National Rural Health Association

February 21, 2023

Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: End of the Public Health Emergency and Associated Flexibilities

Dear Secretary Becerra,

The National Rural Health Association (NRHA) is writing to urge the Department of Health and Human Services (HHS) to take action to ensure that rural patients and providers are prepared to move into a post-public health emergency (PHE) healthcare landscape once the PHE declaration ends on May 11, 2023 . Rural providers have benefited from the PHE flexibilities, namely the 1135 blanket waivers from the Centers for Medicare and Medicaid Services (CMS). Such flexibilities have helped rural providers overcome some of the significant challenges that they face in providing care in rural areas. Where appropriate, **NRHA asks that HHS retain certain flexibilities to continue to support rural health safety net providers and beneficiaries through regulatory action or by working with Congress to enact legislative fixes.**

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, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Facility Flexibilities

NRHA urges HHS to consider permanently waiving certain unnecessary regulations that burden rural facilities like hospitals, critical access hospitals (CAHs), rural health clinics (RHCs), federally qualified health centers (FQHCs), and skilled nursing facilities (SNFs).

- **NRHA asks that HHS work with Congress to permanently end the 96-hour average length of stay rule for CAHs.** CAHs already must meet a separate condition of payment, which requires that physicians certify upon admission that a patient can reasonably expect to be discharged within 96 hours. During the PHE the average length of stay has been waived and subsequently the annual averages at CAHs have not risen above the four-day threshold, proving that this regulation is unnecessary and superfluous.
- Provider-based RHCs affiliated with hospitals that have less than 50 beds are exempted from the payment limits established in the Consolidated Appropriations Act (CAA), 2021. Since April 2020, CMS has allowed those hospitals to go beyond the 50-bed limit without an impact to RHC payment to account for the surge in patients due to COVID-19. **NRHA urges HHS to retain this flexibility for the subset of provider-based RHCs with less than 50 beds in case of a future surge.**

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- **NRHA urges HHS to permanently allow direct admission to hospital swing beds for Medicare patients who do not require acute care but do meet SNF requirements at § 42 C.F.R. 409.31.** This 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 allowing patients in swing beds would ultimately achieve savings for providers, HHS, and beneficiaries, while supporting access and quality for patients.
- **Similarly, NRHA believes that HHS should continue to waive the 3-day hospital stay prior to Medicare coverage of a SNF stay.** This waiver has allowed strained rural hospitals to free up space for other patients and aided beneficiaries by allowing transfer to an appropriate care setting sooner.
- Additionally, HHS has allowed hospitals with more than 100 inpatient beds to provide swing bed services during the PHE. **NRHA urges HHS to allow rural hospitals with more than 100 beds to continue to use swing beds** to transition beneficiaries who meet the criteria for skilled nursing and provide that level of care within the facility. When rural hospitals have the capacity and resources, and local SNF beds are scarce, the hospital should be able to furnish swing bed services so that beneficiaries can receive the appropriate care that they need.
- HHS should continue providing flexibilities for rural hospitals and CAHs related to verbal orders by permanently waiving the requirements at 42 CFR §§ 482.23, 482.24 and 485.635(d)(3). Simplifying rules around verbal orders will make treating rural beneficiaries more efficient for overworked rural practitioners.
- Discharge planning requirements were simplified for hospitals and CAHs during the PHE. Overly complicated discharge planning is a burden for rural providers that are already strained and often wear multiple hats. **HHS should curtail its detailed information sharing regulations by continuing to waive 42 CFR §§ 482.43(a)(8), 482.61(e), and 485.642(a)(8). HHS should also consider streamlining the discharge planning rules for post-acute care at 42 CFR § 482.43(c).** Patients will still receive discharge plans under 42 CFR § 482.43(a)(1)-(7) and 482.43(b) to ensure that they are discharged to an appropriate setting that meets their health goals and needs.

Workforce

HHS issued a number of workforce waivers for rural hospitals, CAHs, RHCs, FQHCs, and SNFs. NRHA believes that some of the waivers should be made permanent to reduce rural provider burdens and facilitate efficient workflows while also balancing patient safety and outcomes.

- HHS waived the physical presence requirement in 42 C.F.R. § 485.631(b)(2) which has allowed physicians in CAHs to provide medical direction, consultation, and supervision of services remotely. NRHA urges HHS to make this waiver permanent and also incorporate the change into rural emergency hospital (REH) conditions of participation at 42 C.F.R. § 485.528(c)(2).
- 42 C.F.R. 491.8(b)(1) states that physicians in rural health clinics (RHCs) must provide medical supervision of health care staff. During the PHE, this requirement was waived for nurse practitioners (NPs). In order to use NPs to the fullest extent possible, HHS should consider making this waiver permanent. **Allowing NPs to practice at the top of their**

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license and training allows physicians to tend to other clinic tasks while still ensuring patients receive the care that they need. HHS should work to remove unnecessary barriers to NP practice, especially where federal regulations are more restrictive than state scope of practice laws.

- **NRHA recommends that HHS permanently allow certified registered nurse anesthetists (CRNAs) to practice without physician supervision of their services.** Permanently waiving supervision requirements can help improve health equity and access to care. CRNAs are the predominant anesthesia providers in underserved areas, and they also provide obstetrical services, surgical services, trauma stabilization, and pain management. Additionally, states have been able to opt-out of this federal requirement and currently almost half of all states have an opt-out agreement in place.
- Long-term care workforce shortages remain an issue across the country, especially in rural areas. **NRHA urges to HHS to consider retaining the waiver for temporary nursing aides (TNA) to become certified within four months of employment in rural facilities with a modification.** NRHA suggests that HHS may make an exception to the requirement for rural facilities specifically to allow TNAs 12 months to become certified as a certified nursing assistant with proof of coursework towards certification.
- **HHS should modify 42 C.F.R. § 410.32(b)(3)(ii) to make virtual supervision by a physician (or non-physician practitioner [NPP] as allowable under state law) for diagnostic tests that need direct supervision available permanently at hospitals and CAHs.** Currently, this flexibility will terminate at the end of the calendar year in which the PHE ends.
- **At SNFs, physicians should remain able to delegate all tasks to NPPs.** HHS should remove 42 C.F.R. § 483.30(e)(4), which was waived until May 2022, so that physicians may delegate all tasks in SNFs to physician assistants, nurse practitioners, or clinical nurse specialists within applicable state scope of practice laws. HHS should provide guardrails in § 483.30(e)(1) to specify that all delegation must happen under physician supervision.
- Additionally, until May 2022, HHS waived 42 C.F.R. § 483.30(c)(3) and allowed NPPs to perform physician visits in SNFs. **HHS should permanently allow NPPs to perform SNF physician visits.** NPPs performing 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. For rural SNFs, HHS must also authorize physician visits to be furnished via telehealth depending on patient circumstances and practitioner availability.

Telehealth

In general, NRHA supports the expanded use of telehealth available during the PHE. We were pleased to see the extension of Medicare telehealth flexibilities through December 31, 2024, in the Consolidated Appropriations Act of 2023 (CAA, 2023), but encourage HHS to work with Congress to make such changes permanent. Notably, NRHA asks that HHS do the following:

- During the PHE, RHCs and FQHCs have been able to serve as distant sites for telehealth and HHS must work alongside Congress to continue this policy. **NRHA strongly supports permanently authorizing RHCs and FQHCs as distant sites** beyond December 31, 2024. In

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conjunction with permanent authorization, HHS should reevaluate its reimbursement and coding methodologies for telehealth services to pay RHCs and FQHCs their all-inclusive rates and count telehealth services as face-to-face encounters.

- **HHS must maintain audio-only telehealth for certain services past the December 31, 2024, date established by Congress.** NRHA urges HHS to adopt a broader reading of the Social Security Act § 1834(m)(2)(A) such that audio-only services are retained permanently. NRHA suggests that CMS allow audio-only for telehealth visits for circumstances in which a beneficiary does not consent to audio-video technology or is not capable due to broadband or other connectivity resource issues. Providing audio-only options can lessen health disparities, increase access, and incentivize care seeking for rural populations.
- **HHS should also permanently expand the practitioners eligible to furnish telehealth services to include occupational therapists, physical therapists, speech-language pathologists, and audiologists.** HHS must work with Congress to allow these practitioners to use telehealth beyond the December 31, 2024, date in the CAA, 2023. Long-standing provider shortages in rural areas have made services, like those furnished by the practitioners above, difficult to access for rural beneficiaries. Continued availability of telehealth services
- NRHA strongly supports the proposed rule from the Substance Abuse and Mental Health Services Administration that would authorize opioid treatment programs to virtually prescribe buprenorphine and methadone after the PHE ends.
- Relatedly, **NRHA urges HHS to work with Drug Enforcement Agency to allow DEA-registered practitioners to continue to prescribe controlled substances via telehealth**, including buprenorphine with audio-only technology. Studies have started to show that prescribing medications for opioid use disorder via telehealth during the PHE had positive outcomes and did not lead to an increase in overdose deaths or misuse.[1] For OTPs mentioned above and DEA-registered practitioners, using telehealth expands treatment options to rural residents experiencing opioid use disorder. Behavioral health workforce shortages are a challenge in rural, especially for practitioners that can prescribe controlled substances. Prescribing medications for opioid use disorder via telehealth ensures rural residents have more equal access to lifesaving medications and can seek treatment without travel burdens.

COVID-19

COVID-19 will likely become another respiratory virus, like the cold and seasonal flu, that surges and declines annually. Despite the COVID-19 PHE ending, it is clear that COVID-19 will remain a threat, particularly to seniors, the immunocompromised, people with chronic conditions, the uninsured and underinsured, racial and ethnic minorities, and people with disabilities. In alignment with its commitment to health equity, HHS must ensure that those most at risk have access to the full suite of preventive measures and treatment options at little to no cost. To do so, HHS should:

- Continue coverage of up to 8 over the counter at-home COVID-19 tests for Medicare beneficiaries every month. At-home COVID-19 tests serve as a more convenient option for

[1] https://nida.nih.gov/news-events/news-releases/2022/08/increased-use-of-telehealth-for-opioid-use-disorder-services-during-covid-19-pandemic-associated-with-reduced-risk-of-overdose and https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800689?source=email.

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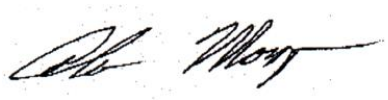
rural beneficiaries who may otherwise travel longer distances to receive a COVID-19 lab-based test. Without a quick, accessible option for COVID-19 tests, NRHA is concerned that high-risk, older rural adults will forgo testing and ultimately not receive COVID-19 treatment when it is needed.

- Continue allowing rural hospitals and CAHs to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19 by waiving enforcement of § 1867(a) of the Emergency Medical Treatment and Labor Act.

NRHA thanks CMS for its continued support of rural communities across America. We look forward to working towards our mutual goal of improving quality and access to care. If you would like additional information, please contact Alexa McKinley at amckinley@ruralhealth.us.

Sincerely,



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