civil monetary penalty changes. In the FY 2025 SNF Prospective Payment System rule, CMS finalized changes to civil monetary penalties (CMPs).[8] Before this final rule, CMS could not impose per day (PD) and per instance (PI) penalties for deficiencies identified during the same survey and per instance penalties could not be imposed concurrently for the same deficiency. CMS will now be able to impose both per instance and per day civil monetary penalties (CMPs) for deficiencies identified during the same survey. The potential amount of CMPs that CMS may levy against rural facilities could be devastating. Total CMPs per day are limited but depending on the number of days of noncompliance and whether both PI and PD CMPs are imposed, the total penalty amount could be extremely high. This expansion of authority for CMS and state agencies equates to unfair duplicative payments put on the back of struggling rural facilities.

4. What alternative approaches could be taken to achieve or accomplish the same goal with a lesser burden? For example, are there less burdensome approaches that are used by other entities such as State governments or private companies that could be adopted by HHS to achieve its goal with less burdensome requirements? What would be the impact on costs and savings?

[8] 42 C.F.R. § 488.408(e)(2)(ii).

HHS should encourage alignment across quality reporting programs at CMS (Medicaid/Medicare), as well as across HHS (particularly for federally qualified health centers and rural hospitals), and across private payers.

All CAHs should be encouraged to report quality metrics to improve quality of care and for CAH benchmarking. NRHA understands the burden of reporting for small hospitals is high in comparison to larger hospitals. As such, quality reporting should not be subject to individual, voluntary reporting, but required for CAHs receiving Flex funding. In return, the Flex program will provide the needed technical assistance and resources to facilitate CAH reporting.

CAH quality measures need to be standardized metrics (core measures) and be rural relevant measures. Standardized metrics would consist of a core set of measures used by States, the Flex Program, CMS, payers and hospital associations. CAH transition to quality reporting should focus on: 1) development of rural-relevant measures, 2) alignment of measurement efforts, 3) measure selection process, and 4) pay-for-performance considerations.

CAH average length of stay and physician certification. CAHs must comply with a 96-hour annual average length of stay (ALOS).[9] This COP was waived throughout the COVID-19 PHE under a blanket 1135 waiver issued by CMS. In addition to the 96-hour ALOS, CAH conditions of payment mandate that physicians certify that Medicare beneficiaries can reasonably be expected to be discharged within 96 hours. These rules are too prohibitive as CAHs need flexibility to treat patients as clinically appropriate in a local setting, while adjusting to fluctuations like infection disease surges and delays in post-acute care placement. The 96-hour ALOS is required by statute[10] as is the physician certification rule[11] and as such NRHA urges the Administration to work with Congress to permanently end these superfluous requirements.

Allow direct admission to post-acute care. Medicare beneficiaries that need post-acute care in a skilled nursing facility (SNF) must meet certain requirements, such as a prior 3-day hospitalization. Like the 96-hour ALOS rule, this requirement was waived throughout the COVID-19 PHE, facilitating timely transfers and freeing up much needed inpatient beds. NRHA asks the Administration to work with Congress to remove this requirement, which is statutorily required.[12] Repealing this rule is in the best interest of rural beneficiaries as they would be able to receive care when showing signs of declining health without waiting to deteriorate further or get sicker. Preventatively admitting patients in SNFs and swing beds would ultimately achieve savings for providers, HHS, and beneficiaries, while supporting access and quality for patients.

NRHA notes that there is precedent for waiving the 3-day qualifying stay. Providers in certain alternate payment models have the benefit of waiving this stay for SNF admissions. In addition, CMS finalized this flexibility for Transforming Episode Accountability Model (TEAM) hospitals to allow

[9] 42 C.F.R. § 485.620(b).
[10] 42 U.S.C. § 1395i-4(c)(2)(B)(iii).
[11] 42 U.S.C. § 1395f(a)(8).
[12] 42 U.S.C. § 1395x(i).

direct admissions to SNFs in the fiscal year 2025 IPPS rule.[13] CMS proposes expanding this waiver to allow direct admissions to swing beds for TEAM hospitals.[14]

CRNA supervision. CRNAs are the predominant anesthesia providers in rural areas and can safely deliver anesthesia care autonomously.[15] NRHA urges CMS to remove physician supervision requirements for CRNAs as part of the Hospital, Critical Access Hospital, and Rural Emergency Hospital COPs.[16] These requirements were originally rescinded in a final rule on January 18, 2001,[17] but this final rule was withdrawn and replaced with a bureaucratic opt-out process for states to individually remove the requirements.[18] These requirements are regulatory overreach as there exists no enabling statute mandating CMS to implement physician supervision requirements of CRNAs or for the state supervision opt out.[19] Furthermore, no other health care provider is required to lobby their state governors to opt out of federal regulations for the purposes of meeting COPs.

Non-physician practitioner (NPP) supervision. Currently, nurse practitioners must be supervised by physicians as part of RHC, CAH, and REH conditions of participation. These requirements are regulatory overreach as there exists no enabling statute mandating CMS to implement physician supervision requirements of nurse practitioners. Nurse practitioners should be able to practice to the full extent of their education and training. These regulatory barriers should be removed to improve rural healthcare access.

Reporting acute respiratory illness. In the fiscal year 2025 Inpatient Prospective Payment System (IPPS) rule, CMS finalized a new COP for hospitals, including rural hospitals and CAHs, to electronically report on acute respiratory illnesses. Specifically, CMS amended existing antibiotic stewardship and infection prevention COPs to mandate ongoing electronic reporting on acute respiratory illness, which includes confirmed infections among newly admitted patients, total bed census and capacity, and some patient demographic information.[20] NRHA would like to see this COP rescinded and voluntary reporting of respiratory illness data incentivized instead.

SNF facility assessment changes. In the Minimum Staffing Standards for Long-Term Care rule, CMS added new facility assessment requirements that became effective in 2024.[21] This regulation provides that SNFs must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and update this assessment at least annually. NRHA asks that this section be rescinded as it is burdensome for rural SNFs.[22]

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[13] 42 C.F.R. § 512.580(b).
[14] 90 Fed. Reg. 18002, 18404 (Apr. 30, 2025).
[15] Brighita Negrusa, et al., *No Measurable Impact of Certified Registered Nurse Anesthetist Expanded Scope of Practice on Anesthesia-related Complications*, 54 MED. CARE. 913 (Oct. 2016) https://journals.lww.com/lww-medicalcare/abstract/2016/10000/scope_of_practice_laws_and_anesthesia.4.aspx.
[16] 42 CFR §§ 482.52(a)(4), (c); 485.639(c)(2), (e); 485.524 (d)(3)(ii), (d)(5).
[17] 66 Fed Reg. 4674 (Jan. 18, 2001) https://www.govinfo.gov/content/pkg/FR-2001-01-18/pdf/01-1388.pdf.
[18] 66 Fed Reg. 56762 (November 13, 2001) https://www.govinfo.gov/content/pkg/FR-2001-11-13/pdf/01-28439.pdf.
[19] 66 Fed Reg. 4685; 66 Fed. Reg. 56768.
[20] 42 C.F.R. §§ 482.42(e), 485.640(d).
[21] 42 C.F.R. § § 483.71.
[22] *Id.*

Hospice recertification flexibility. At 42 C.F.R. § 418.422(a), hospice physicians or hospice nurse practitioners must recertify patient eligibility through a face-to-face encounter; however, through December 2024 this could happen via telecommunications. NRHA urges the agency to extend this flexibility permanently to ease workflows.

Audits and reviews of sole community hospital disproportionate share and uncompensated care data. Medicare Administrative Contractors (MACs) perform a necessary function by auditing or reviewing various data included on the annual Medicare cost reports prepared by hospitals to ensure the proper amount of Medicare reimbursement to the hospital. However, in some circumstances, MACs perform unnecessary audit or review procedures on data that has no bearing on a hospital's Medicare reimbursement. These procedures consume valuable employee resources for both the MACs and the individual hospitals.

Medicare reimburses sole community hospitals (SCHs) for inpatient operating costs based on the higher of their hospital-specific payments or their federal payments. Federal payments include operating DRG payments plus outlier payments, indirect medical education payments, disproportionate share payments (DSH), and uncompensated care payments (UCP). For many SCHs, hospital-specific payments exceed federal payments, and thus they receive no DSH or UCP. Yet, they are still subject to all audit, review, and reporting requirements for these programs.

Hospital-specific payments and federal payments will both change between the time the cost report is prepared and the MACs final settlement of the cost report, but rarely does this significantly change the relationship between hospital-specific payments and federal payments for SCHs. For example, one NRHA member's MAC recently settled their 2023 cost report. When the SCH filed the cost report, their hospital-specific payments exceeded federal payments by 10.18%. On the final settlement from the MAC, the hospital-specific payments exceeded federal payments by 10.24%, with the gap actually widening from when they filed the cost report. If an SCH's hospital-specific payments exceed federal payments by over 1%, CMS should exempt the SCH from audit or review of this data by the MAC. Hospitals still report this data, particularly the uncompensated care data reported on Worksheet S-10 of the cost report, so that it is clear to the public that the SCH serves a large uninsured population. However, SCHs should not be subject to the burden of being audited on data that does not have a direct impact on their Medicare payments.

Reevaluate Psychiatric Bed Carveouts. Current rules prohibit federal Medicaid funding for psychiatric treatment for adults aged 21–64 in facilities with more than 16 beds, limiting the ability of rural providers to deliver critical behavioral health services. NRHA requests CMS revise these regulations to allow carveouts for CAHs and other rural facilities, enabling them to receive Medicaid reimbursement for psychiatric services even if they exceed the 16-bed threshold. Doing so would reduce administrative complexity and strengthen behavioral health infrastructure in rural communities without compromising program integrity.

Medicare Promoting Interoperability Program. Hospitals must demonstrate meaningful use of certified electronic health record (EHR) technology to receive Medicare and Medicaid reimbursements. Reporting requirements include electronic clinical quality metrics (eCQMs), interoperability metrics, and measures related to patient access to records. The program began initially as an incentive program and has transitioned to a mandatory penalty program. Rural

hospitals need a return to a program that provides incentives, not payment reductions, particularly as complexity in compliance with the program increases.
In 2024 HHS finalized two rules around health data, technology, and interoperability (HTI-1 and HTI-2 rules).[23] The 21st Century Cures Act mandates that hospitals avoid information blocking and comply with interoperability rules, including the sharing of electronic health data. These requirements are implemented through the HTI-1 and HTI-2 rules. Rural provider compliance with reporting necessitates substantial investments in technology, staffing, and infrastructure that are not feasible, particularly for small hospitals and clinics. Rules around technology and interoperability must include flexibilities that match what rural hospitals are able to do rather than imposing untenable standards.

FQHC reporting. FQHCs are subject to immense burdens related to Uniform Data System (UDS) requirements. UDS is an annual reporting system that provides standardized information including data on patient characteristics, services provided, clinical processes and health outcomes, patients' use of services, staffing, costs, and revenues. NRHA encourages the Health Resources and Services Administration to look at ways to streamline and simplify the reporting necessary for the UDS.

Cost Report Modernization: Medicare cost report methods date back to 1965 and have remained largely unchanged since. Allocation of Administrative and General (A&G) costs to subsidiary units reduces Medicare cost reimbursement for cost-based providers like CAHs and RHCs. Cost report allocation is the foundation of all strategic initiatives in a CAH. Often subsidiary services are non-or low-margin services, yet critical services required for population health initiatives. NRHA asks HHS to implement cost report modernization to kickstart efforts towards cost report improvements that are much needed to support rural provider viability and beneficiary access.

Additional Recommendations

Many regulations have not been modernized to match the evolving standards of care delivery in rural communities. NRHA offers the following changes to regulations and sub-regulatory guidance to ensure that rural providers are able to stay current and furnish quality care to rural patients.

Modernize the Rural Health Clinic Program: Rural Health Clinics RHCs are a fundamental part of the rural health care delivery system with over 5,400 clinics nationwide providing outpatient care to rural communities. Since RHCs were created in 1977, the designation has remained largely unchanged. NRHA identified several areas to modernize the program.

> Behavioral health services: In 2024, marriage and family therapists (MFTs) and mental health counselors (MHCs) became eligible to bill Medicare directly and also became eligible RHC practitioners, creating an opportunity for expanded behavioral health access in rural areas. However, current RHC guidelines continue to be barriers to fully realizing the utility of MFTs and MHCs in RHCs.
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> RHCs are limited in the amount of behavioral health services that they may furnish due to a CMS definition of mental disease, which inhibits the availability of behavioral health care in rural areas. NRHA calls on CMS to redefine "a facility which is primarily for the care and treatment of mental diseases" as it pertains to how much behavioral health care RHCs can

[23] 45 C.F.R. Pts. 170-72.

furnish. In the CY 2025 PFS final rule, CMS declined to define the term "mental disease", which is found in the RHC statute. "[A] facility which is primarily for the care and treatment of mental diseases" should be defined at 42 C.F.R. § 491.9 as clinic types that provide behavioral health care only: certified community behavioral health centers, community mental health centers, and standalone opioid treatment programs. Doing so would create flexibility for RHCs and allow them to predominantly provide primary care to increase the provision of much-needed behavioral health services.

Sub-regulatory guidance for RHCs states that group services are not included in the RHC benefit, meaning that RHCs are disincentivized from providing these services. CMS excluding group services from the RHC benefit is stifling the effectiveness of MFTs and MHCs in the RHC setting because they cannot bill for group therapy, which is considered a group service. CMS should remove the group services exclusion from section 60.1 in Chapter 13 of the Medicare Policy Benefit Manual or carve out certain providers that can bill for group services, like behavioral health practitioners.

Alternatively, CMS may consider defining behavioral health care, or as the statute states "care and treatment of mental diseases" as primary care. Health care delivery is moving more towards integration of primary and behavioral health care, and this change would help modernize RHC care delivery.

Census Bureau definition of "Urban Area": The Census Bureau removed the terms "urbanized area" and "urbanized cluster" in 2022 and replaced them with a single designation termed "urban area." Under the new term, an "urban area" is one with a population of 5,000 or more, meaning that rural areas are those with a population of less than 5,000. One component of RHC eligibility is being located in "an area that is not delineated as an urbanized area by the Bureau of the Census." CMS issued interim guidance clarifying that RHCs are considered as meeting the rural location requirement if their physical address is either "non-urbanized" under the previous Census definition or identified as not located in an urban area under the new Census definition. NRHA requests that CMS add this guidance to the RHC State Operations Manual to provide clarity for RHCs and survey agencies.

Rural Physician Training. Rural areas continue to face persistent workforce challenges and rural physician shortages are only expected to grow worse in the coming years. As such, NRHA believes there are several regulatory changes that could create needed flexibilities for rural physician training.

FQHC Telehealth Restrictions*:* FQHCs are increasingly using telehealth to expand care, but current CMS policies do not explicitly allow tele-supervision of medical students or residents in FQHC settings.[24] This ambiguity limits rural learners' ability to be trained via telehealth platforms. Modifying this regulation to allow supervised telehealth learning experiences in FQHCs could greatly expand rural training access.

Standardizing State Licensure for Rural Trainees: Resident physicians conducting rotations across rural areas that span state borders must often navigate burdensome, duplicative

[24] 42 C.F.R. § 410.78.

licensing or exemption processes.[25] While the Interstate Medical Licensure Compact exists for licensed physicians, a federal framework for trainee mobility does not. A federally facilitated rural rotation exemption could remove these rules without compromising public safety.

Application of Stark and Anti-kickback Laws: Rural hospitals and clinics often hesitate to form precepting or stipend partnerships with universities due to legal ambiguity around compensation for teaching.[26] Creating clear safe harbors for rural academic-clinical partnerships would allow more physicians to precept learners without fear of regulatory violations, thus expanding the rural training pipeline.

Make Medicare Advantage Work for Rural Communities. Rural Medicare Advantage (MA) enrollment is nearing the 50% mark, and rural providers are feeling the effects ranging from increased administrative burden to undue financial implications.[27] NRHA asks that the Administration work alongside its colleagues in Congress to ensure that MA plans work for both rural patients and providers.

Require MA plans pay rural hospitals and rural health clinics (RHCs) at Traditional Medicare rates if the facility is not under contract with the MA plan: Regulations on MA payment state that services furnished by providers without a contract with an MA plan must accept as payment in full the amount that it could collect if the beneficiary were enrolled in Traditional Medicare. Further, sub-regulatory guidance on MA payment to out-of-network providers states that MA plans are generally required to pay at least Traditional Medicare rates for Medicare covered services.[28]

Even when a rural provider is able to receive payment equivalent to their Traditional Medicare rate, getting timely payments is difficult. NRHA members have voiced that payment-related challenges with MA plans have negatively impacted their patients, staff, and facilities. Payment challenges are heightened for providers with special rural designations and payment systems, like CAHs and RHCs, because of their unique cost-based reimbursement structures. For example, when a provider bills for a service, a plan may deny the claim after the beneficiary received the service despite previously receiving prior authorization. NRHA members note that this happens most often for inpatient stays. NRHA supports CMS' recent final rule around inpatient coverage and concurrent and retrospective coverage reviews.[29] CMS should use its existing authority to enforce coverage and payment rules for MA plans.

Section 1135 workforce waivers. The COVID-19 PHE afforded rural providers various waivers related to workforce rules. Many such waivers continue to be relevant for rural providers and would streamline workflows and make more efficient use of existing staff, while continuing to ensure quality care for rural patients. Through May 2022, CMS allowed non-physician practitioners (NPPs) to

[25] 42 C.F.R. § 61.
[26] 42 C.F.R § 411.351; 42 C.F.R. § 1001.952.
[27] https://rupri.public-health.uiowa.edu/publications/policybriefs/2025/2024%20MA%20Enrollment%20Update.pdf
[28] 42 C.F.R. § 422.214(b) (2023); https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf.
[29] *See* Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, 90 Fed. Reg. 15792 (Apr. 15, 2025).

perform initial physician visits in SNFs by waiving 42 C.F.R. § 483.30(c)(3). NPPs performing initial physician visits may not be appropriate in all circumstances, but leaving the choice up to the practitioner's clinical judgment may be more appropriate than an across-the-board federal regulation. Removing this provision permanently would reduce workloads for physicians and mitigate against rural workforce shortages that persist in the rural long-term care sector. CMS should further consider modifying physician delegation rules in SNFs. Physicians should be able to delegate all tasks to NPPs, as allowed during the PHE by removing 42 C.F.R. § 483.30(e)(4). NPPs, such as nurse practitioners and physician assistants, provide a significant amount of care in rural areas and often serve as the primary care provider for many rural patients.

NRHA thanks HHS for the opportunity to weigh in on much-needed deregulatory efforts. Streamlining and minimizing regulatory requirements will ease rural health care delivery and facilitate greater access to care across rural America. Please contact Alexa McKinley Abel (amckinley@ruralhealth.us) with any questions or to discuss these proposals further.

Sincerely,

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