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**NATIONAL RURAL HEALTH ASSOCIATION****NRHA Requests Regulatory Relief for Rural Providers**

The National Rural Health Association (NRHA) applauds the Biden Administration for identifying rural health as a critical priority. NRHA stands ready to provide information and assistance to the Administration as they begin their efforts. We provide the Administration with the following programmatic and regulatory actions that should be taken to further stabilize and support rural health care.

**Medicare Payment and Regulation**

Many rural hospitals operate on slim-to-negative margins and struggle to continue providing access to care to their communities. NRHA encourages HHS to stop Medicare cuts to rural providers and address administrative barriers on a range of issues.

**Remove the burdensome, onerous price transparency regulation**

On January 1, 2021, CMS implemented the burdensome price transparency regulation requiring all hospitals, including CAHs, to develop a list of shoppable service to help patients better understand the cost of non-emergent services. Throughout 2020, rural hospitals were on the front lines of the COVID-19 pandemic that has impacted rural America disproportionately. These hospitals did not have the time nor the resources they needed to comply with this onerous regulation. It is imperative that CMS remove this burdensome regulation from its agenda as soon as possible so that rural hospitals are not subject to unfair penalties.

**Continue the telehealth advancements during the PHE**

NRHA hopes that once the PHE has ended, CMS will continue to enable Medicare patients to utilize telehealth services. Within the CARES Act, Congress provided the ability for RHCs and Federal Qualified Health Centers (FQHC) to expand the reach of care provided by physicians practicing in rural America by allowing them to serve as distant site providers for telehealth services. Allowing this provision to expire would disproportionately impact rural providers and patients. Currently, due to a special payment rule created in the CARES Act, there is only one billing code for the 238 telehealth services they can provide and a standard, base-level reimbursement of \$92.03 for those services. This does not incentivize providers to transition to telehealth services and it doesn't adequately reflect the cost of services provided. If RHCs and FQHCs are permanently authorized as distant site providers, CMS should reevaluate their reimbursement and coding methodologies for telehealth services to pay RHC/FQHCs their all-inclusive rates and count them as face-to-face encounters.

Additionally, the Administration should aid to reduce administrative burdens on providers associated with telehealth. Every effort possible should be made to harmonize statutes and regulations at the federal, state and local levels to promote the continued adoption and utilization of telehealth. For example, Congress should explore the establishment of a form of blanket patient consent to facilitate the provider connecting with them via the 2-way video method that the patient is most comfortable with. Congress must also work in concert with the Department of Health and Human Services and the Centers for Medicare and Medicaid Services to reduce burdensome regulations that inhibit the expansion of telehealth to smaller physician practices that reduce the ability of clinicians to focus on their most important task: serving their patients

**Support for Low-Wage Medicare Wage Index Adjustments**

CMS made changes to address long-standing rural hospital concerns for hospitals with low-wage structures. The change was originally envisioned as a four-year period that would allow these rural low-wage facilities

to, in effect, catch up and use the extra revenue to increase their wage structures and, over time, increase their wage index. The Administration should consider extending it, particularly in light of the long-term financial shocks that will affect rural hospitals in the light of the pandemic. In addition, HHS may want to consider a public education campaign or technical assistance effort for these facilities to help them use this time as intended in terms of adjusting their wage structure so that at the end of this period they will have a higher wage index.

### **Eliminate the 96-hour Condition of Payment Requirement for CAHs.**

The CAH 96-hour rule creates a condition of repayment that requires a physician to certify that a patient can reasonably be expected to be discharged or transferred within 96 hours. CAHs already must meet a separate condition of participation, which requires that acute inpatient care provided to patients not exceed 96 hours per patient on an average annual basis. CMS, in its 2018 IPPS final rule, made the 96-hour rule a low priority for medical record reviews, but the regulation still causes confusion and interferes with the best judgement of physicians and other health care providers. President Trump suspended this rule for the duration of the PHE, but NRHA believes CMS should eliminate the onerous regulation entirely.

### **Exempting MDHs, RRCs, and SCHs from Site Neutral Payment Adjustments**

Beginning in 2019, CMS pays for certain clinic visit services furnished by excepted (grandfathered) off campus provider-based outpatient departments at the Physician Fee Schedule relativity adjuster rate, i.e., the same payment amount used to pay for services furnished by non-excepted (non-grandfathered) off-campus provider-based outpatient departments. A large majority of hospitals in rural and underserved communities are already financially vulnerable due to a number of factors, including payment inadequacy and uncertainty.

### **Change of Address for Grandfathered Provider-Based RHCs**

Given changes in the Consolidated Appropriation Act of 2021, existing provider-based Rural Health Clinics (RHCs) in rural hospitals 50 beds or less were grandfathered-in to the new payment policy at their current all-inclusive rate (AIR) based on their 2020 rates. NRHA requests CMS consider making adjustments in the base rate limit for extenuating circumstances such as a new building or a relocation that was in process when enacted.

### **Swing Beds Flexibility in PPS Hospitals with DPUs**

Beds associated with Distinct Part Units (DPU) in a PPS hospital should not count in the 100-bed threshold that qualifies a PPS hospital to operate Swing Beds within their acute care operation. Currently, if a rural PPS hospital wants to operate a Swing Bed program, it must have 100 staffed beds or less. Under current rules, DPU beds count in the total. NRHA asks that CMS remove DPU beds from total bed count of a rural PPS hospital in order to determine Swing Bed participation. Since DPUs have their own associated reimbursement programs and are accounted for separately within those payment structures, there is no risk of double payment by the Medicare program.

### **CHART Demonstration**

NRHA would like to see the Biden Administration test and implement sustainable payment models for rural providers. In August 2020, CMS introduced the Community Health Access and Rural Transformation (CHART) Model. Significant improvements need to be made to the model before the demonstration begins to bring it in alignment with other demonstrations such as the Pennsylvania Rural Health Model. Additionally, pandemic surge utilization and its related workforce challenges, preoccupying leadership that would otherwise be able to concentrate on a higher level project application like this. Currently, many providers in rural areas are now focused on vaccination distribution for their communities and organizing efforts related thereto. As such, NRHA recommends revisit the application period in order to make necessary revisions and reopen the opportunity.

### **Establishing the Rural Emergency Hospital Program**

REH rules, CoP, and the additional payment

NRHA believes the Rural Emergency Hospital (REH) model will be an opportunity for vulnerable rural communities to maintain an essential access point for health services. Implementation of the REH will be critical to the success of the model, including development of the REH regulations, Conditions of Participation, and the additional facility payment methodology. NRHA considerations and recommendations can be found at: [Rural Emergency Hospital \(REH\) model summary](#)

## **Medicare Cost Report**

### **Clarify Co-Mingling Regulations**

Address how co-mingling regulations for CAHs and RHCs affect their ability to provide and integrate services like primary care and behavioral health. Because these providers are often paid under different parts of Medicare there are challenges related to how costs are accounted for. These providers are required to carve out certain items on their cost reports to avoid Medicare paying for a service twice. While this is fairly straightforward on the cost report, it creates confusion in actual practice particularly as it relates to surveys. As a result, a CAH that also rents space to a dialysis unit has to have a separate waiting room and entrances. Current cost reporting requirements for CAHs create disincentives for co-location services since any of those costs must be carved out of the cost report.

### **Decreased inpatient volume during Pandemic**

NRHA asks CMS to issue guidance to MACs clarifying that decreased inpatient volume due to the pandemic, and the related cessation of elective services, is clearly outside the hospitals' control and forms the basis for an allowable volume-decreased request. Additionally, CMS needs to provide a streamlined mechanism for SCHs and MDHs to file these requests once their cost report is completed.

## **Workforce Payment Policy**

### **Restriction of payments for physician residents at Critical Access Hospitals**

Physician rotation in rural residencies programs in CAHs and rural PPS hospitals has been proven to dramatically improve workforce shortages in rural and frontier locations. By implementing regulations from the ACA, CMS has restricted Medicare from covering the costs of training resident physicians at a CAH, and this has restricted efforts to expand the training of medical professionals in rural communities.

### **Remove Barriers that Limit Rural Resident Training**

A major limitation in funding of rural graduate medical education exists because of CMS's interpretation of residency cap statutes. CMS currently counts rotating residents who participate in rural training programs in establishing residency caps. This has resulted in artificially low caps on resident training and per resident amounts (PRAs) for rural hospitals. Rural hospitals may extend their caps by establishing a new program, but once the cap is reset, the program cannot expand in the future. The larger concern is that the PRA is set forever, even though the hospital has never sponsored a training program, making it unlikely that a hospital will ever be able to start a new training program. Rural hospitals should be exempt from having a cap on resident positions (and the associated PRA) set if they are only training rotators from other institutions for brief periods of time.

### **Allow urban hospitals to establish rural training tracks.**

The Balanced Budget Act of 1997 (BBA) allows an urban hospital to increase its cap on residency positions in order to accommodate residents training in rural areas as part of a rural training track (RTT) after the first year of training. Unfortunately, CMS's interpretation of the statute has impeded implementation. CMS has determined that once a cap is set for the establishment of a rural training track, no new training tracks will be allowed in the same specialty, even if they are at different rural locations. Additionally, CMS determined that once a cap is set for a RTT, for the training in the rural setting, there is no further ability to

claim additional RTT residents at the urban hospital related to training at that site. CMS should revise regulations to allow: 1) an urban hospital to expand its cap for the purposes of establishing a new RTT; and 2) not count residents who train in rural areas against the cap placed on urban facilities.

## **COVID-19 Response**

### **Ensure reporting requirements for the provider relief fund remain provider friendly**

NRHA continues to advocate that the Provider Relief Funds are fully able to aid rural hospitals combatting the COVID-19 pandemic. We believe Congress intended the fund to give providers a much-needed lifeline to help them through the pandemic. Absent changes to the existing policies laid out in HHS PRF FAQs, many rural hospitals serving low-income, elderly, and severely ill patients, may be required to return much-needed PRF funds to HHS, instead of them being used to support providers on the front lines of the coronavirus response. See [NRHA Requests for HHS on CARES Act Provider Relief Funds](#)

### **COVID-19 Vaccine Distribution**

As COVID-19 continues to ravage rural America, it is imperative that all Americans have access to vaccinations, including in their primary care offices. We urge HHS to ensure rural providers have the infrastructure, resources, and training needed to adequately distribute the vaccine to rural patients. We also urge HHS to ensure vaccine delivery is equitable between rural and urban localities.

### **RHC COVID Vaccine**

We applaud CMS's efforts to ensure COVID-19 vaccine will be available for beneficiaries. One of the changes will include updates to the Medicare cost report instructions for RHC and FQHC to allow the cost pass through of the Covid vaccine cost – like was done for H1N1 a few years ago and is allowed for flu & pneumonia. We didn't see any direct reference to RHC in the released FRN, although it states they will be paid on cost. Given that it will require a change in the cost reporting forms by the vendors we wanted to flag it for your team and to see if there is anything we can do to help.

## **Drug Pricing**

### **Protect the 340B Drug Pricing Program- Contract Pharmacy**

The 340B Drug Pricing Program is pivotal to the financial success of many health care safety-net providers, especially in rural America. The program helps rural providers across the country, including more than 1,000 rural hospitals, stretch scarce resources to provide more comprehensive services and care for more patients. NRHA requests that HHS review existing policies around Medicare payment for 340B-acquired drugs and limitations on covered entities' use of contract community pharmacies.

### **Extending SCH Exception to 340B Cuts**

Rural SCHs are excepted from the Medicare OPPS 340B payment cuts, but CMS revisits this exception on an annual basis. Moreover, urban SCHs, MDHs and RRCs are subject to the adjustment. CMS said that it would watch for negative impacts on other hospitals. Urban SCHs, MDHs and RRCs share many of the same characteristics as rural SCHs, and also should be protected while CMS examines the impact. Further, leaving rural SCHs uncertain from year-to-year whether CMS will maintain this exception makes it difficult to effectively plan and maximize available resources.