

## Headquarters

7015 College Blvd.; Suite 150  
Overland Park, KS 66211  
Telephone: [816] 756.3140  
FAX: [816] 756.3144



## Government Affairs Office

50 F St., N.W. Suite 520  
Washington, DC 20001  
Telephone: [202] 639.0550  
FAX: [816] 756.3144

# NATIONAL RURAL HEALTH ASSOCIATION

January 22, 2021

The Honorable Charles Schumer  
Majority Leader  
United States Senate  
Washington, DC 20510

The Honorable Nancy Pelosi  
Speaker of the House  
United States House of Representatives  
Washington, DC 20515

The Honorable Mitch McConnell  
Minority Leader  
United States Senate  
Washington, DC 20510

The Honorable Kevin McCarthy  
Minority Leader  
United States House of Representatives  
Washington, DC 20515

Dear Majority Leader Schumer, Speaker Pelosi, Leader McConnell, and Leader McCarthy:

### **Additional rural health care provider relief is needed in the next COVID-19 relief package.**

Hundreds of hospitals remain on the brink of closure as COVID-19 continues to ravage rural America. As COVID-19 outbreaks continue to spread in rural communities, the rural health care safety net remains highly vulnerable as providers continue to lose revenue. Prior to the pandemic, rural hospital closures were at crisis levels, and that continued through 2020 with an additional 18 hospital closures last year alone. When a rural hospital closes, the mortality rate in that community increases, nearly a quarter of the local economy vanishes, and disinvestment in the community ensues.

To ensure the stabilization of rural health care, the National Rural Health Association (NRHA) calls for the following actions:

#### **I. Address issues with the rural health clinic (RHC) program.**

- a. Provide technical corrections to Section 130 of the year-end, 2020 appropriations and COVID-19 relief bill.** Included in Section 130 were provisions increasing the freestanding RHC payment limit to \$100 beginning April 1, 2021, taking it to \$190 in 2028. NRHA is supportive of these provisions for freestanding RHCs, however the change also subjects all "new" RHCs, both freestanding and provider-based (created after December 31, 2019), to the new per-visit cap. This eliminates the long-standing exemption of payment limit for new provider-based RHCs. The limitation has significant implications on the provider-based RHC program and may reduce hospitals and health resources, jeopardizing the ability to sustain these safety net providers in the long-term.

NRHA believes that Congress needs to address the date change as soon as possible. ***NRHA asks that Congress change the effective date for “new” RHCs, both freestanding and provider-based, to April 1, 2021.*** That will give hospitals currently in the process of converting provider-based RHCs an opportunity to address their planning and complete pending conversions. During a global pandemic, disproportionately impacting rural America, as much flexibility should be given to rural providers as possible.

**b. NRHA encourages Congress to take action to bring the RHC program into the 21<sup>st</sup> Century with the following modernizations:**

- i. NRHA asks that Congress allow all RHCs to serve as distant-site providers for purposes of Medicare telehealth reimbursement and to set reimbursement for these services at their respective All-Inclusive Rate (AIR). Additionally, these services should be counted as a qualified encounter on the Medicare cost report.
- ii. NRHA asks that Congress continue cost-based reimbursement without a per-visit cap in exchange for requiring provider-based RHCs reporting of quality measures, perhaps per the Uniform Data System (UDS) or another like systems. Provider-based RHCs would use the higher rate to pay for their participation in the program.
- iii. NRHA asks that Congress create an option for low-volume facilities (perhaps those meeting frontier and/or volume threshold) to automatically be eligible to receive a provider-based designation exception to address low-volume issues.
- iv. Modernize physician, physician assistant, and nurse practitioner utilization requirements to allow for arrangements consistent with State and local law relative to practice, performance, and delivery of health services.
- v. Allow RHCs the flexibility to contract with physician assistants and nurse practitioners, rather than solely employment relationships.
- vi. Remove outdated laboratory requirements.

**II. Provide relief payment equity to support rural providers.**

- a. **Include a 20 percent rural carveout within the Provider Relief Fund (PRF).** The PRF has served as a critical lifeline for rural providers throughout the COVID-19 public health emergency (PHE). As rural providers care for 20 percent of the population, or 60 million Americans, NRHA believes that establishing a 20 percent rural carveout for these funds is necessary. Priority would be granted to rural facilities who provide care for patient populations especially vulnerable to COVID-19. NRHA asks that leadership use the ***Save Our Rural Health Providers Act*** ([S. 3823](#)/[H.R. 7004](#)), from the 116<sup>th</sup> Congress, as the foundation for this provision.
- b. **Support additional funding for COVID-19 vaccination deployment, testing, tracing, and mitigation programs through the Centers for Disease Control and Prevention (CDC) with a rural set aside.** NRHA asks that any additional funding provided to address the COVID-19 pandemic through vaccination deployment, testing, tracing, and

mitigation programs be accompanied by language directing equitable funding go toward rural America. At a time when COVID-19 is ravaging rural America particularly hard, it is imperative that Congress provide rural America with the tools they need to adequately combat the ongoing pandemic.

- i. To disperse funding quickly and appropriately to rural America, NRHA asks that Congress create an Office of Rural Health within the CDC to provide leadership and coordination for rural health during the PHE response and beyond.
  - ii. Use existing Federal grant programs in the Federal Office of Rural Health Policy to provide COVID-19 relief to rural communities through: supplementing existing Outreach grants to do contact tracing, vaccine campaign, and deployment of Community Health Works (CHW); and provide resources for vaccine distribution, education, and administration through the Small Hospital Improvement Program, and RHCs through the existing PRF.
- c. Provide additional and sufficient funding for workforce programs.** NRHA asks Congress to provide additional funding for programs like the National Health Service Corps and the Nurse Corps Loan Repayment Program to help place rural providers for the remainder of the PHE.

### **III. Provide stabilizing relief for rural providers to abate the rural hospital closure crisis.**

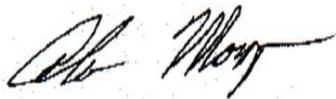
- a. Include a provision allowing the most vulnerable rural hospitals to convert to critical access hospital (CAH) designation.** The year-end 2020 appropriations and COVID-19 relief bill included the creation of the Rural Emergency Hospital (REH) model. NRHA is excited about the opportunity this new payment model brings for a select number of rural providers, but more is needed. While we believe this is a viable, important option for some providers, it is not a large-scale payment model designation, and it is not something that can be obtained by struggling rural providers until January 2023, at the earliest. In the immediate short-term, struggling rural providers need support. NRHA believes that by ***reinstating necessary provider status, which removes the 35-mile limit for CAH designation***, about 200 of the nation's most vulnerable rural hospitals would be able to transition to a more sustainable payment model. This relief could provide the necessary support needed for many rural providers to be there for their communities through the remainder of the PHE. NRHA asks that leadership use the ***Rural Hospital Closure Relief Act of 2019*** ([S. 3103/H.R. 5481](#)), from the 116<sup>th</sup> Congress, as the foundation for this provision.
- b. Continue important CARES Act telehealth provisions beyond the duration of the PHE.** Included in the March 2020 COVID-19 relief bill, commonly referred to as the CARES Act, were important provisions which allowed Federally Qualified Health Centers (FQHC) and RHCs to provide distant site telehealth services for the first time, but only for the duration of the PHE and only through a "special payment rule." Unfortunately, as briefly mentioned above, this special payment rule for RHCs and FQHCs cause unnecessary administrative burden, generates inaccurate claims data, and strongly incentivizes in-person visits over telehealth. To ensure rural patients have full access to the benefits of telehealth, it is ***imperative that RHCs and FQHCs remain distant site providers after the PHE and be reimbursed at their AIR***. NRHA asks

***Congress to extend permanently the important CARES Act telehealth provisions*** and update Medicare payment so it incentivizes utilization of the services.

- i. NRHA also asks that Congress enhance the HHS Office for the Advancement of Telehealth to include language allowing this office to advise the Secretary on telehealth issues including the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in the programs established under titles XVIII and XIX that affect the appropriate use of telehealth and telehealth-related technologies to improve access to high-quality health care services and help broaden the use of the health care workforce. Additionally, this office should have the ability to administer grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to advance the use of telehealth broadly.
- c. **Allow rural hospital to receive Paycheck Protection Program (PPP) dollars.** The PPP, created by Congress in the CARES Act, has been a lifeline for many struggling rural hospitals. However, some rural hospitals have been denied access to this crucial program because their affiliation with a larger system causes them to surpass the 500-employee threshold. By waiving this affiliation rule, Congress would extend this financial lifeline to hundreds of rural hospitals vulnerable to closure. NRHA asks that leadership use the ***PPP Access for Rural Hospitals Act*** ([S. 4217/H.R. 7208](#)), from the 116<sup>th</sup> Congress, as the foundation for this provision.
- d. **Continue Medicare sequestration relief beyond March 31, 2021.** The year-end 2020 appropriations and COVID-19 relief package continued relief from the two percent sequestration on Medicare payments. NRHA calls on Congress to continue Medicare sequestration relief until at least December 31, 2021, as we know the pandemic is likely to continue well into the summer and fall.

On behalf of our 21,000 members nationwide, which encompasses every component of America's rural health care infrastructure, including rural community hospitals, CAHs, health clinics, doctors, nurses, and patients, NRHA implores you to take these important actions to stabilize rural health care providers.

Sincerely,



Alan Morgan  
Chief Executive Officer  
National Rural Health Association